University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	29/11/2022
Time	9:00 - 13:20
Location	Conference Room, Heartbeat/Microsoft Teams
Chair	Jenni Douglas-Todd

1	9:00	**Chair's Welcome, Apologies and Declarations of Interest** Note apologies for absence, and to hear any declarations of interest relating to any item on the Agenda.
2		**Staff Story** The 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	9:20	**Minutes of Previous Meeting held on 29 September 2022** Approve the minutes of the previous meeting held on 29 September 2022
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	9:30	**Briefing from the Chair of the Charitable Funds Committee (Oral)** Dave Bennett, Chair
5.2	9:35	**Briefing from the Chair of the Finance and Investment Committee (Oral)** Jane Bailey, Chair
5.3	9:40	**Briefing from the Chair of the Quality Committee (Oral)** Tim Peachey, Chair
5.4	9:45	**Chief Executive Officer's Report** Receive and note the report Sponsor: David French, Chief Executive Officer
5.5	10:05	**Integrated Performance Report for Month 7** Review and discuss the Trust's performance as reported in the Integrated Performance Report. Sponsor: David French, Chief Executive Officer

5.6 **Finance Report for Month 7**

10:35 Review and discuss the finance report
Sponsor: Ian Howard, Chief Financial Officer

5.7 **People Report for Month 7**

10:45 Review and discuss the people report
Sponsor: Steve Harris, Chief People Officer

6 **Break**

10:55

7 **Infection Prevention and Control 2022-23 Q2 Report**

11:05 Review and discuss the report
Sponsor: Gail Byrne, Chief Nursing Officer
Attendees: Julian Sutton, Interim Lead Infection Control Director/Julie Brooks, Head of Infection Prevention Unit

8 **Medicines Management Annual Report 2021-22**

11:15 Receive and discuss the report
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: James Allen, Chief Pharmacist

9 **Equality, Diversity and Inclusivity (EDI) Update including Workforce Race**
11:25 **Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Results 2022**

Receive and discuss the reports
Sponsor: Steve Harris, Chief People Officer
Attendee: Ceri Connor, Director of OD and Inclusion

10 **Annual Ward Staffing Nursing Establishment Review**

11:35 Discuss and approve the review
Sponsor: Gail Byrne, Chief Nursing Officer
Attendee: Rosemary Chable, Head of Nursing for Education, Practice and Staffing

11 **Guardian of Safe Working Hours Quarterly Report**

11:45 Receive and discuss the report
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Diana Hulbert, Guardian of Safe Working Hours and Emergency Department Consultant

12 **Learning from Deaths 2022/23 Quarter 2 Report**

11:55 Review and discuss the report
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Ellis Banfield, Associate Director of Patient Experience

13 **Freedom to Speak Up Report**

12:05 Review and discuss the report
Sponsor: Gail Byrne, Chief Nursing Officer
Attendee: Christine Mbabazi, Equality & Inclusion Adviser/Freedom to Speak Up Guardian

14 **Annual Assurance Process and Self-assessment against the NHS**
12:15 **England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)**

Review and discuss the report
Sponsor: Joe Teape, Chief Operating Officer
Attendee: John Mcgonigle, Emergency Planning & Resilience Manager

15 **STRATEGY and BUSINESS PLANNING**

15.1 **Board Assurance Framework (BAF) Update**
12:25 Review and discuss the update
Sponsor: Gail Byrne, Chief Nursing Officer
Attendee: Craig Machell, Associate Director of Corporate Affairs and Company Secretary

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

16.1 **Register of Seals and Chair's Actions Report**
12:35 Receive and ratify
In compliance with the Trust Standing Orders, Financial Instructions, and the Scheme of Reservation and Delegation.
Sponsor: Jenni Douglas-Todd, Trust Chair

16.2 **Review of Standing Financial Instructions 2022-23**
12:40 Review and approve the SFIs
Sponsor: Ian Howard, Chief Financial Officer
Attendee: Phil Bunting, Director of Operational Finance

16.3 **Corporate Governance Update**
12:50 Receive and discuss the update
Sponsor: Gail Byrne, Chief Nursing Officer
Attendee: Craig Machell, Associate Director of Corporate Affairs and Company Secretary

17 **Any other business**
13:00 Raise any relevant or urgent matters that are not on the agenda

18 **Note the date of the next meeting: 31 January 2023**

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

19.1 **CRN: Wessex 2022-23 Q2 Performance Report**
Note the report
Sponsor: Paul Grundy, Chief Medical Officer

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

Sponsor: Jenni Douglas-Todd, Trust 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.

21 **Follow-up discussion with governors**

13:05

University Hospital Southampton
NHS Foundation Trust

Minutes Trust Board – Open Session

Date	29/09/2022
Time	9:00 – 13:00
Location	Microsoft Teams
Chair	Jenni Douglas-Todd (JD-T)
Present	Jane Bailey (JB), Non-Executive Director (NED) Gail Byrne (GB), Chief Nursing Officer Cyrus Cooper (CC), NED (from item 5.4 part two) Jenni Douglas-Todd (JD-T), Chair 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 Ian Howard (IH), Chief Financial Officer Tim Peachey (TP), NED Joe Teape (JT), Chief Operating Officer
In attendance	Jane Fisher, Head of Health and Safety Services (JF) (for item 7.3) Sarah Herbert, Deputy Chief Nursing Officer (SHe) (for item 5.7) Femi Macaulay (FM), Associate NED Corinne Miller, Named Nurse for Safeguarding Adults (CM) (for item 5.8) Karen McGarthy, Named Nurse for Safeguarding Children (KMcG) (for item 5.8) Christine McGrath (CMcG), Director of Strategy and Partnerships Helen Potton, Associate Director of Corporate Affairs and Company Secretary (Interim) (HP) Helen Ralph, Manager, Transformation Team (HR) (for item 6.1) Annabel Shawcroft, Clinical Programme Officer, Transformation Team (AS) (for item 6.1) Jason Teoh, Director of Data and Analytics (JTe) (for item 5.11) Diana Ward, Clinical Outcomes Manager (DW) (for item 5.10) One member of the public (observing) 3 governors (observing) 5 members of staff (observing) 1 members of the public (observing)
Apologies	Dave Bennett (DB), NED

1. Chair's Welcome, Apologies and Declarations of Interest

JD-T welcomed all those attending the meeting which was being held by Microsoft Teams. Apologies were received from DB. CC would be joining the meeting later.

2. Patient Story

HP introduced the Patient Story which focused on the experience of a mother and daughter who had used the Trust's services. Mum advised that during the pandemic, her daughter had been diagnosed with cancer in her abdomen at the age of nine years old.

Her daughter had surgery followed by nine rounds of chemotherapy at the Trust followed by radiotherapy in London. Whilst on maintenance chemotherapy her daughter had relapsed and sadly a decision was made that further treatment would not be beneficial.

Her daughter's response was to write a "bucket list". Some of the items were for herself but some related to changes that she wanted for other people including wanting parents to be fed. Her daughter could not understand why, when she was asked what she wanted to eat, that this did not extend to her mum, when her mum was in the hospital supporting her. Her daughter had not wanted mum to leave to go and eat, and no one else could come to sit with her because of the COVID restrictions. Her daughter was scared and going through gruelling treatment and that made it very difficult for mum to leave her. In addition, her treatment had affected her smell, making her feel unwell which resulted in her mum eating in the ensuite toilet as there was nowhere else to sit and eat.

After her daughter died, mum had been working on items from her daughter's bucket list, with senior representatives of the NHS. Work focused on putting in place a national programme to feed parents, improve food for children and also the provision of play specialists.

In terms of food, mum had been working with UHS' Patient Support Hub since January. Initially snack and toiletry boxes were put into every parent room but now, every children's ward across Portsmouth and Southampton, a total of 17 wards, received food and drink every week.

A charity, Sophie's Legacy, had been set up and a trial had started that provided parents with a £4 food voucher for the restaurant, which was in addition to the support provided by the Patient Support Hub. The initiative had been well received by parents. The hope is to roll this out across the Country as looking after parents was important to enable them to support the care of their children.

JD-T thanked mum for sharing noting how devastating it must have been to lose her daughter and how amazing it was that she and her daughter had wanted to support others in this difficult time. GB also thanked mum for sharing the experience and the work that was being done in her daughter's name, which was important to continue.

DAF noted how extraordinary that at the age of nine her daughter was considering the future of others. DAF asked whether mum had good links with the hospital charity and SH confirmed that he would make contact to ensure that this happened.

Action: SH

JT noted the importance of good facilities being available including good quality, affordable food. It was important for the Board to look at this and also to look at the estate to ensure that there was appropriate spaces provided for parents.

3. Minutes of the Previous Meeting held on 28 July 2022

The minutes of the meeting held on 28 July 2022 were approved as an accurate record of the meeting save for the following amendments:

- Page 3 – Correct spelling of Beachcroft
- Page 3 – 5.3 third bullet – should read compliant not complaint.

4. Maters Arising and Summary of Agreed Actions

Actions that were due had been completed.

Action 763 – The complaint data was being compiled and would be sent out shortly.

The remaining actions were not yet due but were being taken forward.

5. QUALITY, PERFORMANCE and FINANCE

5.1 Briefing from the Chair of the Audit and Risk Committee

KE provided a briefing following the meeting on 12 September. The External Auditors had signed off their opinion on the financial statements with a clean opinion being given.

From the Internal Auditors three reviews had been completed. The incident management review had focused on smaller incidents, noting that major incidents would normally be highlighted quickly. A large number had been tested and the conclusion was that the Trust needed to work on turning the reports around within the ten-day period.

The Cyber Security review was one of significant assurance. However, the report highlighted that the Trust did not have formal documentation in terms of a Cyber Security Strategy and that not much training was provided for staff. Finally, in terms of General Data Protection Regulation (GDPR) and personal information, the Trust was required to have a "record of processing activities" (ROPA). The Trust undertook hundreds of activities but did not have a ROPA for every activity and the recommendation was to review and put in place an appropriate policy to enable a more general approach for wider coverage.

The final review was stage 2 of how the Trust managed and governed IT projects. The report had focused on three areas:

- The initial assessment of the benefits of the IT project which had been found to be thorough and well thought out and documented.
- More guidance was recommended on how to evaluate benefits particularly in terms of non financial benefits including safety benefits.
- There were very few post benefit assessments being completed which would help with learning.

Plans were in place to put additional controls in place by March 2023 and a review would take place as part of their follow up procedures.

JT reminded members that he had arranged for Cyber training for the Board and had agreed to provide further assurance around some of the arrangements and the Internal Audit was aligned to this. JT noted that staffing arrangements would need to be reviewed as currently there was only one colleague within the digital team that worked on cyber security issues. HP informed the Board that work was already underway in terms of the work around ROPAs.

Action: JT

5.2 Briefing from the Chair of the Finance and Investment Committee

JB provided an update from the last meeting noting that discussions had taken place around the current financial position and the operational plan, both of which were due to be discussed in the closed board meeting.

There was significant challenge particularly around the deficit position but overall there was a really good grip on exactly where the Trust currently was, with appropriate decisions being made to reflect the balance between managing the financial position, whilst continuing to support our people and activity. A number of ongoing actions around productivity were being addressed together with a clearer view of the future cash position of the Trust.

Finally, JB noted that Model Hospital data had been reviewed to enable the Trust to drive efficiencies compared to other hospitals and to facilitate learning.

5.3 Chief Executive Officer's Report

DAF noted that this was the first time that the Board had met since the death of Her Majesty Queen Elisabeth II and wanted to formally recognise the fantastic public service that she had given.

The state funeral, which gave an additional bank holiday, provided the Trust with some challenging operational issues, with little guidance being provided in terms of what the best approach should be. Where staff were not involved in urgent or emergency care, such as within outpatients, electives and day case procedures, they were given the choice that if they wanted to work that would be gratefully received, but similarly if they wanted to take the day off to pay their respects, they were able to. Some staff wanted to work and others wanted to take the day. More than two thirds of the scheduled activity had been undertaken. DAF thanked all staff for all of their hard work and dedication.

He also noted that:

- The pilot of the care village had been very successful and would be discussed further in the next item.
- Junior doctor pay rates had been quite challenging and was symptomatic of where the Trust was with many members of the workforce. The Royal College of Nursing (RCN) had notified the Trust of an intended ballot for strike action. Also, the British Medical Association (BMA) had published a rate card that they wanted trusts to pay, which was in many cases, significantly above current ratees. DAF noted that there were groups of staff who had indicated that they would not work for the Trust unless paid the new rates. It was a period of instability and people were understandably wanting to protect their income which was manifesting in the behaviours that we were seeing.
- The HR team had been recognised by the Chartered Institute of Professional Management (CIPD), for a National awards which was a testament to the good work that SH and his team did.
- The number of COVID positive cases was increasing with around 70 currently in the hospital. Mask wearing had been re-introduced in clinical areas in an attempt to limit the number of nosocomial transmissions. Care homes were not willing to accept patients with COVID which would impact potential discharges. In terms of staff

absence from COVID this was also increasing and staff were being encouraged to have both COVID and influenza vaccinations.

- UHS was in the process of finalising an IT contract which, at first glance looked like it could be a replacement for our Emergency Department (ED) IT system. The initial contract was small but included from a strategic perspective, as the Trust had recognised the potential for having a longer-term development partner. UHS remained committed to its "Best of Breed" strategy but had been struggling to recruit and retain the people needed to develop the systems and this could be a step to delivering this by working together in partnership. Ultimately this could result in UHS not only being able to bring to develop our systems but also had the potential to bring to the market a number of our IT products that we had developed.
- At the previous month's board, the Trust had been aware of its segmentation under the Single Oversight Framework (SOF) review, but had omitted to formally advise the board. The Trust remained in segment 2, with 1 being good and 4 being bad. Trusts in segments 3 and 4 received more dedicated support and oversight. This was a vote of confidence from the regulators in the Trust despite the challenges it was facing.

TP noted that the BMA pay card had received much criticism and should be resisted unless there was a proper negotiation about the rates. In terms of the IT partnership this was excellent news.

PG noted that the Trust had been very clear through the Local Medical Councils (LMC), and individual conversations with teams, that the Trust would not be entering into negotiations about the BMA rates. It was growing as an issue but was an untenable position to hold in front of the rest of the workforce. Meetings were taking place with teams noting that it was not just about money. PG had been clear with his medical consultant colleagues that he was not able to recommend that consultants were paid as much in one day for an overtime operating list, which was greater than the amount some staff received in a month. In a cost-of-living crisis this was wrong. Many colleagues had understood this approach but there was still many who were very unhappy.

JH congratulated SH for the award noting that this was a very difficult award to achieve, with tough competition, and that to achieve it during the pandemic was outstanding.

Decision: The Board noted the report.

5.4 Integrated Performance Report for Month 5 (part one)

JT noted the challenges that the Trust was currently under and in particular highlighted:

- The previous day had been particularly tough with every space in the hospital full and lots of patients in the ED waiting for beds. This was replicated nationally with many organisations had declared critical incidents due to the pressures being faced. It was caused by increased numbers of COVID positive patients and a big spike in the number of delayed patients in the hospital which had hit 245 patients at the start of the week, with almost a quarter of the bed base who could be treated elsewhere.

- There was a record number of cancer referrals with the waiting list being the highest it had ever been. The Trust continued to deliver more diagnostic capacity than it had ever delivered but continued to struggle with capacity in view of the increased demand. This was a very difficult position alongside a time where staff morale was low and staff were tired due to the pressures over the last couple of years.
- One of the two spotlights related to cancer and the Board had a study session the following week with a deep dive. Referrals had grown by about 25% per month from around 1600 two-week referrals to consistently above 2000 per month. The backlog of patients who had breached 62 days had gone up three-fold in the last two years from around 100 to 370 patients. The overall number of patients on the cancer pathway had also doubled in this period. This was challenging for a group of patients that the Trust wanted to prioritise in terms of access to services and care.
- Across the Wessex Alliance footprint the backlog remained better than the rest of the Country but it was not where we would want to be in terms of cancer services. It was likely that our performance would dip as we started to treat those patients which would impact the 62 day target, despite the levels of activity and delivering relatively well in terms of our peer groups.
- There were some excellent new pathways being developed including the dermatology dream pathway which would make a significant impact on the skin pathway once implemented. Work was also being done with the cancer allowance to map what we had, against what we needed to understand better the gaps.

DAF noted that the cancer performance metrics were a measure of the patients that had been treated. Once you had a number of patients above the 62 days, if you did not treat them and let them remain on the waiting list. your measure would remain strong. However, this was not the right thing to do but once you had treated them this would impact that metric which was likely to be poor over the coming months.

TP noted that the waiting had continued to get bigger which would suggest that either the Trust was not coping with the numbers coming through and people were therefore waiting longer and longer or that there was a higher rate of cancer in the population. Was this as a result of COVID reducing the body's ability to fight small cancers that would normally disappear. JD-T also noted the highest number of referrals happening in August and wondered whether there was any national modelling being done around this.

JT informed members that Professor Peter Johnson would be one of the presenters at the board study session and this would be a good opportunity to explore this. Anecdotally we appeared to be seeing more sicker patients who had a number of co-morbidities presenting as more complex patients and work was underway to investigate this further particularly from an inequality lens in terms of the demographics that were being referred on the two week wait referrals.

PG noted that during COVID people tended to not present which was part of the reason for a backlog of presentations but that diagnosis appeared to also be increasing. Understanding why was not yet known and a discussion in the study session would be helpful to understand that particularly better.
In terms of the appraisals spotlight SH noted:

- That a key element from the People Strategy was the Trust's ability to provide meaningful progression for our staff. From the feedback given in the staff survey many staff believed that during the pandemic they had not received the development, training or the appraisal focus that they would have wanted.
- Work to address that included a multi disciplinary team who had focused on refreshing the appraisal paperwork which had been well received. The team had a wide breadth of staff including clinical, operational and trade union representatives. Previously the number of appraisals carried out had been good but the quality had been low so training for appraisals had been reviewed to improve the quality of the appraisal discussion. Whilst the Trust was better than its peers, this simply highlighted that the NHS was not particularly good at appraisals.
- A pilot had been implemented to better align appraisals with objective setting to enable them to cascade down to staff better which would conclude shortly and would feed into the process.

JD-T noted that Division D consistently outperformed the other Divisions in terms of completed appraisals. In addition the staff survey showed that they were the only division that achieved a green in terms of an appraisal helping staff to undertake their job. This showed a correlation between the two and wondered what was the learning was. SH noted that Division D had historically had good rates of completion and had been involved in the refresh and had highlighted the need to focus at every level of the team.

JH asked whether those within Division D had better promotion and development opportunities which could link back into the value of conducting a good appraisal. SH advised that there was nothing obvious but Division D had some good engagement scores overall but this could be looked at further.

GB noted that the new appraisal paperwork had removed the need to consider how an individual contributed to the values of the organisation, and although the values were still referenced, questioned how through appraisal the behaviours and values continued to sit within the process. SH noted that the review of the values work was important and it would be good to look at how that could be brought back into the appraisal process to add value.

Decision: The Board noted the report.

5.5 Finance Report for Month 5

IH presented the report and highlighted:

- The Trust continued to focus on the underlying deficit, which for months 1 – 4 had been around £3m which had slightly worsened to £3,5m as energy costs started to grow. A deep dive had taken place at the Finance & Investment (F&I) Committee looking at some of the actions being undertaken and some of the future forecasts before the energy cap would come in and whether this would help or otherwise. There would still be a small increase in run rate into the latter half of the year which would deteriorate the Trust's underlying position as we entered the winter months.
- The key drivers were consistent. As well as energy prices, there were some drug costs pressures as we were on a block contract, cost associated with COVID including backfill of staff together with all of the operational pressures that had already been discussed.

- Cost Improvement Programme (CIP) performance had improved following the introduction of the Cost Savings Group. The Trust was currently achieving more than 80% identified which should increase going forward. In month delivery had also been strong. Everything was being done to try and improve the financial position but there were a number of pressures that were outside our control that would impact this.
- Elective recovery framework performance had dipped in line with the operational pressures discussed, but UHS continued to achieve 106%, above the required 104%. UHS was in the top Trusts both in the region and nationally in terms of activity levels compared to 2019/20 levels. However, this was not resolving the waiting list issue that continued to grow. UHS continued to do well in terms of 2019/20 levels compared to other Trusts but this did create a financial pressure.
- The Trust had reported a £12m deficit. The Hampshire and Isle of Wight deficit was £53m. This was an outlier within the region, and the region was an outlier nationally. This had resulted in the system becoming an outlier in terms of financial performance which might have adverse consequences going forward including upon the SOF rating.
- The underlying deficit reduced the Trust's cash balance and that may put pressure on our future capital investment programme.

KE referred to the financial risks table and asked what the difference was between the original worst case of £57m and the forecast assessments which showed, best, intermediate and worst case? IH noted that the original worst-case scenario had been presented to the Board as part of the planning submissions, to show the range of possible financial outcomes with everything that was known at the time. The current best, intermediate and worst case were the current assessments.

KE noted that UHS could not control COVID costs, energy costs and inflationary measures and that this would need Treasury to provide support. IH reminded members that nationally there was a drive to find efficiencies. It was likely that many Trusts would go into deficit this year but it was not clear what the response would be to that.

KE commended the work on the CIP which was a fantastic achievement. He questioned whether the position could improve further with more CIP savings. IH advised that a target date of Month 6 had been agreed in terms of everything being identified 100% and the position might improve next month.

IH noted that UHS was at 106% activity levels with the national average being around 94%. The 12% from the Elective Recovery Fund (ERF) would be worth about £20m to the Trust. If the Trust had undertaken less activity the Trust's financial position would be a lot less stark but UHS continued to put patients first and try and balance performance, money and quality.

In response to a question from JD-T IH confirmed that as of today and what was currently known, UHS could still achieve the best-case scenario.

DAF suggested that in view of what had happened in markets over the recent days it was unlikely that the NHS would want to approach the Treasury. UHS should proceed on the basis that there would be no financial support being provided. In those circumstances the Board would need to consider at what point more significant interventions would need to be made.

5.6 People Report for Month 5

JD-T noted that this was a new report for the board. Previously the report had been presented to the Trust Executive Committee (TEC) and following discussion in that forum a decision was made that it should be presented to the open board for discussion.

SH presented the report and noted that the version before the Board was the detailed report presented to TEC. Going forward a more streamlined report, with key highlights, would be developed for the Board discussion.

SH highlighted:

- Some of the key actions that had been taken in relation to recruitment and retention and also the cost-of-living crisis. There had been discussions at a previous closed board meeting around concerns in relation to the recruitment and retention of certain staff groups and some actions had been put in place to mitigate those concerns.
- SH highlighted the challenges around Advanced Clinical Practitioners (ACPs) and pay rates. A few local organisations including GP practices were providing a differential rate of pay with a higher pay band. In the short term this was being addressed by a recruitment and retention premium to bridge the gap, together with conducting a workforce review that would seek to understand the banding and whether there was a need for a permanent band change. However, it would be important to consider the possible impact on the change to other bands across the Trust and manage that appropriately.
- UHS continued to undertake Health Care Assistant (HCA) recruitment well, but the challenge was retention. There were good pathways in place but work was needed to strengthen landing boards and increase the support available in the hubs and implement some band 2 to band 3 progression roles for those who did not want to utilise the nursing apprenticeship route.
- Demand on the recruitment team had significantly increased with a 25% increase of requested support. Some additional resource had been agreed to support them both within the organisation but also to increase engagement outside of the organisation.
- In terms of cost of living, SH had been undertaking a lot of work with partners across the Trust including trade unions and listening to staff voices. There were a number of elements that were not under the Trust's control including the national pay award and the rising energy crisis so the approach being taking was to take a balanced and fair approach. A number of things would be implemented which would be highlighted to all staff. A substantial discount was being negotiated in the restaurant to help people to eat a broad range of foods at competitive prices. The cycle to work scheme was being expanded, and there was some targeted support for those with high mileage within the organisation. For the 200 or so families who used the nursery the price was being rolled back to April this year.
- The Trust already has a range of general support which would be expanded to make sure that we were targeting the right people. Through a partnership with the ICS we were linking up with the Citizens Advice Bureau to provide really high quality financial advice to our staff. We were focusing on crisis, and working with the Charity, had set up a hardship fund of £20,000 which would be distributed to the most challenging cases where staff had been identified as a particular

hardship case they would be able to eat free at the restaurant. Arrangements had also been made with a local charity to provide vouchers and food parcels. Discussion had taken place as to whether a food bank should be set up on site which logistically would have been difficult, so the decision to work with the charity was agreed to be the best approach to deliver that service for us.

- Discussions had taken place at the Trust Executive Committee (TEC) who had fully supported the measures noting the impact on the non-recurrent spend.

KE suggested that this was a very sensible, targeted group of things to support our people. However, asked if the cost of £2.3m was currently included in the financial reports. IH advised that it was not included although some of the non-recurrent elements had a funding source so would not hit the underlying position. In terms of annual leave buy out there were accruals from previous years. However, there were some recurrent costs. The measures were targeted, proportionate and in line with the Trust's values for the current pressures being faced and if the Trust did not do anything it would likely increase costs or consequences elsewhere.

DAF noted that the report was the same as presented to the TEC at which there had been a more detailed conversation. It would be helpful to understand which areas of the report were more relevant and appropriate for the Board conversation which could be discussed at the next People and OD POD) Committee meeting.

Action: SH.

JH supported the proposals within the paper and noted that they had also been presented to the People and OD Committee (POD). POD would be tracking the progress of each of the initiatives to ensure that they were delivering as anticipated. JH asked if the Trust had looked at what others were doing to ensure that we were doing everything possible for our staff. SH confirmed that discussions had taken place locally and that the Trust was one of the first to implement the range of measures which were similar to those of others. Nationally, there had been a push to have a collective response, noting that the NHS employed 1.5m people and that there would be national support that would be available shortly.

TP noted the importance of having a people report at the Board and whilst the contents were good suggested that they could be presented in a more accessible way.

FM also noted the importance of the report and discussion but wondered what staff morale was. If the finance, performance and people report were considered as a whole it was clear that staff were facing a lot of pressure and there was insufficient staff due to high turnover. The volume of patients was increasing which meant that the staff that the Trust did have, had to work harder and longer with pay that was not great and a cost-of-living crisis to deal with. This must have an impact on staff morale and was there also an impact on patient care?

SH noted that morale was challenged which was recognised in the executive updates. The Trust undertook a quarterly staff survey alongside the current national annual staff survey and those results have been included within the report. The recent results discussed motivation, engagement and advocacy in

the organisation and UHS scores were still consistently in the top 10 of the NHS. However, the entirety of that engagement score was deteriorating. Morale was challenged and how that impacted on care was discussed in other forums. GB chaired the Quality Governance Steering Group (QGSG) which fed into the Quality Committee and focused on quality whether that be from the engagement of our staff or other challenges.

GB suggested that it was a mixed picture. People enjoyed working as a team and we can see them pull together and work as a team through the challenges. There were a number of different pockets in the organisation who believed that they were in a worst situation following the pandemic and it was important to move out of that space and recognise this as a whole. In terms of quality, it was important to retain a close focus on quality and in some other Trusts they were starting to experience a significant challenge with regards to their quality indicators. At UHS there were some potential early indications that were being closely monitored. Without a doubt staffing levels, and the way in which we looked at the wards, impacted on patient experience and outcome.

JD-T noted that one of the proposals was for staff to be able to sell back annual leave and being able to easily access the bank but if this was considered in the wider context, we had staff who were tired and not able to take leave as they had sold it, and were looking to work extra hours on the bank. How did the Trust manage and balance this? How should we look at the overarching risks for the workforce, and consequently patient care and performance, and what were the things that we needed to do to balance that. It would be helpful if the report could address some of those challenges to help the Board's understanding. In addition JD-T asked NEDs to feedback what they would want to see within the report to enable an effective discussion.

Action: SH and All NEDs

JH asked about exit surveys and wondered if there was any information from them that could support our approach. SH advised that approximately 30% of staff completed exit surveys which needed to be increased. Pay for the lower paid staff had become an issue. SH reminded members that he chaired the ICS people officers group and that group had been looking at how collectively they could support retention and were looking to purchase better exit surveys for the system pulling together their collective buying power.

Decision: The Board noted the report.

5.4 Integrated Performance Report for Month 5 (part two)

Having noted the previous discussions under items 5.5 and 5.6 JD-T suggested that a discussion on the remaining of the IPR would be helpful and the following questions and comments were made:

- JB noted that on pages 31 and 35, F1 – F5 this suggested that in terms of digital we believed that this was going to transform our efficiencies but it was not clear what the metrics indicated nor were some of them very high. PG suggested that there was an amazing resource in my medical record which we were not really making the most of. Work was needed to raise awareness with both patients and clinicians. Having used it as a patient it had been really helpful and enabled him to go paperless. JT noted that there was a business case that was overdue

for my medical record around how we industrialised it across the Trust which should provide some huge benefits and would bring a timeline back as to when this would happen.

Action: JT

JT noted that there was some big digital change happening with the rolling out of speech recognition and some E tools. In addition it would be helpful to look at the indicators to understand whether they were the right ones and review them as part of the digital updates which could be discussed at F&I.

Action: JT

The Board discussed the importance of giving people an overwhelming reason to access my medical record noting that the NHS App had initially been used for COVID vaccinations but could now enable people to order prescriptions and book appointments.

JD-T noted the Serious Incident reports and the number of harm falls which looked higher than previously and wondered in terms of the pressures we were seeing and the issues around workforce should the Board be concerned about this? GB advised that it had recently been falls awareness week. There had been a number of successful programmes in the Trust including bay watch, but with reduced staffing numbers that had became a challenge and some more deliberate high impact actions were needed to reduce those falls. A deep dive into this would be brought to a future meeting.

Action: GB

GB confirmed that COVID numbers were rising. There were 66 patients with COVID some of whom were both asymptomatic and symptomatic.

5.7 Break

The break took place prior to the Safeguarding Annual Report.

5.8 Safeguarding Annual Report 2021-22 and Strategy 2022-25

JDT suggested that the strategy should be discussed first noting that both had been discussed at the Quality Committee.

KMcG presented the strategy which had previously been presented to the Trust Board two years ago before Covid. The strategy had been reviewed and updated in line with new legislation and aligned to UHS values and now included maternity services.

Some of the strategy linked to children and adult reviews and making safeguarding personal together with our partners and developing stronger links within maternity, the emergency department and the wider hospital. Joining this up with the domestic abuse strategy and ensuring that we were always improving particularly around training and education including level 3 requirements.

In terms of the Annual Report from a children's perspective there were three main highlights:

- A significant increase, from 3700 to 6004, in the number of information sharing forms (ICF) which come through the ED where a child may possibly be at risk. In particular numbers had increased in the number of children presenting with mental health problems, particularly the 0 – 4 age group. This had been discussed at the Health Safeguarding Looked After Children Partnership who were looking at the 0 – 19 service provision which had changed significantly with COVID and a possible pattern of children of parents accessing through ED rather than going via their GP.
- In terms of mental health, for any child who presented in the ED with a mental health condition an ICF would be completed. The number of presentations remained high. Alongside this the number of deliberate harm incidents had risen from 676 to 898, drugs and alcohol referrals had risen as had assaults over the preceding year.
- Level 3 safeguarding training was at about 61%. There were two main reasons for this which was capacity and demand for the service and also a change of reporting requirements impacting just over 2000 staff. Training was on the Integrated Care Board (ICB) Risk Register as it was a wider system issue.

In terms of the Annual Report for adults CM highlighted the following:

- A 31% increase in safeguarding activity from the previous year with a 162% increase in Section 42 inquiries. This was due to a number of reasons including the impact of COVID including the removal of social distancing rules.
- A 35% increase in the number of allegations made against people in a position of trust which was something that was being seen across other local provider organisations. These were highly sensitive cases and required significant safeguarding oversight and management alongside collaboration with HR colleagues and the relevant clinical areas, which had a significant impact on the team.
- The creation of a new Mental Capacity Act (MCA), Deprivation of Liberty (DoL) and Liberty Protection Safeguards (LPS) team who supported people over the age of 16. Both locally and nationally this was one of the first teams that had been established. The team had worked to embed MCA as every day business which was key to the preparation for when LPS become law later next year or early the following year.
- In terms of Learning Disability and Autism there was a lack of local provision which had been acknowledged by the ICS and work was underway in relation to service review and what this needed to look like going forward.

GB thanked the team noting how hard they worked to safeguard vulnerable adults and children. GB referenced the Panorama programme that had aired the previous night in terms of a number of safeguarding issues against a Mental Health Trust. Whilst often allegations against staff were not grounded they were taken very seriously and investigated thoroughly.

JB noted the 35% increase against staff and wanted to understand what the outcomes of the investigations were and whether they were justified and whether allegations were being made against different groups. CM advised that one of the key areas of allegations focused on restraint and that the level

of restraint applied was disproportionate. These would always be reviewed. Security staff worked in pairs and wore body cameras which would always be reviewed. There had not been any cases recently where that had proved to be an issue.

Although there had been a big increase the total number of cases was 38 so not large numbers. The previous year there had been 23 cases.

CC questioned what element of this sat within the Trust and what sat with the ICS? SH noted the importance of remembering the broader picture. Nationally there had been a rise of safeguarding incidents, but it was important to remember that our workforce formed part of that population and had struggled with lockdown and were experiencing hardship. JD-T noted the need for a system approach to manage the increased mental health demand. However, safeguarding was a key focus for the Care Quality Commission (CQC) inspections post COVID, and a local provider had recently been deemed to be inadequate due to safeguarding issues and was an issue for UHS to pay particular attention to.

KMcG noted that through legislation children had the Local Area Designated Officer (LADO) which was lacking in adults, which provided a really strong link with that external partner.

TP noted that there had been a detailed presentation on this in the Quality Committee. This was a national trend in increased safeguarding problems. Whatever pressure we are put under it was important not to let our safeguarding procedures slip and it needed to be protected to ensure that it worked well.

Decision: The Board received the report.

5.9 Medical Appraisal and Revalidation Annual Report including Board Statement of Compliance

PG presented the report which was a statement of compliance with the medical regulations and had a robust and strong process in place.

PG noted that a new appraisal system had been introduced which had been well received and enabled the ability for medical staff to collect all of their appraisal information within one system instead of the previous three systems. This was beneficial for not only staff but also for those managing the process as it provided real time feedback and information both from a quality assurance perspective but also would enable better management of the process and improve appraisal rates in the future.

JD-T asked whether the doctor appraisal information was included within the IPR information that the Board received and SH confirmed that it was reported separately but included in the report and currently stood at 76.7%. CC suggested that the system was good but asked whether everyone was using it. PG confirmed that the system was a mandatory one and would be the only system going forward in the future. In terms of how many staff had undertaken the process this was a little ahead of the rest of the staff. However, the system enabled us to keep better track as people would need to have completed four appraisals within the previous five years to go forward with revalidation which provided a good incentive to keep on top of this.

JD-T asked for Board members to confirm that they approved the statement of compliance.

Decision: The Board noted the report and approved the statement of compliance.

5.10 Clinical Outcomes Summary

PG introduced the comprehensive summary noting that the clinical lead who had ran the service for a number of years, had now left UHS and a process of recruitment was currently underway which would provide an opportunity to refresh and review.

DW presented the paper and focused on the outcome programme which was unique to UHS, with 64 services out of 86 reporting their outcomes. A total of 484 outcomes had been reported all of which had been reviewed by TP via the Quality Committee.

There was a thriving clinical audit programme in place. The outcomes reported per care group covered a large proportion of patients and dealt with both national and international work. In particular DW highlighted:

- The Research and Development (R&D) team and the work that they had undertaken internationally on the COVID booster trial.
- The Bone Marrow Transparent unit.
- Maternity and the nest support teams who focused on women who may need additional support because of serious mental illness, or they were from socially challenging situations, or were non-English speaking, addiction, were homeless or were suffering from domestic abuse and other difficult situations. 12% of patients that were being seen in maternity required nest care.

KE asked why 18 services were not reported and DW advised that it was because they did not have the mechanisms in place to know what their outcomes were and work was underway to support them to develop those processes.

KE asked whether any of the reds within the report were really poor and JD-T noted that the data used was for 2020 and did not understand why it was so out of date. TP advised that data was provided from national audits was often two years behind, because there was a year of collection, a year of analysis and then it would be published. Within his experience he had never come across a hospital that had measured nearly 500 clinical outcomes let alone published it and it was a very impressive system.

Of the non reporting specialities around 60% were paediatric and it was important to discuss this with the senior leadership team of Division C to support them to move forward.

Further work was needed to put in place a mechanism in for the quality committee to monitor the action plans that were in place to understand how effective they were.

KE suggested the report should include a narrative around the reds noting that the Trust continued to do well against its peers but may not be achieving national or international standards.

GB suggested that the report highlighted an organisation that knew where the issues were and where the learning was and that it would be important for the Quality Committee to have some of those conversations.

Decision: The Board noted the report.

5.11 Health Inequality – Data Analysis Update

PG presented the report. Work had been undertaken in house around waiting lists in particular and we had not seen any inequality on the manner in which we managed people on our waiting list however, we did not know, as others did not know, whether we were achieving equitable outcomes for our patients and this was something that more work was needed on.

JT suggested that the report was the start of a new analytical approach to looking at health inequalities at UHS. The first piece of analysis, working alongside the university, had shown that there had been no clear sign of bias within UHS' RTT waiting list but there was more work to be done to extend that work into our other waiting lists and also to look at outcomes.

JT highlighted some of the limitations of the data noting that there was some missing data as the Trust did not collect all of the protected characteristic data. Where it was collected there was also some missing data. Data between primary and secondary data did not line up and there was more work to be done to deepen our analysis.

Our statistical methodology did not have to be particularly complex but the focus needed to be on the quality of the data. In addition, UHS would need support from other partners to fully understand the next level of detail. For example, UHS could identify that there was a particular postcode which had a higher referral rate than other postcodes but to understand the reason for that would need information from other partners including public health.

There was a newly appointed head of health inequalities and we were working with them to deepen our analysis. Work was underway to look at lung health checks and whether that service was accessible to all together with other waiting lists to look for areas of bias. This was a new piece of work that was being done and if UHS wanted to make a big difference it would be important to fund the right level of analysis with the right number of people.

CC noted the work that he had supported and confirmed that going forward that support continued to be available as and when needed.

JB noted that previous discussions had suggested that we would need the ICS to take a lead and wondered where that had ended. DAF noted that whilst we could analyse the data of those on our waiting list we needed to understand about those who were not on our waiting list. It was important to join this up with the ICS and Derek Sandeman was leading that across the ICS.

PG reminded members that he was a member of the Hampshire and Isle of Wight ICS Prevention and Health Inequalities Board which would also facilitate discussions around data collection.

Decision: The Board noted the report.

6. STRATEGY and BUSINESS PLANNING

6.1 A Smoke-free Site – the UHS Way Forward

PG presented the proposal which was asking the Board to make a commitment to becoming a smoke free site as part of Stoptober and highlighted the following:

- As the responsible officer and Chief Medical Officer PG was an advocate for UHS to become a smoke free site both from a public health and a health inequalities perspective.
- There were some significant challenges and risks to manage this in the right way. It also went hand in hand with the smoking cessation work that the Trust was doing both with patients and staff.
- Where patients were smokers, they would be prescribed within two hours of arrival with nicotine replacement therapy and meet with a smoking cessation advisor as it has been clearly proven that doing those things together increases the chance of people stopping smoking.
- We were a little behind other NHS organisations with around 60% to 70% of them being smoke free.

JD-T asked what was the learning from others was, were they totally smoke free and how did this align to the recently published Khan Review which set a trajectory to be completely smoke free by 2030.

JH asked whether vaping would still be permitted and how far off site would people have to go to have a cigarette and what would that do in terms of distraction from work.

JT noted the importance of consultation. We know what a number of the issues will be including neighbours complaining about people smoking on the periphery of the site and needed to work on the mitigations.

SH noted that we tried to do this in 2010 which was why we had the smoking shelters pushing people to the periphery of the site which had some advantages of being more contained. It was the right time to have a proper conversation about how we took this forward.

PG noted that a survey of 1000 staff and patients had been undertaken most of whom had supported a smoke free site and it was the right thing to do. In terms of what others had done we had looked at this. In terms of vaping there was clear evidence that vaping helped to stop smoking and mitigated many of the risks and whilst it may not be 100% safe it was significantly better than smoking and organisations, including many mental health trusts, had found it to be effective. Currently we received a lot of complaints about smoking on site.

JB as a healthcare organisation it was unethical to allow smoking on site but it was important to have the consultation to make sure it was done the right way.

JD-T noted that the report sought approval to be smoke free by 2039 but believed that we should be smoke free sooner as this date was beyond the Government review and queried why it was so long. PG noted that following the six-month consultation work would take place to move to a smoke free site resulting in this happening within 18 months.

Decision: The Board approved the proposal and committed to becoming a smoke free site.

7. CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

7.1 Register of Seals and Chair's Actions Report

JD-T advised that there had been no seals since the last Board meeting but there had been three actions included in the report.

DAF clarified that these were not contractual commitments but were effectively contract mechanisms on which we can use to trade with those organisations.

Decision: The Board ratified the Chair's actions.

7.2 Feedback from the Council of Governors' (CoG) Meeting on 14 September 2022

JD-T noted that there was the key item for discussion was the Annual Report and Accounts. A combination of HP, KE and others presented the report which had already entered the Parliamentary process. Currently we did not know whether the report had been laid before Parliament.

7.3 Health and Safety Annual Report 2021-22

GB noted that this had been previously reported to TEC and the diagrams on pages 6 and 7 depicted the current issues in terms of health and safety both from an incident and RIDOR perspective part of which was violence and aggression.

JF noted the importance of keeping staff safe. UHS struggled with the reporting of incidents and were supporting staff to do this, noting the strict timelines for reporting to the Health and Safety Executive which was improving. Risk assessments and action plans were really important to demonstrate how we were making improvements.

JD-T noted that some of this had been picked up in the discussion on the IPR.

SH asked how we compared to other large comparable university hospitals. JH advised that we did benchmark and the types of incidents were comparable and this would be something that we would develop further so that we could benchmark and share good practice.

Decision: The Board received the report.

7.4 People and Organisational Development Committee Terms of Reference

SH presented the revised Terms of Reference noting that it formalised the two sessions having the voice of staff via network groups, trade unions and freedom to speak up guardians followed by a closed session which was just

committee members. This was an innovative way of having the staff voice at the highest level of the organisation. Going forward the agenda would be more aligned to aspects of the People Strategy.

JB suggested that reporting was out of sync and it was important that the Committee were able to have those bigger conversations. SH confirmed that scheduling had been raised but because of the concerns around workforce at least a summary report should be coming to Board and was a work in progress. JD-T asked for JH and SH to review prior to the next Board.

Action: JH an SH

Decision: The Board approved the Terms of Reference

8. Any other business

There was no other business.

9. Note the date of the next meeting: 29 November 2022

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

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University Hospital Southampton NHS Foundation Trust

List of action items

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 26/05/2022 5.6 Freedom to Speak Up Report				
704.	Comparative information	Byrne, Gail	29/11/2022	Overdue
	Explanation action item It was requested that future FTSU reports included comparative information from previous years in order to identify trends and also identified cases from previous reporting periods that had not yet been closed. Update: This will be included in the May 2023 report.			
Trust Board – Open Session 28/07/2022 5.7 Complaints Annual Report 2021-22				
763.	Upheld complaints	Byrne, Gail Banfield, Ellis	21/10/2022	Completed
	Explanation action item KE queried whether there were areas of the hospital which had a high proportion of upheld or partially upheld complaints and EB offered to provide that data after the meeting. Update: The upheld complaints data was circulated on 21/10/22.			
Trust Board – Open Session 28/07/2022 6.2 Board Assurance Framework (BAF) Update				
764.	Key controls	Byrne, Gail Potton, Helen	29/11/2022	Completed
	Explanation action item JD-T queried how effective the key controls were and suggested that they were developed. GB, HP and Jake Pursaill agreed to take that forward. Update: Discussions have taken place and the BAF has been updated.			

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 29/09/2022 2 Patient Story				
822.	Links with the hospital charity	Harris, Steve	29/11/2022	Completed
	Explanation action item SH will liaise with the patient's mum to ensure she is in contact with the Trust's Charity. Update: Contact has been made.			
Trust Board – Open Session 29/09/2022 5.1 Briefing from the Chair of the Audit and Risk Committee (Oral)				
823.	Cyber training for the Board	Teape, Joe	08/11/2022	Completed
	Explanation action item JT reminded members that he had arranged for Cyber training for the Board and had agreed to provide further assurance around some of the arrangements and the Internal Audit was aligned to this. JT noted that staffing arrangements would need to be reviewed as currently there was only one colleague within the digital team that worked on cyber security issues. HP informed the Board that work was already underway in terms of the work around ROPAs. Update: Further assurance on the Trust's cyber security arrangements including the Internal Audit Final Report September 2022 was circulated on 08/11/22.			
Trust Board – Open Session 29/09/2022 5.6 People Report for Month 5				
824.	Updated People Report	Harris, Steve	13/12/2022	Pending
	Explanation action item The People and OD Committee should review and discuss the most appropriate format for the People Report for the Trust Board. Update: Discussion to take place in December.			

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 29/09/2022 5.6 People Report for Month 5				
825.	Updated People Report	● Harris, Steve ● Non-Executive Directors	29/11/2022	Completed
	Explanation action item NEDs were asked to contact SH to advise what they want from the People Report. Update: Email reminder sent to all NEDs on 29 September asking for feedback and feedback received.			
Trust Board – Open Session 29/09/2022 5.4 Integrated Performance Report for Month 5 (part two)				
826.	My medical record	● Teape, Joe	28/02/2023	Pending
	Explanation action item JT noted that there was a business case that was overdue for my medical record around how we industrialised it across the Trust which should provide some huge benefits and would bring a timeline back as to when this would happen. Update: In progress and not yet due.			
827.	Digital change and indicators	● Teape, Joe	31/03/2023	Pending
	Explanation action item JT noted that there was some big digital change happening with the rolling out of speech recognition and some E tools. In addition it would be helpful to look at the indicators to understand whether they were the right ones and review them as part of the digital updates which could be discussed at F&IC. Update: In progress and not yet due.			

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 29/09/2022 5.4 Integrated Performance Report for Month 5 (part two)				
828.	Harm falls - deep dive	Byrne, Gail	31/01/2023	Pending
	Explanation action item A deep dive into the falls would be included in the IPR and presented to a future meeting. Update: This will be included in the January 2023 report.			
Trust Board – Open Session 29/09/2022 7.4 People and Organisational Development Committee Terms of Reference				
829.	Reporting	Harris, Steve Harwood, Jane	31/01/2023	Pending
	Explanation action item JB suggested that reporting was out of sync and it was important that the Committee were able to have those bigger conversations. SH confirmed that scheduling had been raised but because of the concerns around workforce at least a summary report should be coming to Board and was a work in progress. JD-T asked for JH and SH to review prior to the next Board. Update: Discussions have taken place and changes were being discussed.			

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Chief Executive Officer's Report**			
Agenda item:	**5.4**			
Sponsor:	**David French, Chief Executive Officer**			
Date:	**29 November 2022**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	My report this month covers updates on the following items: • Operational update • Industrial Action • Discharge Funding • Formation of the Wessex Genomics Laboratory Service • National recognition of UHS Staff • Children's Hospital Alliance • UHS Inclusion and Belonging Conference • Autumn Budget Statement • Vaccination at UHS • Supply Chain Issues			
Response to the issue:	The response to each of these issues is covered in the report.			
Implications: (Clinical, Organisational, Governance, Legal?)	Any implications of these issues are covered in the report.			
Summary: Conclusion and/or recommendation	The Board is asked to note the report.			

Operational update

Operationally the Trust across all services continues to be extremely busy. The last few weeks has seen a drop in COVID numbers within the hospital and this has coincided with a slightly improved operational position, although bed occupancy continues to remain high. Surge capacity across the hospital continues to be open to meet the additional demand we are facing, as well as accommodating over 200 patients who do not meet the criteria to reside in hospital. This continues to be a priority for the whole system to improve the care for these patients through ensuring they are cared for in the most suitable available setting.

The local delivery system winter plan is being reviewed again to identify any further capacity that can be enacted. The current projections for the winter period show that there is a significant probability of losing less urgent elective activity through January and February to accommodate emergency patients unless these alternatives can be found. This in turn will impact on long waiting patients. This remains an urgent focus for the system.

Industrial Action

We have begun planning for both the planned RCN industrial action and the potential for other staff groups to vote to take industrial action either simultaneously or subsequently. We have identified a list of key services and will be meeting with local union representatives to agree what will be covered over the period. We are also participating in the NHS's planning exercise over the next two weeks, Operation Arctic Willow. We expect to maintain safe emergency services but anticipate that the action will have a significant impact on elective and urgent services.

Discharge Funding

The Department of Health and Social Care (DHSC) have confirmed arrangements for the £500m additional discharge funding to support winter 2022/23. The scheme is aimed at speeding up patient discharge, freeing up hospital beds, reducing ambulance handover times and improving capacity in social care.

£300m will be given to Integrated Care Boards (ICBs) to improve bed capacity and £200m will be given to local authorities to bolster the social care workforce, increasing capacity to take on more patients from hospitals. ICBs and local authorities are expected to work together to agree spending across their regions.

The Hampshire and Isle of Wight (HIOW) ICB have 22% of beds occupied by patients not meeting the criteria to reside, compared to a national average of 15% (South East 16%)

HIOW ICB - £12.449m
Hampshire LA - £3.962m
Southampton LA - £0.924m

We will work closely with the HIOW ICB and system partners to ensure this funding is used appropriately and to maximise the impact on discharge from hospital.

Formation of the Wessex Genomics Laboratory Service

This month UHS welcomed 92 colleagues into pathology with the Wessex Regional Genetics Laboratory (WRGL) based at Salisbury District Hospital transferring to UHS management. The newly created Wessex Genomics Laboratory Service (WGLS) comprising WRGL and Molecular Pathology (UHS) will operate a 'one service, two sites' model for now, until a suitable single site is identified. The team continues to operate from their Salisbury site but are very much welcomed into the pathology and UHS family, which aligns to the national reconfiguration of genomics services and testing in England that is being led and commissioned by NHS England. Our new service will provide expert genomics testing for rare diseases, haemato-oncology, solid tumours and pharmacogenomics.

National recognition of UHS Staff

UHS has been recognised at the 2022 Nursing Times Awards for utilising joint roles to maximise collaboration, integration and opportunities for clinical research. Clinical research nursing staff were presented with the award in a ceremony at the Grosvenor House Hotel, London on Wednesday 26 October.

Also, UHS clinician Dr Mayank Patel was part of a team that received two awards at the recent 2022 Quality in Care Diabetes Award's ceremony for a project that uses technology to help train doctors in managing clinical diabetes in emergency situations. As the number of patients with diabetes admitted to hospital continues to increase, so does the need to manage the condition by non-specialist doctors. To help support their understanding and learning, Mayank, a diabetes consultant at UHS, was part of a team that developed a virtual reality package, giving the clinician the opportunity to diagnose and initiate treatment for 'the virtual patient'.

Children's Hospital Alliance

At the recent Health Service Journal (HSJ) Awards, the Children's Hospital Alliance, of which Southampton Children's Hospital is a partner, won the Performance Recovery Award in recognition of the work of the Paediatric Accelerator. The judges said that the programme stood out for the scale of the collaboration, the ambition of the programme and the sustainable changes that were being taken forward.

The award highlights the benefits of collaboration across Children's Hospitals who have taken this £20m investment into children's recovery and turned it into:

- Transformational change to exceed pre-pandemic levels of elective activity by collectively delivering 104% of pre COVID activity and seeing 38,000 more patients.
- Cutting edge innovation by developing and rolling out an artificial intelligence tool to identify children at risk of missing their appointments. This provides a safety net for families who may need extra help whilst supporting our teams to minimise wasted clinic time.
- A programme of work addressing health inequalities to offer additional support to families who need help the most.

This highlights the significance of the integration agenda and the Alliance will work hard to advocate greater focus and attention on children and young people's recovery in conversations with Integrated Care Systems and regional leads.

UHS Inclusion and Belonging Conference

On Thursday, 17th November the Trust held its second annual virtual Equality, Diversion and Inclusion (EDI) conference titled "Championing Individuality and Belonging". The day was attended by over 120 delegates from across the UHS family and from partners in the system. It included powerful stories of people's lived experience from a range of speakers, a discussion on psychological safety, and a chance for people to connect on the issues of inclusion. Speakers included Dr Joan Myers, OBE, a nurse whose career has spanned over 35 years. She described her personal journey as a black nurse in London and her extraordinary rise to a nationally decorated leader. Rosie Jones (a widely celebrated Channel 4 comedian with cerebral palsy) spoke of her journey to television and acting including some of the challenges she has experienced. As part of an engaging session on gender, Gail Byrne (Chief Nursing Officer) also officially launched the UHS women's network.

Delegates were extremely positive about the conference with great feedback received during and after the event.

The Conference provides the perfect platform for the final stages of approval of the Trust's new Inclusion and Belonging strategy which has been reviewed and supported by the EDI committee. The strategy, which has been based on consultation with our people and staff networks, will be shared with board members for discussion and approval during January 2023.

Autumn Budget Statement

On 17th November, the Chancellor set out his Autumn budget statement. This sets out the position on both public and personal finances, and therefore has a significant impact on the NHS, UHS and our staff. The main items impacting UHS are:

- The government committed to publishing a long-term workforce plan for the NHS.
- Social care received a significant financial boost to help free up hospital beds - £2.8bn in 2023/24, growing to £4.7bn in 2024/25. This is made up of additional national funding, delayed reforms and local flexibilities to increase council tax. This means funding is available for 200,000 more care packages.
- Former Secretary of State for Health Patricia Hewitt has been appointed to advise on NHS efficiencies, including how ICBs operate.
- Whilst there remains an expectation on the NHS to increase efficiency, the NHS has also been supported with an additional £3.3bn of recurrent funding in 2023/24 to cover inflationary pressures.
- The commitment to the new hospitals programme was re-confirmed.

From a workforce perspective, UHS staff continue to face the cost-of-living crisis and a fall in living standards. Inflationary increases of 10% have been announced on the National Living Wage, Pensions and Universal Credit. Support for energy pressures continues but is less

generous than the current scheme. There was relatively little additional support announced for employed staff. The UHS workforce may therefore continue to feel financial pressures and a continued squeeze on living standards, potentially impacting retention and the attractiveness to support recruitment. There was also no announcement on resolving the issues with pensions.

The additional investment in social care and the NHS is more than anticipated and very welcome given the operational and financial pressures facing UHS and the NHS. Details of how the additional funding will be distributed is not yet known; however, it is expected this will cover new inflationary pressures, and is unlikely to cover the existing pressures. It is also unclear whether the funding will cover the impact of current and future NHS pay award negotiations.

Vaccination at UHS

Currently, COVID vaccination booster levels are 42% at UHS for all staff. Following the closure of the COVID vaccination hub, with students returning to the lecture facilities in the South Academic block at SGH, the vaccination team is setting up a further concentrated booster clinic during December, for a final push on booster uptake before the regional programme closes on 11 December. This will provide capacity daily for between 300 and 400 vaccinations per day. Staff will have the opportunity to have both COVID and flu vaccinations. Throughout November, roving teams continue to administer both flu and COVID to target areas directly.

With further communication and engagement, it is hoped these additional sessions will increase our final COVID vaccine performance as high as possible. The flu campaign will continue into the new year

Supply Chain Issues

UHS is continuing to face significant challenges with the national/global supply chain for equipment and consumables.

The UHS and the Wessex Procurement Limited (WPL) teams are taking proactive steps to mitigate risks and find alternative routes to supply alternative equipment. We are holding weekly operational meetings and diverting significant resource within WPL to resolving specific issues. Clinical and front-line staff are understandably anxious, and we are writing to all staff to ensure they are aware of the issue and to remind staff of the importance of kindness to our stretched supplies team.

Some of the pressures that we are facing include:

- Tracheostomy tube – airways that are essential for emergency care and need to be available for certain types of elective care (eg head & neck cancers). This vital equipment is subject to a national shortage, with no alternative options available in the market and we are aware of other hospitals cancelling elective activity as a result. The proactive steps we have taken have prevented this at UHS to date, however there remains a risk that we may be forced to cancel elective activity (including head & neck cancers) putting patient safety and operational waiting time performance at risk.

- UHS clinical teams are having to accept alternative products often with little or no notice (eg bowel management systems). This means teams are not familiar with how to use the equipment, increasing our safety risk.

The risk associated with these challenges has been included on the risk register with an increased score of 15. Whilst the Trust and WPL are doing everything possible in terms of mitigations, risks associated with cancelling elective activity and patient safety remain.

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Integrated Performance Report 2022/23 Month 7**			
Agenda item:	**5.5**			
Sponsor:	**David French, Chief Executive**			
Author	**Jason Teoh, Director of Data and Analytics**			
Date:	**29 November 2022**			
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.			

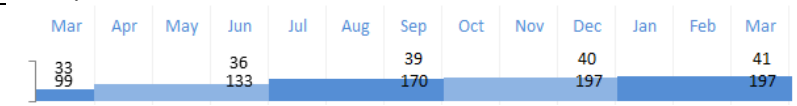
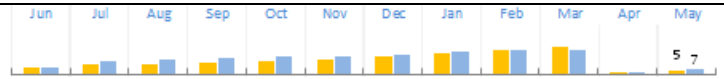
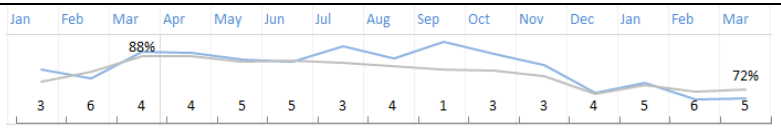
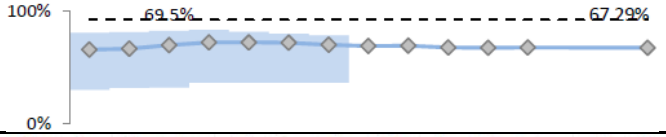
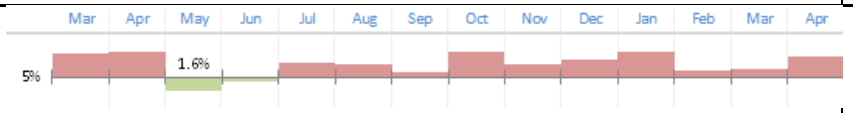
University Hospital Southampton NHS
NHS Foundation Trust

Integrated KPI Board Report

Covering up to
October 2022

Sponsor – David French, Chief Executive Officer
Author – Jason Teoh, Director of Data and Analytics

Report guide

Chart type	Example	Explanation
Cumulative Column		A cumulative column chart is used to represent a total count of the variable and shows how the total count increases over time. This example shows quarterly updates.
Cumulative Column Year on Year		A cumulative year on year column chart is used to represent a total count of the variable throughout the year. The variable value is reset to zero at the start of the year because the target for the metric is yearly.
Line Benchmarked		The line benchmarked chart shows our performance compared to the average performance of a peer group. The number at the bottom of the chart shows where we are ranked in the group (1 would mean ranked 1st that month).
Line & 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; and
- 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; and
- An 'Appendix', with indicators presented monthly, aligned with the five themes within our strategy.

This month there have been no material changes in the format of the report.

Some minor changes have been made to the report this month:

- Updated data: The Medication Errors (UT11) August figure has changed (2 to 4) and September (5 to 4) after internal reviews and regrading of the incidents.
- Change of graph: To provide additional clarity, the Workforce Numbers (WR3) graph has been revised to now show the planned and actual substantive WTE rather than the planned growth.

Summary

This month the 'Spotlight' section contains reports on Emergency Department (ED) performance and Red Flag Staffing Incidents at the Trust.

The ED performance spotlight highlights:

- That ED four hour performance is not at the level we aspire to; however, we continue to benchmark well to teaching hospital comparators, as well as across the South East. Alongside increased attendance, our performance is being impacted by other factors such as patients no longer meeting the Criteria to Reside (CtR) at UHS leading to a lack of availability of beds, rising acuity (more people requiring treatment in majors), and an increase in mental health cases which are being treated at UHS.
- We are maintaining a conscious decision to ensure that patients do not queue in ambulances, although this is at the expense of patients being queued within ED Majors. This is reflected within our statistics which shows very low rates of 30 and 60 minute handovers at UHS.
- We have service improvement plans in place to address and improve ED performance, and have recently trialled an "Urgent Care Village" which showed some promising performance.

The Red Flag Staffing Incident spotlight highlights:

- That there has been an increase in red flag incidents and staffing incidents at the Trust which ultimately may impact on patient safety at UHS.
- Although some of this will be linked to an increased awareness of the process and reporting system, the volume of incidents reflects the ongoing challenge of potential burnout and fatigue, with fewer staff covering gaps and vacancies, a reduction in training time, and other factors potentially leading to patient incidents.
- The key actions – predominantly around staffing and increasing the care hours per patient day – are being addressed through additional recruitment, and mitigation of staff turnover and attrition.

Areas of note in the appendix include:

1. There has been a significant drop in two week wait and 62 day cancer performance. Two week wait performance was linked to significantly higher referrals to the skin tumour site (as per previous months), while head and neck capacity has had capacity challenges (due to vacancies) alongside higher referral volumes. This under performance in two week wait, has then also impacted on the overall 62 day cancer targets.
2. ED four hour performance in October has worsened, linked to significantly higher attendance and challenges with hospital flow (in line with other peer hospitals). Additional information can be found within the spotlight.

3. There has been an increase in Red Flag staffing incidents, predominantly linked to staffing availability. We have included a spotlight on this within the report to provide assurance of the actions that are in place.
4. COVID-19 transmission within the hospital saw a significant increase in October, in line with prevalence in the community and nationally. There were 87 confirmed healthcare-acquired COVID infections (up from 29 the previous month), and 49 probable hospital-associated COVID infections (up from 15 the previous month).
5. The number of patients not meeting the Criteria to Reside in hospital further increased, to an average of 208 patients through October 2022. Although, on average, only two higher than September 2022 figures, it is 31% higher than October 2021.
6. Clostridium difficile cases were again above the monthly target (12 cases, compared to monthly target of five), although the growth remains in line with national trends and peer hospitals. Due to the continued prevalence of clostridium difficile, we are changing the way that we review and investigate cases of infection to gain a better understanding and assurance relating to factors that may have contributed to the cases (including any parts of the patients care pathway, management pre and post diagnosis, and infection control practice) to identify any learning, actions, and recommendations to improve practice.
7. There has been an increase in the Crude Mortality Rate, although it remains better than our target level. This measure is calculated as a 12 month rolling average figure, and more detailed assessment of the figures have linked this to increased COVID-19 related deaths over the last 12 months.
8. UHS Research Recruitment in October was ranked 8th nationally. Through this financial year we have been consistently behind our target of being within the top five nationally. There are multiple reasons why research recruitment is difficult at present, with no one singular theme. Routine performance monitoring has been re-instated with a particular focus on recruitment and time to target around individual studies to look to address some of the multiple issues we are encountering.

Ambulance response time performance

The table shows the latest Category 1 to 4 information published by South Coast Ambulance Service (SCAS) published within its November 2022 board papers, relating to the Southampton, Hampshire, Isle of Wight, and Portsmouth area. This information shows that in October, the response times were worse than previous months, particularly for Category 3 and 4, after a slightly improved September performance.

Southampton, Hampshire, Isle of Wight, and Portsmouth SCAS response time by category

Performance measure	October 22 Actual	YTD Actual	Target
Category 1 Mean	00:09:21	00:09:38	00:07:00
Category 1 90th percentile	00:16:34	00:16:53	00:15:00
Category 2 Mean	00:43:34	00:42:00	00:18:00
Category 2 90th percentile	01:33:54	01:30:18	00:40:00
Category 3 90th percentile	05:51:30	06:30:10	02:00:00
Category 4 90th percentile	08:47:09	07:44:51	03:00:00

Using NHS England published ambulance handover data, we have benchmarked performance against other hospitals in the South East and South West regions. Data for October 2022 can be seen in the graph and demonstrates that UHS was one of the top 3 performers in minimising handover delay at both the 30-60 and 60+ minute categories.

Ambulance Handover Delay Distribution, by hospital, for October 2022

Spotlight: Emergency Department (ED) Performance, Ambulance Handover Performance, and Attendances

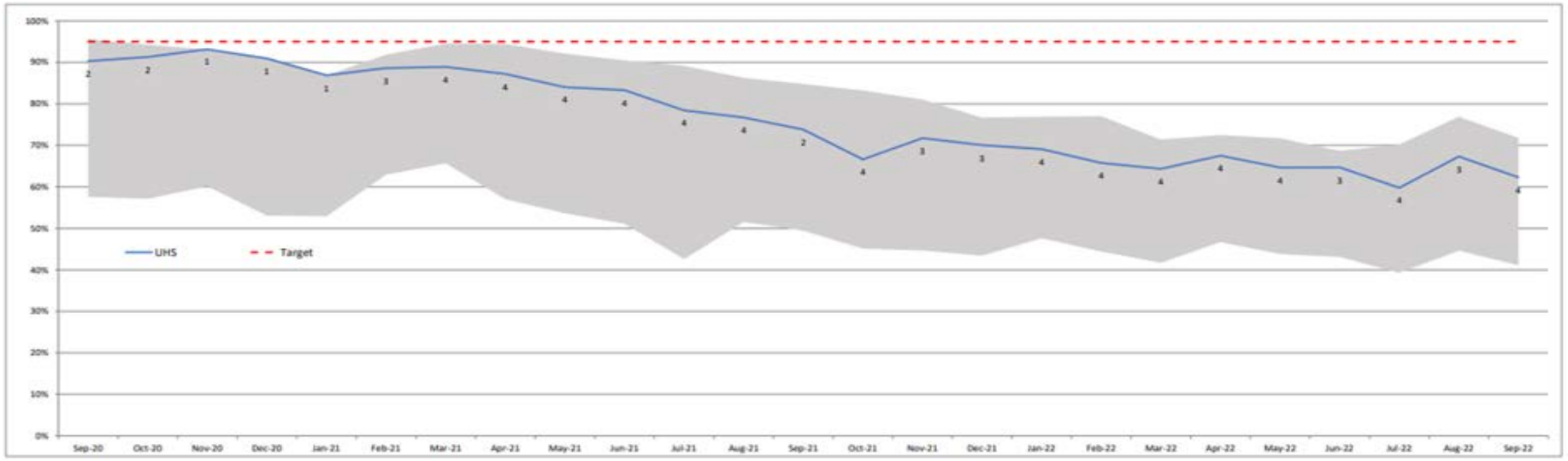
Four hour standard, from arrival to admission, transfer or discharge from the Emergency Department

UHSFT is not currently meeting the national ED target, although our performance is good compared with similar teaching hospitals and the South East region as shown in the graphs below.

Type 1 attendances to ED continue to be high and have averaged 370 per day from April to October 2022, compared to an average of 320 per day for the same time-period in 2019 (at 15% increase). In the last two weeks we have seen Type 1 attendances over 440 again on multiple days. Despite this, UHS ED continues to minimise ambulance delays. There is also a significant focus on improvements, within the department and across the whole emergency pathway.

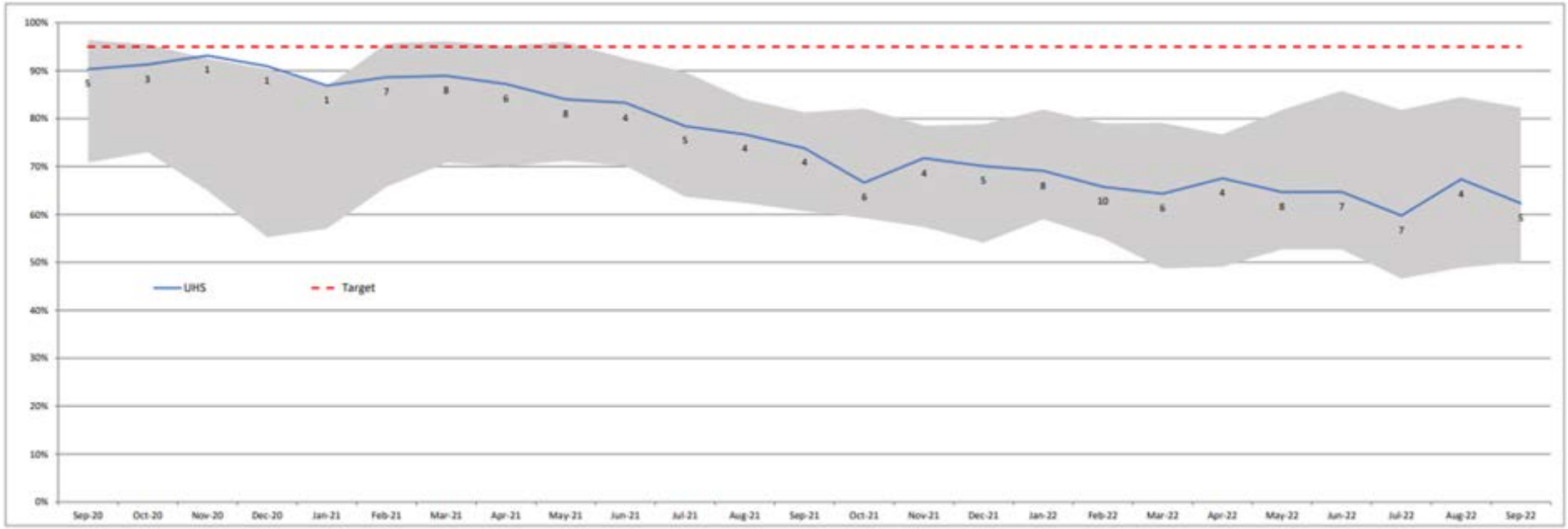
Teaching Hospital Performance Comparison

The graph below highlights our Type 1 performance compared to 17 similar Teaching Hospitals, where in September 2022 UHS ED to ranked fourth best (upper quartile).



South East Region Performance Comparison

The following graph highlights our Type 1 performance compared to all fourteen hospitals reporting results in the South East region, where in September 2022 UHS ED ranked fifth best an improvement from seventh best in July 2022.

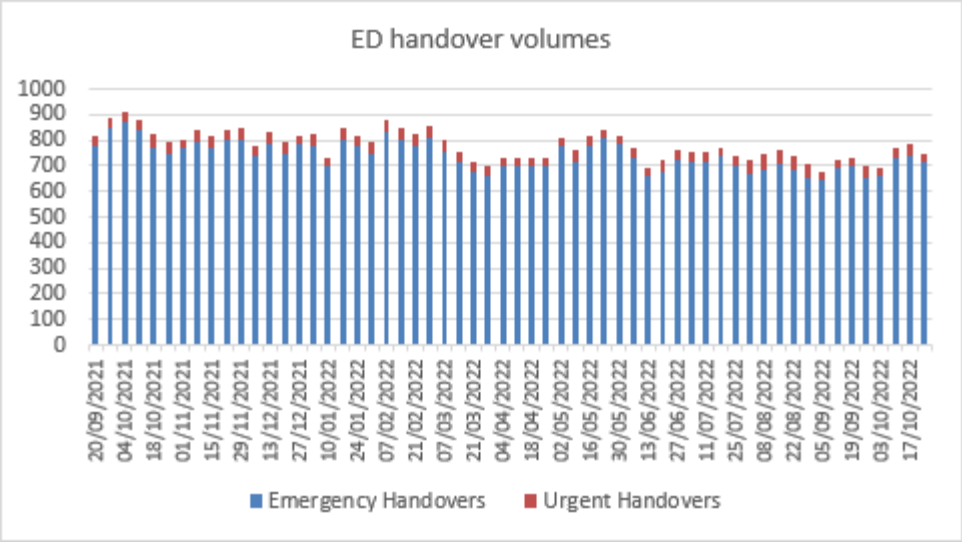


Ambulance Handover Performance Target "All handovers must take place within 15 minutes with none waiting more than 30 minutes"

Ambulance Handovers are a current focus area for NHS England, and will also form one of the key areas within the upcoming Winter Plan. UHS performs very well in relation to measures of timely ambulance handover, and recent trends demonstrate further local improvement. As a Trust we made, and are maintaining, a conscious decision to ensure that patients do not queue in ambulances, although this is at the expense of patients being queued within ED Majors. However, every effort is made to manage the queue safely.

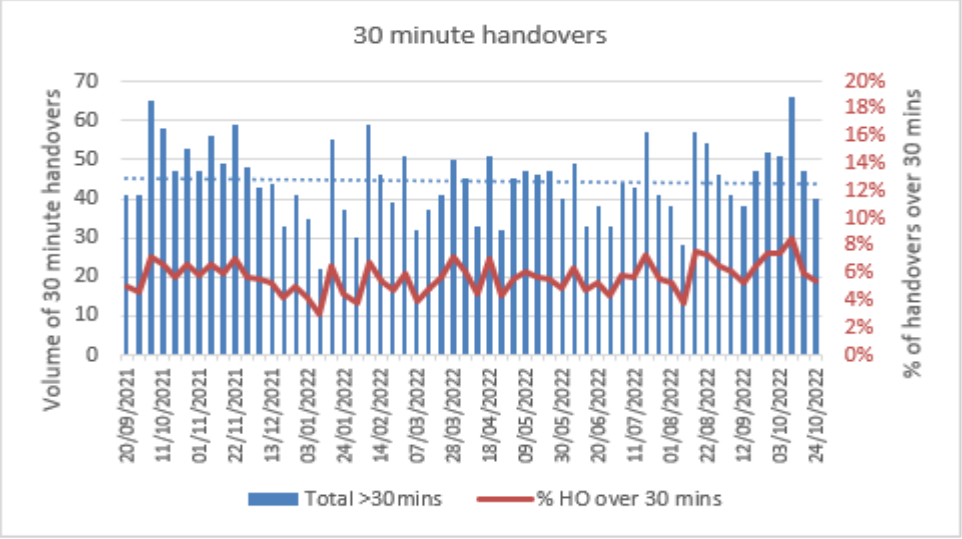
Since April 2022, we have seen, on average, up to 800 ambulance handovers each week at UHS. Although there were some challenges in handover during July (linked to the overall challenges we experienced in ED), over this financial year we have sustained the good performance on the number of 30 minute handovers, and rarely see any 60 minute handover delays.

UHS Performance (unvalidated):



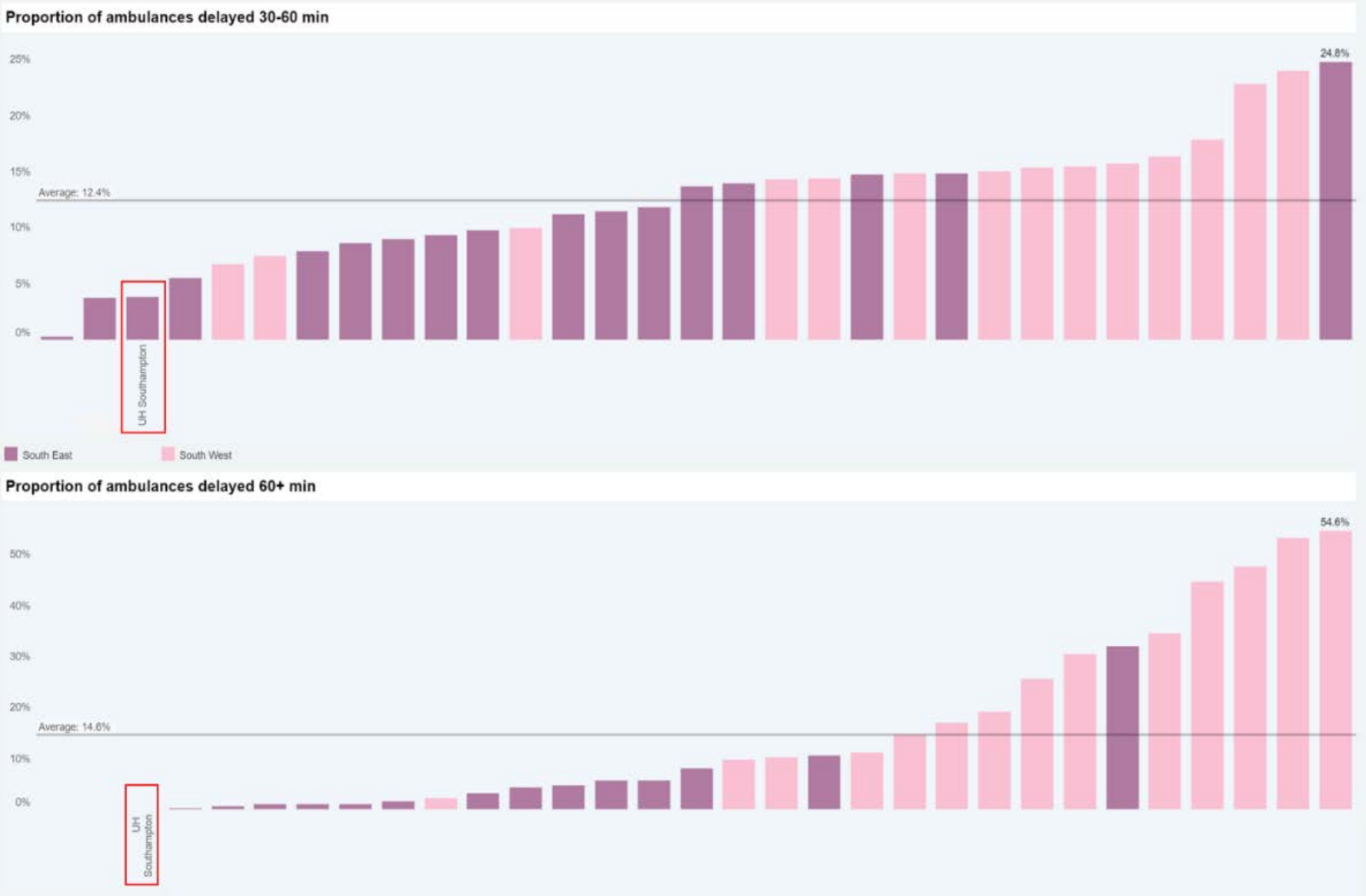
Total ambulance handover volumes into the Emergency Department per week from September 2021 to mid-October 2022.

- Overall volumes have been relatively static and are reducing from the high seen in 2021.
- Current ambulances handing over to the ED per day are on average 120.
- 70% of our daily attendances are from patients who walk-in to the ED. On Sunday 13th November 2022 this accounted for 310 attendances out of a total of 438.
- One of our key areas of work is to tackle the high level of attendances walking in to the ED as discussions with the regional Clinical Director has shown UHSFT ED are an outlier looking at current national trends. This is potentially linked to access to primary care within Southampton City.



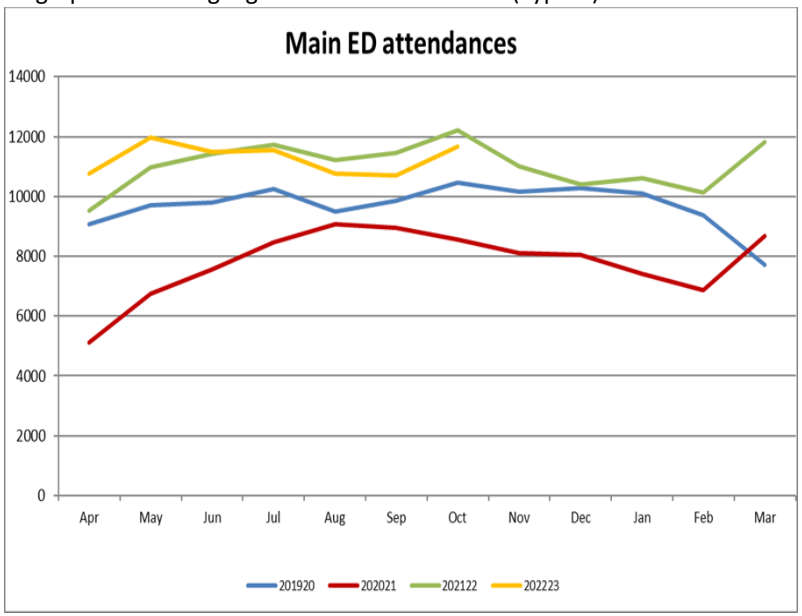
Ambulance handovers into the Emergency Department taking longer than 30 minutes as a volume and percentage, per week, from September 2021 to mid-October 2022.

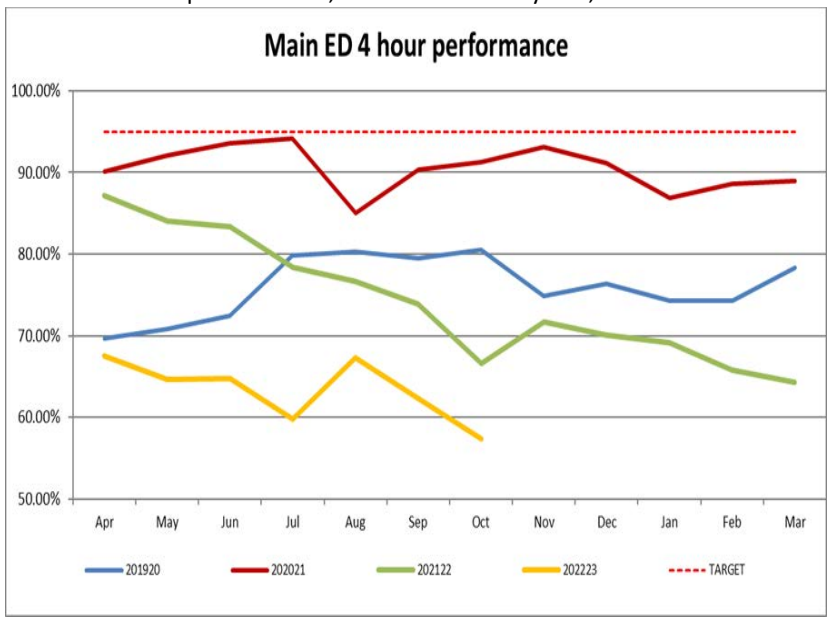
- UHS ED 30 mins handover performance remains strong, and our average handover time is less than 17mins.
- Equally our performances versus 60 mins handover delays continue to hold-up compared to other Trusts in the SE & SW regions.
- Regional benchmarking on ambulance handover performance for October 2022 is shown on the next page. Ongoing discussions take place regarding risk held within the Trust and as such we have agreed we queue in the ED and not outside in ambulances.


Proportion of ambulances delayed 30-60 min
25%
20%
15%
10%
5%
0%
Average: 12.4%
24.8%
UH Southampton
South East
South West
Proportion of ambulances delayed 60+ min
50%
40%
30%
20%
10%
0%
Average: 14.6%
54.6%
UH Southampton

Trended ED attendance and performance information

The graphs below highlight the number of main (Type 1) UHS ED attendances, and associated four hour performance, over the last four years, to October 2022.





Excluding the Covid impacted financial year of 2020/21, ED attendance growth has been rising year on year with an overall increase of 26% from 2018/19 to 2021/22. The performance graphs demonstrate the link between a rise in attendances and our ability to manage patients within four hours. Other factors linked to performance challenges, but not exhaustive, include:

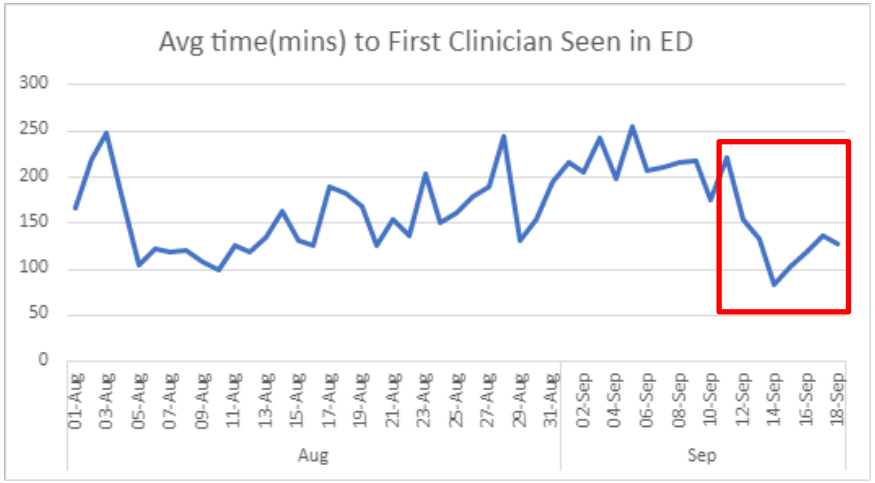
- Rising acuity – measured by resus being "double-bayed" more frequently, alongside the number of times majors is over capacity.
- Hospital wide bed flow – partly driven by rise in the number of Medically Optimised for Discharge (MOFD) patients which is now consistently at 220 per day.
- ED is seen as the place of safety for both the community, and our own hospital services, when these teams' own services are at capacity.
- Workforce – some rotas in ED are running at 50% vacancy levels increasing the difficulty to keep on top of timely decision-making although fewer patients are being admitted currently than historically.
- Continuing delays in getting patients back home due to transport and/or refusal from Care/Nursing Homes due to a combination of infection control challenges and numbers or time cut-offs placed by the individual organisations.
- Increase in complex patients alongside a rise in acuity. This is leading to an increase in the number of incidents of violence and aggression directed at staff in the Emergency Department, further impacting on the team's ability to manage demand in a timely fashion.

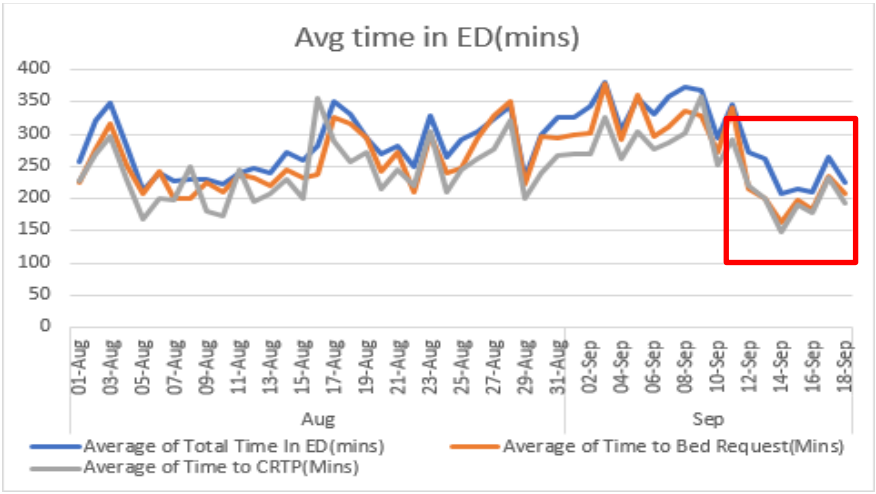
Service Improvement Plans

The following are main areas of focus within the ED, Emergency Medicine Care Group, UHS, and wider external stakeholders.

Scheme	How?
Focus on specialty pull out of ED	1) Discussions ongoing post Chief Medical Officer & Chief Operating Officer comms requesting specialty teams to feedback on plan B pathway ideas to reduce the referral to ED for "known/expected" patients which occurs when specialty capacity is constrained 2) Weekly rapid change process to be established between site & ED (Emergency Department) 3) Ongoing review of performance against the 1hr standard linked to CRTP (Clinically Ready to Proceed) at Divisional Performance meetings 4) Medicine continuing with SDEC (Same Day Emergency Care) pilot downstream to support earlier discharge and improve flow at the front door 5) Constantly refining of the "Who goes where document" discussed at Divisional Clinical Directors and clinical leads to support e-referral discussions linked to output related to CRTP and to support enacting of direct admission from ED when appropriate
External Focus	1) Review of Directory of Service (DoS) between ICB (Integrated Care Board), primary care and acute to ensure most appropriate place for treatment is clear for clinical teams 2) Establishing forums to discuss decompression of ED i.e. with Nursing /Care Homes to ensure patients can go home timely although this may have to be out of hours 3) Benchmarking work seeking an understanding of best practice/areas to improve at UHS via direct engagements with other local and regional departments. Data received from Oxford and visit planned with Royal Berks in early December22. 4) Ongoing comms in the community regarding messaging around alternative providers - 111, UTC (Urgent Treatment Centre), GP, pharmacy 5) Regular contact with clinicians who are part of SE region and NHS Emergency Care Improvement Support Team discussing hot topics such as demand & capacity modelling, workforce gaps 6) CCGs discussions linked to utilisation of UTCs and increasing capacity at UHS times of surge. Discussions around better shared learning and working and understanding pressures
ED Escalation	1) ED escalation policy/scoring reviewed and amended to include management of majors queue, awaiting Trust wide escalation framework review to then incorporate ED escalation framework into it. 2) Trust wide review of boarding has been undertaken to support capacity at times of surge. Linked to use of discharge lounges 3) ED Huddle now also attended by AMU (Acute Medical Unit) and psychiatric liaison reps to support flow out of ED being escalated and management of complex MH patients
Mental Health focus	1) Continuing to build up collaborative relationship with main mental health provider 2) Additional funding for CORE24 service resulting from work completed on the gap analysis
Workforce	1) Ongoing quarterly meetings with senior ED team discussing all thing workforce linked to workforce strategy using output from workforce analysis looking at number of attendances, day of the week, time of day, senior decision makers and where they focus efforts. Discussions focus on new ideas to reduce gaps on the rota and resilience on bank & usage fill. 2) Outcome of UCV pilot focused on dedicated pitstop presence from ED senior. Business case in development.
Estates	1) Review of Ambulatory stream led by transformation team 2) Trust wide Point of Care business case discussed at Trust Investment Group to support central hub for all infection testing for admitting areas 3) Continued use of fallow pitstop as surge area Renal Assessment Unit or AMU 5.
Culture & Staff Support	1) Violence & Aggression discussions ongoing with Exec and multi-agency colleagues to respond the increase in volume of presentations and threat current posed to the ED team 2) Constant update to Exec and Trust Board via fortnightly meeting and regular updates to Trust Board as part of IPR

Urgent Care Village pilot





The two graphs above are part of feedback from the Urgent Care Village pilot. They show the average time to first clinician seen, and overall average time in UCV, during the pilot. The dates of the pilot are indicated (12/9/22 – 18/9/22) with the impact shown. It should be noted also that during the week of the trial, attendances were representative but overall number of breaches was around half that of the two weeks previous and after, with much of this attributable to bed availability within the Trust.

Next steps following UCV are to continue to identify opportunities for change, with or without additional investment. Key streams in this are:

- Prioritising an ED consultant in the 'pitstop' area
- In-reach work from AMU/SDEC consultants
- SDEC pathways
- Shorter HMRs to reduce burden of work on admitting areas
- Clinically led MDT meetings daily
- Ongoing work on the DoS

Longer term considerations:

- Understand models of resource: close to 'front door' versus co-located with specialty
- Potential longer pilots
- Understand options for varying degrees of UCV within the Trust

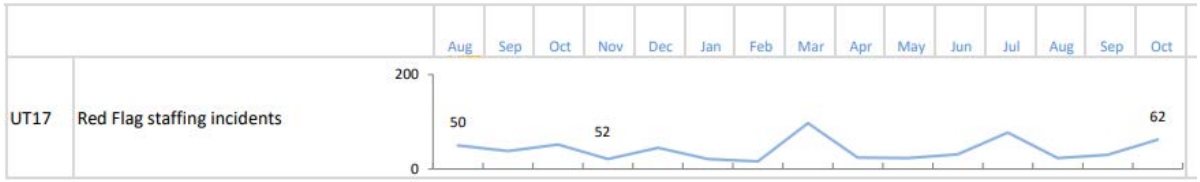
Spotlight: Staffing incidents and red flags

Context

Staffing capacity at the trust remains challenging in the wake of Covid. While there is a concerted and shared focus on reducing the elective backlog and maintaining high levels of care and quality, Covid-related absences (whether by testing positive or having a household member test positive) are continuing to have a significant adverse impact on operational performance and service delivery.

Furthermore, the trust reported an Opel 4 alert status in early October 2022 and remains at this escalated level at the time of this report. The protracted operational escalated status reflects the capacity issues, insufficient workforce in place to manage the elective backlog, and ED waiting time attainment of circa 60-70% against a 95% operational standard.

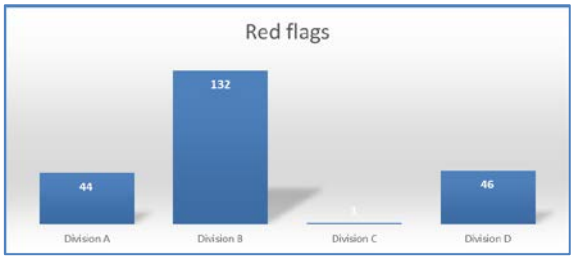
The Integrated Performance Report for November 2022 depicts a continued trend of **red flag incidents** and increased **staffing incidents**.



This report aims to identify and address the heightened incidents (both in terms of severity and frequency) and provide details on the specific actions required to address the causes.

When and where the incidents are being reported

Staffing incidents relate to all staff; Red Flags are only used for nursing. Reports come from either the safeguard (AER) system or HealthRoster SafeCare system. Both sets of information are presented at the Nursing & Midwifery Staffing Review Group and emergent themes are identified and reviewed.



Red Flags from the HealthRoster system increased significantly in October with 233 incidents reported, up significantly from September which saw 138. This was alongside the 62 red flags from the safeguard (AER) system identified in the IPR.

NICE guidance was published in 2014 to set out 'red flag events' for nursing care in wards. These events include patients not being provided with basic care such as pain relief or help to visit the bathroom.

Most of the Red Flag incidents are within Division B with 'high acuity' being the most cited red flag (96 of the 132) and a further 29 cases due to 'working below agreed tipping points'.

Division A (29 out of 44) and Division D (13 out of 46) also cited 'high acuity'.

Staffing incidents in October 2022 totalled 155; a significant increase from September (80). These incidents were rated from near miss to moderate (9) and severe/major (2) impact. This is also an increase in the severity of incident reported. Most staffing incidents were reported by the nursing team (111 of the 155).

Emergent themes by division are:

Div A	Div B	Div C	Div D	THQ
Incidents ranged from 'near miss' to 'moderate impact' Incidents were raised from Critical Care, Surgery and Theatres linked to increased skill-mix challenges and pulling staff from non-clinical duties to support	Incidents ranged from 'near miss' to 'severe impact' with the latter reflecting pressure and staffing challenges across AMU The incidents were reported from a wide range of different areas with no clusters noted Incidents were also reported from across ED and AMU reflecting the challenges on capacity and care	Incidents ranged from 'near miss' to 'low impact' The incidents were reported from a range of clinical areas, reflecting the pressures around matching staffing to the operational challenges	Incidents ranged from 'near miss' to 'moderate impact' The incidents came from a range of clinical areas, reflecting the pressures around matching staffing to the operational challenges	Incidents ranged from 'none/negligible' to 'moderate'. The incidents came from Security and Estates; the moderate incident related to electrical cover for the trust

Impact on patients and workforce

Red Flags have a significant impact on patient experience and safety; in terms of staffing Red Flags this impacts on the current workforce in terms of potential burnout and fatigue with fewer staff covering staffing gaps and vacancies. The level of red flag reporting is both reflective of a better understanding and use of the system as well as a quality indicator of pressures experienced in the clinical areas around staffing. For October the rise in red flag incidents reflects the capacity, staffing and care challenges the trust has experienced with the next wave of COVID-19. This also mirrors the increased rate of reporting via the safeguard AER system.

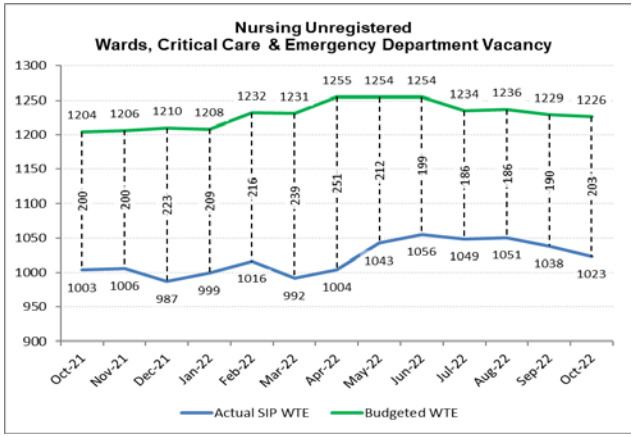
9.4% (21) of the incidents resulted in a clinical impact either in the delay or omission of key nursing interventions and related to delays in administering pain relief, delays in turnaround or the timeliness of vital sign recording. This is a significant rise in the month. Most of the red flags (138) again relate to the rising acuity levels of patients.

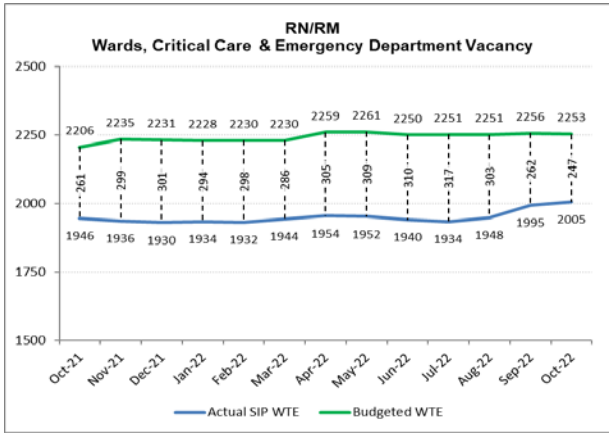
Underlying causes

These relate to staffing capacity, decreasing Care Hours Per Patient Day (CHPPD), increasing vacancies and fewer staff in post, and inability to resolve via temporary resourcing.

Staffing capacity

Concerns around staffing capacity at the trust have necessitated several targeted actions to address and improve staffing in the short-medium term. These include: reviewing high-cost agencies and booking in advance; seeking research and development nursing redeployment; reviewing the rosters in advance, particularly during out-of-hours and weekends; and reviewing the reservist list again.

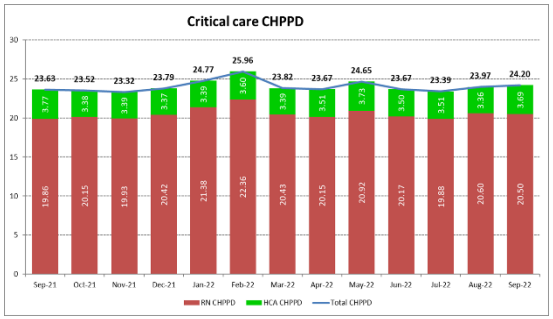


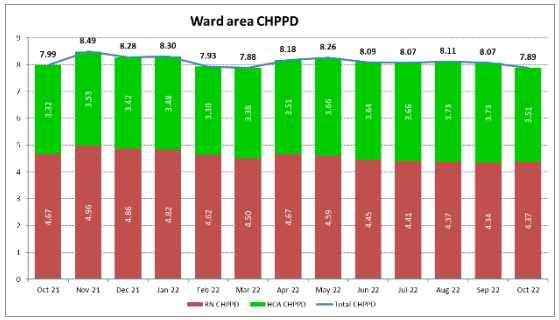


These two charts show that RN/RMs remain flat against the budget, with no discernible increase in numbers in the last 12 months, except a small uptick since August 2022; and that unregistered nursing is decreasing, causing a surge in vacancies, particularly since June 2022. Prior to August 2022, before there was a significant increase in Red Flags, staffing (both registered/ non-registered) was in an improved position, suggesting that this is having a direct impact on the prevalence of Red Flags.

Care hours per patient day (CHPPD)

The Ward areas CHPPD rate in the trust has decreased since August, which is linked to increasing patient numbers; workforce numbers remain constant as patient and activity levels return to pre-pandemic levels. Pre-Covid, the critical care and ward area CHPPD was around 9.0; it spiked due to a fall in patient numbers and has been slowly recovering since.





Risks

The risks associated with staffing incidents are:

- Patient safety and experience
- Staff burnout and sickness because of working additional hours
- Additional financial cost associated with temporary resourcing, particularly usage of high-cost agencies
- The workforce plan for 2022/23, which sets out ambitions to reduce temporary resourcing reliance, will not be achieved

Mitigation

RECRUITMENT: The risks outlined above are slightly offset by newly qualified starters and overseas recruits, although there needs to be consideration of supernumerary periods. There is also a proactive, joined-up process in place to identify incoming workforce against the workforce plan. The HR team are actively involved with promotions of job vacancies and monitor this against both budget and the workforce plan.

RETENTION: A revised and targeted retention action plan is underway and supported by and reporting to the Recruitment & Retention Group. There is also a specific Nursing Retention Action Plan which will be reported to the same group. These have been supported by People & OD Committee and the UHS People Board.

To address staffing incidents, the following actions are underway or planned:

- Real-time monitoring of the red flags and associated actions to mitigate is continuously reviewed through the staffing hub
- A detailed review is undertaken at the time of each report by the Divisions to examine each incident and the impact, action and learning to be achieved.
- A detailed breakdown of the numbers and trends of incidents by department, care group, division and trust can be found in the supporting safeguard data pack circulated to divisions. This pack includes information on risk ratings.
- Actions under temporary resourcing are expected to support staffing levels. These include a focus on rostering and redeployment across UHS wards.

Summary

The board is asked to note the significant rise in the number of incidents relating to staffing, the corresponding rise in red flagged incidents, and the planned actions (some of which are already underway) to mitigate the risks associated with increased staffing incidents.

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) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	9 / 7	10 / 9	68.9% / 10 / 9	10 / 9	9 / 8	8 / 8	6 / 8	5 / 7	5 / 7	3 / 7	4 / 6	4 / 6	5 / 6	6 / 6	65.0%	≥92%	65.9%
CN1-N	% Patients following a GP referral for suspected cancer seen by a specialist within 2 weeks (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	16 / 14	17 / 14	17 / 81.7% / 14	14 / 9	16 / 10	12 / 7	13 / 5	13 / 4	13 / 4	15 / 5	14 / 7	8 / 4	9 / 4	80.0% / 8	9	≥93%	85.9%
UT34-N	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	16 / 7	74.7% / 13 / 2	12 / 4	15 / 5	13 / 3	13 / 4	11 / 4	12 / 2	7 / 3	11 / 5	14 / 6	10 / 5	10 / 3	16 / 10	54.5%	≥85%	66.5%
UT25-N	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 16) South East average (& rank of 16)	4 / 4	4 / 2	66.6% / 6 / 4	4 / 3	5 / 3	8 / 4	10 / 4	6 / 4	4 / 4	8 / 4	7 / 4	7 / 3	4 / 4	5 / 3	57.3% / 7 / 4	≥95%	63.3%
UT33-N	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching Hospital average (& rank of 20) South East Average (& rank of 18)	7 / 13	7 / 14	19.3% / 7 / 14	7 / 13	6 / 12	7 / 13	8 / 12	9 / 13	8 / 13	9 / 11	9 / 8	9 / 8	9 / 7	11 / 9	23.7%	≤1%	23.8%

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**	95 77.6 76.8											91.4 90			70	≤100	92.4	≤100
UT2	HSMR - Crude Mortality Rate	3.1% 2.6%											2.9%			2.5%	<3%	2.7%	<3%
UT1-N / UT2: At time of IPR publication, the latest information available in Doctor Foster was from July 2022. Metrics are 12 month rolling. YTD target is for UHS for financial year																			
UT3	Percentage non-elective readmissions within 28 days of discharge from hospital	15% 11.2%											11.8%			10%	-	11.5%	
		Q2 21-22			Q3 21-22			Q4 21-22			Q1 22-23			Q2 22-23		Q3	Quarterly target		
UT4-L	**Cumulative Specialties** with Outcome Measures Developed (Quarterly)	65 406			383			393			419			403		25	+1 Specialty per quarter		
UT5	Developed Outcomes RAG ratings (Quarterly) Red Amber Green	100% 78%			77%			76%			74%			74%		50%			
UT5 -	Red : below the national standard or 10% lower than the local target Amber : below the national standard or 5% lower than the local target Green : within the national standard or local target																		

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 **Most recent 12 Months** vs. **Previous 12 Months**	43	44	50	49	52	56	55	64	57	71	63	74	7	9	16	11	21	18	25	24	33	31	39	39	44	51	≤5	51	≤35
UT7	**Healthcare-acquired COVID infection**: COVID-positive sample taken >14days after admission (validated)	0	7	6	11	21	20	14	42	36	23	45	45	2	29	87	-	267	-
UT8	**Probable hospital-associated COVID infection**: COVID-positive sample taken >7 days and <=14 days after admission (validated)	4	3	9	11	14	17	10	31	35	12	32	37	4	15	49	-	184	-
UT9	Pressure ulcers category 2 per 1000 bed days	0.50														0.42	<0.3	0.31	<0.3
UT10	Pressure ulcers category 3 and above per 1000 bed days	0.33														0.37	<0.3	0.38	<0.3
UT11-N	Medication Errors (severe/moderate)															4	≤3	21	≤21

		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
UT12	Watch & Reserve antibiotics, usage per 1,000 adms Most recent months vs. 2018*95.5%	2,499	2,447											2,499	2,667		2,511	13,937	13,582
UT12 - For 2022/23, a new requirement is applied: Reduction of 4.5% from calendar year 2018 usage in combined WHO/NHSE AWaRE subgroups for “watch” and “reserve” agents. The performance data relate to successive FINANCIAL years, however the comparator denominator remains CALENDAR year 2018 (we are not using 2020 or 2021 due to the disruptive effect of COVID on both usage and admissions). Data is reported 3 months in arrears.																			
UT13	Serious Incidents Requiring Investigation (SIRI) (based upon month reported as SIRI, excluding Maternity)			7												4	-	80	-
UT14	Serious Incidents Requiring Investigation - Maternity			1												1	-	7	-
UT15	Number of falls investigated per 1000 bed days			0.08												0.17	-	0.16	-
UT16	% patients with a nutrition plan in place (total checks conducted included at chart base)	691	755	787	444	397						53	742	572	750	719	≥90%	94.3%	≥90%
		92.0%														94.0%			
UT16 - monthly audit was paused due to pressure on all ward areas between Dec 2021 to May 2022. The audit was partially restarted in some ward areas in May 2022, and fully restarted in June 2022.																			
UT17	Red Flag staffing incidents			50		52										62	-	270	-

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	3% 0%		0.4%												0.2%	≤5%	1.0%	≤5%
UT19-N	FFT Negative Score - Maternity (postnatal ward)	20% 0%		10.3%												1.8%	≤5%	2.9%	≤5%
UT20	Total UHS women booked onto a continuity of carer pathway	50% 30%		41.0%												46.5%	≥35%	44.2%	≥35%
UT21	Total BAME women booked onto a continuity of carer pathway	100% 35%		45.3%												78.0%	≥51%	80.0%	≥51%
UT22	% Patients reporting being involved in decisions about care and treatment	100% 80%		88.0%												89.0%	≥90%	89.7%	≥90%
UT23	% Patients with a disability/ additional needs reporting those needs/adjustments were met (total number questioned included at chart base)	100% 70%		91.0%												87.0%	≥90%	89.2%	≥90%
				197	153	165	155	131	95	143	117	121	120	139	178	173	145		
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		33												62	-	333	-

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 - (Type 1) UHSFT Teaching hospital average (& rank of 16) South East average (& rank of 16)	4 4 4	4 2	6 66.6% 4	4 3	5 3	8 4	10 4	6 4	4 4	8 4	7 3	7 4	4 3	5 4	7 57.3% 4	≥95%	63.3%	≥95%
UT26	Average (Mean) time in Dept - non-admitted patients	03:14														03:28	≤04:00	03:18	≤04:00
UT27	Average (Mean) time in Dept - admitted patients	05:03														06:24	≤04:00	05:47	≤04:00
UT28-N	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	9 10 7	68.9% 9	10 9	10 8	9 8	8 8	6 8	5 7	5 7	3 7	4 6	4 6	5 6	6 6	65.0% 6	≥92%	65.9%	≥92%
UT29	Total number of patients on a waiting list (18 week referral to treatment pathway)	44,749														53,913	-	53,913	-
UT30	Patients on an open 18 week pathway (waiting 52 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	7 2,255 15	7 15	7 15	7 15	7 14	7 14	7 14	7 14	7 14	7 12	5 12	5 13	5 13	5 13	2,340	2,011	2,340	2,011

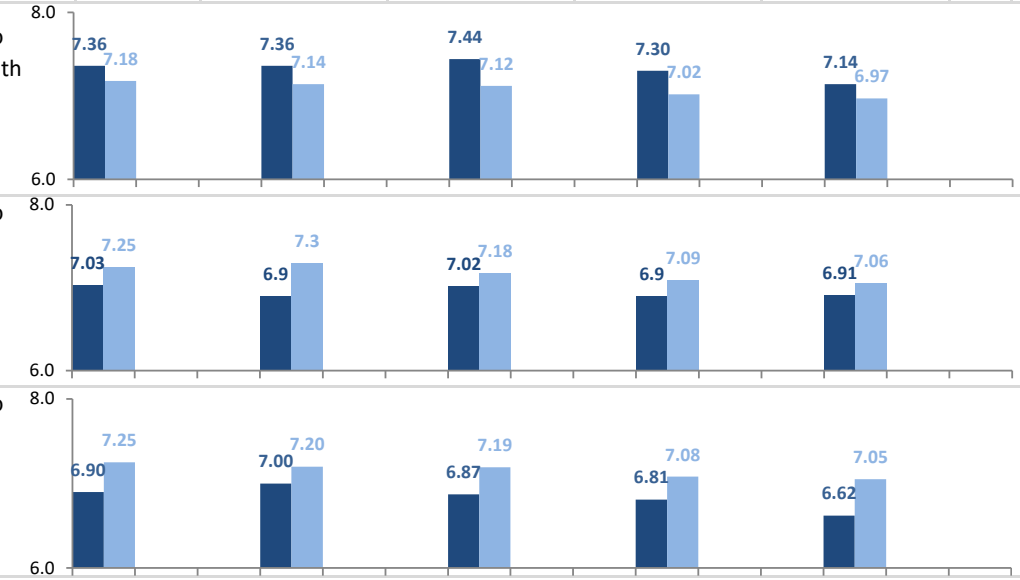
		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
UT31	Patients on an open 18 week pathway (waiting 104 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	600 137 17	8 17	8 17	8 17	8 17	8 17	8 17	6 17	8 17	5 13	6 13	6 13	6 14	7 14	1 0	0	1	0
UT31a	Patients on an open 18 week pathway (waiting 78 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	3,000 837 14	6 14	6 15	7 15	7 15	7 15	8 15	8 15	7 15	7 15	7 13	7 13	7 14	7 15	271 0		271	
UT32	Patients waiting for diagnostics	12,500 9,129 8,500														10,593	-	10,593	-
UT33-N	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	50% 19.3% 13	7 14	7 14	7 13	6 12	7 13	8 12	9 13	8 13	9 11	9 8	9 8	9 7	11 9	23.7% 0%	≤1%	23.8%	≤1%
UT34-N	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	100% 16 74.7% 7	13 2	12 4	15 5	13 3	13 4	11 4	12 2	7 3	11 5	14 6	10 5	10 3	16 10	54.5% 40%	≥85%	66.5%	≥85%
UT35-N	31 day cancer wait performance - decision to treat to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	100% 16 88.6% 13	18 15	9 3	9 3	11 2	12 5	14 6	16 14	14 9	16 12	15 8	15 10	17 16	16 12	88.7% 80%	≥96%	90.6%	≥96%
UT36-N	31 day cancer wait performance - Subsequent Treatments of Cancer (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	100% 13 90.4% 10	18 17	14 13	16 15	15 16	11 8	14 11	15 8	13 15	9 10	12 10	13 13	13 13	13 13	89.7% 85%	≥96.0%	89.8%	≥96.0%

R&D Performance		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	10	9	9	9	8	9	8	9	1	1	3	4	5	6	7	Top 10	-	-
PN2-L	Comparative CRN Recruitment Performance - weighted	4	3	3	3	3	4	4	3	6	8	11	7	7	7	8	Top 5	-	-
PN3-L	Comparative CRN Recruitment - contract commercial	4	4	3	7	7	8	9	10	2	1	3	2	3	4	4	Top 10	-	-
PN4-L	Achievement compared to R+D Income Baseline Monthly income increase % YTD income increase %	143.0%	-5.0%	334.0%	99.0%	0.0%	29.0%	-234.0%	143.0%	359.0%	63.0%	74.0%	56.0%	177.0%	94.0%	48.0%	23.0%	76.0%	≥5%	-	-
PN4-L	Note – Monthly and YTD Income are affected by a permanent change in accounting treatment implemented in M10 (Jan) 2021/22 in order to improve accuracy. Prior to M10, R+D open and ongoing studies/ grants in credit had anticipated future costs accrued. From M10 onwards, income received is deferred where costs have not yet been incurred/ invoiced. This change results in an adjustment of -£5m to monthly and YTD income which has been applied in M10. (An equivalent adjustment to the costs accounted for means that the balance of income and expenditure is not affected).																		

Thrive		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
WR1-L	Substantive Staff - Turnover **-R12M turnover %** **-Leavers in month (FTE)**	16% 10%		13.3% 155												14.6% 122	200 0	R12M <= 12.0%	14.9%	-
WR2-L	Staff Vacancies **-Nursing vacancies** (registered nurses only in clinical wards) **-All Staff vacancies**	20% 0%		11.8% 6.2%												11.1% 7.3%		-	-	-
WR3-L	Workforce Numbers **-Planned substantive WTE** **-Actual substantive WTE** *-Including - Month-end contracted staff in post (ESR), Consultant APAs, Junior doctors Extra Rostered Hrs* *-Excluding - Bank and agency; honorary contracts; career breaks; secondments; hosted services; WPL; Chilworth; Vaccination Hub*	12,500 11,000											11,570 11,570			12,006 11,695		11,900 WTE by March 2023	-	-
WR4-L	Staff - Sickness absence **-R12M sickness %** **-Sickness in month %**	7% 0%		4.8% 3.9%												4.8% 4.4%		R12M <= 3.4%	4.8%	-
Excel		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
WR5-L	Non-medical appraisals completed **-R12M appraisal %** **-Appraisals in month**	100% 50%		75.1% 591												73.7% 461	725 325	R12M >= 92.0%	72.9%	-
WR6-L	Medical staff appraisals completed - Rolling 12-months	90% 50%		83.0%												77.9%		-	-	-

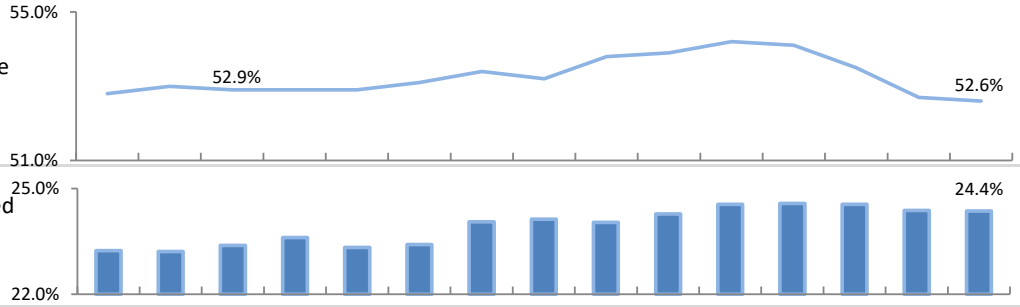
		Q2 21-22	Q3 21-22	Q4 21-22	Q1 22-23	Q2 22-23	Q3		Quarterly target		
WR7-L	Staff recommend UHS as a place to work score: National Quarterly Pulse Survey (NQPS) National NHS Staff Survey	7.3	7.1	7.24	7.05	6.96			-	-	-
WR7-L - Metric has changed from The Friends and Family Test (%, Q4 2020) to the Pulse Survey (out of 10).											
WR8-L	Staff survey engagement score National Quarterly Pulse Survey (NQPS) National NHS Staff Survey	7.21	7.2	7.17	7.08	7.03			-	-	-
WR8-L - Maximum score = 10, Average of "Acute and Acute&Community", group is 7.											
Belong		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct		Monthly target	YTD	YTD target
WR9-L	% of Band 7+ staff who are Black and Minority Ethnic		10.1%													10.6%		19% by 2026	10.6%	-
WR10	% of Band 7+ Staff who have declared a disability or long term health condition		13.4%													13.1%		-	-	-

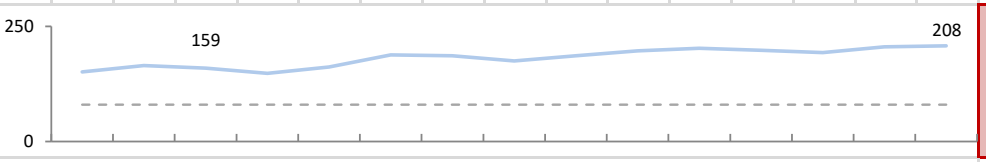
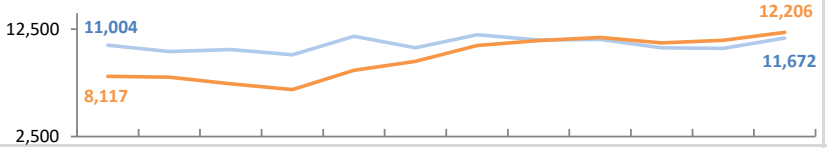
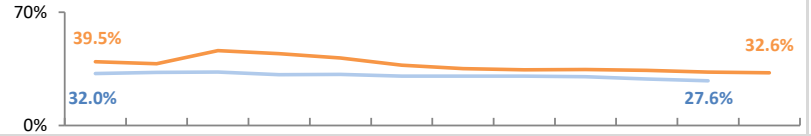
		Q2 21-22	Q3 21-22	Q4 21-22	Q1 22-23	Q2 22-23	Q3	Quarterly target		
WR11	Staff recommending UHS as a place to work: White British staff compared with all other ethnic groups combined -White British -All other ethnic groups combined	7.36 / 7.18	7.36 / 7.14	7.44 / 7.12	7.30 / 7.02	7.14 / 6.97		-	-	-
WR12	Staff recommending UHS as a place to work: Non disabled /prefer not to answer compared with Disabled -Non disabled /prefer not to answer -Disabled	7.03 / 7.25	6.9 / 7.3	7.02 / 7.18	6.9 / 7.09	6.91 / 7.06		-	-	-
WR13	Staff recommending UHS as a place to work: Sexuality = Heterosexual compared with all other groups combined -Sexuality = Heterosexual -All other groups combined	6.90 / 7.25	7.00 / 7.20	6.87 / 7.19	6.81 / 7.08	6.62 / 7.05		-	-	-

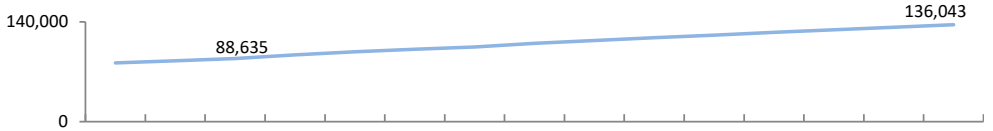
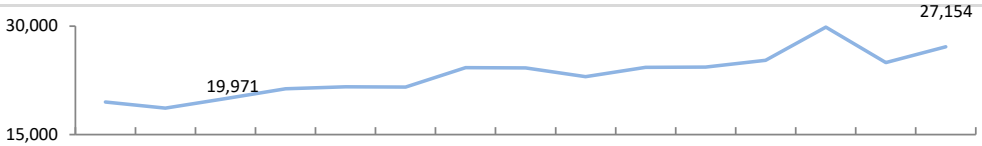
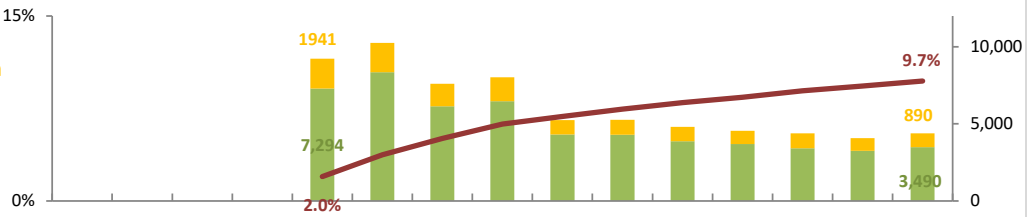


WR11, WR12,WR13: Average recommendation score of 10 = Highly recommend to 0 = Strongly not recommended, results from National Quarterly Pulse Survey.

		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 (inside the Southampton City boundaries)			52.9%												52.6%	-	-	-
FN7	Percentage of staff residing in deprived areas (lowest 30% - national Index of Multiple Deprivation)															24.4%	-	-	-



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	199	-
NT2	Emergency Department activity - type 1 This year vs. last year																-	78,960	-
NT3	Percentage of virtual appointments as a proportion of all outpatient consultations This year vs. last year																≥25%	29.7%	≥25%

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 (cumulative number of accounts in place at the end of each month)																-	136,043	
FN2	My Medical Record - UHS patient logins (number of logins made within each month)																-	178,909	
FN3	Patients choosing digital correspondence - Total choosing paperless in the month - Total offered but not yet choosing paperless in the month - % of total My Medical Record service users who have chosen paperless (cumulative)																-		

Report notes - Nursing and midwifery staffing hours - October 2022

Our staffing levels are continuously monitored through our staffing hub 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, these wards had in the main returned to their normal size and purpose. Over the last few months COVID-19 numbers again increased so wards and departments have 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. September aand October have again seen a rise in the number of beds required to support COVID-19 and therefore ward changes have occured and additional beds have been staffed.

Ward		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered midwives/ nurses	CHPPD Care Staff	CHPPD Overall	Comments
CC Neuro Intensive Care Unit	Day	5203	4751	713	634	91.3%	88.9%	29.7	3.9	33.7	Safe staffing levels maintained by sharing staff resource; Staff moved to support other wards.
CC Neuro Intensive Care Unit	Night	5172	4786	707	632	92.5%	89.4%				Safe staffing levels maintained by sharing staff resource; Staff moved to support other wards.
CC - Surgical HDU	Day	2158	1892	711	540	87.7%	75.9%	15.0	4.1	19.1	Staff moved to support other wards.
CC - Surgical HDU	Night	2140	1912	690	508	89.4%	73.7%				Staff moved to support other wards.
CC General Intensive Care	Day	10973	10467	1899	1245	95.4%	65.6%	29.0	3.6	32.6	Safe staffing levels maintained; Staff moved to support other wards.
CC General Intensive Care	Night	10693	9811	1774	1298	91.7%	73.2%				Safe staffing levels maintained; Staff moved to support other wards.
CC Cardiac Intensive Care	Day	5817	5047	1397	981	86.8%	70.3%	28.1	4.6	32.7	Staff moved to support other wards.
CC Cardiac Intensive Care	Night	5943	5395	860	738	90.8%	85.8%				Staff moved to support other wards.

Ward		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered midwives/ nurses	CHPPD Care Staff	CHPPD Overall	Comments
SUR E5 Lower GI	Day	1466	1320	872	957	90.0%	109.9%	3.9	3.0	6.9	Staff moved to support other wards; Additional staff used for enhanced care - Support workers.
SUR E5 Lower GI	Night	714	669	347	536	93.7%	154.7%				Staff moved to support other wards; Additional staff used for enhanced care - Support workers.
SUR E5 Upper GI	Day	1472	1284	1014	928	87.2%	91.5%	4.1	2.7	6.7	Staff moved to support other wards.
SUR E5 Upper GI	Night	725	844	346	478	116.4%	138.4%				Increase in acuity/dependency of patients in the month
SUR E8 Ward	Day	2586	2086	1367	1442	80.7%	105.5%	4.7	3.5	8.2	Staff moved to support other wards; Additional staff used for enhanced care - Support workers.
SUR E8 Ward	Night	1719	1258	1052	1019	73.2%	96.9%				Staff moved to support other wards
SUR F11 IF	Day	1894	1647	835	739	87.0%	88.5%	4.6	2.9	7.5	Safe staffing levels maintained.
SUR F11 IF	Night	713	702	699	771	98.4%	110.2%				Safe staffing levels maintained.
SUR Acute Surgical Unit	Day	1484	1080	747	692	72.8%	92.6%	6.7	4.3	11.0	Staff moved to support other wards.
SUR Acute Surgical Unit	Night	713	759	704	471	106.5%	66.9%				Safe staffing levels maintained.
SUR Acute Surgical Admissions	Day	2145	2111	850	1001	98.4%	117.7%	3.8	2.4	6.2	Additional staff used for enhanced care - Support workers.
SUR Acute Surgical Admissions	Night	1070	1050	1056	1039	98.1%	98.4%				Safe staffing levels maintained.
SUR F5 Ward	Day	1992	1596	951	1342	80.1%	141.1%	3.4	2.8	6.3	Skill mix swaps undertaken to support safe staffing across the Unit.
SUR F5 Ward	Night	1163	987	700	761	84.9%	108.7%				Skill mix swaps undertaken to support safe staffing across the Unit.
OPH Eye Short Stay Unit	Day	1150	1032	810	923	89.8%	113.9%	10.8	9.9	20.7	Staff moved to support other wards; Increase in acuity/dependency of patients in the month.
OPH Eye Short Stay Unit	Night	330	354	324	341	107.3%	105.2%				Increase in acuity/dependency of patients in the month; Continued use of inpatient beds for patients from other specialties.
THR F10 Surgical Day Unit	Day	1271	1852	2651	2055	145.7%	77.5%	3.9	4.5	8.4	Increase in acuity/dependency of patients in the month; Continued use of facility to support 18-24 inpatients
THR F10 Surgical Day Unit	Night	287	434	269	599	151.0%	222.9%				Increase in acuity/dependency of patients in the month; Continued use of facility to support 18-24 inpatients overnight; Increased night staffing to support raised acuity.

Ward		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered midwives/ nurses	CHPPD Care Staff	CHPPD Overall	Comments
CAN Acute Onc Services	Day	989	968	681	632	97.9%	92.9%	7.7	6.5	14.2	Safe staffing levels maintained.
CAN Acute Onc Services	Night	362	562	359	658	155.1%	183.3%				Additional beds open in the month.
CAN C4 Solent Ward Clinical Oncology	Day	1764	1498	1017	1167	84.9%	114.8%	4.2	3.9	8.1	Safe staffing levels maintained.
CAN C4 Solent Ward Clinical Oncology	Night	1071	945	714	1095	88.3%	153.3%				Safe staffing levels maintained.
CAN C6 Leukaemia/BMT Unit	Day	2839	2559	663	769	90.1%	116.0%	7.1	1.8	8.9	Safe staffing levels maintained by sharing staff resource.
CAN C6 Leukaemia/BMT Unit	Night	2063	1905	349	384	92.4%	110%				Safe staffing levels maintained by sharing staff resource.
CAN C6 TYA Unit	Day	1203	929	415	177	77.2%	42.7%	8.6	1.1	9.7	Safe staffing levels maintained by sharing staff resource.
CAN C6 TYA Unit	Night	653	659	0	34	100.9%	Shift N/A				Safe staffing levels maintained.
CAN C2 Haematology	Day	2353	2439	1141	963	103.6%	84.4%	5.4	2.6	7.9	Safe staffing levels maintained.
CAN C2 Haematology	Night	1784	1856	1067	1082	104.0%	101.4%				Safe staffing levels maintained.
CAN D3 Ward	Day	1796	1569	770	1387	87.4%	180.0%	4.2	3.9	8.1	Safe staffing levels maintained by sharing staff resource.
CAN D3 Ward	Night	1055	1129	687	1099	107.0%	159.9%				Additional staff used for enhanced care - Support workers.

Ward		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered midwives/ nurses	CHPPD Care Staff	CHPPD Overall	Comments
ECM Acute Medical Unit	Day	4014	4629	3940	4038	115.3%	102.5%	5.8	4.7	10.6	Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource; Additional 8 bed capacity open as required. Total bed capacity intermittently 68 beds. RMNO3 supporting registered nurses.
ECM Acute Medical Unit	Night	4079	4661	3526	3515	114.3%	99.7%				Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource; Additional 8 bed capacity open as required. Total bed capacity intermittently 68 beds. RMNO3 supporting registered nurses.
MED D5 Ward	Day	1271	1632	1711	1360	128.5%	79.5%	4.1	3.3	7.4	Additional staff used for enhanced care - RNs;Patient requiring 24 hour 1:1 nursing in the month; Ward Leader Supervisory shifts used to support staffing numbers.
MED D5 Ward	Night	1060	1390	921	1116	131.2%	121.2%				Additional staff used for enhanced care - RNs; Additional staff used for enhanced care - Support workers; Safe staffing levels maintained; Ward Leader Supervisory shifts used to support staffing numbers.
MED D6 Ward	Day	1046	1398	1510	1549	133.7%	102.6%	3.6	3.4	7.0	Additional staff used for enhanced care - RNs; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained; Ward Leader Supervisory shifts used to support staffing numbers.
MED D6 Ward	Night	1060	1190	949	899	112.3%	94.8%				Additional staff used for enhanced care - RNs; Safe staffing levels maintained
MED D7 Ward	Day	687	854	1380	1018	124.3%	73.8%	3.2	3.4	6.5	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained; Ward Leader Supervisory shifts used to support staffing numbers.
MED D7 Ward	Night	718	657	691	586	91.5%	84.8%				Safe staffing levels maintained
MED D8 Ward	Day	1060	1000	1546	1361	94.4%	88.0%	2.7	3.1	5.8	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Ward Leader Supervisory shifts used to support staffing numbers.
MED D8 Ward	Night	1072	911	925	872	85.0%	94.3%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers
MED D9 Ward	Day	1297	1457	1749	1119	112.3%	64.0%	2.9	2.7	5.5	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Ward Leader Supervisory shifts used to support staffing numbers.
MED D9 Ward	Night	1072	821	923	1003	76.6%	108.7%				Staff moved to support other wards; Band 4 staff working to support registered nurse numbers; Ward Leader Supervisory shifts used to support staffing numbers.
MED E7 Ward	Day	1305	1264	1632	1329	96.8%	81.5%	3.2	2.9	6.1	Safe staffing levels maintained by sharing staff resource.
MED E7 Ward	Night	702	1221	804	888	174.1%	110.4%				Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained by sharing staff resource.
MED F7 Ward	Day	737	1151	1378	1149	156.0%	83.4%	3.1	3.1	6.1	Band 4 staff working to support registered nurse numbers; Staff moved to support other wards.
MED F7 Ward	Night	713	701	687	690	98.4%	100.4%				Staffing appropriate for number of patients.
MED Respiratory HDU	Day	2300	1475	442	375	64.1%	84.7%	15.5	2.7	18.2	Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Safe staffing levels maintained; Ward Leader Supervisory shifts used to support staffing numbers.
MED Respiratory HDU	Night	2157	1637	330	173	75.9%	52.5%				Beds flexed to match staffing; Safe staffing levels maintained by sharing staff resource.
MED C5 Isolation Ward	Day	1187	966	1113	695	81.4%	62.4%	5.2	3.2	8.5	Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained;Ward Leader Supervisory shifts used to support staffing numbers.
MED C5 Isolation Ward	Night	1072	857	329	427	80.0%	129.8%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
MED D10 Isolation Unit	Day	1116	996	1357	1099	89.2%	81.0%	3.5	3.6	7.1	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
MED D10 Isolation Unit	Night	713	879	684	851	123.3%	124.3%				Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained by sharing staff resource.

Ward		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered midwives/ nurses	CHPPD Care Staff	CHPPD Overall	Comments
MED G5 Ward	Day	1424	1260	1469	1382	88.5%	94.1%	2.7	2.6	5.4	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers; Safe staffing levels maintained by sharing staff resource.
MED G5 Ward	Night	1070	1002	683	769	93.6%	112.5%				Band 4 staff working to support registered nurse numbers;Additional staff used for enhanced care - Support workers.
MED G6 Ward	Day	1440	1412	1518	1198	98.1%	79.0%	3.1	2.8	5.9	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
MED G6 Ward	Night	1051	819	683	876	77.9%	128.2%				Band 4 staff working to support registered nurse numbers.
MED G7 Ward	Day	738	656	631	738	88.9%	116.9%	3.3	2.9	6.2	Increase in acuity/dependency of patients in the month; Additional staff used for enhanced care - Support workers.
MED G7 Ward	Night	702	679	325	436	96.7%	134.2%				Increase in acuity/dependency of patients in the month; Additional staff used for enhanced care - Support workers.
MED G8 Ward	Day	1472	1188	1463	1450	80.7%	99.1%	2.8	2.9	5.7	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
MED G8 Ward	Night	1058	943	669	782	89.1%	116.9%				Band 4 staff working to support registered nurse numbers.
MED G9 Ward	Day	1464	1397	1459	1334	95.4%	91.4%	3.2	2.7	6.0	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers; Safe staffing levels maintained by sharing staff resource.
MED G9 Ward	Night	1070	1069	679	783	100.0%	115.3%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
MED Bassett Ward	Day	1258	829	2509	2126	65.9%	84.7%	2.2	4.2	6.4	Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit.
MED Bassett Ward	Night	1072	899	1037	1118	83.9%	107.8%				Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month.

Ward		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered midwives/ nurses	CHPPD Care Staff	CHPPD Overall	Comments
CHI High Dependency Unit	Day	1611	1396	0	173	86.6%	Shift N/A	14.8	1.0	15.8	Non-ward based staff supporting areas; Safe staffing levels maintained.
CHI High Dependency Unit	Night	1065	1069	0	0	100.4%	Shift N/A				Safe staffing levels maintained.
CHI Paed Medical Unit	Day	1979	1605	743	869	81.1%	117.0%	6.9	3.8	10.7	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
CHI Paed Medical Unit	Night	1705	1376	644	770	80.7%	119.5%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
CHI Paediatric Intensive Care	Day	6577	5830	1166	466	88.6%	39.9%	30.2	3.1	33.2	Band 4 staff working to support registered nurse numbers; Non-ward based staff supporting areas; Safe staffing levels maintained;Beds flexed to match staffing.
CHI Paediatric Intensive Care	Night	5698	5031	863	639	88.3%	74.0%				Band 4 staff working to support registered nurse numbers;Beds flexed to match staffing;Safe staffing levels maintained.
CHI Piam Brown Unit	Day	3793	2426	1063	431	64.0%	40.5%	11.4	1.7	13.0	Beds flexed to match staffing; Non-ward based staff supporting areas.
CHI Piam Brown Unit	Night	1424	1071	674	92	75.2%	13.6%				Beds flexed to match staffing.
CHI Ward E1 Paed Cardiac	Day	2209	1293	592	736	58.5%	124.4%	5.9	3.1	9.0	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
CHI Ward E1 Paed Cardiac	Night	1427	1154	317	550	80.8%	173.5%				Band 4 staff working to support registered nurse numbers;Safe staffing levels maintained by sharing staff resource.
CHI Bursledon House	Day	797	629	521	318	78.9%	61.2%	4.5	2.8	7.3	Band 4 staff working to support registered nurse numbers;Non-ward based staff supporting areas.
CHI Bursledon House	Night	187	187	146	188	100.0%	128.4%				Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month.
CHI Ward G2 Neuro	Day	798	806	903	165	100.9%	18.2%	9.2	1.5	10.7	Safe staffing levels maintained.
CHI Ward G2 Neuro	Night	729	824	702	106	113.0%	15.1%				Safe staffing levels maintained.
CHI Ward G3	Day	2516	1595	1711	900	63.4%	52.6%	5.9	3.1	9.0	Band 4 staff working to support registered nurse numbers; Non-ward based staff supporting areas; Beds flexed to match staffing.
CHI Ward G3	Night	1687	1320	982	613	78.2%	62.4%				Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Safe staffing levels maintained.
CHI Ward G4 Surgery	Day	2480	2115	1272	645	85.2%	50.7%	6.8	1.9	8.8	Band 4 staff working to support registered nurse numbers; Non-ward based staff supporting areas; Beds flexed to match staffing.
CHI Ward G4 Surgery	Night	1706	1380	639	348	80.9%	54.4%				Band 4 staff working to support registered nurse numbers;Beds flexed to match staffing.

Ward		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered midwives/ nurses	CHPPD Care Staff	CHPPD Overall	Comments
W&N Bramshaw Womens Unit	Day	1164	1002	690	581	86.1%	84.2%	4.1	2.8	6.9	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
W&N Bramshaw Womens Unit	Night	759	759	613	600	100.0%	98.0%				Safe staffing levels maintained.
W&N Neonatal Unit	Day	6448	4722	2059	1484	73.2%	72.1%	9.6	3.2	12.8	Safe staffing levels maintained.
W&N Neonatal Unit	Night	5069	3691	1642	1276	72.8%	77.7%				Safe staffing levels maintained.
W&N PAH Maternity Service combined	Day	10686	8733	3672	3186	81.7%	86.8%	8.8	2.8	11.6	Safe staffing levels maintained.
W&N PAH Maternity Service combined	Night	6729	5326	1607	1321	79.2%	82.2%				Safe staffing levels maintained.

Ward		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered midwives/ nurses	CHPPD Care Staff	CHPPD Overall	Comments
CAR CHDU	Day	4917	4556	1774	1325	92.7%	74.7%	14.2	4.2	18.4	Safe staffing levels maintained; Skill mix swaps undertaken to support safe staffing across the Unit.
CAR CHDU	Night	3894	3859	960	1146	99.1%	119.3%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAR Coronary Care Unit	Day	2710	2586	1059	1112	95.4%	105.0%	8.2	3.7	11.8	Safe staffing levels maintained;Additional staff used for enhanced care - Support workers.
CAR Coronary Care Unit	Night	2340	2252	893	1053	96.2%	117.9%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAR Ward D4 Vascular	Day	1940	1889	1183	1102	97.4%	93.2%	4.9	3.4	8.3	Safe staffing levels maintained
CAR Ward D4 Vascular	Night	1045	1237	968	1079	118.4%	111.5%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAR Ward E2 YACU	Day	1599	1342	838	936	83.9%	111.7%	4.2	3.6	7.8	Staff moved to support other wards; Additional staff used for enhanced care - Support workers.
CAR Ward E2 YACU	Night	716	755	627	827	105.5%	132.0%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAR Ward E3 Green	Day	1595	1457	1441	1234	91.4%	85.6%	3.4	3.2	6.6	Safe staffing levels maintained; Staff moved to support other wards.
CAR Ward E3 Green	Night	706	758	964	906	107.4%	94.0%				Safe staffing levels maintained by sharing staff resource; Safe staffing levels maintained.
CAR Ward E3 Blue	Day	1627	1363	920	848	83.8%	92.2%	4.0	3.1	7.1	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
CAR Ward E3 Blue	Night	718	733	614	807	102.1%	131.4%				Safe staffing levels maintained by sharing staff resource; Additional staff used for enhanced care - Support workers.
CAR Ward E4 Thoracics	Day	1585	1337	1444	1296	84.3%	89.7%	4.1	3.3	7.4	Band 4 staff working to support registered nurse numbers; Staff moved to support other wards.
CAR Ward E4 Thoracics	Night	1045	1027	415	630	98.3%	151.7%				Safe staffing levels maintained by sharing staff resource; Additional staff used for enhanced care - Support workers.
CAR Ward D2 Cardiology	Day	1403	956	685	1157	68.1%	169.0%	3.6	4.7	8.3	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
CAR Ward D2 Cardiology	Night	716	652	628	924	91.1%	147.1%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.

Ward		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered midwives/ nurses	CHPPD Care Staff	CHPPD Overall	Comments
NEU Acute Stroke Unit	Day	1430	1531	2595	2378	107.1%	91.6%	2.9	4.9	7.9	Additional staff used for enhanced care - RNs.
NEU Acute Stroke Unit	Night	1024	936	1646	1794	91.4%	109.0%				Band 4 staff working to support registered nurse numbers.
NEU Regional Transfer Unit	Day	1182	939	390	364	79.4%	93.2%	6.7	4.8	11.4	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
NEU Regional Transfer Unit	Night	682	528	622	683	77.4%	109.8%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
NEU ward E Neuro	Day	1876	1804	1131	1674	96.2%	148.1%	4.1	4.1	8.1	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
NEU ward E Neuro	Night	1354	1358	961	1474	100.3%	153.3%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers; Increase in acuity/dependency of patients in the month.
NEU HASU	Day	1573	1275	376	500	81.1%	133.2%	7.0	2.6	9.6	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
NEU HASU	Night	1398	1225	279	408	87.6%	146.3%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
NEU Ward D Neuro	Day	1894	1627	1936	1802	85.9%	93.1%	3.6	4.2	7.8	Band 4 staff working to support registered nurse numbers.
NEU Ward D Neuro	Night	1375	1289	1652	1598	93.7%	96.7%				Safe staffing levels maintained.
SPI Ward F4 Spinal	Day	1583	1549	1110	1372	97.8%	123.6%	4.1	4.0	8.1	Additional staff used for enhanced care - Support workers.
SPI Ward F4 Spinal	Night	1023	1038	959	1169	101.5%	121.8%				Additional staff used for enhanced care - Support workers.

Ward		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered midwives/ nurses	CHPPD Care Staff	CHPPD Overall	Comments
T&O Ward Brooke	Day	1048	1086	1079	897	103.6%	83.2%	3.3	3.3	6.7	Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards.
T&O Ward Brooke	Night	714	725	1004	898	101.5%	89.4%				Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards.
T&O Trauma Admissions Unit	Day	906	830	750	617	91.6%	82.2%	8.1	7.3	15.4	Staff moved to support other wards; Safe staffing levels maintained by sharing staff resource
T&O Trauma Admissions Unit	Night	682	561	616	625	82.3%	101.4%				Staff moved to support other wards; Safe staffing levels maintained by sharing staff resource
T&O Ward F1 Major Trauma Unit	Day	2292	2500	1946	1877	109.1%	96.4%	4.5	3.8	8.3	Patient requiring 24 hour 1:1 nursing in the month; Increase in acuity/dependency of patients in the month; Additional staff used for enhanced care - Support workers.
T&O Ward F1 Major Trauma Unit	Night	1783	1768	1715	1749	99.2%	102.0%				Patient requiring 24 hour 1:1 nursing in the month; Additional staff used for enhanced care - Support workers; Safe staffing levels maintained by sharing staff resource.
T&O Ward F2 Trauma	Day	1654	1437	1895	2232	86.9%	117.8%	3.0	5.1	8.1	Patient requiring 24 hour 1:1 nursing in the month; Additional staff used for enhanced care - Support workers; Staff moved to support other wards.
T&O Ward F2 Trauma	Night	1013	904	1284	1741	89.2%	135.6%				Patient requiring 24 hour 1:1 nursing in the month; Additional staff used for enhanced care - Support workers; Staff moved to support other wards.
T&O Ward F3 Trauma	Day	1595	1702	2125	2083	106.7%	98.0%	3.9	5.7	9.5	Patient requiring 24 hour 1:1 nursing in the month; Additional staff used for enhanced care - Support workers; Staff moved to support other wards.
T&O Ward F3 Trauma	Night	1023	1036	1636	1918	101.3%	117.2%				Patient requiring 24 hour 1:1 nursing in the month; Additional staff used for enhanced care - Support workers; Staff moved to support other wards.
T&O Ward F4 Elective	Day	1397	1256	779	880	89.9%	113.0%	3.6	3.2	6.8	Patient requiring 24 hour 1:1 nursing in the month; Additional staff used for enhanced care - Support workers; Staff moved to support other wards.
T&O Ward F4 Elective	Night	683	662	946	862	97.0%	91.1%				Patient requiring 24 hour 1:1 nursing in the month; Additional staff used for enhanced care - Support workers; Staff moved to support other wards.

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Finance Report 2022-23 Month 7**			
Agenda item:	**5.6**			
Sponsor:	**Ian Howard – Chief Financial Officer**			
Author:	**Philip Bunting – Director of Operational Finance**			
Date:	**29 November 2022**			
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:	**M7 Financial Position** UHS reported a deficit of £2.5m in October 2022, which is now a £16.7m deficit YTD. This is £11.5m adverse to plan across the first seven months of 2022/23 for which a £5.2m deficit was planned. In month, there were a number of one-off costs as follows: • £0.9m of reclassified drugs costs previously flagged as pass through • £0.4m of costs relating to the additional September bank holiday paid in arrears. • £1m of other clinical supplies and non pay adjustments following an internal review of accruals These were however more than offset with non-recurrent benefits of £3.6m generating a net movement of £1.3m deficit as a result of one offs. **Underlying Position** The underlying position for M7 is therefore a deficit of £3.8m (£23m deficit YTD). The position highlights a deterioration from the £3m - £3.5m range seen in earlier months, primarily relating to energy usage and planned winter pressures funding / flex bed costs. The increase is therefore cyclical and would expect to reduce to the previous range outside of the winter months. **ERF Position** UHS achieved 104% in September, broadly consistent with performance in recent months. UHS remains at 106% YTD and has now booked £4.2m of additional income into the position. The payment of this remains uncertain, with ICB and national CFO conversations ongoing.			

UHS continues to be one of a small number of Trusts above the 104% national target, with the majority of Trusts achieving between 95% - 100%.

Key drivers

Further analysis of the key drivers has been incorporated into the Financial Recovery Plan and is therefore not duplicated within the finance report. This will be reinstated in M8.

CIP

The Trust has achieved delivery of £23.7m YTD, above the target of £20.4m.

Identification of CIP schemes has now reached £40.6m of the £45.4m target (89%) and equates to an overall achievement of 3.5% of income. We are looking to commit to achievement of the full target and close the remaining gap within the Financial Recovery Plan.

This achievement level is beyond what has previously been achieved by the Trust, particularly given the operational challenges faced and the financial framework meaning inability to achieve CIP through additional activity.

Capital

The Trust has reported capital expenditure of £16.4m YTD against CDEL, which is broadly consistent with plan. The Trust has £33m of internally funded programmes for delivery in M7-12, including wards and theatres.

The Trust is also forecasting expenditure of £19m on externally funded schemes, predominantly for delivery in M7-12. This includes £10m of wards funded linked to the internal scheme.

Due to the risk of slippage, we have identified a number of schemes to bring forward expenditure from 2023/24, including increasing the profile of wards expenditure. This is mitigating the risk at the end of the year. We are therefore over-committed, off-set by an assumed level of slippage.

The amount left to spend has been circulated to responsible owners in month to ensure clarity, with progress and risks reported regularly.

Wider System Performance

A verbal update on the latest external position will be provided, which broadly remains consistent with previous months.

Forecast

We have received guidance on the forecasting protocol, which is incorporated into the Financial Recovery Plan update. The HIOW ICB

	process is likely to result in an opportunity to formally change our forecast in M9. We are therefore continuing to forecast a break-even position, despite the pressures evident in our YTD position. However, we continue to supplement this forecast with a risk-analysis including various scenarios, with an intermediate case deficit at year-end of £28.7m. This is covered in more detail in the Financial Recovery Plan. **Cash** The cash position remains consistent with the previous forecast. In M7 there has been a further deterioration partially due to unpaid HEE Q3 invoices, but also linked to the operating deficit. Cash is anticipated to reduce further in future months as capital expenditure increases. We are continuing to have a current-account deficit, which is being funded by our capital investment savings account. Should the current run-rate continue, UHS will approach the set Minimum Cash Holding position in mid-2023/24. **Productivity** The latest productivity data is incorporated into the Financial Recovery Plan. It should be noted that is shows improved productivity compared to the M5 data. Whilst under pressure on financial performance, UHS remains significantly more productive than the national average (comfortably within top quartile), with costs associated with that activity contributing to the underlying deficit. Whilst our comparative productivity looks healthy, this does however reflect a loss of overall productivity since 19/20, driven by the same drivers outlined in the reported position. We are continuing to review this movement in productivity by Specialty as part of the Trust Savings Group.
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 relating to the underlying run rate and projected potential deficit if the run rate continues. • Investment risk related to the above • Cash risk linked to volatility above • Inability to maximise CDEL (which cannot be carried forward)
Summary: Conclusion and/or recommendation	Trust Board is asked to note this report.

Finance Report Month 7

Report to:	**Board of Directors and Finance & Investment Committee** **October 2022**
Title:	**Finance Report for Period ending 31/10/2022**
Author:	**Philip Bunting, Director of Operational Finance**
Sponsoring Director:	**Ian Howard, 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 Month 7, UHS reported a deficit position of £2.5m adverse which was £3m adverse to the planned £0.5m surplus. The YTD position is £16.7m deficit which is £11.5m adverse to the planned deficit target of £5.2m.

2. The underlying position is however £23m deficit YTD with one off benefits helping improve the in year reported position. Estimates of the forecast indicate an intermediate projection of £28.7m after accounting for non recurrent costs and benefits. This is heavily influenced by largely uncontrollable costs relating to covid, inflation, MOFD numbers and energy expenditure.

3. CIP YTD delivery is £23.7m, a significant increase from the £18.8m achieved at M6. This exceeds the planned YTD delivery of £20.4m by £3.3m. Additional delivery in M7 includes £0.6m recognition of CIP that has been achieved over the previous six months. Of the £23.7m delivered YTD £10.6m has been transacted by Divisions and Directorates and £13.1m has been transacted through Central Schemes.

1. The main income and activity themes seen in M7 were:
    1. UHS has delivered 104% of Elective Recovery activity in M7, which is on target.
    2. An ERF payment of £4.2m year to date has been provisionally included within Trust income, at 75% of tariff, off-setting additional variable costs of delivery.
    3. Covid absences saw a peak in October (daily average absence count was 125) but this is smaller than previous peaks in April and July

2. The underlying deficit of £3.8m per month is predominantly driven by:
    1. Drugs & Devices (£0.8m per month) – partly offset with CIP
    2. Energy costs – (£0.9m per month) – Inflationary pressure increasing – partly offset by CIP
    3. Covid related staff costs – (£0.7m per month) – continued sickness absence costs and covid spend which has not reduced as per planning assumptions
    4. Inflationary and pay award pressures (£1.2m per month) – costs are unfunded
    5. Activity and MOFD related pressures (£0.5m per month) – ED costs above plan as a result of significant operational pressure. This is also reducing the potential for further ERF.

Finance: I&E Summary

A deficit position of £2.5m was reported in October adverse to the planned position of £0.5m surplus. The YTD position of £16.7m deficit is also £11.5m adverse to the planned £5.2m deficit target.

In month there was particular pressure on bank spend as Covid sickness absence increased together with significant operational pressures requiring flex bed capacity to be utilised. The cost pressure on drugs has also spiked with expenditure £1.8m over plan in month.

Other income is significantly over plan YTD (£25m) relating to two significant covid R&D studies. These do however have offsetting costs within Other non pay. CIP delivery within clinical supplies has helped report below plan spend within this category. The Trust continues to formally report a breakeven annual forecast for 2022/23 whilst flagging the risks of delivery.

		Current Month			Cumulative			Forecast		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
NHS Income:	Clinical	69.8	70.3	(0.6)	488.3	493.4	(5.1)	837.0	845.8	(8.7)
	Pass-through Drugs & Devices	11.2	12.4	(1.2)	78.5	86.7	(8.2)	134.6	148.6	(14.0)
Other income	Other Income excl. PSF	10.5	14.0	(3.5)	73.8	98.9	(25.0)	126.6	149.5	(22.9)
	Top Up Income	0.6	0.4	0.1	5.4	4.4	1.0	8.3	7.6	0.7
Total income		**92.1**	**97.2**	**(5.1)**	**646.1**	**683.4**	**(37.3)**	**1,106.6**	**1,151.5**	**(44.9)**
Costs	Pay-Substantive	49.2	48.4	(0.8)	342.4	351.8	9.4	591.6	603.0	11.5
	Pay-Bank	2.7	4.4	1.7	21.7	28.6	6.9	33.2	44.0	10.8
	Pay-Agency	1.0	1.1	0.1	7.9	8.6	0.7	12.0	12.4	0.4
	Drugs	4.9	6.7	1.8	35.7	35.6	(0.1)	59.7	63.5	3.8
	Pass-through Drugs & Devices	11.2	12.4	1.2	78.5	86.7	8.2	134.6	148.6	14.0
	Clinical supplies	5.9	6.6	0.8	47.4	46.9	(0.5)	74.6	77.9	3.2
	Other non pay	15.7	19.2	3.5	111.1	136.5	25.4	189.6	191.5	1.9
Total expenditure		**90.6**	**98.9**	8.2	**644.7**	**694.6**	**49.9**	**1,095.3**	**1,141.0**	**45.7**
EBITDA		**1.5**	**(1.7)**	**3.2**	**1.4**	**(11.2)**	**12.6**	**11.2**	**10.5**	0.8
EBITDA %		1.6%	-1.7%	3.4%	0.2%	-1.6%	1.9%	1.0%	0.9%	0.1%
	Non operating expenditure/income	(0.9)	(0.7)	0.2	(6.5)	(5.9)	0.6	(11.1)	(11.1)	0.0
Surplus / (Deficit)		**0.6**	**(2.4)**	**3.0**	**(5.1)**	**(17.1)**	**11.9**	**0.1**	**(0.7)**	**0.8**
Less	Donated income	(0.1)	(0.3)	0.2	(0.8)	(0.8)	(0.0)	(1.4)	(1.4)	0.0
Add Back	Donated depreciation	0.1	0.2	0.1	0.8	1.2	0.4	1.3	2.0	0.7
Net Surplus / (Deficit)		**0.5**	**(2.5)**	**3.1**	**(5.2)**	**(16.7)**	**11.5**	**0.0**	**(0.0)**	**0.1**

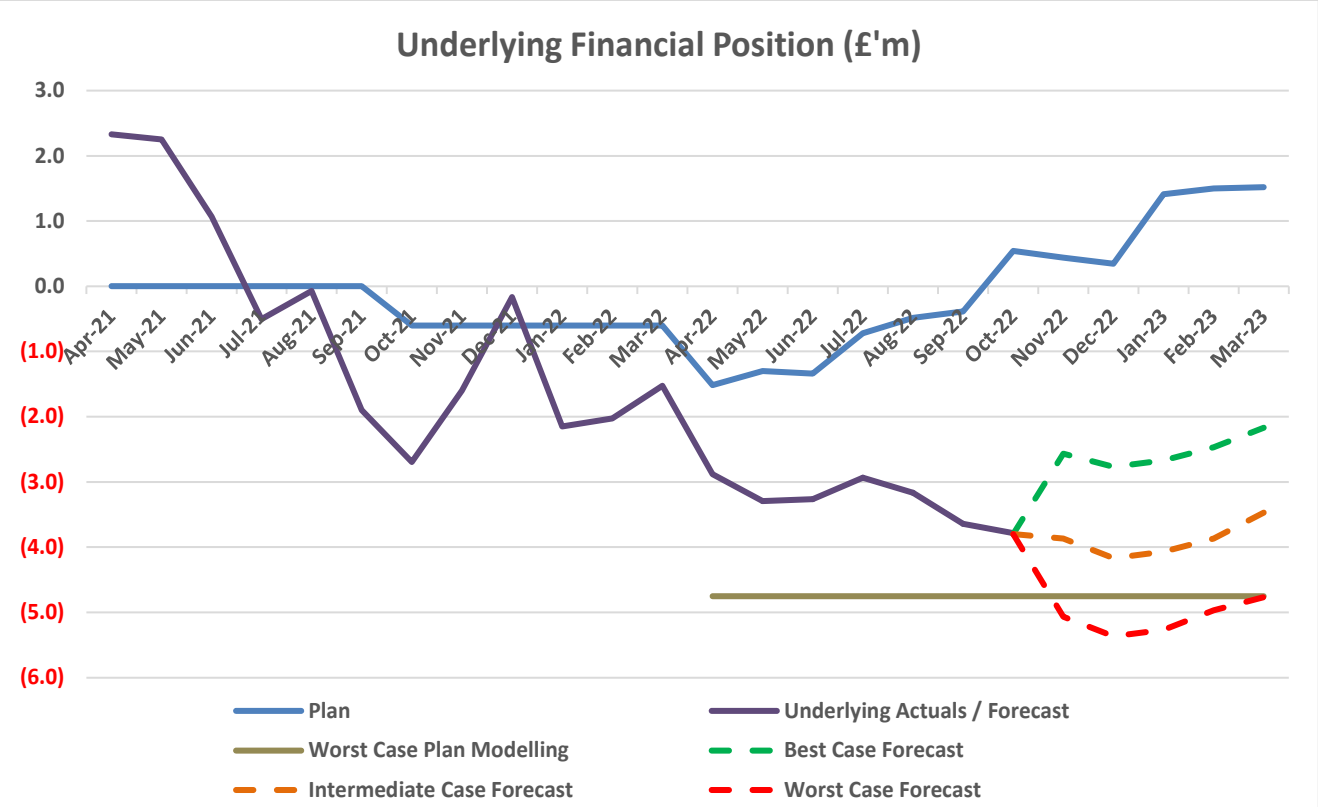
Monthly Underlying Position

The graph shows the underlying position for the Trust from April 2021 to present.

This differs from the reported financial position as it has been adjusted for non recurrent items (one offs) and also had any necessary costs or income rephased by month to get a true picture of the run rate. The underlying position is £3.8m deficit in M7 higher than the reported deficit with backdated items removed.

The run rate from month 1 to month 7 is now on average £3.3m deficit per month due mainly to energy cost pressures, continuing covid pressures, inflationary pressures and the unfunded pay award pressures. This is in addition to activity related operational pressures especially within ED and related to delayed discharges.

A range of deficit scenarios have been modelled which are shown on the graph. The variables within this projection are detailed overleaf.



Financial Risks

The table illustrates the key variables driving the underlying deficit position.

It is acknowledged that this generates a wide ranging forecast between £34m deficit and £50m deficit with an intermediate forecast assessment of £44m deficit before non recurrent CIP is added and any stretch. This is a slight increase on M6 as risks have been reassessed as part of financial recovery planning.

Drugs and inflation are two areas where more detailed analysis has been undertaken to more accurately assess the level of financial overspend.

Additionally Elective Recovery Fund income is now flagged as a risk with regards to potential non payment if this cannot be agreed within the system.

			Forecast Assessment		
Risk Variable	**Controllable / Uncontrollable**	**Original Worst Case Assessment (£m)**	**Best Case (£m)**	**Intermediate Case (£m)**	**Worst Case (£m)**
Cost Improvement Plans not fully delivered	Controllable	(28.9)	0.0	0.0	0.0
Covid 19 remains at above 'background' levels meaning costs don't reduce	Uncontrollable	(17.0)	(7.4)	(8.4)	(9.4)
Inflationary pressures impacting the price of goods and services (including stockouts)	Uncontrollable	(11.3)	(10.9)	(11.9)	(12.9)
Energy Cost prices continue to rise	Uncontrollable		(7.2)	(8.2)	(9.2)
Depreciation / PDC Pressure from Central Capital Schemes	Uncontrollable	0.0	(1.4)	(1.4)	(1.4)
Block drugs and devices costs continue to overspend	Uncontrollable	0.0	(7.8)	(9.3)	(10.8)
Medically optimised for discharge numbers do not reduce and flex beds remain open	Controllable	0.0	(1.8)	(2.3)	(2.8)
Emergency Department	Controllable	0.0	(3.2)	(3.7)	(4.2)
Pay Award Funding Gap	Uncontrollable	0.0	(1.7)	(2.7)	(2.7)
Additional Bank Holiday Costs	Uncontrollable	0.0	(2.9)	(2.9)	(2.9)
Elective Recovery Fund Risk	Uncontrollable	0.0	0.0	(3.8)	(4.1)
Cost Improvement Plans Offsetting (Within Plan)	Controllable	0.0	10.6	10.6	10.6
Deficit Subtotal		**(57.2)**	**(33.7)**	**(44.0)**	**(49.8)**
Non Recurrent CIP (Within Plan)			5.0	5.0	5.0
Additional CIPs			28.7	10.3	0.0
Reported Deficit Total		**(57.2)**	**0.0**	**(28.7)**	**(44.8)**

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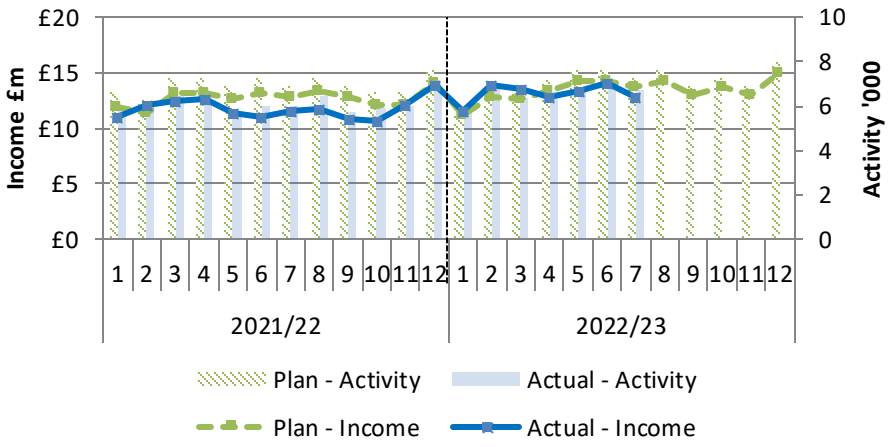
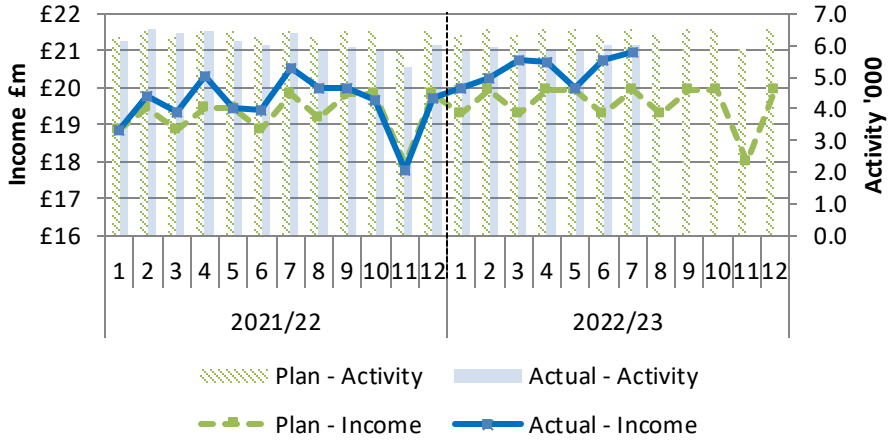
Clinical Income

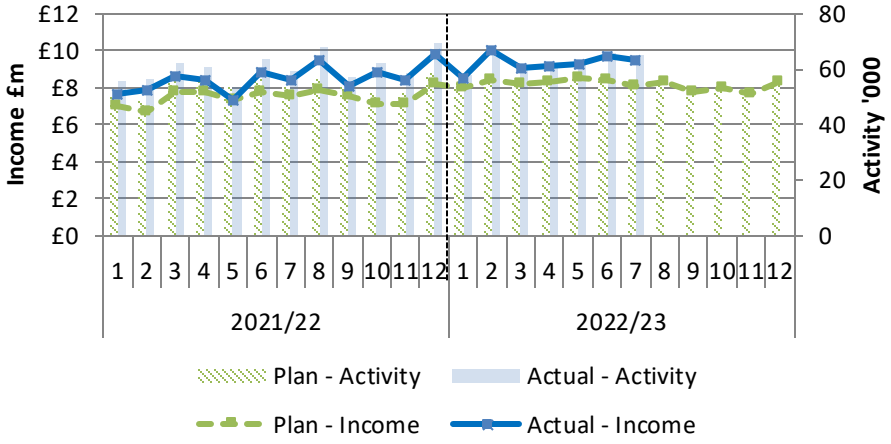
Elective spells



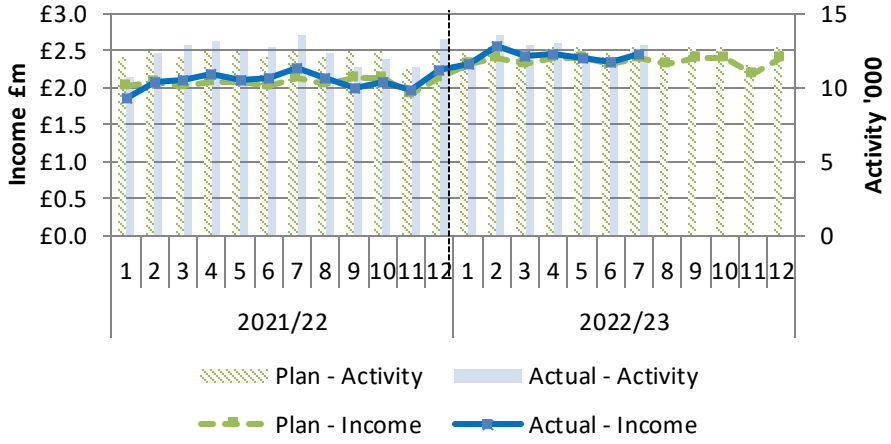
Non elective spells



Outpatients Total



A&E



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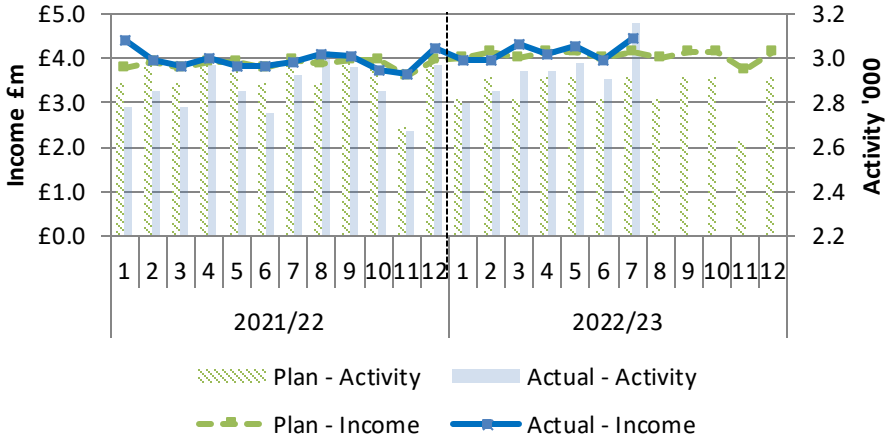
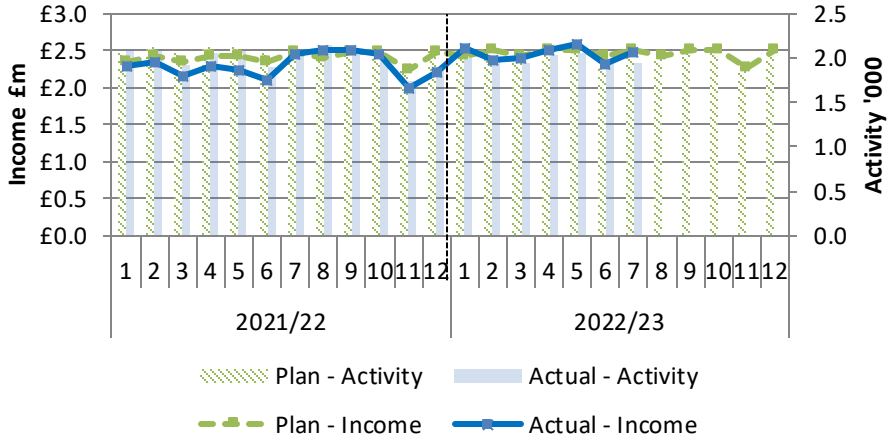
Clinical Income

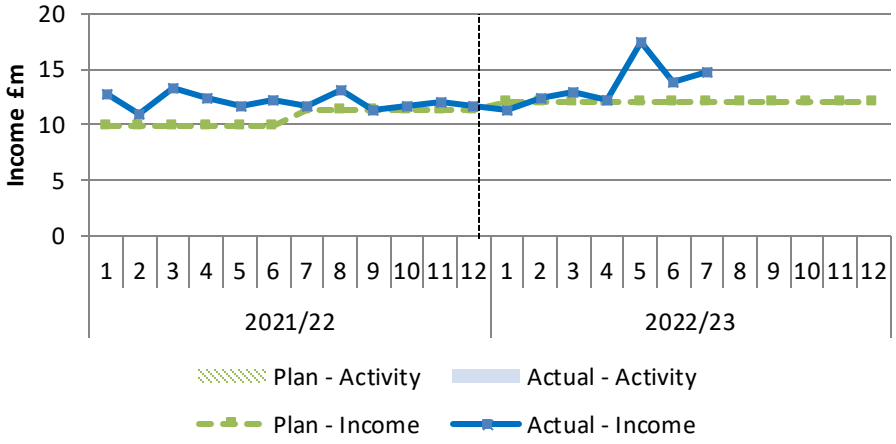
Adult critical care



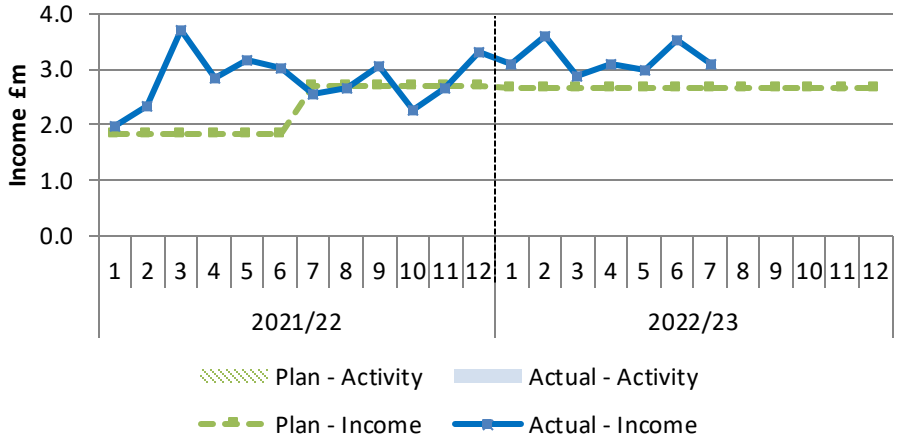
Neonatal & paediatric critical care



Tariff excluded drugs



Tariff excluded devices



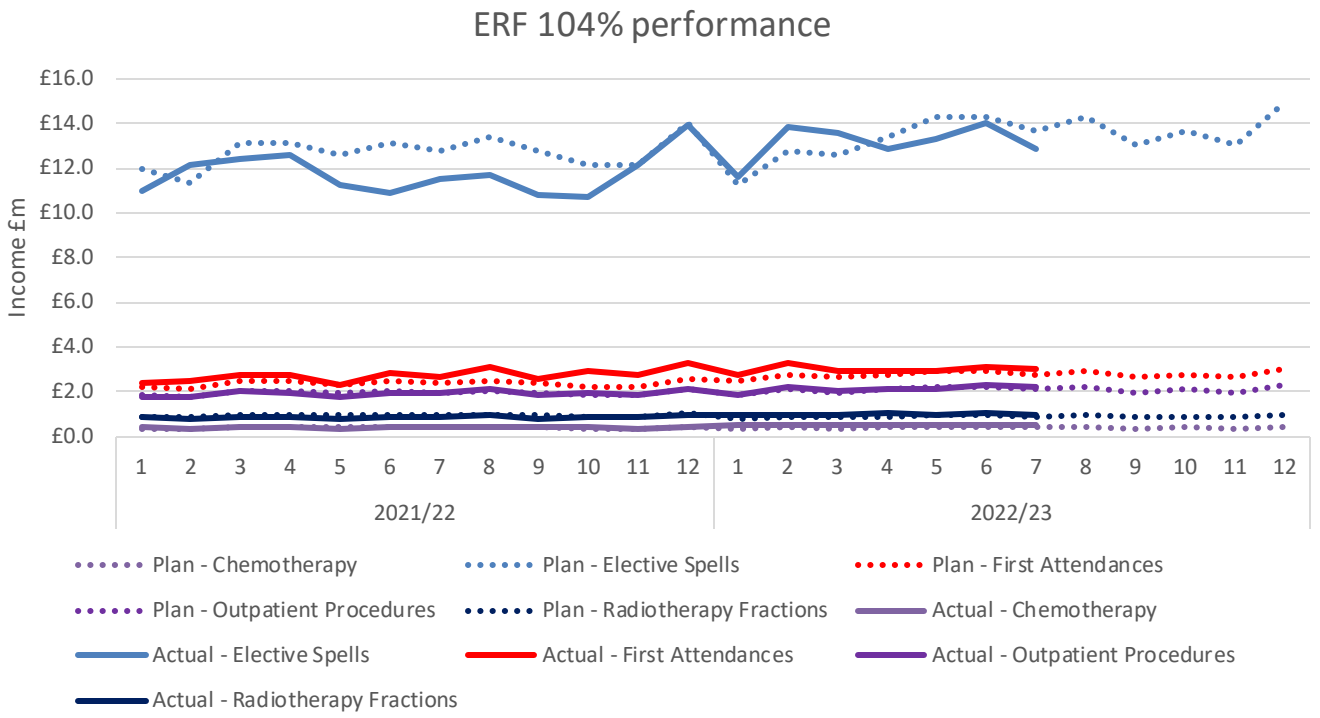
Elective Recovery Fund 22/23

The graph shows the ERF performance for 22/23 as well as a trend against plan for 21/22.

In 22/23 the Trust has a plan to achieve 106% of 19/20 activity for elective inpatients, outpatient first attendances and outpatient procedures, above the 104% national target. This stretch was applied as part of the plan resubmission.

The table highlights overall performance against the 19/20 pre-Covid baseline, highlighting M7 performance of 104%.

An ERF payment of £4.2m year to date has been provisionally included within Trust income, off-setting additional variable costs of delivery. However, there remains some uncertainty over the national calculation, with figures currently being reviewed for months 1-4.



Elective Recovery Framework Performance	M1	M2	M3	M4	M5	M6	M7	YTD
Elective performance	99%	107%	110%	99%	98%	104%	100%	103%
Outpatient first and procedures performance	109%	117%	112%	108%	104%	109%	111%	110%
Chemotherapy performance	146%	127%	142%	127%	128%	134%	134%	134%
Radiotherapy performance	119%	112%	114%	116%	104%	113%	113%	113%
Overall ERF performance	**104%**	**111%**	**112%**	**103%**	**101%**	**106%**	**104%**	**106%**
Anticipated ERF payment (incl. A&G)	**£826**	**£1,673**	**£1,502**	**£125**	**-£410**	**£399**	**£52**	**£4,168**
Outpatient follow up performance	130%	137%	130%	125%	120%	127%	132%	129%

Drug and Device Income 22/23

The tables show the performance for block funded and pass-through drugs in 2022/23 YTD.

The majority of NHS England Specialised Commissioned drugs and devices are being funded on a cost and volume (C&V) basis but all those which are ICB commissioned are subject to a fixed block payment. At M7 the unfunded pressure for these block funded drugs and devices is £5.4m of which £3.7m is from drugs. This is £1m up on the same period in 21/22. Long term conditions form one of the key areas of cost growth particularly within gastroenterology, rheumatology and ophthalmology. These services are seeing disproportionate growth in patient numbers and significant impact from NICE technical appraisals particularly around biologics.

The forecast overperformance for block drugs and devices is £9.3m although areas for saving and efficiency are being explored.

Block	YTD Plan	YTD Actual	Unfunded performance
Drugs	£21,470,325	£25,173,161	£3,702,836
Devices	£3,424,460	£5,114,770	£1,690,309
Total	**£24,894,786**	**£30,287,931**	**£5,393,145**

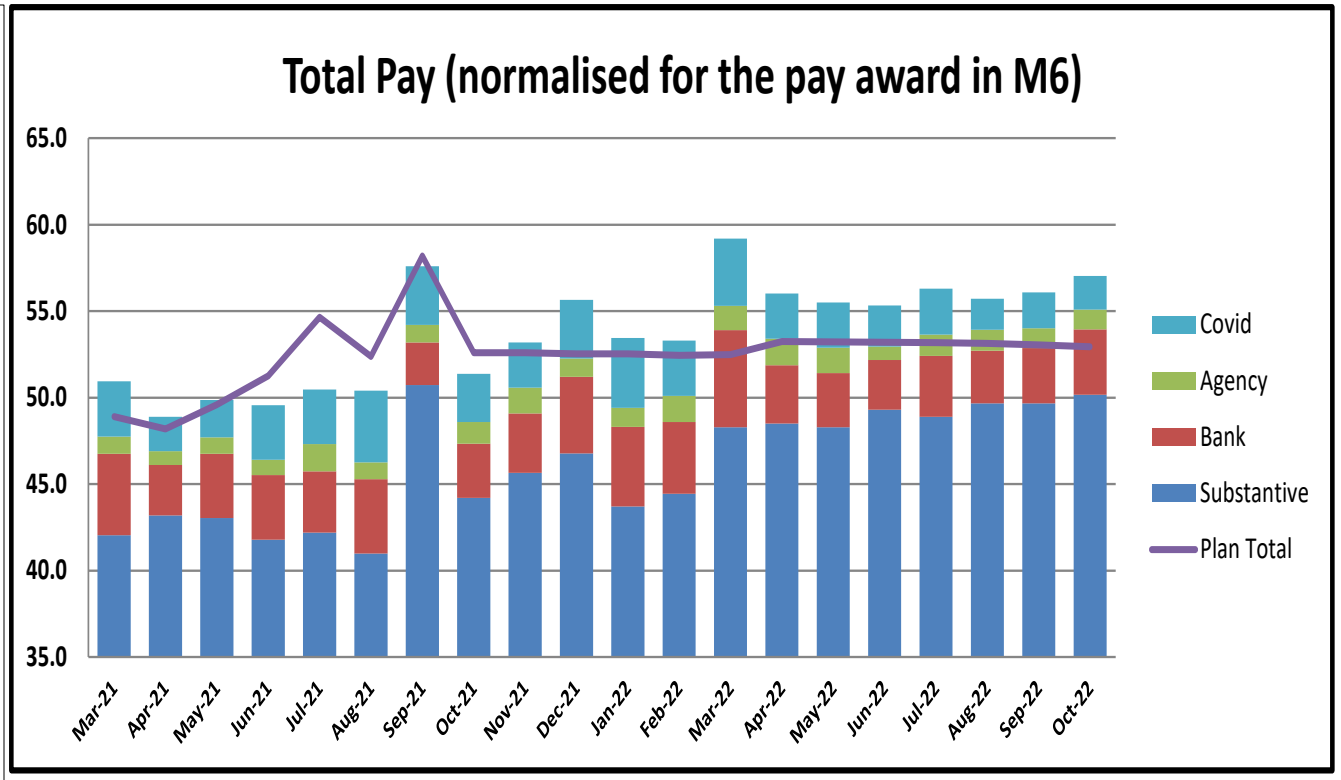
C&V	YTD Plan	YTD Actual	Funded performance
Drugs	£63,356,610	£69,526,481	£6,169,872
Devices	£15,174,584	£17,180,999	£2,006,415
Total	**£78,531,194**	**£86,707,480**	**£8,176,287**

Substantive Pay Costs

Total pay expenditure in October was £57m, up from September's normalised position by £0.9m. The increase was driven by bank holiday payments (£0.4m) and increased Bank staff spend (£0.5m).

Staff in post are over against plan as of M7 on substantive, bank and agency workforce. This is partly because of the Genomics transfer which was not within plan numbers and is fully funded. Sickness rates continue to cause pressure on temporary staffing spend and are consistently above 19/20 levels. Winter pressures also spiked in month with flex beds required to a greater level than previous months.

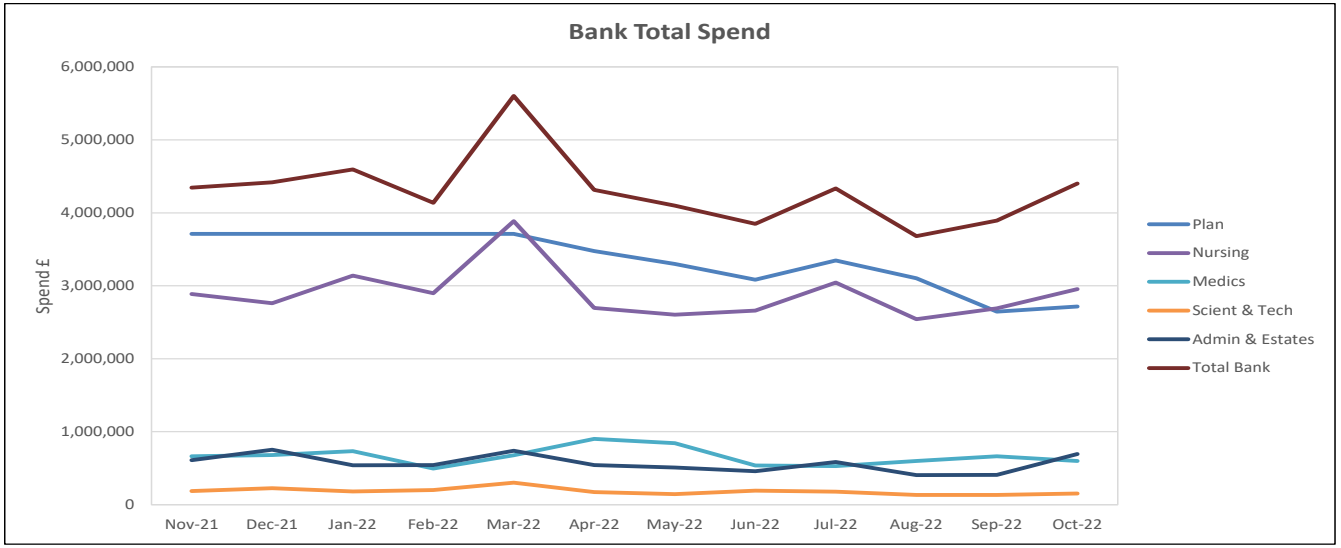
Covid staff costs are estimated at £1.9m which is broadly flat from September. Much of this relates to sickness absence backfill costs.

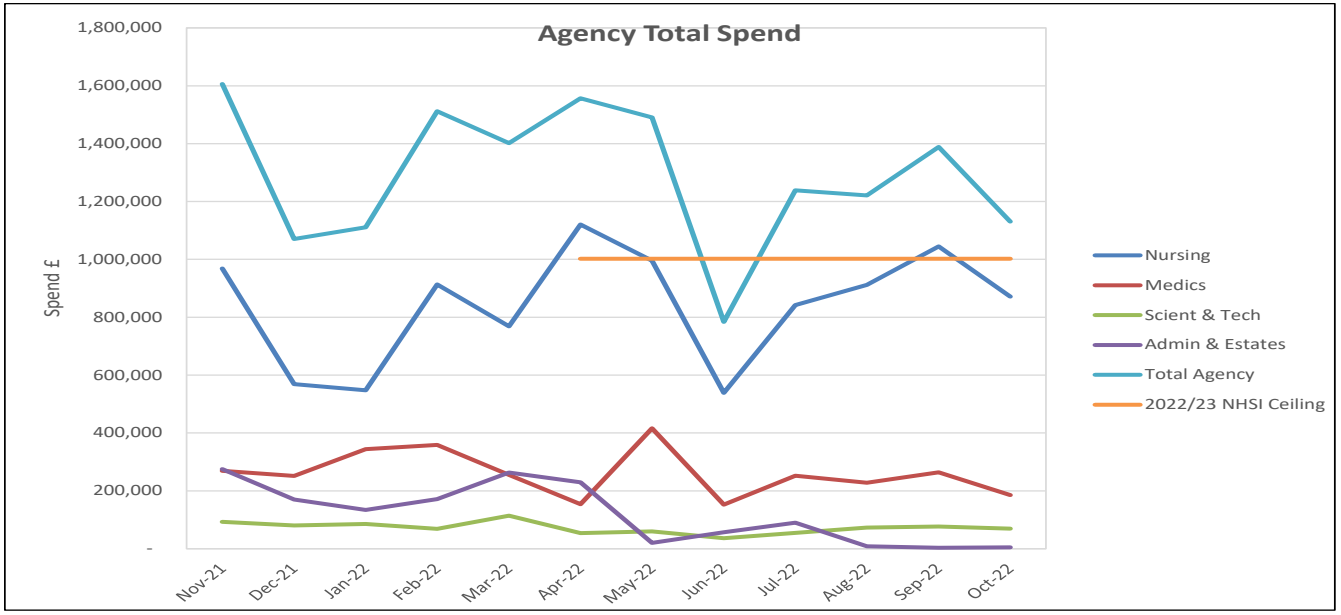


Temporary Staff Costs

Expenditure on Bank staff increased by £0.5m from September to £4.4m in month. The majority of this increases was in nursing driven by sickness levels and ED / critical care shift cover (up 65 wte bank in month).

Agency spend decreased by £0.3m mainly due to decreases in nursing spend of £0.1m and medics of £0.1m. Spend is above the 22/23 agency ceiling however remains comparably lower than other similar sized trusts. There is significant volatility within monthly spend however with costs ranging between £0.8m and £1.6m per month over the last year. Reducing agency spend remains a focus area for the Trust Savings Group (TSG).





University Hospital Southampton NHS
NHS Foundation Trust

Covid Costs 22/23

The table illustrates Covid costs incurred YTD versus 22/23 plan.

YTD costs are £17m which is £4.9m ahead of plan. This is due particularly to staff sickness absence and associated backfill costs being incurred which are £0.4m over plan. Critical Care and ED contribute a further £5m of costs in excess of plan.

All areas of spend are under continuous review especially those associated with national guidance changes. Alternatively for some areas where an ongoing need has been identified discussions with commissioners have taken place to explore recurrent funding sources. Critical care is the main example of this with NHSE supporting £1.5m in recurrent funding increase from 22/23. ED remains a particular concern as demand remains much higher than pre-Covid levels.

Description	2022/23 Annual Plan (£'000)	2022/23 YTD Plan (£'000)	2022/23 YTD Actual (£'000)	2022/23 YTD Variance (£'000)
Covid Related Staff Sickness / Absence	9,123	5,322	5,649	(327)
Critical Care Additional Capacity	4,914	2,867	5,295	(2,429)
Emergency Department Additional Costs	1,800	1,050	3,718	(2,668)
Car Parking Income - Patients / Visitors	1,320	770	770	0
Additional Cleaning / Decontamination	812	474	518	(44)
C5 uplift to L2 facility for 12 beds for Covid	480	280	280	0
Staff / High Risk Patient Covid Testing	500	292	210	82
PPE / Perso Hoods and Consumables	320	187	12	175
Staff Psychology Support	200	117	37	80
Car Parking Income - Staff	183	107	107	0
Clinical Engineering	138	81	0	81
Covid Medical Model (Div B)	115	67	67	0
PAH Theatres social distancing	108	63	0	63
Infection Control Team	107	62	15	47
Other (sub £100k plans)	694	405	358	47
TOTAL	**20,813**	**12,141**	**17,035**	**(4,894)**

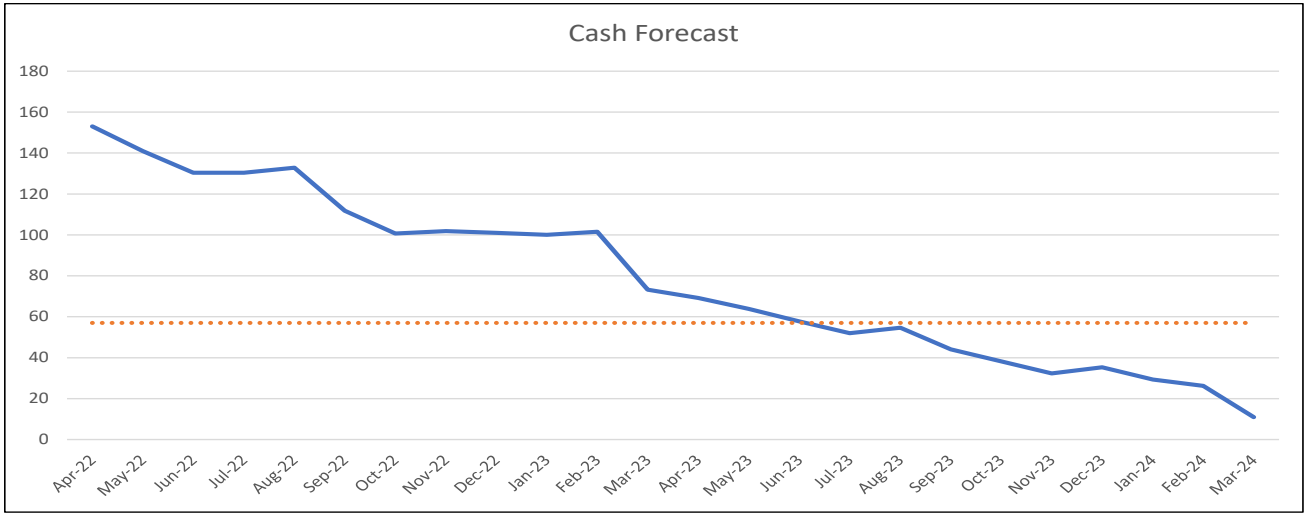
University Hospital Southampton NHS
NHS Foundation Trust

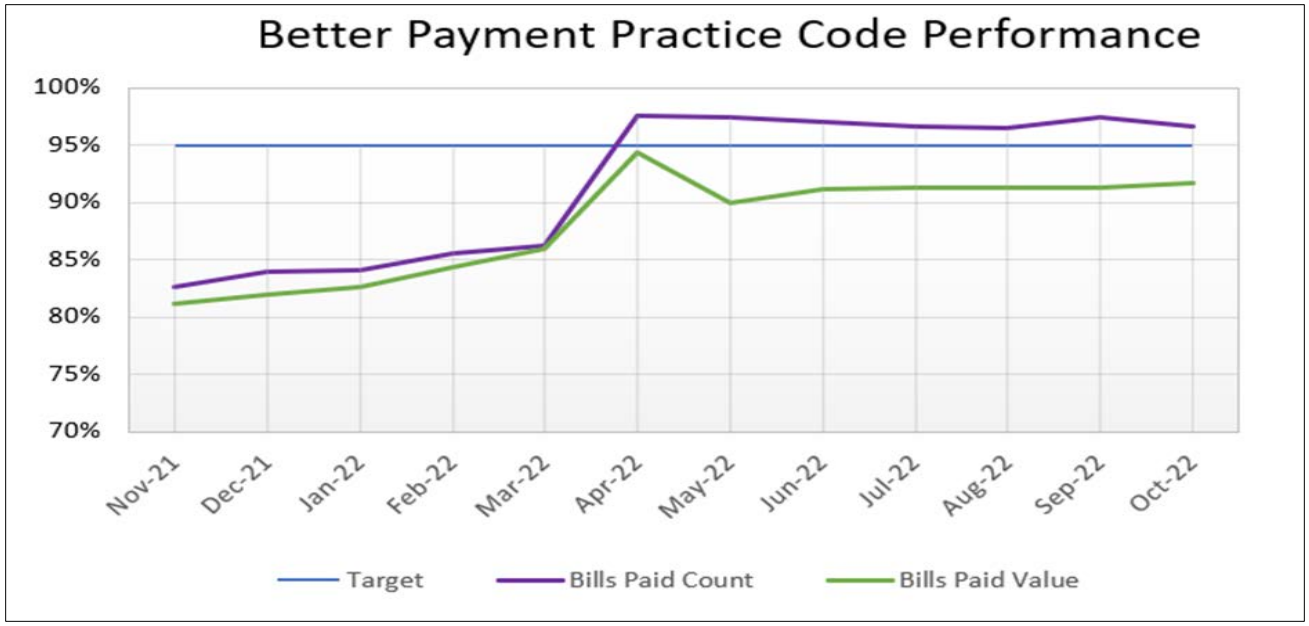
Cash

The cash balance reduced by £11m in October to £101m and is analysed in the movements on the Statement of Financial Position.

A cash forecast has been completed for the next 18 months projecting a material decline in cash driven by an underlying deficit and sizeable internally funded capital programme of £49m per annum. It is however difficult to predict beyond 22/23 as the financial regime has yet to be confirmed for future years.

BPPC in month for October is over the 95% target at 96.07%, (September 97.4%) for number of invoices and now for value at 95.18% (September 91.30%). With our YTD position still above target for count and increasing for value. We hope to continue making improvements and getting closer to the 95% target for value YTD.





Capital Expenditure

(Fav Variance) / Adv Variance

Expenditure on capital schemes was £30.8m for the year to Month 7. Excluding the Adanac Park multi-storey car park expenditure that will be claimed from the IFRS 16 fund (£14.4m), expenditure for the year to month 7 was £16.4m, against a budget of £16.8m. The total in month expenditure was £3.8m. The main areas of expenditure this month were on the wards above oncology (£0.9m), the refurbishment of neuro theatres 2 and 3 (£0.9m) and PICU side rooms (£0.6m).

		Month			Year to Date			Full Year Forecast		
		Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var
Scheme	Org	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Internally Funded Schemes										
Strategic Maintenance (excl. Neuro Ventilation)	UHS	433	388	45	3,011	1,909	1,102	7,185	6,941	244
Refurbish of neuro theatres 2 & 3 (incl. Ventilation)	UEL	244	969	(725)	487	2,220	(1,733)	1,800	3,412	(1,612)
General Refurbishment Fund	UHS	7	0	7	22	22	(0)	1,097	2,250	(1,153)
Theatres 10 & 11/F level Fit Out	UEL	0	259	(259)	218	717	(499)	5,000	5,000	0
Oncology Centre Ward Expansion Levels D&E	UEL	0	931	(931)	886	4,578	(3,692)	8,000	11,521	(3,521)
Fit out of C Level VE (MRI) Capacity	UEL	3,296	75	3,221	6,592	75	6,517	6,592	5,092	1,500
Donated Estates Schemes	UHS	771	255	516	2,213	553	1,660	5,362	4,293	1,069
Other Estates Schemes	UHS	486	557	(71)	1,763	1,761	2	2,681	2,672	9
Information Technology (incl. Pathology Digitisation)	UHS	508	298	210	3,075	2,260	815	5,448	5,448	0
IMRI	UHS	1,196	125	1,071	1,300	323	977	1,300	400	900
Medical Equipment panel (MEP)	UHS	250	0	250	625	728	(103)	2,500	2,810	(310)
Other Equipment	UHS	125	6	119	742	325	417	1,550	1,625	(75)
Other	UHS	17	93	(76)	673	935	(262)	691	1,261	(570)
Slippage	UHS	0	0	0	(3,000)	0	(3,000)	(3,380)	(5,255)	1,875
Donated Income	UHS	(1,248)	(287)	(961)	(2,927)	(775)	(2,152)	(6,760)	(5,191)	(1,569)
Total Trust Funded Capital excl Finance Leases		**6,085**	**3,669**	**2,416**	**15,680**	**15,632**	**48**	**39,066**	**42,279**	**(3,213)**
Leases										
Medical Equipment Panel (MEP) - Leases	UHS	37	0	37	267	249	18	700	390	310
Equipment leases	UHS	70	(8)	78	175	134	41	500	400	100
IISS	UHS	0	0	0	285	0	285	3,115	1,190	1,925
Fit out of C Level VE (MRI) Capacity	UHS	0	0	0	0	0	0	5,619	4,969	650
Total Trust Funded Capital Expenditure		**6,192**	**3,661**	**2,531**	**16,407**	**16,016**	**391**	**49,000**	**49,228**	**(228)**
Disposals	UHS	0	0	0	0	0	0	0	0	0
Top Up to external Schemes		0	0	0	0	0	0	0	(228)	228
Total Including Technical Adjustments		**6,192**	**3,661**	**2,531**	**16,407**	**16,016**	**391**	**49,000**	**49,000**	**0**

University Hospital Southampton NHS
NHS Foundation Trust

Capital Expenditure

(Fav Variance) / Adv Variance

The Trust has currently spent 33% of it's £49.0m internal capital funding and very little of the external funding. However, the rate of expenditure is likely to increase rapidly as large estates projects such as the wards above oncology, theatres refurbs and fit out of C level of the vertical extension increase their expenditure. In order to ensure that we utilise our full allocation of CDEL funding, £3.5m of expenditure on the wards above oncology will be brought forward from 2023-24 to this financial year to offset anticipated slippage on other schemes.

		Month			Year to Date			Full Year Forecast		
		Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var
Scheme	Org	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Externally Funded Schemes										
Maternity Care System (Wave 3 STP)	UHS	0	(2)	2	89	89	0	89	239	(150)
Digital Outpatients (Wave 3 STP)	UHS	49	16	33	343	124	219	592	592	0
Oncology Centre Ward Expansion Levels D&E	UEL	0	0	0	0	0	0	0	10,000	(10,000)
Neonatal Expansion	UHS	0	30	(30)	0	97	(97)	0	177	(177)
Targeted Lung Health Checks CT Scanner	UHS	0	0	0	0	0	0	0	1,363	(1,363)
Pathology Digitisation / LIMS	UHS	0	79	(79)	0	99	(99)	0	250	(250)
Community Diagnostic Centre Phase 2	UHS	0	0	0	0	0	0	0	3,250	(3,250)
Asceptic Pharmacy Building	UHS	0	0	0	0	0	0	0	1,000	(1,000)
P1P2 Additional IT Funding	UHS	0	0	0	0	0	0	0	2,320	(2,320)
Transfer from schemes within CDEL	UHS	0	0	0	0	0	0	0	228	(228)
Total Externally Funded Schemes		**49**	**123**	**(74)**	**432**	**410**	**22**	**681**	**19,419**	**(18,738)**
Total CDEL Expenditure		**6,241**	**3,784**	**2,457**	**16,839**	**16,425**	**414**	**49,681**	**68,419**	**(18,738)**
Outside CDEL Limit										
Adanac Park Car Park	UHS	0	0	0	3,000	14,400	(11,400)	0	14,400	(14,400)
Total Capital Expenditure		**6,241**	**3,784**	**2,457**	**19,839**	**30,825**	**(10,986)**	**49,681**	**82,819**	**(33,138)**

Notes

Electronic Patient Record Match Funding (£1,070k), Breast Screening (£36k) and Diagnostics funding have also been bid for

Statement of Financial Position

(Fav Variance) / Adv Variance

The October statement of financial position illustrates net assets of £464.1m.

The comparison between Month 6 and Month 7 has been made more difficult as a result of the ongoing movement of accounting for most of Theatres to UHS Estates Ltd. Although most of the changes have been netted off on consolidation there are still some differences at the receivables and payables level.

The movement on Receivables includes £3m VAT on unpaid UEL invoices, £5.6m unpaid Q3 Health Education England invoices and a £2.2m increase in UHS VAT debtor. The movement on Payables is due to a catch-up in month on NHS Professionals invoices. The cash reduction reflects the movement in working capital.

Statement of Financial Position	2021/22 YE Actuals £m	2022/23 M6 Act £m	2022/23 M7 Act £m	2022/23 MoM Movement £m
Fixed Assets	471.9	476.4	478.4	2.0
Inventories	17.0	15.5	15.1	(0.4)
Receivables	53.1	67.4	78.2	10.8
Cash	148.1	111.7	100.7	(11.0)
Payables	(204.2)	(194.5)	(198.5)	(4.1)
Current Loan	(1.7)	(1.7)	(1.7)	0.0
Current PFI and Leases	(9.1)	(8.2)	(8.1)	0.1
Net Assets	**475.0**	**466.7**	**464.1**	**(2.6)**
Non Current Liabilities	(23.0)	(20.8)	(21.2)	(0.4)
Non Current Loan	(6.8)	(6.1)	(6.1)	0.0
Non Current PFI and Leases	(33.6)	(43.0)	(42.4)	0.6
Total Assets Employed	**411.6**	**396.9**	**394.5**	**(2.4)**
Public Dividend Capital	261.9	261.9	261.9	0.0
Retained Earnings	115.6	100.9	98.5	(2.4)
Revaluation Reserve	34.1	34.1	34.1	0.0
Other Reserves				
Total Taxpayers' Equity	**411.6**	**396.9**	**394.5**	**(2.4)**

University Hospital Southampton NHS
NHS Foundation Trust

Efficiency and Cost Improvement Programme 22/23 – M7

UHS Total - £40.6m identified, 89% of the total 22/23 requirement which = £45.4m

Divisions and Directorates - £17.6m of CIP schemes identified (an increase from £17m at M5). This represents 88% of it's 22/23 target which = £20m

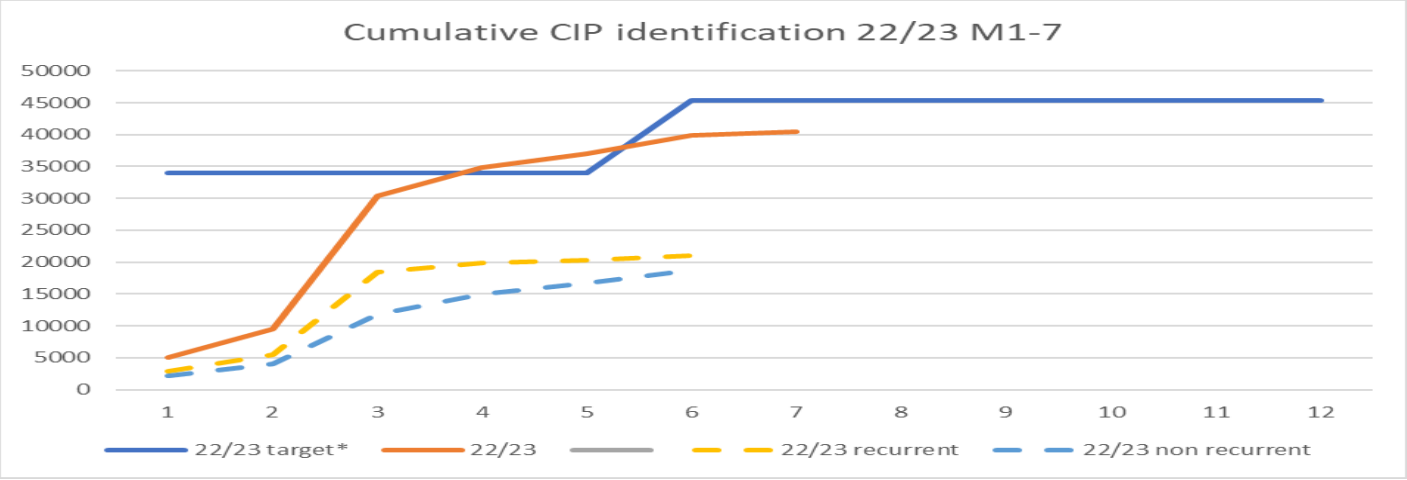
Central Schemes - £23m of CIP schemes identified (an increase from £22.9m at M5). This represents 90% of the 22/23 target which = £25.4m

Of the identified UHS total, £8m is Pay, £25.5m is Non-Pay, and £7.1m is Income

Divisional identification varies from 71% to 92%, a detailed breakdown by Care Group can also be found in Appendix 1

Month 7 CIP Identification	Non Recurrent ('000s)	Recurrent ('000s)	Total ('000s)	Target ('000s)	% Identified
Division A	£2,478	£1,459	£3,937	£4,260	92%
Division B	£2,004	£2,526	£4,530	£5,535	82%
Division C	£2,262	£520	£2,782	£3,938	71%
Division D	£1,119	£2,130	£3,249	£3,573	91%
THQ	£816	£1,714	£2,530	£2,695	94%
Unallocated Procurement Schemes	£0	£598	£598		
Central Schemes	£10,422	£12,542	£22,964	£25,400	90%
Grand Total	**£19,101**	**£21,467**	**£40,569**	**£45,400**	**89%**

**Procurement schemes not yet allocated to care group schedules*



**based on 75% identification by the end of Q1 and 100% identification by the end of Q2*

Efficiency and Cost Improvement Programme 22/23 – M7

University Hospital Southampton NHS
NHS Foundation Trust

M7 Trust YTD delivery is £23.7m, an increase from the £18.8m achieved at M6.

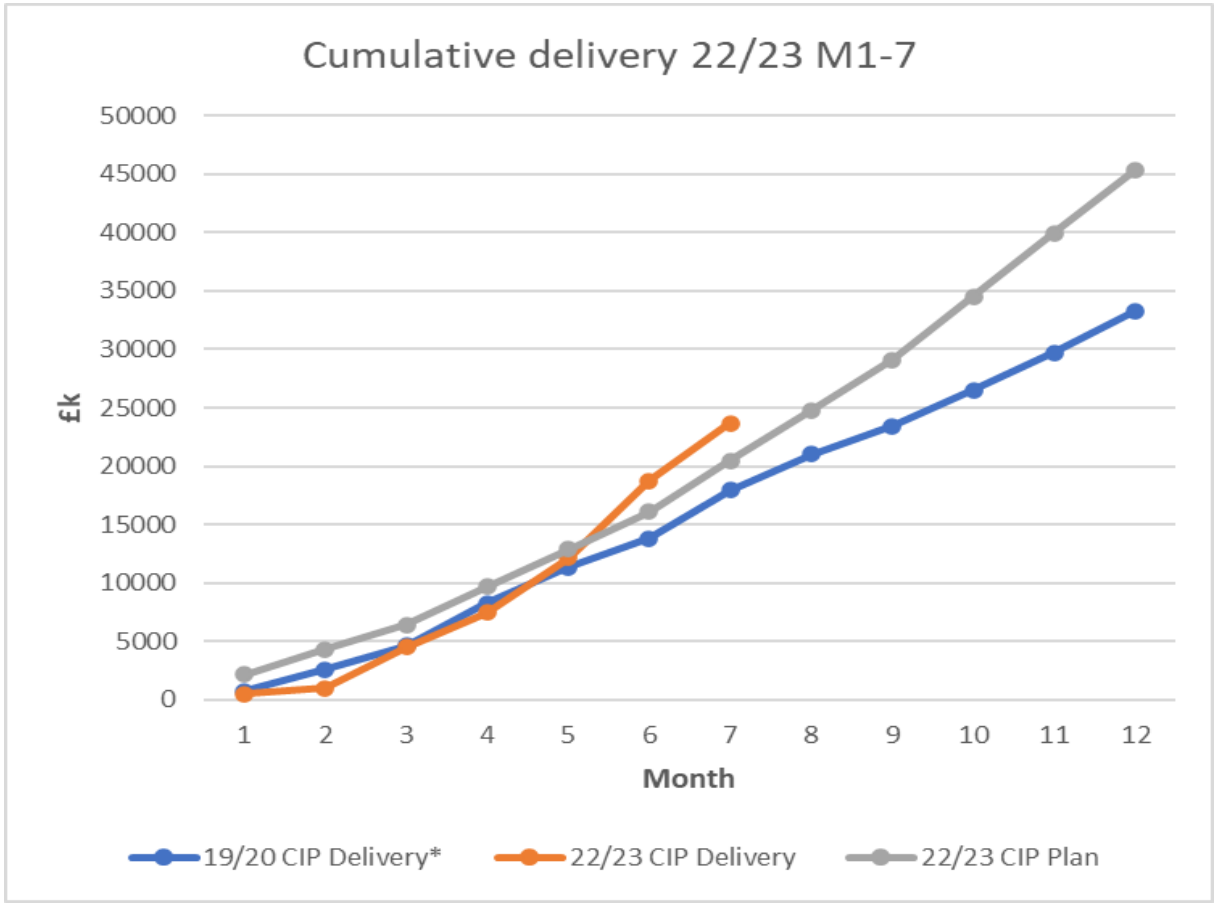
Our £23.7m delivery YTD now exceeds planned YTD delivery of £20.4m.

Additional delivery in M7 includes £0.6m recognition of CIP that has been achieved over the previous five months.

Of the £23.7m delivered YTD:

- £10.6m has been transacted by Divisions and Directorates
- £13.1m has been transacted through Central Schemes.

Of the Trust YTD achievement, £13.7m is non-recurrent. This includes £7.2m of non-recurrent Central schemes.



**19/20 CIP Delivery included profit generated on NHS commissioner income, and LOS scheme 'buy-out'*

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**People Report 2022-23 Month 7**			
Agenda item:	**5.7**			
Sponsor:	**Steve Harris, Chief People Officer**			
Author:	**Workforce Team**			
Date:	**29 November 2022**			
Purpose:	**Assurance or reassurance** **X**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	The UHS People Strategy (World Class People) sets out our goals to support the delivery of the Trust's Corporate Strategy. The 5-year Strategy, based on the insights from our UHS family, was approved by Trust Board in March 2022. Its key areas of THRIVE, EXCEL, and BELONG shape the work of people focus across UHS. The Monthly People report summarises progress against the delivery of the key metrics in the strategy. It is provided monthly to Trust Executive Committee and reviewed by the People and OD committee. The report is based on October 2022 data.			
Response to the issue:	The Chief People Officer can report the following to the Board: THRIVE (Our workforce supply) • Despite the significant labour market challenges UHS recruitment activity continues. **The WTE for UHS has grown** by +436 at the end of October against our workforce plan (agreed in our operating plan) for the year. Our WTE also substantially increased during October with the completion of the TUPE transfer of the Genomics service from Salisbury NHS FT to UHS. Vacancies have reduced to 7.3% (876, down from 1000 in August). Additional resources for recruitment, supported by TEC, are beginning to start in post. • There has been growth in the workforce in most areas. **TEC have agreed to undertake a half year review** of our WF numbers to understand growth against investments, capacity demands, and also against temporary staff expenditure. • **Absence still remains an operational challenge with COVID-related absence still causing operational pressures.** Rates are at 4.8% (rolling 12 month), considerably higher than our trust target of <3.4%. Our absence rate is still tracking considerably above pre-pandemic levels (3.4%), contributing to continued high temporary staffing spending.			

	• **HCAs are still a key risk for UHS with** vacancies at 21% (315 WTE). The focused effort continues on HCA recruitment with a healthy pipeline of recruits and a focus on retaining in post. EXCEL (Career growth, reward, well-being) • In the month recorded **appraisal completion has fallen again during October,** attributable to the significant operational pressures in the Trust. The overall rate is at 73.7% (rolling 12 months). Despite continued pressure, the importance of a quality conversation on development, progress, well-being and career remains a critical part of our people strategy. • Targeted work has commenced led by Occupational Health on stress support and prevention on key operational roles at UHS. The task and finish group is focused on increasing preventative measures to support our people. • **A package of leadership support** has been put in place for key senior positions, matrons and other operational roles. The package provides access to coaching and other interventions to help our leaders manage through the challenging period ahead. • The Trust continues to promote its popular **cost-of-living packages**. The 60% discount in feast has now been extended to include the Princess Anne café. Discussions are taking place with property management at Royal South Hants to provide an increased offering to our people based at this site. The Trust continues to provide discreet and targeted support to individuals in crisis. BELONG (Equality, Diversity, Inclusion) • **The 2022 National Staff Survey is reaching its completion.** The completion rate at UHS is currently 48% against our internal target of 60%. The national average for comparative organisations is currently 39%. The survey closes on 25 November and a final push is taking place. Average take up across the NHS appears lower this year at this stage. • **The UHS virtual inclusion conference** took place in November with good attendance and feedback on the event. The UHS new Inclusion and belonging (EDI) strategy has been approved by the UHS EDI committee. It is due to commence through the Trust sign off process and be presented to Board in January. • The rate of **disclosure of people with long term illnesses and disabilities continues to gradually decline** to 13.1%. Continued promotion is taking place to explain the value of disclosure. This will be continued during disability awareness month in November.
Implications: (Clinical, Organisational, Governance, Legal?)	Implications are for good governance, meeting legal requirements, and the provision of safe clinical and organisational delivery (as this report provides intelligence on current and future workforce challenges).

Risks: (Top 3) of carrying out the change / or not:	There is a risk that we fail to meet our strategic objectives as set out in the business assurance framework for UHS. Specifically: a) We fail to increase the UHS workforce to meet service demands b) We fail to develop a diverse, compassionate, and inclusive workforce providing a more positive staff experience for all staff c) We fail to create a sustainable and innovative education and development response to meet the current and future workforce needs to be identified in the Trust's longer-term workforce plan.
Summary: Conclusion and/or recommendation	Trust Board is required to: • Note the feedback from the Chief People Officer and the People Report

UHS People Report

WORLD CLASS PEOPLE

November 2022

THRIVE EXCEL BELONG

Update for UHS Trust Board

1. To **provide the Trust staffing position** and to provide assurance through the Trust Executive Committee (TEC) of our workforce risks, and associated mitigating actions
2. To **inform and improve decision support** about recruitment and safe staffing alongside our financial and activity plans
3. To **support and facilitate the work** of the Divisional Management Teams (DMTs)
4. To provide an **update against the People Strategy themes of Thrive; Excel; Belong**

The Trust Board is requested to **discuss the information** in this report.

Purpose and Executive Summary

Purpose: The purpose of this report is to provide a monthly retrospective update on UHS workforce, linked with the UHS People Strategy, and to highlight any current or future areas of risk or concern.

Executive Summary:

The report highlights the following:

(1) **Covid absences (p.5)** saw a peak in October (daily average absence count was 125) but this is smaller than previous peaks in April and July

(2) **Workforce Plan (p.9):** we are significantly over against plan as of M7 on substantive, bank and agency workforce. The growth is mostly in healthcare scientists (Genomic Lab staff were TUPE'd into the trust)

(3) **HCA supply (p.14):** The number of HCA starters (n=37) in October was nearly double that of September, and October saw a similar number of leavers as September

(4) **Sickness (p.20):** Rates are at 4.8% (rolling 12 month), considerably higher than our trust target of <3.4%. October sickness was broadly similar to September with more sickness due to respiratory conditions and Covid

Workforce Summary

HCA Supply
Over half of HCA leavers leave within 12 months; a third within six months. HCA SIP decreased further in Oct

Turnover
There were 122 leavers in October 2022 – similar to the previous month

Sickness
Sickness remains at 4.8% (r12M) owing primarily to Covid, mental health and respiratory

Covid-19
Over 5000 boosters have been delivered; average of 125 staff absent daily throughout Oct

THRIVE
In September we had a SIP growth of +584 WTE
(Compared with Dec-21 baseline)

EXCEL
Appraisal completions in October have decreased

BELONG
Proportion of our staff with reported disabilities at B7+ has decreased in Oct

Levels of attainment
Job plan sign off has reduced to 16%
Medic eJP is LoA 1; close to 2

Patient Safety
An increase in red flag incidents which cited staffing in October (155) compared with September (80); spotlight at Trust Board

Other contextual updates
NHS Staff Survey launched
Workforce & Education Strategy 2022-2026 discussed at PODC

NHS England and Improvement Operational Planning Update

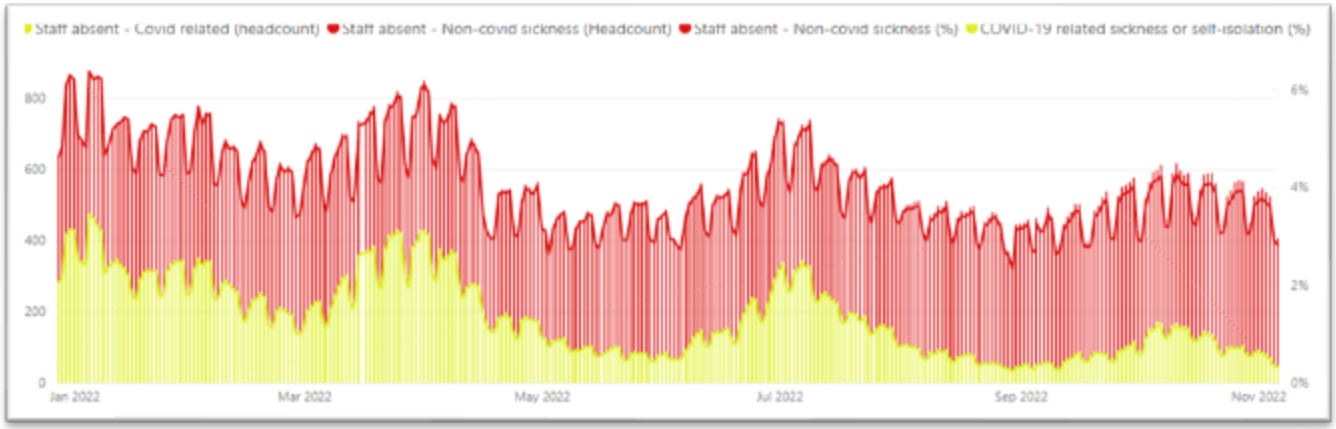
Planning for 2023/24 is expected to start December 2022

People Report - Covid

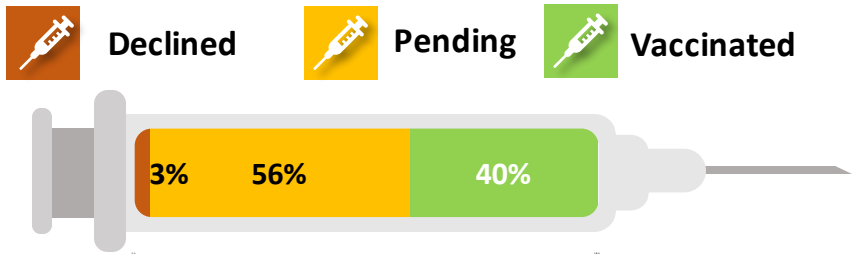
COVID UPDATE

Covid-related absences
The average staffing absence in the month of October for Covid reasons was **125** (0.9%) headcount; this is an increase from September where the average was **71** (0.5%).

Covid vaccine boosters
UHS has delivered over 5000 boosters to its staff since September 2022



Total Substantive Staff Booster uptake



Source: HealthRoster - Unavailability
Source: APEX & ESR - Booster programme

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

To achieve our ambition of World Class People, our strategy sets out three key areas of focus. These will inform our intention to grow our UHS family.

1. THRIVE

We will thrive by looking to the future to plan, attract and retain great people, and to ensure every area is resourced to meet demand. Working with our education partners, we will invest in opportunities for people to nurture and grow their skills, as well as work with them to grow our future workforce. We will offer flexible careers and make the best use of technology to ensure we plan and deploy our people to provide safe, high quality care.

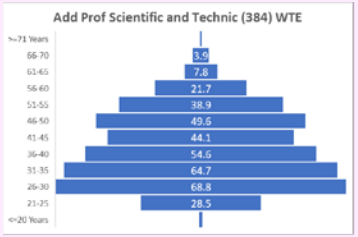
Relevant information:

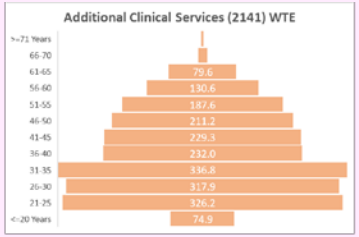
Staff in post | HCA supply | Vacancy rates (all staff; RNs) | Temporary resourcing | Turnover | Sickness absence | NHSEI Levels of Attainment | New investments

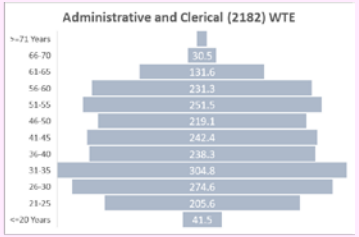
People Report

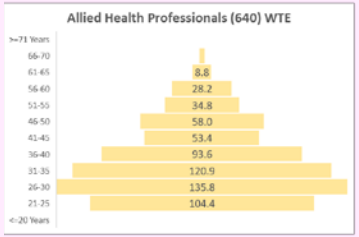
THRIVE | EXCEL | BELONG | PATIENT SAFETY

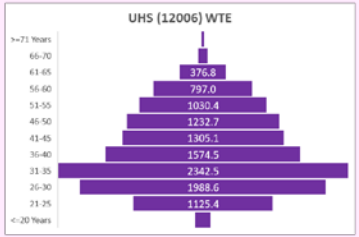
STAFF IN POST (n = 12,006 WTE) – 31 Oct 2022

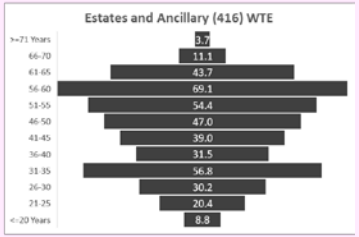


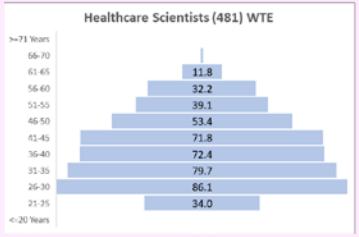


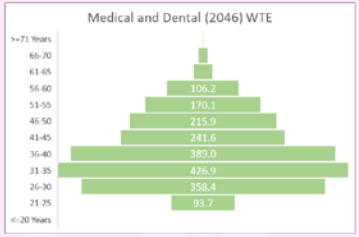


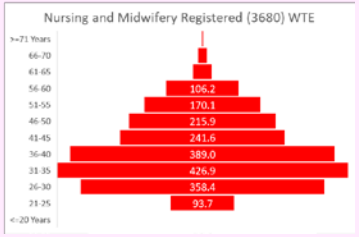












Source: ESR substantive staff as of 31 Oct 2022; includes consultant APAs and Junior extra rostered hours

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

Monthly Staff in Post (WTE) for 2022/23

	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M7 (Oct)	M8 (Nov)	M9 (Dec)	M10 (Jan)	M11 (Feb)	M12 (Mar)	Sparkline Trend
Add Prof Scientific and Technic	392	395	377	372	369	380	384						
Additional Clinical Services	2107	2158	2171	2150	2153	2149	2141						
Administrative and Clerical	2119	2149	2164	2156	2152	2175	2182						
Allied Health Professionals	622	624	624	617	622	643	640						
Estates and Ancillary	394	391	394	399	401	406	416						
Healthcare Scientists	392	397	400	403	408	420	481						
Medical and Dental	1963	1969	1966	1961	2030	2052	2046						
Nursing and Midwifery Registered	3551	3553	3560	3564	3593	3655	3680						
Students	30	29	29	29	29	29	35						
Grand Total	**11570**	**11664**	**11684**	**11651**	**11757**	**11907**	**12006**						

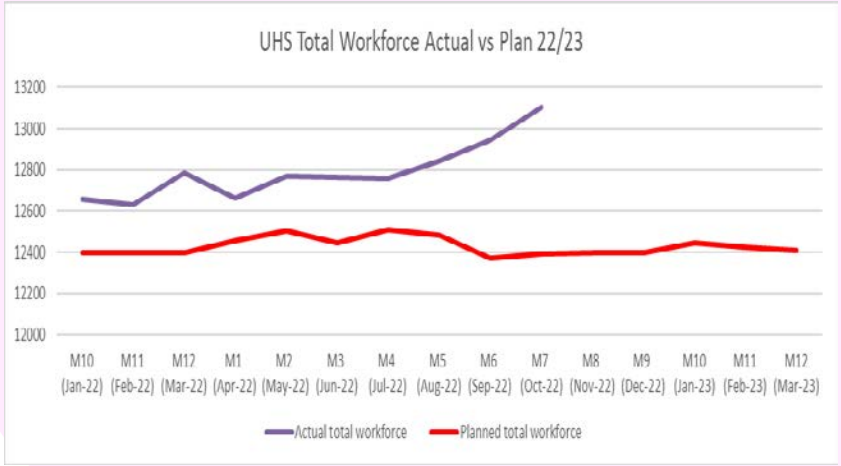
Source: ESR substantive staff as of 31 October 2022; includes consultant APAs and Junior extra rostered hours

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

Total Workforce – performance to date (substantive, bank and agency)

	M10 (Jan-22)	M11 (Feb-22)	M12 (Mar-22)	M1 (Apr-22)	M2 (May-22)	M3 (Jun-22)	M4 (Jul-22)	M5 (Aug-22)	M6 (Sep-22)	M7 (Oct-22)	M8 (Nov-22)	M9 (Dec-22)	M10 (Jan-23)	M11 (Feb-23)	M12 (Mar-23)
Actual WTE	12658	12632	12787	12664	12770	12764	12757	12819	12944	13105					
Planned WTE	12397	12397	12397	12458	12506	12445	12510	12485	12371	12391	12399	12398	12446	12427	12409
Deviation from Plan	+262	+235	+390	+206	+264	+319	+247	+356	+573	+714					



Inclusions:

Month-end contracted staff in post (ESR)
Consultant APAs
Junior doctors Extra Rostered Hrs
Bank and Agency usage including Overtime, Excess Hours and WLI

Exclusions:

Honorary contracts; career breaks; secondments; hosted services; WPL; Chilworth; Vaccination Hub

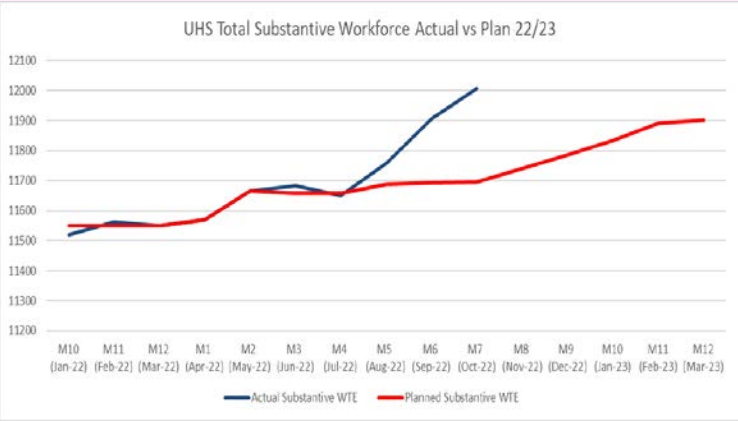
Source: ESR substantive staff as of 31 October 2022; ESR (Overtime&ExcessHrs, WLI); NHS Professionals (bank and non-medical agency); 247 Time (medical agency); HealthRoster MedicOnline (medical bank) as in October 2022

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

Total substantive Workforce – performance to date

	M10 (Jan-22)	M11 (Feb-22)	M12 (Mar-22)	M1 (Apr-22)	M2 (May-22)	M3 (Jun-22)	M4 (Jul-22)	M5 (Aug-22)	M6 (Sep-22)	M7 (Oct-22)	M8 (Nov-22)	M9 (Dec-22)	M10 (Jan-23)	M11 (Feb-23)	M12 (Mar-23)
Actual WTE	11519	11561	11550	11570	11664	11684	11651	11757	11907	12006					
Planned WTE	11549	11549	11549	11570	11664	11659	11657	12485	12371	12391	12399	12398	12446	12427	12409
Deviation from Plan	-30	+12	+1	+0	+0	+25	-5	+69	+214	+311					



Inclusions:

Month-end contracted staff in post (ESR)
Consultant APAs
Junior doctors Extra Rostered Hrs

Exclusions:

Bank and agency; honorary contracts; career breaks; secondments; hosted services; WPL; Chilworth; Vaccination Hub

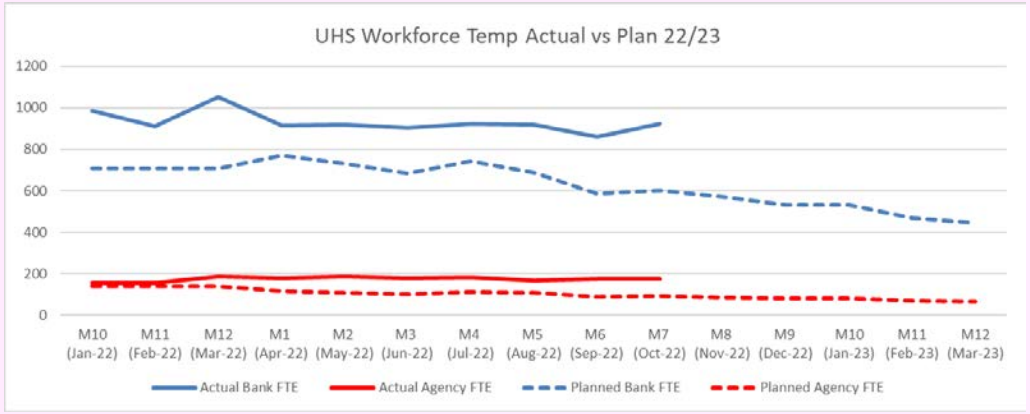
Source: ESR substantive staff as of 31 October 2022; consultant APAs and Junior doctors Extra Rostered Hrs in month.

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

Temporary Staffing – performance to date (bank and agency)

	M10 (Jan-22)	M11 (Feb-22)	M12 (Mar-22)	M1 (Apr-22)	M2 (May-22)	M3 (Jun-22)	M4 (Jul-22)	M5 (Aug-22)	M6 (Sep-22)	M7 (Oct-22)	M8 (Nov-22)	M9 (Dec-22)	M10 (Jan-23)	M11 (Feb-23)	M12 (Mar-23)
Actual Bank WTE	984	913	1050	914	920	902	924	917	859	924					
Planned Bank WTE	706	706	706	770	731	684	741	688	587	602	570	532	532	467	444
Deviation from Plan	+278	+207	+345	+144	+189	+219	+184	+229	+273	+322					
Actual Agency WTE	156	158	187	179	187	178	182	167	177	174					
Planned Agency WTE	142	142	142	118	111	103	112	109	91	93	88	81	80	69	65
Deviation from Plan	+14	+16	+45	+61	+76	+75	+70	+58	+86	+81					



Inclusions:

Bank and Agency usage including Overtime, Excess Hours and Waiting List Initiative (WLI)

Source: ESR (Overtime&ExcessHrs, WLI); NHS Professionals (bank and non-medical agency); 247 Time (medical agency); HealthRoster MedicOnline (medical bank) as of 31 October 2022

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

Developments for 2023/24 and beyond

No	Investment	Approved by Finance & Investment Committee?	Approved by Trust Board or TEC?	Workforce Implication	Other Comments
1	Chimeric Antigen Receptor T-cell (CAR-T) Cellular Therapy service for blood cancer patients	Yes	Yes	+95.28 WTE over three years	All posts are new posts; there is no plan to transfer staff from other departments

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TRUST-WIDE VACANCIES (October 2022)

Staffing group	Vacancy* (WTE / %)
Registered nursing (all)	300 / 8% ↑
Registered nursing (clinical wards only)	247/ 11.0% ↓
Unregistered nursing (bands 2-3 HCAs)	315 / 21.3% ↑
Consultants	35 / 4.7% ↓
Allied Healthcare Professionals	101 / 16.2% ↑
Healthcare Scientists	12 / 2.5% ↓
Estates & Ancillary	43 / 9.3% ↓
Admin and Clerical	79 / 3.5% ↓
UHS Total	**876 / 7.3%** ↑

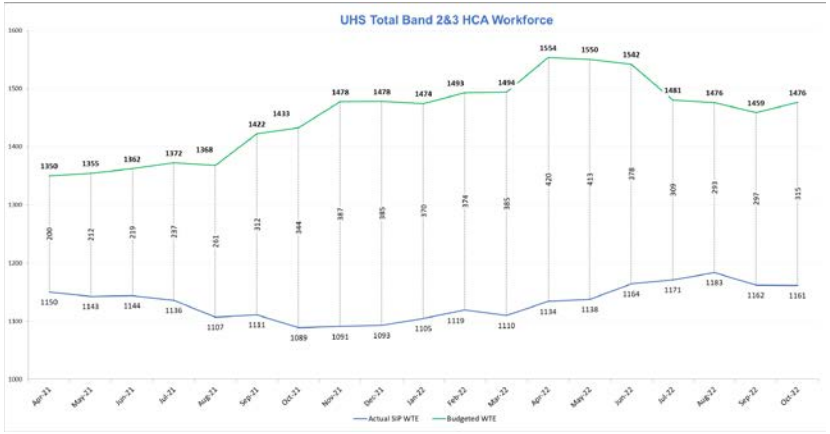
*Calculated by: (Budget – Staff in Post) / Budget in Month

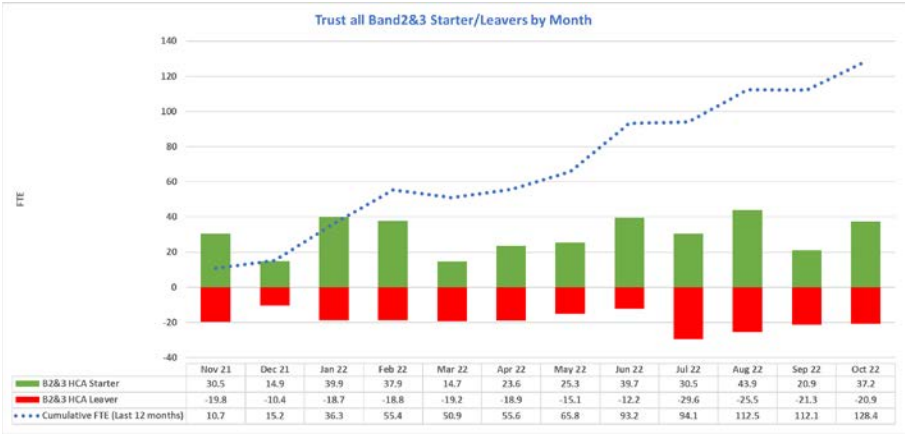
People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

HCA SUPPLY

- UHS continue to be involved in the national NHS England & Improvement HCA recruitment and retention programme. There are a number of initiatives already in place, including extended two-week inductions, a HCA hub, Welcome Wards, and a HCA Project Lead. Initiatives have shown signs of improved retention and there needs to be an agreed plan beyond 2022/23 to continue this.
- Vacancies have decreased significantly from the peak in April 2022 (420 WTE; 27%) to October 2022 (315 WTE; 21.3%)
- The budget, linked to safe staffing and additional capacity and service delivery, has increased in 12 months from 1433 WTE to 1476 WTE. The recent reduction of the budget is due to correcting previous data errors.
- The last 12 months have seen a net increase of +73 WTE HCAs
- There has been a further -134WTE reduction due to HCAs with contract changes (reducing contract hours, moving to non-HCA posts or taking nursing degree or Training Nursing Associate courses). These staff were retained in the UHS workforce
- During the last 12 months 230.5WTE HCAs left UHS, of which 45% left with less than one year service at UHS and 25% had less than six months' service





	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
B2&3 HCA Starter	30.5	14.9	39.9	37.9	14.7	23.6	25.3	39.7	30.5	43.9	20.9	37.2
B2&3 HCA Leaver	-19.8	-10.4	-18.7	-18.8	-19.2	-18.9	-15.1	-12.2	-29.6	-25.5	-21.3	-20.9
Cumulative FTE (Last 12 months)	10.7	15.2	36.3	55.4	50.9	55.6	65.8	93.2	94.1	112.5	112.1	128.4

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TEMPORARY RESOURCING

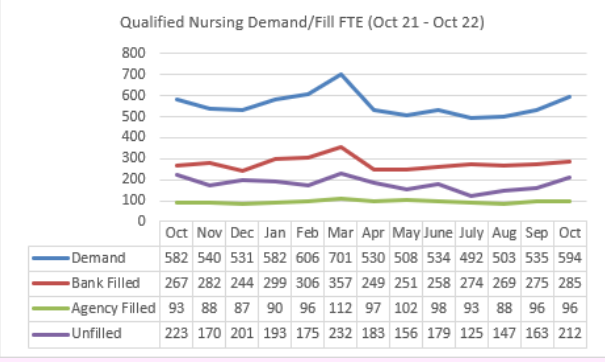
Status

- Qualified nursing demand/fill (FTE): Demand increased from 535 FTE in in September to 594 FTE in October, of which, bank filled 285, agency filled 96 and 212 remained unfilled
- Bank fill for qualified nursing decreased from 51% in September to 49% in October
- Demand for October 2022 is 12 FTE higher than October 2021

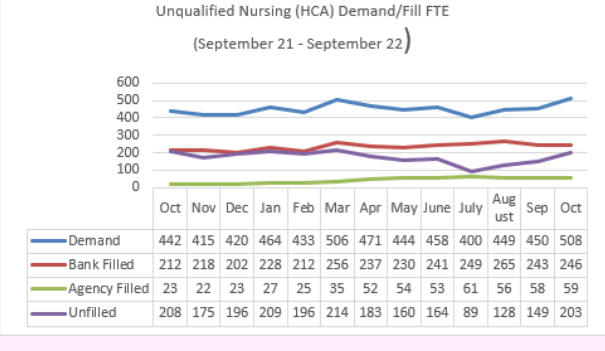
- HCA demand/fill (FTE): Demand increased to 508 FTE in October, of which, bank filled 246, agency filled 59 and 203 remained unfilled
- Bank fill decreased from 54% in September to 50% in October
- Demand for HCA's 66 FTE higher than in October 2021

Actions

- Rate reduction plan agreed for Critical care and ED.
- Golden Key changes implemented to centralised through the staffing hub. Golden key added to all tier 2 agencies.
- NHSP working to migrate agency HCA's
- Allocate on Arrival introduced with premium rate for bank



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct
Demand	582	540	531	582	606	701	530	508	534	492	503	535	594
Bank Filled	267	282	244	299	306	357	249	251	258	274	269	275	285
Agency Filled	93	88	87	90	96	112	97	102	98	93	88	96	96
Unfilled	223	170	201	193	175	232	183	156	179	125	147	163	212



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	August	Sep	Oct
Demand	442	415	420	464	433	506	471	444	458	400	449	450	508
Bank Filled	212	218	202	228	212	256	237	230	241	249	265	243	246
Agency Filled	23	22	23	27	25	35	52	54	53	61	56	58	59
Unfilled	208	175	196	209	196	214	183	160	164	89	128	149	203

Source: NHSP – Temporary resourcing team

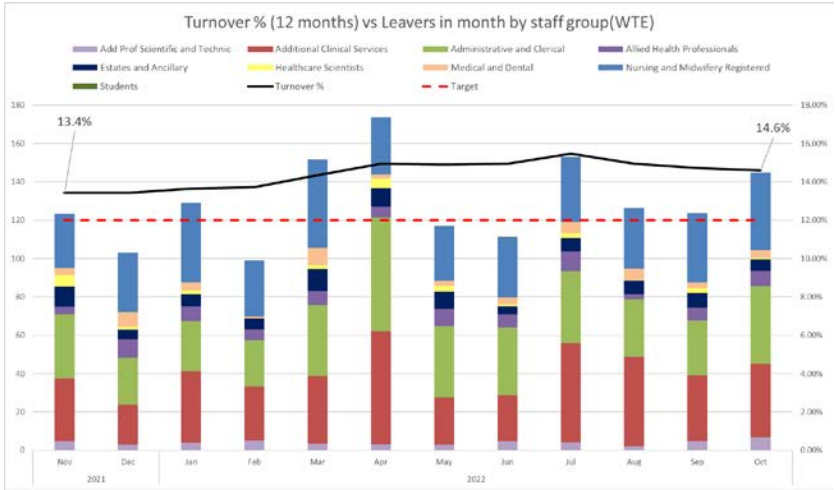
People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TURNOVER

Turnover has been decreasing since July 2022; in October there were 122 WTE leavers, which is 37 fewer than October 2021. Turnover is currently 14.6% which remains higher than the trust-wide target of <12%.

March 2022 saw an increase in leavers due to retirements; April 2022 was due to the termination of the workforce employed in the Chilworth laboratory; July 2022 was due to increased numbers of voluntary resignations, particularly amongst Additional Clinical Services (HCAs).



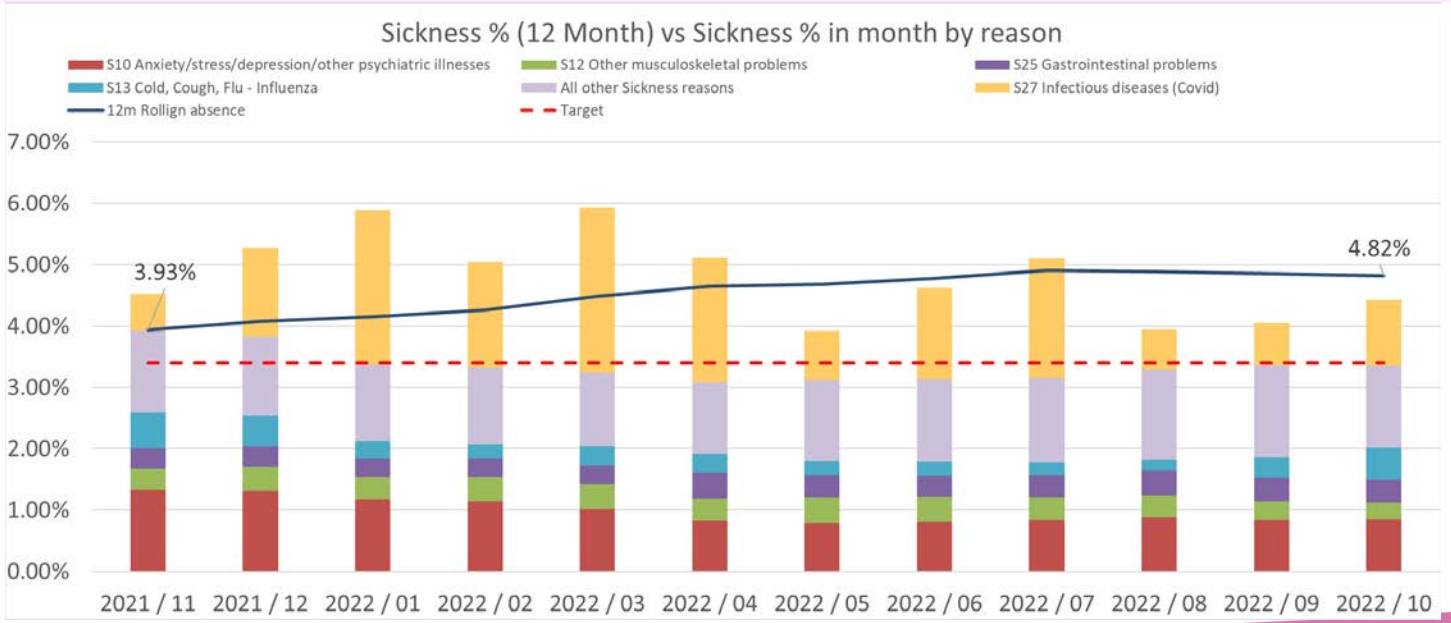
Source: ESR – Leavers Turnover WTE

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

SICKNESS

The rolling sickness rate has been increasing throughout the year but is now starting to reduce. Overall sickness remains higher than 21/22 figures with the current rate at 4.82%. The reasons for this include COVID-related sickness, mental health, gastrointestinal and MSK. Employee relations will continue to work with/assist managers to support staff suffering from work related stress to improve wellbeing and decrease absence levels



Source: ESR – Absence data

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

To achieve our ambition of World Class People, our strategy sets out three key areas of focus. These will inform our intention to grow our UHS family.

2. EXCEL

We want to excel within an organisation where forward-thinking people practices are delivered at the right time and where team structures, culture and environment are all designed to support wellbeing and develop potential. We will deliver progressive opportunities for individuals to develop their knowledge and skills to become their best selves. We will recognise and reward our people for the great work they do in well-designed roles that provide the freedom to innovate and improve.

Relevant information:

NHS Staff Survey | NHS Pulse Survey | Apprenticeships | Appraisals | Statutory and Mandatory Training compliance

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

APPRENTICESHIPS

We currently have 388 apprentices on programme, on 40 difference apprenticeship, with 35 different training providers. These include staff working in clinical apprenticeships in nursing, ODP, Occupational Therapy and Diagnostic Radiology. Other non- medical professions e.g. Dietetics, Speech and Language, Midwifery and Radiotherapy are looking to start apprentices as programmes come on stream.
Overall, the 2022/23 focus will be on reviewing systems, process and education to support the need to increase capacity and provide high quality experiences for students which meets their required programme outcomes.
UHS has drawn down **59%** of its apprenticeship levy as of March 2022.
We have 35 nursing apprentices who started in October, 9 ODPs, and 2 Radiographer degree apprenticeships. Levy remains at £5M, with average monthly spend of £120K, and monthly contributions of £220K. We transfer some of our levy to four different small businesses to support the local community apprentices.
Half of our first cohort of register nurse degree apprentices are qualifying and taking RN posts in October; the remainder have been offered Band 5 posts starting between November 2022 and January 2023.

Division	Headcount
Division A	71
Division B	96
Division C	76
Division D	74
THQ	69
CLRN	2
Grand Total	**388**

STUDENTS

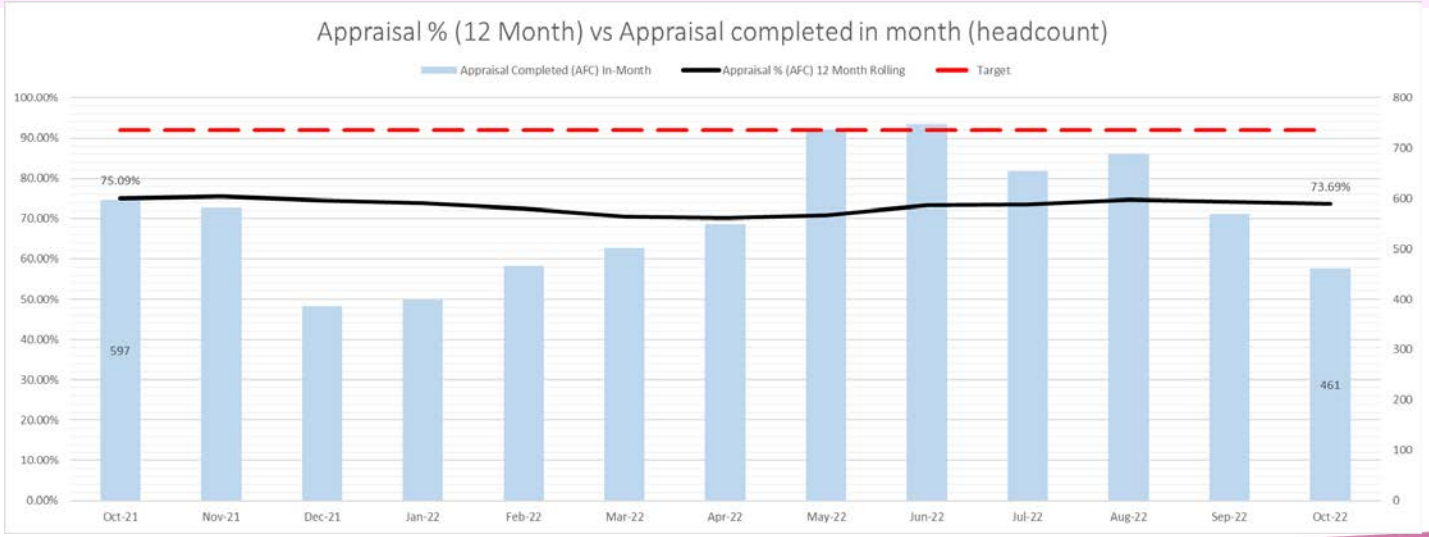
UHS has been able to return to a pre-COVID position with increased placement capacity for non-medical students. UHS is also supporting students from an increased number of Higher Education Institutions (HEIs). An example of this is in nursing where the overall student capacity has increased by 60 over the last year. It is noted that apprentices are additional to allocated HEI capacity and so this has led to a significant increase in placement requirements

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

APPRAISALS

2022/23 heralded the launch of a new appraisal process for the trust to enhance the opportunity for staff to have a meaningful yearly appraisal. The aim was to optimise the appraisal experience, making it more meaningful and focussed on the individual. It is anticipated the changes will increase trust and confidence in the process, and in turn increase meaningful participation. The pilot period concluded at the end of September 2022 with an evaluation and in-depth analysis taking place with the 402 people in the pilot group. The outcome will be reported through the People Board, and People and OD Committee with any recommendations and actions required.

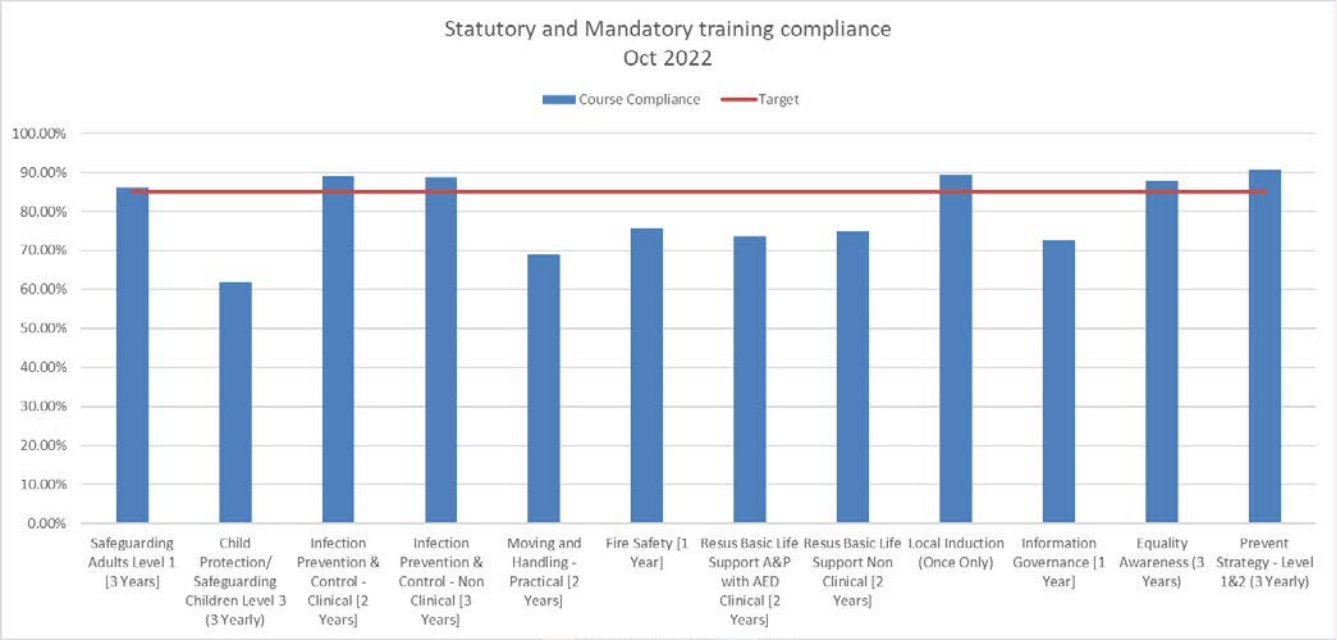


Source: ESR – Appraisal data

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

STATUTORY AND MANDATORY TRAINING



Source: VLE

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

To achieve our ambition of World Class People, our strategy sets out three key areas of focus. These will inform our intention to grow our UHS family.

3. BELONG

We want to nurture a compassionate, inclusive and welcoming environment that values and supports every individual, both personally and professionally. We will ensure that every person feels free and comfortable to bring their whole selves to work, safe in the knowledge that they are welcomed, respected and represented.

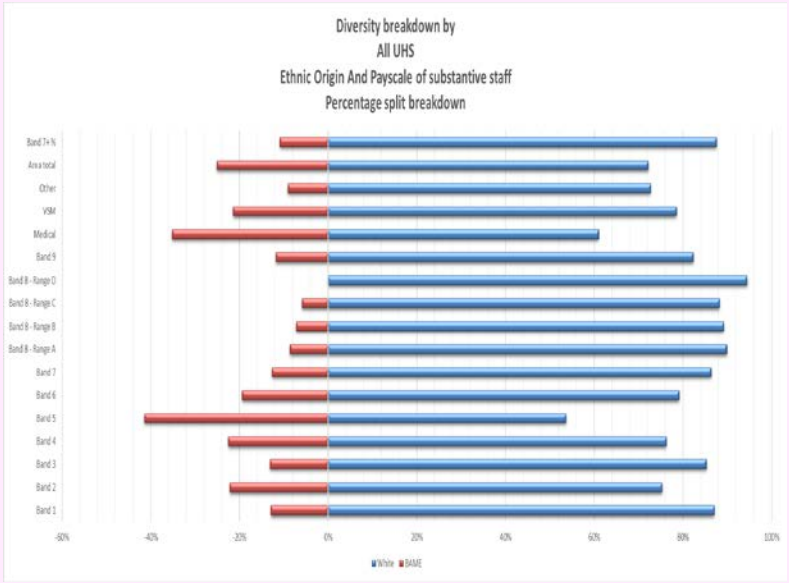
Relevant information:

Percentage of staff employed at AfC B7+ from non-white backgrounds | Percentage of staff employed at AfC B7+ with a disability or long-term condition

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

STAFF IN POST - ETHNICITY

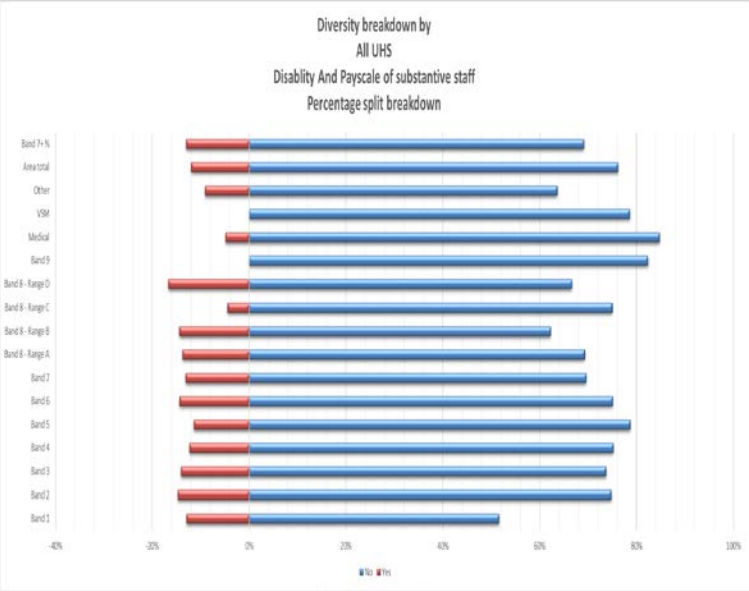


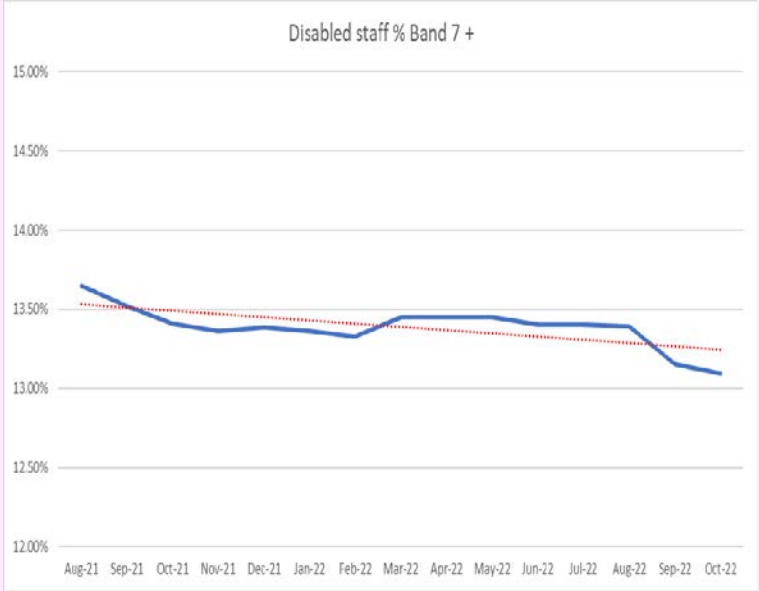
Source: ESR

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

STAFF IN POST – DISABILITY STATUS





Source: ESR

Report to the Trust Board of Directors				
Title:	**Infection Prevention & Control 2022-23 Quarter 2 Report**			
Agenda item:	**7**			
Sponsor:	**Gail Byrne, Chief Nursing Officer/Director of Infection Prevention & Control**			
Author:	**Julie Brooks, Head of Infection Prevention.** **Dr Julian Sutton, Interim Lead Hospital Infection Control Doctor**			
Date:	**29 November 2022**			
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 Q2 2022/23 report .			
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. • 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	Q2 has continued to be challenging in relation to COVID-19 and other HCAIs. Improvements are required in a number HCAI indicators where performance has exceeded expected thresholds for Q2. Trust Board is 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 in practice relating to reduction of C.difficile and Gram negative bacteraemia. 3. Note the actions required over the winter period to minimise the risk of in-hospital transmission and outbreaks associated with COVID-19, other respiratory viruses and Norovirus 4. Note the ongoing concerns in relation to the environment (e.g. ventilation and lack of toilet/bathroom facilities) and the impact on preventing & controlling infection.			

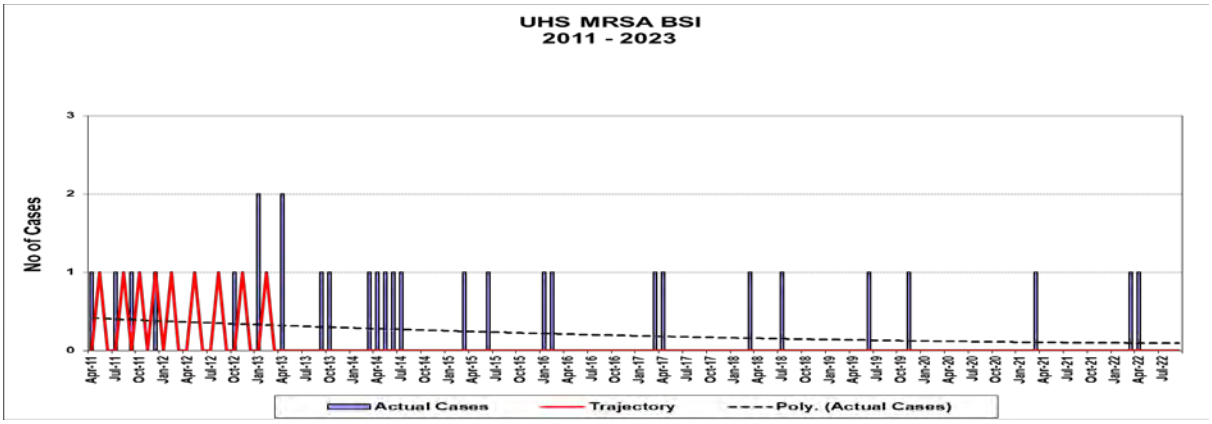
1. Introduction

Summary of progress in reducing risk of healthcare associated infection in UHS.

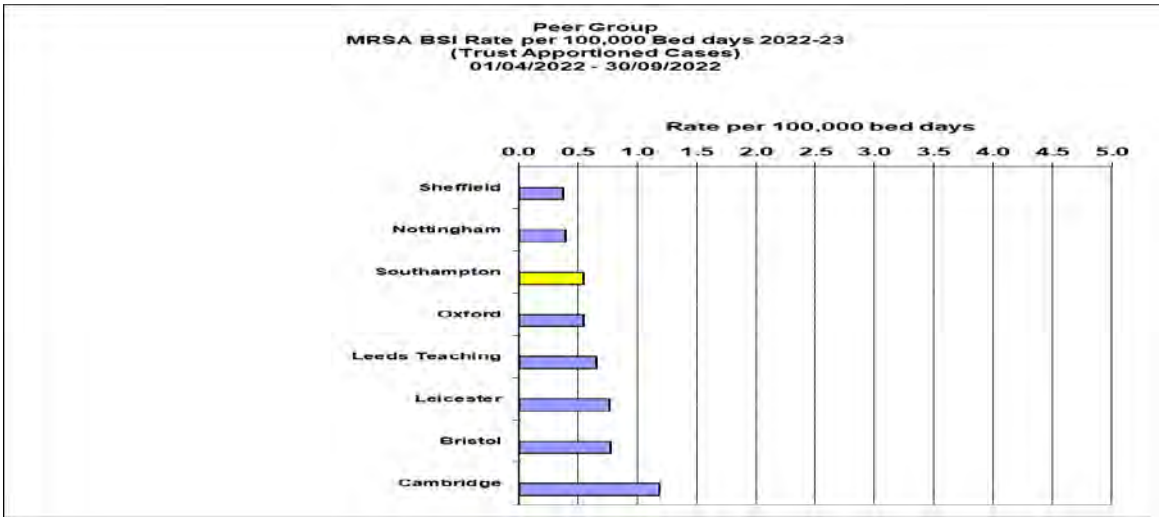
Category		Q2	Annual Limit	Action /Comment
National Objectives:	MRSA bacteraemia (Threshold = 0)	G	R	1 MRSA BSI attributable to UHS 2021/22 in April 2022.
	Clostridioides difficile infection (Threshold = 61)	R	G	39 cases against a Q1& 2 threshold of 30
	E coli Bacteraemia (Threshold = 127)	R	G	78 cases against a Q1 & 2 threshold of 61
	Klebsiella Bacteraemia (Threshold = 73)	G	G	28 cases against a Q1 & 2 threshold of 36
	Pseudomonas Bacteraemia (Threshold = 36)	R	G	20 cases against a Q1&2 threshold of 18
Other	MSSA			15 post 48hr cases in Q1&2
	Hospital onset, healthcare associated COVID19.			60 hospital-onset probable healthcare-associated cases in Q2 83 hospital onset -definite healthcare associated cases in Q2.
Antimicrobial Stewardship	Prudent antibiotic prescribing	G	G	NHS standard contract requires a reduction in the use of broad-spectrum antibiotic usage of 4.5% for 2022/23
Provide assurance of basic infection prevention practice:	Assurance of Infection Prevention Practice Standards	G	G	The annual infection prevention audit programme recommenced in May 2022 for the monitoring and assurance of infection prevention and control practices.

2. Analysis
2.1 Healthcare Associated Infection

MRSA Bacteraemia : 0 UHS acquired MRSA BSI in Q2.
1 UHS acquired MRSA year to date (Q1 2022/23)



UHS has an attributable MRSA BSI rate of 0.5 cases/100,000 bed days and ranks 3 of 8 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

16 patients acquired MRSA (colonisation or infection) in UHS in Q2 2022/23.

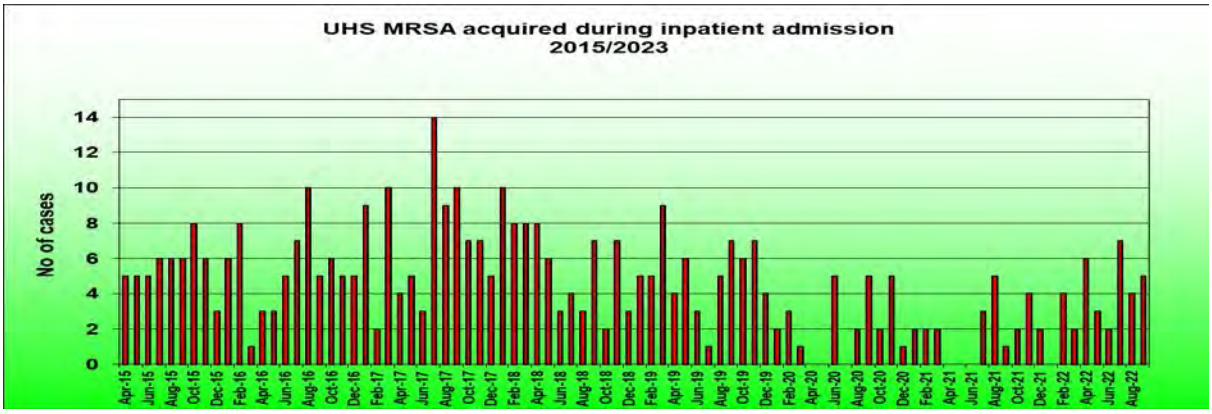
Hospital acquired cases continued to be reviewed by the Infection Prevention Team (IPT) in Q2 and enhanced surveillance undertaken to review assurance that all elements of the MRSA care bundle were being met (prevention of spread, patient management prior to result, patient management following result).

Areas of good practice included clinical cleaning, MRSA screening on admission, patient isolated within 4 hours of presumptive result, daily chloride based cleaning of isolation room, use of contact

precautions, MRSA positive status documented in notes, tropical decolonisation prescribed ,additional measures re wounds management etc
Key areas where expected practice standards have not always been followed relate to the use of standard infection control precautions, prescribing of chlorhexidine washes, additional screening at 14 days, completion of isolation risk assessments, and display of correct isolation signage/poster. Additional support and training is provided by the IPT to wards with frequent failures in elements of the care bundle.

Actions to reduce risk of acquisition of MRSA remain in place including:

- Ongoing focus and awareness on key elements of IP&C practice.
- Review of the Trust MRSA policy for adults and paediatrics following publication of updated national guidance.



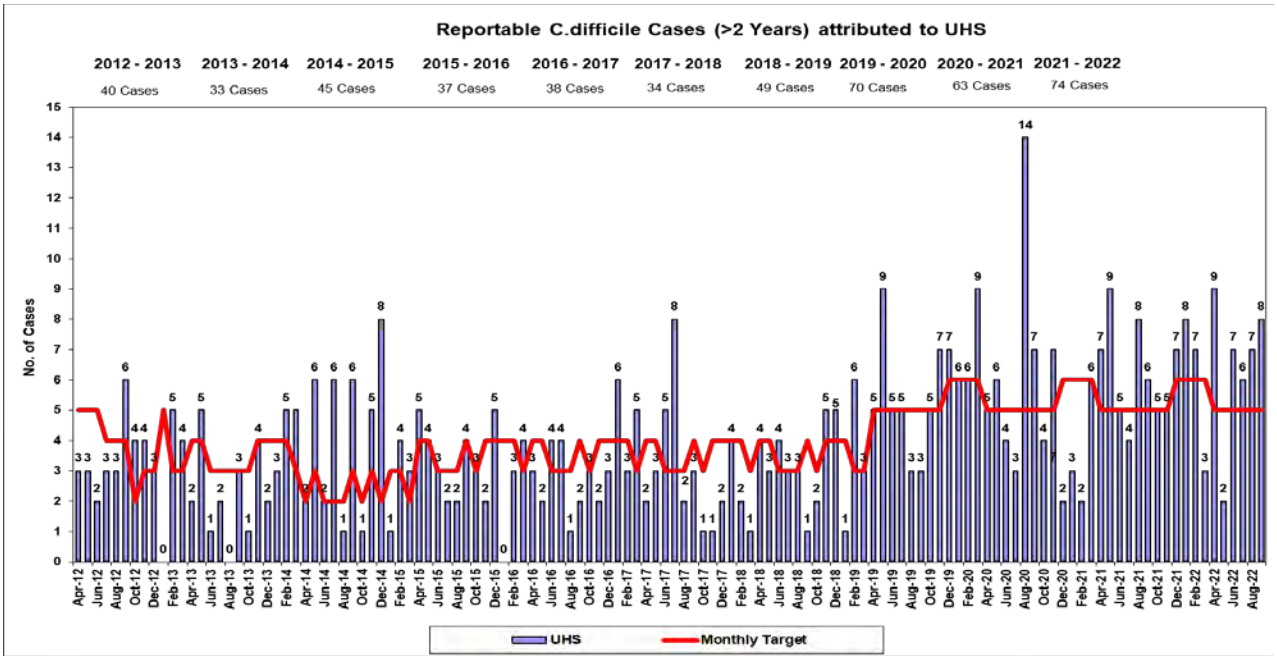
Clostridioides difficile (C.difficile)

Trusts are required under the NHS Standard Contract 2022/23 to minimise rates of C. difficile so that they are no higher than the threshold levels set by NHS England and Improvement. Thresholds for 2022/23 are derived from a baseline of the 12 months ending November 2021 (the most recent available data at the time of calculating the figures). Trust-level thresholds comprise total healthcare-associated cases i.e. Hospital-onset healthcare associated (HOHA) and Community-onset healthcare associated ((COHA). UHS has been set a national performance threshold of 61 cases for 2022/23.

Q2 2022/23 progress:
21 cases in Q2 against an internal threshold of 15 (39 cases year to date against a national threshold of 61).

- 6 Community Onset – Hospital Attributable (COHA)
- 15 Hospital Onset – Hospital Attributable (HOHA)

Count of Date Rec'd		NewSource				
NHSCCG	Date Rec'd	COHA	HOHA	COIA	COCA	Grand Total
NHS Isle of Wight CCG	Aug	1				1
NHS Southampton CCG	Jul	1	1		2	4
	Aug			3	1	4
	Sep		3	1	1	5
NHS West Hampshire CCG	Jul	1	1		6	8
	Aug	2	4	3	4	13
	Sep	1	3		5	9
NHS Dorset CCG	Jul		2			2
NHS North Hampshire CCG	Sep		1			1
NHS South Eastern Hampshire CCG	Aug				1	1
Grand Total		**6**	**15**	**7**	**20**	**48**



An increase in C.difficile cases continues to be seen across the Hampshire and Isle of Wight integrated care system (HIOW ICS) and nationally. Reasons for this are likely to be multifactorial, including increased complexity of patients and associated use of necessary antimicrobials to treat these patients.

Toxin positive inpatient cases of C. difficile have 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 met. All hospital acquired cases continue to be reviewed by a consultant microbiologist/Infection Control Doctor to identify learning and actions required. In addition, detailed case reviews are undertaken to identify any learning. All hospital-acquired or hospital-onset C.difficile cases are reviewed by a multidisciplinary panel, including IPC colleagues from the HIOW ICS, and most of the cases are found to be unavoidable. The MDT panel review includes review of antimicrobial prescribing, infection prevention & control standards within UHS and any learning for Primary care.

Areas of good practice include daily chloride based cleaning of isolation room and clinical cleaning. Key areas where expected practice standards have not always been followed relate to completion of isolation risk assessments, patient isolated with 2 hours of onset of symptoms, display of correct isolation signage/posters, completion of the C.difficile integrated care pathway, monitoring of fluid balance and C.difficile patient information leaflet not given. The need to encourage the use of Fidaxomicin to prevent relapse and shorter Tazocin prescribing periods has been identified by the MDT review panel.

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.

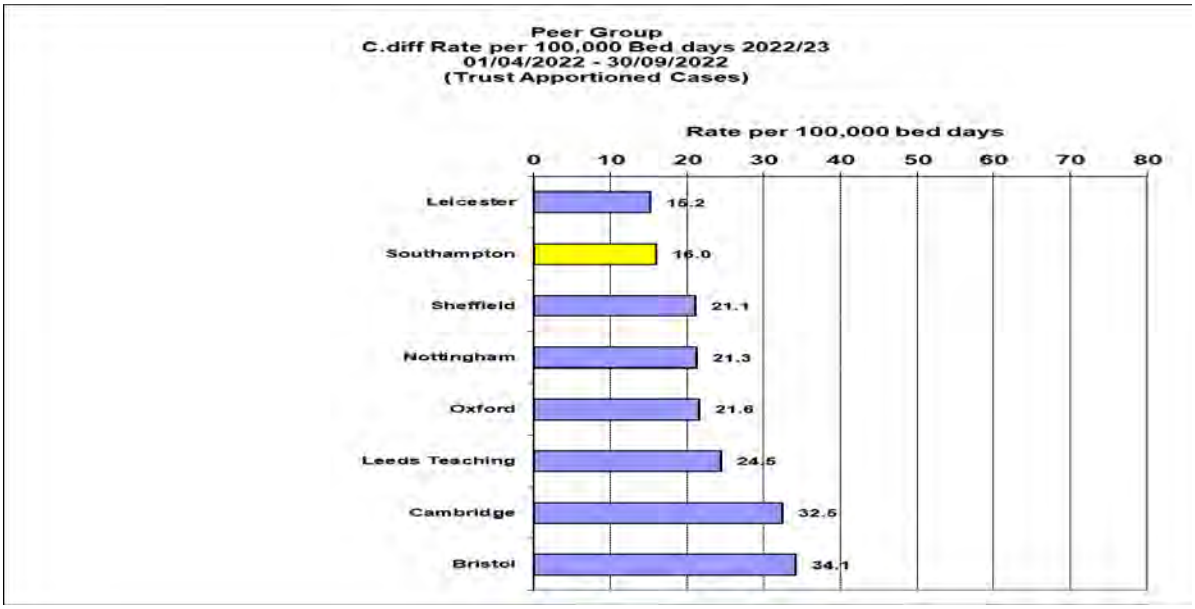
Actions/ measures to facilitate improvements in practice relating to reduction of C.difficile are ongoing with further enhanced focus planned for Q3 including:

1. Antimicrobial Stewardship
    - Ongoing focus on antimicrobial stewardship via stewardship ward rounds and increasing the number of ward rounds across the trust.
    - Activities planned for World Antibiotic Awareness Week in November 2022.
    - Ongoing focus on the reduction of the use of high-risk antibiotics as advised in national guidelines for reducing C.difficile.

2. Introduction of a post infection review (PIR) process for cases of hospital acquired C.difficile. This will include a requirement for clinical teams, with the support of the IPT ,to undertake a post infection review of cases in order to identify risk factors, antimicrobial prescribing patterns, IPC practice gaps/areas of good practice. These will then be reviewed at an MDT C.difficile panel to identify any themes, learning and actions to improve practice and patient management.
3. Isolation: continued focus on early assessment and isolation of patients presenting with symptoms of diarrhoea; optimising the management of isolation facilities and improving standards of isolation care.
4. Cleaning & Decontamination - continued focus on consistent cleaning standards by contracted the cleaning service (SERCO) and clinical staff. Planned programme of work to increase utilisation of the available UVC technology within the Trust. Training/awareness for clinical staff on clinical equipment cleaning planned for end October 2022. Planned programme of work to increase utilisation of the available UVC technology within the Trust.
5. Education & training – focus on education and training of staff in relation to antimicrobial stewardship; identification, assessment, management and treatment of cases; infection prevention and control practices including isolation and washing hands with soap and water.

Detailed case reviews are also being undertaken for community cases by the ICS IP&C team , including review of antimicrobial prescribing. Reviews have identified that many cases are occurring in complex patients requiring multiple antibiotics which are being appropriately prescribed. In addition the use of PPIs (proton pump inhibitors) has been identified as a theme, which is associated with an increased risk of C.difficile infection.

UHS ranks second out of 8 self-selected peer acute trusts, with a rate of 16.0 cases/ 100,000 bed days. Comparative data needs careful interpretation because of differences in test selection, methodology and reporting criteria between trusts.



Post 48 hr Bacteraemia (excluding MRSA)

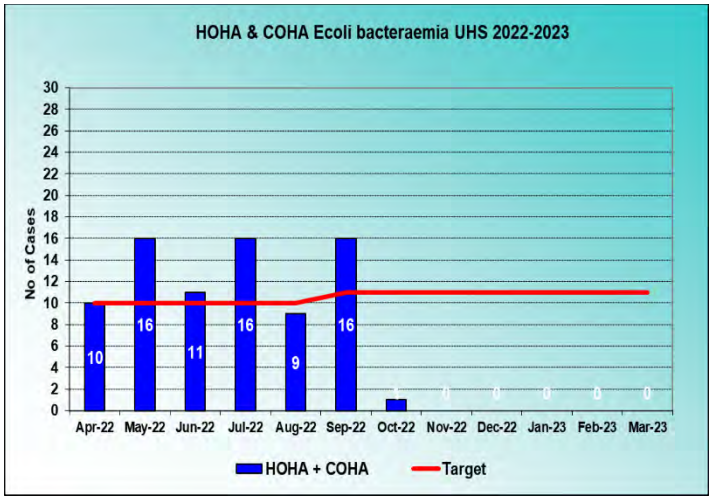
Trusts are required under the NHS Standard Contract 2022/23 to minimise rates of Gram-negative bloodstream infections so that they are no higher than the threshold levels set by NHS England and Improvement. Thresholds for 2022/23 are derived from a baseline of the 12 months ending November 2021 (the most recent available data at the time of calculating the figures). Trust-level thresholds comprise total healthcare-associated cases i.e. Hospital-onset healthcare associated (HOHA) and Community-onset healthcare associated (COHA).

Post-48h BSI	Q1&2 2022 2023	2021-22	2020-21	2019-20	2018-19	2017-18
E coli	78(127)	138 (151)	67	67	67	81
Klebsiella	28 (73)	64 (64)	40	57	42	39
Pseudomonas	20 (36)	30 (34)	13	24	23	19
MSSA	15	43	36	30	44	36
VRE	1	9	7	12	10	10

(National thresholds in brackets)

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. Investigation by post infection review of cases supports identification of emerging trends/themes, identification of organisational learning and targeted improvement actions.

E coli Bacteraemia: UHS have been set a threshold of 127 Cases for the Year 2022/23.
(78 cases year to date against a national threshold of 127)



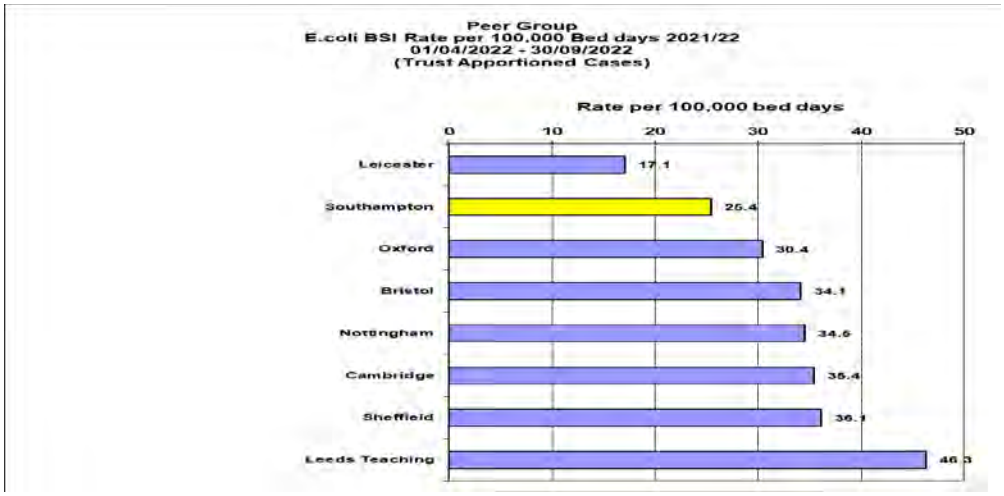
Q2 Progress

41 cases against an internal threshold of 31

- 12 Community Onset – Hospital Attributable (COHA)
- 29 Hospital Onset – Hospital Attributable (HOHA)

Of the 41 cases:

- All have undergone a detailed review by consultant microbiologist.
- 37 cases were assessed to have been managed appropriately
- 4 cases post infection review by the clinical team requested.



Key themes/leaning from cases

Learning from post infection reviews undertaken in Q2 has identified:

- the need to facilitate earlier removal of catheters by early trial without catheter (TWOC)
- poor urinary catheter documentation.
- the need to promote the use of bladder scanner
- the need to promote use of catheter securement devices.

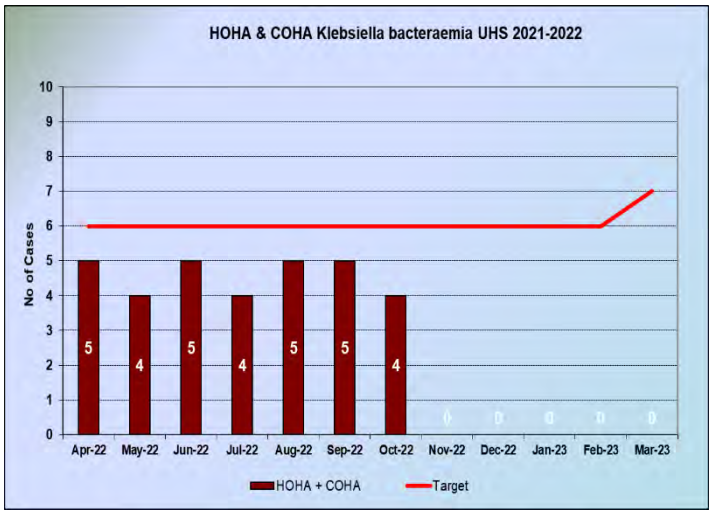
Of the 41 cases, 4 (8%) have been assessed as avoidable and associated with the presence, care and management of indwelling urinary catheters. The remainder were assessed as unavoidable. Due to the nature and complexity of the patients within UHS it is likely that we will see a sustained level of E- coli bacteraemia which are unavoidable.

Actions to reduce E-coli bacteraemia are ongoing and include continued focus on reducing risk of catheter associated UTI (CAUTI) through management of urinary catheters, avoiding unnecessary catheterisation and early removal.

- Project work has commenced within the T&O care group with a plan to extend this to other areas within the Trust in Q3/4. Baseline data collected in T&O on catheter utilisation has indicated that the length of time that catheters remain in place needs reducing. The project will explore ways to facilitate MDT decision-making for catheter removal with the aim of ensuring proactive review and timely removal. If successful, this approach will be implemented more widely.
- A digital version of the indwelling urinary catheter record has undergone clinical acceptance testing and will then go live on F8 Ward. It will be easy for clinicians to locate in the patient record and provides a clear audit trail of decisions relating to use and management of the catheter. Ultimately, it will enable data on indwelling catheters to be more readily accessible for audit of practice and measurement for improvement.
- A pathway for the management of acute urinary retention in ED is in development to ensure patients receive the most appropriate care and follow-up, including prompt review and removal of the catheter when no longer required.
- Work continues with the Hampshire and Isle of Wight Integrated Care Board to focus on improving the pathway for patients with a urinary catheter using a system-wide approach.

In addition to the work on improving urinary catheter management, a stronger focus on health prevention measures such as promoting hydration and good personal hygiene is required on a wider community and system level. This has been raised with the HIOW ICS, Southampton City Health Protection board and via the Southeast Regional IP&C network.

Klebsiella Bacteraemia: UHS have been set a threshold of 73 Cases for the Year 2022/23. (28 cases year to date against a national threshold of 73)

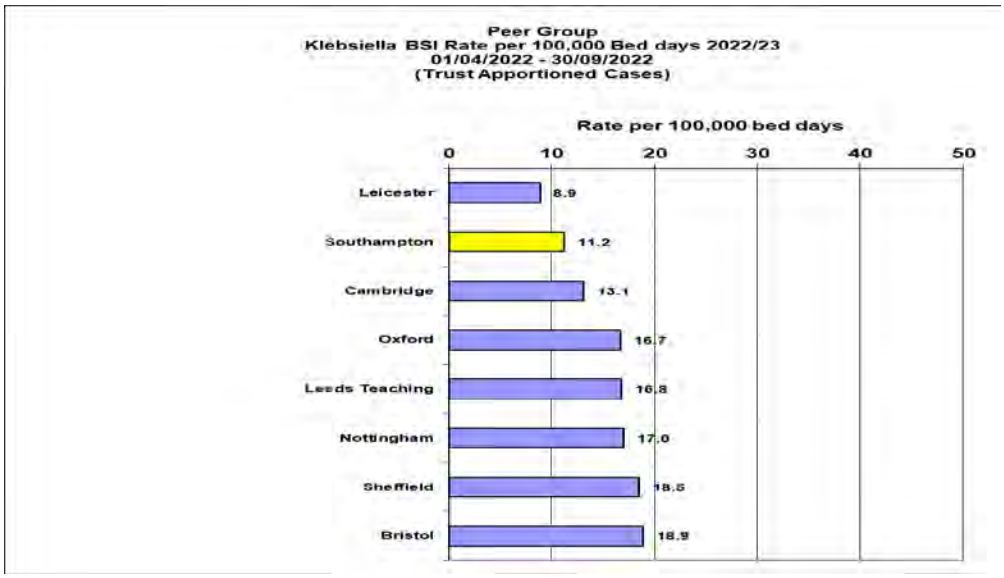


End of year outcome:
14 cases in Q2 2022/23 against an internal threshold of 18

- 4 Community Onset – Hospital Attributable (COHA)
- 10 Hospital Onset – Hospital Attributable (HOHA)

Of the 14 cases:

- 11 cases were assessed as being managed appropriately
- 3 cases underwent post infection review by the clinical team.



Key themes/leaning from cases

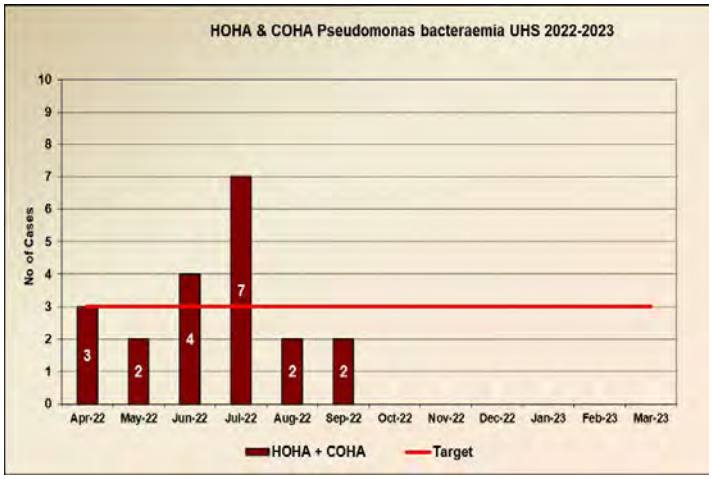
Learning from post infection reviews undertaken in Q2 has identified:

- Improvements are required relating to the management and documentation of care associated with patients accessing own lines, patient hand hygiene and personal care.
- Focus on ensuring that IV devices are removed using aseptic non-touch technique.
- IV device care documentation requires improvement.

Ongoing actions to reduce Klebsiella bacteraemia include:

- Improving invasive device care and management.

Pseudomonas Bacteraemia: UHS have been set a threshold of 36 Cases for the Year 2022/23. (20 cases year to date against a national threshold of 36)

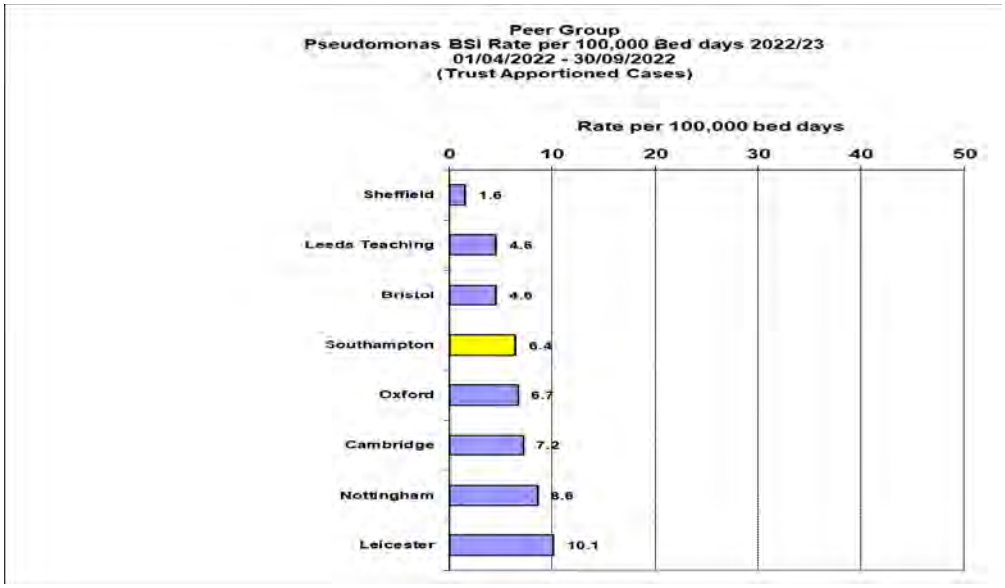


End of year outcome:
11 cases in Q2 2022/23 against an internal threshold of 9

- 2 Community Onset – Hospital Attributable (COHA)
- 9 Hospital Onset – Hospital Attributable (HOHA)

Of the 11 cases:

- 10 cases were assessed as being managed appropriately
- 1 case underwent post infection review by the clinical team.



Key themes/leaning from cases

Learning from post infection reviews undertaken in Q2 has identified:

- Documentation of intravenous device removal requires improvement.
- Surgical dressings not changed in accordance with planned dates
- Improvements are required in hand hygiene practice.

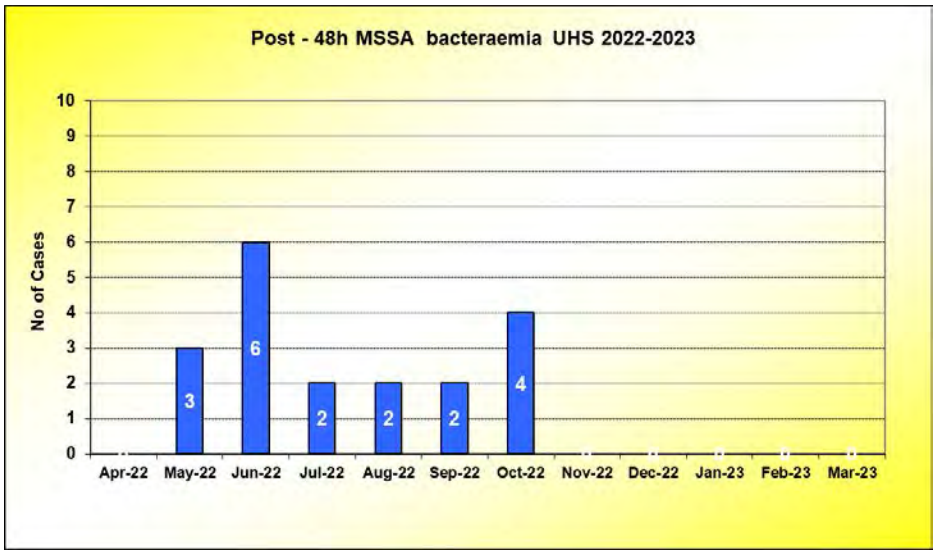
Many patients in UHS are immunocompromised and neutropenic and therefore at higher risk of pseudomonas bacteraemia. Use of invasive devices in augmented care units (level 2 and level 3) increases the risk of bacteraemia making it an important area of focus.

Ongoing actions to reduce Pseudomonas bacteraemia include:

- Improving invasive device care and management.
- Continued 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.
- 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



Key themes/learning:
Key themes/learning identified from post infection reviews of cases of MSSA bacteraemia undertaken in Q2 continue to relate to peripheral intravenous cannula care, management and documentation including:

- Documentation of IV device care requires improvement
- Delayed removal of IV devices requires a documented rationale.

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

Actions/ measures to facilitate improvements in practice related to care and management of IV devices in order to reduce MSSA and other bacteraemia are ongoing with enhanced focus planned for Q3 including:

- Commencement of a quality improvement project to reduce the length of time that IV devices are in place.
- Ongoing focus on hand hygiene and principles of aseptic non-touch technique.

2.2 COVID-19

The Trust has continued to focus on preventing transmission of COVID-19, whilst supporting the recovery and restoration of services and operational activity, alongside transitioning to 'Living with Covid' in our hospital settings.

COVID-19 continued to present challenges for UHS during July 2022, followed by a decline in cases in August and a further increase in September. An increase in case numbers in the community resulted in an increase in hospital admissions and this, alongside the high transmissibility of the virus, resulted in a significant increase in hospital onset infections and outbreaks within UHS along with challenges associated with COVID related staff absence.

Strategies to reduce the risk of in-hospital transmission of COVID-19 continue to be 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 has continued 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, incident meetings and the Infection Control Gold Command Committee.

Living with COVID-19.

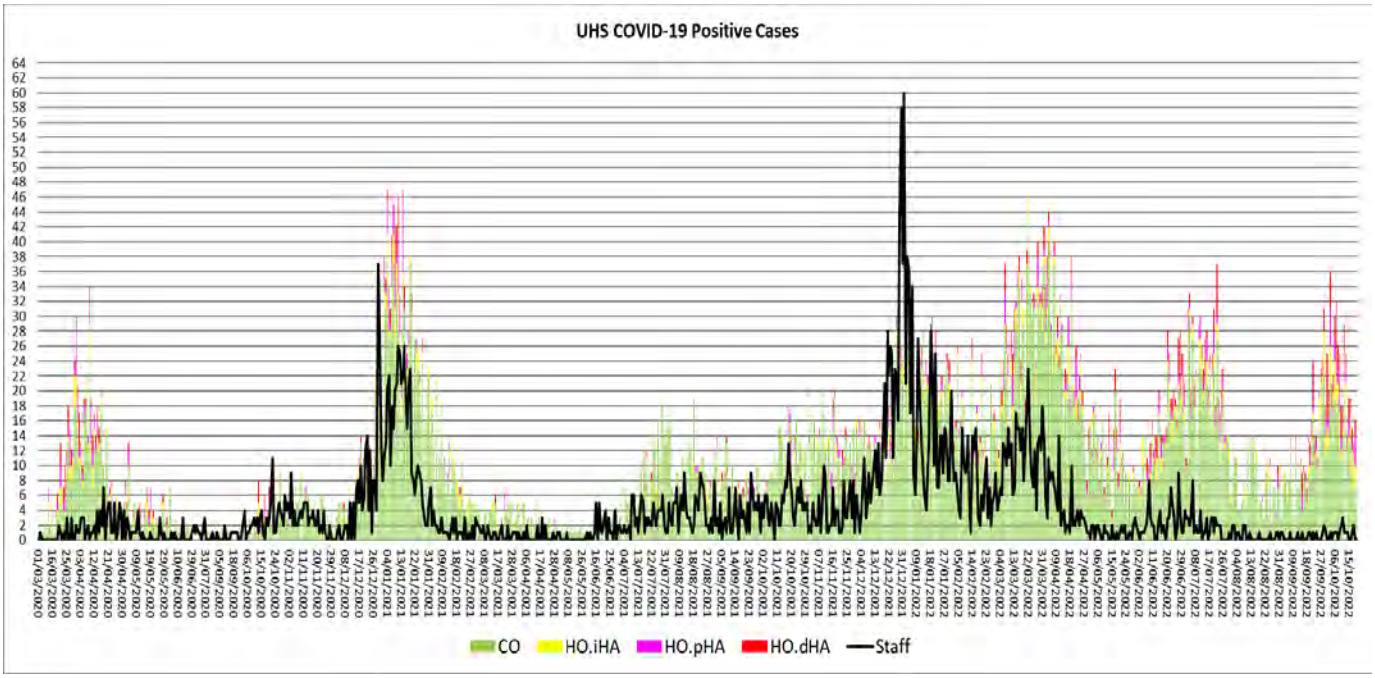
Focus on transition to 'Living with COVID' within our hospital settings/services has been ongoing during Q2 with number of actions/changes undertaken including:

- Full decentralisation of the management of adult COVID-19 positive patients from G-level West wing back into their own specialities.
- Further reintroduction of activities and lifting of IP&C measures as part of the ongoing review of the UHS roadmap.
- Changes to testing requirements for COVID-19 (staff & patients)

Careful review and consideration of IP&C measures and restriction remains in place within the Trust with the re-introduction of restrictions if required, led by DIPC and the Infection Prevention Gold Command Committee. In Q2 the IP&C Gold Command Committee was stepped down to be replaced by the IP&C Senior Oversight Group.

The Trust has continued to review and respond to updated national guidance when issued and has undertaken local risk assessments where required to ensure safe systems of work, balancing risks across the whole patient pathway, ensuring safe care for our patients, the safety of our staff, reducing the risk of nosocomial transmission, and supporting the delivery of elective recovery.

Planning and preparedness for future variants, along with the potential for future pandemics remains a key area of focus for the Trust.



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

Cases identified in UHS: April 2022 to June 2022

Community Onset (CO)	Indeterminate (HO.iHA)	Probable (HO.pHA)	Definite (HO.dHA)
1087	88	60	83

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 continues 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. Close liaison between the Infection Prevention Team and clinical/non-clinical teams is in place to support identification, investigation and management of increased incidence of infection.

Total Number of Outbreaks July 2022-Sept 2022	**26**
Outbreaks involving Patients and Staff	4
Outbreaks involving Patients Only	22
Outbreaks involving Staff Only	0
Total Number of Positive **Patients**	152
Total Number of Positive **Staff**	7

All outbreaks have been managed by the Infection Prevention Team and reported onto the national outbreak management system where required, with ongoing monitoring until 28 days following the last confirmed case.

Outbreaks 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. 2 patients were identified as a probable or definite hospital-onset healthcare associated COVID-19 infection death.

Incident or Outbreak Date	Details of Incident	Ward	Total No of patients in outbreak	No of patient RIP< 28 days
07/07/2022	Covid 19 Outbreak	**G5**	8	**1**
14/07/2022	Covid 19 Outbreak	**G9**	6	**1**

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 remain unchanged.

- Risks associated with the physical environment, particularly lack of mechanical ventilation and difficultly in achieving good airflow by natural ventilation (due to lack of windows/ inability to open windows in some areas), has been identified as a significant factor in relation to aerosol transmission in the context of outbreaks. Other risks related to the physical environment include the lack of bathroom/toilet facilities on some wards resulting in a high number of patients sharing facilities or difficulty in allocating dedicated facilities for Covid contacts.
- Patient adherence with mask use and physical distancing. This included challenges with confused and wandering patients, complex patients with significant physical or mental health needs and individual inpatients frequently leaving the ward for non-clinical/treatment reasons (e.g.to meet others in retail outlets/outside) increasing the risk for COVID-19 transmission.
- Lack of onward care provision in the community resulting in delayed patient discharge.
- Patients and staff testing positive to COVID-19 despite being fully vaccinated, indicating apparent waning immunity and immune evasion with the new variants.
- The need to undertake multiple bed/ward moves in order to create capacity for both emergency/elective demand and for COVID-19 patients (due the increase in COVID admissions and hospital cases) and ensure that clinical care was not compromised, is likely to have resulted in transmission events and subsequent outbreaks.

2.3 Viral Gastroenteritis including Norovirus.

No viral gastroenteritis including norovirus outbreaks have occurred in Q2.

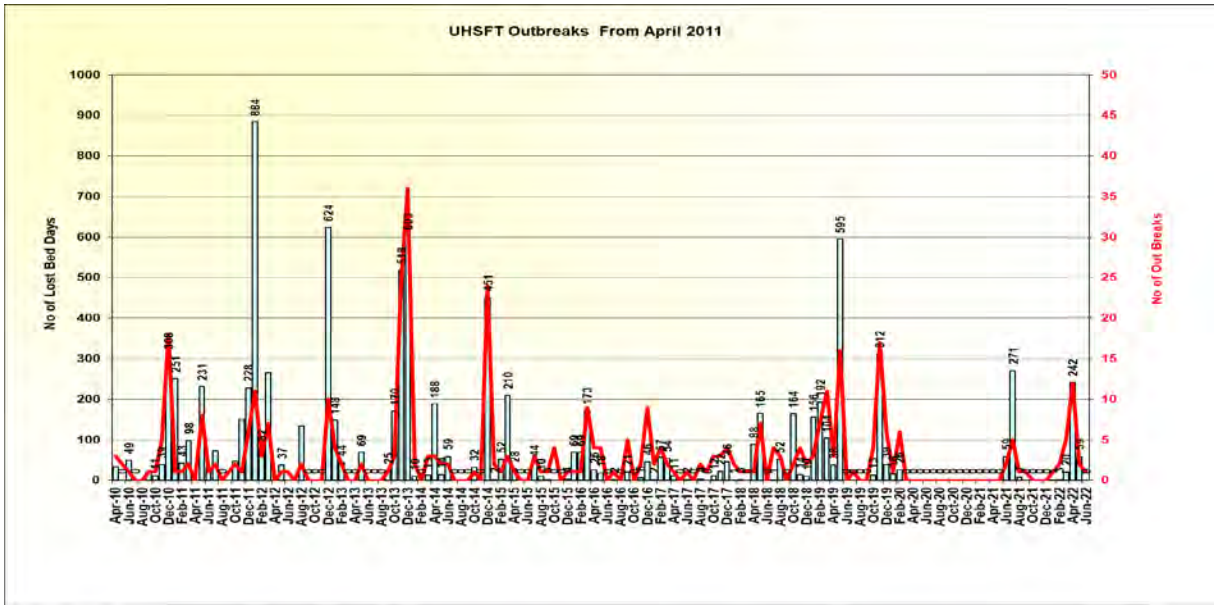
Year	Bed days lost due to bay/ward closures
2016-17	**232**
2017– 8	**101**
2018-19	**946**
2019-20	**1039**
2020-21	**0**
2021-22	**361**
April 22 to Sept 22	**308**

UHS continues to be at risk of Norovirus outbreaks due to the limited single room capacity and limited toilet/bathroom facilities in some of the wards.

Key actions required to improve future performance and support prevention and management of Norovirus outbreaks within UHS include:

- Programme of re-education and awareness of basic infection prevention standards including in the assessment and management of unexplained/unexpected D&V and expected infection prevention practices (planned for Q3).
- Improved capacity for rapid diagnostic testing (result within 2 hours) for gastrointestinal pathogens (including Norovirus) to support rapid decision making and management– both point of care testing in admission pathways and rapid in-lab testing. Implementation of rapid testing for gastrointestinal pathogens in AMU has demonstrated significant benefits in relation to diagnosis, patient management and optimization of isolation capacity. A pilot using rapid GI testing will be undertaken by the IPT in Q3 with the aim of facilitating rapid decision-making in relation to bay closures due to D&V.
- Ongoing focus on effective management of existing isolation capacity within UHS to ensure optimal use and explore longer term options to increase isolation capacity.
- Enhancing processes/practices to support prevention of outbreaks occurring including rapid assessment, identification and isolation of suspected cases.
- Ongoing implementation of a robust communication plan/strategy for use prior to/during outbreaks
- Enhancing practices/processes to support management and control of outbreaks when they occur.
- Work with partners and local/national agencies, e.g. CCGs/ICS/ UKHSA/local Health Protection Teams, to improve intelligence and communication relating to community Norovirus activity.

Preparations for winter 2022/23 incorporating improvements are underway.



2.4 Respiratory virus infections.

In Q2 2022/3 there were 0 outbreaks related to Influenza A/B or RSV.

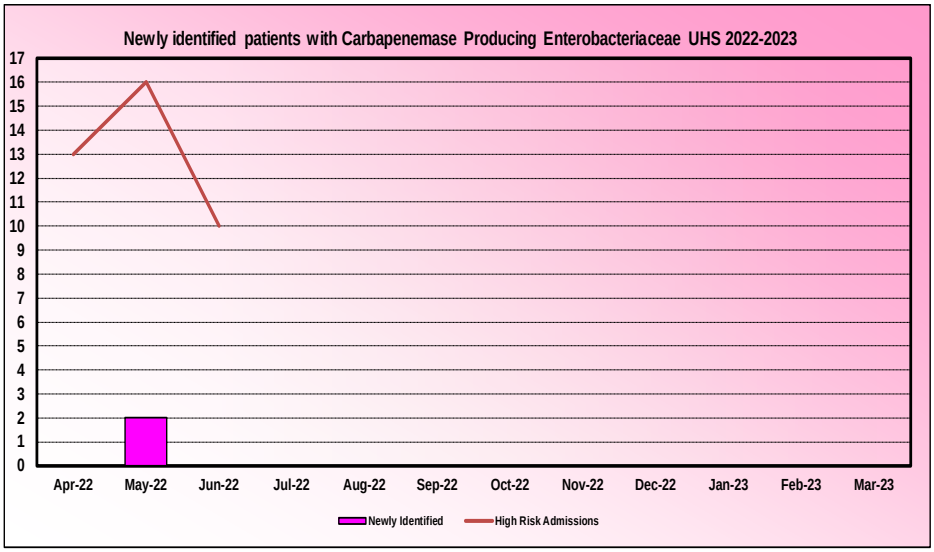
2.5 Actions to minimise the risk of in-hospital transmission and outbreaks associated with COVID-19, other respiratory viruses and Norovirus

Actions and strategies to reduce the risk of in-hospital transmission of respiratory viruses (including COVID 19 and influenza) and Norovirus, along with planning for potential increase in cases have

remained in place and under ongoing review. 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.
- 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.
- Ongoing focus on more effective management and optimal use of single room capacity to facilitate rapid isolation of patients presenting with suspected infections.
- 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 in Autumn 2022.
- Winter Virus awareness campaign in Q3 2022/23.
- 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.

2.6 Carbapenemase-producing Gram negative bacteria



CPE continues to be a 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 a 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.

July 2022 to Sept 2022:

- 32 High Risk patients admitted to UHS

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 in 2022-2023.
- To continue undertake extensive screening of CPE in key areas of hospital including patients on carbapenems.

2.7 Surgical Site Infections

Surgical site surveillance (using UKHSA SSI modules) is undertaken for hip and knee replacement surgery, including use of post discharge patient questionnaires.

In Q2 2022/23 UHS recorded 0 infected cases both in the hip and the knee replacement category.

Knee replacement

A total of 35 patients were operated on.22(35) were primary cases and 12(35) were revision procedures. 20(35) had an ASA score of 3 and the rest had an ASA score of 2. 16(35) were in the 71-80 age group and 5(35) were more than 80yrs old. The rest were in the 50-70yrs age group.

Overall, nearly half the patients were in the high-risk group. The cohort is still under surveillance until April 2023. UHS uses the CDC guidance (1992) which states that if an infection occurs within a year if an implant is in place and the infection appears to be related to the surgical procedure, the infection is a deep incisional healthcare acquired infection.

Key findings in relation to compliance with NICE guidance for preventing surgical site infection: Normothermia throughout the peri-operative period of the patient is recommended as part of the care bundle to prevent surgical infection, especially for the high-risk patients that we have. Temperatures are not always recorded during surgery as per guidance. The issue has been escalated to the IPT who have escalated to the Theatre Matrons.

Hip replacement

A total of 51 patients were operated on. 30 (51) had an ASA score of 3 and 3(51) had an ASA score of 4. 13(51) were in the 71-80 age group, 7(51) were more than 80 years old and the rest were in the 50-70years age group. Overall, also nearly half the patients were in the high-risk group. The cohort is also still under surveillance until April 2023.

2.8 Assurance of Infection Prevention Practice standards, including environmental cleaning

Infection Prevention Practice standards

The Trust annual infection prevention audit programme was re-instated in May 2022, following, suspension for the majority of 2021/2022, to monitor infection prevention and control practice standards in clinical and non-clinical areas.

Audits undertaken in Q2 2022/23

High Impact Intervention Audits (Care processes to prevent infection) - self-assessed audits.

	Element	% Standards met
Surgical Site Infection August 2022	Pre Operative	96%
	Intra Operative	100%
	Post Operative	95%
Ventilated Patients August 2022		93%

Hand Hygiene

The hand hygiene audit process covers a wide selection of staff groups and ensures any missed opportunities for hand hygiene are addressed during the audits.

Monitoring and assurance of hand hygiene practice for inpatient areas in 2022/23 consists of:

- Self-assessed audits by Ward Leaders and/or Matron with Clinical Lead.
- Covert audits carried out by an independent infection prevention nurse out of uniform.

Monitoring and assurance of hand hygiene practice for outpatient areas consists of:

- peer audits only

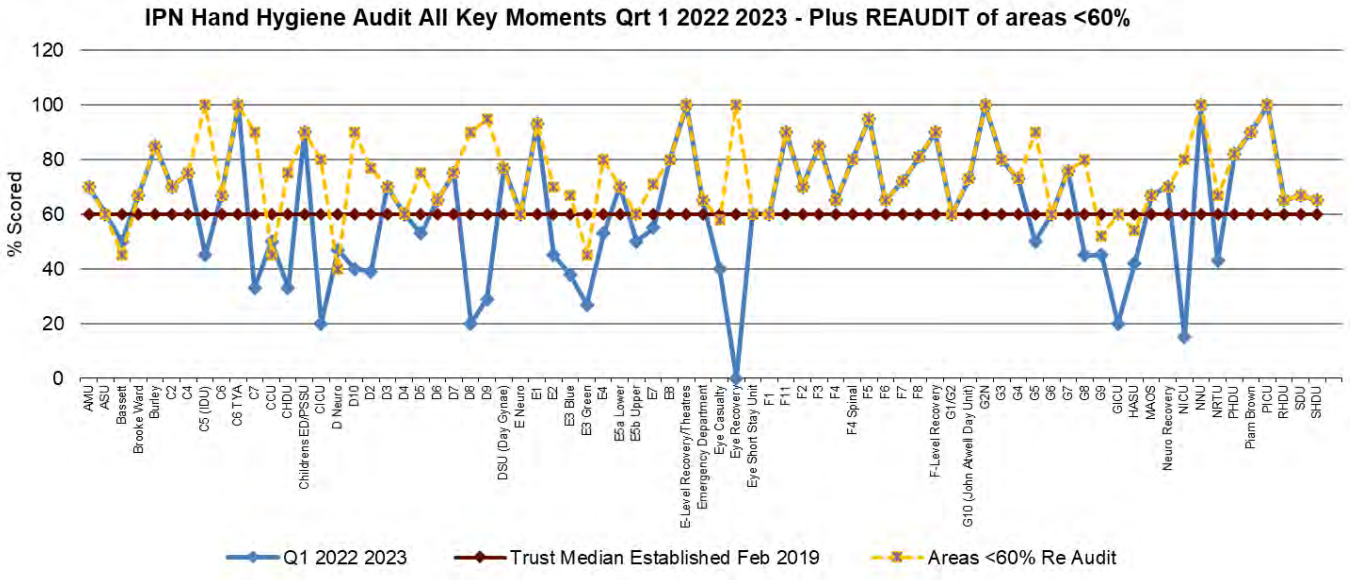
Audit type	Month	% Standards met	
Inpatient areas (self-assessed)	July 2022	94%	
Outpatient areas (self-assessed)	July 2022	97%	
Inpatient areas (covert audit undertaken by Infection Prevention Nurses)	Q1 -all inpatient areas Q2 - reaudit of areas who did not achieve the trust median score in Q1 audits.	Q1 overall trust median score = 62%. Overall trust median score following re-audits = 74%	Against a performance improvement target of 60% (the trust median score established following February 2019 covert audits).

Within the hand hygiene performance improvement framework (non-self-assessed audits) inpatient areas are measured against a performance improvement target of 60% (the trust median score established following the first covert audits undertaken in February 2019).

All areas are expected to improve performance to score above the trust median score. Those scoring 30-59% will require action plans to improve to the median score. Those scoring below 30% will have improvement plans supported by IPT.

Following the Q1 IPN audits 27 areas scoring below 60% were reaudited. Of the 27 areas that were reaudited 24 areas showed an improvement in hand hygiene practice and 20 areas achieved over the trust median target of 60%.

7 areas scoring between 40-58% continue to be supported by the Infection Prevention Team who are working with ward leaders and matrons to improve hand hygiene practice.



Improving standards of hand hygiene practice continues to be an ongoing area of focus in 2022/23.

Miscellaneous Audits (all self-assessed with exception of IPT PPE audit)

Audit	Month	% Standards met
Personal Protective Equipment	Sept 2022	98%
Cleaning and Decontamination	Sept 2022	(non-infected patients in non-contaminated area) 97%
		(infected patient/in a contaminated area) 94%

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 has been undertaken through a range of avenues:

- As part of IPT visits and reviews of clinical areas.
- Ward leader/Matron walkabouts & spot checks

Summary of actions being taken to facilitate improvements in practice

- The Infection Prevention Team (IPT) continue to review practice, visiting areas, undertaking spot checks and arranging education/awareness sessions as required.
- IPT provide support to areas not achieving expected standards.
- Processes are in place for regular review of areas not achieving expected standards and the introduction of intensive support/special measures will be undertaken where required.

Environmental Cleaning

Monitoring of environmental cleaning standards (domestic and clinical) have continued to be undertaken by the environmental monitoring team in Q2 2022/2023.

Serco has consistently delivered high levels of cleaning across the hospital, with all monthly targets achieved in Q2 2022/23

Audits have however identified concerns in some areas with cleaning of patient care equipment by clinical staff. This has been escalated to Divisional Heads of Nursing and Matron with actions to improve practice, including additional education/training planned in Q3.

2.9 Antimicrobial Stewardship.

See Appendix 1 for full report.

2.9 Estates

Water Quality

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

Progress/actions continue to include

- Pseudomonas risk assessments –clinical, domestic, IPT and engineering meeting together to implement solutions to eradicating Pseudomonas in augmented care areas. Positive samples have started to drop as a result of remedial actions.
- Better training of maintenance staff continues to enable us to complete remedial actions

Air Quality/Ventilation

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.

Providing a clean environment, including fresh air, is considered essential to the healthcare environment. The focus on the importance of ventilation has been highlighted further during the COVID-19 pandemic, where the apparent association between transmission/outbreaks and poor ventilation in a range of settings (healthcare and non-healthcare) has been established.

The COVID-19 pandemic has further highlighted key areas in UHS where mechanical ventilation is lacking or does not meet current standards in clinical areas. General ventilation across UHS wards, outpatient areas and offices is variable, with only a small number of areas having good ventilation (see table below). Many areas where ventilation is poor also experience high temperatures which affects both patient and staff wellbeing.

Block	RAG	Notes
West Wing Wards G5, G6, G7, G8 & G9		
West Wing Wards F5, E5, D5		
West Wing Wards C5, C6, SHDU, RDHU, Endoscopey		
All other West Wing Wards		
East Wing Wards G2 PHDU/Neuro, G4 Heamo-dialysis area & CHDU & CCU		
East Wing Original A&E Footprint		Majors Area & RAU (Old minors) perform well; remaining areas perform poorly
East Wing Ward C3 & Plaster Suite		Performance considerably lower than anticipated
East Wing all other wards (G1, G2 & E1)		No mechanical Ventilation
East Wing all other wards (G3 & G4)		No mechanical Ventilation
East Wing NIC/Infill areas		
East Wing Annex - "New" A&E & D Level Out Patients		
Centre Block PICU		
Centre Block GICU Side A, B & B2		
Centre Block Piam Brown		
Centre Block F10, F11, D10		Extract Ventilation only
Centre Block Pulmonary Function Suite		4 x Rooms suitable for AGPs

Many of our COVID-19 outbreaks within UHS continue to occur in areas of poor ventilation. Of particular concern within UHS are wards within East wing, particularly F level, who have experienced a higher number of outbreaks compared to other areas (see table below). Outbreaks of COVID-19 have resulted in bay/ward closures impacting on bed capacity and overall operational capability.

Air purifier units have been temporarily deployed as a control measure into areas affected by outbreaks/at high risk of outbreaks and have also been deployed into high-risk areas such as admission units. However, use of these units is only a temporary short-term solution and a long-term solution is required.

Covid-19 outbreaks (April 2020-September 2022)

Area	Total number of Outbreaks (excluding staff only outbreaks)	Total number of Staff	Total number of patients
UHS Total	146	288	834
EAST Wing	66	154	405
East Wing D Level	18	25	101
East Wing E Level	16	31	106
East Wing F Level	28	82	202
East Wing G Level	5	16	7
WEST Wing	56	93	317
West Wing C Level	1	0	7
West Wing D Level	18	23	81
West Wing E Level	13	25	86
West Wing F Level	8	5	38
West Wing G Level	14	21	103
Wessex Neuro	13	28	54

Actions are in place to explore ways to improve the current state of ventilation in key areas of the hospital. Short-medium term solutions are being explored with the limiting factor in relation to long

term solutions being the large scale of work with potential disruption and the significant investment required for rectification work. Currently, the risk is managed by the careful placement of portable air purifiers. These air purifiers are likely to play an essential role in risk mitigation.

The ongoing concerns regarding ventilation have been escalated to the Infection Prevention Committee and Quality Governance Steering Group by both the infection Prevention Team and Division D.

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.

4.0 Appendices

Appendix 1 : Pharmacy Anti-infectives Team Report to IPC Q2 (July– Sept 2022)
Appendix 2 : Q1 Division A Matron and CGCL Report
Appendix 3: Q1 Division B Matron and CGCL Report
Appendix 4: Q1 Division C Matron and CGCL Report
Appendix 5: Q1 Division D Matron and CGCL Report

Appendix 1

Pharmacy Anti-infectives Team Report to Infection Prevention Committee and TEC
November 2022 Covering Q2 (July-September 2022)

Introduction

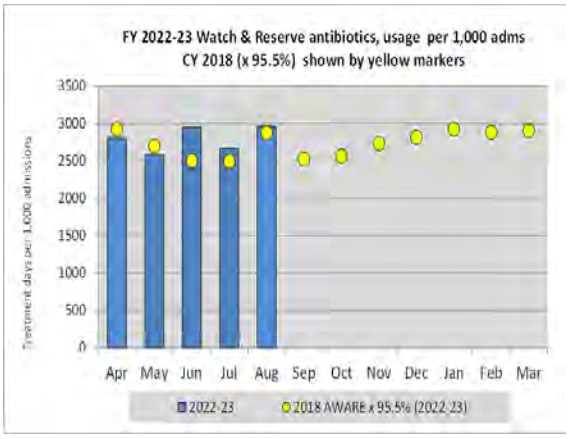
Antimicrobial stewardship is, of course, part of the role of many individuals and teams at UHS but formal activity and strategic development at UHS is principally undertaken by a small team, comprising Dr Tom Cusack (averaging 1.4 PA/wk) and the pharmacy anti-infectives team (4 individuals, 3 WTE*). Wider groups comprise the adult and paediatric Antimicrobial Stewardship Teams (AST), which meet approximately quarterly to review progress and discuss strategy. The stewardship teams comprise of specialists in infectious disease, microbiology, pharmacy and infection prevention & control.

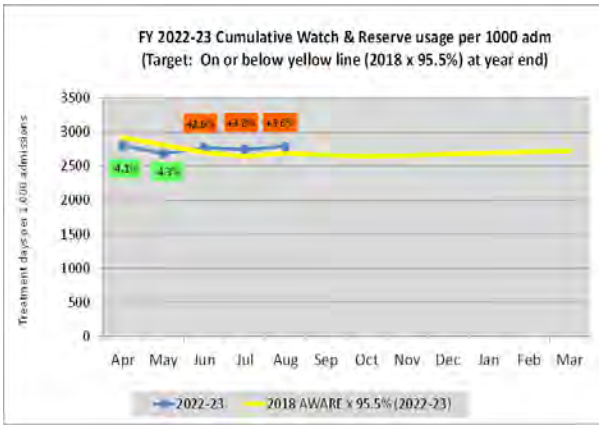
As reported previously antimicrobial stewardship activities have been *limited from the pharmacy anti-infectives team for the past 30+ months due to their redeployment to support the management of COVID-19 patients in the trust and supply of medicines to patients in the community, this has continued throughout quarter 2 of FY22/23. **Management of COVID-19 therapies and vaccination by specialist pharmacists needs to be properly resourced as this small team cannot continue to divert their time and expertise to COVID-19 at the expense of antimicrobial stewardship and non-COVID-19 infection management within the trust.**

1. Total Antibiotic Consumption

a. Internal performance

The NHS standard contract 2022-23 requires a reduction in the use of broad-spectrum antibiotic usage of 4.5% for FY 2022-23 when compared to Calendar year 2018 as baseline. Practically this means increasing our usage of WHO AWaRe programme Access category antibiotics and reducing our usage of the Watch and Reserve antibiotics: https://www.who.int/publications/i/item/2021-aware-classification. Current performance can be found in the chart below; September data is not yet available. The blue columns (actual usage) need to be below the yellow dots (target) to be meeting our contractual obligations. UHS has not been meeting the required reductions in antibiotic consumption since June 2022.





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

This has been discussed in the UHS adult AST meeting and potential reasons for this include:

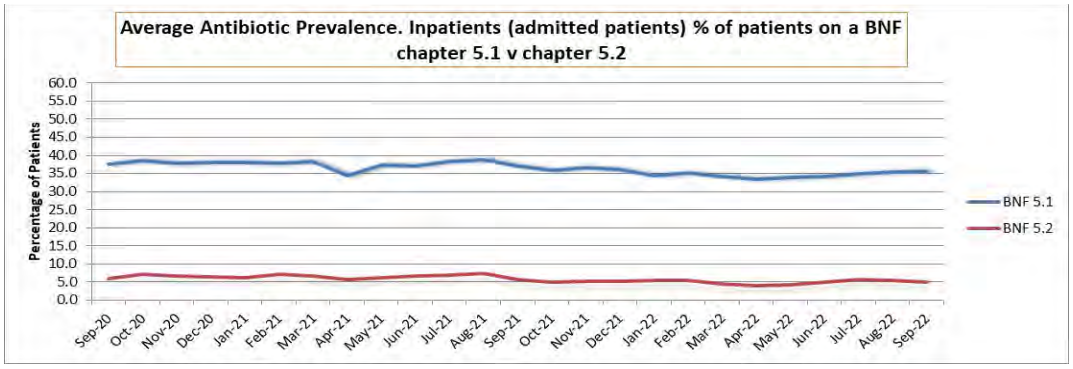
- A higher patient complexity being seen, possibly resulting in a higher proportion of admitted patients being prescribed multiple antibiotics

- Increase in COVID patients, who are routinely prescribed antibiotics
- Limited formal antimicrobial stewardship activity taking place

The AST are going to meet (time and resource dependent) to set up a strategy to try and reverse this trend but the most important factor here is the **need for high level trust leadership and buy in of all clinical leads** to support appropriate prescribing and use of antibiotics. This will include attempts to compare with other trusts (national data not readily available at present).

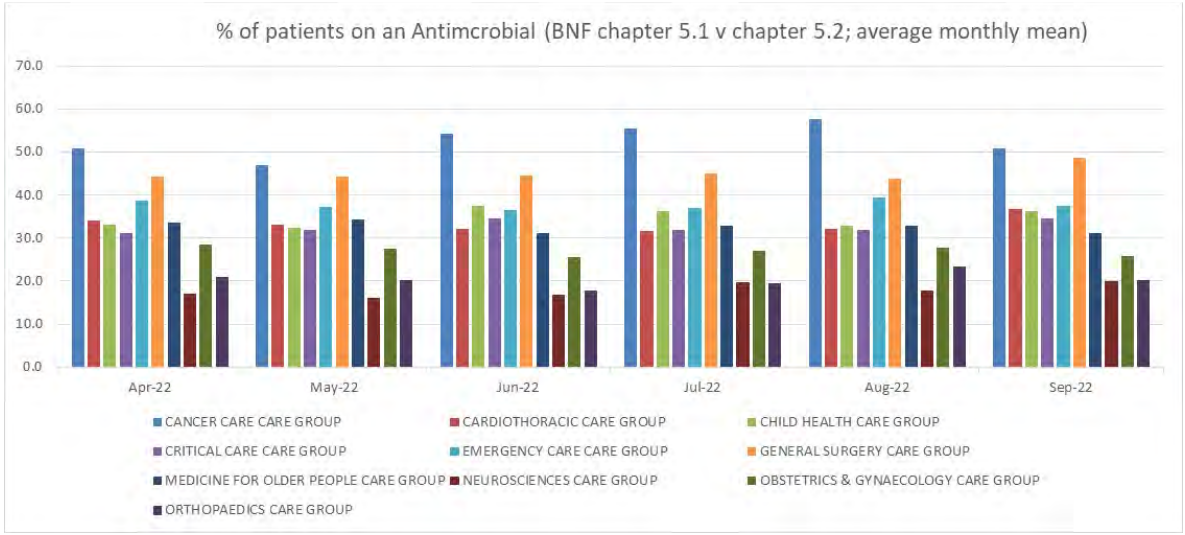
b. Proportion of Patients on Antibiotics

The proportion of admitted patients prescribed an antibiotic at any one time remains steady at about 35%.



Ref: Reporting data from JAC prescribing system

This can be broken down by speciality. Cancer care have a high prevalence of patients on antimicrobials. There is high antifungal usage and prophylactic antimicrobials necessary for management of their patients. However in regular *C. difficile* review meetings it has been noted that the lack of regular, prospective Consultant microbiologist input into the antimicrobial management of non-BMT cancer care patients is a contributory factor to the *C. difficile* occurrence in some cases and **additional Consultant microbiology resource is required not only to support this area which is a high user of antimicrobial agents, but also to increase regular, prospective Consultant microbiologist input into other Care Groups to promote good practice and improve antimicrobial stewardship.**



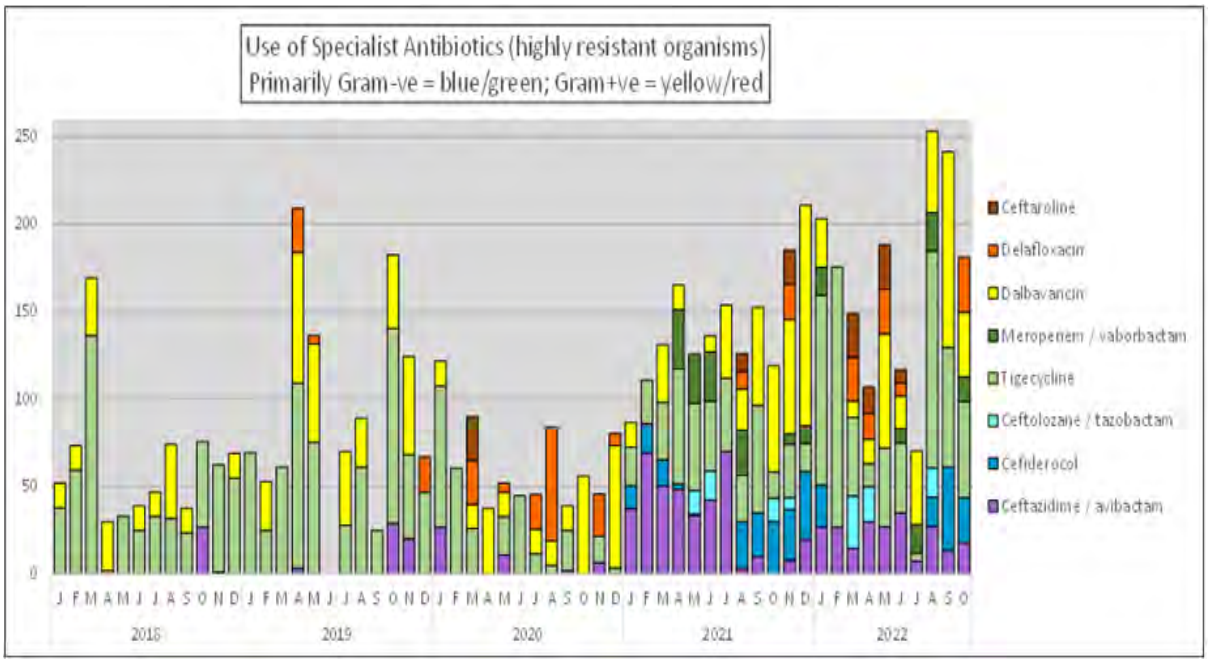
Ref: Reporting data from JAC prescribing system

c. HAPPI Audits

Hospital Antibiotic Prudent Prescribing Indicators (HAPPI) audits have been re-introduced (September '22) to gain information on antimicrobial prescribing. The aim is for 5 audits to be completed each month for each ward by the ward pharmacists. For September and October over 300 audits have been completed. We are working with the apex team to report this data in a meaningful manner. Data collected includes "is prescribing in accordance with trust guidance" and "has there been documentation of antimicrobial indication and review" in the patient's medical notes. We hope to include this data in the next report.

d. Specialist Antimicrobial Usage

In response to the increase in gram negative resistant infections nationally and being seen at UHS our use of expensive last-line restricted antimicrobials is increasing. We are monitoring the use of these antimicrobials to ensure they are used in-line with sensitivities and on expert advice. As our usage continues to increase appropriate use of these antimicrobials is currently the subject of a medical student project, supported by the pharmacy team. Nationally, Blueteq reporting forms have been introduced from the 1st July '22 for two of these antibiotics, which require clinical detail and completion by a specialist.



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

2. CQUIN: CCG2 Appropriate antibiotic prescribing for UTI in adults aged 16+

Description: Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment, specifically **ALL** of:

1. Documented diagnosis of specific UTI based on clinical signs and symptoms
2. Diagnosis excludes use of urine dipstick in age 65+ years and in all **C**atheter-**A**ssociated **UTI** (CAUTI)
3. Empirical antibiotic regimen prescribed following NICE/local guidelines
4. Urine sample sent to microbiology as per NICE requirement
5. For diagnosis of CAUTI, documented review of urinary catheter use is made in clinical record.

With finance supplied via the CQUIN funding route we have successfully recruited a specialist pharmacy technician to support this CQUIN with data collection and quality improvement work.

Q2 results (116 patients of which 16 had CAUTI):

Parameter	% Achievement
Documented diagnosis of specific UTI based on clinical signs and symptoms	90%
Diagnosis excludes use of urine dipstick* in people aged 65+ years and in all CAUTI **as sole diagnostic method*	90%
Empirical antibiotic regimen prescribed following NICE/local guidelines	87%
Urine sample sent to microbiology as per NICE requirement	86%
For diagnosis of CAUTI, documented review of urinary catheter use is made in clinical record.	88%
Proportion satisfying ALL relevant parameters (i.e. CQUIN achievement) (Minimum threshold for any payment, 40%; maximal payment ≥ 60%)	**61%**

Full payment is expected for Q2.

3. Other Stewardship Activities In Q2

- Antimicrobial stewardship rounds have continued, conducted by microbiologists and pharmacists in many clinical areas. Gaps noted in provision to general medicine, general surgery, cancer care (exd. BMT) and pharmacy/microbiology support to paediatric stewardship. General surgery is to be covered by Dr Mahobia from September following his reduction in IPC work, however support to *C. difficile* weekly rounds and monthly reviews has been reduced following this switch.
- Monthly retrospective review of *C. difficile* cases and weekly review of active C.*difficile* infection patients has continued throughout Q2. **The plans for this in Q3 are uncertain given the reduction in IPC focus of the link microbiologist.**
- FY1 and FY2 Medical education sessions have been run by the stewardship team

Appendix 2

Division A Q2 Matron and CGCL Report

Care Groups: Surgery, Critical Care , Ophthalmology and Theatres and Anaesthetics

Matrons: Kerry Rayner, Jo Rigby, Kathy Bowen Jake Smokcum, Charlie Morris, Lisa Turnbull, Linda Monk, Michaela Jones. Ryan Bird, Leah Marriott, Tracy Richards, Mitzi Garcia, Raquel Domene Luque and Fretzie Condevillamar

Clinical Lead: John Knight, Lucy White, Aris Konstantopoulos and Aby Jacob

Date of Report: October 2022

Author: Colette Perdrisat

Performance Quarter 2 – 1st July to 30th September 2022

Key Indicator	Number	Limit	Status
MRSA Bacteraemia	**0**	**0**	**Green**
***Clostridium difficile* diarrhoea**	**3**	**3**	**Amber**
E. coli (HOHA)	**3**	**Trust Limit of 30**	**Trust Total 41** (HOHA + COHA)
Pseudomonas (HOHA)	**5**	**Trust Limit of 9**	**Trust Total 11** (HOHA + COHA)
Klebsiella (HOHA)	**4**	**Trust Limit of 18**	**Trust Total 14** (HOHA + COHA)
MSSA Bacteraemia	**1**	**No Limit**	
GRE	**1**	**No Limit**	

	Number	Cause	Comments
HCAI-Related Deaths	**0**		
Incidents/ Outbreaks of Infection	**1**	CPE Case in ASU	High Risk CPE patient admitted to ASU via ED. CPE screening delayed by 48hrs

Performance Year to Date

Key Indicator	Number	Limit	Status
MRSA Bacteraemia	**0**	**0**	**Green**
***Clostridium difficile* diarrhoea**	**5**	**6**	**Green**
E. coli (HOHA)	**8**	**Trust Limit of 61**	**Trust Total 78** (HOHA + COHA)

Pseudomonas (HOHA)	**6**	**Trust Limit of 18**	**Trust Total 20** (HOHA + COHA)
Klebsiella (HOHA)	**8**	**Trust Limit of 36**	**Trust Total 28** (HOHA + COHA)
MSSA Bacteraemia	**4**	**No Limit**	
GRE	**1**	**No Limit**	

Key Learning from Investigation of Infections and Deaths:

GICU – Ecoli BSI (July 2022) deemed an avoidable infection. Investigation into urinary catheter care. Advocate using a bladder scanner to help with decision making before re-insertion of catheter, especially if previously anuric. Empower nurses to discuss with medical staff and consider the prompt urinary catheter removal especially when anuric/ oliguric and use a bladder scanner before considering a bladder washout if anuric. Ensure G strap is used to support urinary catheter as per policy and provide a documented reason if unable or not used.

Staff to complete insertion and removal records of all invasive devices. Enhanced hand hygiene. No meetings scheduled with IPT. Case closed.

CICU – Pseudomonas BSI (July 2022) deemed an avoidable infection. Investigation into line care. Staff who remove invasive devices are to complete line removal forms. Enhanced hand hygiene. Ensure medical staff are aware of correct cleaning procedures of cardiac echo machine post procedure. No meetings scheduled with IPT. Case closed.

Ophthalmology

nil

Surgery

C-diff case on E8/F6 September 2022: Nursing feedback was that Care pathway not started in timely manner and fluid chart and patient information leaflet not given

E8 covid outbreak12/09/22, 4 patients: actions from RCA for NIC to check covid results, increase ventilation, via windows and hepa filters, all E8 staff asked to wear masks, prior to formal reinstatement across the trust.

Klebseilla bacteraemia infection secondary to catheter associated infection F11 august 2022

Theatres

nil

Progress and Success:

CICU – C.Diff (July 2022) although surveillance was 'green'. Audit results CVC ongoing care and insertions 100%, peripheral cannulas ongoing care and insertions 100%, surgical site infection pre and post op 100%, PPE 100% and cleaning and decontamination 100%, VAP 100%,
GICU: audit results CVC ongoing care and insertions 100%, peripheral cannulas ongoing care and insertions 100%, surgical site infection pre and post op 100%, PPE 100% and cleaning and decontamination 100%, VAP 100%,
NICU: audit results CVC ongoing care and insertions 100%, peripheral cannulas ongoing care and insertions 100%, surgical site infection pre and post op 100%,
SHDU: audit results CVC ongoing care and insertions 100%, peripheral cannulas ongoing care and insertions 100%, surgical site infection pre and post op 100%, PPE 100% and cleaning and decontamination 100%. No further incidence relating to CVC safety.
Improvements seen in hand hygiene audits although there is still room for improvement across all ICU's and SHDU.

Ophthalmology
We have achieved 5 star ratings in all of our cleaning audits for the quarter
100% on hand hygiene compliance in Eye Casualty on July audit
Aug 22 hand hygiene audit conducted by IPT in Eye Casualty achieved 58%, just short of Trust performance target of 60%. This related to one staff group, request for additional support from IPT. Previous audit score of 40%. Team congratulated on improvement and supported to challenge colleagues further
Eye Theatre Recovery achieved 100% in Aug 22 IPT hand hygiene audit. Up from 0% at previous audit. Team congratulated and encouraged to share best practice with rest of care group at our Service Leads meeting

Surgery

nil

Theatres
Good environmental reports continue.

Ongoing Challenges:

Ensuring that hand hygiene compliance is >95% on all critical care areas. Ongoing education and surveillance is maintained.

NICU PPE - 87% (September) – ongoing education, surveillance and re-audits scheduled for all critical areas to ensure learning and compliance with IP practices. Sharps safety – education specifically on what to do if a sharps injury were to occur.

Fit testing staff 'pulled into numbers' to work clinically, reducing the number of staff to fit test all staff for at least 2 FFP3 masks and 2 yearly updates. Although central fit testing service is still available. Records also now available on VLE and Healthroster so staff can easily see when they need retesting.

Reminding staff to wear visors for all AGPs and covid positive/contact patients as per UHS policies – more so when surgical masks didn't have to be worn in certain areas. This challenge will ease with the change in what is now classed as an AGP.

Ophthalmology

We are seeing an increasing number of COVID positive patients, especially through Eye Casualty. We currently have 1 dedicated isolation room

We have had elective patients cancelled on day of theatre due to COVID positive result. We are now not routinely lateral flow testing for our day cases so are embedding asking the triage questions on admission to Eye Short Stay

75% on hand hygiene audit in Eye Outpatients on July 22 audit

Non submission from ESSU on inpatient hand hygiene audit July 22

Non submission from Eye Theatres on peri operative element of surgical site infection audit Aug 22

Surgery

Covid isolation and contact management.

Increased number of hosted patients within footprint, who unfortunately have become covid contacts, this has led to a number of closed beds and reduction in flow.

Theatres

Multiple issues with humidity across vertical extension level E theatres. Currently awaiting progress report from UEL/UHS Estates.SOP developed for when humidity is too high, alongside a SOP for high temperatures in all theatres. 1X cardiac patient known to have been cancelled due to the humidity.

Summary of Action since Last Report, Current Focus and Action Plan:

Reminders to all staff to ensure FFP3 masks (or equivalent) and visors are worn for all patients with AGPs, although this will ease with the change in what is now classed as an AGP.

Reminders for staff to be fit tested for at least 2 FFP3 masks or RPE.

Focus on hand hygiene across Critical Care and ensuring that all line removal forms are completed.

Advocate use of bladder scanner for anuric patients, prompt removal of catheters when no longer required and support with G straps when insitu.

Continue to audit as per IP programme and step up where non-compliance needs addressing.

Ophthalmology

Recent non submissions of audits to be raised with area leads at 1:1 and gain clarity around processes and how we can re-embed these in practice and support further as a Matron team

Surgery

Nil

Theatres

nil

Any Other Issues to Bring To the Attention of TEC and Trust Board:

None

Date this report will be an agenda item at Care Group Governance Meeting	Date this report will be an agenda item at Divisional Governance Meeting
Oct 2022	Oct 2022

Appendix 3

Division B Q2 Matron and CGCL Report

Care Groups: Cancer Care, Emergency Medicine, Helicopter Emergency Medical Services, Medicine and Medicine for Older People, Pathology and Specialist Medicine

Matrons: Jenny Milner, Steph Churchill, Julia Tonks, Abigail Fail, Susie Clarke, Erica Wallbridge, Steve Hicks, Emma Lavelle, Katie McEvoy, Tracy Whale, Emma Chalmers, Nat Kinnaird, Samantha Brownsea and Kat Black.

Clinical Lead: Matthew Jenner, David Land, Gayle Strike and Michelle Oakford

Date of Report: October 2022

Author: Suzy Pike

Performance Quarter *2* – 1st July to 31st September 2022

Key Indicator	Number	Limit	Status
MRSA Bacteraemia	**0**	**0**	**Green**
***Clostridium difficile* diarrhoea**	**7**	**6**	**Red**
E. coli (HOHA)	**17**	**Trust Limit of 30**	**Trust Total 41** (HOHA + COHA)
Pseudomonas (HOHA)	**2**	**Trust Limit of 9**	**Trust Total 11** (HOHA + COHA)
Klebsiella (HOHA)	**2**	**Trust Limit of 18**	**Trust Total 14** (HOHA + COHA)
MSSA Bacteraemia	**2**	**No Limit**	
GRE	**0**	**No Limit**	

	Number	Cause	Comments
HCAI-Related Deaths	**0**		
Incidents/ Outbreaks of Infection	**5**	G8 MRSA PII	2 patients with hospital associated MRSA on G8. Learning: Need to check patient alerts, management of patients transferred from other care groups and patients' property being stored in sluice.
		G5 C.diff PII	4 patients with hospital associated C.diff on G5 Learning: Clean linen placed on patients chair in bay, cleaner not removing gloves between side rooms and bays.

		C5 Monkey Pox	Junior member of staff with correct PPE scratched and broke skin when doffing. Learning: To contact Occupational health in hours to support and coordinate post exposure vaccination
		Pathology Covid Results	Covid results reported incorrectly resulting in false positives due to changes made within system not communicated.
		D5 CPE Patient	Positive CPE patient in Bay on D5 Learning: Need to check patient alerts.

Performance Year to Date

Key Indicator	Number	Limit	Status
MRSA Bacteraemia	**0**	**0**	**Green**
***Clostridium difficile* diarrhoea**	**16**	**12**	**Red**
E. coli (HOHA)	**28**	**Trust Limit of 61**	**Trust Total 78** (HOHA + COHA)
Pseudomonas (HOHA)	**6**	**Trust Limit of 18**	**Trust Total 20** (HOHA + COHA)
Klebsiella (HOHA)	**8**	**Trust Limit of 36**	**Trust Total 28** (HOHA + COHA)
MSSA Bacteraemia	**4**	**No Limit**	
GRE	**0**	**No Limit**	

Key Learning from Investigation of Infections and Deaths:

Cancer Care:

- Nothing reported.

Emergency Medicine – AMU:

- Nothing reported.

Emergency Medicine – ED:

- Nil to note for ED.

HEMS:

-

Medicine – Gastro:

- Nothing reported

Medicine – Respiratory:

- D5 CPE – Staff now checking alerts on e-CAMIS when patients transfer to the ward.
- C5 – Process to contact occupational health shared with all staff.

Medicine – MOP:

- Patient alert status not checked for MRSA as has become lower priority with rise of COVID numbers.
- Nursing staff to monitor all MDT members with regards to infection prevention practices and report concerns.
- Isolation practices good with rapid isolation of patients.

Pathology:

-

Specialist Medicine:

- **Key learning from Death following COVID delay of patient awaiting ERCP – October 2022:** Initial delay caused by patients NBM status but further delay caused by misunderstanding in COVID pathway within Endoscopy department. New SOP in progress to ensure that patient pathways are not delayed due to COVID status. This is shared with clinicians whilst being drafted and with nursing staff to escalate any COVID positive results are found. Shared at governance meetings and team lead meetings to ensure that all areas have no delays in their own pathways due to COVID.

Progress and Success:

Cancer Care:

- Updated respiratory policy for cancer care now available on Staffnet. Includes COVID.
- Continue to manage Covid positive patients within own footprint.

Emergency Medicine – AMU:

- GI POCT ensure early specific treatment commenced.
- Also early isolation and efficient use of side rooms to support patients coming out of isolation. Time to result 1.7 hours v 44.7 hours!!

Emergency Medicine – ED:

- One community MRSA bacteraemia being investigated by CCG. Positive blood cultures taken in ED.

HEMS:

-

Medicine – Gastro:

- Ongoing work on improving the C.diff protocol on the wards. Surveillances returned via poor completion of the C.diff pathway. Education provided to ward staff to ensure completion is optimised.
- Green rating for D10 for C.diff surveillance

Medicine – Respiratory:

- Nothing reported.

Medicine – MOP:

- Improved management of patients with diarrhoea through earlier isolation and timely stool samples.
- Effective management of wards with COVID positive, COVID contact, COVID stepdown and clean patients all on same ward.

Pathology:

-

Specialist Medicine:

- No areas of outbreak.
- Controlled changes in COVID swabbing implemented with teams to avoid confusion and incident.
- Mask wearing compliance and good hand hygiene compliance noted.

Ongoing Challenges:

Cancer Care:

- Increased focus on commode cleaning as flagging on environmental audits.
- Side room capacity remains challenging due to competing demands for side room use (respiratory viruses, immunosuppressed patients, diarrhoea, etc.).
- This pressure will increase for the next four months due to the closure of 2- 4 side rooms on C2 to enable the essential maintenance work for the new wards above.
- Closure of swabbing hub impacting elective admissions.
- Mixing sex in bays to enable cohorting of patients with the same virus.

Emergency Medicine – AMU:

- Cleaning regimes in POCT room. Contamination episode resolved.

Emergency Medicine – ED:

- When higher presentations of COVID symptoms/positive patients' pressure on RAU capacity. Limited to 6 trolley bays and 2 chairs, this is an area for both confirmed and suspected COVID patients. Escalation plans in place to support finding appropriate beds to decompress RAU when needed.

HEMS:

-

Medicine – Gastro:

- Now COVID is located on D9 we are having issues with staff being mask fit tested. We are working on ensuring testing is available and also requesting Perso hoods to return to the wards. Moving staff to other areas to accommodate those who have medical reasons not to work in a COVID area.

Medicine – Respiratory:

- Nothing reported.

Medicine – MOP:

- Nursing vacancies increased due to requirement to staff a 7th area and increase of beds at Bassett ward.
- Education to wider MDT to ensure they are compliant with infection prevention practices, particularly hand hygiene.
- Need more work with AMU as patients are still transferred with potential infections into bay beds without appropriate handover/risk assessment performed.
- Crowding on wards due to multiple team attendance secondary to locality model.

Pathology:

-

Specialist Medicine:

- LFT process within some areas remains complex, causing delays within the departments. Multiple LFTs used as patients were non-complaint with the planned process despite information being supplied. This has improved since the swabbing guidelines changed for outpatients.
- Ongoing review of Lymington space to support Dermatology clinics. Progress update to follow in next quarterly report.

Summary of Action since Last Report, Current Focus and Action Plan:

Cancer Care:

- Focus on commode cleaning.
- Continued focus on respiratory viruses and how to manage within capacity including cohorting in bays.
- Reviewing process for identifying severely immunosuppressed patients to ensure not placed in bays.

Emergency Medicine – AMU:

- New Ebola questions for patients and PPE.

Emergency Medicine – ED:

- Continued refresher training for infection control in relation to PPE and hand hygiene.
- Current focus is ensuring nursing and medical team aware of Ebola guidelines and plans for if patient presents with symptoms/triggers.
- Meetings with IP to update Trust protocols and confirm pathway for directly admitting to C5.

HEMS:

-

Medicine – Gastro:

- Management of COVID in Medicine.
- Improvement in C.diff pathway.

Medicine – Respiratory:

- Cleaning of equipment between patients.
- Focus across wards on management of Intravenous peripheral devices.
- D5 managing Covid patients. No current concerns.

Medicine – MOP:

- Nil to note

Pathology:

-

Specialist Medicine:

- Ongoing – Infection control team working with dermatology to review air changes and theatre restrictions (lesion size) at the RSH, this is to balance the risk of operating on larger lesions where lesions have grown due to the long waits for our routine patients against risk of infection. Approval from Infection Prevention that this can go ahead – work in progress to implement this within the service.

Any Other Issues to Bring To the Attention of TEC and Trust Board:

Cancer Care:

- Loss of swabbing hub.
- Access to the rapid GI panel would positively impact on cancer care's ability to move patients out of side rooms and improve flow in AOS where only 2 side rooms available.

Emergency Medicine – AMU:

- None.

Emergency Medicine – ED:

- Many outstanding estates requests, such as replacing dirty ceiling tiles, backs of toilets/sinks that are visibly rusty and lifting away, holes in flooring and damages caused by patients.

HEMS:

-

Medicine – Gastro:

- Nil

Medicine – Respiratory:

- Nothing reported.

Medicine – MOP:

- Continued request to review how COVID is managed to reduce movement of patients across wards.

Pathology:

-

Specialist Medicine:

- Nothing reported.

Date this report will be an agenda item at Care Group Governance Meeting	Date this report will be an agenda item at Divisional Governance Meeting
Nov 2022	Nov 2022

Appendix 4

Division C Q2 Matron and CGCL Report

Care Groups: Women and Newborn, Maternity, Child Health and Clinical Support

Matrons: Karen Elkins, Angie Ansell, Ronilo Ramos, Alison Millman, Kim Allsop, Kirsteen Dick, Rachel Harris, Ann Hood, Lisa Ingram, Carol Purcell, Nikki Medhurst, Victor Taylor, Lucia Lazzeri-Ford and Andrea Robson

Clinical Lead: Sarah Walker and Charlie Keys

Date of Report: October 2022

Author: Louisa Green, Emma Northover

Performance Quarter *2* – 1st July to 31st September 2022

Key Indicator	Number	Limit	Status
MRSA Bacteraemia	**0**	**0**	**Green**
***Clostridium difficile* diarrhoea**	**1**	**3**	**Green**
E. coli (HOHA)	**5**	**Trust Limit of 30**	**Trust Total 41** (HOHA + COHA)
Pseudomonas (HOHA)	**0**	**Trust Limit of 9**	**Trust Total 11** (HOHA + COHA)
Klebsiella (HOHA)	**1**	**Trust Limit of 18**	**Trust Total 14** (HOHA + COHA)
MSSA Bacteraemia	**1**	**No Limit**	
GRE	**0**	**No Limit**	

	Number	Cause	Comments
HCAI-Related Deaths	**0**		
Incidents/ Outbreaks of Infection	**1**	C.diff PII on Piam Brown	4 patients (1 under 2) with healthcare associated C. diff on Piam Brown Learning: Isolation risk assessments not updated. Parents assuming responsibility for measuring urine in bed pans and using sluice facilities.

Performance Year to Date

Key Indicator	Number	Limit	Status
MRSA Bacteraemia	**1**	**0**	**Red**
***Clostridium difficile* diarrhoea**	**2**	**6**	**Green**
E. coli (HOHA)	**6**	**Trust Limit of 61**	**Trust Total 78** (HOHA + COHA)
Pseudomonas (HOHA)	**0**	**Trust Limit of 18**	**Trust Total 20** (HOHA + COHA)
Klebsiella (HOHA)	**1**	**Trust Limit of 36**	**Trust Total 28** (HOHA + COHA)
MSSA Bacteraemia	**4**	**No Limit**	
GRE	**0**	**No Limit**	

Key Learning from Investigation of Infections and Deaths:

SCH

Patients and parent hand washing needs focus due to recurrent theme across SCH related to infections. All areas are being audited for effectiveness.

PB – C. diff 4 cases within 28 days. Key learning to ensure isolation risk assessments are updated. Patient / parent are provided with C. diff information leaflet.

Patient /parents are taught effective hand washing technique to reduce contamination, particularly after taking their child's used bedpan to the sluice.

G3 – Possible hospital acquired Giardia (02/08). Patient was going off site to have meals made by mum in Ronald McDonald. Advised to ensure parents are taught effective hand washing technique with orientation to the ward.

G3 – Suspected case of diphtheria (15/09), isolated and treated with antibiotics, cultures negative. UK HSA contacted for further guidance and advice.

PMU – One hospital acquired salmonella case (04/09). CPAP / BIPAP mask being cleaned in handwashing sink. Possible source of infection from splash back. Advised to clean NIV masks with Clinell universal wipes and only use handwashing sinks for handwashing. Stickers / posters are now displayed on paper towel dispensers to remind staff of this.

G2N – Parent positive to covid (29/09), Went to main open bay – not discharged. All admissions to G2N & any discharges to other wards risk assessed. All patient and parent screening negative, resumed usual practice 10/10

Progress and Success:

SCH:
PICU build of 5 extra cubicles well underway. PICU in temporary accommodation on GICU (A1 & A2). Drilling had caused some delay as forced to stop work due to noise and vibration in theatres, communication between teams has improved this. Potential completion date 2nd December 2022, with a handover date after 6th December 2022.
Good feedback from UHS infection control team on prompt isolation measures of a covid positive ECMO patient on PICU.
Low numbers of Covid positive / contact cases, prompt action taken to avoid outbreaks.
Plans ongoing for new sluices on G1-4, JADW and Bursledon house to ensure that they meet with infection prevention standards.

PAH

Outpatients
Environmental Cleaning Monitoring: Serco: 98.5%, Clinical: 97%; Overall 5*

Bramshaw / SDU/PAH Theatres
Latest Serco audit: Theatres and GDU and Recovery100% on both domestic and nursing cleaning; 5 Star rating; Bramshaw – 99% and 100%
A review of cleaning in theatres underway – focus on day cleaning.

Maternity
Good compliance with COVID management noted given the challenges with infrastructure and facilities.
Bed management within Maternity eased with COVID lateral flow tests facilitating rapid results.
Consistently good environmental and Cleaning Audit scores.

0 Clinical Cleaning Audit failures
0 Serco Cleaning Audit failures

Neonates
Staff are more aware of the importance of hand hygiene and modes and spread of infection.

Ongoing Challenges:

SCH
Environmental challenges, high patient numbers and increased level of sickness, making it challenging to prioritise infection prevention audits on time.

PICU patients nursed very close proximity whilst in temporary accommodation. Risk assessments are undertaken to review acuity of patients and ability to isolate.

Maternity

Environmental challenges. Significant damage to floors, skirting, walls, and doors. Ongoing escalation to Estates for repairs and refurbishing.

Neonates

The Neonatal unit has been has seen unprecedented levels of activity and acuity exacerbated by staffing levels.

Nursery 4 remains on the risk register for lack of space and unsafe conditions.

Summary of Action since Last Report, Current Focus and Action Plan:

SCH

Focus on ensuring effective handwashing techniques are taught to parents when they are orientated to the wards and ensuring patient risk assessments are updated. These have been advised following recent incidents. This practice is being audited.

Staff are now escalating when they are unable to complete IP audits to provide senior oversight and support.

PAH

Standards of cleaning during the night are being monitored following feedback. Serco is aware and supervisors are now having constant checking during that shift.

Maternity

Maternity admissions and Birth partners screened for COVID using Lateral Flow testing.PCR testing used if symptomatic of viral infection with respiratory symptoms such as cough /cold.

Flu and COVID vaccine programme for women and their partners commenced. Flu and COVID booster vaccines now available for staff.

Neonates

Focus on ANTT and hand hygiene for existing and new multi professional staff members

Relocation of waste bins to ensure correct disposal of items.

Any Other Issues to Bring to the Attention of TEC and Trust Board:

Neonates

General capacity including the dirty utility remains substandard, preventing us from achieving the incubator cleaning compliance recommended by GOV.UK (April 2022). Mitigation against this includes plans for neonatal expansion.

Date this report will be an agenda item at Care Group Governance Meeting	Date this report will be an agenda item at Divisional Governance Meeting
October 2022	Oct 2022

Appendix 5

Division D Q2 Matron and CGCL Report

Care Groups: Cardiovascular and Thoracic, Neurosciences, Trauma and Orthopaedics and Radiology
Matrons: Jenny Dove, Georgina Kirk, Jean-Paul Evangelista, Sarah Halcrow, Beverley Ann Harris, Rebecca Tagg, Claire Liddell, Tracy Mahon, and Rebecca Tagg.
Clinical Lead: Edwin Woo, Boyd Ghosh, Jonathan Hempenstell, Nick Hancock, and Charles Peeble
Date of Report: 31/10/22
Author: Natasha Watts

Performance Quarter *2* – 1st July to 31st September 2022

Key Indicator	Number	Limit	Status
MRSA Bacteraemia	**0**	**0**	**Green**
***Clostridium difficile* diarrhoea**	**4**	**3**	**Red**
E. coli (HOHA)	**4**	**Trust Limit of 30**	**Trust Total 41** (HOHA + COHA)
Pseudomonas (HOHA)	**2**	**Trust Limit of 9**	**Trust Total 11** (HOHA + COHA)
Klebsiella (HOHA)	**3**	**Trust Limit of 18**	**Trust Total 14** (HOHA + COHA)
MSSA Bacteraemia	**2**	**No Limit**	
GRE	**0**	**No Limit**	

	Number	Cause	Comments
HCAI-Related Deaths	**0**		
Incidents/ Outbreaks of Infection	**2**	F1 C.diff PII	4 patients with hospital associated C. diff on F1 Learning: Uncovered clean linen trolley in corridor. Dirty commodes
		F4 Spinal C. diff PII	2 patients with hospital associated C. diff on F4 Spinal Learning: Incorrect items stored in sluice PPE for handling body fluids not in sluice

Performance Year to Date

Key Indicator	Number	Limit	Status
MRSA Bacteraemia	**0**	**0**	**Green**
***Clostridium difficile* diarrhoea**	**6**	**6**	**Amber**
E. coli (HOHA)	**8**	**Trust Limit of 61**	**Trust Total 78** (HOHA + COHA)
Pseudomonas (HOHA)	**3**	**Trust Limit of 18**	**Trust Total 20** (HOHA + COHA)
Klebsiella (HOHA)	**5**	**Trust Limit of 36**	**Trust Total 28** (HOHA + COHA)
MSSA Bacteraemia	**3**	**No Limit**	
GRE	**0**	**No Limit**	

Key Learning from Investigation of Infections and Deaths:

T&O-

Covid outbreak learning- ensuring that the hepa filters are kept plugged in and switched on at all times and these are changed by estates and this is chased if not timely.

Ventilation remains a concern- in particular bays on F1 and F2 on same side of ward.

Capacity and side room ability is difficult.

CVT:

Vigilance with standards of cleaning and escalating any concerns.

Promotion of good hand hygiene and appropriate glove usage. Issues raised included gloves being used for multiple procedures, gloves not being removed immediately after an episode of care and followed with effective hand hygiene

Reinforcement of standard infection control policies with staff education sessions.

Questioning anyone that does not follow Trust guidelines and policies.

Neuro:

F8 and ENU covid outbreak: Good practice was observed in all areas of PPE wearing so unclear of the cause of outbreak, following this outbreak all staff were asked to wear masks , air filters were in use in all bays, visiting was restricted to one hour a day for each patient and were covid screened before arrival on the ward. Staff compliant with PPE.

Progress and Success:

T&O:

MTU-protection of 18 MTU beds to enable the service to continue.

Good practice- no covid spread from bay to bay/ no link to the C diff cases

CVT:
Hand hygiene reaudits by Infection Control showed improvement in all areas.

Neuro:
Daily IP team review with ward NIC to ensure Good Practice in place. e.g. Hand Hygiene, PPE.

Ongoing Challenges:

T&O:
Volume of side rooms required for all infection cases.

CVT:
Increase in COVID-19 cases in the care group this quarter.
Available side rooms for COVID +ve patients as well as other infectious diseases.
Restrictions reinstated, patients asked to wear face masks and visitors further restricted.

Neuro:
Hand hygiene audit showed a significant reduction of good standards.
Continuous staff engagement for education, training and refreshing of Hand Hygiene.
Spot checks are being made.
Glowbox is used to do further refresh Good hand hygiene technique.
Encouraging patients to wear face masks.

Summary of Action since Last Report, Current Focus and Action Plan:

Constant review and learning cascaded to ward teams. - excellent IP ward lead engagement.
Ongoing support for charge nurses and IP links across all areas.
Education on wards (walkarounds, lunchtime teaching, ward study days).
Focus on hand hygiene, correct isolation processes and appropriate PPE for infections.
Posters reviewed on wards, renewed/replaced with up-to-date information, and placed at eye-level.
Increase ANTT sessions available to staff.

Any Other Issues to Bring To the Attention of TEC and Trust Board:

T&O side room and isolation due to bed capacity a constant concern.
Ventilation within Division D east wing wards remains a huge concern and this has contributed to outbreaks of covid, especially within the T&O footprint.
Been very challenging due to lack of capacity to cohort covid positive patients within speciality footprint, but doing this has ensured patients are cared for with the correctly skilled staff as they have not been required to be out lied.

Date this report will be an agenda item at Care Group Governance Meeting	Date this report will be an agenda item at Divisional Governance Meeting
Oct 2022	Oct 2022

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Medicines Management Annual Report 2021-22**			
Agenda item:	**8**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Authors:	**James Allen, Chief Pharmacist**			
Date:	**29 November 2022**			
Purpose	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	• An annual report providing information on the status of medicines management activity, governance and performance within the trust, highlighting achievement, progress, concerns and proposed actions. • The report details the key strategic considerations relating to medicines management in UHS with reference to the priorities outlines in the Hospital Pharmacy Transformation Plan (HPTP). • The committee is requested to note the report's contents and raise any questions or concerns. • The committee is requested to support the Medicines Management Strategy and Action Plan.			
Response to the issue:	Provide formal update to Trust Board on Medicines Management for UHS			
Implications: (Clinical, Organisational, Governance, Legal?)	Implications primarily: - Organisational risk and governance - Regulatory in relation to medicines prescribing, acquisition and storage. - Financial regarding medicines budgetary oversight			
Risks: (Top 3) of carrying out the change / or not:	Not applicable			
Summary: Conclusion and/or recommendation	Trust Board is asked to acknowledge the report and support the UHS Medicines Management Strategy and Action Plan.			

1. Summary introduction

1.1. Medicines are the most commonly used healthcare intervention. Virtually all UHS patients will receive medicines whilst in hospital, on discharge from hospital, as an outpatient and/or via homecare. Organisational use of medicines is associated with significant risks related to patient safety, compliance with statutory regulations and financial risk.

1.2. At UHS approximately 2.3 million prescriptions are written, and 6 million doses are administered each year.

1.3. There were 2,496 safety incidents involving medicines reported in 2021/22 of which 28% resulted in some level of harm. The number of medication incidents has increased slightly from last year. The rate of moderate to severe harm has remained constant.

1.4. This paper informs the Trust Executive Committee about progress, strengths and weaknesses within UHS medicines management systems. It includes updates on progress with the HPTP and makes recommendations for strategy and improvement where appropriate. The report primarily focuses on 2021/22 with reference to key strategic updates and recommendations to date.

1.5. A medicines management summary action plan is included (Appendix A).

1.6. The Model Hospital Dashboard and RPS Hospital Pharmacy Standards are still in the process of being revised and updated with additional evidence submissions. Once completed a separate report will be developed.

2. Analysis and Discussion

2.1. Key areas of progress and improvement

Leadership

2.1.1. UHS pharmacy professionals maintain their leadership roles in regional and national networks to ensure that UHS medicines management stays at the forefront of practice and has a good reputation across the pharmacy profession.

2.1.2. The UHS pharmacy team co-led the regional workstream designing the community delivery model for monoclonal antibody and antiviral therapies for COVID-19. Throughout 21-22 several thousand vulnerable patients were reviewed and managed by specialists in acute trusts with the support of the pharmacy team. While these emergency arrangements provided critical support to our vulnerable patients, the process resulted in significant operational pressure in several specialist services and pharmacy. In recognition of this demand, a new service model was designed and commissioned. This service model, which began in Oct 22, has shifted all the clinical review into primary care. The UHS Pharmacy team continue to support in an advisory capacity with the expectation that this service can be accommodated entirely by primary care before Dec 2022.

2.1.3. The Chief Pharmacist is the designated Controlled Drugs Accountable Officer (CDAO). The Trust's CDAO is responsible for the safe and effective use and management of controlled drugs and has a statutory responsibility to provide quarterly occurrence reports to the NHS England (South) CDAO. These reports detail any concerns regarding management or use of controlled drugs across the Trust or other organisations/agencies involved. All occurrence reports have been completed and submitted for 21/22 as required. The CDAO is also a member of the NHS England (South) local intelligence network (LIN). A formal CDAO report is in development for review at the end of 22-23.

2.1.4. Regular antimicrobial stewardship ward rounds continue within the key specialities. With the rise in *C.difficile* cases noted over the last year, the infection control and pharmacy teams have continued with the monthly review process for all UHS-acquired cases of *C.difficile*. There is now also a weekly specialist pharmacist-led (supported by a consultant microbiologist) review of current C.difficile cases to ensure best management and prospective changes to care. In addition, the ward-based pharmacy teams have restarted monthly monitoring and audit of antimicrobial prescriptions. This is expected to provide detailed prescribing data to develop our antimicrobial stewardship strategy further.

2.1.5. UHS continues to be a national leader in transferring medicines-related information to patient's community pharmacies. The ward-based pharmacy team referred 2,800 patients to their community pharmacist for follow-up and support regarding their medicines after discharge. The NHS Discharge Medicines Service is now an essential service within the community pharmacy contract. This has given further incentive to continue these referrals with greater reassurance that referrals will be followed up in the community. Work continues with community colleagues to ensure that community pharmacies submit claims for undertaking this service as the percentage of claims compared to discharges from UHS forms the basis of our CQUIN assessment. The next steps are extending this referral system to local care homes to support the national medicines optimisation in care homes programme and to PCN based pharmacists to support medicines rationalisation in GP practices.

2.1.6. Public health promotion in relation to smoking and alcohol advice continues to be provided on admission by the Medicines Management Team after the success in delivering the CQUIN for Risky Behaviours in 19/20. The CQUIN was placed on hold for 2020/21 due to the COVID pandemic but the intervention continues as part of the NHS Long Term Plan for health promotion. This involves the novel use of medicines management technicians to ask patients on admission about both their alcohol consumption and smoking status, offering advice and referring any patients who wish to receive support. Additionally, the pharmacy team have supported the development of a system to enable electronic referrals from specialist nurses to community pharmacies for nicotine replacement therapy (NRT) and/or smoking cessation support (dependent on whether the pharmacy is registered for this service).

2.1.7. Systematic processes to improve the early identification and communication of shortages remain in place. In particular, monitoring outstanding orders, improved lines of communication and improved data analysis have allowed pharmacy to improve its identification of shortages and the timeliness of escalations where necessary. Nevertheless, medication shortages remain a significant national issue for both primary and secondary care. This is primarily due to supply chain disruption due to the EU exit and the opportunities for suppliers to make larger profits in alternative international markets.

2.1.8. The security of medicines in UHS theatres has been highlighted as a concern with several significant security incidents throughout 21-22 and 22-23. A range of actions have been developed by stakeholders in security, UEL, anaesthetics, pharmacy and estates to ensure the organisation meets its obligations to safe storage of medicines.

Medicines Finance

2.1.9. In 2021/22, UHS expenditure on medicines was £161.5m. This is a 23% increase on the £130m in 2020/21 and reflects the larger growth we've seen since 2020. The key drivers for this increase were:

- A £28 million increase in NHS England commissioned medicines. As per previous years, growth was concentrated in cancer care (+£6million), cystic fibrosis (+£10 million) and multiple sclerosis (+£5 million) and can be attributed to newly commissioned therapies in these areas.
- Expenditure on Integrated care systems (ICSs) commissioned therapies has increased by +£4.8 million due to both newly commissioned therapies and increased patient numbers.

Data from the Model Hospital Dashboard places UHS in the top 25% of trusts for medicine spend. Given the range and depth of specialist services, this is to be expected and remains below peer organisations of Cambridge (£168m), Bristol (£175m) and Nottingham (£180m).

2.1.10. Formal reporting processes have been developed to provide detailed oversight of the block contract medicine spend. In addition, monthly contracting and pharmacy oversight meetings now feed into the newly formed ICB high-cost drugs group. This new group will support the implementation of new therapies alongside identifying areas of regional variation and savings. In 21-22 the established ICS block contract resulted in significant financial cost pressure of £6.3 million above allocation (total £28.1m). The two primary drivers for this were newly commissioned therapies and higher patients numbers (average increase of 19%). Work to address this shortfall in funding is ongoing with the ICB.

2.1.11. Throughout 21/22, UHS clinicians and pharmacy continued to deliver essential savings in a range of schemes that released UHS capacity and promoted best value medicines usage. For this period, these savings equated to £1.1m for UHS. These were achieved through homecare schemes and our focus on switching to new generic or biosimilar medicines. UHS Pharmacy has now developed a more comprehensive model for identifying and reporting savings incorporating volume analysis and the new commissioning landscape. At present, over £900k of in tariff or block medicine savings have been captured. Work is now underway to undertake a more detailed analysis concerning budgets and planned spending for next year to support divisions in the financial planning.

Workforce and Training

2.1.12. High-quality training and development remain a mainstay of the pharmacy department with a 100% success rate for trainees in 21/22 with many delayed in their final exam due to COVID. The pharmacy team continue to be commissioned by HEE South to provide foundation trainee pharmacist training for Hampshire and Isle of Wight local learning sets and by the University of Southampton to deliver teaching for medical, nursing and AHP students. We continued to build our trainee pharmacy technician numbers through the new apprenticeship with two intakes per year now in September and February. The first Science Manufacturing Technician apprentice working in our aseptic units started with a second in March 2022.

2.1.13. Following significant recruitment challenges in previous years, we have seen a marked improvement in our ability to recruit into pharmacist posts at all levels. Part of this success is due to the creation of several progressive posts which allow more junior pharmacists to be appointed with the promise of structured training and support. This has been backfilled by strategic recruitment into foundation pharmacist posts at key points during the year when many are looking for their first position. In addition, we have been fortunate to have had several successful external candidates, which has boosted the workforce and reduced our vacancy rate significantly. The recruitment status for pharmacy technicians and pharmacy support workers is not quite as positive, with significant numbers of staff applying for secondments and leaving UHS to further their careers in other sectors. Our challenge for next year is to increase the opportunities and job satisfaction for these staff in order to improve retention.

2.1.14. The number of non-medical prescribers (NMPs) within UHS continues to rise. Currently there are 313 active/in training NMPs recorded on the live register a slight increase since last year (306). Of these 59 are pharmacists, 8 are AHPs, and the remaining 246 are nurses. The new advanced practice pathways for nurses and AHPs may include prescribing. The new undergraduate pharmacy course includes prescribing, students graduating in 2026 will be qualified as independent prescribers.

Research & Development

2.1.15. The pharmacy team's clinical trial activity has now begun to recover with 87 studies opened in 21-22, representing a significant increase from 49 in 20-21. The team remains on track to exceed this number for 22-23 with over 45 studies already opened. The focus of improvement work has now shifted to the ongoing challenge of approving oncology studies.

2.1.16. Advanced Therapeutic Medicinal Products (ATMP) workload has also begun to recover since a decrease during the pandemic. Additional investment in the pharmacy AT(I)MP team and isolator capacity has increased resilience in this highly specialist area of pharmacy. All areas of medicine are likely to see the emergence of AT(I)MP therapies in the next few years with pharmacy working closely with Research and development to deliver the objectives outlined in the emerging therapies unit strategy.

Medication Incidents

2.1.17. The number of medication incidents reported this year increased by 96 to 2496. It is hoped that this trend will continue so that we reach our previous plateau of approx. 3000 incident reports per year. Despite higher reporting rates, incidents resulting in moderate harm were fewer in number this year. There was one medicine related never event involving potassium chloride injection. It resulted in no harm. A full investigation was completed and action has taken place as detailed in the Medication Safety Officer (MSO) report to the Quality Committee.

2.1.18. Demand for the patient Medicines Helpline increased, compared to last year, to around 150 calls per month during 2021/22. Often calls are for clinical advice or follow an error or oversight relating to the discharge process. The helpline team can intervene to prevent patient harm, avert potential complaints, or the need to see another HCP. The lead pharmacist for the Helpline works with the Medication Safety Group to identify and address the causes of the most common types of error and has provided data to inform the trustwide Discharge Checklist and improvements to the Trust discharge paperwork.

2.1.19. The Southampton Medicines Advice Services (SMAS) continues to develop its national training website Medicines Learning Portal. It teaches clinical problem-solving skills to hospital pharmacists, is being used across the whole NHS and has exceeded 1 million visits. This success enabled the Medicines Advice Team to develop a second national website (Medicines Safety Portal) in partnership with the AHSN network. This site aims to help GPs, pharmacists, and nurses in primary care use medicines safely and offer them advice and resources to help with clinical problem-solving on identified topics.

Operational & Infrastructure

2.1.20. All remedial work and refurbishment of the pharmacy technical services unit are now complete. A subsequent regional Quality Assurance inspection recognised the unit is now in the best possible position to bridge until the Adanac park facility is opened in June 2024.

2.1.21. The pharmacy department has worked with UPL to support their service during periods of significant pressure in 21-22. The concerns raised during this period relating to medication errors and poor patient experience have now largely been resolved. In addition, formal reporting mechanisms have been established into Quality Safety and Governance Group (QGSG) to improve oversight and divisional assurance.

2.1.22. The homecare service for medicines has continued to increase, releasing critical UHS capacity and moving care closer to home for our patients. Current patient numbers are now over 6,300, with patient numbers expected to exceed 7000 by the end of April 2023. The pharmacy homecare and clinical pharmacy teams are expected to require additional investment to provide the necessary infrastructure for current and future patient numbers.

Medicines Policy & Governance

2.1.23. The UHS Drugs Committee met monthly in 21/22, undertaking the following activities:

- approved the addition of 61 items to the formulary of which 24 were because of published NICE guidelines.
- removed 3 items from the formulary
- reviewed and approved 70 policies and procedures/clinical guidelines, including rapid review and implementation of national guidance relating to therapies for COVID-19 and new vaccine handling and management policies.
- engaged in the consultation process for 18 national shared care protocols

2.1.24. Patient Group Directions (PGDs) allow specific healthcare professionals to supply and/or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber. The pharmacy team have worked hard to significantly reduce the number of expired PGD in the Trust, with a plan to update all the remaining PGDs by next year. Further developments include the implementation of the national PGD template to improve local governance and exploring ways to digitalise approvals and authorisation to streamline the overall PGD process. The PGD committee has:

- reviewed and approved 26 PGDs
- reviewed and approved 9 occupational health work instructions for staff vaccination
- removed 22 unnecessary PGDs from use
- reviewed and approved the UHS 'Medicines administered at the discretion of nurses and midwives' list

2.1.25. Free of Charge (FOC) and compassionate use schemes provide early access to or compassionate use of medicines that would otherwise be unavailable to patients. They must be considered carefully for clinical, ethical, and financial risk. The Drugs Committee continues to provide the governance and oversight to these schemes using newly updated policy guidance based on national guidance released in Jan 2020. As a major teaching hospital with regional specialities these schemes remain an essential component of patient care. An expansion in the number of individual requests for compassionate use was observed in 21/22 with the Drugs Committee reviewing 10 schemes for their suitability for use in UHS.

2.1.26. Individual Funding Requests (IFRs) are requests for medicines in patients that are not commissioned. In 21-22 applications reduced significantly in comparison to pre-pandemic levels. The combination of a new electronic application process and the widespread understanding that they are largely rejected are the likely drivers for low application rates. A summary of the applications throughout 21-22 is below:

	Total Last year in parenthesis	CCG	NHSE
Submitted	16 (23)	9	7
Approved	11 (11)	9	2

Digital

2.1.27. The Medcura system, developed by UHS to improve patient safety and service capacity within the Oncology Pharmacy, has been further enhanced by developing and implementing a clinical trials module. The next phase is deploying the system in our Central Intravenous Additives Service (CIVAS) in 2022. In addition, we are continuing to work to generate a funding case to the national aseptics panel to support additional software development and deployment in additional partner sites.

2.1.28. The QPulse document management system is currently being deployed in the pharmacy aseptics and radiopharmacy departments. It is expected that this will develop the necessary document rigour for our future licensed aseptic unit and make improvements in the meantime. In addition, a concurrent project is working on implementing the system to improve governance, data integrity and record-keeping across the rest of the pharmacy department.

2.1.29. Triscribe, our data warehouse project, continues to offer a range of data warehouse opportunities for UHS and were critical during the pandemic in developing tools to monitor critical medicine utilisation. Development work continues in areas such as anticholinergic burden, Parkinson's medicines delayed and omitted doses of critical medicines and quantifying the medicine administrative burden for ward managers.

2.1.30. The Trust purchased a new fleet of digital medicines administration and storage trolleys to replace our old, poorly functioning fleet in March 22. New trolleys will be gradually rolled out from Oct 22 for allocation to areas where the current trolley is failing.

Integrated Care Board and Regional Medicines Optimisation

2.1.31. The UHS Chief Pharmacist is actively involved in the HIOW system leadership group for Pharmacy. The primary strategic objective of this group is developing and delivering the Integrating NHS Pharmacy and Medicines Optimisation (IPMO) programme for the HIOW Integrated Care Board (ICB). The plan covers key workstreams for medication safety, digital, workforce, medicines savings and sustainability.

2.1.32. The formation of the ICB has led to the amalgamation of the medicines management processes across HIOW. The newly formed ICB Prescribing Committee will arise as a result of the merging of the district (Southampton, Winchester, and Basingstoke), Portsmouth and Isle of Wright Committees. Additional sub-committees covering high-cost drugs, medication risk, shared care and guideline development are expected to reduce duplication of effort, reduce inequity of medicine provision and support block finance arrangements across the system.

2.1.33. The planned development of an offsite aseptic unit at Adanac park remains on track for commissioning in June 2024. The design of the unit and equipment schedules are now close to being finalised. Work is still ongoing at a regional level with the four local trusts (UHS, PUHT, IOW and HHFT) to take a collaborative approach across the ICS. At this stage, Adanac is expected to provide sufficient capacity to become the regional unit and provide much-needed aseptic resilience to the local system and neighbouring systems.

2.2. Key areas requiring action/improvement

Digital

2.2.1. An upgrade to the pharmacy stock control and ward-based e-prescribing system (JAC) remains outstanding. Several critical issues were identified during system

validation, which has delayed the ability to deploy the upgrade. At present, these delays are prohibiting progress with other strategic projects, including:

- Regional procurement hub
- The full benefits of Omnicell cabinets on AMU
- Electronic controlled drug management in pharmacy

A revised options appraisal is being developed for review by the Digital Programme Delivery Group relating to the most appropriate next steps.

2.2.2. The regional chemotherapy and prescribing system has become increasingly unstable over the course of the last 12 months. This is primarily thought to be due to the system needing an upgrade to handle the increased demand. Initial discussions suggest that the IT server architecture and the system software require an upgrade. The system is currently hosted and managed by PUH, who have indicated reluctance to continue this arrangement after the next upgrade cycle. An immediate solution is being investigated and supported by UHS Trust IT while a more detailed options appraisal is developed for next year.

2.2.3. There remains a risk that medicine prescribing and/or administration is omitted or duplicated when patients move between clinical areas that have JAC and MetaVision. Several process-driven mitigations are managing the risk adequately at present. However, there remains a concern that as operational pressure increases, these processes may fail. Further mitigations and options may become available following a similar project in HHFT. However, early indicators suggest they are experiencing similar challenges with implementation, and their project has been placed on hold until solutions are found.

2.2.4. A variety of different drug libraries are used across different electronic systems in UHS. To achieve complete interoperability, each library requires review and amendment in line with international standard DM+D codes. When assessed the primary drug database in UHS (JAC) had a high (>98%) level of conformity. Therefore, the next area of focus is the other critical systems with independent drug databases.

2.2.5. The uptake and utilisation of electronic prescribing in outpatients remains consistently low (~10%). Additional work is required to improve the prescriber experience and realise the potential benefits.

2.2.6. Three Omnicell cabinets have been implemented as standalone systems since Nov 20. However, we have yet to implement the full link between our EPMA system and the cabinets limiting several of the expected benefits of the cabinets. In addition, the next available upgrade of JAC will not allow the full functionality to be attained. The pharmacy IT team will continue to review this with the ward-based team once JAC has been upgraded and explore options that allow safe use.

Operational and Infrastructure

2.2.7. The pharmacy oncology aseptic unit was relocated to a new modular aseptic unit beside the day-case chemotherapy unit in 2021-22. A formal follow-up quality assurance commissioning visit occurred in Nov 21 and detailed several important process and unit design interventions. These will require short-term closure of the unit and the pharmacy team have been working hard to plan these in conjunction with the estates and cancer care teams.

2.2.8. Specialist oncology pharmacist and technician workforce shortages throughout 21-22 led to significant challenges with the timely provision of chemotherapy. Significant improvements have been made throughout the year, with the proportion of delayed chemotherapy treatments reducing from 67% in Oct 21 of all treatments experiencing delay to 36% in March 22. However, further improvements are required and considered a priority for the pharmacy service. Three additional workstreams are now targeting these additional improvements

- Review and maximise the use of items available for pre-purchase in dose-banded preparations. A shift toward standardised treatment regimens will reduce delays and also enable UHS pathways to take full advantage of the capacity provided by Adanac park once that facility becomes available in 2024.
- Re-allocation to homecare services (e.g. Avelumab). As part of this work programme, several chemotherapy products have been identified as suitable for home administration.
- Redesign of the scheduling and pathways for items with short self-lives or long preparation times.

2.2.9. Progress in implementing the regional medicines procurement hub has stalled pending the availability of the digital architecture. This project was the primary mitigation for the ageing pharmacy logistics robot. A replacement robot is now required and work is underway with procurement, estates and finance to take this forward.

2.2.10. There is insufficient space within the pharmacy footprint to accommodate the team despite the use of remote working. Furthermore, the expansion of clinical trials and the storage of increased numbers of investigational medicinal products presents a challenge. The pharmacy team have been working closely with the estates team to shape the 10-year masterplan and provide a vision to re-utilise the space released when the TSU relocates to Adanac park.

2.2.11. The current fridge monitoring at ward level is retrospective and does not record how long a fridge has been out of range. There is currently no escalation of a fridge alarm at ward level. A fridge monitoring system for wards would provide cost-saving from wasted stock, added assurance for CQC, and the hospital's quality/storage of our medicines. The trust wide asset tracking project is collaborating with pharmacy to deliver a solution for UHS.

Research & Development

2.2.12. While the challenges around clinical trial capacity have largely been resolved there remains a significant challenge in relation to cancer-related trial approval. A detailed action plan has been developed with regular updates provided at both Research and Development Steering Group (RDSG) and Cancer Board. As we enter 2023, the primary actions (recruitment and training) are beginning to realise improvements with the expectation that the backlog of trials will be cleared and routine monthly approvals will exceed the requirements of the Emerging Therapies Unit. However, there remains a significant level of fragility in this area due to the ongoing national shortages of trained oncology pharmacists.

Workforce and Development

2.2.13. The Pharmacy workforce strategy needs to be updated to ensure medicines management is robustly supported by a trained, high-quality, motivated and flexible workforce. UHS aspires to remain ahead of peers in considering the future workforce and is actively working to develop programmes of work for the future that are aligned with the research aspirations of UHS, including pharmacogenomics and data-driven care.

Sustainability and UHS Green Plan

2.2.14. The emerging sustainability agenda brings with it three key priorities within medicines management.

- Metered dose inhalers – switching patients to sustainable versions and recycling used inhaler cannisters.
- Reducing the use of volatile anaesthetic agents such as desflurane.
- Monitoring and reducing the use of nitrous oxide for both anaesthesia and when combined as Entonox.

The pharmacy team are activity working on schemes to support these programmes of work and develop new initiatives as the evidence-based interventions are published.

3. Conclusion

3.1. The actions required to address the concerns raised in section 2.2 above are listed in the action plan (Appendix A). The action plan also includes areas of innovative development in support of the Trust's values.

3.2. Progress against the action plan will be reviewed periodically by the Senior Pharmacy Managers, with escalation through Division C management as required. It will be reported formally in the 2022/23 Medicines Management Report.

4. Recommendation

4.0 The Board is requested to acknowledge the report and support the UHS Medicines Management Strategy and Action Plan.

5. Appendices

Separate Files

- Appendix A – UHS Medicines Management Strategy & Action Plan.

Appendix A

UHS Medicine Management Strategy and Action Plan

UHS strives to be at the leading edge of excellence in all aspects of medicines management and medicines optimisation. The UHS medicines management strategy has three themes: -

1. Best practice in the use of medicines.
2. Improving patient experience.
3. Best value from resources.

The components of each theme are aligned to the Trust's forward vision: -

Medicine Management Theme	Component	Alignment to Trust Values		
		Patients First	Working Together	Always Improving
Best practice in the use of medicines	Excellence in all drug use processes, procurement, storage, prescribing dispensing, administration, monitoring, disposal	✓	✓	✓
	Evidence-based formulary and guidelines	✓		
	Medication error monitoring and learning	✓		✓
	Education and training		✓	✓
	Implementation of national guidance	✓		✓
	Research and quality improvement	✓	✓	✓
	Clinical audit	✓		✓
	Regulatory compliance and strong governance	✓	✓	✓
Improving patient experience	Medicines optimisation – maximising patient benefit from medicines	✓	✓	✓
	Patients as partners in selection of treatment	✓		
	Optimising transfer between care settings		✓	
	Implementing alternative care pathways	✓	✓	✓
	Provision of information, advice and support	✓	✓	
	Timely intervention – access to medicines when and where they are needed seven days a week	✓		
	Promoting self-care and healthy living	✓		
Best value from resources	Develop and support the medical, nursing and pharmacy workforce and explore new ways of working		✓	✓
	Integrate technology and innovation and use data effectively			✓
	Medicine procurement for value and safety	✓	✓	
	Evaluate and measure to improve effectiveness and productivity	✓		✓
	Partnership working with other organisations		✓	

Summary of medicines management actions

Actions completed, closed or paused due to dependencies in 2021/22

	Action	Outcome	Additional information
1	Implement e-prescribing to ED.	Paused	A scoping exercise undertaken in early 2020 identified that e-prescribing was only part of a much larger digitisation project within the ED. As such the implementation of e-prescribing has been delayed until a full digitisation project can be fully explored. The design and development of an emergency care village will also be a key determinant as to how e-prescribing is implemented in the ED. Plan to implement electronic outpatients in the ED is linked to separate action.
2	Major rebuild/refurbishment of main pharmacy aseptic dispensing unit.	Complete	The technical services unit is now fully operational and expected to bridge until the Adanac aseptic facility is commissioned in June 2024.
3	Review previous NPSA and NHS medication safety alerts for relevance and identification of new risks or new solutions.	Complete	Review completed alongside a review of all the patient safety standards. Additionally, an audit plan has been devised that covers all previous alerts.
4	Implement QPulse document management system across pharmacy	Complete	System now deployed for Quality Assurance activities in pharmacy
5	Unifying the E-prescribing Drug Libraries in line with nationally recognised standards	Complete	Phase 1 – Complete – External validation by Wessex One Medication Record project complete. Recent NHSD review detailed high level of compliance (>98%) alongside several areas for improvement that are underway and expected to improve this compliance.
6	Develop systematic process for monitoring and reporting block contract medicines and assessing impact of new medicinal therapy	Complete	Routine monitoring with contracting and finance teams is underway. In addition, formal reporting regarding the impact of newly commissioned therapies is underway via Drugs Committee, with escalation as appropriate.
7	Implement digital homecare management system to reduce administrative burden and improve contingency arrangements	Paused	Initial scoping suggests no suitable systems available. Further exploration including scope to build bespoke solution expected when Alcidion partnership is finalised
8	Review and reconsideration of the risks and mitigations associated with the transfer of patients between clinical prescribing systems	Closed	Ongoing medication safety monitoring suggest current process are mitigating risks.

Ongoing Action Plan

RAG Status

	No progress or significantly delayed
	Progress is underway but delayed or slower than plan
	On track, no significant concern

	Identified	Actions	Progress / Update	RAG Status	Lead
1	20/21	Transition the UHS medicines procurement and distribution service to the Solent Acute Alliance hub	UHS approval of business case expected Aug 19. Plan to transfer all ordering to procurement hub while progress with digital architecture is developed.		Deputy Chief Pharmacist – Mark Pepperrell
2	20/21	Extend implementation of Medcura within UHS to fully realise safety benefits and provide evidence for national adoption	Phase 1 – Complete - To utilise the functionality of Medcura within clinical trials to reduce the incidence of internal errors. Phase 2 – Deploy in CIVAS in preparation for Adanac aseptic facility		Deputy Chief Pharmacist Mark Pepperrell & Andy Fox
3	20/21	Develop the nurse discharge checklist for paediatric areas & work with nurse leaders to improve utilisation in adult ward areas.	Anecdotal evidence from incident reports and ward areas using the checklist suggests it does avoid discharge errors and reduce the need for post-discharge interventions Work to finalise extension in paediatrics is still required alongside additional work to improve consistency of use and realise full benefits of the checklist across adult ward areas.		Deputy Chief Pharmacist – Nicola Howarth

	Identified	Actions	Progress / Update	RAG Status	Lead
4	21/22	Ensure the new aseptic unit based at Adanac park delivers on the organisation's investment and strategic requirements	Design of the unit is complete with input from estates and specialist cleanroom manufacturers. Additional expertise regarding MHRA licensing requirements has been secured. Oversight and delivery group to be created with regular reporting requirements to TEC. Ongoing discussions are occurring at ICS level regarding the regional status of the unit. Submission for funding to National Aseptic Review (Oct 22)		Chief Pharmacist – James Allen & Deputy Chief Pharmacist – Mark Pepperrell
5	21/22	Upgrade JAC system to - Achieve the full safety and operational benefits from Omnicell Implementation - Ensure digital communication with the regional procurement hub - Respond to concerns raised in the Klas survey undertaken in 2021.	Validation of the system was completed in the previously agreed timescales but highlighted several critical issues that have delayed deployment. Options appraisal paper developed and to be discussed at digital medicines optimisation group and then DPDG.		Deputy Chief Pharmacist – Andy Fox
6	21/22	Electronic outpatient prescribing – objectively increase the proportion of outpatients prescribed digitally from baseline (10%).	Technical infrastructure and ability deployed throughout the pandemic. Additional training materials have been developed and shared. Dedicated work with each prescriber group is required to ensure all protocols and prescribable therapies are available.		Deputy Chief Pharmacist – Andy Fox

	Identified	Actions	Progress / Update	RAG Status	Lead
7	21/22	Submit Medcura for national consideration as part of the newly formed National Aseptic review panel	National aseptics have now allocated pathfinder monies and are planning a site visit to review Medcura and its role in the national programme.		Deputy Chief Pharmacist – Mark Pepperrell
8	21/22	Update the pharmacy workforce strategy in light of the new NHS people plan and regional workforce programmes	A regional workforce plan is under development with the expectation that a UHS plan can be devised once complete. Key areas such as aseptics are already under development in preparation for Adanac aseptics		Chief Pharmacist – James Allen
9	21/22	Formalise a programme of work to consider and implement evidence-based interventions to reduce the organisation's carbon footprint concerning medicines.	Carbon footprint is now routinely considered in relation to new medicines reviewed as part of the regional formulary process. Formal plans to remove desflurane from UHS are also underway.		Chief Pharmacist – James Allen
10	22/23	Ensure ongoing stability in electronic chemotherapy prescribing	An initial review and scoping exercise has been started with plans to develop a plan and table any resource requirements at Trust Investment Group in early 2023		Chief Pharmacist – James Allen

University Hospital Southampton
NHS Foundation Trust

Report to Trust Board of Directors				
Title:	**Equality, Diversity, and Inclusion Update including Workforce Race Equality Standard (WRES) and Workforce Disability Standard (WDES) Results 2022**			
Agenda item:	**9**			
Sponsor:	**Steve Harris, Chief People Officer**			
Author:	**Ceri Connor, Director of OD and Inclusion**			
Date:	**29 November 2022**			
Purpose:	**Assurance or reassurance** x	**Approval**	**Ratification**	**Information** x
Issue to be addressed:	As part of our People Strategy 2022-26, under the 'belong' pillar we have an ambition to: "Create a compassionate, inclusive and welcoming environment that values and supports every individual, both personally and professionally. As per the national requirement of all NHS organisations, the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) is reported annually between September and October. These metrics provide an important part of our KPI data for progress against our People Strategy. This report and its data has been presented at Trust Executive Committee and People and OD committee during October with good discussion taking place. This report sets out: • The results of our WRES and WDES data for Trust Board, including a look at progress over the last 4 years • Progress against the actions outlined in the 2021 WRES and WDES report • The action being taken for board to note			
Response to the issue:	Whilst the results had showed a slowly improving picture across most indicators, it was clear to meet the intentions and ambitions in the People Strategy, a shift was needed from initiative based activity, to more systemic changes, and to make sustained improvements at greater pace. In order to achieve the shift, a set of immediate priorities were proposed and agreed to enable UHS to improve the experiences of people from marginalised and underrepresented groups in our workforce, in a more sustained way, and at greater pace. We are still in the early stages of that shift; however, this paper will show progress to date and impact of the work against an improving WRES/WDES picture. We use a diverse range of data and indicators to measure our progress towards all the ambitions in the UHS People Strategy covering equality, diversity, and inclusion for all people. However, we are mandated to report on the WRES and WDES in isolation as a nationally mandated framework. There are no national frameworks for measuring experiences of those with other protected characteristics, however we have been developing our internal data set as part of our agreed priorities alongside the WRES/WDES.			

The WRES has **nine indicators**. Four of the indicators focus on workforce data, four are based on data from the national NHS Staff Survey questions, and one indicator focuses upon BME representation on Trust Boards. The WRES highlights any differences between the experience and treatment of white staff and BME staff in the NHS with a view to organisations closing those gaps through the development and implementation of action plans focused upon continuous improvement over time.

The WDES was introduced in April 2019. The WDES is a collection of **10 metrics** (including the subcategories) that aim to compare the workplace and career experiences of Disabled and non-disabled staff. The social model of disability, the ethos of 'Nothing About Us Without Us' and the concept of 'Disability as an Asset', which are advocated by Disabled people and disability rights organisations, underpin the WDES.

It is important that we continue to engage with our staff networks and other voices across the organisation to ensure we hear the true experiences of people from every part of our UHS community.

As per national requirements this report details the changes from 2021 to 2022 WRES/WDES, but also provides a 5 year view on WRES, and four years for WDES (appendix 2).

2022 WRES: All 9 indicators have improved from 2021;

- % of BME staff in overall workforce
- Likelihood of BME staff being appointed from shortlisting
- Likelihood of being entered into the disciplinary process
- % of staff experiencing bullying, harassment and abuse from patients, relatives or public
- % of staff experiencing bullying, harassment and abuse from staff
- % of staff believing that the trust provides equal opportunities for career progression or promotion (although the disparity gap remains over 10%)
- % of staff personally experiencing discrimination at work by team leaders/other colleague (although the disparity gap is 8.8%)
- % of staff experiencing harassment, bullying or abuse from staff
- Likelihood of BME staff accessing CPD or Non-Mandatory training (although there is still a disparity gap)
- % difference of White and BME voting members on the Trust Board.

2022 WDES: 7 indicators have improved from 2021;

- Relative likelihood of disabled staff being appointed from shortlisting
- Relative likelihood of disabled staff entering a formal capability process
- % of staff experiencing harassment, bullying or abuse from patients, relatives or the public
- % of staff experiencing harassment, bullying or abuse from managers/team leader
- % of staff experiencing harassment, bullying or abuse from other colleagues
- % of staff believing that trust provides equal opportunities for career progression or promotion
- % 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.

4 indicators have declined:

- % of Disabled staff in overall workforce that have declared a disability
- % of staff saying they are satisfied with the extent to which their organisation

	values their work ➢ % of staff saying that they their employer has made adequate adjustments to enable them to carry out their work ➢ % 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. (This indicator has improved for people without disabilities or long term illness). 1 indicator has remained unchanged: ➢ % of Board members with declared disability or long term illness which is still zero (Data for each indicator can be found in appendix 2)
Implications: (Clinical, Organisational, Governance, Legal?)	The following implications should be noted: • **Culture** – The 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. • **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). • **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. • **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 3b) We fail to recruit, retain, and develop a diverse, compassionate, and inclusive workforce to meet our corporate strategy aims.
Summary: Conclusion and/or recommendation	The WRES and WDES 2022 shows an improving picture, and UHS compares well with other Trusts nationally, UHS scores highest in the acute sector in Hampshire and IOW with a diversity and Inclusion sub score of 8.4 for the theme of "We are compassionate and Inclusive" (2021 Staff survey). However, we know that the WRES and WDES has to be viewed in line with other insights and lived experiences. The disparity gap is still wide in some areas, and it is never acceptable for staff to be subject to bullying, harassment, racism and discrimination at work. We will not have achieved our goal of a truly inclusive culture until we know that disparity between experiences has been eliminated. There is a clear intent in the draft EDI strategy for UHS to become an anti-racist and anti-discriminatory organisation, this requires action from every one of us to not stand by, to live our values, and to be willing to challenge what we think we know, and to at times, feel uncomfortable.

	Trust Board members are asked to: • Receive the information contained in this report, including the WRES and WDES outcomes for 2022 to enable mandatory reporting to NHSE/I. • As Board members, act as ambassadors for the improvements detailed in this paper, and act as public supporters and role model behaviours. • Receive the draft EDI strategy at Trust Board Study session in January 2023 for approval, and implementation thereafter.

1. Introduction and Purpose

1.1. As part of our People Strategy 2022-26, under the 'belong' pillar we have an ambition to: "Create a compassionate, inclusive and welcoming environment that values and supports every individual, both personally and professionally. We want every person to feel free and comfortable to bring their whole selves to work, safe in the knowledge that they are welcomed, respected and represented."

1.2. As per the national requirement of all NHS organisations, the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) is reported annually between September and October. In October 2021, the WRES/WDES report was presented to the People and OD Committee and Trust Executive Committee, it contained a reflective observation of the WRES/WDES outcomes over the preceding four year period, as well as the improvements or declines from 2020.

1.3. This paper sets out our results for 2022 WRES and WDES scores and updates on progress against core actions in our EDI initiatives to support these.

2. Equality, Diversity and Inclusion, looking back 12 months.

2.1. As part of the recommendations, the research paper 'No More Tick Boxes' by NHS East of England and Roger Kline [1] was used as a good practice toolkit, and a set of priorities were proposed to "Shift the paradigm". An EDI plan was created with a set of priorities incorporating the actions from the Race Equality Action Plan 2020[2], and 2021 WRES and WDES, also the priorities of the national People Plan, including the national ED&I 6 high impact actions to close the gap in recruitment and promotion.

2.2. Last year in October 2021, members of the People and OD Committee, TEC, and later Trust Board were presented with the 2021 WRES and WDES results in addition to recommendations to shift our approach aligning with the work of Roger Kline and NHS England (No more tix boxes). Board were asked to support the recommendations the following six actions:

- Support and engage in the implementation of the EDI plan, and creation of the EDI strategy.
- To support the development of regular EDI data scrutiny, including the co-design of data packs to be used within existing performance and governance frameworks.
- Support the creation of a gender specific monitoring standard, aligned to WRES/WDES, to enable increased scrutiny and action on gender equality.
- 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.
- Commitment to senior leadership role modelling, personal action, decision making and learning. To commit to more progressive actions as per the EDI plan.

2.3. An EDI plan was created with a set of priorities incorporating the actions from the Race Equality Action Plan 2020[3], and 2021 WRES and WDES, also the priorities of the national People Plan, including the national ED&I 6 high impact actions to close the gap in recruitment and promotion

[1] NHSE-Recruitment-Research-Document-FINAL-2.2.pdf (england.nhs.uk)
[2] Our race equality improvement plan (uhs.nhs.uk)
[3] Our race equality improvement plan (uhs.nhs.uk)

2.4. A year on progress against the six actions can be found in appendix two of this document. Progress has overall been positive, however pace of overall and deep systemic change remains a challenge.

3. Measuring impact of actions to date; Summary of WRES/WDES 2022

3.1. The WRES was first collected by the NHS nationally in 2014. The WRES has nine indicators. Four of the indicators focus on workforce data, four are based on data from the national NHS Staff Survey questions, and one indicator focuses upon BME representation on boards. The WRES highlights any differences between the experience and treatment of white staff and BME staff in the NHS with a view to organisations closing those gaps through the development and implementation of action plans focused upon continuous improvement over time.

3.2. The WDES was introduced in April 2019 as a mandated data collection. The WDES is a collection of 10 metrics that aim to compare the workplace and career experiences of Disabled and non-disabled staff. The social model of disability, the ethos of 'Nothing About Us Without Us' and the concept of 'Disability as an Asset', which are advocated by Disabled people and disability rights organisations, underpin the WDES.

3.3. The WRES and WDES results 2022 show improvements across many of the indicators from 2021. This is a positive sign. However, we know the participation in the annual staff survey from those from black and ethnic backgrounds, and those who declare a disability or long term illness needs to increase. In addition, WRES/WDES only provides indicators relating to staff from black and ethnic backgrounds and those with disability and long term illness. It does not reflect experiences of all people with protected characteristics. That said, the WRES/WDES is vital to help us improve experiences for people covered by the metrics and to help us make decisions to help us improve or eliminate disparity of experience at UHS.

4. WRES Trends; a long term look

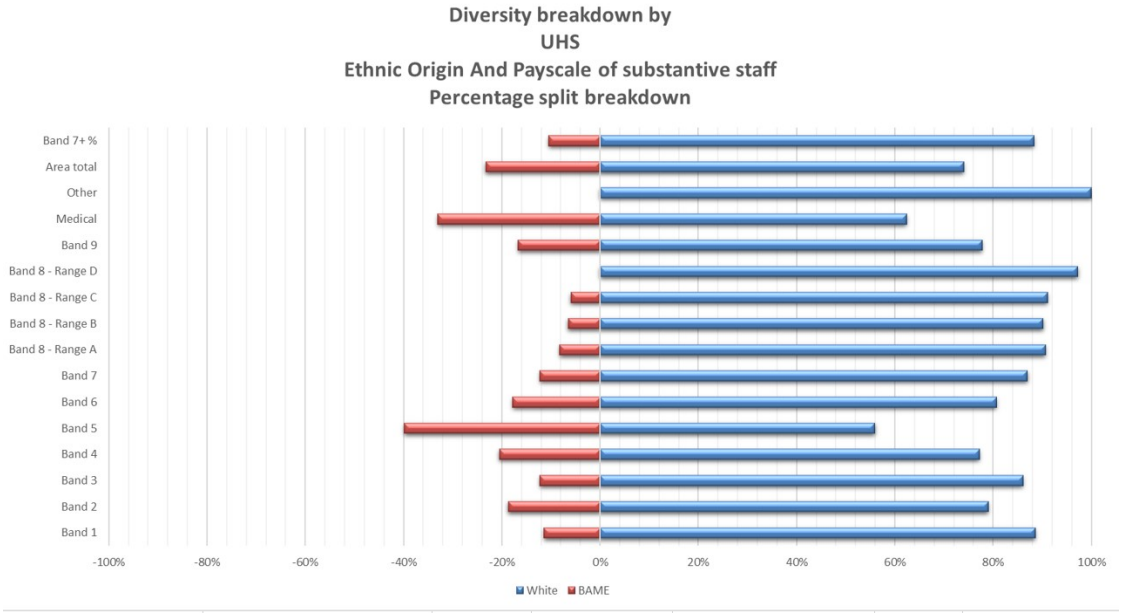
4.1. Whilst it is important to reflect on year-to-year changes, it is also important to consider the metrics and our performance over a longer period of time. An ability to take a "helicopter view" of whether we are making significant changes, sustained over time, consistently and at pace.

4.2. Appendix 2 of this report details WRES results across all indicators 2018 – 2022 (five year view). This clearly shows a picture of performance and indicates whether we have seen sustained improvement, decline, a static picture, or fluctuation.

Specific areas to highlight; WRES:

4.3. Continual increase in numbers of staff from black and ethnic backgrounds in our total workforce. An increase of 7.1% in the overall workforce in the last four years, breakdown shown in Fig 1 below. A 10.6% increase in clinical roles, and 2.7% in non-clinical roles in the same period should be celebrated.

Fig 1: Overall workforce by race



4.4. Fig 2 below shows the breakdown in the nursing and midwifery workforce, and Fig 3 for Medical and Dental. It is likely the increase in clinical workforce is directly attributed to the overseas recruitment programme. Nurses and Midwives from black and ethnic backgrounds are represented at B5 nursing roles and then a steady decrease between band 6 to 8b, and no representation at bands 8c and 9

Fig 2: Breakdown of workforce by race – Nursing and Midwifery

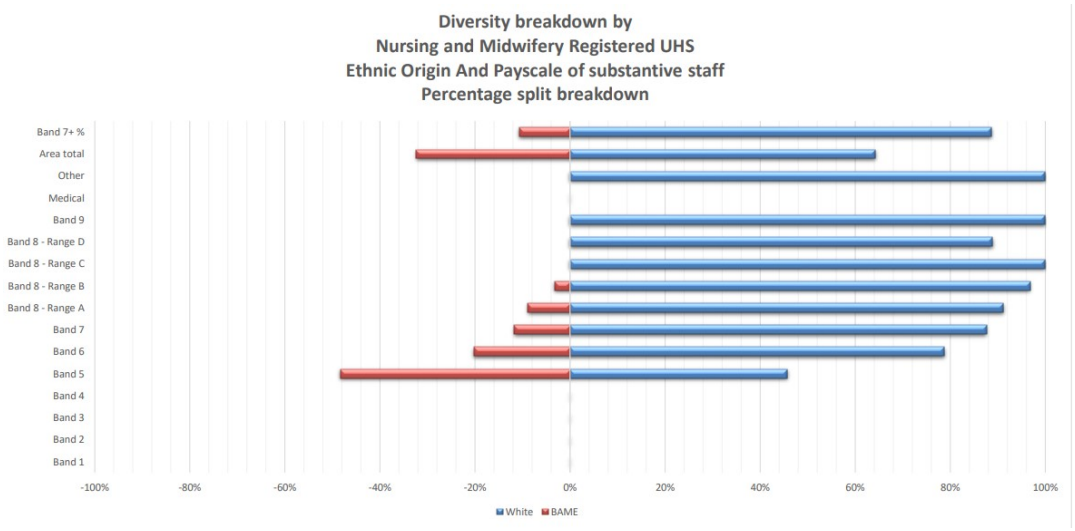
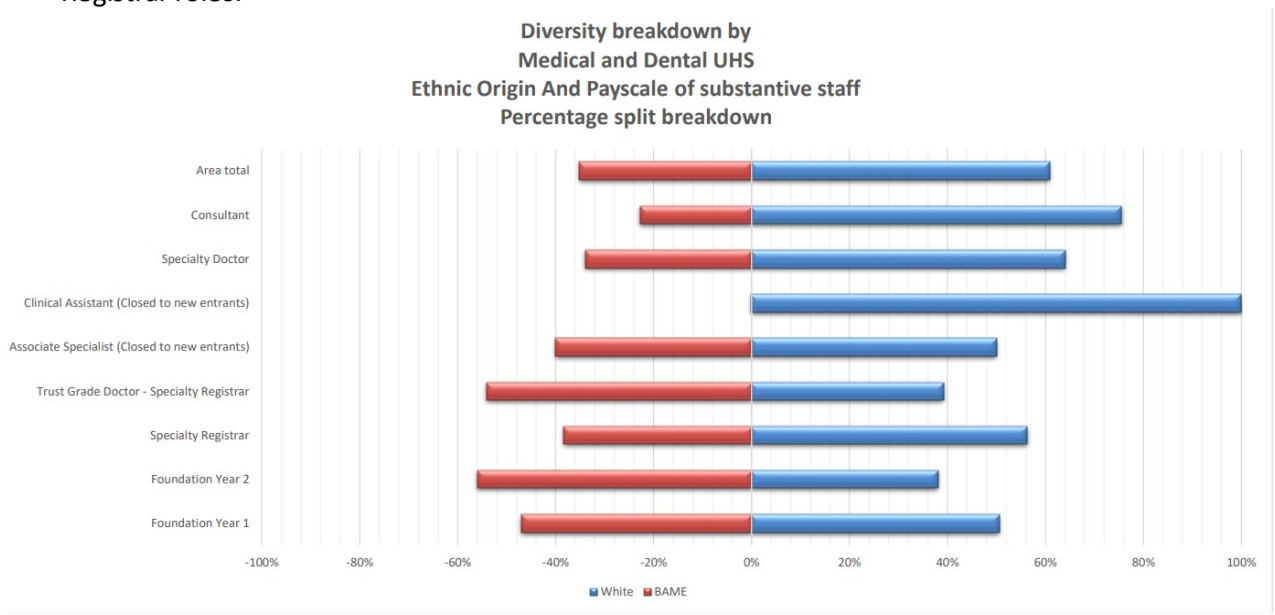


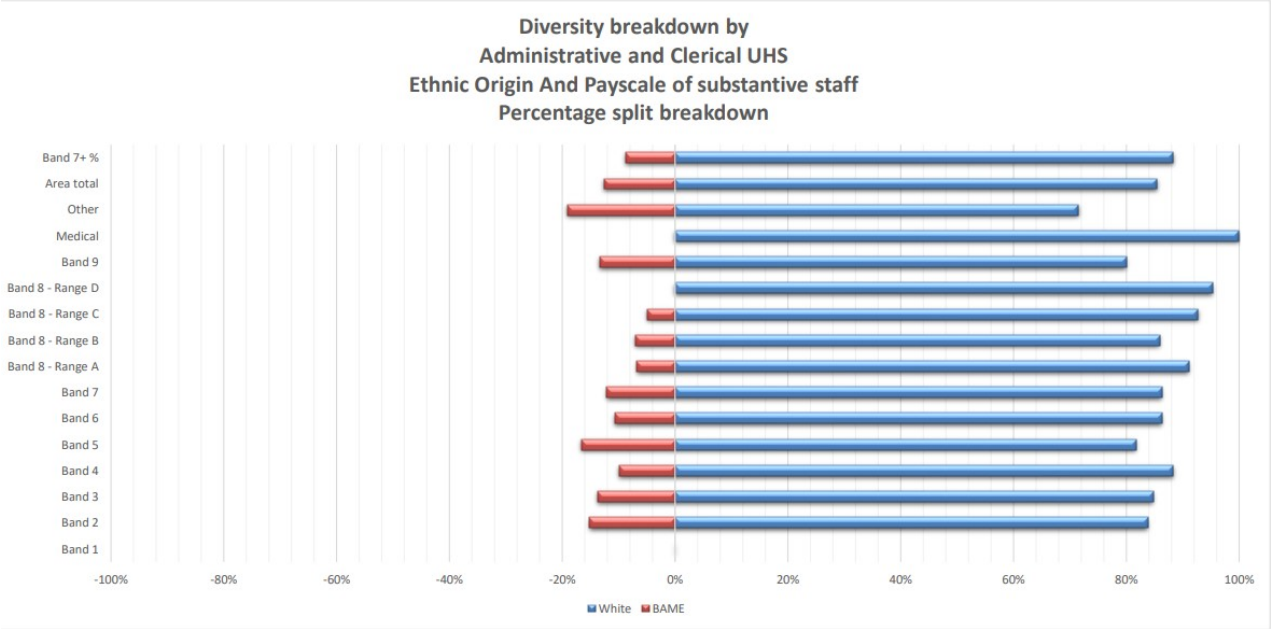
Fig 3: Breakdown of workforce by race – Medical and Dental

4.5. Largest population of medical staff from black and ethnic backgrounds at FY2 and in Specialist Registrar roles.



4.6. Fig 4 details Admin and Clerical, whilst there have been small increases in black and ethnic backgrounds in this workforce this is a potential area for more substantial increases reflective of the communities in Southampton.

Fig 4. Breakdown of workforce by race – Admin and Clerical



4.7. Access to non-mandatory training and CPD for staff from black and ethnic minority backgrounds has seen fluctuations but has seen a slight improvement from 2021. Results indicate that White staff were 0.94 times more likely to access CPD and non-mandatory training in 2019, declining to 1.87 in 2021 and improving to 1.33 in 2022. Note that more than "1" is an indicator of greater disparity. Data collection for this indicator can be improved, in relation to the eligibility of what is in scope/out of scope of non-mandatory training. This will be incorporated within the EDI data work programme with the aim of improving the inclusion of all elements considered as non-mandatory training and CPD.

4.8. Currently, the only data recorded on the VLE is used for this metric. It does not include any locally recorded training or learning, or any externally sourced learning which may not get recorded on the personal VLE record. As part of the talent development steering group the VLE redesign workflow will consider this indicator and any potential improvements.

4.9. We must work hard to attain assurance that staff from black and ethnic backgrounds are having equal access and opportunities for development and CPD as white counterparts. This must be done through a triangulation of improved data and by continuing to listen to lived experience. The Positive Action programme and talent development work programme (an evolution of the inclusive leaders' programme) will respond to these needs. Applications to the positive action programme will open shortly.

4.10. Disparity of experience between staff from black and ethnic backgrounds and white colleagues on equal opportunities for career progression or promotion shows a continued gap. This has fluctuated over the four years of the data collection; at worst the disparity was 18.5% in 2019, the gap has narrowed to 10.9% in 2022, which is positive, but this statistic remains unacceptable. There are several work programmes to respond to this, the Talent Development programmes, and Positive Action programmes will aim to ensure people from black and ethnic backgrounds are engaged in their career options and offered development to increase chances of success at interview for promotion or stretch opportunities. In turn, the Inclusive recruitment programme will continue to build on changes already made and ensure the processes are free from bias and continue to develop our recruiting managers. The inclusive leadership development modules will upskill managers and

provide learning to challenge own stance and thinking in terms of racism or bias related to recruitment or offering opportunities.

5. WDES Trends; a long term look

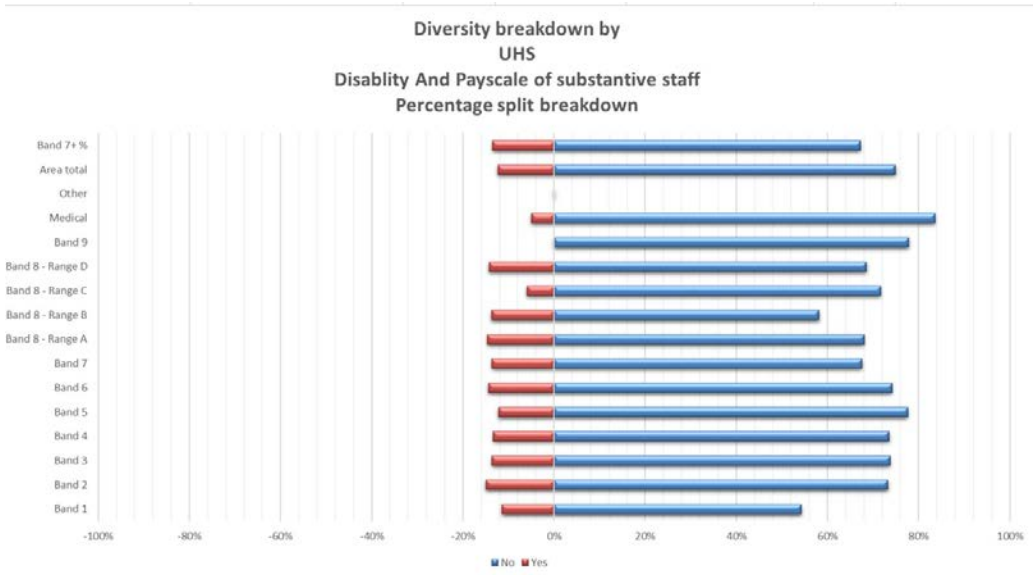
Appendix 2 details the WDES indicators and results 2019-22 (four years).

Specific areas to highlight; WDES:

5.1. Workforce representation and declarations. In 2020 the number of staff with a declared disability or long term illness increased to 15% due to the Covid Risk Assessments (COVID age), this is the highest declaration rate ever at UHS and the highest rate in NHS England. Since then, the rate has been steadily declining, the data collection date for WDES was 31 March 2022, we know from the People Report that the rate has declined further since the WRES data was extracted, it is now nearer to 12%.

5.2. Fig 5 below details the breakdown of the UHS workforce by band by disability and long term illness. There are no particular roles/bands where disability and long term illness is declared more than others, however there are no declarations at B9 or at Trust Board. Declarations is already a work programme in the EDI plan.

Fig 5. Breakdown of workforce by band; Disability and long term illness



5.3. Experience of bullying, harassment and abuse, from patients, other colleagues, managers (under metric 4a). This indicator has remained broadly the same with the exception of harassment, bullying and abuse by managers, which has slightly decreased over the four year period. However, the experience and the disparity between those with disabilities and those without is still a cause for concern.

5.4. As part of the work programme in the draft EDI strategy under theme 2 – Safe and healthy working environments, free from all racism, aggression, hate and discrimination, work will take place to improve alignment of the Hate Crime, and Violence and Aggression group, to improve analysis of data related to these incidents. This activity will be included in the data workstream. This information will enable divisional steering groups to understand where they have incidences related to bullying, harassment and discrimination and can act accordingly. We must not accept violence,

aggression, bullying or harassment in the workplace for any person, and must work harder to see experiences significantly improve.

5.5. Staff with disabilities or long term illness feeling that they have felt pressure from their managers to come to work despite not feeling well enough to perform their duties. Since 2019 this indicator has reduced, which is a positive trend. However, the disparity between people with disabilities and long term illness, and those without, is too wide. Despite a drop in 2020, likely to be attributed to the Covid pandemic when many people with disabilities or long term conditions were shielding or working remotely where possible, this indicator has largely remained unchanged.

5.6. This is concerning due to the potential expectation that people with disabilities and long term illness are more likely to take sick leave, and therefore may feel compelled to work, or pressure is applied even when their condition may require them to be off work.

5.7. Given the link to declaration, and potential links to experiencing bullying, harassment and abuse from managers, improvements in this area are linked to development of psychological safety, development of trust, and people feeling safe to have better quality conversations between individual and managers. Improvement in manager awareness and knowledge of what support is available, options for agile or flexible working, and/or adjustments to the working environment. UHS disability advisory service is a unique service, feedback from the Long Term Illness and Disability (LID) Network confirms that many managers are still not aware of this service. Occupational Health team are making clear plans to improve the profile of services which will raise awareness. General improvements to this metric will also be driven by the Inclusive Leadership and management theme in the draft EDI strategy, and the theme of Safe and healthy working environments.

5.8. Staff feeling they are satisfied with the extent to which their organisation values their work, has seen a steady decline for staff with disabilities and long term conditions since 2019, although the experience from people without disabilities has also declined, it hasn't been at the same rate. This has been seen nationally throughout the staff survey results, but the disparity remains at around 10%.

5.9. A specific action from the 2022 WDES to raise the profile and value of the work of people with disabilities and long term illness will be scoped with the LID network members. Aligned to the broader trust wide recognition and reward/appreciation programme, we will aim to improve how people with disabilities and long term illness are valued within the UHS family.

6. Conclusion and Recommendations

6.1. The WRES and WDES results for 2022 are in line with our expectations, and over the timeframe the data has been collected we have seen improvements on the majority of indicators. We can be assured that we are moving in the right direction. However, as already mentioned in this report, there remains a continue disparity compared to the experience of white staff and those who do not declare as disabled. We need to continue to sustain improvements, with more consistency, and at greater pace.

6.2. The priorities already agreed in the draft EDI strategy and plan will aim to respond to these, there is no change of direction recommended, we need to go harder and faster, and commit more energy. The agenda needs to be owned by the whole organisation. It cannot be limited to the specific resources within the OD inclusions team, our staff networks, or other members of the People Directorate.

6.3. Role modelling and leadership from very senior leaders is imperative to the success of this work. As part of the draft EDI strategy theme of Inclusive leadership and management a programme of work will be delivered to support senior leaders to meet this challenge, the first step is learning, listening, and acting on what is learned and heard.

6.4. The work on developing our behaviour framework behind our Trust Values will also contribute to clearly articulating the behaviours we expect for all UHS staff in relation to inclusion. Early feedback from this programme demonstrates how important members of the UHS family feel inclusion is, and how it should be prominently reflected in the way we behave.

6.5. There is a clear intent in the draft EDI strategy for UHS to become an anti-racist and anti-discriminatory organisation, this requires action from every one of us to not stand by, to be clear on our stance, and to be willing to challenge what we think we know, and to at times, feel uncomfortable as we stretch our learning and understanding.

6.6. Trust Board members are asked to:

- Receive the information contained in this report, including the WRES and WDES outcomes for 2022 to enable mandatory reporting to NHSE/I, and publication thereafter.
- To support the final stages of the draft EDI strategy through to approval in the next two months.
- Act as ambassadors for the improvements detailed in this paper, and act as public supporters and role models wherever possible.

Appendix 1: Progress towards actions agreed in 2021 paper

Action from EDI paper (2021)	Progress/Risk to progress	EDI Strategy theme & related workstream
Clear strategic narrative Support and engage in the implementation of the EDI plan, and creation of the EDI strategy		
Development of a Trust EDI position statement and EDI strategy aligned to our People Strategy and wider Trust Strategic Framework	Phase 1: Engagement complete (Jan-April 2022) Phase 2: Development, engagement, design (to complete October) Phase 3: Approvals (scheduled for governance approvals throughout November and December and Trust Board Study Session in January 2023) Phase 4: Launch and implementation plan Jan-March 2023.	All themes
Ensure all Trust strategies promote and enable our EDI strategic intentions	Discussion with Christine McGrath to include EDI strategic themes in care group business and transformation plans 2023/24	All themes
To support the development of regular EDI data scrutiny, including the co-design of data packs to be used within existing performance and governance frameworks.		
Use data more effectively and more regularly through existing performance and governance mechanisms. Creation of an EDI data set to drive accountability, broaden understanding, and monitor performance and progress	Part 1 complete: Data dashboard by ethnicity, disability, age breakdown by: ➢ Pay band ➢ Appraisal completion ➢ Turnover ➢ Sickness ➢ Sexual orientation Phase 2: in development same as above by: ➢ Roles Applied, shortlisted, rejected, appointed ➢ CPD, learning and development inc. apprenticeships ➢ Secondments ➢ Promotions (upwards movement on pay band) ➢ Leavers Work has started on an HIOW ICS wide EDI dashboard.	Theme 1
Implement EDI Steering Groups in each division and agree KPIs linked to EDI strategy themes and WRES/WDES improvements.	All divisions have either commenced EDI Divisional Steering Groups or have plans to. They will agree EDI objectives and actions for the division using themes of EDI strategy to localise actions informed by divisional data and themes from staff survey and other local insights.	All themes.

Support the creation of a gender specific monitoring standard, aligned to WRES/WDES, to enable increased scrutiny and action on gender equality.		
Creation of sex and gender equality metrics	Progress on this priority has been paused whilst we make further improvements in the data workstream. 1st attempt to create the metric against the WRES/WDES framework was unsuccessful. Next steps are to identify the issues around gender and sex inequality and then create the actions to improve and the data metric to measure progress. UHS Women's Network to be launched on 17 November as part of Inclusion Conference.	Theme 1 and 2.
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.		
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.	Inclusive Recruitment Work Programme to commence November 2022. Working group to develop and lead workflows to include leads from People teams, THQ teams, representatives from staff networks, R&R leads, divisional reps.	Inclusive recruitment processes, free from bias. Inclusive leadership and management.
Appraisal – Appraisals are the cornerstone of talent management and performance. Full review of quality of appraisal conversations is required.	Appraisal working group set up with diverse representatives across UHS to review and redesign approach. Appraisal review completed March 2022. Simplified appraisal process and paperwork designed, training and resources launched on VLE, all launched May 2022. Pilot group set up to trail "appraisal period" between May and September and to complete formal evaluation (taking place currently). Next phase of appraisal improvement is to scope use of VLE and maximise digital solutions.	Inclusive leadership and management. Safe and healthy work environments. Workforce reflective of communities, all roles, all levels.
Participate in the Actionable Allyship Programme, and undertake continuous learning on this agenda, as guided by the OD and Inclusion team and network leads.		
Actionable Allyship programme; add to suite of mandatory training for all staff. This will ensure that everyone participates in the learning, this also provides a clear intention that the Trust is	Actionable Allyship now part of mandatory suite and on individual matrix on VLE for completion within 2 years. 721 have attended to date since the launch of the programme in	Theme 2

committed to changing the culture.	October 2021. Demand for training spaces currently out ways capacity. A plan is in place to train more facilitators and expand numbers on each session, facilitators can come to team events/meetings and be flexible on approach. Also, to create a digital alternative to post of VLE to enable completion at larger scale.	
Various learning and awareness sessions for staff to participate and develop knowledge	Pride month events Black History Month calendar of learning and events Pro Nouns masterclass Transgender and gender identity masterclass Inclusion and Belonging Conference Development of EDI huB (virtual learn on VLE)	
Commitment to senior leadership role modelling, personal action, decision making and learning. To commit to more progressive actions as per the EDI plan.		
Leadership role modelling and involvement	Execs and senior leaders rainbow badge pledges	All themes
	Exec attendance at Pride, and senior leadership support.	
	Exec support and attendance at People's Pride	
	Trust Chair launched partnership with Black History Month South, and exec and senior leadership attendance at event.	
	Executive involvement in Inclusion Week.	
	Divisional leadership of EDI steering groups and related actions.	
	Exec and senior leader continuation of reverse mentoring.	
Support for more progressive actions.	Trust committee support for development of EDI strategy	

EDI strategy themes:

1. Workforce reflecting our communities, at all roles, at all levels
2. Safe and healthy working environments, free from all racism, aggression, hate and discrimination.
3. Recruitment processes and experiences which are free from bias and are inclusive
4. Inclusive leadership and management
5. Networks that thrive and support creation of an inclusive and safe place to work.

Appendix 2: WRES Indicators and data (2017-2022) WDES Indicators and data (2019-2022)

Data Source	WRES Indicator	2018	2019	2020	2021	2022
UHS Workforce Data	**1:** % of staff in overall workforce, non-clinical workforce, and 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	**23.5%** BME staff in workforce **11.49%** BME staff in non-clinical workforce **26.72%** BME staff in clinical workforce
UHS Workforce Data	**2:** Relative likelihood of staff being 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	White staff are **0.94** times more likely to be appointed from shortlisting
UHS Workforce Data	**3:** 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 **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	BME staff are **0.65** times more likely to enter a disciplinary process.

Data Source	WRES Indicator	2018	2019	2020	2021	2022
UHS Workforce Data *NB. A figure below "1" would indicate that white staff members are **less likely** than BME staff to access CPD or non-mandatory training.*	**4.** Likelihood of White staff accessing CPD accessing non-mandatory training and CPD	No data	White staff are **0.94** times more likely to access CPD	White staff are **0.89** times more likely to access CPD	White staff are **1.82** times more likely to access CPD	White staff are **1.33** times more likely to access CPD
NHS Annual staff survey (data source is the preceding year's survey)	**5.** % of staff experiencing harassment, bullying or abuse from patients, relatives or public	24.5% White 23.6% BME Disparity = 0.9%	24.3% White 25.2% BME Disparity = 0.9%	25.7% White 28% BME Disparity = 2.3%	25.2% White 30.5% BME Disparity = 5.3%	21.8% White 25.1% BME Disparity = 3.3%
NHS annual staff survey	**6.** % 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.*	20.77% White 26.01% BME Disparity = 5.24%	22% White 28% BME Disparity = 6%	21.0% White 25.7% BME Disparity = 4.7%	21.3% White 28.5% BME Disparity =7.2%	18.2% White 22.8% BME Disparity = 4.6%
NHS annual staff survey	**7.** % 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.*	69% White 59% BME Disparity = 10%	67.6% White 49.1% BME Disparity = 18.5%	66.6% White 55.9% BME Disparity = 10.7%	66% White 51.4% BME Disparity = 14.6%	64.6% White 53.7% BME Disparity = 10.9%

Data Source	WRES Indicator	2018	2019	2020	2021	2022
National Staff Survey	**8.** % of staff personally experiencing discrimination at work by a team leaders/other colleague	7.1% White 14.6% BME Disparity = 7.5%	6.4% White 13% BME Disparity = 6.6%	5.3% White 13% BME Disparity = 9.4%	5.5% White 16% BME Disparity = 10.5%	5.9% White 14.7% BME Disparity = 8.8%
UHS workforce data	**9.**% Difference of white and BME voting members on the Trust Board	84.6% White 15.4% BME	84.6% White 15.4% BME	84.6% White 15.4% BME	91.6% White 8.4% BME	86% White 14% BME (Out of 12 voting members)

WDES Indicators and data (2019 to 2022)					
Data Source	**WDES Indicator**	**2019**	**2020**	**2021**	**2022**
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	**12.16%** disabled staff in the 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	Disabled staff are **0.90** times more likely to be appointed from shortlisting
UHS workforce data	**3:** Relative likelihood of disabled staff entering a formal capability process *A figure below "1" would indicate that Disabled staff members are **less likely** than non-Disabled staff to enter the formal capability process*	Not required to report in 2019.	Disabled staff are **0.84** times more likely to enter a formal capability process	Disabled staff are **0.97** times more likely to enter a formal capability process	Disabled staff are no more likely to enter a formal capability process. *Zero people with disability/LTC entered the capability process in the reporting period.*
NHS annual staff survey	**4Ai):** % 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 Disparity = 9.1%	**30.8% Disabled** 25% Non-disabled Disparity = 5.8%	**30% Disabled** 25.2% Non-disabled Disparity = 4.8%	**26.7% Disabled** 21.4% Non-disabled Disparity = 5.3%
NHS annual staff survey	**4Aii)** % of staff experiencing harassment, bullying or abuse from managers/team leader *% 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 Disparity = 6.2%	**15.8% Disabled** 8% Non-disabled Disparity = 7.8%	**13.7% Disabled** 9.1% Non-disabled Disparity = 4.6%	**11.9% Disabled** 7% Non-disabled Disparity = 4.9%

Data Source	WDES Indicator	2019	2020	2021	2022
NHS annual staff survey	**4Aiii)** % of staff experiencing harassment, bullying or abuse from other colleagues *% of staff who selected "Yes" when answering this question of the total number of people who participated in the staff survey.*	**26.3% Disabled** 16.5% Non-disabled Disparity = 9.8%	**24.6% Disabled** 16.4% Non-disabled Disparity = 8.2%	**26.7% Disabled** 16.2% Non-disabled Disparity = 10.5%	**21.6% Disabled** 13.6% Non-disabled Disparity = 8%
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 Disparity = 5.8% More people with disability or LTC have reported.	**45% Disabled** 45% Non-disabled Disparity = 0%	**49.6% Disabled** 46.9% Non-disabled Disparity = 2.7% More people with disability or LTC have reported.	**47% Disabled** 48.7% Non-disabled Disparity = 1.7% More people without disability of LTC have reported.
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*	**61.3% Disabled** 66% - Non- Disabled Disparity = 4.7%	**59.6% Disabled** 65.5 - Non- Disabled Disparity = 5.9%	**58% Disabled** 64.5% - Non- Disabled Disparity = 6.5%	**60% Disabled** 63% Non- disabled Disparity = 3%
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 Disparity = 8.3%	**21.9% Disabled** 18.9% Non-disabled Disparity = 3%	**33.1% Disabled** 23.6% Non-disabled Disparity = 9.5%	**26.9% Disabled** 19.9% Non-disabled Disparity = 7%

Data Source	WDES Indicator	2019	2020	2021	2022
NHS Staff Survey	**7:** % of staff saying they are satisfied with the extent to which their organisation values their work	**46.8% Disabled** 56% Non-disabled Disparity = 9.2%	**44.5% Disabled** 56.4% Non-disabled Disparity = 11.9%	**42.7% Disabled** 54.9% Non-disabled Disparity = 12.2%	**39.6% Disabled** 49.6% Non-disabled Disparity = 10%
NHS Staff Survey	**8:** % of staff that they their employer has made adequate adjustments to enable them to carry out their work	**81.5%**	**77.9%**	**79.8%**	**78.9%**
UHS Workforce data	**9: %** of Board members with declared disability or long term illness	**0%** of staff with a declared disability or long term illness sit on Trust Board	**0%** of staff with a declared disability or long term illness sit on Trust Board	**0%** of staff with a declared disability or long term illness sit on Trust Board	**0%** of staff with a declared disability or long term illness sit on the Trust Board

NOTE: The WRES/WDES methodology below as articulated in the technical guidance, and the timeline for retrospective data collection, as follows:

- The data set for workforce demographic as of 31 March 2022.
- The data set which provides information on likelihood of entering into disciplinary/capability processes and likelihood of being appointed from shortlisting, is taken from the timeframe 1 April 2021 to 31 March 2022. This data is presented as an average, under or over "1" where "1" represents equality of opportunity, and lower than "1" represents positive experience, higher than 1 represents negative disparity.
- The data set for experience on bullying, harassment, abuse in the workplace, work feeling valued, perception of equal opportunities for career progression is taken from the 2021 national staff survey, from those who responded to the related questions on these themes from black and ethnic backgrounds and those with long term illness and disability. The data from the staff survey is reported by % of people who have participated in the relevant question in the survey – not the % of the workforce.

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Ward Staffing Nursing Establishment Review August 2022 – October 2022**			
Agenda item:	**10**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Rosemary Chable - Head of Nursing for Education, Practice and Staffing**			
Date:	**29 November 2022**			
Purpose:	**Assurance or reassurance R**	**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 1st November 2022 and discussed at TEC on 16 November 2022.			
Response to the issue:	The paper is presented for DISCUSSION. The report details the methodology, findings, risk assessment and recommendations arising from the ward staffing review undertaken from August 2022 – October 2022. 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 1:10 registered nurse to patient ratio in most areas during the day with the majority (45) set between 1:4 to 1:8. Differences relate to specialty and overall staffing model. This is an increase in the number of wards with lower RN: patient ratios and this will require ongoing monitoring to ensure there is not further drift. 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 (18 wards) are linked to the systematic and evaluated implementation of trained band 4 staff where appropriate and those with higher ratios (3) are all higher intensity care areas requiring a higher registered skill. o 34 wards (up from the 30 last year and up significantly from 25 in 2019) are below the 60:40 ratio. o Planned total Care Hours Per Patient Day (CHPPD) range from 5.5 – 17.3 and average at 8.3 · Impact of budget setting on staffing levels for 2022/23 and Divisional requirements for consideration as part of budget setting 2023/24. · To note the ongoing progress in UHS compliance with the guidance from the National Quality Board on safe, sustainable, and productive staffing. · To note the ongoing progress in UHS compliance with the NICE guideline on safe staffing for nursing in adult inpatient wards. · To note and acknowledge the ongoing risks and challenges of matching actual staffing to established staffing levels due to the current vacancy position and the ongoing COVID-19 situation. · 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, rising acuity and elective recovery. · 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 2022 – October 2022. 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 Due to the ongoing impact of COVID-19, Division B were unable to complete the scheduled Divisional 'light touch' 6 monthly staffing review in March/April 2021. The other 3 divisions completed and reported to their relevant divisional boards. The impact of the ongoing COVID-19 situation, however, is that all ward establishments and nurse staffing levels have continuously been 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 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 Health System data
- Review of eRostering data
- Review of ward quality metrics

- For the 3rd 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 (August 2022) shows maintenance of compliance levels despite the ongoing 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 2022 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 and to introduce the revised national preceptorship framework (October 2022). Additionally, learner numbers (students, overseas and apprentices, preceptors) 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 (August 2022) 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 the continued vacancy position and capacity situation does not enable assurance that wards are not compromised by staff movements. *COVID-19 particularly necessitates a higher 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.

2.2.6 In September 2022 a key research study was published (Zaranko B, Sanford NJ, Kelly E et al. BMJ Quality and Safety Epub) which highlights the link between higher registered nurse numbers and seniority and patient outcome.

2.3 6 monthly Ward Staffing review August 2022 – October 202 – Outcomes

2.3.1 The 6 monthly review was carried out from August 2022 – October 2022 with initial review meetings taking place with each Division (attended by DHN, Matrons, Ward Leaders, Finance representatives, workforce representatives and facilitated by the Head of Nursing for Education, Practice and Staffing). 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 continued COVID-19 impact and recovery plan 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 continue to be regularly 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 to ward level was delayed this year as a result of the COVID-19 funding arrangements and therefore not all 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 ongoing COVID-19 experience alongside managing recovery of service for their area following further waves during the year.

2.4.2 There was for the third 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. It has now taken on a stronger role in the daily deployment of staff and the ongoing management of bank/agency bookings.

The value of this service came out strongly in the reviews 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 (E7, Bassett) and 1:10 (F7) depending on specialty and overall staffing model. This is an increase in the number of wards with lower RN: patient ratios and this will require ongoing monitoring to ensure there is not further drift.

- The average level is set to achieve 1:4 to 1:8 registered nurse to patient ratio in most areas during the day (45 wards) with 42 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 where ratios of registered to unregistered staff are also lower.

- The areas on or above 1:7 (15 wards) are the medicine wards, Medicine for Older People (all MOP wards including Bassett), F2 and the Acute Stroke Unit. These areas include a higher ratio of band 2 to 4 staff creating a total nurse to patient ratio of 1:3 – 1:4. It should be noted that the ratio of patients to registered nurse can regularly increase when wards are not fully established and these wards with lower RN 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 again 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 2 in-patient ward areas with ratios higher than 1:11 (RN to patient) at night (a reduction on the 4 last year as a result of budget setting). These are E3(G) and E7 where the ratios rise to 1:13. In E3 (G) this is offset by a total nurse to patient ratio of 1:5 and utilisation of planned band 2 or band 4 models. In E7 the total nursing level is at 1:7 which remains a high ratio which requires further review.

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 ideally not fall below unless planned as the model of care.

- 13 wards are now rostered at between 60:40 and 70:30. This is a reduction on the 19 the previous year with most wards now having reduced registered nurse ratios.

- 34 wards (up from the 30 last year and up significantly from 25 in 2019) are below the 60:40 ratio. These wards are utilising band 4 staff as a key contribution to the model of care and are areas where there is a wider multidisciplinary team contributing to care (e.g., MOP, T & O, Medicine, Acute Stroke). It should be

noted however that this reducing trend needs to be kept under close review against other metrics to ensure safe, quality care can be provided within the establishments. As highlighted previously, recent research highlights the impact on patient outcomes in areas with reduced registered nurse cover.

- 6 wards (same level as 2020) 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, CVT, 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 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 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. A project is planned to manage the Trust-wide rollout of a new version of the software during the autumn/winter which will also see a total refresh of the use and application of the safer nursing care tool to ensure this is being used consistently across the organisation.

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

- Planned total Care Hours Per Patient Day (CHPPD) range from 5.5 (F7, G6, G9, D9) – 17.3 (TAU) and average at 8.3. This average is slightly higher than last year.
- Registered care hours per patient day range from 2.1 (Bassett) – 12.6 (Piam Brown) and average at 5.2. The same level as last year.
- Unregistered care hours per patient day range from 0.5 (C6 TYA) – 8.3 (TAU) and average at 3.6. 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, and availability of skilled staff.

- 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. In August 2022 the average achievement of this was 49% with 10 wards not achieving it at all and 24 wards below the 49% achievement as we have continued to need to include ward leaders in the numbers throughout COVID-19 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 ongoing 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.

The management of increasing acuity and dependency on the wards has also been impacted by the ongoing challenges with recruiting to our advanced practice teams. Outreach in particular have been unable to support the wards out of hours creating additional pressure to the ward staffing model.

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.

We have also seen a significant rise in the episodes of violence and aggression experienced in our clinical areas which creates additional needs for staffing support.

This continues 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.

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 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 continuous 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.

New national guidance has been issued in October 2022 with additional requirements in relation to the provision of preceptorship for newly qualified staff. Protected time for both preceptors and preceptees is now an expectation for organisations.

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.

External bid opportunities around overseas recruitment and healthcare support worker recruitment have been well utilised in 22/23 to strengthen the education teams and clinical supervision support to the clinical areas. The capacity and capability within these teams needs to be further reviewed for 23/24 to ensure they can continue to 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 (September 2022) were running at 475 (12.9%) with registered nurse vacancies at 261 (11.6%) and unregistered at 190 (15.5%). Encouragingly registered nurse vacancies continue to gradually reduce with the continued range of recruitment and retention initiatives, but unregistered vacancies are proving harder to fill. Retention of this group of staff is key and focussed work, with a number of initiatives funded from successful bids, are being undertaken to target recruitment and retention for this group. The trust continues to be part of a national collaborative.

A continued key action nationally, corporately and for all Divisions in 2022/23 is to continue to concentrate efforts to fill these vacancies.

2.5.5 ***Benchmarking using the Model Health System***

UHSFT provides data monthly to the national Model Health System (MHS) detailing the CHPPD for all clinical areas including critical care.

Direct comparison of ward areas or specialty is no longer available via the benchmarking system however an overall average of total CHPPD is available to review via peer group and this is used as part of the staffing review.

Table 1

Organisation/Group	Total CHPPD	Registered CHPPD	Unregistered CHPPD
UHS with Critical Care	9.8	6.2	3.7
UHS excl. Critical Care	8.3	5.2	3.6
Shelford Group	9.9	6.5	3.0
MHS Peer Group	8.1	5.1	3.1
Region	8.3	5.3	3.0

*All data submissions (registered and unregistered) are averaged so will not necessarily equal the total CHPPD)

Hospitals with a high volume of critical care beds (providing 1:1 care) will have a higher CHPPD.

2.5.6 ***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'.

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 RCN Nursing Workforce Standards

3.2 The review for the 3rd 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 again identified the level of agility and flexibility shown by all the teams during this time and the continued message of thanks was shared at all the reviews.

3.3 Overall the staffing establishments remain appropriate and within recommended guidelines. There are some key exceptions where acuity and dependency levels and growing demand 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 1:10 registered nurse to patient ratio in most areas during the day with the majority (45) set between 1:4 to 1:8. Differences relate to specialty and overall staffing model. This is an increase in the number of wards with lower RN: patient ratios and this will require ongoing monitoring to ensure there is not further drift.
- The majority of wards (33) are staffed at between 50:50 and 80:20 registered/unregistered ratio or above. Those wards with lower ratios (18 wards) are linked to the systematic and evaluated implementation of trained band 4 staff where appropriate and those with higher ratios (3) are all higher intensity care areas requiring a higher registered skill.
- 34 wards (up from the 30 last year and up significantly from 25 in 2019) are below the 60:40 ratio.
- Planned total Care Hours Per Patient Day (CHPPD) range from 5.5 – 17.3 and average at 8.3
- Impact of budget setting on staffing levels for 2022/23 and Divisional requirements for consideration as part of budget setting 2023/24.

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 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, rising acuity and elective recovery.

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 2023.

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.

NATIONAL QUALITY BOARD - JULY 2016

Appendix 2

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 (August 2022) 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. New preceptorship framework from September 2022 with have additional requirements for protected time for preceptors and preceptees. 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 arising from COVID-19 due to raised sickness levels. Discussions ongoing to reflect accurate headroom levels as part of budget setting	Dec-22	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
		3.2 Efficient deployment and flexibility						

Expectation 3: Right place and time		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

Appendix 3 V23 August 2022 - Reviewed at NMSRG 25th August 2022

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	August 2022 compliance	August 2022 (37 compliant, 1 requiring action)
	Organisational strategy - Recommendations for hospital boards, senior management and commissioners in line with NQB expectations									
Recommendations for hospital boards, senior management and commissioners in line with NQB expectations	1.1.1	Ensure patients receive nursing care they need regardless of ward, time, day.	M	Specialty and sub-specialty ward system in place Outlying/inlying patients monitored through site	C	Continued monitoring of compliance	Maintain	Clinical teams/DMT	C	Continued monitoring of compliance. Reconfiguration of ward specialties and skills occurring due to COVID-19 and ongoing review of skills taking place as part of staffing allocations.
	1.1.2	Develop procedures to ensure ward staff establishments are sufficient to provide safe nursing care for each patient	M	6 monthly establishments reviews in place led by DoN team with DHN/Matron/ward leaders as appropriate.	C	Continued development of staffing review methodology linked to NICE guidance		Chief Nurse/DDoN/ DHN	C	6 monthly light touch review not completed in all divisions in March due to COVID-19 but all establishments reviewed regularly during crisis and as part of restart. Full reviews scheduled for July/Aug 2020
	1.1.3	Ensure final ward establishments developed with registered nurses responsible and approved through chief nurse and trust board	M	6 monthly establishments reviews in place led by DoN team with DHN/Matron/ward leaders as appropriate. Reported and discussed through board	C	Strengthen involvement of ward sisters through supervisory competencies	Maintain	Chief Nurse/DDoN/ DHN	C	6 monthly reviews now involving ward leaders
	1.1.4	Ensure senior nursing managers are accountable for nursing rosters produced	M	Reflected in job descriptions for DHN/Matrons/Ward Leader and included in ward leader competencies Hierarchy in eRoster reinforces requirements	C	Strengthen the monitoring and follow up of roster KPI's	Maintain	Chief Nurse/DDoN/DHN/ HR	C	Roster audits now reinstated and accountability for rosters clearly within ward leader and matron job roles. Workforce systems centrally supporting some roster approvals during the COVID-19 period
	1.1.5	Ensure inclusion of adequate 'uplift' to support staffing establishment	M	23% uplift included in all inpatient nursing establishments	C	Continued monitoring of achievement of allocated 'uplift' through eRostering KPI's		DHN/Matron/Ward Leaders	C	Continued monitoring of achievement of allocated 'uplift' through eRostering KPI's. Focussed project taking place on headroom and headroom increases formally acknowledged due to COVID-19
	1.1.6	Include seasonal variation/fluctuating patient need when setting establishments	M	Included as a consideration when setting establishments	C	Continued consideration at establishment reviews	Maintain	DDoN/DHN	C	Continued consideration at establishment reviews
	1.1.7	Establishments should be set appropriate to patient need taking account of registered/unregistered mix and knowledge and skills required	S	Included as a consideration when setting establishments	C	Continued consideration at establishment reviews		DDoN/DHN	C	Continued consideration at establishment reviews
	1.1.8	Ensure procedures in place to identify differences between on the day requirements and staff available	M	Escalation processes in place through bleep-holders through to site. Matrons responsible for reviewing staffing daily	C	Further strengthen the daily review processes through site. Strengthen the matron out of hours model to provide further oversight for staffing through to site	Maintain	DDoN/DHN/Matrons/Site	C	Safe staffing meetings extended to cover 7 days per week. Winter on-call matron arrangements now discontinued but staffing review meetings maintained. Safecare used actively at meetings
	1.1.9	Hospital to have a system in place for nursing red flag events to be reported by nursing teams, patients, relatives to registered nurse in charge (see separate tab)	M	eReporting of incidents becoming embedded. Staff informally include red flag information	A	Formalise 'red flag' inclusions on e incident reporting. Educate staff on 'red flag' events through safe staffing master classes and local care group/divisional updates. Review 'red flags' on all quality review visits to ward areas.	Maintain	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.
	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	Mar-23	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.

Organisational strategy - Recomme	1.1.12	Ensure there is a separate contingency and response for patients requiring continuous presence 'specialling'	M	Specialling processes in place and agreed escalation process within divisions.	C	Review the process for requesting specialling support.	Maintain	DDoN/DHN	C	Escalation processes clear. Policy updated in 2020
	1.1.13	Consider implementing approaches to support flexibility such as adapting nursing shifts, skill mix, location and employment contracts	C	Variety of shift patterns worked within the trust and flexibility within rostering policy allows for variation	C	Continue to review as part of professional judgement element of staffing reviews	Maintain	DDoN/DHN	C	Continue to review as part of professional judgement element of staffing reviews
	1.1.14	Ensure procedures in place for systematic ongoing monitoring of safe nursing indicators and formal review of nursing establishments twice a year	M	Nursing indicators monitored through incident reporting, ongoing monitoring and through CQD. Twice yearly formal staffing reviews embedded and managed through DON team	C	Continue to strengthen the process	Maintain	DDoN/DHN	C	Included at establishment reviews
	1.1.15	Make appropriate changes to ward establishments as a response to reviews	M	Establishments amended as result of staffing reviews. Staffing review linked to budget setting process. Evidenced increases noted through trust board reporting	C	Continue to strengthen and evidence the process	Maintain	DDoN/DHN	C	Continue to strengthen and evidence the process
	1.1.16	Enable nursing staff to have appropriate training for the care they are required to provide	M	Strong track record of training within Trust. Individual care group education teams support ongoing development needs	C	Continue to strengthen and evidence the process	Maintain	DDoN/DHN/ Education leads	C	Continue to strengthen and evidence the process
	1.1.17	Ensure there are sufficient registered nurses who are experienced and trained to determine day-to-day staffing needs in 24 hour period	M	Bleep-holder role includes requirement to assess and review staffing and risk assess	A	Review to ensure all bleep-holders are competent and capable in staffing assessment and risk management	Maintain	DHN/Matron	C	Additional education put into bleep holding as part of winter pressure oversight arrangements. Now in place with bleep holding and band 7 weekend review
	1.1.18	Organisation should encourage staff to take part in programmes to assure quality of nursing care and care standards	S	Nursing staff involved in range of quality improvement programmes e.g. essence of care, nursing practice, turnaround, clinical accreditation scheme	C	Continue to involve staff at all levels in nursing quality standard development	Maintain	DHN/Head of Quality and Clinical Assurance	C	Continue to involve staff at all levels in nursing quality standard development
	1.1.19	Involve nursing staff in developing nursing policies which govern nursing staff requirements such as escalation policies	S	Nursing staff involved in developing policy through groups and consultation	C	Continue to involve staff at all levels in nursing policy development	Maintain	DHN/Head of Quality and Clinical Assurance	C	Continue to involve staff at all levels in nursing policy development
Principles for determining nursing staffing requirements - Recommendations for registered nurses in charge of individual wards or shifts		**Principles for determining nursing staffing requirements -** Recommendations for registered nurses in charge of individual wards or shifts who should be responsible for assessing the various factors used to determine nursing staff requirements								
	1.2.1	Use systematic approach to determining nursing staff requirements when setting nursing establishments and on day to day	M	Professional judgement and SNCT embedded for use within the Trust. Clear 'established levels' identified on eRoster	C	Continue to support staff at local ward level to understand establishments and staffing models	Maintain	DHN/Matrons/Ward Leaders	C	Continue to support staff at local ward level to understand establishments and staffing models. Staffing hub has strengthened the understanding of staff at different levels
	1.2.2	Use a decision support toolkit endorsed by NICE to determine nursing staff requirements		Not yet available through NICE but UHS already uses nationally validated Safer Nursing Care Tool (SNCT) as part of methodology for reviewing staffing levels	C	Review NICE endorsed tools as they emerge	Continuous review of emerging national guidance	DDoN	C	Review NICE endorsed tools as they emerge. Continue to use endorsed SNCT and incorporate into safe care module.
	1.2.3	Use informed professional judgement to make a final assessment of nursing staff requirements	M	Professional judgement used as mainstay of methodology for reviewing establishments and day to day staffing	C	Continue to support staff at local ward level to understand establishments and staffing models	Maintain	DHN/Matrons/Ward Leaders	C	Continue to support staff at local ward level to understand establishments and staffing models. Stregnthened through the staffing hub
	1.2.4	Consider using nursing care activities included in guidance as a prompt to help inform professional judgement (see separate tab)	C	Already considered routinely as part of professional judgement and methodology	C	Continue to support staff at local ward level to understand establishments and staffing models	Maintain	DHN/Matrons/Ward Leaders	C	Continue to support staff at local ward level to understand establishments and staffing models
ior registered nurses responsible for 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
				Methodologies not previously		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. reviewed as a metric in the staffing hub

Setting the ward nursing staff establishment - Recommendations for sen determining nursing staff requirements or those involved in setting	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	based on nursing hours per patient but safe nursing care tool and professional judgement	A	Introduce next version of eRostering which has functionality to convert data into hours per patient	Maintain	DDoN/Workforce Systems	C	Safe care rollout complete
	1.3.3	Formally analyse the average nursing hours required per patient at least twice a year when reviewing the ward nursing staff establishments	S	Methodologies not previously based on nursing hours per patient but safe nursing care tool and professional judgement	A	Include nursing hours per patient as a methodology in the staffing reviews from November 2014	Maintain	DDoN/Workforce Systems	C	Care hours per patient day now embedded as part of monthly reporting and included in safecare module of eRoster. Used as part of 6 monthly review from July 2016
	1.3.4	Multiply the average number of nursing hours per patient by the average daily bed utilisation	S	Methodologies currently based on using 100% bed occupancy - bed utilisation considered as part of the professional judgement	A	Introduce bed utilisation into the staffing review methodology for November 2014	Maintain	DDoN/Workforce Systems	C	Bed utilisation discussed as part of the staffing review sonce July - Sept 2015 particularly in admission areas. Continue to calculate on 100% bed occupancy
	1.3.5	Add an allowance for additional nursing workload based on the relevant ward factors such as turnover, layout and size and staff factors	S	Already included in professional judgment considerations	C	Continued consideration at establishment reviews	Maintain	DDoN/DHN	C	Continued consideration at establishment reviews
	1.3.6	Identify appropriate knowledge and nursing skill mix required - registered to unregistered - reviewing appropriate delegation	S	Trust baseline registered: unregistered 60:40 - no inpatient ward establishment drop below this. Assessed as part of professional judgement	C	Continued consideration at establishment reviews	Maintain	DDoN/DHN	C	Continued consideration at establishment reviews
	1.3.7 and 1.3.8	Ensure planned uplift included in the calculation on average patients nursing needs	S	Trust baseline to include 23% on all ward establishments to cover uplift. Additional 0.8 wte uplift being rolled out for supervisory ward leader model	C	Continued consideration at establishment reviews. Continued monitoring of 23% headroom through eRostering	Maintain	DDoN/DHN	C	Continued consideration at establishment reviews. Continued monitoring of 23% headroom through eRostering
Assessing if nursing staff available on the day meet patients' nursing needs - Recommendations for registered nurses on wards	**Assessing if nursing staff available on the day meet patients' nursing needs -** Recommendations for registered nurses on wards who are in charge of shifts									
	1.4.1	Systematically assess that the available nursing staff for each shift or at least each 24 hour period is adequate to meet the actual nursing needs of patients on the ward	S	Daily spreadsheet used in site to review safe staffing - Matrons expected to link with all wards to determine staffing levels	C	Continued review of staffing levels included as a key responsibility in the ward leader and matron role	Maintain	Ward Leaders/ Matrons/ DHN	C	Continued review of staffing levels included as a key responsibility in the ward leader and matron role. Oversight from the staffing hub now enhancing the 24 hr view
	1.4.2	Monitor the occurrence of the nursing red flag events throughout a 24hour period	M	Escalation processes in place through bleep-holders through to site. Matrons responsible for reviewing staffing daily and this should include red flags	A	Care groups/Divisions to develop processes for review, reporting and capture of red flags through escalation processes	Maintain	Ward Leaders/ Matrons/ DHN	C	Monitoring of red flags on ongoing basis and key metric considered at staffing hub huddles. Reflected in AER reporting
	1.4.3	If a nursing red flag occurs it should prompt an immediate escalation response by the registered nurse in charge - with potential to allocate additional nursing staff	M	Escalation processes in place through bleep-holders through to site. Matrons responsible for reviewing staffing daily and this should include red flags	A	Care groups/Divisions to develop processes for review, reporting and capture of red flags through escalation processes	Maintain	Ward Leaders/ Matrons/ DHN	C	Monitoring of red flags on ongoing basis. Reflected in AER reporting and noted in bleep-holder logs
	1.4.4	Keep records of the on-the-day assessments of actual nursing staff requirements and reported red flag events so that they can be used to inform future planning or establishments	M	Escalation processes in place through bleep-holders through to site. Matrons responsible for reviewing staffing daily and this should include red flags	A	Care groups/Divisions to develop processes for review, reporting and capture of red flags through escalation processes	Maintain	Ward Leaders/ Matrons/ DHN	C	On the day records maintained and all red flag events captured through AER. Information used as part of the annual staffing reviews for each area to inform establishment changes. Examples at budget setting of changes as a result.
Monitor & evaluate ward nursing establishments - Recommendations for senior management and matrons	**Monitor and evaluate ward nursing staff establishments -** Recommendations for senior management and nursing managers or matrons to support safe staffing for nursing at ward level									
	1.5.1	Monitor whether the ward nursing staff establishment adequately meets patients nursing needs using safe nursing indicators. Consider continuous data collection of these nursing indicators	S	Majority of safe nursing indicators already included as part of the clinical quality dashboard	A	Expand the clinical quality dashboard to include the identified safe nursing indicators	Maintain	DHN/DDoN/Head of Quality and Clinical Assurance	C	Clinical Quality Dashboard reviewed and relaunched September 2015. Review of indicators included as part of clinical accreditation scheme completed
	1.5.2	Compare results of safe nursing indicators with previous results over 6 month period	S	Review as part of monitoring of clinical quality dashboard	A	Include review of safe nursing indicators as part of staffing reviews from 2015 onwards	Maintain	Matrons	C	Review of indicators included as part of clinical accreditation scheme and annual matron reviews completed
	1.5.3	Monitor all of the nursing red flags and safe nursing indicators linked to wards exceeding 1 RN to 8 patients during the day	S	1:8 indicator included in daily staffing spreadsheet as a trigger to review staffing	A	Matrons to review all safe nursing indicators routinely for all ward areas	Maintain	Matrons	C	Matrons review all safe nursing indicators routinely for all ward areas. Retrospective review of red flag/AER incidents included as part of staffing discussions.

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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 at midnight

					Finance budgeted			Staffing Numbers						Planned on Template (long day factor applied)		Actual demand average in Sep 2022 (In Safe Care)	Actual average in Sep 2022 (Calculated on actual hours provided and
Division	**Care Group**	**Unit Name**	**Shift**	**Total Beds**	**Budgeted Nursing (WTE)**	**Budgeted Registered Staff (WTE)**	**Budgeted Unregistered Staff (WTE)**	**Demand Registered (Count)**	**Demand Unregistered (Count)**	**Total nurse per shift**	**Skill Mix (RN:URN)**	**Patients RN Ratio (RN: Patient)**	**Patients Nursing Ratio (Total Nurse: Patient)**	**Total Planned CHPPD**	**Safe care**	**Total Actual Demand CHPPD**	**Total Actual CHPPD**
Division A	Surgery	SUR Acute Surgical Admissions	Early	30	39.1	19.7	19.4	6	3	9	67 : 33	1 : 5	1 : 4	6.7	5.38	7.7	6.7
		SUR Acute Surgical Admissions	Late	30				6	2	8	75 : 25	1 : 5	1 : 4				
		SUR Acute Surgical Admissions	Night	30				3	3	6	50 : 50	1 : 10	1 : 5				
		SUR Acute Surgical Unit	Early	12	24.6	13.8	10.8	3	2	5	59 : 41	1 : 5	1 : 3	12.4	9.96	6.4	12.4
		SUR Acute Surgical Unit	Late	12				4	1	5	80 : 20	1 : 3	1 : 3				
		SUR Acute Surgical Unit	Night	12				2	3	5	40 : 60	1 : 6	1 : 3				
		SUR E8 Ward	Early	26	54.5	30.9	23.7	7	4	11	64 : 36	1 : 4	1 : 3	7.7	8.60	7.2	7.7
		SUR E8 Ward	Late	26				7	4	11	64 : 36	1 : 4	1 : 3				
		SUR E8 Ward	Night	26				5	4	9	57 : 43	1 : 6	1 : 3				
		SUR E5 Lower GI	Early	18	28.2	18.7	9.5	4	2	6	66 : 34	1 : 5	1 : 4	7.2	6.08	61.0	7.2
		SUR E5 Lower GI	Late	18				4	2	6	67 : 33	1 : 5	1 : 3				
		SUR E5 Lower GI	Night	18				2	2	4	50 : 50	1 : 9	1 : 5				
		SUR E5 Upper GI	Early	18	28.6	16.1	12.5	4	3	7	58 : 42	1 : 5	1 : 3	8.2	6.32	8.5	8.2
		SUR E5 Upper GI	Late	18				3	2	5	60 : 40	1 : 6	1 : 4				
		SUR E5 Upper GI	Night	18				2	2	4	52 : 48	1 : 9	1 : 5				
		SUR F11 IF	Early	17	30.3	21.3	9.0	4	2	6	67 : 33	1 : 5	1 : 3	7.6	7.08	10.1	7.6
		SUR F11 IF	Late	17				4	2	6	67 : 33	1 : 5	1 : 3				
		SUR F11 IF	Night	17				3	2	5	60 : 40	1 : 6	1 : 4				
		SUR F5 Ward	Early	28	37.0	20.4	16.6	5	3	8	63 : 38	1 : 6	1 : 4	6.1	5.29	6.7	6.1
		SUR F5 Ward	Late	28				5	2	7	71 : 29	1 : 6	1 : 4				
		SUR F5 Ward	Night	28				3	2	5	63 : 37	1 : 9	1 : 6				
	Emergency Care	ECM Acute Medical Unit	Early	60	144.5	81.7	62.9	10	10	20	50 : 50	1 : 6	1 : 4	11.9	14.28	9.6	11.9
		ECM Acute Medical Unit	Late	60				11	11	22	50 : 50	1 : 6	1 : 3				
		ECM Acute Medical Unit	Night	60				12	10	22	54 : 46	1 : 6	1 : 3				
	Cancer Care	CAN C4 Solent Ward Clinical Oncology	Early	23	39.3	23.6	15.7	5	3	8	63 : 37	1 : 5	1 : 3	8.6	6.36	7.9	8.6
		CAN C4 Solent Ward Clinical Oncology	Late	23				5	3	8	62 : 38	1 : 5	1 : 3				
		CAN C4 Solent Ward Clinical Oncology	Night	23				3	2	5	60 : 40	1 : 8	1 : 5				
		CAN C6 Leukaemia/BMT Unit	Early	21	47.0	38.6	8.4	8	0	8	95 : 5	1 : 3	1 : 3	8.8	7.50	6.6	8.8
		CAN C6 Leukaemia/BMT Unit	Late	21				8	0	8	95 : 5	1 : 3	1 : 3				
		CAN C6 Leukaemia/BMT Unit	Night	21				6	0	6	100 : 0	1 : 4	1 : 4				
		CAN C6 TYA Unit	Early	6	17.0	15.5	1.5	3	1	4	78 : 22	1 : 2	1 : 2	9.6	12.18	6.7	9.6
		CAN C6 TYA Unit	Late	6				3	1	4	73 : 27	1 : 3	1 : 2				
		CAN C6 TYA Unit	Night	6				2	0	2	100 : 0	1 : 4	1 : 4				
		CAN C2 Haematology	Early	27	56.1	39.4	16.7	7	3	10	70 : 30	1 : 4	1 : 3	8.1	7.70	8.2	8.1
		CAN C2 Haematology	Late	27				7	3	10	70 : 30	1 : 4	1 : 3				
		CAN C2 Haematology	Night	27				5	3	8	63 : 38	1 : 6	1 : 4				
		CAN D3 Ward	Early	22	34.6	21.6	13.0	5	3	8	63 : 38	1 : 5	1 : 3	8.0	6.57	8.1	8.0
		CAN D3 Ward	Late	22				5	2	7	71 : 29	1 : 5	1 : 4				
		CAN D3 Ward	Night	22				3	2	5	60 : 40	1 : 8	1 : 5				
Division B	Medicine	MED D5 Ward	Early	28	38.7	19.0	19.7	4	5	9	44 : 56	1 : 7	1 : 4	6.2	5.72	7.5	6.2
		MED D5 Ward	Late	28				3	4	7	43 : 57	1 : 10	1 : 4				
		MED D5 Ward	Night	28				3	3	6	50 : 50	1 : 10	1 : 5				
		MED D6 Ward	Early	24	39.3	14.6	24.7	3	5	8	38 : 63	1 : 8	1 : 3	6.5	6.18	6.2	6.5
		MED D6 Ward	Late	24				3	3	6	50 : 50	1 : 8	1 : 4				
		MED D6 Ward	Night	24				3	3	6	49 : 51	1 : 9	1 : 5				
		MED D7 Ward	Early	16	23.7	12.0	11.7	2	3	5	41 : 59	1 : 8	1 : 4	6.9	7.45	6.5	6.9
		MED D7 Ward	Late	16				2	3	5	40 : 60	1 : 8	1 : 4				
		MED D7 Ward	Night	16				2	3	5	40 : 60	1 : 8	1 : 4				
		MED D8 Ward	Early	24	34.0	14.7	19.3	3	5	8	39 : 61	1 : 8	1 : 4	5.9	6.13	6.9	5.9
		MED D8 Ward	Late	24				3	3	6	51 : 49	1 : 8	1 : 5				
		MED D8 Ward	Night	24				3	3	6	50 : 50	1 : 8	1 : 4				
		MED D9 Ward	Early	28	40.3	19.0	21.3	4	5	9	44 : 56	1 : 7	1 : 4	5.5	5.67	6.4	5.5
		MED D9 Ward	Late	28				3	4	7	43 : 57	1 : 10	1 : 4				
		MED D9 Ward	Night	28				3	3	6	50 : 50	1 : 10	1 : 5				
		MED D10 Isolation Unit	Early	18	31.0	13.7	17.3	3	4	7	44 : 56	1 : 6	1 : 3	7.1	6.98	6.4	7.1
		MED D10 Isolation Unit	Late	18				3	3	6	52 : 48	1 : 6	1 : 3				
		MED D10 Isolation Unit	Night	18				2	2	4	50 : 50	1 : 9	1 : 5				
		MED E7 Ward	Early	26	33.4	14.7	18.7	3	4	7	43 : 57	1 : 9	1 : 4	6.3	6.25	9.5	6.3
		MED E7 Ward	Late	26				3	3	6	49 : 51	1 : 9	1 : 5				
		MED E7 Ward	Night	26				2	2	4	48 : 52	1 : 13	1 : 7				
		MED F7 Ward	Early	20	31.3	15.0	16.3	2	4	6	33 : 67	1 : 10	1 : 4	5.5	5.92	8.4	5.5
		MED F7 Ward	Late	20				2	3	5	39 : 61	1 : 10	1 : 4				
		MED F7 Ward	Night	20				2	2	4	50 : 50	1 : 10	1 : 5				
		MED G5 Ward	Early	28	37.5	14.6	22.9	4	4	8	50 : 50	1 : 7	1 : 4	5.6	5.32	12.4	5.6
		MED G5 Ward	Late	28				4	4	8	50 : 50	1 : 7	1 : 4				
		MED G5 Ward	Night	28				3	2	5	60 : 40	1 : 10	1 : 6				
		MED G6 Ward	Early	26	36.9	14.6	22.3	4	4	8	50 : 50	1 : 7	1 : 4	5.5	5.75	9.3	5.5
		MED G6 Ward	Late	26				4	4	8	50 : 50	1 : 7	1 : 4				
		MED G6 Ward	Night	26				3	2	5	60 : 40	1 : 9	1 : 6				
		MED G7 Ward	Early	14	32.3	12.4	19.9	2	3	5	40 : 60	1 : 7	1 : 3	8.3	6.94	7.5	8.3
		MED G7 Ward	Late	14				2	2	4	50 : 50	1 : 7	1 : 4				
		MED G7 Ward	Night	14				2	2	4	50 : 50	1 : 7	1 : 4				
		MED G8 Ward	Early	26	37.5	14.6	22.9	4	4	8	50 : 50	1 : 7	1 : 4	5.6	5.38	8.2	5.6
		MED G8 Ward	Late	26				4	4	8	50 : 50	1 : 7	1 : 4				
		MED G8 Ward	Night	26				3	2	5	60 : 40	1 : 9	1 : 6				
		MED G9 Ward	Early	26	32.7	15.5	17.3	4	4	8	50 : 50	1 : 7	1 : 4	5.5	5.72	7.9	5.5
		MED G9 Ward	Late	26				4	4	8	50 : 50	1 : 7	1 : 4				
		MED G9 Ward	Night	26				3	2	5	61 : 39	1 : 9	1 : 6				
		MED Bassett Ward	Early	26	43.0	17.6	25.4	3	6	9	33 : 67	1 : 9	1 : 3	6.3	6.81	11.5	6.3
		MED Bassett Ward	Late	26				3	5	8	38 : 63	1 : 9	1 : 4				
		MED Bassett Ward	Night	26				3	4	7	43 : 57	1 : 9	1 : 4				
		MED C5 Isolation Ward	Early	14	27.6	12.9	14.7	3	3	6	50 : 50	1 : 5	1 : 3	9.3	8.58	6.9	9.3
		MED C5 Isolation Ward	Late	14				3	3	6	50 : 50	1 : 5	1 : 3				
		MED C5 Isolation Ward	Night	14				3	1	4	75 : 25	1 : 5	1 : 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 at midnight
					Finance budgeted			Staffing Numbers							Planned on Template (long day factor applied)		Actual demand average in Sep 2022 (In Safe Care)	Actual average in Sep 2022 (Calculated on actual hours provided and
Division	**Care Group**	**Unit Name**	**Shift**	**Total Beds**	**Budgeted Nursing (WTE)**	**Budgeted Registered Staff (WTE)**	**Budgeted Unregistered Staff (WTE)**	**Demand Registered (Count)**	**Demand Unregistered (Count)**	**Total nurse per shift**	**Skill Mix (RN:URN)**	**Patients RN Ratio (RN: Patient)**	**Patients Nursing Ratio (Total Nurse: Patient)**	**Total Planned CHPPD**	**Safe care**	**Total Actual Demand CHPPD**	**Total Actual CHPPD**
Division C	Child Health	CHI Paed Medical Unit	Early	22	56.2	39.1	17.1	5	2	7	71 : 29	1 : 5	1 : 4	14.7	10.09	10.7	14.7
		CHI Paed Medical Unit	Late	22				5	2	7	71 : 29	1 : 5	1 : 4				
		CHI Paed Medical Unit	Night	22				5	2	7	72 : 28	1 : 5	1 : 4				
		CHI Piam Brown Unit	Early	12	41.0	40.0	1.0	13	3	16	82 : 18	1 : 1	1 : 1	14.9	14.92	11.5	14.9
		CHI Piam Brown Unit	Late	12				5	2	7	71 : 29	1 : 3	1 : 2				
		CHI Piam Brown Unit	Night	12				4	2	6	67 : 33	1 : 3	1 : 2				
		CHI Ward E1 Paed Cardiac	Early	16	37.7	27.6	10.1	6	2	7	77 : 23	1 : 3	1 : 3	8.7	7.34	9.5	8.7
		CHI Ward E1 Paed Cardiac	Late	16				5	2	7	75 : 25	1 : 4	1 : 3				
		CHI Ward E1 Paed Cardiac	Night	16				4	1	5	80 : 20	1 : 5	1 : 4				
		CHI Ward G2 Neuro	Early	6	12.6	12.6	0.0	2	2	4	50 : 50	1 : 3	1 : 2	8.4	17.97	9.7	8.4
		CHI Ward G2 Neuro	Late	6				2	2	4	50 : 50	1 : 3	1 : 2				
		CHI Ward G2 Neuro	Night	6				2	2	4	49 : 51	1 : 4	1 : 2				
		CHI Ward G3	Early	20	46.2	31.6	14.6	6	4	10	60 : 40	1 : 4	1 : 3	9.8	11.02	9.0	9.8
		CHI Ward G3	Late	20				6	4	10	60 : 40	1 : 4	1 : 3				
		CHI Ward G3	Night	20				5	3	8	63 : 38	1 : 4	1 : 3				
		CHI Ward G4 Surgery	Early	18	53.7	38.6	15.1	6	3	9	68 : 32	1 : 3	1 : 2	9.7	13.77	12.4	9.7
		CHI Ward G4 Surgery	Late	18				6	3	9	68 : 32	1 : 3	1 : 2				
		CHI Ward G4 Surgery	Night	18				5	2	7	72 : 28	1 : 4	1 : 3				
	Women & Newborn	W&N Bramshaw Womens Unit	Early	18	28.8	17.6	11.2	3	2	5	62 : 38	1 : 6	1 : 4	8.3	6.05	4.7	8.3
		W&N Bramshaw Womens Unit	Late	18				3	2	5	62 : 38	1 : 6	1 : 4				
		W&N Bramshaw Womens Unit	Night	18				2	2	4	54 : 46	1 : 9	1 : 5				
	Cardiovascular and Thoracic	CAR Coronary Care Unit	Early	22	62.5	42.8	19.7	7	2	10	74 : 26	1 : 4	1 : 3	14.0	9.87	7.6	14.0
		CAR Coronary Care Unit	Late	22				7	2	9	74 : 26	1 : 4	1 : 3				
		CAR Coronary Care Unit	Night	22				7	3	10	74 : 26	1 : 4	1 : 3				
		CAR Ward D4 Vascular	Early	22	43.3	22.4	21.0	5	3	8	62 : 38	1 : 5	1 : 3	7.5	7.52	8.0	7.5
		CAR Ward D4 Vascular	Late	22				5	3	8	62 : 38	1 : 5	1 : 3				
		CAR Ward D4 Vascular	Night	22				3	3	6	51 : 49	1 : 8	1 : 4				
		CAR Ward E2 YACU	Early	17	31.5	19.9	11.5	4	2	6	67 : 33	1 : 5	1 : 3	7.7	7.21	7.1	7.7
		CAR Ward E2 YACU	Late	17				4	2	6	68 : 32	1 : 5	1 : 3				
		CAR Ward E2 YACU	Night	17				2	2	4	51 : 49	1 : 9	1 : 5				
		CAR Ward E3 Green	Early	24	39.6	25.8	13.8	4	4	8	49 : 51	1 : 6	1 : 3	6.4	6.05	8.2	6.4
		CAR Ward E3 Green	Late	24				4	3	7	60 : 40	1 : 6	1 : 4				
		CAR Ward E3 Green	Night	24				2	3	5	41 : 59	1 : 12	1 : 5				
		CAR Ward E3 Blue	Early	18	32.5	15.9	16.6	4	3	7	58 : 42	1 : 5	1 : 3	7.6	6.62	8.5	7.6
		CAR Ward E3 Blue	Late	18				4	2	6	68 : 32	1 : 5	1 : 3				
		CAR Ward E3 Blue	Night	18				2	2	4	52 : 48	1 : 9	1 : 5				
		CAR Ward E4 Thoracics	Early	20	37.6	22.4	15.2	4	3	7	55 : 45	1 : 5	1 : 3	7.5	7.67	7.0	7.5
		CAR Ward E4 Thoracics	Late	20				4	3	8	55 : 45	1 : 5	1 : 3				
		CAR Ward E4 Thoracics	Night	20				4	2	6	69 : 31	1 : 6	1 : 4				
		CAR Ward D2 Cardiology	Early	15	29.5	12.9	16.6	3	2	5	61 : 39	1 : 5	1 : 3	8.0	7.00	12.9	8.0
		CAR Ward D2 Cardiology	Late	15				3	2	5	61 : 39	1 : 5	1 : 3				
		CAR Ward D2 Cardiology	Night	15				2	2	4	51 : 49	1 : 8	1 : 4				
Division D	Neurosciences	NEU Acute Stroke Unit	Early	28	61.8	22.7	39.1	4	7	11	36 : 64	1 : 7	1 : 3	7.8	7.85	8.6	7.8
		NEU Acute Stroke Unit	Late	28				4	7	11	36 : 64	1 : 7	1 : 3				
		NEU Acute Stroke Unit	Night	28				3	5	8	38 : 63	1 : 10	1 : 4				
		NEU HASU	Early	13	32.6	25.3	7.3	4	1	5	81 : 19	1 : 4	1 : 3	10.6	11.50	10.0	10.6
		NEU HASU	Late	13				4	1	5	81 : 19	1 : 4	1 : 3				
		NEU HASU	Night	13				4	1	5	80 : 20	1 : 4	1 : 3				
		NEU Regional Transfer Unit	Early	10	25.9	16.3	9.7	3	1	4	77 : 23	1 : 4	1 : 3	16.7	9.08	7.6	16.7
		NEU Regional Transfer Unit	Late	10				3	1	4	76 : 24	1 : 4	1 : 3				
		NEU Regional Transfer Unit	Night	10				2	2	4	50 : 50	1 : 5	1 : 3				
		NEU Ward D Neuro	Early	27	61.0	28.8	32.2	5	5	10	50 : 50	1 : 6	1 : 3	8.0	7.96	7.8	8.0
		NEU Ward D Neuro	Late	27				5	5	10	50 : 50	1 : 6	1 : 3				
		NEU Ward D Neuro	Night	27				4	5	9	45 : 55	1 : 7	1 : 4				
		NEU Ward E Neuro	Early	26	47.6	28.8	18.9	5	3	8	63 : 38	1 : 6	1 : 4	8.5	7.30	8.5	8.5
		NEU Ward E Neuro	Late	26				5	3	8	63 : 38	1 : 6	1 : 4				
		NEU Ward E Neuro	Night	26				4	3	7	57 : 43	1 : 7	1 : 4				
		SPI Ward F4 Spinal	Early	22	41.6	22.7	18.9	4	3	7	57 : 43	1 : 6	1 : 4	7.9	6.89	8.4	7.9
		SPI Ward F4 Spinal	Late	22				4	3	7	57 : 43	1 : 6	1 : 4				
		SPI Ward F4 Spinal	Night	22				3	3	6	50 : 50	1 : 8	1 : 4				
	Trauma & Orthopaedics	T&O Ward Brooke	Early	18	36.1	16.6	19.5	3	3	6	50 : 50	1 : 6	1 : 3	6.9	5.55	13.7	6.9
		T&O Ward Brooke	Late	18				3	3	6	50 : 50	1 : 6	1 : 3				
		T&O Ward Brooke	Night	18				2	3	5	41 : 59	1 : 9	1 : 4				
		T&O Trauma Admissions Unit	Early	8	26.5	13.2	13.4	2	2	4	50 : 50	1 : 4	1 : 2	17.3	11.55	7.5	17.3
		T&O Trauma Admissions Unit	Late	8				2	2	4	50 : 50	1 : 4	1 : 2				
		T&O Trauma Admissions Unit	Night	8				2	2	4	50 : 50	1 : 4	1 : 2				
		T&O Ward F1 Major Trauma Unit	Early	32	65.5	34.9	30.6	6	5	11	55 : 45	1 : 6	1 : 3	8.6	7.78	9.6	8.6
		T&O Ward F1 Major Trauma Unit	Late	32				6	5	11	55 : 45	1 : 6	1 : 3				
		T&O Ward F1 Major Trauma Unit	Night	32				5	5	10	50 : 50	1 : 7	1 : 4				
		T&O Ward F2 Trauma	Early	26	52.9	22.7	30.2	4	5	9	44 : 56	1 : 7	1 : 3	7.9	7.29	10.0	7.9
		T&O Ward F2 Trauma	Late	26				4	5	9	44 : 56	1 : 7	1 : 3				
		T&O Ward F2 Trauma	Night	26				3	4	7	43 : 57	1 : 9	1 : 4				
		T&O Ward F3 Trauma	Early	24	52.9	22.7	30.2	4	6	10	40 : 60	1 : 6	1 : 3	8.9	8.37	11.2	8.9
		T&O Ward F3 Trauma	Late	24				4	5	9	44 : 56	1 : 6	1 : 3				
		T&O Ward F3 Trauma	Night	24				3	5	8	38 : 63	1 : 8	1 : 3				
		T&O Ward F4 Elective	Early	18	32.9	18.3	14.6	4	2	6	66 : 34	1 : 5	1 : 4	6.7	6.96	7.5	6.7
		T&O Ward F4 Elective	Late	18				3	2	5	60 : 40	1 : 6	1 : 4				
		T&O Ward F4 Elective	Night	18				2	3	5	40 : 60	1 : 9	1 : 4				

Specific Divisional issues emerging - Ward Staffing Review 2022

Division A

With recent uplifts the established staffing levels are now appropriate in the majority of wards (excepting F5) for the level and acuity of patients in Division A.

Skill mix remains an issue and therefore investment and support into the education teams currently is key.

It has been noted that all areas have seen an increase in both acuity & dependency and additionally an increase in patients presenting with Mental Health conditions requiring 1:1 nursing.

Areas to be put forward at budget setting post 2022 review – Division A:

F5 have a slightly lower nurse/patient ratio than other surgical wards and this will need a review based on the acuity of patients (major ENT ops).

It was decided that the request for a transfer team for ASU should be removed as this was felt not to be the best solution, future considerations will include an increase in footprint to accommodate new direct pathways which would require an increase in WTE.

It is worth noting that the SDU (Surgical Day Unit) is currently funded for 6 overnight inpatient beds. This unit has been running with 18+ overnight patients consistently for the past 6 months (and at times 24pts). This is currently staffed by bank/agency. The unit is undergoing a review and the future use may change. If it is decided to accommodate an increased number of inpatients on a permanent basis this will require extra funding for a substantive workforce.

Division B

Medicine care group have adjusted staffing numbers to reflect the changes associated with decentralisation of covid out of the MOP footprint. This has been managed at a local level and not reflected in budget requests.
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 have had an uplift of band 4 posts to band 5 across all areas.

Alongside this, establishments have been realigned to reflect a standard approach to allocation of B4 nursing associates across the care group as an approach to support our ongoing pipeline for registered nurses. The care group is also seeing the benefit from the uplift in 2021/22 budget:

- 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

Going forward Medicine are going to see an increase of 24 beds linked to the new ward build due to be completed in summer 2023.

Cancer care continues to see a sustained increase in acuity across their wards and continue to recruit to the below posts funded through budget setting 2022/23:

- Band 7 post on TYA and 1 x B5, 1 B6 and 0.5 HCA

- C4 - 2 x B5, 2 xB2
- D3 - 4.21 B2
- C6 - 0.6 x B2
- C7 1.4 B6 uplifted to band 7 and 2 x B5

Likely to see a further increase in acuity as CAR-T goes live, the nursing uplift for this has been approved through the CAR-T business case and recruitment due to start imminently. Going forward cancer care is going to see an increase of 2 beds linked to the new ward build due to be completed in summer 2023.

It should be noted that Division B have specifically seen a rise in episodes of violence and aggression within the clinical areas. Management of these incidents requires a responsive increased staffing level to protect both the staff and patients.

Areas to be put forward at budget setting post 2022 review – Division B:

Medicine/MOP
C5 staffing budget based on level 1 patient care but again due to covid, C5 has become a mixed L1/L2 facility to care for covid patients. .
If ongoing plan is to continue to use C5 in this capacity, staffing budget will need to reflect the uplift in RN ratio to maintain this.

Bassett opened originally as a 20 bedded MOP ward and staffing budget transferred from F7. Bassett has consistently used all 26 beds available since opening, and staffing increased to support this.
This uplift will need to reflected permanently in the staffing budget, as currently only recognised non-recurrently.

Medicine have been allocated 24 additional beds in the new ward build, due to open summer 2023. Request that staffing budget reflects the appropriate ratios for the size of the ward and the expected acuity of the patients.

Cancer Care

No current asks as a reflection of the approved CAR-T business case and substantial uplift from budget setting 2021/22.

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.

Budget has been provided 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 weekdays). In addition, SCH has had an uplift in E1 staffing to support 2 more HDU beds within the ward environment.

Areas to be put forward at budget setting post 2022 review – Division C:

G3 and Bramshaw (and PB) 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

All of division D budget establishments have required further in-depth review following the staffing establishment review meeting in August.

Previously the majority of established staffing levels have been appropriate for the level of acuity in all care groups. Despite some wards receiving budget uplifts this year, some budgets have become misaligned to required establishments, the reasons for this are multifaceted.
The divisional finance manager who was newly appointed this year, working with the DHN and the matrons, are realigning budgets with establishments, which will have some implications at budget setting for next year, particularly for CV&T.

Division D have continued to see additional pressures on staffing models in areas where the acuity and dependency continues to increase. The number of patients requiring enhanced care and specialist mental health nursing continues to increase and creates additional staffing pressures across all care groups.

F4 spines underwent a full establishment review. They are under pressure when they have more than one tetraplegic patient, as some require 1:1 care, at times over the past year they have had up to 6 at any one time. They have received additional therapy support and the team are supported to ensure staffing is safe at these times, but this breaches their normal staffing establishment.

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, reduction in the advanced practice cover and expertise, increasing capacity challenges and reducing skill mix are putting additional requirements on the bleep holder who cannot be released from practice to support.

This was not previously supported at budget setting and remains of real concern.

Areas to be put forward at budget setting post 2022 review – Division D:

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, due to the increase in pressures within ED and on patient flow out of hours this is now considered an essential requirement going forward.

CCU, CHDU (Cardiac High Dependency Unit) and D2 will require uplifts to their current budgets to maintain safe staffing levels following the realignment of budgets to required establishments. This is due to the increase in acuity and changes to pathways.

RCN Nursing Workforce Standards – May 2021

Overview

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Guardian of Safe Working Hours Quarterly Report November 2022**			
Agenda item:	**11**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Author:	**Dr Diana Hulbert** **Emergency Medicine Consultant & Guardian of Safe Working Hours**			
Date:	**29 November 2022**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** ✓
Issue to be addressed:	Exception Reporting continues to be both low risk and low cost to the Trust. Junior Doctor vacancy rate for November 2022 is currently at 6.2%; this equates to vacancies of 54 posts (including non-training fellows). The spend on internal bank for locums continues to be high, relating to covering both short-term vacancies and longer-term gaps in the rotas. The recent consultation around new locum rates for junior doctors has improved clarity around locum rates and identified departments which have significant challenges in recruitment and retention. Significant measures have been taken to improve UHS communication and facilitate future negotiation with the junior doctors. The provision of Self Development Time (SDT) is incompletely supported across the Trust.			
Response to the issue:	See main report.			

Implications: (Clinical, Organisational, Governance, Legal?)	There needs to be ongoing monitoring of exception reporting and appropriate support given to the Consultant Rota Leads. Additional support needs to be given to promote exception reporting across the medical workforce. Medical recruitment must remain a high priority for the Trust. There must be continued vigilance around rotas, sickness, and sustainability of junior doctor working patterns. Future negotiations which affect junior doctors need to involve this group at the earliest opportunity. Poor communication can lead misunderstandings on both sides. The junior doctors of today are part of the senior workforce of tomorrow, and I am optimistic that future working relationships will be positive and effective.
Risks: (Top 3) of carrying out the change / or not:	Risk of financial penalties if rota gaps/vacancies are not addressed. There is a risk of poor recruitment in the future if UHS is believed to underestimate the basic needs of junior doctors.
Summary: Conclusion and/or recommendation	The Board is invited to note the report and the concerns regarding work intensity, exception reporting, rota gaps, locum expenditure and the working lives of junior doctors. The next quarterly report will be submitted to Trust Board in January 2023

Executive Summary

Employment

There are 751 Junior Doctors in Training employed by the Trust and they all work on the 2016 contract (including lead employer hosted placements).

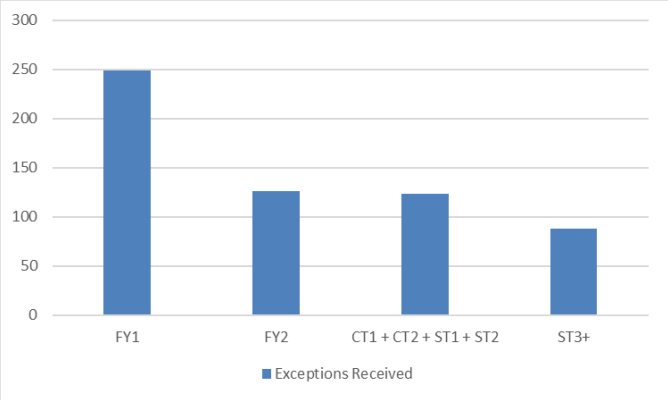
There are 375 Junior Doctors employed in non-training posts; all these doctors work on UHS local terms and conditions which mirror the 2016 contract

The current vacancy rate has reduced in November 22 to 6.2% which equates to 54 wte vacant posts. Recruitment continues for current vacancies and Medical HR are working with departments to plan for future gaps.

Exception reporting

Since August 2022 (the most recent junior doctor changeover) there have been 191 exception reports

The majority of exception reports are submitted by F1 and F2 doctors



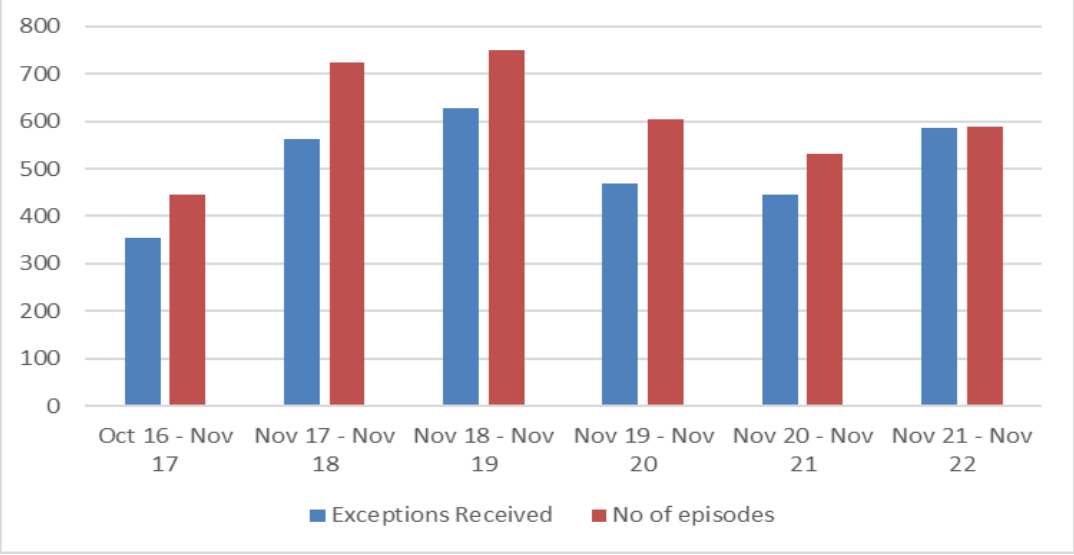
In total 2930 exception reports have been received at UHS since the implementation of the Junior Doctor Contract in October 2016.

The most common reason for the submission of an exception report is additional working hours and the most common resolution is additional payment for the additional hours worked.

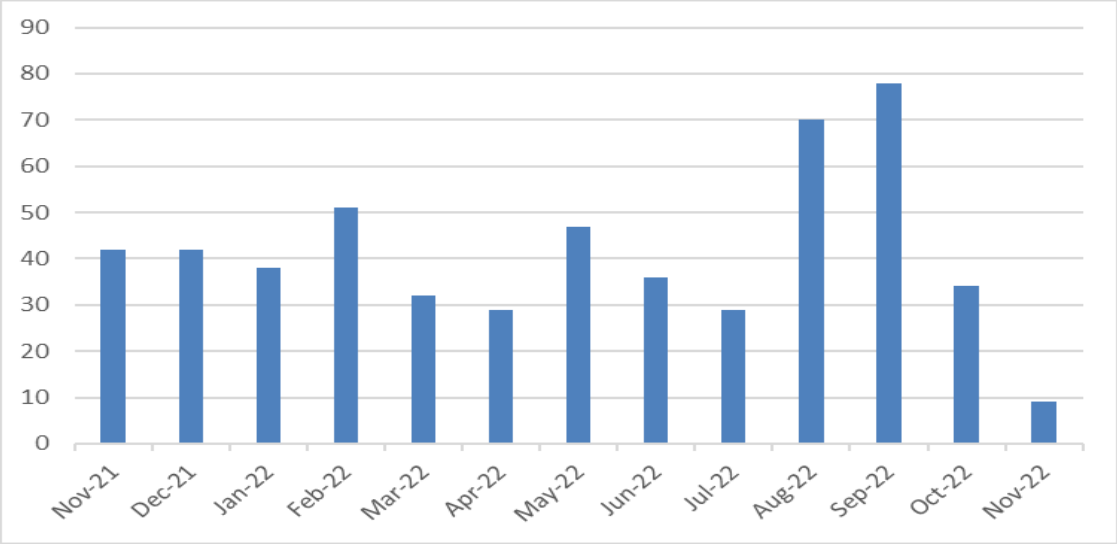
To date no exception report has been a breach incurring a financial penalty.

The cost of exception reporting to UHS continues to remain low.

Total exceptions and episodes received since implementation of contract:



Total exception reports received over last 12 months:



Self Development Time

All doctors in training and trust appointed are required to be given two hours of dedicated self development time (SDT) per week to complement that already available for training and is a requirement to be recorded in the doctors' work schedules.

To enable doctors to take SDT UHS encourages the use of the exception reporting mechanism to raise concerns when SDT has been missed on at least 25% of occasions over a 12-week period. This allows us to review and adjust rotas.

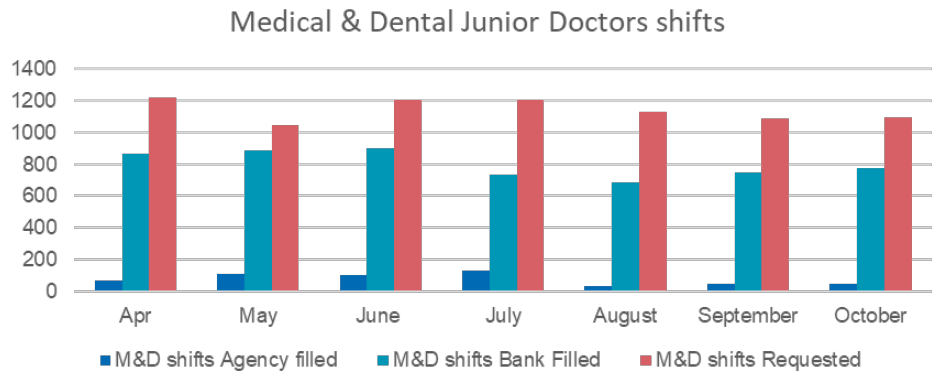
In the last 12 months we have only received 4 exception reports stating missed SDT.

	Exceptions Received	No of episodes
FY1	11	11
FY2	6	6
CT1 + CT2 + ST1 + ST2	1	1
ST3+	0	0

Medical Locum Bank

From the 1st July 2022, NHSP:Connect contract was ceased and all locum bank duties were processed through Medic OnLine and HealthRoster – software that was already procured and funded by UHS.
New pay rates were also implemented from September 2022.

Medical & Dental Junior Doctors shifts				
Month	Agency filled	Bank Filled	Requested	Bank fill %
Apr	72	863	1223	70.56
May	112	884	1048	84.35
June	102	901	1206	74.71
July	131	736	1207	60.98
August	34	687	1133	60.64
September	46	750	1090	68.81
October	48	774	1093	70.81



Activity summary

The Junior Doctor Executive Committee is led by the chief registrar and meets quarterly with increasing representation from across the specialties. This meeting brings together the Chief Registrar, the junior doctor representatives, the Mess presidents, the Guardian and the UHS Executive

The Junior Doctor Forum meets monthly and remains an informal method of communication between the junior doctors, the chief registrars, the Guardian and the Medical Workforce Team.

Dr Ahmed Daoud is the UHS Chief Registrar; he took up this post in August 2022 and will be with us for one year.

I aim to meet the rota leads and the workforce managers regularly to share good practice and discuss current issues in recruitment, retention and training.

The Guardian and Medical Workforce Team attend monthly Trust induction and are hoping to arrange to meet junior doctors in the Doctors' Mess with pizza on a monthly basis to answer questions and discuss improvements. The fluctuating course of the covid pandemic has rendered face to face meetings problematic,

Challenges

There are ongoing concerns over the issue of rota gaps in several areas of the hospital. The situation is unstable and small changes (such as annual leave) can reveal the fragility in the system.

Work intensity remains high and the impact of the covid pandemic, the beginning of recovery and the appearance of new variants has been significant.

In the last six months the impact of staff rather than patient sickness numbers has been huge, and rotas have been over-stretched. It is not only medical staff sickness that impacts medical rotas; shortages in other professional groups have a significant effect on junior doctor work patterns as the hospital becomes inefficient and medics take on tasks usually carried out by other members of the MDT. Of note the reduction of night cover by ACPs in a number of specialties (a consequence of workforce gaps) has significantly impacted the out of hours work burden for some junior doctors.

These problems are national; I am confident that the divisional management and executive teams are aware of these issues and seeking improvement plans.

Rota annualisation should help alleviate the problem of annual leave and the introduction of a new locum system should aid more efficient and timely coverage of short-term rota gaps.

Engagement with the exception reporting system remains variable; whilst it has highlighted some areas that need review, it is unlikely that this system reflects the true situation across the hospital. A true understanding of most of the areas of concern has come from direct discussion with the junior and senior clinicians in various departments rather more than through the exception reporting system.

There is an ongoing need to discuss the evolution of the workforce. Work is being carried out around the role of junior doctors, advanced nurse practitioners, physician assistants and a range of non-clinical roles.

The significant expenditure on locums suggests that a review of medical and non-medical staffing is required to increase our baseline staffing which should lead to a decrease in the locum spend.

An uplift in the workforce will need innovative solutions for staffing patterns and recruitment but would undoubtedly help retention.

The UHS locum rates change was to ensure greater transparency, more consistency and a closer equity between different specialties. UHS recognizes that there are some hard-pressed specialties including Emergency Medicine and Paediatrics and this is also now reflected in the locum pay rates. There was a concern that many junior doctors (particularly those in the hard-pressed specialties) would be paid less for locum shifts; this has largely not been the case. The way in which this was communicated to the junior medical workforce was less than ideal and there have now been a series of very positive meetings between Steve Harris (Chief People Officer), the BMA, the junior doctor BMA leads and various other colleagues.

UHS has taken on the concerns raised by several groups and there will be regular meetings between the junior doctors and members of the Executive. There is an absolute understanding that safety and risk will not be compromised and there will be close monitoring of both. The Trust understands that some shifts and some specialties require a higher pay rate, and this will be transparent.

In addition, a local price agreement with neighboring hospitals will be sought.

I am hopeful that these pay agreements will be successful and acceptable to all. There will be regular review of the agreements. It will be particularly important to review the needs of the most hard-pressed specialties by assessing the regularity with which exceptional payments are requested, the number of unfilled locums and the number of exception reports.

In addition to the challenges of providing rotas which are sustainable and promote high quality work alongside an attractive life/work balance there are other issues that are important to the junior doctor workforce. These issues are the subject of the work that I do with the Junior doctors, the Chief Registrar, the Medical Workforce Team led by Becci Mannion, the Executive and other colleagues.

The concerns include communication and representation, provision of non-clinical space, the availability of reasonably priced hot meals overnight, free tea and coffee and the presence of sleep rooms after night shifts.

We are introducing a new sleep room provision method and I am optimistic that this will be successful.

There is a piece of work which will scope the office space available to junior doctors which we hope to review in December.

Recruitment of junior doctors at UHS is based on many factors. We know that feeling valued is important and I am convinced that the apparently small things matter.

A junior doctor embarks on a new career in an unfamiliar city (sometimes in an unfamiliar country) in a big Trust where she or he knows no one, is working a shift system and only has four months to understand, assimilate and succeed before moving on. It is the provision of support in all its forms that determines the ability to thrive. We are determined to ensure that the building blocks for a successful junior doctor workforce are in place in UHS.

Appendix 1: Summary of junior doctor training vacancies November 2022

Cost centre	No of posts	No of vacancies (November 2022)	Fill rate @ 7Nov22
Vascular Surgery	5	0	100%
Cardiothoracic Surgery	28	1	96.43%
Cardiology	43	3	93.02%
Neurology	20	1	95.00%
Neurosurgery	22	0	100.00%
Neurophysiology	2	0	100.00%
Spinal Surgery	3	0	100.00%
T&O	48	0	100.00%
Neonates	34	1	97.06%
O&G	32	0	100.00%
Paediatric Cardiology	14	0	100.00%
Paediatrics	60	3	95.00%
PICU	17	0	100.00%
Chemical Pathology	2	1	50.00%
Microbiology	10	1	90.00%
Histopathology	16	1	93.75%
Palliative Care	7	1	85.71%
Medical Oncology	20	4	80.00%
Haematology	19	0	100.00%
Clinical Oncology	15	0	100.00%
Dermatology	8	0	100.00%
General Medicine	10	1	90.00%
Endo/Diabetes	4	0	100.00%
Clinical Genetics	3	0	100.00%
Rheumatology	5	0	100.00%
GI Renal	23	4	82.61%
Allergy/Respiratory	23	3	86.96%
MOP	46	3	93.48%
Acute Med	20	5	75.00%
Acute Med OOH	6	0	100.00%
PHEM	3	1	66.67%
ED	69	9	86.96%
Anaesthetics	57	3	94.74%
GICU	37	1	97.30%
SHDU	9	0	100.00%
NICU	14	0	100.00%
CICU	12	0	100.00%
Ophthalmology	27	3	88.89%
ENT	13	0	100.00%
Urology	11	0	100.00%
OMFS	10	1	90.00%
General Surgery	44	3	93.18%
Total	**871**	**54**	**93.80%**

Report to the Trust Board of Directors				
Title:	**Learning from Deaths 2022-23 Quarter 2 Report**			
Agenda item:	**12**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Authors:	**Ellis Banfield, Associate Director of Patient Experience**			
Date:	**29 November 2022**			
Purpose:	**Assurance or reassurance** **x**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	This report ensures that mortality reporting in relation to deaths, reviews, investigations, and learning is regularly provided to the board. The report also provides an update on the development and effectiveness of the medical examiner service.			
Response to the issue:	**Summary** • Q2 deaths failing under medical examiner review have increased from previous year. • 99% of deaths reviewed by medical examiners were found to be not avoidable • 4 deaths were reviewed and found to be possibly or probably avoidable. • Most cases were deemed good care or better by the medical examiner review • HMSR still sits within the low range, but there has been an upwards trend in the reporting period.			
Implications:	The National Guidance on Learning from Deaths sets out expectations that: *Boards must ensure robust systems are in place for recognising, reporting, reviewing, or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care. Providers should ensure such activities are adequately resourced.* This paper sets out a plan to meet these requirements more fully.			
Risks:	1. The Trust does not reduce avoidable deaths in our hospitals. 2. The Trust does not promote learning from deaths, including relating to avoidable deaths and good and poor quality of care. 3. The Trust does not promote an open and honest culture and support for the duty of candour.			
Summary:	This paper is provided for assurance.			

1. Introduction

In 2016 the CQC found that Trusts in England were unable to demonstrate best practice across all aspects of identifying, reviewing, and investigating deaths and capturing and actioning learning identified from these reviews. The CQC's report and recommendations was that mortality governance should be a key priority for Trust boards.

At UHS, IMEG was started in the Trust in September 2014 and has scrutinised all inpatient deaths since. Following national developments, the service has transitioned into the Medical Examiner Service, working to national guidelines, requirements, and expectations. Scrutiny starts with the electronic patient record's being reviewed by a Medical Examiners Officer (MEO) who looks at the pre-hospital care, presentation, and case history to be able to flag any potential issues to the Medical Examiner and identify cases for coronial referral. A doctor (of any grade) from a clinical team will come down and discuss the case with a trained Medical Examiner (ME) and offer a cause of death. This is either agreed upon or discussed further. If any further questions arise from the scrutiny or a potential issue is picked up the case will then be sent for an in-depth mortality review. These reviews can come in the form of questions directed to the speciality Morbidity and Mortality meeting, or presentation at Trust Mortality Review Group (TMRG) which is a multi-disciplinary and multi-professional group who follow the Structured Judgement Review (SJR) template, or an Urgent Case Review with the Patient Safety Team.

2. Analysis and Discussion

2.1 Total Deaths

Having seen a lower number of Q1 deaths compared to the previous two years, Q2 deaths have increased year-on-year as the table below illustrates:

Quarter	2022-23	2021-2022	2020-2021	2019-2020
Q1	578	504	564	606
Q2	653	429*	511	541
Q3		639*	529	589
Q4		531*	634	620
Total		2103	2,234	2,356

*Across Q2-Q4 the medical examiner service reviewed an additional 323 deaths from CMH & Oakhaven hospices

2.2 Mortality Reviews

In addition to medical examiner scrutiny other additional or more detailed levels of scrutiny may be applied. Some review processes are subject to national guidelines and directives such as the reviews for learning disability, paediatric and neonatal deaths. Others such as Morbidity & Mortality (M&M), Trust Mortality Review Group (TMRG) and serious adverse event case review are locally managed governance processes, although they may feed into other national reporting processes.

The table below lists the total number of case referrals from the medical examiner service into the additional and more detailed scrutiny groups:

Quarter	M&M	TMRG	Scoping	Paediatric	Neonates	LeDeR
Q1	15	n/a	2	17	3	1
Q2	19	n/a	7	-	-	2
Q3						
Q4						
Total	96	41	23	18	11	14

As the table makes clear, in addition to Medical Examiner scrutiny, Q2 saw:

- 19 deaths sent to sub-speciality Morbidity and Mortality groups (M&M) for further clarification / questions
- 7 cases were sent for a urgent serious adverse event Case review (commonly known as a scoping meeting within the Trust) with the Patient Safety Team because the reviewing medical examiner felt that death probably avoidable with different or better care
- 2 LeDer referrals were also made
- Information on paediatric and neonate reviews not available at time of writing

Most cases get assigned an initial avoidability and quality rating which then gets adjusted accordingly if they are sent for further review:

The table below outlines outcomes from Medical Examiner Service:

Avoidability	Q2	Q3	Q4	Q1	Q2
1. Definitely Avoidable			1		
2. Strong Evidence of Avoidability					
3. Probably Avoidable (>50:50)		1	1		2
4. Possible Avoidable (<50:50)		4		2	2
5. Slight Evidence of Avoidability	2	8	2	3	6
6. Definitely not avoidable	490	743	611	573	638
Quality of care					
1. Very Poor					
2. Poor care		1	2		2
3. Adequate Care	2	4	3	1	7
4. Good Care	491	743	611	575	617
5. Excellent Care	2		2	2	18
Not yet reviewed yet					

Deaths are also reviewed through 53 different subspecialty Morbidity and Mortality (M&M) meetings currently known of at the Trust. An appointment has been made for a new mortality coordinator post who will pull together identified learning from these M&M meetings into a central bulletin.

Avoidable deaths

Above, 2 deaths were reviewed and categorised as ‘possibly’ avoidable and 2 as ‘probably’ avoidable.

- Possibly avoidable case 1, medical examiner review felt death possibly avoidable but noted contributing factors of stroke, fall, frailty, and ultimately heart failure. Aspects of care could have been improved, namely better handover of x-ray results and case was referred to M&M for learning. The other case is at inquest following a coroner's post-mortem.

- Of the probably avoidable, both have gone to inquest following a coroner's post-mortem.

- Details of these cases will be provided in a future report once the inquests are completed

2.3 Paediatric and neonatal mortality review

Please note that paediatric and neonatal mortality data was not received in time for this report. Q2 data will be included in the Q3 report.

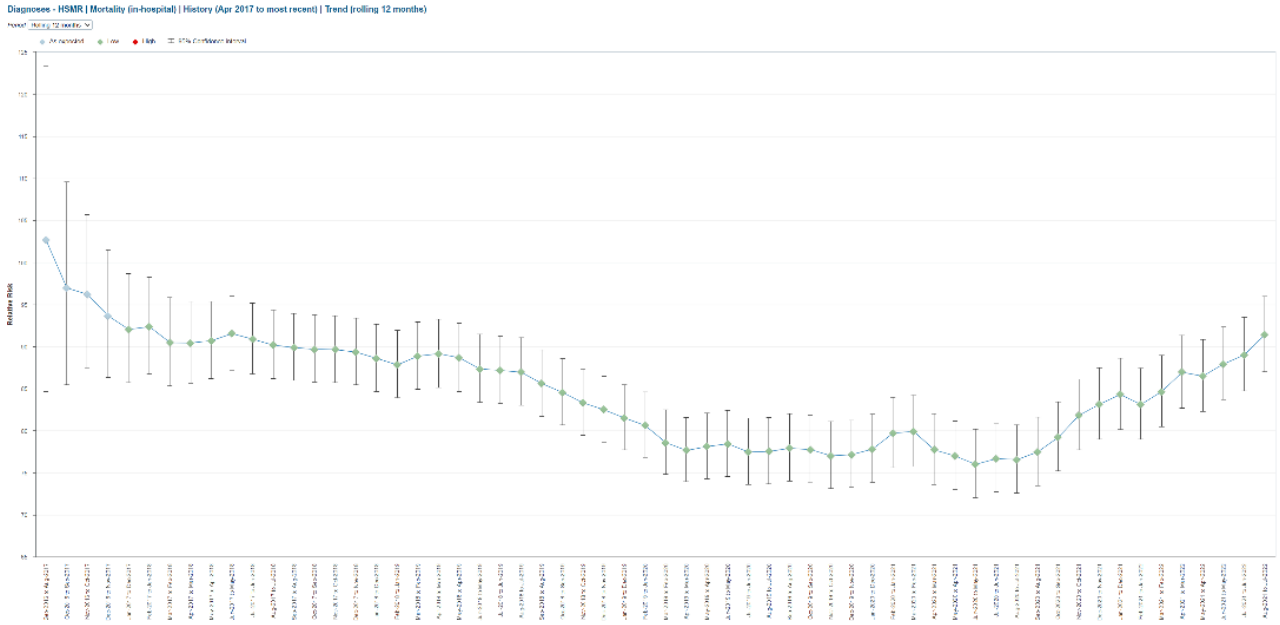
2.4 HSMR

HSMR has increased again due to a further spike in July 2022. Current 12-month UHS HSMR is **91.4**. Despite this increase, overall mortality rate remains low at 2.9% and is still lower than pre-Covid levels of 3%-5%. HSMR remains statistically significantly below benchmark despite the rise.

The Business Intelligence team have conducted a review of the increase in HSMR and have highlighted several driving factors. In the first instance, spikes in Oct 21 and Jul 22 have been a factor in increasing the HSMR. The increase in HSMR can be explained by:

- HSMR is derived b dividing the observed deaths by the expected deaths and multiplying by 100, so when the expected number of deaths is lower than observed HSMR is higher. As the values involved are not big, changes in low volumes have a material effect on the HSMR value.

- Palliative care involvement in outpatient settings leading up to a patient's death is not always documented in the admitting record. Recording palliative care involvement with patients makes a very significant HSMR change and would have likely reduced our HSMR by increasing the expected mortality value.



3. Medical Examiner Service Update

3.1 A new substantive lead medical examiner for UHS has been appointed in Dr Harnish Patel. Dr Patel will oversee the scrutiny and review of all deaths referred into the service from the Trust. The service is also in the process of appointing a lead medical examiner for community deaths.

3.2 Substantive recruitment for remaining available medical examiner PA sessions has been completed.

3.3 Pilot reviewing on community deaths has progressed well, and once the community lead is appointed the service will prioritise onboarding Southampton's primary care networks and refining the referral and review process.

4. Improving learning from deaths

4.1 As identified in the previous learning from deaths report, the coordination and integration of the different local mortality review processes within the Trust is challenging and opportunities for wider learning and dissemination have not always been taken.

4.2 The Trust's mortality governance coordinator has developed a data portal app for M&M and other mortality review processes to submit identified learning for cascading and sharing Trust-wide

4.3 The app integrates seamless with Power BI and enables the creation of a database of learning, with automated file tagging to identify learning areas and themes

4.4 Data will be stored securely in Sharepoint and the app can be accessed through Teams, web browser or locally on a PC or tablet.

4.5 The result will be the opportunity, for the first time, to create a centralised cache of learning from deaths that can be analysed, shared, and reported on systematically – rather than currently the learning remaining within specialties.

4.6 App will be launched Trust-wide by the end of Q3.

5. Conclusion

5.1 UHS continues to demonstrate low levels of avoidable mortality and overall good quality of care for most patients who die during their admission. HSMR has increased but is within 'low' range and overall mortality rate remains lower than pre-Covid levels.

5.2 New lead medical examiner appointed which will provide substantive clinical leadership of the service going forward as the scope of its reviews increase.

5.3 Development of a centralised mortality governance tool for capturing learning will ensure that identified opportunities for improvements and changes to practice are shared widely.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Freedom to Speak Up Report**			
Agenda item:	**13**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Christine Mbabazi, Freedom to Speak Up Guardian**			
Date:	**29 November 2022**			
Purpose	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** ✓
Issue to be addressed:	To provide an update on the Freedom to Speak Up (FTSU) agenda and report on the number of cases received by the Trust.			
Response to the issue:	Trust Board is asked to: • Note the actions taken to deliver the vision. • Note the outcomes and measures.			
Implications: (Clinical, Organisational, Governance, Legal?)	1. Mechanism to support for the creation of a culture where staff feel safe and can 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	Trust Board is asked to note this report.			

1 Executive Summary

To provide an update following the last report written in May 2022. The Trust received 30 FTSU cases from 23rd November 2021 – 12th May 2022 and 29 cases from 13th May 2022 to 15th November 2022. The key themes remain bullying and harassment as well as team dynamics. The solutions/interventions required to manage these cases remain unchanged and continue to be implemented as described in the previous Trust board report. However, the purpose of this paper is to show the implementation of the strategy and vision of FTSU so far (See Appendix A).

2 Purpose/Context/Introduction

The purpose of this report is to update Trust Board on the progress against key actions related to the FTSU vision and strategy.

3. Our FTSU Vision.

The Trust is committed to continuing to promote an open, honest, and transparent culture where all employees, workers and volunteers feel safe and supported to speak up.

Freedom to Speak Up has a dedicated Executive director and Non-Executive director and provision of resources required to support the FTSU agenda.

4. Our Strategy

The Trust has taken the following actions to deliver the vision:

Embedding the Freedom to Speak Up Culture is a continuous process, and the following actions are being undertaken in the Trust.

- Raising awareness regarding the FTSU policy and making sure it is easily available to all.
- Provision of FTSU awareness at Trust induction to ensure that all new starters, middle managers and senior managers are aware of Freedom to Speak Up.
- Growing the FTSU network within the organisation - we now have 60 Freedom to Speak Up Champions and number still growing to support the work of the guardian in the Trust. The FTSU champions are from a range of occupations, clinical and non-clinical, from different backgrounds, teams and staff groups. Taking the champion network from 15 in 2018 to 60 in 2022 has been a real achievement. This role is a voluntary role and champions would be doing this alongside their substantive post, and that staff are willing to take on this additional responsibility is very positive.
- The raising concerns (whistleblowing) steering group acts as the oversight group for all cases logged with the Trust. The group is chaired by the executive lead, the Chief Nursing Officer, and attended by the FTSU guardian and senior HR/patient safety leads. When concerns are raised the FTSU Guardian signposts these concerns to the different persons on the raising concerns committee depending on the concern.
  This process ensures that senior managers are responsible for the concerns and the guardian remains independent and impartial to make sure that the issues raised are adequately addressed.

5.Outcomes and Measures

The Trust's progress in achieving the vision and strategy has been measured through:

- The annual Staff Survey and Friends and Family Test results.
- Feedback from those who have raised the concerns
- The Steering Group reviews lessons learnt from case reviews of past and current FTSU cases. It is used for consultation on FTSU matters, utilising research from NHS bodies on embedding a speaking up culture, ensuring learning is shared across all divisions.
  The group reports to the UHS People Board on a quarterly basis identifying the work that has been undertaken, cases, themes, lessons learnt and National Guidance. (See attached Raising Concerns /Freedom to Speak Up Steering Group Terms of Reference- Appendix A).
- Investigations are carried out by different persons with expertise in the organisation depending on the case details.

6. Monitoring

A FTSU report have been presented to Trust Board twice a year by the FTSU Guardian and the Executive lead for raising concerns since 2018. This report includes;

- An overview of the cases reported and themes are identified. The current consistent themes are bullying and harassment as well as Team dynamics. Different measures have been put in place by the Organisation development team, as mentioned in the previous report and these will be consistently monitored by the Raising concerns steering group (See TOR appendix B below.)
- We have highlighted the progress against the National FTSU Office for example using case reviews, FTSU Index and self-assessment tools as mentioned in different reports.

7. Next Steps / Way Forward / Implications / Impact

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

8. Recommendation

Trust Board is asked to:

- Note the actions taken to deliver the vision.
- Note the outcomes and measures

Below is the Freedom to Speak Up -Vision and Strategy – Appendix A

Background and Purpose

Sir Robert Francis's 'Freedom to Speak Up' (FTSU) review[1] recommended that all NHS Trusts develop a more open and supportive culture to ensure that all employees, workers, and volunteers feel safe in speaking up about issues of patient care or safety. Such a culture was recognised as being vital in safeguarding patients from harm and promoting an environment where mistakes are acknowledged, learned from, and prevented from happening again. A national policy was published for the NHS that set out minimum standards and recommendations for developing the right culture for healthcare[2].

In line with national recommendations, the Trust has appointed its own 'FTSU Guardian' as an independent and impartial source of advice for those wishing to speak up. The role is supported by the newly established FTSU National Guardian's Office, which is responsible for providing leadership, training, and advice to FTSU Guardians.

This document sets out the Trust's Freedom to Speak Up vision and strategy and should be read alongside the Trust's Raising Concerns (Whistleblowing) Policy, which is available on StaffNet under Working Here > HR > HR Policies, and the UHS Staff Strategy (2018 – 2023).

Our Vision

The Trust is committed to continuing to promote an open, honest, and transparent culture where all employees, workers, and volunteers feel safe and supported in speaking up.

The Trust Board and Senior Leadership Team are committed to this vision and will support it by:

- Acting as role models in promoting a speaking up culture across the organisation in line with the Trust's values and behaviours.
- Providing the resources required to support the FTSU agenda.

Our FTSU Guardian and other champions have a key role in:

- Helping to raise the profile of raising concerns in the organisation and promoting a speaking up culture.
- Providing confidential advice and support to employees, workers, and volunteers when they have concerns and encouraging them to raise them with the organisation.

The Trust is fully engaged with the National Guardian's Office and the local network of Freedom to Speak Up Guardians in the region to learn and share best practice.

Our Strategy

The Trust will take the following actions to deliver the vision:

- Provide FTSU awareness sessions at the Trust induction to ensure that all new starters are aware of the FTSU Guardian/Champions and Raising Concerns (Whistleblowing) policy.
- Establish a network of FTSU Champions to increase the number of contact points for individuals or groups who wish to raise a concern.
- Ensure managers are clear about their roles and responsibilities when handling concerns and are supported to do so effectively.
- Provide regular communications across the Trust to raise the profile and understanding of the raising concerns agenda.
- Have a multidisciplinary approach to concerns raised through the monthly Raising Concerns (Whistleblowing) Steering Group, which is chaired by the Executive Lead.
- Share the key findings/recommendations from concerns that have been raised to foster a culture of openness, transparency, and learning from mistakes.

Outcomes and Measures

The Trust's progress in achieving the vision and strategy will be measured through:

- The annual Staff Survey and Friends and Family Test results.
- Feedback from those who have raised concerns.
- Benchmarking concerns received by the Trust against national FTSU Guardian's Office data and the regional FTSU Guardian network.
- Evidence that investigations are evidence based and led by someone suitably independent in the organisation.
- High level findings provided to the Trust board on a bi-annual basis.

Monitoring

A FTSU report will be presented to Trust Board on a bi-annual basis by the FTSU Guardian and the Executive Lead for raising concerns. This will include:

- An overview of the cases reported and any themes identified.
- An assessment of the continued effectiveness of the Trust's Raising Concern (Whistleblowing) Policy.
- Progress against the National FTSU Office guidance for NHS Trusts and self-assessment tool.
- Progress against key actions related to the vision and strategy.

Below is the RaisingConcerns/Freedom to Speak Up Steering GroupTerms of Reference – Appendix B

1. Aims and objectives

The Group has been established to guide University Hospital Southampton NHS Foundation Trust in all aspects of Raising concerns/Freedom to Speak Up towards its staff. The group will lead the Trust's approach to Raising concerns/Freedom to Speak Up.

The Group will review lessons learnt from case reviews, past and current FTSU cases and research from NHS bodies on embedding a speaking up culture and ensure learning is shared across all divisions. The group will work with all staff and partner agencies to ensure that staff feel supported when speaking up is concerned.

The Group will report to the UHS People Board on a biannual basis identifying the work the group has undertaken, cases, themes, lessons learnt and National guidance.

2. Membership

2.1 The group will comprise of both clinicians and managerial staff to support the best outcomes for staff, patients, visitors, and the Trust.

2.2 The group membership:

Joint Chairs Chief Nursing Officer and Chief People Officer.
Group Administrator: P.A. to HR Senior Management Team

Representation from the following groups/teams and agencies:
Deputy CMOs
Deputy Heads of Nursing/ Deputy Nursing Officer
Director of Organisational Development
Head of Patient Safety
Freedom to Speak Up Champions
Union Representative – Staffside Chair
Human Resources

2.3 When a member is unable to attend a meeting, they should appoint a deputy to attend on their behalf. The nominated deputy will have the same voting rights as the member.

2.4 Other Trust officers may be asked to attend when the group is discussing areas that are the responsibility of that individual.

2.5 The group will contribute to the Trust Board reports that are bi-annual.

2.6 The group will produce reports for Trust Board once a year.

3. Quorum

3.1 The quorum for the meeting shall be: The Chairperson (one of the two joint Chairs) plus the FTSU Guardian.

4. Frequency of Meetings

4.1 The group shall meet quarterly.

4.2 Poor attendance will be followed up by the group chair.

5. Administration

5.1 It is the duty of the Group Chair to ensure that:

- the administration of the Group is managed efficiently and effectively
- the Group undertakes the duties assigned to it
- reports to the Group and actions arising from meetings are completed in a timely manner
- the Chair, operational lead and Group Administrator meet as required to set agendas and follow-up action points
- meeting papers are circulated within seven (7) days before each meeting by the Administrator.

5.2 The Group Administrator's duties include:

- agreement of the agenda with the Chair, operational lead and attendees
- collation of the Group papers
- taking the minutes and keeping a record of action points and issues to be carried forward
- forward planning of agenda items
- ensuring records of Group business, terms of reference etc are stored appropriately and are retained in line with the corporate record retention requirements
- reminding contributors of report deadlines
- distributing papers at least five (5) days in advance of meetings
- keeping mailing lists up-to-date
- recording attendance and drawing the Chair's attention when this needs follow up action.

6. Duties

6.1 The Group will:

- Review CQC/FTSU national office reports and implement any relevant recommendations.
- Have a responsibility to ensure that all staff are supported in speaking up.
- Ensure that issues raised are used as opportunities for learning and improvement.
- Ensure barriers to speaking up are addressed
- Ensure a positive culture of speaking up is fostered.

7. Authority:

7.1 The Group has delegated authority from the Chief Nursing Officer and is authorised to investigate any activity involving raising concerns/Freedom to speak Up, within its terms of reference. It may seek and secure the information it requires from any employee, and all employees are directed to co-operate with any request made by the Group.

7.2 The Group can seek external advice from any source if necessary, taking into consideration issues of confidentiality and Standing Financial Instructions.

8. Monitoring Compliance and Effectiveness

8.1 In order to support the continual improvement of governance standards, sub-committees of the UHS People Board are required to annually:

- Complete a self-assessment of the effectiveness of the committee
- Review the terms of reference for the group, reaffirming the purpose and objectives
- Prepare an annual work plan, where appropriate
- Pesent a written report with the results of the assessment of its effectiveness and its annual report to the Trust Board or group from which the group derives its delegated authority.

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:	**14**			
Sponsor:	**Joe Teape, Chief Operating Officer**			
Author:	**John Mcgonigle, UHS EPRR lead**			
Date:	**29 November 2022**			
Purpose:	**Assurance**	**Approval**	**Ratification**	**Information** X
Issue to be addressed:	This report is provided to the Trust Board regarding the 2022 / 2023 NHS England Emergency Preparedness, Resilience and Response (EPRR) assurance process.			
Response to the issue:	This Assurance Report provides the Trust Board with confirmation that UHS has met the core standards and is Substantially Compliant. This report provides an overview of: • The process for 2022/23 • The level of assurance • The EPRR Improvement Plan			
Implications: (Clinical, Organisational, Governance, Legal?)	• The Civil Contingencies Act (CCA) 2004 and the NHS Act 2006, as amended by the Health and Social Care Act 2022, underpin EPRR within health. Both Acts place EPRR duties on NHS England and the NHS in England. Additionally, the NHS Standard Contract Service Conditions (SC30) requires providers of NHS funded services to comply with the EPRR Framework and other NHS England guidance. • The NHS Core Standards for EPRR provide a common reference point for all organisations through the EPRR annual assurance process and assurance report. Organisations must have an appointed AEO who is a board level director and responsible for EPRR in their organisation.			

	• It is the responsibility of the UHS EPRR team to coordinate and deliver the EPRR requirement and provide the assurance report to the AEO / Trust Board for review.
Risks: (Top 3) of carrying out the change / or not:	• Inability to meet legal requirements under CCA 2004, NHS Act 2006, Health and Social Care Act 2022 or EPRR framework. • Inability to respond and provide safe clinical services to emergencies, major, critical, or business continuity incidents. • Reduction in NHSE / community / staff / patient confidence in Trust leadership and performance delivery
Summary: Conclusion and/or recommendation	Trust Board is asked to note EPRR Assurance position 2022 / 2023 and support activities being taken to improve.

Background

1. The core standards 2022 / 2023 criteria have increased from 42 to 64 areas for assessment.

2. On 29 September 2022, the UHS EPRR team conducted a self-assessment together with other Hampshire and Isle of Wight Trusts. This process was facilitated by the ICB. This ensured a consistent approach to evidence was taken. The indicative assurance assessment to UHS is Substantially Compliant with 58 / 64 core standards fully met (91%)

3. The following domain areas are assessed Fully Compliant:
   - Governance
   - Duty to Risk Assess
   - Command and Control
   - Training and Exercising
   - Response
   - Warning and Informing
   - Cooperation
   - CBRN

4. Despite the independently assured Fully Compliant grading against all sub-headings indicated above, there is a refreshed approach to innovation and improvement across all domains including those assessed as fully compliant in 2022 / 2023. This includes revisiting command and control

protocols affecting all emergency incident plans and designing a framework to monitor and evaluate EPRR performance. A quarterly report will be provided to the Quality Governance Steering Group (QGSG) on progress against objectives.

5. The following areas numbered 6 – 11 represent the areas in which UHS submitted, and it was provisionally agreed by the ICB lead, that the award of Partially Compliant is the correct grading.

Areas for Improvement

6. Domain 3 – Duty to maintain plans – Incident response
    - UHS has declared partially compliant in this domain. Whilst there is an Incident Response Plan, it is to be reviewed in conjunction with command and control protocols, Major Incident response, Mass Casualty, CBRN procedures, Critical Incident and escalation protocols, and Business Continuity response. This is to be captured on the MIPG Action Tracker and is to be monitored through that governance group.

7. Domain 3 – Duty to maintain plans - New and emerging pandemics
    - Plan to be reviewed and re-written as a pandemic plan (not specifically influenza) following the COVID-19 pandemic. Lessons learnt from the recent pandemic to be incorporated into the new plan.

8. Domain 3 – Duty to maintain plans – Mass Casualty
    - As at point 6 above. To be monitored through governance group MIPG.

9. Domain 3 – Duty to maintain plans – Evacuation and Shelter
    - Subject to deep-dive review within assurance process, UHS declared partially compliant in this domain. Review meeting occurred 14 September 2022 and areas for improvement / development identified. Updated guidance from NHSE 2021 required to be embedded including Personal Evacuation Plans. This is to be captured on the MIPG Action Tracker and is to be monitored through that governance group. Note: all Hampshire and IOW Acute Trusts declared partially compliant in this domain.

10. Domain 3 – Duty to maintain plans – Lockdown
    - UHS has declared partially compliant in this domain. Lockdown capability is tied to infrastructure / estate and staff contracts / resourcing through Mitie Security. Lockdown capability considered area for improvement. Key risks captured and managed through Trust Risk Register. Led by Head of Security, options paper to Trust Board planned December 2022. This is being managed through EFDC Divisional Board.

11. Domain 9 – Business Continuity – Data Protection / Security Toolkit
    - Of 109 mandatory assertions, UHS has failed to meet one relating to mandatory training requirement for achieving 95%, and therefore UHS regarded as approaching standards. Improvement plan submitted and approved by NHS Digital.

Summary

12. Trust Board is asked to note EPRR Assurance position 2022 / 2023 and support activities being taken to improve as at Appendix 1.

Appendix 1 - EPRR Improvement Plan: University Hospital Southampton NHS Foundation Trust

University of 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 2022 / 2023. 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.

The progress of the Improvement plan shall be monitored and reported upon at Major Incident Planning Group (MIPG) with regular progress updates provided to Quality Governance Steering Group (QGSG).

Core Standard	Current self-assessed level of compliance **(RAG rating)**	**Remaining actions required to be fully compliant**	**Planned date for actions to commence / complete**	**Lead name**	**Further comments**
10	**Duty to maintain plans – Incident Response**	Incident Response Plan to be rewritten following lessons learned embedding revision to command and control procedures	Jan 2023 – Mar 2023	EPRR Lead	UHS has an Incident Response Plan which was approved by Major Incident Planning Group in May 2021. This plan covers arrangements to support the Trust in response to both major and critical incidents. Arrangements within the plan are currently being reviewed following recent incident learning and considering recent operational pressures. Trust wide Incident Command training scheduled December 2022 with programme to amend IRP accordingly in Q4 22 / 23.
13	**Duty to maintain plans – New and emerging pandemics**	Plan to be reviewed and re-written as a pandemic plan (not specifically influenza) following the COVID-19 pandemic.	Dec 2022 – Jan 2023	Head of Infection Prevention Unit	Lessons learned from the recent pandemic to be incorporated into the new plan.

15	**Duty to maintain plans – Mass Casualty**	Review to run concurrent to Incident Response Plan (IRP)	Jan 2023 – Mar 2023	EPRR Lead	UHS has an Incident Response Plan which was approved by Major Incident Planning Group in May 2021. This plan covers arrangements to support the Trust in response a mass casualty incident. As per the supporting information for standard 10 (Incident Response), arrangements within the plan are currently being reviewed following recent incident learning and considering recent operational pressures. Estate review required following amendments to capacity / flow. Trust wide Incident Command training scheduled December 2022 with programme to amend IRP accordingly in Q4 22 / 23.
16	**Duty to maintain plans – Evacuation and shelter**	Updated guidance from NHSE 2021 required to be embedded and test programme required. This is to be captured on the MIPG Action Tracker and is to be monitored through that governance group.	Jan 2023 – Mar 2023	EPRR Lead	Meeting 14/09/22 to identify scope / scale of work required for full compliance. Requirement to re-write Triage Priorities, Personal Emergency Evacuation Plans (PEEP) process, and Generic Emergency Evacuation Plans (GEEP). Planning and evacuation assumptions require test-programme jointly with Fire Safety through 2023. This will be incorporated within Business Continuity / command testing through 2023.
17	**Duty to maintain plans - Lockdown**	Lockdown capability tied to infrastructure / estate and staff contracts / resourcing through Mitie Security	Oct 2022 – Mar 2023	Head of Security	Led by Head of Security, options paper to Trust Board planned December 2022. This is being managed through EFCD Divisional Board.
18	**Business Continuity – Data Protection and Security Toolkit**	Improvement plan has been submitted to NHS Digital – awaits approval.	Oct 2022 – Dec 2022	Head of Data Protection	Current compliance 72%

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Board Assurance Framework (BAF)**			
Agenda Item:	**15.1**			
Sponsor	**Gail Byrne, Chief Nursing Officer**			
Author:	**Jake Pursaill, Corporate Governance and Risk Manager**			
Date:	**29 November 2022**			
Purpose	**Assurance or reassurance** ✓	**Approval** ✓	**Ratification**	**Information**
Issue to be addressed:	The Board Assurance Framework (BAF) provides assurance against the achievement of our strategic objectives; highlighting those that are at risk of not being delivered. The BAF provides evidence to support the annual governance statement, and is a focus of CQC and audit scrutiny. This report sets out the strategic risks, control framework, sources of assurance and action plans. The BAF is a dynamic document that will reflect the Trust's changing strategic position.			
Response to the issue:	The BAF has been developed with input from responsible executives and relevant stakeholders. It satisfies good governance requirements on information and scoring. This report reflects recent discussion at the Audit & Risk Committee, incorporating challenges around risk titles.			
Risks: (Top 3) of carrying out the change / or not:	The ability of the Board to effectively manage strategic risk is fundamental to the delivery of the Trust's strategic objectives and is a core element of the CQC's 'well led' inspection process. An organisation that does not monitor its strategic risk through a Board Assurance Framework or similar document may not be aware of key risks or may not understand failures in the control environment and actions planned to address these failures.			
Summary: Conclusion and/or recommendation	The Board Assurance Framework has been refreshed to reflect the updated corporate action plan for 2022/23, as well as increases in risk relating to finance, staffing, and capacity. Scores and dates have been reviewed and updated with pragmatic targets.			

1. Purpose

The University Hospital Southampton Board Assurance Framework identifies the strategic ambitions and the key risks facing the organisation in achieving these ambitions. This paper provides the full Board Assurance Framework relating to the 2022/2023 strategic objectives.

This document seeks to provide assurance to the Board that the Trust is appropriately sighted on, and working to mitigate, key strategic risks through an appropriate governance structure.

It is acknowledged that several of the critical risks described are not expected to be mitigated for several years. While this might suggest that the organisation will tolerate these critical risks for an extended period, instead it should be understood that mitigations for these risks exist outside of the Trust: National and international drivers are responsible and controls are similarly to be implemented by the wider NHS infrastructure.

Following discussion at Board sub committees the Board Assurance Framework has been updated to reflect key gaps in both controls and assurances, and to reflect the updated corporate action plan. The Trust strategic risk relating to outcomes and patient experience has increased to reflect the negative impact of long waiting times. The full BAF is provided as ***appendix 1***.

The Board is asked to consider:

- the level of assurance provided by the Board Assurance Framework and those areas or actions around which further assurance may be required, or conversely where excessive assurance is being sought;
- the appropriateness and timeliness of key actions to develop either the control or assurance framework for these strategic risks, and
- any risks to the delivery of our strategic objectives that are not currently included in the Board Assurance Framework.

Appendix 1

Trust Status

Trust status

Executive summary:

The key strategic risks for the Trust are:

- capacity (1a);
- staffing (3a); and
- the financial position (5a),

all of which are interrelated. As of June 2022 the financial pressures on the Trust have been escalated, as each depends on funding to mitigate. The capacity and staffing risks has also increased in score.

The recent significant increase in COVID infections within the community has impacted on the number of patients being admitted with COVID symptoms, increasing staff absences, and bays being closed following contact. This adds increased pressure to the capacity and staffing limitations.

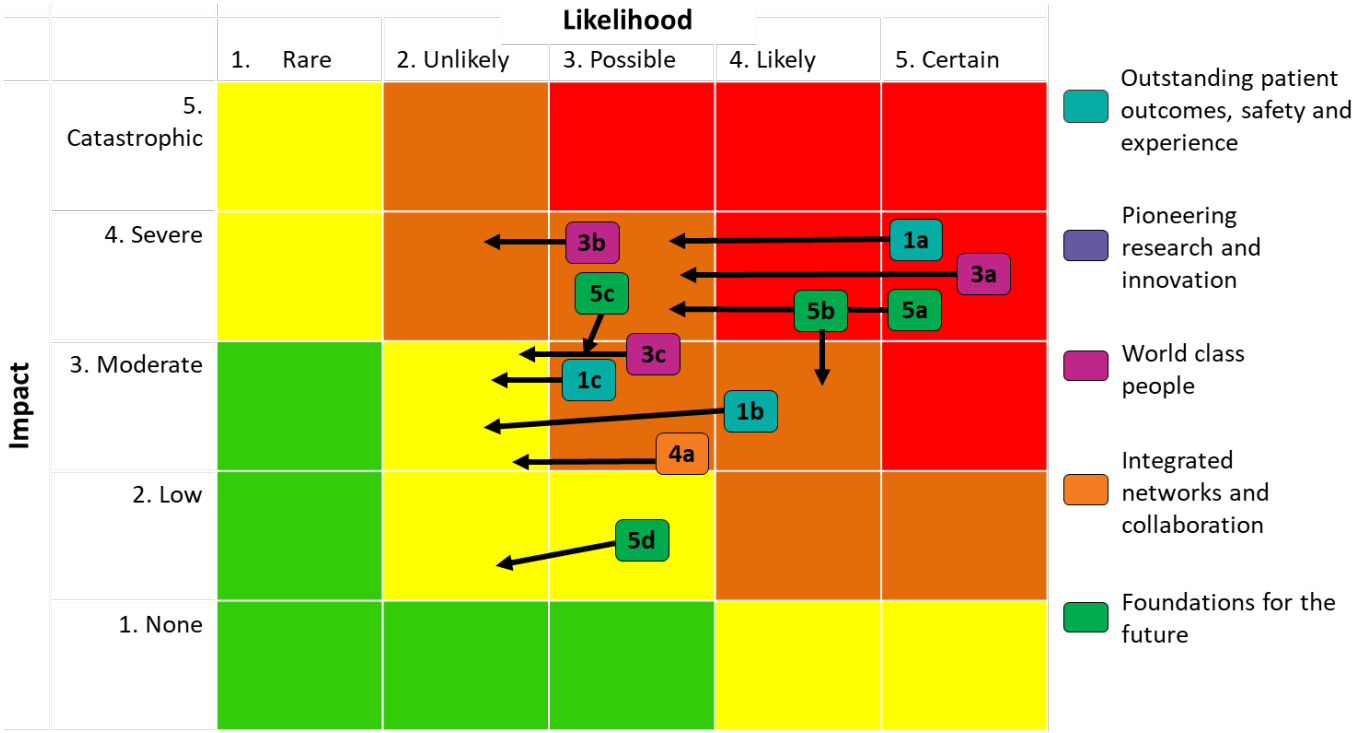
Patients who are waiting a long time for treatment are an increasing concern. This is impacting on outcomes and experience of care. Risk 1b) has increased to reflect this.

Increased capacity will not be available until 2023/24. The multi-year estates programme, to match the projected demand, has been agreed, however, there is likely to be significant pressure on capital in 2023/24 and 2024/25.

Trajectory:

The heatmap provided here summarises the current impact and likelihood scoring, along with an arrow illustrating the target score to be achieved through additional actions. The dates by which these scores are to be achieved have been RAG rated in the 'target score' column and the key is below.

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



Outstanding patient outcomes, safety and experience	Monitoring Committee: Quality Committee
	Executive Leads: COO, CMO, CNO

1a) Lack of capacity to appropriately respond to emergency demand, manage the increasing waiting lists for elective demand, and provide timely diagnostics, that results in avoidable harm to patients.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Use of independent sector to increase capacity Triage of patient lists based on risk of harm Consultant-led flagging of patients of concern Clinical Prioritisation Framework Capacity and demand planning including trajectories, surge capacity and continuity arrangements Specific operational plans for urgent care and cancer care Business continuity arrangements in place to provide continuity of care Outpatient, theatres and inpatient improvement programmes Successful staff and patient vaccination and testing programmes and dispensing of neutralising monoclonal antibody therapies (nMAD) to eligible patients in the community to reduce COVID-19 related hospitalisations	Primary and social care limitations are directly impacting on UHS – excess demand on primary care, impact of Brexit on social care, employment market for domiciliary/home care and care homes Limited funding, workforce and estate to address capacity mismatch in a timely way Lack of integrated care system (ICS) response and local strategy to manage demand in our emergency department as well as to address delays in discharge from the acute sector Staff capacity to engage in quality improvement projects due to focus on managing operational pressures	4 x 5 20	Clinical Assurance Framework, reported monthly to executive Live monitoring of bed occupancy and capacity data Monitoring of urgent care and cancer care pathways Monitoring and reporting of waiting times Harm reviews identifying cases where delays have caused harm.	Limited capacity within the Local Authority to support Medically Optimised Fit for Discharge. Limited cooperative engagement as an ICS to meet emergency medicine demand, impacting on flow. Data suggests waiting lists and ED performance are not likely to improve	Outpatient theatres and inpatient flow transformation programmes Review of ED workforce model Trial of urgent care village concept Review of local delivery system plan for reducing delays throughout the hospital. Deliver target of 106% of 19/20 baseline activity to secure additional funding and address waiting lists. Review plans to deliver no 78 week waiters by end of 22/23.	4 x 3 12 Apr-25

Outstanding patient outcomes, safety and experience					Monitoring Committee: Quality Committee Executive Leads: CNO, CMO	
1b) Due to the current challenges, we fail to provide patients and their families / carers with a high quality experience of care and positive patient outcomes.						
Key Controls	**Gaps in Controls**	**Current Risk Score (I x L)**	**Key Assurances**	**Gaps in Assurance**	**Key Actions**	**Target Risk Score* (I x L)**
Trust Patient Safety Strategy and Experience of care strategy Organisational learning embedded into incident management, complaints and claims Learning from deaths and mortality reviews Mandatory, high quality training Health and safety framework Robust safety alert, NICE and faculty guidance processes Integrated Governance Framework Trust policies, procedures, pathways and guidance Recruitment processes and regular bank staff cohort Culture of safety, honesty and candour Clear and supportive clinical leadership Always Improving	No agreed funding for the quality of outcomes programme to go forward beyond this year Staff capacity to engage in quality improvement projects due to focus on managing operational pressures	3 x 4 12	Monitoring of patient outcomes CQC inspection reporting: Good overall Feedback from Royal College visits Getting it right first time (GIRFT) reporting to Quality Committee External accreditations: endoscopy, pathology, etc. Kitemarks and agreed information standards Clinical accreditation scheme (with patient involvement) Internal reviews into specialties, based on CQC inspection criteria Current and previous performance against NHS Constitution and other standards Matron walkabouts and executive led back to the floor Quality dashboard, KPIs, quality priorities, clinical audits and involvement in national audits Integrated performance reporting Patient Safety Strategy Oversight Committee	Negative outlier on follow-ups for outpatients.	**Introducing a robust and proactive safety culture:** Implement plan to enable launch of PSIRF in Q2 2022/23 Embed learning from deaths lead & lead medical examiner roles (primary and secondary care) and develop objectives and strategy Introduce thematic reviews for pressure ulcers and falls. Implement the second round of Ockenden recommendations. **Empowering and developing staff to improve services for patients** Completion of SDM project, data analysis and formulate plan for ongoing roll-out, predominantly focussed on specialist services. To embed as business as usual from April 2023. Baseline assessments and two quarters' submissions have completed and this will form part of the CQINN this year **Always Improving strategy** Delivery of year 1 outpatients and theatres agreed quality, operational and financial benefits Increase specialties contributing to	3 x 2 6 Mar-24

Outstanding patient outcomes, safety and experience	Monitoring Committee: Quality Committee
	Executive Leads: COO, CMO, CNO

1a) Lack of capacity to appropriately respond to emergency demand, manage the increasing waiting lists for elective demand, and provide timely diagnostics, that results in avoidable harm to patients.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Programme					CAMEO There is currently no clinical lead for this project. We expect to recruit within three months, and will develop a new strategy linking outcomes, transformation, and safety. Actively managing waiting list through points of contact, escalating patients where changes are identified. Ongoing harm reviews for p2s and recurring contact for p3 and p4 patients.	

Outstanding patient outcomes, safety and experience					Monitoring Committee: Quality Committee Executive Leads: CNO, COO	
1c) We do not effectively plan for and implement infection prevention and control measures that reduce the number of hospital-acquired infections and limit the number of nosocomial outbreaks of infection.						
Key Controls	**Gaps in Controls**	**Current Risk Score (I x L)**	**Key Assurances**	**Gaps in Assurance**	**Key Actions**	**Target Risk Score* (I x L)**
Annual estates planning, informed by clinical priorities Digital prioritisation programme, informed by clinical priorities Infection prevention agenda Local infection prevention support provided to clinical teams Compliance with NHSIE Infection Assurance Framework COVID ZERO and #Don'tGoViral campaigns Digital clinical observation system Implementation of My Medical Record (MMR) Screening of patients to identify HCAIs Risk assessments in place for individual areas for ventilation, bathroom access, etc. to ensure patient safety.	Transmissibility of Omicron Non-compliant patients Refamiliarisation with response to resurgence of other common infections such as norovirus	3 x 3 9	Gold command infection control Hand hygiene and cleanliness audits Patient-Led Assessment of the Care Environment National Patient Surveys Capital funding monitored by executive NHSE/I infection assurance framework compliance reporting to executive, Quality Committee and Board Clinical audit reporting Internal audit annual plan and reports Finance and Investment Committee oversight of estates and digital capital programme delivery Digital programme delivery group meets each month to review progress of MMR Quarterly executive monitoring of Estates KPIs (maintenance, cleanliness, fire safety, medical devices, etc.)	None	Ongoing COVID ZERO and #Don'tGoViral campaign to expand to include all viruses supported by internal and external communications plan Review infection prevention measures in response to changes in guidance and move to 'living with COVID' Look to decentralise COVID pathways, with COVID positive patients to be cared for in the appropriate specialist areas. Review of infection prevention methods for C-diff following missing trajectory.	3 x 2 6 Apr-23

World class people	Monitoring Committee: People and Organisational Development Committee
	Executive Lead: CPO

3a) We do not increase the UHS substantive workforce by 481 by March 2023 to meet current and planned service requirements through recruitment to vacancies and maintaining annual staff turnover below 12% and to develop a longer-term workforce plan to linked to the delivery of the Trust's corporate strategy.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
New 5 year People Strategy and clear objectives for Year 1 monitored through POD. Recruitment and resourcing processes Workforce plan and overseas recruitment plan General HR policies and practices, supported by appropriately resourced HR team Temporary resourcing team to control agency and bank usage Overseas recruitment Recruitment campaign Apprenticeships New recruitment branding and successful targeted campaigns in critical are, ED, Ophthalmology and theatres. Bank and agency cost project – Joint finance and HR controls	Multi-year workforce and education plan to be developed in cooperation with the wider ICS Implementation of talent management and development programme Appropriate resourcing of people directorate commensurate with ongoing recruitment and retention activity Workforce plan is a risk due to current recruitment market challenges, rising pay in private sector, and buoyancy of job market. Inflation of 11% against national pay awarded of 3% is resulting in cost of living outstripping pay Differential pay grading across the ICS leading to retention difficulties	4 x 5 20	Fill rates, vacancies, sickness, turnover and rota compliance NHSI levels of attainment criteria for workforce deployment Annual post-graduate doctors GMC report WRES and WDES annual reports - annual audits on BAME successes Gender pay gap reporting NHS Staff Survey results and pulse surveys	Robust board reporting on wellbeing, belonging and morale	Approval of Year 1 objectives supporting delivery of the Trust's People Strategy Deliver workforce plan for 22/23 including increasing substantive staff and reducing temporary agency spend. Targeted campaigns in key areas. Refresh talent management and succession planning processes Deliver an increase in apprenticeships starters by 20% 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 Review of KPIs via IPR in light of new strategy to address identified gaps in assurance Agree long-term workforce education plan, including building relationships across the ICS and with education providers. Introduce measures to support staff during cost of living increases.	4 x 3 12 Mar-25

World class people	Monitoring Committee: People and Organisational Development Committee
	Executive Lead: CPO

3b) We fail to develop a diverse, compassionate and inclusive workforce, providing a more positive staff experience for all staff.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Great place to work including focus on wellbeing 22/23 Workforce planning completed to support COVID recovery Wellbeing and occupational health support for staff Guardian of Safe Working Hours **Building an inclusive and compassionate culture** FTSU guardian and FTSU policies Diversity and Inclusion Strategy/Plans Collaborative working with trade unions	Development of gender equality matrix (GEM) to provide measurements and assurance To recruit to the new network leads for the Trust and re-energise the network capacity and capability EDI strategy Values and behavioural frameworks	4 x 3 12	**Great place to work including focus on wellbeing** Annual NHS staff survey and introduction of quarterly pulse engagement surveys Guardian of Safe Working Hours report to Board Regular communications monitoring report Wellbeing guardian Staff Networks Exit interview process **Building an inclusive and compassionate culture** Freedom to Speak Up reports to Board Qualitative feedback from staff networks data on diversity Annual NHS staff survey and introduction of quarterly pulse engagement Insight monitoring from social media channels Staff listening sessions – 'Talk to David' Allyship Programme	Maturity of staff networks Maturity of datasets around EDI, and ease of interpretation	**Building an inclusive and compassionate culture** 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 Refresh and re-launch of the Trust's Wellbeing offer post COVID. Approval of Year 1 objectives supporting delivery of the Trust's People Strategy Improvement of diversity and inclusion insight and intelligence to inform priorities within divisions Creation of divisional steering group for EDI Re-launch a refreshed EDI strategy Deliver a programme on refreshing the underpinning behaviours to the Trusts Values Re-launch appraisal and talent management programme. refresh the underpinning behaviours of our Trust Values and produce a new behaviours framework. This will underpin future leadership development and OD interventions.	4 x 2 8 Mar-25

World class people	Monitoring Committee: People and Organisational Development
	Executive Lead: CPO

3c) We fail to create a sustainable and innovative education and development response to meet the current and future workforce needs identified in the Trust's longer-term workforce plan.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Education Policy Leadership and development opportunities, apprenticeships, secondments In-house, accredited training programmes Provision of high quality clinical supervision and education Access to apprenticeship levy for funding Access to CPD funding from HEE and other sources	Quality of appraisals Limitations of the current estate and access to offsite provision Access to high-quality education technology Estate provision for simulation training Staff providing education being released to deliver education, and undertake own development Releasing staff to attend training, due to capacity and demand	3 x 3 9	Annual Trust training needs analysis reported to executive Trust appraisal process GMC Survey Education review process with Health Education Wessex Utilisation of apprenticeship levy	None	**Great place to work including focus on wellbeing** To have recovered development and education of our people post pandemic (this includes improving appraisals carried out to 92% and appraisal quality as measured through the staff survey) Wellbeing programme Further develop education offer and formal launch of improvement education strategy/ five year education plan Approval of Year 1 objectives supporting delivery of the Trust's People Strategy Relaunch/refresh of the VLE need to be put down as a key action in terms of supporting people to access more self directed learning opportunities?	3 x 2 6 Mar-25

Integrated networks and collaboration					Monitoring Committee: Quality Committee Executive Leads: CEO, CMO, Director of Networks & Strategy	
4a) We do not implement effective models to deliver integrated and networked care, resulting in sub-optimal patient experience and outcomes, increased numbers of admissions and increases in patients' length of stay.						
Key Controls	**Gaps in Controls**	**Current Risk Score (I x L)**	**Key Assurances**	**Gaps in Assurance**	**Key Actions**	**Target Risk Score* (I x L)**
Key leadership role within local ICS Key leadership role within local networked care and wider Wessex partnership UHS strategic goals and vision Establishment and development of Hampshire and Isle of Wight Acute Provider Collaborative (HIoW APC) Establishment of UHS Integrated Networks and Collaboration Board focussing on delivery of the four network types, (Integrated community, Hospital networks, Specialised services and Diagnostic networks)	Potential for diluted influence at key discussions Arrangements for specialised commissioning – delegated from centre to ICS – historically national and regional, rather than local Form and scope of role for HIoW APC in relation to ICS and other acute provider collaboratives Work to develop a shared pharmacy model with Portsmouth has been delayed, and the Trust is looking at alternative options. The costs associated with the Elective Hub in Winchester may have been underestimated. Additional funding sources may need identifying.	3 x 3 9	CQC and NHSE/I assessments of leadership CQC assessment of patient outcomes and experience National patient surveys Friends and Family Test Outcomes and waiting times reporting Integrated networks and collaborations Board set up for regular meetings at executive level	Delay in implementation of new ICS framework and structures until July 2022, and delay in implementation of changes to specialised commissioning to April 2023	**ICS and PCNs** Priority networks agreed **Integrated Networks and Collaboration** Urology Area Network plan agreed and proceeding at pace Identify appropriate programme management support for networks following appointment for Urology Area Network and approval for HIoW Eye Care Alliance Business case for future working of the Southern Counties Pathology Network due for consideration by Trust Board in early 2022/23 Business case development for aseptic services and elective hub by HIoW APC Further development of HIoW APC to drive improvements in outcomes Development of proposals for next phase for Community Diagnostics Centres. Integrated networks and collaboration team set up and recruited to. Elective hub in Winchester – in final business case review. A two year plan to build, recruit, and open.	3 x 2 6 April-23

Foundations for the future	Monitoring Committee: Finance and Investment Committee
	Executive Lead: CFO

5a) We are unable to deliver a financial breakeven position and support prioritised investment as identified in the Trust's capital plan within locally available limits (CDEL).

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Financial strategy and Board approved break even plan Cost improvement programme (CIP, ~£45mil) and transformation programme (Always Improving) Additional income sources Robust business planning and bidding processes Engagement in ICS financial architecture Robust controls over investment decisions via the Trust Investment Group and associated policies and processes Robust controls over recruitment via the Recruitment Control Panel and associated policies and processes Established counter-fraud specialists and processes 2022/23 Operating Plan	Inflationary pressures, including price of energy Our restricted ability to run full elective programme, impacting on funding Impact of the pandemic on staff sickness levels, requiring high-cost backfill. Efficiency target of 4%.	4 x 5 20	Benchmarking of financial KPIs against other trusts Monitoring of the break even plan contained in regular finance reports to Board. Reporting of level of activity against spend, with executive oversight CQC assessment of use of resources Divisional performance on cost improvement reviewed by senior leaders on a quarterly basis Regular review of counter fraud control effectiveness via LCFS, reporting to Audit and Risk Committee ICS Capital Board overseeing CDEL Executive oversight of control groups	Current short-term nature of operational planning at a national level more generally	Deliver the forecast financial breakeven position for second half of 2022/23, targeting 106% elective activity Finalise and deliver 2022/23 operating plan (£33m of savings) including approach to COVID-19, elective recovery, investment in transformation and CIP and quantify unavoidable cost pressures underpinning deficit position Develop a medium-term financial plan for 23/24 to 24/25 Support the organisation to understand the impact and required cultural change relating to the new financial infrastructure Development of savings plan for 2022/23 Development of capital programme for future years Financial recovery programme and Board to be established, reporting to TEC	4 x 3 12 Mar-23

Foundations for the future	Monitoring Committee: Finance and Investment Committee
	Executive Lead: COO

5b) We do not adequately maintain, improve and develop our estate to deliver our clinical services and increase capacity.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Multi-year estates planning, informed by clinical priorities and risk analysis Up-to-date computer aided facility management (CAFM) system Asset register Maintenance schedules Trained, accredited experts and technicians Replacement programme Construction Standards (e.g. BREEM/Dementia Friendly Wards etc.) Six Facet survey of estate informing funding and development priorities Estates masterplan 22-32 approved.	Missing funding solution to address identified gaps in the critical infrastructure Timescales to address risks, after funding approval Operational constraints and difficulty accessing parts of the site affecting pace of investment including refurbishment	4 x 4 16	Compliance with Health Technical Memoranda monitored by estates and reported for executive oversight Patient-Led Assessments of the Care Environment Statutory compliance audit and risk tool for estates assets Monitoring at Finance and Investment Committee, including progress of capital investment and review of critical infrastructure risk and updates to Six Facet survey Quarterly updates on capital plan and prioritisation to the Board of Directors	Funding streams to be identified to fully deliver capacity and infrastructure improvements	Continue work on the estates strategy following the finalisation and agreement of the estates masterplan, including engagement with all clinical and non-clinical divisions Confirmation of impact of approved funding on critical infrastructure risk Identify future funding options for additional capacity in wards, theatres and diagnostics Delivery of 2022/23 capital plan Develop schemes for additional theatres and beds within UHS, and developing plan for HIOW elective hub. Develop the business case for the future of Chilworth LAMP facility. Deliver £9m of critical infrastructure backlog maintenance Agree plan for remainder of Adanac Park site	3 x 4 12 Apr-25

Foundations for the future					Monitoring Committee: Finance and Investment Committee Executive Lead: COO	
5c) We fail to introduce and implement new technology and expand the use of existing technology to transform our delivery of care through the funding and delivery of the digital strategy.						
Key Controls	**Gaps in Controls**	**Current Risk Score (I x L)**	**Key Assurances**	**Gaps in Assurance**	**Key Actions**	**Target Risk Score* (I x L)**
Digital prioritisation programme, informed by clinical priorities and safeguarded by clinical safety officers Global digital exemplar (GDE) recognition Digital strategy incorporating: • technology programme • clinical digital systems programme • data insight programme	Uncertainty around Hampshire and Isle of Wight ICS digital strategy and our direction of travel, including digital convergence, and alignment with wider expectations. Funding to technically refresh and for digital development, including the impact of proposals for 'levelling up' as part of funding distribution decisions for the funding available. Lack of workforce plan to retain staff needed to underpin strategy Development of a non-clinical/business systems strategy Greater alignment of Always Improving and digital transformation plans	3 x 4 12	Monthly executive-led digital programme delivery group meeting Finance oversight provided by the Finance and Investment Committee Quarterly Digital Board meeting, chaired by the CEO	Revised timetable to achieve paper switch-off target Difficulties in understanding benefits realisation of digital investment.	Achieve 200,000 My Medical Record (MMR) accounts and 30% paper switch-off Plan in place for generic PROM (patient-reported outcome measure) such as QOL (quality of life) 75% migration from outsourced transcription to digital speech recognition completed Digital ophthalmology system project 'open eyes' to be implemented Monitor opportunities for national funding for digital transformation Approve utilisation of funding received from Hampshire and Isle of Wight ICS Identify funding streams to support 2022/23 digital programmes and / or reduce programme in line with available funding. Develop clearer understandings of benefits across whole digital programme Develop digital literacy across trust to support rollout of new products Explore commercial partnership options to mitigate lack of UHS workforce to deliver strategy.	3 x 3 9 Mar-24

Foundations for the future					Monitoring Committee: Trust Executive Committee Executive Lead: CMO	
5d) We fail to prioritise green initiatives to deliver a trajectory that will reduce our direct and indirect carbon footprint by 80% by 2028-2032 (compared with a 1990 baseline) and reach net zero direct carbon emissions by 2040 and net zero indirect carbon emissions by 2045.						
Key Controls	**Gaps in Controls**	**Current Risk Score (I x L)**	**Key Assurances**	**Gaps in Assurance**	**Key Actions**	**Target Risk Score* (I x L)**
Governance structure including Sustainability Board (with patient representation), Sustainability Delivery Group and Clinical Sustainability Group Appointment of Executive Lead for Sustainability Green Plan	Clinical Sustainability Plan/Strategy (CSP) Sustainable Development Management Plan (SDMP) Long-term energy/decarbonisation strategy Communications plan	2 x 3 6	Progress against the NHS direct emission net zero target by 2040, with an ambition to reach an 80% reduction by 2028 to 2032 Progress against the NHS indirect emissions target to be net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039 Quarterly reporting to NHS England and NHS Improvement on sustainability indicators Green Plan and Clinical Sustainability Programme has been approved by Trust Investment Group and Trust Board.	Definition of and reporting against key milestones	Agree funding requirements to commence the delivery of the strategies Progress decarbonisation study and evaluation of potential for an energy performance contract (EPC) as part of the development of a specification ahead of the end of the Trust's energy contract in March 2023. Business case to be presented for approval in September 2022. Review green energy ambitions following extreme rises in electricity costs.	2 x 2 4 Dec-22

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Register of Seals and Chair's Actions**			
Agenda item:	**16.1**			
Sponsor:	**Jenni Douglas-Todd, Chair**			
Date:	**29 November 2022**			
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.			
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 Chair's action and application of the seal.			

1 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.

1.1 **Award of a call-off contract** for the provision of Dermatology insourcing from 18 Week Support LLP to support additional surgical capacity for long waiters and skin cancer, for 9 months at a cost of up to £604,440 excluding VAT. Approved by the Chair on 31 October 2022.

2 Signing and Sealing

2.1 **Agreement** executed as a Deed between University Hospital Southampton NHS Foundation Trust (the Employer) and LST Partnership LLP (Trading as LST Projects) (the Contractor) incorporating the JCT Standard Building Contract 2016, relating to works at Oncology vertical extension Levels D&E, East Wing, University Hospital Southampton, Tremona Road, Southampton SO16 6YD. Seal number 237 on 18 November 2022.

3 Recommendation

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

University Hospital Southampton
NHS Foundation Trust

Report to the Board of Directors				
Title:	**Review of Standing Financial Instructions 2022/23**			
Agenda item:	**16.2**			
Sponsor:	**Ian Howard, Chief Financial Officer**			
Author:	**Philip Bunting, Director of Operational Finance**			
Date:	**29 November 2022**			
Purpose	**Assurance or reassurance**	**Approval** x	**Ratification**	**Information**
Issue to be addressed:	The Standing Financial Instructions (SFIs) require an annual review and update. This paper outlines the key changes proposed.			
Response to the issue:	This paper outlines proposed changes to Trust SFIs for consideration and approval by Trust Board, following recommendation for approval by the Audit & Risk Committee and Southampton Hospital Charity Charitable Funds Committee. Given annual reviews have been completed over the last three consecutive years, the changes proposed are relatively light.			
Implications: (Clinical, Organisational, Governance, Legal?)	SFIs are a key governance document for the Trust.			
Risks: (Top 3) of carrying out the change / or not:	• Lack of clarity about financial authorities and responsibilities. • Insufficient probity and accuracy in financial transactions • Financial transactions do not support the delivery of economy, efficiency, and effectiveness by the Trust			
Summary: Conclusion and/or recommendation	Trust Board is asked to recommend the proposed changes to SFIs for approval.			

1. Introduction or Background

The Trust's Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They require annual review with the last review having been completed in October 2021.

The review completed this year is relatively light touch as it follows on from a robust review completed last year but has included engagement with the following people.

- Associate Director of Corporate Affairs
- Trust Legal Services Facilitator and Head of Claims
- Director of Estates, Facilities and Capital Development
- Director of Planning and Productivity
- Local Counter Fraud Specialist
- Financial Controller
- Director of Wessex Procurement Limited (WPL)
- Commercial Director
- Contracting Director
- Charity Director
- Chief Financial Officer
- Director of Research & Development

Additionally audit committee members were asked to forward on comments and contributions for consideration at the previous meeting.

2. Changes to Core SFIs

The main changes to the SFIs are outlined below.

Section	Section Title	Overview of Change	Rationale
7.9	Quotation & Tendering Procedures – Building and Engineering Contracts	Updated to include reference to the electronic tendering system (Delta)	A move away from paper based tendering.
7.10	Quotation & Tendering Procedures – Goods and Services Contracts	A new paragraph has been included (7.10.4) clarrifying arrangements for subsidiaries contract sign off	Potential conflict could exist with regards to Subsidiary contracts.
7.11	Waiving or Variation of Competitive Tendering/Quotation Procedure	A new paragraph has been included (7.11.3) to clarrify when waivers are not required in certain circumstances.	Waivers were previously being requested despite areas being out of scope for procurement process.
8.3 & Appendix 3	Tendering	Change in requirement for all tenders to be made aware to Business Development and/or Commercial teams plus increase in lower threshold to £0.5m.	Previous lower threshold was only up to £50k and inconsistent with other elements of the SFIs and responsibility for approvers at this level.
12.2.2 / 13.1.2	Approval of Capital Business Cases / Inventory Stores and Inventory	New references included related to UEL's expanded responsibilities for theatres.	Updated following UEL Theatres expansion and therefore new contracted responsibilities for stock and equipment capital replacement.
17.5	Charitable Fund Expenditure and Grants	Changes to the approvals process and limits	Refresh of previous procedures

A tracked changes version of the SFIs is also enclosed within the appendix. Please note page numbers align once tracked changes removed. Other changes around language and terminology are not explicitly outlined above but are included in the tracked changes document supplied. This covers changes in organisational titles and framework changes within the NHS.

3. Charity Changes

The Charity Director has reviewed with the CFO section 17 of the SFI's (Charitable Funds Held on Trust) to make sure policies and procedures are robust, up-to-date and in keeping with the charity sector and a charity of this size. The main changes proposed relate to the Charity Director role being responsible for ensuring appropriate fund holders are appointed to support the effective management and use of charitable funds (Section 17.5.3) together with a change to the authorisation process and approval limits (Section 17.5.5).

These changes have been ratified by the Southampton Hospital Charity Charitable Fund Committee at their November meeting.

4. Trust Authorisation Framework Changes

The Trust Authorisation Framework is proposed to remain as per previous financial limits with the exception of tender bid approvals for which the lower value threshold has been proposed to increase from £50k to £500k. The previous value was out of kilter with other elements of the trust authorisation framework and was unnecessary burdensome for the Tender Steering Group and CFO.

Although tenders are less common under the current NHS financial framework there are still a large volume particularly within R&D for which the lower threshold provides greater agility to operate. Under section 8.3.4 it is still a requirement of the SFI's to notify the Business Planning and Development team and/or Commercial team in all tendering exercises so a record can be kept. Similarly, the 'Bidding for Contracts' policy, referred to in the SFI's, is being revised in early 2023 by the Interim Commercial Director.

5. Conclusion

In summary, this paper outlines proposed changes to SFIs following annual review. These have been supported by the Audit and Risk Committee and Southampton Hospital Charity Charitable Fund Committee.

6. Recommendation

Trust Board is asked to APPROVE the proposed changes.

7. Appendices

- Standing Financial Instructions – final version with track changes.

Standing Financial Instructions

Version:	**NovemberNovember 20212 Version**
Authorisation Committee:	**Trust Board**
Date of Authorisation:	**298 NovemOctobber 20221**
Signature of authorising Committee:	**Jenni Douglas-ToddPeter Hollins, Trust Chair**
Ratification Committee (Category 1 documents):	**N/A**
Date of Ratification (Category 1 documents):	**N/A**
Signature of ratifying Committee Group/Chair(Category 1 documents):	**N/A**
Lead Job Title of originator/author:	**Chief Financial Officer**
Name of responsible committee/individual:	**Ian HowardDavid French**
Date issued:	**1 DecembNovember 20221**
Review date:	**30 November1 October 20223**
Target audience:	**All Divisions/Directorates**
Key words:	**Trust powers; Trust Board; Chair; Directors; appointment; meetings; committees; delegation; declarations; interests; contracts; tenders; business conduct; signature; documents; approval. (See also contents to the document.)**
Main areas affected:	**All Divisions/Directorates**
Consultation:	**Audit and Risk Committee** **Trust Executive Committee**
Equality Impact Assessments completed and policy promotes Equity	
Number of pages:	**5757**
Type of document:	**Level 1**

Clause **Page No.**

STANDING FINANCIAL INSTRUCTIONS ("SFIs")

1. INTRODUCTION

1.1 General

1.1.1 University Hospital Southampton NHS Foundation Trust ("the Trust") became a Public Benefit Corporation on 1st October 2011, following authorisation by NHS Improvement (formerly Monitor), the Independent Regulator of NHS Foundation Trusts pursuant to the National Health Service Act 2006 (the "NHS 2006 Act" or "2006 Act").

1.1.2 These Standing Financial Instructions (SFIs) are issued for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect, as if incorporated in the Standing Orders (SOs) of the Foundation Trust's Board of Directors (note that SOs are a statutory requirement for Foundation Trusts (FTs) but SFIs are not termed as such, although an equivalent set of rules is required by NHS EnglandImprovement, which this document represents).

1.1.3 The *NHS Oversight Framework* details how NHS EnglandImprovement oversees and supports all NHS Trusts. Additional financial guidance is included in *National Audit Office – Code of Audit Practice,* NHS Foundation Trust Annual Reporting Manual and the *Department of Health and Social Care Group Accounting Manual (DHSC GAM)*, all as updated, replaced or superseded from time to time. Other relevant guidance may also be issued.

1.1.4 These SFIs detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust (collectively called the "Scheme of Delegation").

1.1.5 These SFIs identify the financial responsibilities which apply to everyone working for the Foundation Trust and its hosted organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial policies and procedures.

1.1.6 Should any difficulties arise regarding the interpretation or application of any of the SFIs, then the advice of the CFO must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders of the Board of Directors (as well as the separate Standing Orders of the Council of Governors).

1.1.7 Failure to comply with Standing Financial Instructions and Standing Orders of the Board of Directors can in certain circumstances be regarded as a disciplinary matter that could result in an employee's dismissal.

1.1.8 Overriding Standing Financial Instructions – if for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next meeting of the Audit and Risk Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these SFIs to the CFO, as soon as possible.

1.2 Responsibilities and delegation

Foundation Trust Board of Directors

1.2.1 The Board of Directors exercises financial supervision and control by:

a) Formulating the financial strategy;

b) Requiring the submission and approval of budgets within specified limits;

c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

d) Defining specific delegated responsibilities placed on members of the Board of Directors and employees as indicated in the "Scheme of Delegation."

1.2.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the "'Schedule of Decisions Reserved to the Board" document, which is part of the Scheme of Delegation document. All other powers have been delegated to such Executive Directors in the Scheme of Delegation, Subsidiary Boards or committees of the Board, as the Trust has established. The Board must approve the terms of reference of all committees reporting directly to the Board.

1.2.3 The Board will delegate responsibility for the performance of its functions in accordance with its Constitution, the SOs and the Scheme of Delegation adopted by the Trust. The extent of delegation shall be kept under review by the Board.

The Chief Executive Officer (CEO), Chief Financial Officer (CFO)

1.2.4 The Chief Executive Officer and CFO will delegate their detailed responsibilities as permitted by the Constitution and SOs, but they remain accountable for financial control.

1.2.5 Within the SFIs, it is acknowledged that the Chief Executive Officer is ultimately accountable to the Board, and as Accounting Officer, to the Secretary of State for Health and Social Care, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive Officer has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.2.6 It is a duty of the Chief Executive Officer to ensure that Members of the Board, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

1.2.7 In the event of absence of the Chief Executive Officer, the Deputy Chief Executive will temporarily be delegated the authorisation limits outlined within this document.

The Chief Financial Officer

1.2.8 The CFO is responsible for:

a) These SFIs and for keeping them appropriate and up to date;

b) Implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

c) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

d) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

e) Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the CFO include:

i) Provision of financial advice to other members of the Trust Board and employees;

ii) Design, implementation and supervision of systems of internal financial control;

iii) Preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.2.9 In the event of absence of the Chief Financial Officer, the Director of Operational Finance will temporarily be delegated the authorisation limits outlined within this document.

Board of Directors and Employees

1.2.10 All members of the Board of Directors and employees, severally and collectively, are responsible for:

a) The security of the property of the Trust;

b) Avoiding loss;

c) Exercising economy and efficiency in the use of resources;

d) Conforming to the requirements of NHS England~~Improvement~~, the conditions of the NHS provider licence, the Constitution, Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

Contractors and their employees

1.2.11 Any contractor or, employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or, who is authorised to obtain income, shall be covered by these instructions. It is the responsibility of the Chief Executive Officer to ensure that such persons are made aware of this.

1.2.12 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the CFO.

2. AUDIT

2.1 Chief Financial Officer

2.1.1 The CFO is responsible for:

a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control, including the establishment of an effective internal audit function. An internal audit function is required by NHS England~~Improvement~~'s "NHS Foundation Trust Accounting Officer Memorandum" (August 2015);

b) Ensuring that the Internal Audit service to the Trust is adequate and meets NHS England~~NHS Improvement~~'s mandatory internal audit standards;

c) Deciding at what stage to involve the police in cases of misappropriation of assets and any other irregularities (subject to the provisions of SFI 2.4 in relation to fraud and corruption);

d) Ensuring that an annual internal audit report is prepared (with interim progress reports) for the consideration of the Audit and Risk Committee. The report(s) must cover:

i) A clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the DHSC, including for example compliance with control criteria and standards. This opinion provides assurances to the Accounting Officer, especially when preparing the "Statement of Internal Control" and also provides assurances to the Audit and Risk Committee;

ii) Any major internal financial control weaknesses discovered;

iii) Progress on the implementation of internal audit recommendations;

iv) Progress against plan over the previous year;

v) A detailed work-plan for the coming year.

2.1.2 The CFO and designated auditors are entitled without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) Access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

c) The production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

d) Explanations concerning any matter under investigation.

2.2 Role of Internal Audit

2.2.1 Internal Audit provides an independent and objective opinion to the Chief Executive Officer, the Audit and Risk Committee and the Board on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives.

2.2.2 Internal Audit will review, appraise and report upon:

a) The extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

b) The adequacy and application of financial and other related management controls;

c) The suitability of financial and other related management data including internal and external reporting and accountability processes;

d) The efficient and effective use of resources;

e) The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

   i) Fraud and other offences (responsibility for investigation of any suspected or alleged fraud is held by the Local Counter Fraud Specialist)

   ii) Waste, extravagance, inefficient administration;

   iii) Poor value for money or other causes;

   iv) Any form of risk, especially business and financial risk but not exclusively so.

f) The adequacy of follow-up actions by the Trust to internal audit reports;

g) Any investigations/project work agreed with and under terms of reference laid down by the CFO;

h) The Trust's Annual Governance Statement and Assurance Framework;

i) The Trust's compliance with the Care Quality Commission's fundamental standards.

2.2.3 Whenever any matter arises (in the course of work undertaken by internal audit) which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the CFO must be notified immediately and, in the case of alleged or suspected fraud, the Local Counter Fraud Service (LCFS) must be notified.

2.2.4 The Head of Internal Audit (or equivalent title) will normally attend Audit and Risk Committee meetings and has a right of access to Audit and Risk Committee members, the Chair and Chief Executive Officer.

2.2.5 The reporting system for internal audit shall be agreed between the CFO, the Audit and Risk Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the "Audit Code," the "DHSC Group Accounting Manual" and the "NHS FT Accounting Officer memorandum".

2.3 External Audit

2.3.1 The External Auditor is appointed by the Council of Governors with advice from the Audit and Risk Committee.

2.3.2 The Audit and Risk Committee must ensure a cost-effective service is provided and agree audit work-plans, except statutory requirements.

2.3.3 The External Auditor must ensure that this service fulfils the functions and audit access and information requirements, as specified in Schedule 10 of the NHS Act 2006.

2.3.4 The Trust shall comply with the Audit Code and shall require the External Auditor to comply with the Audit Code.

2.3.5 If there are any problems relating to the service provided by the External Auditor this should be resolved in accordance with the Audit Code.

2.3.6 Prior approval must be sought from the Audit and Risk Committee (the Council of Governors may also be notified) for each discrete piece of additional external audit work (i.e., work over and above the audit plan, approved at the start of the year) awarded to the external auditors. Competitive tendering is not required and the CFO is required to authorise expenditure.

2.4 Fraud, Corruption and Bribery

2.4.1 In line with their responsibilities, the Chief Executive Officer and CFO shall monitor and ensure compliance with the NHS Standard Contract Service Condition 24 to put in place and maintain appropriate counter-fraud, bribery and corruption arrangements, having regard to the NHS Counter Fraud Authority counter-fraud requirements and guidance (informed by Government Functional Standard GovS 013: Counter Fraud).

2.4.2 The CFO is the executive board member responsible for countering fraud, bribery and corruption in the Trust.

2.4.3 The Trust shall nominate a professionally accredited Local Counter Fraud Specialist ("LCFS"), to conduct the full range of counter-fraud, bribery and corruption work on behalf of the trust as specified in the NHS Counter Fraud Authority counter-fraud requirements and guidance.

2.4.4 The LCFS shall report to the CFO and shall work with staff in the NHS Counter Fraud Authority, in accordance with the NHS Counter Fraud Authority counter-fraud requirements and guidance, the NHS Counter Fraud Manual, including the NHS Counter Fraud Authority's Investigation Case File Toolkit.

2.4.5 If it is considered that evidence of offences exists and that a prosecution is desirable, the LCFS will consult with the CFO to obtain the necessary authority and agree the appropriate route for pursuing any action e.g. referral to the police or NHS Counter Fraud Authority.

2.4.6 The Local Counter Fraud Specialist will provide a written report, at least annually, on anti-fraud, bribery and corruption work within the Trust to the Audit and Risk Committee.

2.4.7 The LCFS will ensure that measures to mitigate identified risks are included in an organisational work plan which ensures that an appropriate level of resource is available to the level of any risks identified. Work will be monitored by the CFO and outcomes fed back to the Audit and Risk Committee.

2.4.8 In accordance with the Raising Concerns (Whistleblowing) Policy, the Trust shall have a whistle-blowing mechanism to report any suspected or actual fraud, bribery or corruption matters and internally publicise this, together with the national fraud and corruption reporting line provided by the NHS Counter Fraud Authority.

2.4.9 The Trust will report annually on how it has met the Government Functional Standard GovS 013: Counter Fraud in relation to counter-fraud, bribery and corruption work and the CFO shall sign-off the annual return and authorise

its submission to the NHS Counter Fraud Authority. The CFO shall sign-off the annual qualitative assessment (in years when this assessment is required) and submit it to the relevant authority.

2.5 Security Management

2.5.1 The Chief Executive Officer has overall responsibility for the safety and security of employees, patients and visitors of the Trust, as part of the Trust's role as an employer and healthcare provider and for keeping the Trust's premises secure. However, the management of security risks within the Trust has delegated to the Chief Operating Officer and also to the appointed Local Security Management Specialist ("LSMS") in line with Trust policies and procedures.

2.5.2 Any prosecution of other offences relating to fraud, bribery or corruption against the Trust not involving the LCFS should be authorised by the CFO and will be reported to the Audit and Risk Committee.

3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 Preparation and Approval of the Trust Operational Plan and Budgets

3.1.1 In accordance with the annual planning cycle, the Chief Executive Officer will compile and submit to the Board of Directors and to the Council of Governors the annual "Operational Plan" which takes into account financial targets and forecast limits of available resources. The Trust Operational Plan will contain:

a) A statement of the significant assumptions on which the plan is based;

b) Details of major changes in workload, delivery of services or resources required to achieve the plan;

c) The Financial Plan for the year;

d) Such other contents as may be determined by NHS England~~NHS Improvement~~.

3.1.2 The annual Operational Plan must be submitted to NHS England~~NHS Improvement~~ in accordance with NHS England~~NHS Improvement~~'s requirements.

3.1.3 The CFO will, on behalf of the Chief Executive Officer, prepare and submit an annual budget for approval by the Board of Directors. Such a budget will:

a) Be in accordance with the aims and objectives set out in the Trust Operational Plan;

b) Accord with demand, workforce and capacity plans;

c) Be produced following discussion with appropriate budget holders;

d) Be prepared within the limits of available funds;

e) Identify potential risks;

f) Be based on reasonable and realistic assumptions; and

g) Enable the Trust to comply with the whole regulatory framework for FTs.

3.1.4 The Trust Operational Plan, which will include the annual budget, will be submitted to the Council of Governors in a general meeting.

3.1.5 The CFO shall monitor financial performance against budget, and report to the Board of Directors.

3.1.6 All budget holders must provide information as required by the CFO to enable budgets to be compiled.

3.1.7 The CFO has a responsibility to ensure that adequate training is delivered on an ongoing basis to budget holders to help them manage their budgets successfully.

3.2 Operating Plan and Budget Setting Process

3.2.1 The Chief Financial Officer will submit to the Board of Directors a paper outlining the annual budget setting process for the year. This will include a baseline formed from a set of clearly defined assumptions.

3.2.2 Each Department and Director will be asked to submit a list of Business Cases and cost pressures for consideration in budget setting~~, as part of the Strategic Review process~~. Only approved business cases will be incorporated into delegated budgets. Funded business cases will require approval as per the Trust Approval Framework in Annex 3, section 1.

3.2.3 The Chief Executive Officer and Chief Financial Officer will set an annual process for approving cases to be incorporated into the budget and Operational Plan.

3.2.4 ~~Each Department and Director will be asked to provide assumptions for the setting of the~~The Trust's Production Plan (income plan) will be set utilising internal data sources and after consultation with service managers ~~. These will be considered~~ alongside external data sources ~~factors~~ including Commissioner and Integrated Care Board plans~~. in order to set the Trust's income budget.~~

3.2.5 The Chief Financial Officer will set a Cost Improvement Programme (CIP) savings target, delegated to each budget holder.

3.2.6 The Chief Financial Officer may set reserves to cover potential ~~unknown~~ cost pressures and risks at the planning stage, which may then subsequently be delegated in-year.

3.3 In-Year Adjustments to Budgets

3.3.1 The Chief Financial Officer may authorise budget virements in the following circumstances:

a) To reflect an in-year business case approved by the relevant committee;

b) To utilise~~distribute~~ reserves~~ set to cover cost pressures that were unknown at the planning stage~~;

c) To reflect where the distribution of income and expenditure has materially changed from the original plan, where this is net neutral for the Trust. For example, to reflect the reality of CIP delivery where this changes materially from the original planning assumption

3.3.2 Budget virements for in-year business cases can only be allocated on an overall neutral basis, to ensure the budget remains balanced to the Operational Plan. Additional expenditure will require funding via additional

income assumptions, release of reserves or additional savings in another part of the budget.

3.4 Budgetary Delegation

3.4.1 The Chief Executive Officer, through the CFO, may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

a) The amount of the budget;

b) The purpose(s) of each budget heading;

c) Individual and group responsibilities;

d) Achievement of planned levels of service;

e) The provision of regular reports.

3.4.2 Except where otherwise approved by the Chief Executive Officer, taking account of advice from the CFO, budgets shall only be used for the purpose for which they were provided.

3.4.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the CFO, subject to guidance on budgetary control in the Trust.

3.4.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive Officer or the CFO.

3.4.5 Budget Holders are expected to sign their acceptance of their annual expenditure budget.

3.5 Budgetary Control and Reporting

3.5.1 The CFO will devise and maintain systems of budgetary control. These will include:

a) Monthly financial reports to the Board of Directors in a form approved by the Board of Directors, containing sufficient information to allow the Directors of the Board to ascertain the financial performance of the Trust. This may include the following:
   i) Income and expenditure to date, showing trends and the forecast year-end position;
   ii) Movements in working capital;
   iii) Movements in cash;
   iv) Capital project spend and projected outturn against plan;
   v) Explanations of any material variances from budget;
   vi) Details of any corrective action where necessary and the Chief Executive Officer's and/or CFO's view of whether such actions are sufficient to correct the situation

b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

c) Investigation and reporting of variances from financial and workforce budgets;

d) Monitoring of management action to correct variances; and

e) Arrangements for the authorisation of budget transfers and virements.

3.5.2 Each Budget Holder is responsible for ensuring that no permanent employees are appointed without the approval of the Chief Executive Officer, other than those provided for within the budgeted workforce establishment. Any expenditure required beyond budgeted establishment will require an in-year business case.

3.5.3 The Chief Executive Officer is responsible for identifying and implementing cost improvement programmes ("CIPs") and income generation initiatives in order to deliver a budget that will enable compliance with NHS England~~NHS Improvement~~'s Use of Resources regime.

3.5.4 The Chief Executive Officer will incorporate a Recruitment Control Panel, responsible for approving recruitment as per Terms of Reference agreed by the Trust Executive Committee. Proposed recruitment will ~~All new appointments will~~ be considered by the Recruitment Control Panel where within scope of the criteria contained within the Terms of Reference.

3.5.5 All new Clinical consultant appointments will require the approval of the Trust Executive Committee.

3.6 Capital Expenditure

3.6.1 General rules applying to delegation and reporting shall also apply to capital expenditure. Accounting for fixed assets must comply with the DHSC Group Accounting Manual. The specific instructions relating to capital are contained in section 12 of these SFIs.

3.7 Performance Monitoring Forms and Returns

3.7.1 The Chief Executive Officer is responsible for ensuring that the appropriate monitoring forms and returns are submitted to NHS England~~NHS Improvement~~. The performance figures reported to the Board of Directors should reflect the same figures, though not necessarily presented in the same format.

3.8 In-Year Business Cases

3.8.1 It is expected that most business cases will be identified and prioritised during the setting of the Trust Operational Plan and therefore Budget Setting Process. These cases will then be sent for approval at an appropriate point during the year.

3.8.2 Any case with a capital implication will be considered in section 12 and outlined in Annex 3, section 1.

3.8.3 Revenue cost only business cases will be subject to the approval as outlined in Annex 3, section 1.

4. ANNUAL REPORT AND ACCOUNTS AND QUALITY REPORT

4.1 The CFO, on behalf of the Trust, will:

a) Prepare annual financial accounts and corresponding financial returns in such form as NHS England~~NHS Improvement~~ and HM Treasury prescribe;

b) Ensure these annual accounts and financial returns comply with current guidelines and directions given by NHS England~~NHS Improvement~~ as to their technical accounting content and information/data shown therein, before submission to NHS Improvement.

4.2 The Associate Director of Corporate Affairs will prepare the Annual Report in accordance with the guidance in the NHS Foundation Trust Annual Reporting Manual.

4.3 The Trust's Annual Report, Annual Accounts and financial returns to NHS England~~NHS Improvement~~ must be audited by the external auditor in accordance with appropriate international auditing standards.

4.4 The Annual Report and Accounts (including the auditor's report) shall be approved by the Board of Directors, or by the Audit and Risk Committee (when specifically delegated the power to do so, under the authority of the Board of Directors).

4.5 The Annual Report and Accounts (including the auditor's report) is submitted to NHS England~~NHS Improvement~~ (in accordance with its timetable) by the CFO and put forward to be laid before Parliament in accordance with the prescribed timetable.

4.6 The Annual Report and Accounts (including the auditor's report) must be published and presented to a general meeting of the Council of Governors each year and made available to the public for public inspection at the Trust's headquarters and made available on the Trust's website. Any summary financial statements published are in addition to, and not instead of, the full annual accounts.

4.7 The Chief Nursing Officer will prepare the Annual Quality Report in the format prescribed by NHS England~~Improvement~~ and/ the Care Quality Commission and in accordance with the NHS Foundation Trust Annual Reporting Manual incorporating the requirements of the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010.

4.8 The Chief Executive Officer and Chair shall sign off the "Statement of Directors' Responsibilities in Respect of the Quality Report" .

5. GOVERNMENT BANKING SERVICE BANK ACCOUNTS

5.1 General

5.1.1 The CFO is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts in accordance with these SFI's and the Treasury Management Policy.

5.1.2 The Audit and Risk Committee of the Board of Directors will review banking arrangements periodically.

5.1.3 The Audit and Risk Committee will approve recommendations regarding the opening of any bank account in the name of the Trust.

5.2 Government Banking Service ("GBS") Bank Accounts

5.2.1 In line with public sector practice, the Trust's principal bankers are those commercial banks working in partnership with the GBS, referred to in 5.2.2(a)

below. However, these SFIs will apply to any other accounts opened in the name of the Trust or its subsidiaries from time to time.

5.2.2 The CFO is responsible for:

a) GBS bank accounts and any non GBS bank accounts held for banking and merchant services.

b) Establishing separate bank accounts for the Trust's non-exchequer funds as appropriate;

c) Ensuring payments made from bank/GBS/Natwest~~RBS~~ accounts do not exceed the amount credited to the account except where arrangements have been made;

d) Reporting to the Board of Directors any arrangements made with the Trust's bankers for accounts to be overdrawn;

e) Monitoring compliance with NHS England~~Improvement~~ or DHSC guidance on the level of cleared funds;

f) Ensuring covenants attached to bank borrowings are adhered to.

5.3 Banking Procedures

5.3.1 The CFO will prepare detailed instructions on the operation of bank accounts which must include:

a) The conditions under which each bank account is to be operated, including the overdraft limit if applicable;

b) Those members of staff with mandated authority to carry out transactions (by signing transfer authorities or cheques or other orders) in accordance with the authorisation framework of these GBS bank accounts.

5.3.2 The CFO must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.4 Tendering and Review (applicable to any non-GBS bank accounts only)

5.4.1 The CFO will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and value for money.

6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The CFO is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The CFO is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges (including for private use of Trust assets)

6.2.1 The Trust shall follow the ~~"Payment by Results" ("PbR")~~ financial regime ~~or any alternative financial regime~~ as determined by NHS England where applicable. The CFO may agree alternative payment mechanisms with Commissioners or the Integrated Care Board.

6.2.2. The CFO is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care or by legislation. Independent professional advice on matters of valuation shall be taken as necessary.

6.2.3 All Employees must inform the CFO promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.2.4 Contracts must conform to the strategy and operational plans of the Trust and shall be approved according to the limits specified at SFI Annex 3, section 3.

6.2.5 Any employee wishing to use Trust assets for private use must comply with the Trust's policies, including those on use of the telephone and the loan of equipment.

6.3 Debt Recovery

6.3.1 The CFO is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income and salary overpayments not received, after all attempts at recovery have failed should be written off in accordance with the following approvals limits.

6.3.3 The following VAT exclusive limits shall be applied to debt write offs:

Monetary Value	**Approval**
Up to £10,000	Director of Operational Finance
Up to £100,000	CFO
£100,000 plus	Audit and Risk Committee

The limits apply to individual items. A schedule of written off debt shall be presented to the Audit and Risk Committee at least annually. A schedule of debts written off in excess of £100,000 and approved by the Audit and Risk Committee should be presented to the Trust board for noting.

6.4 Security of Cash, Cheques and Other Negotiable Instruments

6.4.1 The CFO is responsible for:

a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) Ordering and securely controlling any such stationery;

c) The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 Trust monies shall not, under any circumstances, be used for the encashment of private cheques or loans or IOUs.

6.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, before banking, except under arrangements approved by the CFO.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes, unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust shall not be liable for any loss, and written and signed "declarations of indemnity" must be obtained from the organisation or individuals fully absolving the Trust from responsibility for any loss.

7. TENDERING & CONTRACTING PROCEDURES

7.1 Duty to comply with Standing Financial Instructions

7.1.1 The procedure for making all contracts on behalf of the Trust shall comply with these Standing Financial Instructions and Standing Orders.

7.1.2 University Hospitals Southampton procurement services are provided through Wessex NHS Procurement Ltd ("WPL").

7.2 Thresholds Tender Guide/Placing Contracts/Waivers

7.2.1 The tables outlined in the Trust Authorisation Framework in Annex 3 outlines the correct procurement process to be followed relative to value and the type of product or service being purchased.

7.2.2 In circumstances where the specified number of quotations/tenders cannot be obtained (e.g. where there is a limited number of suppliers) the reasons for receiving a lower number of quotations/tenders must be recorded.

7.2.3 Subject to the limits outlined in Annex 3, the Managing Director of Wessex Procurement Limited, Director of Estates, Facilities & Capital Development, Director of Informatics, Divisional Directors of Operations and Chief Pharmacist may sign and place contracts on the Trust's behalf, providing a valid Procurement Approval Document is signed by the relevant Trust authorised signatory.

7.2.4 The waiving or variation of the competitive tendering and quotation procedure can be approved subject to the limits outlined in Annex 3.

7.3 Electronic Tendering

7.3.1 All formal invitations to tender shall utilise the WPL on-line E-tendering solution. Where there are national framework providers facilitating tendering activity then those E-tendering solutions may be utilised, but records maintained by WPL.

7.3.2 All tendering carried out through e-tendering will be compliant with the Trust policies and procedures as set out in SFIs 7.2 – 7.8.2. Issue of all tender documentation should be undertaken electronically through a secure website with controlled access using secure login, authentication and viewing rules.

7.3.3 All tenders will be received into a secure electronic vault so that they cannot be accessed until an agreed opening time. Where the electronic tendering package is used the details of the persons opening the documents will be recorded in the audit trail together with the date and time of the document opening. All actions and communication by both WPL staff and suppliers are recorded within the system audit reports.

7.4 Manual Tendering – General Rules

7.4.1 All invitations to tender on a formal competitive basis shall state that no tender will be considered for acceptance unless submitted in either:

a) A plain, sealed package bearing a pre-printed label supplied by the Trust (or bearing the word `Tender' followed by the subject to which it relates and the latest date and time for the receipt of such tender); or

b) In a special envelope supplied by the Trust to prospective tenderers and the tender envelopes/packages shall not bear any names or marks indicating the sender.

7.4.2 Every tender for goods, materials or manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in Section 7.4.3 and 7.4.4 below.

7.4.3 Every tender for building and engineering works, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or NEC 3 or NEC 4 form of contract amended to comply with Concode. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers (IMechE) and the Association of Consulting Engineers (ICE) (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers.

7.4.4 Every tender for goods, materials, services (including consultancy services) or disposals shall embody the NHS Standard Contract Terms and Conditions as are applicable. Every supplier must have given a written undertaking not to engage in collusive tendering or other restrictive practice.

7.5 Receipt, Safe Custody and Record of Formal Tenders

7.5.1 All tenders on the approved form shall be addressed to the appropriate officer according to the appropriate limits specified in SFI 7.2.

7.5.2 The date and time of receipt of each tender shall be endorsed on the unopened tender envelope/package.

7.5.3 The appropriate officer shall designate an officer or officers, not from the originating department, to receive tenders on his/her behalf and to be responsible for their endorsement and safe custody until the time appointed for their opening, and for the records maintained in accordance with SFI 7.6.

7.6 Opening Formal Tenders

7.6.1 As soon as practicable after the date and time stated as being the latest time for the receipt of tenders they shall be opened by two officers designated by the officer as appropriate.

7.6.2 Every tender received shall be stamped with the date of opening and initialled by two of those present at the opening.

7.6.3 A permanent record shall be maintained to show for each set of competitive tender invitations despatched:

a) The names of firms/individuals invited;

b) The names of and the number of firms/individuals from which tenders have been received;

c) The total price(s) tendered;

d) Closing date and time;

e) Date and time of opening; and

f) The persons present at the opening shall sign the record.

7.6.4 Except as in SFI 7.6.5 below, a record shall be maintained of all price alterations on tenders, i.e. where a price has been altered, and the final price shown shall be recorded. Every price alteration appearing on a tender and the record should be initialled by two of those present at the opening.

7.6.5 A report shall be made in the record if, on any one tender, price alterations are so numerous as to render the procedure set out in SFI 7.6.4 above unreasonable.

7.7 Admissibility and Acceptance of Formal Tenders

7.7.1 In considering which tender to accept, if any, the designated officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the CFO or nominated officer.

7.7.2 Tenders received after the due time and date may be considered only if the CFO or nominated officer decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned. The CFO, or nominated officer, shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender should be reported to the Board at its next meeting.

7.7.3 Technically late tenders (i.e. those despatched in good time but delayed through no fault of the supplier) may at the discretion of the CFO or nominated officer be regarded as having arrived in due time.

7.7.4 Materially incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the supplier upon his own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders under SFI 7.7.2.

7.7.5 Where examination of tenders reveals a need for clarification, the supplier is to be given details of such clarifications and afforded the opportunity of confirming or withdrawing his offer.

7.7.6 Necessary discussions with a supplier of the contents of their tender, in order to elucidate technical points etc., before the award of a contract, will not disqualify the tender.

7.7.7 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the CFO.

7.7.8 Where only one tender/quotation is received the CFO /nominated officer (within delegated limits) shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

7.7.9 All tenders shall be evaluated on the basis of MEAT (Most Economically Advantageous Tender) and in conjunction with published Award Criteria and Weightings.

7.7.10 Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive Officer or nominated officer (within 7.9.1 below).

7.7.11 All tenders should be treated as confidential and should be retained for inspection.

7.8 Extensions to Contract

7.8.1 In all cases where optional extensions to contract are outlined at the time of tendering, approval will be required as if it were a new contract.

7.8.2 Variations to building and engineering contracts shall be authorised by the Director of Estates, Facilities & Capital Development. These variations shall not be authorised if doing so would result in exceeding the values within the capital project approved business case. Where a variation does result in the capital project approved business case financial value being exceeded then further approval shall be required from the appropriate authorising body. These values are subject to the tolerances contained in these SFIs.

7.8.3 Where building and engineering contracts are being varied to include new pieces of work outside the scope of the original business case then a new business case will be required to be approved prior to this variation being issued.

7.9 Quotation & Tendering Procedures – Building and Engineering Contracts

7.9.1 Quotation & Tendering Procedures Summary - Building and Engineering Contracts

a) Unless permitted by Standing Orders, competitive quotations/tenders will be sought for all contracts according to the financial limits specified in SFI 7.2.

a) Tender documents will be issued by the office of the Director of Estates, Facilities & Capital Development~~.~~ via the Delta e-tendering portal administered by Wessex NHS Procurement Limited (WPL). All tenders will be returned via the Delta e-tendering portal and will opened automatically at the prescribed date/time set at the time tenders were published in accordance with the SFIs of the Trust.

~~b) Tenders for contracts estimated to exceed £500,000 (excluding VAT) will be returned to the Chief Executive Officer's office, otherwise tenders will be returned to the Director of Estates, Facilities & Capital Development's office who will arrange for them to be opened in accordance with the SFIs of the Trust.~~

~~c) No tender shall be considered which bears any mark or name indicating the sender.~~

~~d)~~b) Tender lists for building and engineering works will be compiled by the Director of Estates, Facilities & Capital Development from "Constructionline" the Trust's approved list of Contractors.

~~e)~~c) Before obtaining Tenders for the execution of any work the Director of Estates, Facilities & Capital Development will arrange for a pre-

tenderfinal estimate to be prepared. This should include works, VAT, fees, equipment and any other costs. The pre-tender estimate for the works element only should be stated on the tender return forms.

f)d) Where there is a wide discrepancy (>10%) between the pre-tenderfinal estimate and the final total scheme cost involving an increase in expenditure this is to be reported by the Director of Estates, Facilities & Capital Development to the CFO for further instructions.

g)e) The number of firms to be invited to tender for a particular contract shall be in accordance with the financial limits specified in SFI 7.2.

h)f) A tender report quotation/tender return form will be completed by the relevant project manager. It will include the scheme name, pre-tender estimate, names of contractors invited, date of invitation and date and time of return. According to the limits of delegation, it will signed bybe sent to the Director of Estates, Facilities & Capital Development / Associate Director of Estates / Head of Estates Projects or the Chief Executive Officer for the opening of the tenders in accordance with these SFIs.

i)g) Adjudication must be made in accordance with SFI 7.7. A tender ratification prepared by the Design Team and endorsed by the Project Manager should be submitted to the Director of Estates, Facilities & Capital Development for approval or to seek authorisation, according to delegated limits.

j)h) Acceptance of the tender/quotation must comply with the financial limits set out in SFI 7.2.

k)i) All contract documentation must be finalised promptly (ideally prior to the commencement of the contract) after the award of contact, this should include presenting it to the Associate Director of Corporate Affairs to meet the requirement for signing and sealing where required.

l)j) The waiving of variation of competitive tendering/quotation procedures shall be reported to the Audit and Risk Committee regularly.

7.10 Quotation & Tendering Procedures – Goods and Services Contracts

7.10.1 Financial limits for placing goods and services contracts are outlined in Annex 3, Section 4.

7.10.2 Where appropriate, pharmacy orders will be placed against Regionally/Divisionally agreed Pharmacy Contracts, which should cover the majority of orders placed by the Pharmacy Department.

7.10.3 The Director of Informatics is authorised to place contracts for Informatics Contracts only.

7.10.4 When contracting with subsidiary companies and companies where UHS are shareholders, the trust will follow the goods and services authorisation framework. In examples where there is a conflict of approving personnel, due

to individuals holding multiple directorships within each entity, the approval level will escalate to the next appropriate person in the hierarchy.

7.10.54 The values listed also apply to disposals (SFI 14). All other Financial Limits are detailed at SFI 7.2.

7.10.65 The legally compliant tendering process will be advised by WPL.

7.10.76 Where the total contract value exceeds £25,000 (excluding VAT) the Trust has a legal obligation to ensure that they advertise the opportunity through the national Government Contracts Finder portal and must subsequently ensure the respective award is also published.

7.10.87 Where the total contract value exceeds the published UK legislative thresholds (currently defined as the WTO GPA thresholds) ~~OJEU Thresholds~~ then the Trust is committed to a compliant procurement process as advised by WPL.

7.11 Waiving or Variation of Competitive Tendering/Quotation Procedure

7.11.1 Where goods, services and/or capital works are to be supplied over a period of time, the values listed must be taken as the value of the contract, not the annual value and should not seek to circumvent public sector procurement regulations. Competitive Procedure Waivers will be required as part of the Procurement Approval Document for all waivers over £25,000 (excluding VAT).

7.11.2 In circumstances where the specified number of quotations/tenders cannot be obtained (e.g. where there is a limited number of suppliers) the reasons for receiving a lower number of quotations/tenders must be recorded.

7.11.3 Waivers are not required in a limited number of circumstances. Firstly, if a partnership / joint venture contract exists that precludes the requirement for a competitive tendering process. This should be subject to confirmation by the Director of Wessex Procurement Limited and CFO. Secondly if a single supplier is mandated by NHS England or the contract is intra-NHS and not open to competition. Thirdly as part of a pay over agreement to another government entity. The Chief Financial Officer will maintain and monitor the list of exemptions, including:

a) Pay overs i.e. HMRC, Pensions, child voucher schemes, court fees;
b) Intra NHS Recharges;
c) NHS Litigation Services (NHS Resolution);
d) NHS Pensions Authority
e) Transactions between UHS Group entities e.g. WPL, UEL, UPL
University of Southampton shared service provisions i.e. consultant medical staff with joint contract
f)

7.12 Quotation & Tendering Procedures Summary - Contracts

7.12.1 Competitive quotation/tenders will be obtained for all items according to the financial limits specified in SFI 7.2.

7.12.2 No Pre Qualifications stages should be conducted for below threshold quotations/tenders in accordance with Public Contract Regulations 2015 (Regulation 111).

7.12.3 Quotations will be obtained for single purchases where the estimated value does not exceed the limit specified in SFI 7.2.

7.12.4 Tenders shall be invited for all purchases of goods and/or services to be supplied over a period of time where the estimated contract value exceeds that specified in SFI 7.2.

7.12.5 Tenders will be issued by WPL and shall incorporate standard NHS Terms and Conditions of Contract.

7.12.6 After tenders/quotations have been opened, WPL will arrange for adjudication of the tenders/quotations. Adjudication must be made in accordance with SFI 7.7.

7.12.7 A Procurement Approval Document and Ratification Report prepared by WPL should be submitted for approval according to delegated contract approval limits as specified in SFI 7.2.

7.12.8 Acceptance of the tender/quotation must comply with the financial limits set out in SFI 7.2.

7.12.9 All waiving of variation of competitive tendering/quotation procedures shall be reported to the Audit and Risk Committee on a six monthly basis highlighting all waivers over £25,000 (excluding VAT) and those over £75,000 (excluding VAT) approved by the Chief Executive Officer or Chief Financial Officer.

7.12.10 Where a competitive tender ratification process has already been conducted for goods or equipment and approved within the delegated levels, authority is given to the Managing Director of Wessex Procurement Limited to approve any subsequent lease contract award for the same goods or equipment.

7.12.11 In accordance with the Public Contract Regulations 2015 (Regulations 106 and 110) the Trust has a legal obligation to ensure that they advertise any new contract opportunity over £25,000 (excluding VAT) through the national Government Contracts Finder portal and must subsequently ensure the respective award is also published. All competitive quotations/tenders should come through the e-tendering portal to ensure compliance and publication to the Government Contracts Finder.

7.12.12 All Trust quotation/tenders or waivers over £25,000 (excluding VAT) in value must result in a signed contract between the supplier and the Trust under agreed terms and conditions, clear specifications and KPI's where appropriate. These will be retained through the WPL Source To Contract

System. Any exceptions to this are at the discretion of the Managing Director of Wessex Procurement Limited.

7.13 Non-Disclosure Agreements

7.13.1 Non-disclosure agreements (also referred to as NDAs or confidentiality agreements) may be entered into by the Trust when it is developing a new product, service or process with someone else. The agreement will restrict the way in which any confidential information shared by the Trust and the other party can be used and ensure that this information and the fact that the parties are working together are kept confidential. These agreements are entered into at the outset of the process and will not generally have a financial value associated with them.

7.13.2 Legal advice should be sought when the Trust is asked to enter into a non-disclosure agreement or the agreement entered into should follow the format of the template non-disclosure agreement used by the Trust. Non-disclosure agreements must be authorised and signed by any Executive Director, the Director of Informatics, the Managing Director of Wessex Procurement Limited~~Procurement and Supply~~ or the Commercial Director.

8. CONTRACTS FOR THE PROVISION OF SERVICES

8.1 Service Contracts

8.1.1 The Board of Directors shall regularly review and shall at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services referred to in its Terms of Authorisation and related schedules.

8.1.2 The Chief Executive Officer, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable Service Contracts with NHS England/Integrated Care Boards~~Clinical Commissioning Groups~~ and other commissioners for the provision of services and for considering the extent to which any NHS Standard Contracts issued by the Department of Health and Social Care or NHS England~~Improvement~~ are mandatory for Service Contracts.

8.1.3 Where the Trust enters into a relationship with another organisation for the supply or receipt of other services, clinical or non-clinical, the responsible officer should ensure that an appropriate contract is present and signed by both parties.

8.1.4 All Service Contracts and other contracts shall be legally binding, shall comply with best costing practice and shall be devised so as to manage contractual risk, in so far as is reasonably achievable in the circumstances of each contract, whilst optimising the Trust's opportunity to generate income for the benefit of the Trust and its service users.

8.1.5 In discharging this responsibility, the Chief Executive Officer should take into account:

(a) Costing and pricing (in accordance with the NHS England financial regime ~~Payment by Results~~ or any alternatively agreed payment mechanism) and the activity / volume of services planned;

(b) The standards of service quality expected;

(c) The relevant national service framework (if any);

(d) Payment terms and conditions;

(e) Amendments to contracts and non-contractual arrangements; and

(f) Any other matters relating to contracts of a legal or non-financial nature.

8.1.6 Prices should match national tariff, where appropriate, but the Trust can negotiate locally agreed prices, where services are not covered by the national tariff.

8.1.7 The CFO shall produce regular reports detailing actual and forecast income.

8.1.8 The CFO shall oversee and approve cash flow forecasts, including figures relating to the collection of all income due under the contracts.

8.1.9 The authorisation limits for signing service contracts are set out in Annex 3.

8.2 Involving Partners and Jointly Managing Risk

8.2.1 A good contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive Officer to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the risk in question and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.3 Tendering (where UHS is a competing body)

8.3.1 Where UHS participate in a tendering exercise (whether in competition with others or not) for a health related service, approval must be sought according to the delegated authority limits. This includes bidding for external sources of capital or revenue funding.

8.3.2 Delegated authority limits associated with tendering are outlined in Annex 3.

8.3.3 No tender must be submitted without sign-off from the relevant authority. For absolute clarity, no Trust employee should sign a tender or contract unless they have authority and the total contract value is within the ~~above~~ stated financial limits as per the Trust Authorisation Framework. All tender decisions will be reported to the Trust Executive Committee for noting.

8.3.4 Staff who participate in a tendering exercise must notify the Planning and Business Development ~~Strategy~~ team and/or commercial team and follow processes in accordance with the "Bidding for Contracts" policy (available on Staffnet).

9. TERMS OF SERVICE AND PAYMENT OF BOARD DIRECTORS AND EMPLOYEES

9.1 Remuneration and Appointment Committee

9.1.1 The Trust Board shall establish a Remuneration and Appointment Committee, with clearly defined terms of reference specifying which posts fall within its area of responsibility, its composition and its reporting arrangements.

9.1.2 Any Trust Board post and some Senior Manager posts will be subject to the requirements of the Fit and Proper Persons Test which is administered by

Human Resources. Human Resources are responsible for keeping the list of applicable posts up to date.

9.1.3 Appointments to senior management or Director posts above the salary of the Prime Minister (currently circa £160k) must be referred to NHS England~~NHS Improvement~~ and onward opinion from the Secretary of State.

9.2 Staff Appointments, Terminations and Changes

9.2.1 An Employee or Director to whom a staff budget or part of a staff budget is delegated may engage employees, or hire agency staff subject to any approval that may be required by the Recruitment Control Panel (if applicable) and provided the post is within the limit of his approved budget and affordable staffing limit. He/she may also regrade employees after consultation with their Human Resources Business Partner and job evaluation has taken place in accordance with Trust policy.

9.2.2 The Trust's primary mechanism of engagement is for workers to be placed on payroll either through permanent employment or fixed term contracts. Where a requirement for temporary resourcing appears (or a specific short-term skills shortage) alternative forms of resourcing may be used including Bank and Agency. The use of bank must be in line with the Trust's procedures for booking temporary staff. Agency bookings should be in line with the Trust procedures, ensuring required sign off is obtained and that NHS and Tax regulation are complied with. Any off-payroll engagements must be compliant with IR35 legislation and approved by the CFO prior to contract signature.

9.2.3 All contracts of employment including recruitment, promotions and terminations will be transacted via ESR (Electronic Staff Record) by Self Service or where applicable through the appropriate HR team. Please see the Staffnet Quick Guide to HR processes for guidance.

9.2.4 All staff employed by the Trust will be issued a contract of employment. All agency staff engaged should be via an approved framework agency and through the Trust's agreed supplier. Any individuals directly engaged, who sit outside of these 2 categories, should have a suitable contractual agreement in place. Engagement of agencies should also be in line with prevailing NHS England / NHS Improvement requirements and rules.

9.2.5 A termination of employment form must be submitted by the employee's line manager through manager self service on ESR before the termination date.

9.2.6 Any appointments should follow the Trust Recruitment Policy found on Staffnet.

9.2.7 As a general principle the Trust will seek to avoid the requirement to make staff redundant. The Trust will therefore always seek to redeploy staff where appropriate.

9.2.8 In the event that redundancy cannot be avoided the Trust shall:

i) Develop selection criteria based upon the agreed Trust Organisational Change Policy which includes affordability, and

ii) Complete the Trust redundancy approval form and submit to the HR Business Partner.

9.2.9 Changes to, and / or the creation of, local terms and conditions require approval by ~~will be a matter for P~~Pay Steering Group. Where necessary, for

major changes, it may be appropriate for this to be authorised by either the Trust Board's Remuneration and Appointment Committee or Trust Board.

9.3 Processing Payroll

9.3.1 The Chief People Officer shall be responsible for the final determination of pay, including the verification that the rate of pay and relevant conditions of service are in accordance with current agreements.

9.3.2 The CFO is responsible for the agreement to and management of the Payroll Contract with outside providers.

9.3.3 Regardless of the arrangements for providing the payroll service, the CFO shall ensure that the chosen method is supported by appropriate (contractual) terms and conditions, adequate internal controls and audit review procedures, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.3.4 Managers and employees are jointly responsible and accountable for ensuring claims for pay and expenses are timely, correct and any under or over payments are highlighted as soon as discovered. The process and procedures related to pay related claims and under / overpayments is contained in the Trust's Pay Policy.

10. NON-PAY EXPENDITURE

10.1 Delegation of Authority and Service Development Business Cases

10.1.1 The Trust Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive Officer will determine the level of delegation to budget managers.

10.1.2 Council of Governors will be consulted on significant transactions – see Annex 2.

10.2 Requisitioning and Ordering Goods and Services

10.2.1 The Chief Financial Officer will set out:

a) The list of managers who are authorised to place requisitions for the supply of goods and services, via an approvals hierarchy; and

b) The maximum level of each requisition and the system for authorisation above that level. Authorisation limits are specified at Annex 3.

10.2.2 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Managing Director of Wessex Procurement Limited~~Trust Director of Procurement and Supply~~ shall be sought. Where this advice is not acceptable to the requisitioner, the CFO shall be consulted.

10.2.3 Once the item to be supplied (or service to be performed) has been identified the requisitioner should raise a requisition.

10.2.4 The Trust operates a "No Purchase Order No Pay" policy. All orders require a Purchase Order prior to being place. The Chief Financial Officer will maintain and monitor a list of exemptions, including:

a) Invoices relating to the previous financial system;
b) Pay overs i.e. HMRC, Pensions, child support, court fees;

c) Salary sacrifice;
d) Opticians;
e) Intraer NHS Recharges ~~(in certain prescribed places)~~;
f) General personal reimbursements;
g) Litigation;
h) Local Authority costs;
i) Payments controlled in other systems e.g. JAC for Pharmacy
j) Transactions between UHS Group entities e.g. WPL, UEL, UPL

10.3 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

10.3.1 The CFO shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.3.2 The CFO will:

a) Prepare procedural instructions (where not already provided in the Scheme of Delegation or procedure notes for budget managers) on the obtaining of goods, works and services incorporating these thresholds;

b) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) **Authorisation:**

- a list of Directors and Employees able to authorise invoices and that the expenditure has been authorised by the officer responsible for the contract or budget which is to be charged

ii) **Certification:**

- goods have been duly received, examined and are in accordance with specification and the prices are correct. Certification of accounts may either be through a goods received note or by personal certification by authorised officers;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined and are reasonable;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- where an officer certifying accounts relies upon other officers to do preliminary checking he/she shall, wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and

negotiated prices and terms and that such checks are evidenced;

- in the case of contract for building and engineering works which require payment to be made on account during process of the works the CFO shall make payment on receipt of a certificate from the appropriate technical consultant or authorised officer. Without prejudice to the responsibility of any consultant, or authorised officer appointed to a particular building or engineering contract, a contractors account shall be subjected to such financial examination by the CFO and such general examination by the authorised officer as may be considered necessary, before the person responsible to the Trust for the contract issues the final certificate;

iii) **Payments and Creditors:**

- a timetable and system for submission to the CFO of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iv) **Financial Procedures:**

- instructions to employees regarding the handling and payment of accounts within the Finance Department;

c) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received (except where a prepayment is agreed).

10.3.3 Prepayments are only permitted where the financial advantages outweigh the disadvantages. In such instances:

a) The appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his/her commitments;

b) The supplier is of sufficient financial status or able to offer a suitable financial instrument to protect against the risk of insolvency;

c) There are adequate administrative procedures to ensure that where payments in advance are made the goods or services are received or refunds obtained;

d) The CFO must approve the proposed arrangements before those arrangements are contracted; and

e) The Budget Manager is responsible for ensuring that all items due under a prepayment contract are received and must immediately inform the appropriate Director if problems are encountered.

10.3.4 Managers must ensure that they comply fully with the guidance and limits specified by the CFO and that:

a) All contracts (other than for simple purchase permitted within the Scheme of Delegation or delegated budget), tenancy agreements and other commitments which may result in a liability are notified to the CFO in advance of any commitment being made;

a) The following contracts should be submitted to the Finance department for review prior to seeking approval as they are likely to need

submission to Trust Investment Group under revised accounting standard IFRS16:

- Equipment leases
- Property leases (including those with peppercorn rents)
- Other contracts which include the supply of equipment which include separate charges for that equipment (embedded leases)
- Other contracts which include the supply of equipment which do not include separate charges for that equipment (as the charging mechanism may need apportioning between the supply of goods or services and the supply of equipment as an embedded lease)
- Other property guarantees

b) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the relevant approval body outlined in Annex 3;

c) Changes to the list of Directors and Employees authorised to certify invoices are in accordance with the scheme approved by the Board;

d) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the CFO;

e) Petty cash records are maintained in a form as determined by the CFO;

f) Contracts above specified thresholds are advertised and awarded in accordance with UK legislation and ~~EU and~~ WTO rules on public procurement; and

g) All requisitions must be approved in line with the Trust Authorisation Framework.

h) In certain circumstances, where regular transactions are made for items such as travel, course and accommodation bookings and one-off purchases, a Trust purchasing card can be an alternative means of procurement. All purchase card holders are required to follow the Trust purchasing card procedure and will be required to sign a declaration agreeing to the terms of the procedure.

11. EXTERNAL BORROWING, PUBLIC DIVIDEND CAPITAL AND CASH INVESTMENTS

11.1 External Borrowing

11.1.1 The Trust may borrow money for the purposes of, or in connection with, its strategic objectives and its operational functions.

11.1.2 The total amount of the Trust's borrowing must be affordable within NHS England~~NHS Improvement~~'s NHS Oversight Framework for Trusts.

11.1.3 Any application for a loan or overdraft facility must be approved by the Board and will only be made by the CFO or a person with specific delegated powers from the CFO. Use of such loans or overdraft facilities must be approved by the CFO.

11.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash position. Any short-term borrowing requirement in excess of one month must be authorised by the CFO.

11.1.5 All long-term borrowing must be consistent with the plans outlined in the current Trust Operational Plan approved by the Board.

11.2 Public Dividend Capital ("PDC")

11.2.1 The Trust will comply with the guidance on dividend payments contained in the DHSC Group Accounting Manual.

11.3 Investments

11.3.1 The Trust may invest money for the purposes of its strategic objectives and operational functions.

11.3.2 The Audit and Risk Committee shall set the investment policy (setting out acceptable risks and unacceptable risks) and oversee all investment transactions by the Trust. The Treasury Management Policy shall set out the guidelines and shall be approved by the Audit and Risk Committee.

11.3.3 Investments may be made in forming and / or acquiring an interest in bodies corporate where authorised by the Board.

11.3.4 Temporary cash surpluses must be held only in investments permitted by NHS England~~Improvement~~ and meeting the criteria approved by the Treasury Management Policy. The Treasury Management Policy will be refreshed and approved by the Audit and Risk Committee on an annual basis.

11.3.5 The CFO is responsible for advising the Board on investments and shall periodically report the performance of all investments held to the Board through the Audit and Risk Committee.

11.3.6 The CFO will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

11.3.7 The CFO (or a senior finance manager with specific delegated powers from the CFO) will authorise all investment transactions and ensure compliance with the Treasury Management Policy at all times, with no investment made which would be outside the laid-down parameters for investment risk management in the policy. All investments are subject to periodic review and monitoring by the Audit and Risk Committee.

12. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

12.1 Capital Investment

12.1.1 The Trust will establish a Trust Investment Group comprising at least two Executive Directors and chaired by the Chief Financial Officer to oversee its allocation of capital investment. The Chief Financial Officer will ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon the Trust's Operational Plan and the Capital Investment Plan.

12.1.2 The Investment Group will oversee the development and monitoring of an annual capital plan, including any changes to the plan as necessary in year.

12.2 Approval of Capital Business Cases

12.2.1 Approval of capital business cases will follow the approval limits outlined in the Trust Approval Framework in Annex 3.

12.2.2 Defined groups with specific approval limits are as follows:

Programme allocations within Capital Plan	***Group/ individual responsible for approval***
Backlog Maintenance	Director of Estates, Facilities & Capital Development / Associate Director of Estates
Replacement leases	Leasing sub-committee
Health & Safety	Health & Safety Manager
Infrastructure, Development Infrastructure, Space Issues, Defects Resolution, Fire Safety, Advanced Design Fees, Contingency	Director of Estates, Facilities & Capital Development
Medical Equipment	Medical Equipment Panel
Theatres Equipment	UEL Board
Information Systems	Digital Board
~~Theatre Instrumentation~~	~~Director of Operations, Division A~~

12.2.3 Delegated capital limits refer to overall contract values, regardless of the form of funding (e.g. lease, capital up-front, bullet payment or managed service contract).

12.2.4 The delivery of capital schemes within approved budgets will be the responsibility of a named officer within the business case. Where costs are reasonably foreseeable to exceed the approved budget by more than £150k or more than 10%, whichever is greater, then further approval from the authorising body will be required. In extremis, where this threshold is reached and it is not possible to obtain the necessary approval in a timely manner, the Chair of the authorising body will be informed and may exercise Chair's action to approve the additional expenditure with subsequent reporting to the authorising body at its next meeting. In situations where the additional expenditure increases the cost of the scheme beyond the approval limit of the original authorising body, that authorising body may approve the additional expenditure but will report such to the body with which the approval limit for the revised total scheme cost resides.

12.2.5 Minor changes to the Trust's IISS (Imaging Infrastructure Support Service) managed service contract, up to a maximum value of £100k, can be approved by the Director of Operational Finance. All changes must be reported to the Trust Investment Group.

12.2.6 The Trust Investment Group will set out and periodically review and update the format and minimum required content of business cases. This will typically include:

a) An option appraisal of potential benefits compared with known costs;

b) Ensuring an appropriately detailed analysis of expenditure and income flows is undertaken, including documented responses from purchasers as appropriate and risk analysis testing the assumptions made; and

c) An analysis of the project's discounted cash flow, based on an agreed rate of return.

12.2.7 The Trust Investment Group will report on major issues to the Trust Executive Committee and Trust Board via the capital section of the monthly Finance Report and within the quarterly capital update.

12.2.8 The Southampton Hospital Charity, or other charities, may choose to donate assets to the Trust. The governance outlined in Section 17 (Charitable Funds

Held on Trust) shall apply. Any financial consequences on the Trust must be approved by the appropriate body as outlined in the Trust Authorisation Framework (Annex 3).

12.2.9 Once capital is approved, the Chief Financial Officer is responsible for choosing the most appropriate source of finance, aligned to the Trust Treasury Management Policy.

12.2.10 Finance leases reaching the end of their contractual term are included as Capital expenditure. The Trust Investment Group has authorised the Leasing Sub-Committee to manage and approve the buy-out and/or direct replacement of leases. Where new equipment is required, a business case needs to go to Trust Investment Group for approval before a decision on whether to lease or direct purchase can be made.

12.3 Private Finance Initiative

12.3.1 Proposals for Private Finance must be submitted to the Trust Investment Group for approval or review prior to request for approval by Trust Board if required.

12.4 Asset Registers

12.4.1 The Chief Executive Officer is responsible for the maintenance of registers of assets, taking account of advice from the CFO concerning the form of any register and the method of updating. Appropriate adjustments must be made to reflect actual Trust assets currently in use. All items over £5,000 must be recorded on the Fixed Asset Register.

12.4.2 The CFO shall prepare procedural instructions on the disposal of assets.

12.4.3 Additions to the fixed asset register must be clearly identified to the associated senior service user/ owner and be validated by reference to:

a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) stores, requisitions and wages records for own materials and labour including appropriate overheads.

12.4.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.4.5 The CFO shall approve procedures for reconciling balances on fixed assets accounts in the general ledger against balances on the fixed asset register.

12.4.6 The value of each asset shall generally be depreciated using appropriate methods and rates in line with accounting standards.

12.5 Security of Assets

12.5.1 The overall control of fixed assets is the responsibility of the Chief Executive Officer.

12.5.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, including donated assets) must be approved by the CFO. This procedure shall make provision for:

a) Recording managerial responsibility for each asset;

b) Identification of additions and disposals;

c) Identification of all repairs and maintenance expenses

d) Physical security of assets;

e) Periodic verification of the existence of, condition of, and title to, assets recorded;

f) Identification and reporting of all costs associated with the retention of an asset; and

g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.5.3 The CFO shall approve procedures for reconciling balances on fixed assets accounts in the general ledger against balances on the fixed asset register.

12.5.4 All discrepancies revealed by verification of physical assets to the fixed asset register shall be notified to the appropriate manager who shall inform the CFO who shall decide what further action shall be taken.

12.5.5 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Trust Board. Any breach of agreed security practices must be reported.

12.5.6 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and Employees in accordance with the procedure for reporting losses and the requirements of insurance arrangements.

12.5.7 Whenever practicable, assets should be marked as Trust property.

12.5.8 Inventories shall also be maintained and receipts obtained for:

a) Equipment on loan;

b) All contents of furnished lettings.

12.6 Property (Land and Buildings)

12.6.1 Significant changes relating to the Trust's Estate must receive the prior approval of the Trust Investment Group and the Trust Executive Committee.

12.6.2 The following matters related to property must be approved by the Trust Board:
a) An Estate Strategy;
b) Acquisition of freehold property over £2.5 million (excluding VAT); and
c) Acquisition of property where the total value of the agreement is over £2.5 million (excluding VAT) by means of a lease, whether it is deemed to be capitalised or not under IFRS 16~~an operating or finance lease~~.

12.6.3 Property purchases, licences and leases up to £150,000 each (excluding VAT) may be authorised by the CFO and those at or above this value but not exceeding £2.5 million each (excluding VAT) may be authorised by the Trust Investment Group, provided in each case that they fall within the Board's approved Estates Strategy and that the cost is within 10% of an independent valuation. Licences connected with existing leases or other transactions previously authorised by the CFO, Trust Investment Group and Trust Board will not require separate authorisation provided that these do not result in significant changes to the Trust's Estate.

12.6.4 The complexity of any property reports to the Trust Board should be determined by the materiality of the consideration or lease payments and any contentious issues, and must contain:

a) Details of the consideration or lease payments;
b) Details of the period of the lease;
c) Details of the required accounting treatment;
d) Annual running costs of the property;
e) Funding sources within the Trust of both capital and revenue aspects of the acquisition;
f) The results of property and ground surveys;
g) Professional advice taken and the resultant cost;
h) Details of any legal agreement entered into;
i) Any restrictive covenants that exist on the property; and
j) Planning permission.

12.6.5 Any property acquisition should be in accord with Department of Health and Social Care guidance.

12.6.6 The contracts to acquire the property must be signed by two Executive Directors, one of whom should be the Chief Executive Officer.

12.6.7 Appointment of professional advisors must be in line with the separate procedures for the appointment of advisors.

12.6.8 Trust Board approval must be obtained for the disposal of any property over £2.5 million (excluding VAT) which is recorded on the balance sheet of the Trust. A business case must be presented to the Trust which must include:

a) The proceeds to be received;

b) Any warrants or guarantees being given; and

c) Independent valuations obtained.

12.6.9 The disposal must be effected in full accord with Estate code.

12.6.10 Disposals of protected assets require the approval of NHS England~~NHS Improvement~~.

12.6.11 Material or Significant Transactions, as defined in NHS England~~NHS Improvement~~'s transactions guidance, may require the approval of NHS England~~NHS Improvement~~.

12.6.12 The granting of property leases by the Trust must have prior Board approval where the annual value of the lease is in excess of £2.5 million.

13. INVENTORY AND RECEIPT OF GOODS

13.1 Inventory Stores and Inventory

13.1.1 Inventory Stores, defined in terms of controlled stores and department stores (for immediate use) and stock held by the Trust should be kept to a minimum subjected to at least an annual stock take valued at the lower of cost and net realisable value. Inventory shall be controlled on a First In First Out (FIFO) basis wherever possible; cost shall be ascertained on either this basis or on the basis of average purchase price. The cost of inventory shall be the purchase price without any overheads, but including value added tax where this cannot be reclaimed on purchase.

13.1.2 Subject to the responsibility of the CFO for the systems of control, overall responsibility for the control of Inventory Stores and Inventory shall be the responsibility of the Managing Director of Wessex Procurement Limited~~and Supply~~. The day-to-day responsibility may be delegated by him/her to departmental officers and stores managers and keepers, subject to such delegation being entered in a record available to the CFO. The control of pharmaceutical stocks shall be the responsibility of the Deputy Chief Pharmacist; and the control of fuel oil the responsibility of the Director of Estates, Facilities & Capital Development. The control of stock within UHS subsidiaries shall be the responsibility of subsidiary directors and their respective Boards.

13.1.3 The responsibility for security arrangements and the custody of keys for all Inventory Stores and locations shall be clearly defined in writing by the Head of Supply Chain wherever practicable, stocks should be marked as Health Service property.

13.1.4 The CFO, in conjunction with the Managing Director of Wessex Procurement Limited ~~and Supply~~, shall set out procedures and systems to regulate the Inventory stores and the inventory contained therein, including records for receipt of goods, issues, and returns to suppliers, and losses and specify all goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification; a delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods; all goods received shall be entered onto an appropriate goods received/inventory record (whether a computer or manual system) on the day of receipt:

a) If goods received are unsatisfactory the records shall be marked accordingly. Where goods received are seen to be unsatisfactory, or short on delivery, they shall only be accepted on the authority of a designated officer and the supplier shall be notified immediately;

b) Where appropriate the issue of stocks shall be supported by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer independent of the storekeeper.

13.1.5 Stocktaking arrangements shall be agreed with the CFO and shall specify:

a) The procedures of system for the control of consignment stock will be defined in the Consignment Inventory Policy;

b) That there shall be a physical check covering all items in store at least once a year;

c) The physical check shall involve at least one officer other than the storekeeper, and a member of staff from the Finance Department shall be invited to attend;

d) The stocktaking records shall be numerically controlled and signed by the officers undertaking the check;

e) Any surplus or deficiencies revealed on stocktaking shall be reported in accordance with the procedure set out by the CFO.

13.1.6 Where a complete system of inventory control is not justified, alternative arrangements shall require the approval of the CFO.

13.1.7 The Managing Director of Wessex Procurement Limited ~~and Supply~~ shall be responsible for a system approved by the CFO for a review of slow-moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. Any evidence of significant overstocking and of any negligence or malpractice shall be reported to the CFO (see also SFI 14, Disposals, Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.1.8 Breakages and other losses of goods in stock shall be recorded as they occur. Tolerance limits shall be established for all stocks subject to unavoidable loss, e.g. natural deterioration of certain goods (see also SFI 14, Disposals, Condemnations, Losses and Special Payments).

13.1.9 Inventory that has deteriorated, or are not usable for any other reason for their intended purposes, or may become obsolete, shall be written down to their net realisable value. The write down shall be approved by the CFO and recorded.

13.1.10 For goods supplied via the NHS Supply Chain central warehouses, or Trust Supplies Stores, the Chief Executive Officer shall identify those authorised to requisition and accept goods from the store.

13.1.11 It is a duty of officers responsible for the custody and control of inventory to notify all losses, including those due to theft, fraud and arson, in accordance with SFI 14.

14. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 Disposals and Condemnations (see also Trust Disposals Policy)

14.1.1 The CFO shall prepare detailed procedures for the disposal of assets including capital assets and condemnations.

14.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will:

a) Establish whether it is needed elsewhere in the Trust;

b) Determine and advise the Finance Department of the estimated market value of the item, taking account of professional advice where appropriate. The highest possible disposal value will be realised, taking into account potential risks and reputational impacts.

14.1.3 All unserviceable articles shall be:

a) Condemned or otherwise disposed of by an employee authorised for that purpose by the CFO;

b) Recorded by the condemning officer in a form approved by the CFO which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the CFO.

14.1.4 The condemning officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the CFO, who will take the appropriate action.

14.1.5 Disposals of assets valued at over £100k (higher of either market value or net book value) must be approved by the Chief Executive Officer.

14.2 Losses and Special Payments Procedures

14.2.1 The CFO must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments in accordance with DHSC Group Accounting Manual and prepare a register.

14.2.2 The CFO must also prepare a 'fraud response plan' that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it. (See Trust Fraud, Bribery and Corruption Policy).

14.2.3 Any employee discovering or suspecting a loss of any kind must immediately act according to the Trust's Fraud, Bribery and Corruption Policy.

14.2.4 The CFO is responsible for monitoring compliance with the Directions of the Secretary of State and with any other instructions issued by the NHS Counter Fraud Authority.

14.2.5 The Directorate or Service Manager shall inform the CFO of all other losses or recoveries of previous reported losses so that they can be entered in the losses and special payments register.

14.2.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the CFO shall inform the Chief Executive Officer in cases where the loss may be material or where the incident may lead to adverse publicity.

14.2.7 The CFO shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

14.2.8 For any loss, the CFO should consider whether any insurance claim can be made against insurers.

14.2.9 All losses and special payments (other than compensation payments) shall be recorded without delay in the Trust's Losses Register, to be maintained by the CFO and investigated in such a manner as the CFO may require. Write-off action shall be recorded against each entry in the register. Losses and special payments are defined at Annex 1.

15. INFORMATION TECHNOLOGY

15.1 Computer Systems and Data

15.1.1 The Chief Executive Officer, supported by the Director of Informatics, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall devise and implement any necessary procedures to ensure

adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018 and the General Data Protection Regulation; ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment, ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out ensure procedures are in place to limit the risk of, and recover promptly from, interruptions to computer operations.

15.1.2 The CFO shall be satisfied that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

15.1.3 The CFO shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage and ensure that appropriate technical and organisational measures are in place to achieve compliance. The contract should also ensure rights of access for audit purposes.

15.1.4 Where another health organisation or any other agency provides a computer service for financial applications, the CFO shall periodically seek assurances that adequate controls are in operation.

15.1.5 Where computer systems have an impact on corporate financial systems the CFO shall be satisfied that:

a) Systems acquisition, development and maintenance are in line with the Trust's Information Strategy;

b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

c) Finance staff have access to such data;

d) Have adequate controls in place; and

e) Such computer audit reviews as are considered necessary are being carried out.

15.1.6 No software package for use on trust equipment (PCs, laptops, tablets) should be purchased without the knowledge of the Informatics department. Any quotes to purchase software should therefore be managed through the IT helpdesk.

No hardware equipment should be connected to the network without the approval of the Informatics department.

The Trust's Digital Board ~~Information Strategy Steering Group (ISSG)~~ has an approval limit of £300k for projects where within budgetary limits. It will be at the discretion of the Director of Informatics or other senior Informatics managers whether a case requires discussion at Digital Board~~ISSG~~.

16. PATIENTS' PROPERTY

16.1 Patients' Property and Income

16.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival. Staff have a duty of care to make every effort to take care of patients' possessions, which are **not** handed in for safe keeping, particularly if the patient does not have the capacity to look after their own possessions. This includes items of daily living such as glasses, false teeth, hearing aids etc.

16.1.2 The Chief Executive Officer is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission, (by notices and information booklets, hospital admission documentation and property records, and/or the oral advice of administrative and nursing staff responsible for admissions), of the Trust's policy that the Trust will not accept responsibility or liability for patients' property brought into health service premises, subject to the exceptions identified above, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt. Patients electing not to conform to this guidance must indemnify the Trust against any loss.

16.1.3 The CFO will provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty it is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money.

16.1.4 Where Department of Health and Social Care instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the CFO.

16.1.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

16.1.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.1.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the patient or patient's representative as appropriate, in writing.

16.1.8 Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Health and Social Care and Department of Work and Pensions instructions and guidelines**.**

17. CHARITABLE FUNDS HELD ON TRUST

17.1 Introduction

17.1.1 The Trust is the sole corporate Trustee of Southampton Hospital Charity (registered charity number 1051543), and is responsible for the management of funds it holds on trust. Although the management processes may overlap with those of the Trust, the trustee responsibilities must be discharged separately and full recognition given to the accountability to the Charity Commission for charitable funds held on trust.

17.1.2 This section of SFIs is intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee. As management processes overlap, most of the sections of these SFIs will apply to the management of funds held on trust. This section covers those instructions which are specific to the management and governance of funds held on trust.

17.1.3 The overriding principle is that the integrity of each fund must be maintained and statutory and fund obligations met. Materiality must be assessed separately from Exchequer activities and funds.

17.1.4 The Trust Board hereby nominates the Chief People Officer, who has executive responsibility for the Charitable Funds team, to have primary responsibility to the Trust Board for ensuring that these SFIs are applied in respect of Charitable Funds.

17.1.5 The Trust shall ensure the establishment of the Southampton Hospital Charity Charitable Funds Committee, to which it delegates the majority of its Trustee role as set out in the Committee's Terms of Reference.

17.2 Administration of Charitable Funds

17.2.1 The CFO or nominated deputy shall:

a) Authorise any transaction of funds between investment vehicles;

b) Oversee the preparation and procedure of the annual accounts and the annual audit.

17.2.2 The Charity Director shall arrange for the following functions to be undertaken:

a) Arrange for the administration of all existing charitable funds including clear electronic and paper record keeping in accordance with the recommendations of internal and external audit;

b) Ensure that each fund has a specific fund objective and that funds are spent appropriately, timely and in line with the donor wishes;

c) Produce codes of procedure covering the financial management of funds held;

d) Ensure funds are held within ~~designated or~~ restricted accounts are managed in accordance with charity law;

e) Periodically review the funds and any subsidiary funds, rationalise funds within statutory guidelines, and report changes to the Southampton Hospital Charity Charitable Funds Committee;

f) Recommend additional funds where this is consistent with good practice for ensuring the safe and appropriate management of restricted/designated funds, in particular ensuring that the new fund could not adequately be managed as part of an existing fund;

g) Ensure that all charitable funds are banked in accordance with the Trust's SFI for banking arrangements;

h) Report income and expenditure totals on a monthly basis to the Chief People Officer and to the Southampton Hospital Charity Charitable Funds Committee at the quarterly meetings;

i) Ensure that charitable funds' income and expenditure is managed with due regard to taxation implications;

j) Prepare the annual accounts and Trustee's report in the required format for timely submission to the Auditors, Southampton Hospital Charity Charitable Funds Committee and the Charity Commission.

17.3 Fundraising & Incoming Funds

17.3.1 The Director of Southampton Hospital Charity shall:

a) Introduce and enforce policies, systems and procedures to ensure that officers of the Trust are informed as to how to proceed when offered funds that donors' intentions are recorded and that formal receipting and thanking procedures are in place;

b) Identify and prioritise, in conjunction with appropriate elements of the Trust, fundraising projects/appeals.

c) Market and promote fundraising while maintaining a unified brand and adhering to charity regulations;

d) Build, maintain and utilise donor records in accordance with the Data Protection and Freedom of Information Acts;

e) Work in close partnership with other charities supporting the hospital, performing a liaison role where appropriate;

f) Build and maintain a staff team and network of volunteers and funders;

g) Generate continuous and unrestricted income in order to become sustainable;

h) Alert the Charitable Funds Committee to any irregularities regarding the use of the charity's name or its registered charity number;

i) Ensure that adequate insurance is in place for all fundraising activities.

17.4 Investment Income

17.4.1 Investment will be the responsibility of Southampton Hospital Charity Charitable Funds Committee or if appropriate will be devolved to a sub-committee (to include the Charitable Funds Committee Chair, the CFO, and the Charity Director and/or appropriate replacements when required).

17.4.2 Its responsibilities will include:

a) Ensure that investment is in accordance with the Charity's investment policies;

b) Commission any required investment advisors;

c) Monitor the performance of investments and seek clarification from the investment advisors on any relevant issues;

d) Report any significant concerns to the Trust Board;

e) Review and recommend to the Trust Board the appointment of investment advisors every three years.

17.4.3 The Charity Director, with support from the Trust Finance Team will:

a) Report investment performance to the Southampton Hospital Charity Charitable Funds Committee;

b) Minute investment decisions;

c) Allocate dividends, interest, and realised and unrealised gains and losses across the funds appropriately.

17.5 Fund Expenditure and Grants

17.5.1 Day-to-day management of individual expenditure is delegated to the Charity Director and in turn to the individual charitable fund holders, within the limits set out in these instructions.

17.5.2 The powers of delegation available to commit resources are detailed in the table below. The levels of authority relate to single orders or connected multiple orders.

17.5.3 The Charity Director is responsible for ensuring appropriate fund holders are appointed to support the effective management and use of charitable funds. This includes periodic review of fund holders and their role.

17.5.~~4~~3 A connected multiple order could be for example:

a) The refurbishment of a room where several suppliers are involved

b) An ECG machine and its trolley

c) An order to cover a period of more than one year (the whole value of the order is considered rather than each annual value).

17.5.~~5~~4 ***Levels of Authority***

The following levels of approval shall apply:

£ (excl VAT)	**Approval Process for designated funds**
All levels	Application made to the Charity funds officer. Proposed expenditure discussed with fund holders and approval code issued if agreement. The Charity will require additional sign-off in support of the application depending on amount requested: Up to £10k – Fund holders £10k to £75k – Fund holders + CGM (or THQ director) Above £75k- Fund holders + DDO (or THQ director)
	Once approval code is issued the following approval levels apply
Up to £5,000	Senior Funds Officer
£5,001 - £25,000	Head of Charity Operations
£25,001 - £75,000	Charity Director
£75,001 - £1m	Charitable Funds Committee *Requires a business case*

Over £1m	Trust Board as Corporate Trustee *Requires a business case*

~~£~~	~~**Orders can only be processed once the following people give their authority**~~
~~Up to £10,000~~	~~The Fund Holder~~ ~~+ One other authorised signatory from the relevant fund~~
~~£10,001 - £50,000~~	~~As above~~ ~~+ The appropriate Care Group Manager~~
~~£50,001 - £100,000~~	~~As above~~ ~~+ The Southampton Hospital Charity Charitable Funds Committee~~
~~Over £100,000~~	~~As above~~ ~~+ The Trust Board in its capacity as the board of directors of the corporate trustee of the Southampton Hospital Charity~~

~~*For matters outside the Divisional Structure:*~~

For the purpose of the non-pay authorisation framework, the CFO will be the £1m approver and the CEO will be the unlimited approver.

- ~~The CFO or his/her deputy takes the place of the Care Group Manager.~~

17.5.6~~5~~ Points to note:

~~a)~~ If the Fund Holder is absent from work for an extended period of time or , ~~an alternative signatory on the fund that holds the next senior position in the Trust (to the Fund Holder) may authorise expenditure.~~

~~b)~~a) ~~I~~in cases where, for example the Fund Holder and the Care Group Manager are one and the same, the Charity Director or Head of Charity Operations can exercise discretion to accept authorisation from fewer signatories, subject to the minimum of two.

~~c)~~b) If anyone seeking to authorise the expenditure of charitable funds is in any doubt whether the proposed expenditure is legitimate charitable expenditure, they should contact the Charity Director.

~~d)~~c) Expenditure above £75~~10~~,000 must be supported by an appropriate business case.

17.5.7~~6~~ Where the expenditure has an impact on NHS costs, the approval of the Trust shall be sought prior to contractual commitment.

17.5.8~~7~~ The delivery of charitably funded capital schemes within approved budgets will be the responsibility of a named officer within the business case. Where costs are reasonably foreseeable to exceed the approved budget by more than £10k or more than 5% then further approval from the authorising body will be required. In extremis, where this threshold is reached and it is not possible to obtain the necessary approval in a timely manner, the Chair of the authorising body will be informed and may exercise Chair's action to

approve the additional expenditure with subsequent reporting to the authorising body at its next meeting.

17.5.9 Although exempt from public sector procurement roles, the Charity will follow the Trust's procurement processes except in situations where these rules are not appropriate or applicable to charitable purposes. In these cases approval will be sought from Charitable Funds Committee.

17.6 Asset Management

17.6.1 Charitable funds can be considered as a source of funds for the maintenance of assets granted to the Trust, subject to agreement between the Charity and the Trust.

17.6.2 Assets granted by the Charity to the ownership of or to be used by the Trust, shall be maintained along with the general estate and inventory of assets of the Trust.

17.6.2 The Charity accepts no responsibility, financially or otherwise, for any liabilities arising out of the expenditure other than where the Charity has agreed to fund the maintenance or revenue costs.

17.6.3 The Trust shall:

a) Be responsible for insuring, safeguarding and protecting all equipment and must pay its operating, maintenance costs (unless prior agreement to be funded by the Charity), and all other costs arising from the day to day running of the equipment, including any insurance;

b) Be responsible for replacement of the equipment, if it is to be replaced, when it comes to the end of its natural life.

17.7 Risk Management

17.7.1 The Charity Director will be responsible for updating an annual risk register for agreement by the Southampton Hospital Charity Charitable Funds Committee. This will address the following key areas of risk for the charity:

a) Governance risks – e.g. inappropriate organisational structure, conflict of interest;

b) Operational risks – e.g. Service quality or development, security of assets, fund-raising activity;

c) Financial risks – e.g. accuracy and timeliness of financial information, adequacy of reserves and cash flow, investment management, recession;

d) External risks – e.g. public perception and adverse publicity, government policy;

e) Compliance with law and regulation – e.g. breach of charity law, lottery regulations.

18. STANDARDS OF BUSINESS CONDUCT

18.1 The Chief Executive Officer shall ensure that all staff, volunteers, and any other person associated with the activities of the Trust are made aware of, and comply with, the Trust's Standards of Business Conduct Policy. This policy details the conduct and behaviour expected of individuals with regard to:

a) Interests (financial or otherwise) in any matter affecting the Trust and the provision of services to patients, public and other stakeholders;

b) Conduct by an individual in a position to influence purchases;

c) Employment and business which may conflict with the interests of the Trust;

d) Relationships and loyalties which may conflict with the interests of the Trust;

e) Hospitality and gifts and other benefits in kind such as sponsorship.

Declarations relating to the above must be made in accordance with the Trust's Standard of Business Conduct Policy for inclusion in the Register of Interests.

18.2 The Bribery Act 2010 reforms the criminal law of bribery, making it easier to tackle this offence proactively in the public and private sectors.
It introduces a corporate offence which means that organisations are exposed to criminal liability, punishable by an unlimited fine, for negligently failing to prevent bribery. In addition, the Act allows for a maximum penalty of 10 years' imprisonment for offences committed by individuals.

Under the Bribery Act 2010 it is a criminal offence to:

a) Bribe another person by offering, promising, or giving a financial or other advantage to induce them to perform improperly a relevant function or activity, or as a reward for already having done so.

b) Be bribed by another person by requesting, agreeing to receive or accepting a financial or other advantage with the intention that a relevant function or activity would then be performed improperly, or as a reward for having already done so.

These offences can be committed directly or by and through a third person and, in many cases, it does not matter whether the person knows or believes that the performance of the function or activity is improper. It is, therefore, extremely important that staff adhere to this and other related policies (specifically, Fraud, Bribery and Corruption, Standards of Business Conduct and Raising Concerns (Whistleblowing) policies, available via staffnet).

The action of all staff must not give rise to, or foster the suspicion that they have been, or may have been, influenced by a gift or consideration to show favour or disadvantage to any person or organisation. Staff must not allow their judgement or integrity to be compromised in fact or by reasonable implication.

Staff should not be afraid to report genuine suspicions of fraud, bribery or corruption and should report all suspicions to the Local Counter Fraud Specialist (LCFS) who is responsible for tackling any concerns. Alternatively, suspicions can be reported via the National NHS fraud and corruption reporting line (0800 028 4060) or via the National Fraud Reporting website reportfraud.cfa.nhs.uk.

19. RETENTION OF RECORDS AND INFORMATION

19.1 The Chief Executive Officer shall be responsible for maintaining archives for all records, information and data required to be retained in accordance with

NHS England~~Improvement~~/DHSC guidelines. The delegated responsibility for holding and safekeeping of contracts, in secure storage where applicable, shall be as follows:

Document	Held By
Property Deeds	Director of Estates, Facilities & Capital Development
Building & Engineering Contracts	Director of Estates, Facilities & Capital Development
Estate Maintenance Contracts	Associate Director of Estates
Maintenance Contracts	WPL
Clinical Contracts	Director of Contracting
WPL Contracts	Associate Director of Corporate Affairs
Contracts for goods and services other than the above	WPL

The managers noted in the table above will also be responsible for maintaining registers of the contracts held by them. Any other contracts not covered by the above which may be held by other Managers must be reported to the Associate Director of Corporate Affairs for a register to be maintained.

19.2 The records held in archives shall be capable of retrieval by authorised persons.

19.3 Records and information held in accordance with latest NHS England~~Improvement~~/DHSC guidance shall only be destroyed before the specified guidance limits at the express authority of the Chief Executive Officer or CFO. Proper details shall be maintained of records and information so destroyed.

20. GOVERNANCE, RISK MANAGEMENT AND INSURANCE

20.1 Risk Management

20.1.1 The Chief Executive Officer shall ensure that the Trust has a sound system of risk management and internal control set out in strategy, policy, and procedural documentation. The functioning and efficacy of the system of internal control and risk management shall be monitored and assessed for suitability by the Board of Directors and its duly established committees.

20.1.2 The risk management and associated policies shall include:

a) A process for identifying and quantifying risks;

b) The authority of all managers with regard to managing the control and mitigation of risk;

c) Management processes to ensure all significant risks and potential liabilities are addressed, including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of residual risk;

d) Contingency plans to offset the impact of adverse events;

e) Audit arrangements including internal audit, external audit, clinical audit and health and safety reviews.

The existence, integration and evaluation of these elements will provide a basis to make the Annual Governance Statement within the Annual Report and Accounts as required by current NHS guidance.

20.2 Insurance

20.2.1 On an annual basis, the CFO shall review membership of the Non-Clinical Risk Pooling Scheme plus other insurance arrangements and recommend whether or not to continue with current arrangements

20.2.2 The Associate Director of Corporate Affairs shall act as the Trust's lead contact on insurance matters~~,~~ and ensure ~~liaising with I~~Insurance Brokers are liaised with over queries and negotiating renewal terms.

20.2.3 The Associate Director of Corporate Affairs shall ensure timely reporting of incidents against insurance provision on the third party liability scheme.

20.2.4 The Associate Director of Corporate Affairs shall ensure timely reporting of losses and the submission of claims against insurance provision on the third party liability scheme in line with the agreed limits set in these SFIs.

20.2.5 The Associate Director of Corporate Affairs shall ensure timely reporting of incidents and losses and the submission of claims against insurance provision.

20.3 Clinical Risk Management/CNST

20.3.1 The Chief Nursing Officer shall:

a) Provide a central point of contact within the Trust for NHSR/CNST issues;

b) Report on claims to Trust Board within the set limits and values.

21. LITIGATION PAYMENTS

21.1 Claims from Staff, Patients and the Public

21.1.1 Out of court settlement of claims from staff, patients and the public shall be made where ~~the~~ NHS Resolution, in joint agreement with the Associate Director of Corporate Affairs, considers it appropriate to do so. ~~–~~Occupier liability claims carry an excess of £3k and employer liability claims carry an excess of £10k. Any occupier liability cases handled in house by the Trust ~~———~~within the excess of £3k will be notified and approved by~~to~~ the Trust Legal Services Facilitator and Head of Claims and Insurance ~~for acknowledgement only~~.

21.1.2 The limits for notification of individual damages payments are as follows, given that financial responsibility for the payment of all claims is the

responsibility of the NHS Resolution with the University Hospital Southampton NHS Foundation Trust as the defendant.

Up to £500k	DCD or DHoN or DDO
£501k - £1.5m	DCD and DHoN and shared with an Executive Director (usually Medical or Nursing)
>£1.5m	DCD and DHoN and shared with at least two Executive Directors and the CEO for final review and approval then reported to Trust Board

The DHSC must be consulted before making any special payments that are novel, contentious or repercussive. Any payments made against legal advice must be approved by the CEO and Trust Board.

21.2 Health and Social Care (Community Health and Standards) Act 2003 – NHS Charges

21.2.1 Part 3 of the Health and Social Care (Community Health and Standards) Act 2003 makes provision for the establishment of a scheme to recover the costs of providing treatment to an injured person in all cases where that person has made a successful personal injury compensation claim against a third party.

21.2.2 Regarding any claim settled by the Trust and/or by the NHS Resolution, there is a requirement to report all such matters in advance of settlement to the Compensation Recovery Unit (DWP). In the event that any NHS charges are payable these will be met in full by the compensator i.e. any other NHS trust. In the event the compensator is University Hospital Southampton NHS Foundation Trust the act provides that UHS is exempt from repaying their "own" costs.

22. EMPLOYMENT TRIBUNALS

22.1 All settlement agreements must be approved by the Chief People Officer.

22.2 Any settlement agreement in excess of contractual entitlement must be approved by the Chief People Officer and the CFO. In certain cases, additional approval should be sought from NHS England~~NHS Improvement~~ and/~~-~~or HM Treasury.

22.3 The out of court settlement of Employment Tribunal applications shall only be made where the Chief People Officer advises it to be prudent so to do and only after taking into account the monetary sum involved and any legal advice received. The limits are as follows:

Value of Payment	**Approval**
Up to £30,000	Chief People Officer
£30,001 to £100,000	Chief Executive Officer
£100,000 plus	Trust Board

22.4 NHS England ~~NHS Improvement~~ must be consulted before making any special payments that are novel, contentious or repercussive. The Chief People Officer, in the case of any compromise agreements, shall submit a

business case to be ~~a~~approved by HM Treasury. Any payments made against legal advice must be approved by the Trust Board.

23. SUBSIDIARIES, SHAREHOLDINGS, HOSTED BODIES, PARTNERSHIPS AND COLLABORATIONS

23.1 Subsidiaries and Shareholdings

23.1.1 Subsidiary companies and companies where UHS are joint-shareholder (e.g. WPL) are separate, distinct legal entities for commercial purposes and have distinct taxation, regulatory and liability obligations. As a separate, independent company, subsidiaries and shareholdings are subject to their own governance arrangements, which are the responsibility of the subsidiary's board of directors, and therefore these Standing Financial Instructions are not applicable, with the exception of where the group position is directly impacted (e.g. Group CDEL limit for capital). Reference to the subsidiary's documentation will need to be made.

23.1.2 Whilst subsidiaries operate independently, their SFIs include a schedule of changes where prior written approval of the Shareholder is required. This includes alteration of any constitutional documents of the company. Any changes to the schedule of prior Shareholder approval will require approval of Trust Board, following review and recommendation by the Audit and Risk Committee.

23.2 Hosted Bodies, Partnerships and Collaborations

23.2.1 Hosted bodies are organisations for which UHS provide services under a service level agreement (SLA). The arrangements for administration of hosted bodies are managed by the Commercial Development Team. UHS also works in partnership and collaboration with other organisations under service level agreements, memoranda of understanding or similar documents.

23.2.2 Dependent on the terms of the SLA, memorandum of understanding or equivalent, these standing financial instructions may or may not be applicable. Individual SLAs, memorandum of understanding or equivalent should be referred to on a case by case basis.

24. Force Majeure

24.1 In the event of a force majeure, such as a Pandemic, the existing Standing Financial Instructions and Scheme of Delegation should be followed as normal where possible.

24.2 If compliance with Standing Financial Instructions (SFIs) and Schemes of Delegation (SODs) is expected to generate delays to the procurement of goods (either revenue or capital expenditure) and such delay causes unacceptable detriment to patients and / or staff, the SFIs and SODs may be waived on the written authority of either the CFO or Director of Operational Finance. In the event that neither the CFO nor Director of Operational Finance is available, the CFO may delegate the authority to waive SFIs / SoD to another Executive Director.

24.3 If the value of the transaction exceeds £2.5m, the written authority of the Chair, or another Non-Executive Director nominated by the Chair, will also be required.

24.4 A schedule of transactions showing transactions where SFIs / SoD have been waived shall be maintained to include the date of waiver, name of supplier, description of goods ordered, name of approving officer and why the waiver was approved. This schedule shall be reported regularly to Trust Board and to each Audit and Risk Committee.

24.5 The Audit and Risk Committee are responsible for ratifying decisions made under force majeure.

24.6 The Trust Board and / or Audit and Risk Committee need to confirm when Force Majeure arrangements can come into force and when they are terminated.

24.7 The CFO or Director of Operational Finance can also waive section 10.3.3 of Trust SFIs relating to prepayments, where this is in line with HM Treasury policy regarding payments to Suppliers during a force majeure (for example "Procurement Policy Note 02: Supplier relief due to coronavirus").

Annex 1

Writing-Off of Losses and Special Payments

LOSSES:

1. Losses of cash due to:
   a. theft, fraud etc.
   b. overpayment of salaries etc.
   c. other causes
2. Fruitless payments
3. Bad debts and claims abandoned in relation to:
   a. private patients
   b. overseas visitors
   c. other
4. Damage to buildings, property etc. due to:
   a. theft, fraud etc.
   b. other

SPECIAL PAYMENTS:

5. Compensation under legal obligation
6. Extra contractual to contractors
7. Ex gratia payments in respect of:
   a. loss of personal effects
   b. clinical negligence with advice
   c. personal injury with advice
   d. other negligence and injury
   e. severance payments on termination of employment
   f. other employment payments
   g. patient referrals outside the UK and EEA Guidelines
   h. other
   i. maladministration, no financial loss
8. Extra statutory and regulatory

Annex 2

Significant Transactions

The Trust is obliged to report significant transactions to NHS EnglandNHS Improvement (the independent regulator of NHS Foundation Trusts) prior to entering the transaction. Such transactions may take the form of major investments such as PFI's, incorporation of Subsidiaries, long-term contracts for the provision of services or acquisitions or mergers with other NHS organisations or private sector companies.

The Trust would require both Trust Board and the Council of Governors to approve all significant transactions prior to submission to NHS EnglandNHS Improvement.

Significant transactions are defined by NHS EnglandNHS Improvement as being equivalent to a 10% change in any one of the following three financial criteria:

1. Gross Assets
2. Attributable Income
3. Capital

The full details of the NHS EnglandImprovement guidance on significant transactions can be found in Annex 13 of the Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts (published November 2016).

Annex 3 – Trust Authorisation Framework

Section 1 – Authorisation Bodies and Limits

Trust Authorisation Framework

Group	Revenue (Including revenue implications of capital)	Capital (gross value)
Divisional Management Boards	Utilisation of existing expenditure budget only.	Up to £150k, where this is within annual Capital allocation for Division. All capital expenditure to be reported to TIG
Defined groups as outlined in Capital section of SFIs	N/A	Up to £150k, where this is within annual Capital allocation. All capital expenditure to be reported to TIG
Recruitment Control Panel	Recruitment of new posts and some replacements - as per Terms of Reference.	N/A
DoOF or COO	Up to £50k additional expenditure budget.	Up to £50k. All capital expenditure to be reported to TIG.
CEO or CFO	Up to £150k additional expenditure budget.	Up to £150k. All capital expenditure to be reported to TIG.
Trust Investment Group	Up to £1,000k additional expenditure budget. Schemes requiring significant clinical or stragetic input regardless of value - recommendation to Trust Executive Committee.	£0k to £2,500k. Unless approved by group above. All schemes over £2,500k should include a recommendation from TIG. Schemes requiring significant clinical or stragetic input regardless of value - recommendation to Trust Executive Committee.
Trust Executive Committee	£1,000k to £2,500k; and Schemes requiring significant clinical or stragetic input regardless of value All schemes above £2,500k should go to Trust Executive Committee for noting. New consultant business cases Replacement clinical consultant cases for noting	£2,501k - £5,000k; and Schemes requiring significant clinical or stragetic input regardless of value All schemes above £5,000k should go to Trust Executive Committee for recommendation to Trust Board.
Finance & Investment Committee	All schemes above £2,500k; and Schemes judged by Trust Executive Committee as of significant strategic importance should go to F&IC for review and recommendation to Trust Board.	All schemes above £5,000k; and Schemes judged by Trust Executive Committee as of significant strategic importance should go to F&IC for review and recommendation to Trust Board.
Trust Board	All schemes above £2,500k; and Schemes judged by Trust Executive Committee as of significant strategic importance Any proposed major scheme with FT compliance arrangement	All schemes above £5,000k; and Schemes judged by Trust Executive Committee as of significant strategic importance Any proposed major scheme with FT compliance arrangement
NHS Improvement	N/A	Any proposed major scheme within FT compliance arrangements

Group	Revenue (Including revenue implications of capital)	Capital (gross value)
Divisional Management Boards	Utilisation of existing expenditure budget only.	Up to £150k, where this is within annual Capital allocation for Division. All capital expenditure to be reported to TIG
Defined groups as outlined in Capital section of SFIs	N/A	Up to £150k (£300k for Digital Board), where this is within annual Capital allocation. All capital expenditure to be reported to TIG
Recruitment Control Panel	Recruitment of new posts and some replacements - as per Terms of Reference.	N/A
DoOF or COO	Up to £50k additional expenditure budget.	Up to £50k. All capital expenditure to be reported to TIG.
CEO or CFO	Up to £150k additional expenditure budget.	Up to £150k. All capital expenditure to be reported to TIG.
Trust Investment Group	Up to £1,000k additional expenditure budget. Schemes requiring significant clinical or stragetic input regardless of value - recommendation to Trust Executive Committee.	£0k to £2,500k. Unless approved by group above. All schemes over £2,500k should include a recommendation from TIG. Schemes requiring significant clinical or stragetic input regardless of value - recommendation to Trust Executive Committee.
Trust Executive Committee	£1,000k to £2,500k; and Schemes requiring significant clinical or stragetic input regardless of value All schemes above £2,500k should go to Trust Executive Committee for noting. New consultant business cases Replacement clinical consultant cases for noting	£2,501k - £5,000k; and Schemes requiring significant clinical or stragetic input regardless of value All schemes above £5,000k should go to Trust Executive Committee for recommendation to Trust Board.
Finance & Investment Committee	All schemes above £2,500k; and Schemes judged by Trust Executive Committee as of significant strategic importance should go to F&IC for review and recommendation to Trust Board.	All schemes above £5,000k; and Schemes judged by Trust Executive Committee as of significant strategic importance should go to F&IC for review and recommendation to Trust Board.
Trust Board	All schemes above £2,500k; and Schemes judged by Trust Executive Committee as of significant strategic importance Any proposed major scheme with FT compliance arrangement	All schemes above £5,000k; and Schemes judged by Trust Executive Committee as of significant strategic importance Any proposed major scheme with FT compliance arrangement
NHS Improvement	N/A	Any proposed major scheme within FT compliance arrangements

Annex 3 – Trust Authorisation Framework

Section 2 – Non-Pay Authorisation Framework

Finance and Procurement System - Rulesets		First Approver	Second Approver	Third Approver	Fourth Approver	Fifth Approver	Sixth Approver
Rule 1	Divisional Hierarchy	5k approver	25k approver	75k approver	250k approver	1m approver	Unlimited approver
Rule 2	R&D Hierarchy	5k approver	25k approver	75k approver	250k approver	1m approver	Unlimited approver
Rule 3	THQ Hierarchy	5k approver	75k approver	250k approver	1m approver	Unlimited approver	
Rule 4	Other Hierarchy - including capital, estates	75k approver	250k approver	1m approver	Unlimited approver		

Authorised Non-Pay Expenditure Limits	
Band	**LIMIT £**
All Staff	
Bands 1 – 4	£0
Band 5	£5k
Band 6	£5k
Band 7	£5k
Band 8a	£25k
Band 8b	£25k
Band 8c	£75k
Band 8d	£75k
Band 9	£250k
Trust Board / Directors	
Chief Executive Officer	Unlimited
Chief Financial Officer	Unlimited
Chief Operating Officer	£1m
Other Executive Director	£1m
Director of Operational Finance	£1m
Finance	
Assistant Director of Finance	£250k
Financial Controller	£250k
Head of Financial Accounting	£75k
Treasury Manager	£5k
Head Cashier +	£5k
Materials Manager	£5k
Pharmacy	
Chief Pharmacist	£250k
Estates & Capital Development	
Director of Estates, Facilities & Capital Development	£250k

Section 3 – Contracting – Financial Limits

Contract Value (Excl VAT)	Type of Contract	Authorisation To Place or sign Contract
Nil	Non-Disclosure Agreements	Any Executive Director, the Director of Informatics, the Director of Procurement and Supply or the Commercial Director
Up to £0.5m	Goods & Services	Director of Estates, Facilities & Capital Development, Director of Informatics, Chief Pharmacist, DoOF, DDO
£0.5m - £1.0m	Goods & Services	CFO, Managing Director of Wessex NHS Procurement Ltd
£1m - £2.5m	Goods & Services	Chief Executive Officer
Over £2.5m	Goods & Services	Trust Board/Chair

Ensuring Procurement & Tender limits also complied with

Up to £0.5m	Building & Engineering	Associate Director of Estates, Deputy Director of Estates, DoOF
£0.5m - £2.5m	Building & Engineering	Director of Estates, Facilities & Capital Development, CFO
£2.5m - £5m	Building & Engineering	Chief Executive Officer
Over £5m	Building & Engineering	Trust Board / Chair

Ensuring Procurement & Tender limits also complied with

Up to £0.5m	Non-NHS Income	DDO / Commercial Director / DoOF
£0.5m - £1.0m	Non-NHS Income	CFO
£1m - £2.5m	Non-NHS Income	Chief Executive Officer
Over £2.5m	Non-NHS Income	Trust Board / Chair

Up to £10m	NHS Income	Director of Contracting
£10m - £200m	NHS Income	CFO
Over £200m	NHS Income	Chief Executive Officer

Up to £50k	Bidding for Tenders	DDO
£50k to £12.5m	Bidding for Tenders	Tender Steering Group / CFO
£12.5m to £25m	Bidding for Tenders	Chief Executive Officer
Over £25m	Bidding for Tenders	Trust Board

Based on gross expenditure, not off-set with income.

Total Contract Value (Excluding VAT)	Type of Contract	Authorisation To Place or sign Contract
Nil	Non-Disclosure Agreements	Any Executive Director, the Director of Informatics, the Director of R&D, the Managing Director of Wessex Procurement Ltd or the Commercial Director
Up to £0.5m	Goods & Services	Director of Estates, Facilities & Capital Development, Director of Informatics, Chief Pharmacist, DoOF, DDO, Director of R&D
£0.5m - £1.0m	Goods & Services	CFO, Managing Director of Wessex NHS Procurement Ltd
£1m - £2.5m	Goods & Services	Chief Executive Officer
Over £2.5m	Goods & Services	Trust Board/Chair
Ensuring Procurement & Tender limits also complied with		
Up to £0.5m	Building & Engineering	Associate Director of Estates, Deputy Director of Estates, DoOF
£0.5m - £2.5m	Building & Engineering	Director of Estates, Facilities & Capital Development, CFO
£2.5m - £5m	Building & Engineering	Chief Executive Officer
Over £5m	Building & Engineering	Trust Board/Chair
Ensuring Procurement & Tender limits also complied with		
Up to £0.5m	Non-NHS Income	DDO / Commercial Director / DoOF / Director of R&D
£0.5m - £1.0m	Non-NHS Income	CFO
£1m - £2.5m	Non-NHS Income	Chief Executive Officer
Over £2.5m	Non-NHS Income	Trust Board / Chair
Up to £10m	NHS Income	Director of Contracting
£10m - £200m	NHS Income	CFO
Over £200m	NHS Income	Chief Executive Officer
Up to £0.5m	Bidding for Tenders	DDO / Commercial Director / Director of R&D
£0.5m to £12.5m	Bidding for Tenders	Tender Steering Group / CFO
£12.5m to £25m	Bidding for Tenders	Chief Executive Officer
Over £25m	Bidding for Tenders	Trust Board
Based on gross expenditure, not off-set with income.		

[BP1]

Annex 3 – Trust Authorisation Framework

Section 4 – Authorisation Framework for Procurement and Tendering of expenditure

Products & Services Procurement

Contract Value (Excl VAT)	Quotations/Tenders for Goods & Services	Min number invited to Quote/Tender	Form of Contract
Up to £10,000	No formal tender requirement	0	Purchase Order
£10,000 - £75,000	Quotation	3	Up to £24,999 -Purchase Order Over £25k - Procurement Approval Document (PAD)
£75,001 - published UK PCR Limit (as advised by WPL)	Formal Local Tender	4	Contract as specified in Tender and Purchase Order
>published UK PCR Limit (as advised by WPL)	Formal Local Tender	4	Contract as specified in Tender or via compliant framework process and Purchase Order

Threshold limits represent the contract's lifetime value e.g., a 5-year contract of £25,000 per year requires £125,000 method and authorisation.

Building and Estates Engineering Procurement

Contract Value (Excl VAT)	Tender for Building & Engineering	Min number invited to Quote/Tender	Form of Contract
Up to £10,000	No formal tender requirement	0	Purchase Order
£10,000 - £75,000	Quotation	3	Up to £24,999 -Purchase Order Over £25k - Procurement Approval Document (PAD)
£75,001 - £499,999	Formal Local Tender	3	Contract as specified in Tender and Purchase Order
£500,000 - published UK PCR Limit (as advised by WPL)	Formal Local Tender	4	Contract as specified in Tender and Purchase Order
>published UK PCR Limit (as advised by WPL)	Formal Local Tender	4	Contract as specified in Tender or via compliant framework process and Purchase Order

Waiving or Variation of Competitive Tendering/Quotation procedure

Type Of Contract	Monetary Value (Excl. VAT)	Authorisation To Place or sign Contract
Products /Services Building/Engineering/Works Contracts/Consultancy Services	Up to £75,000	Director of Estates, Facilities & Capital Development, Managing Director of WPL, Director of Informatics, Head of Estates Maintenance, DDO
As above	£75,001 - £499,999	Chief Executive Officer / CFO
As above	Over £500,000	Trust Board

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Corporate Governance Update – November 2022**			
Agenda item:	**16.3**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Craig Machell, Associate Director of Corporate Affairs**			
Date:	**29 November 2022**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **x**
Issue to be addressed:	NHS England issued the following new corporate governance-related documents in October 2022: • 'Code of governance for NHS provider trusts' • 'Guidance on good governance and collaboration' • An addendum to existing duties of trust governors • A consultation on changes to provider licences			
Response to the issue:	The update provides a summary of the documents and highlights any particular changes and/or points to note.			
Implications: (Clinical, Organisational, Governance, Legal?)	The changes introduced by the new code and associated guidance will apply from April 2023. This will require a review of certain aspects of the trust's corporate governance arrangements at the Board level in particular to ensure compliance with any changes.			
Summary: Conclusion and/or recommendation	The Board is asked to note the report.			

Corporate Governance Update – November 2022

Introduction

During October 2022, a number of documents were published by NHS England, which will modify the current NHS Foundation Trust Code of Governance (issued in 2014) and associated guidance, and which will apply from April 2023. These documents are: a new 'Code of governance for NHS provider trusts', 'Guidance on good governance and collaboration' and an addendum to existing duties of trust governors.

In addition, a consultation on certain changes to provider licences was launched on 27 October 2022.

The most significant changes to be introduced reflect the situation following the coming into force of the Health and Social Care Act 2022 ('2022 Act'), which included the formal constitution of the Integrated Care System (ICS) model and the requirement for trusts to collaborate within the relevant framework(s). In addition, a number of changes will be introduced that reflect evolving corporate governance practice in other sectors as well as legislative/regulatory changes since 2014.

This paper intends to provide a summary of the most significant changes for the Board to **note**.

1. Code of governance for NHS provider trusts

The 'Code of governance for NHS provider trusts' issued by NHS England on 27 October 2022 will apply from April 2023. The new code notes that there have been significant organisational changes in the NHS since the NHS Foundation Trust Code of Governance was issued in 2014, and that the single framework for overseeing NHS systems and organisations makes it appropriate for the new code to apply to both NHS trusts and foundation trusts on the basis that whilst the two organisations are constituted differently, there are certain corporate governance principles that apply more generally.

The 'comply or explain' principle continues to apply, except where compliance is a licence condition or a matter of law/regulation.

In terms of the code itself, it is structured into five sections (A to E), namely: Board leadership and purpose; Division of responsibilities; Composition, succession and evaluation; Audit, risk and internal control; and Remuneration. Each section begins with a series of high-level principles followed by several provisions intended to provide further clarification in terms of applying the principles.

There are a number of changes introduced by the new code. Many of these changes broadly mirror the revised language and expectations used in other corporate governance codes, such as the 2018 UK Corporate Governance Code issued by the Financial Reporting Council. For example, the new code makes clear the Board's role in 'establishing the trust's vision, values and strategy' (A.1.2). In addition, reference is made to the Board's role in terms of monitoring the organisation's culture (A.2.3), which broadly mirrors the UK Corporate Governance Code.

One of the most notable areas of change relates to the Board's role in terms of the trust's relationship with the Integrated Care Partnership (ICP), including to ensure alignment with the ICP's strategy, as well as incorporation of the various expectations in terms of the trust's contribution to the Integrated Care Board's five-year and annual plans and other ICS-related matters. Similarly, responsibility for encouraging collaboration at all levels with system partners is now included.

The code also makes specific reference to the trust's role in reducing health inequalities in access, experience and outcomes (A.1.3). This is further reinforced through the incorporation of significantly expanded obligations on the part of the Board to be diverse in terms of its range of skill sets, backgrounds and lived experience (B.2.9), and the requirement that appointments and succession plans should 'promote diversity of gender, social and ethnic backgrounds, disability, cognitive and personal strengths' as well as a requirement for Boards to publish how the Board and senior managers will, in percentage terms, 'at least match the overall black and minority composition of its overall workforce, or its local community, whichever is the higher' (C.1.1).

There are also other changes to note, including:

- Explicit mention that governors', chairs' and non-executive directors' total length of service should not exceed nine years (C.4.3, C.4.4).
- The requirement to hold an externally facilitated review of the Board every three years will be replaced with an obligation to carry out externally facilitated developmental review of the trust's leadership and governance using the 'Well-led' framework every three to five years (C.4.7).
- A number of the previous principles/provisions relating to technical/legal matters have been removed (e.g. the need for a foundation trust to have a constitution) on the basis that these obligations are already stated elsewhere.

In summary, therefore, whilst there have been a number of changes to the wording and/or structure of many of the current code's principles and provisions, the main changes result from the organisational, legal and regulatory changes since the code was last updated in 2014, particularly in terms of the formal introduction of the ICS framework. Another element of note is the increased emphasis of the importance of considering diversity in terms not only of Board/senior management composition, but also more broadly in terms of decision-making and the impact on those served by the trust.

2. Guidance on good governance and collaboration

2.1 Expectations

This document aims to provide guidance on the expectations of how providers collaborate with system partners following the changes introduced by the 2022 Act. These expectations include:

a. Providers will engage consistently in shared planning and decision-making

For example, leaders are to participate with appropriate authority in system and place-based partnerships to ensure shared or joined up planning; organisations are to commit sufficient resources to, and ensure digital and data systems enable, system and place-based partnerships; information is to be shared with partners; and cases for new service delivery models are to be explored.

b. Providers will consistently take collective responsibility with partners for delivery of services across various footprints including system and place

For example, organisations should share demand and capacity information; engage in mutual aid with other providers; work collaboratively with partners to improve care quality; and participate in clinical networks to raise standards and deliver benefits.

c. Providers will consistently take responsibility for delivery of improvements and decisions agreed through system and place-based partnerships, provider collaboratives or other relevant forums

For example, clearly articulating how organisational plans integrate with the ICB five-year joint plan and annual capital plan; actively participating in system quality groups; working to deliver the financial duties and objectives for which the provider is collectively responsible with ICB partners; and committing sufficient workforce and resources to deliver agreed improvements.

2.2 Governance

The guidance also provides a summary of the characteristics of the governance arrangements which should be put in place in order to ensure that organisations are collaborating effectively. These are summarised as:

a. Developing and sustaining strong working relationships with partners
b. Ensuring decisions are taken at the right level
c. Setting out clear and system-minded rationale for decisions
d. Establishing clear lines of accountability for decisions
e. Ensuring delivery of improvements and decisions

3. Addendum to existing duties of trust governors

The 'Your statutory duties: A reference guide for NHS foundation trust governors' document was last updated in August 2013. As a result, it does not reflect subsequent changes in the NHS, and, in particular, the changes introduced as a result of the 2022 Act. Although the statutory duties of councils of governors have not changed, the considerations required in order to discharge those duties have changed.

For instance, governors will need to take into account a broader range of stakeholders, including other partners within the ICS and the public at large, and, in holding the non-executives to account, should consider the foundation trust's contribution to the ICS's objectives. Similarly, when considering a significant transaction, the council of governors should also consider interests beyond that of the foundation trust, e.g. where a transaction will not immediately benefit the trust itself, but will benefit the population of the wider ICS.

4. Provider licence consultation

The consultation on potential changes to provider licences closes on 9 December 2022. The changes centre around four main areas:

a. Supporting system working

The proposed changes reflect expectations around collaboration and cooperation with a new licence condition outlining the expectations of how NHS trusts, foundation trusts and controlled providers should work together across the newly formed ICS.

In addition, a new licence condition will mirror the expectations in the 2022 Act requiring consideration of the Triple Aim and health inequalities.

Other changes include: a new licence condition and amendments reflecting digital obligations; reframing integrated care as a positive obligation; expanding the patient choice condition; and removal of the competition condition.

b. Enhancing oversight of key services provided by the independent sector

The proposed changes will broaden the range of providers to whom 'continuity of service' provisions will apply and expanding the scope of these provisions to include quality governance standards (which already apply to NHS trusts and foundation trusts).

c. Addressing climate change

The proposed changes are to reflect expectations set out in the 2022 Act and in guidance around net zero and climate change ambitions.

d. Technical amendments

A number of technical amendments are also proposed to update and remove certain sections of the licence in line with legislative changes. In addition, costing conditions will be separated from pricing conditions and the pricing conditions updated to reflect changes in policy and legislation.

Most notable in terms of the changes to pricing conditions is the modification to Pricing Condition 3, which will remove the requirement to submit assurance reports to NHS England, replacing this with a requirement to have in place processes to ensuring accuracy and completeness of information collected and submitted to NHS England.

Certain self-certification requirements will also be removed due to duplication with annual reporting requirements.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**CRN: Wessex 2022-23 Q1-2 Performance Report**			
Agenda item:	**19.1**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Author:	**Graham Halls, Business Intelligence Manager, CRN Wessex** **Clare Rook, Chief Operating Officer, CRN Wessex**			
Date:	**29 November 2022**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** ✓
Issue to be addressed:	Unless otherwise stated, this report covers Clinical Research Network (CRN) Wessex's performance in quarters one to two of the 2022/23 financial year (April to September 2022). Key achievements/issues: ● The National Institute of Health and Care Research (NIHR) areas of strategic focus for UK clinical research have been provided in the first section. They are the themes for the CRN Wessex 2022/23 annual plan, with local initiatives underway to support them. ● COVID-19 research has dropped in line with infection rates. As the region moves away from pandemic research, the reset and recovery of the overall clinical research portfolio become the priority for CRN Wessex. ● CRN Wessex is not meeting all of the High Level Objectives (HLO) set by the NIHR and agreed upon with the Department of Health and Social Care (DHSC). However, the region's performance is mainly above or meeting the English average. Work is underway to ensure that the region achieves the objectives within the capacity restraints caused primarily by the after effects of the pandemic. ● Research recruitment within the Wessex region in quarter two has fallen from quarter one. However, the number of recruiting studies has not dropped, nor the geographical spread of the research being offered to patients. The CRN and its partner organisations are taking steps described in this report to ensure research opportunities increase for the remainder of the year.			
Response to the issue:	**1 Purpose/Context/Introduction** This report informs the UHS Board of Directors of the clinical research activities within the Wessex region. The report covers COVID-19 research, the performance against the NIHR's high level objectives, and general research activity in Wessex. This report focuses on quarters one to two (Apr-Sep) of the 2022/23 financial year. **2 Key issues** **National areas of strategic focus for health research** In June 2021, the Department of Health and Social Care (DHSC) and the National Institute of Health and Care Research (NIHR) published a paper titled *Best Research*			

for Best Health: The Next Chapter. The report outlined six areas of strategic focus for the NIHR (Figure 1).

These focus areas guide NIHR-supported research activities in Wessex, so it is necessary to be aware of them. The areas of strategic focus are also the themes of the 2022/23 CRN Wessex annual plan, under which the network is leading many local and national initiatives.

Figure 1 – NIHR Areas of strategic focus from Best Research for Best Health: The Next Chapter (nihr.ac.uk).

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.

Recruitment in Wessex on COVID-19 research studies since April 2021 is provided in Figure 2. Over 2,800 participants were recruited on thirty-one studies during the first two quarters of this financial year. Queen Alexandra Hospital in Portsmouth was one of the top recruiting sites on COVID-19 research studies in the UK (Figure 3).

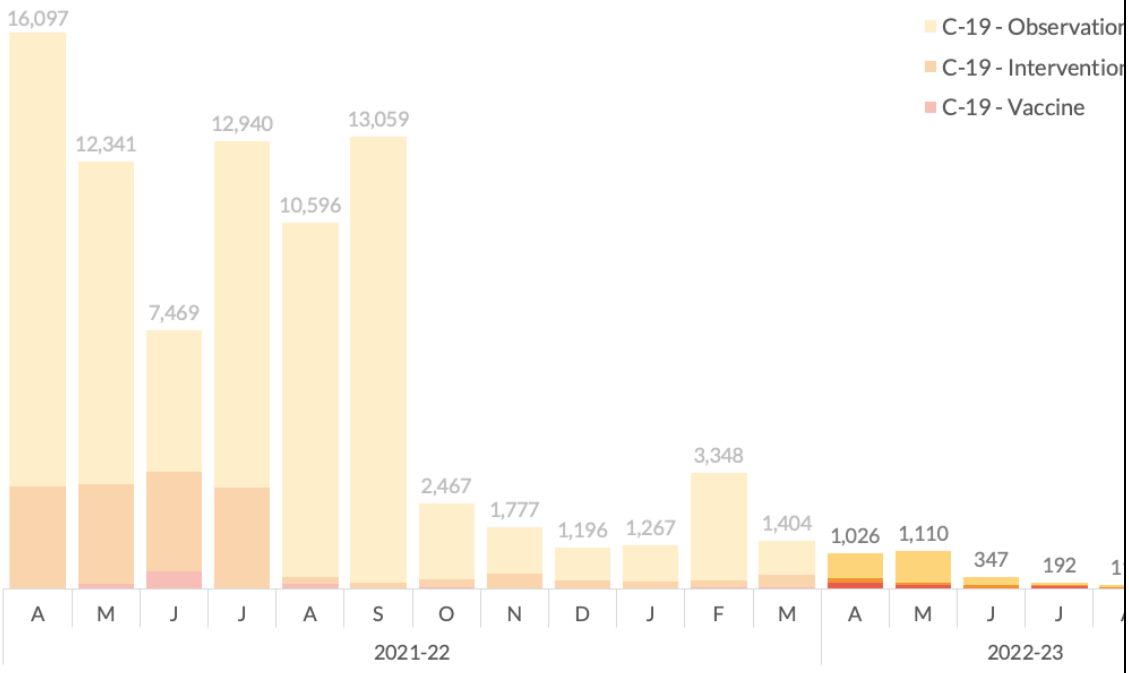


Figure 2 – COVID-19 study recruitment by type in Wessex: 1 April 2021 – 30 September 2022.

Site	Region	Recruiting studies	Recruit
Southmead Hospital	West of England	6	3,042
Bristol Royal Infirmary	West of England	3	2,483
Queen Alexandra Hospital	Wessex	6	1,117
Hammersmith Hospital	North West London	5	540
Salford Royal	Greater Manchester	7	511
St Thomas' Hospital	South London	8	470
Moorfields Eye Hospital	North Thames	1	463
Leeds Community Healthcare	Yorkshire and Humber	1	400
St James's University Hospital	Yorkshire and Humber	12	387
King's College Hospital	South London	7	386

Figure 3 – Top ten highest recruiting NHS trusts and CCGs for COVID-19 research in quarters one to two of the 2022/23 financial year: 1 April 2022 – 30 September 2022.

COVID-19 recruitment has fallen to fourteen per cent of the total activity in Wessex. However, the pandemic's effect on general research activity is more widespread. Follow-up remains necessary for the disproportionately high numbers of participants recruited during the height of the pandemic, and general pressures on the NHS from the backlog of delayed routine care have led to fewer resources for research. As the region moves away from pandemic research, the reset and recovery of the portfolio become the priority for CRN Wessex. The latter sections of this report discuss the progress to date.

NIHR CRN High level objectives for 2022/23 (HLOs)

The purpose of the NIHR CRN is to provide efficient and effective support for initiating and delivering 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 HLOs. These are outlined in Figure 4, with current Wessex and English (all LCRNs) performance linked to ambitions agreed with the DHSC.

The ambitions for *effective study delivery* have now been confirmed at eighty per cent of studies closing at sites having met their recruitment targets. For closed studies funded and sponsored by a commercial company only ('commercial' research), Wessex is currently achieving the ambition. Wessex is also within one per cent of achieving this for non-commercial studies. The projection for studies that are now open and plan to close this year is that Wessex will not achieve this ambition. The same is true for all English regions.

The DHSC's 'Research Reset' programme (Research Recovery and Reset | NIHR) is supported by local sponsors and CRN Wessex. It aims to make CRN research portfolio delivery achievable within planned timelines and sustainable within the resource and capability the UK currently have in the NHS. The secondary aim is to free up capacity across the research system by working with funders and sponsors to support the review of studies that have already been completed or that are unlikely to be able to deliver their endpoints. One of the outcomes of the programme is that some studies are being closed early by sponsors having not met their recruitment targets. It is expected that this will affect the reported performance for all LCRN regions.

Two new high level objectives were introduced in November 2022. These are to keep track of the open studies and their predicted ability to meet their recruitment targets. The ambition for these objectives has been set at sixty per cent, but the details haven't yet been provided to LCRNs to allow these to be calculated.

In general, recruitment against targets is improving slowly in Wessex. CRN Wessex is discussing these objectives with partner organisations as part of weekly general updates, regular specialty-specific meetings, or other events. In addition, the industry (commercial studies) workstream leads have reintroduced regular performance reports, which will be shared with the organisations delivering commercially funded research in the region.

Objective		Measure	Ambition	Wessex			
Efficient Study Delivery	Deliver NIHR CRN Portfolio studies to recruitment target	(1) Percentage of closed to recruitment commercial studies which have achieved their recruitment target	80%	100%			
		(2) Percentage of closed to recruitment non-commercial studies which have achieved their recruitment target	80%	79%			
		(3) Percentage of open to recruitment commercial contract studies which are predicted to achieve their recruitment target	60%	TBC in Q3 how this will be calculated			
		(4) Percentage of open to recruitment non-commercial studies which are predicted to achieve their recruitment target	60%	TBC in Q3 how this will be calculated			
Provider Participation	Widen participation in research by enabling the involvement of a range of health and social care providers	(1) Percentage of General Medical Practices with recruitment in NIHR CRN Portfolio studies	45%	40% (103/257)			
		(2) Percentage of NHS Acute trusts with recruitment in NIHR CRN Portfolio studies every quarter	99%	Q1 100 % (7/7)	Q2 100 % (7/7)	Q3	Q4
		(3) Percentage of NHS Acute trusts with recruitment in commercial contract NIHR CRN Portfolio studies every quarter	70%	Q1 57% (4/7)	Q2 57% (4/7)	Q3	Q4
		(4) Percentage of NHS Ambulance, Care and Mental Health trusts with recruitment in NIHR CRN Portfolio studies every quarter	95%	Q1 100 % (4/4)	Q2 100 % (4/4)	Q3	Q4
Participant Experience	Demonstrate to participants in NIHR CRN supported research that their contribution is valued through collecting their feedback and using this to inform improvement in research delivery	Number of NIHR CRN Portfolio study participants responding to the Participant Research Experience Survey	1,237	224 (18%)			

Figure 4 – Local and national performance for the NIHR CRN High Level Objectives for quarters one to two of the 2022-23 financial year: 1 April 2022 – 30 September 2022.

The involvement of GP practices and NHS trusts in research is being measured annually for the former and quarterly for the latter group. Over forty per cent of GP practices in Wessex are research active (Figure 5), with the ambition for this to increase to over forty-five per cent. All NHS trusts in the region are research active (Figure 6); however, not all acute trusts have yet supported commercial research. The dispersal of research studies and recruitment is essential so all communities can access and experience research benefits.

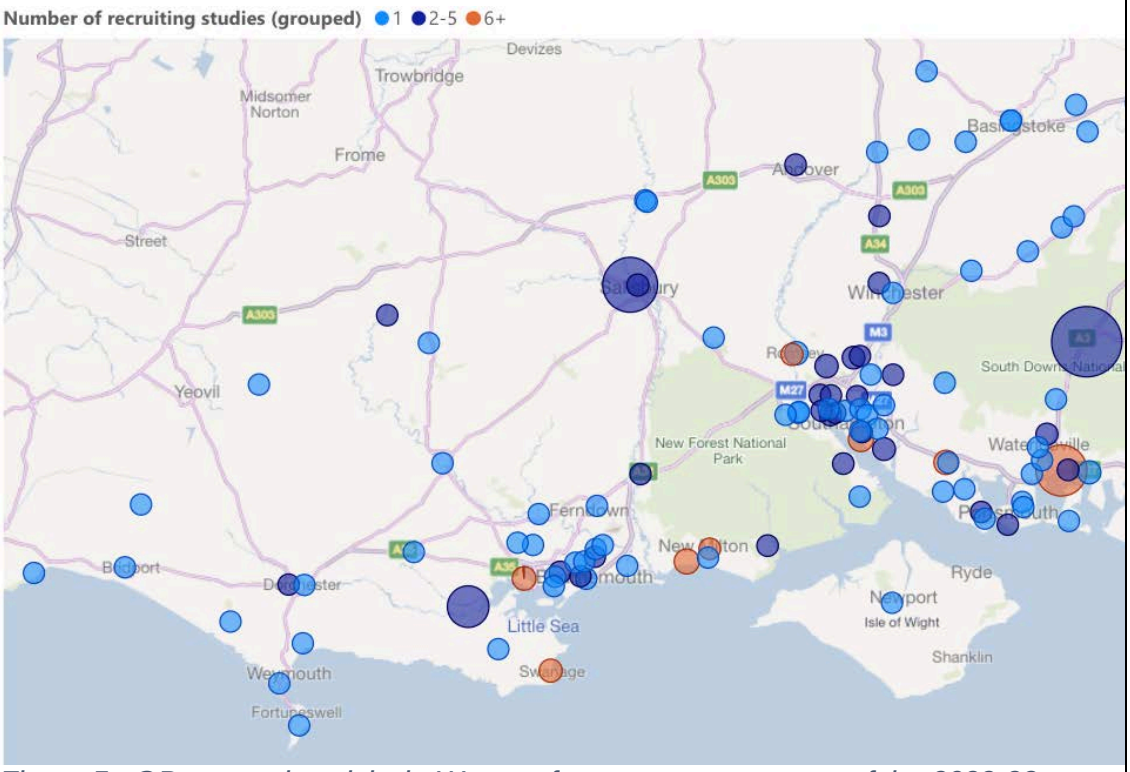


Figure 5 - GP research activity in Wessex for quarters one to two of the 2022-23 financial year: 1 April 2022 – 30 September 2022. The size of the bubble indicates the volume of recruitment.

The Participant in Research Experience Survey (PRES) is completed throughout the year and refreshed annually, with almost twelve hundred respondents in 2021/22. In quarters one to two, there were two hundred and twenty-four responses against a to-date target of six hundred and nineteen (Figure 7). Partner organisations have been provided with additional materials, e.g., business cards, to support their invitations to the survey, and specific high-enrolment studies are being targeted to ensure this goal is achievable by the end of March 2023.

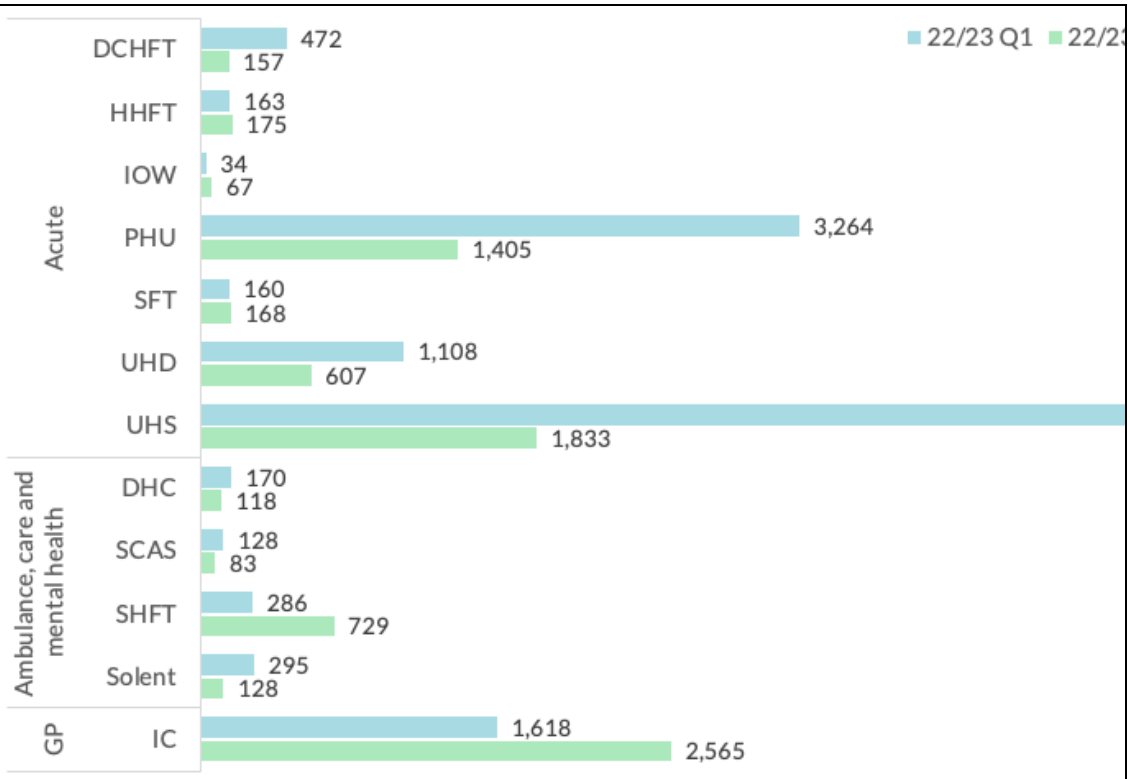


Figure 6 – Quarterly combined commercial and non-commercial CRN Portfolio study recruitment by organisation type in Wessex for quarters one to two of the 2022-23 financial year: 1 April 2022 – 30 September 2022.

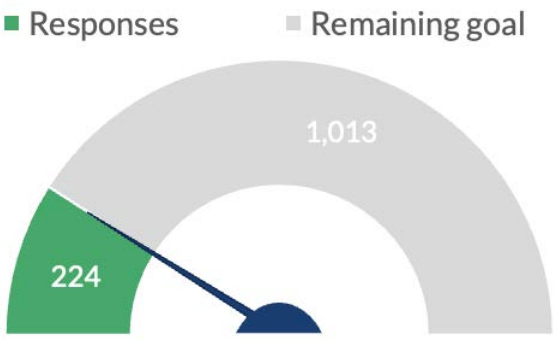


Figure 7 - Participant in research experience survey recruitment in Wessex for quarters one to two of the 2022-23 financial year: 1 April 2022 – 30 September 2022.

Non-commercial research activity in Wessex

Non-commercial studies include NIHR CRN portfolio studies that are not wholly funded and sponsored by the life sciences industry. Recruitment over time in Wessex has been benchmarked against the whole of the United Kingdom's activity in Figure 8. The UK trend line has been scaled down to twenty to one, with the justification that the Wessex population is one-twentieth of the UK's. The trendline indicates whether the region is recruiting above or below what has been completed by the country. There was a peak during the pandemic, with the introduction of very large prevention,

treatment and epidemiological studies. Recruitment has fallen in line with the total cases in Wessex and the UK.

In the latest quarter, Wessex was below the national benchmark for recruitment. CRN Wessex has reintroduced 'championed' studies based on their clinical significance, potential to recruit participants or other factors that make them important for participants. These criteria are not mutually exclusive. Partner organisations have been asked to consider whether they can deliver the championed studies list within the constraints of their current capacity. The list is updated as and when studies are identified, and the live version is available on a business intelligence dashboard maintained by the CRN. It is also expected that the DHSC's Research Reset programme, discussed earlier in the report, will increase the capacity to deliver research.

Figure 8 - Wessex non-commercial study recruitment benchmarked against the UK (20:1 scale) by quarter for the 2018/19 - 2022-23 financial year period: 1 April 2018 – 30 September 2022.

Figure 9 and Figure 10 compare year on year recruitment for the LCRN regions and the Wessex NHS organisations, respectively. If the first six months' recruitment continues for the remainder of the financial year, around forty-one thousand people will participate in research in 2022/23.

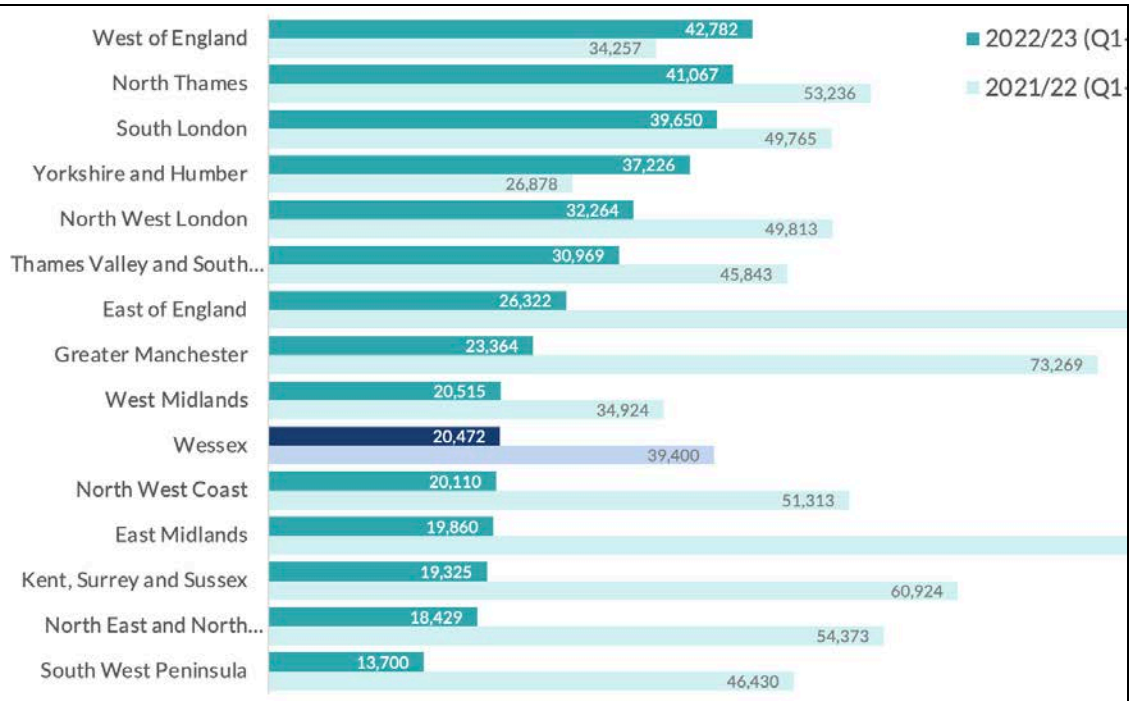


Figure 9 - Wessex non-commercial study recruitment by local clinical research network in quarters one to two of the 2022/23 financial year, compared to the same period in 2021/22. Regional population sizes can be found in appendix two.

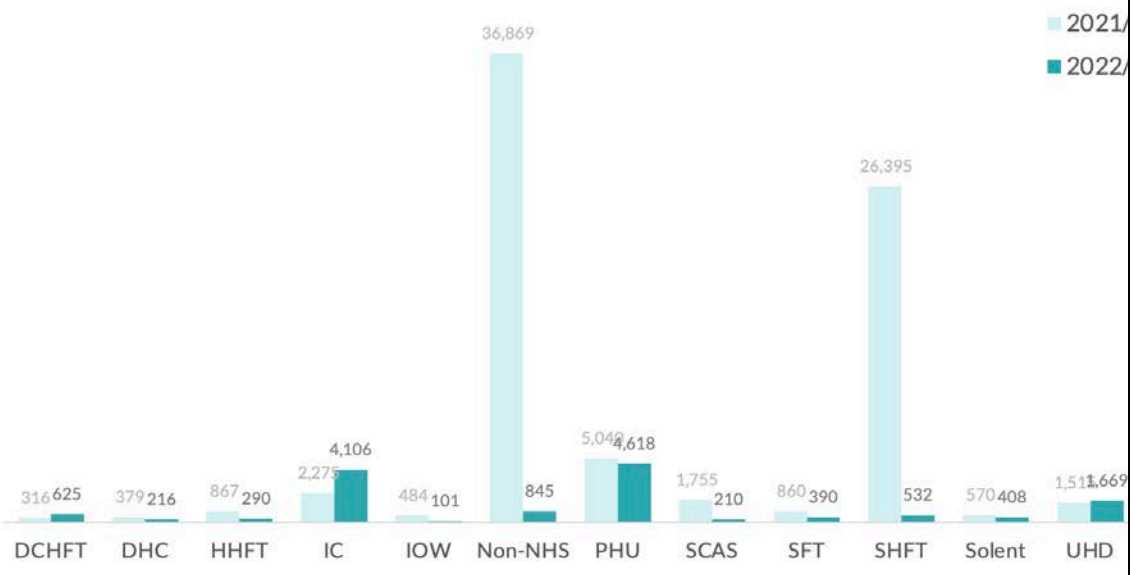


Figure 10 - Wessex non-commercial study recruitment by organisation in quarters one to two of the 2022/23 financial year, compared to the same period in 2021/22.

Recruiting studies in Wessex

The number of studies that have recruited each quarter since April 2018 is shown in Figure 11. The three-month rolling average indicates that there has been some recovery towards pre-pandemic levels but has been maintained at approximately the

same level for three quarters. It suggests that this represents the current limits on the capacity of research infrastructure in the region.

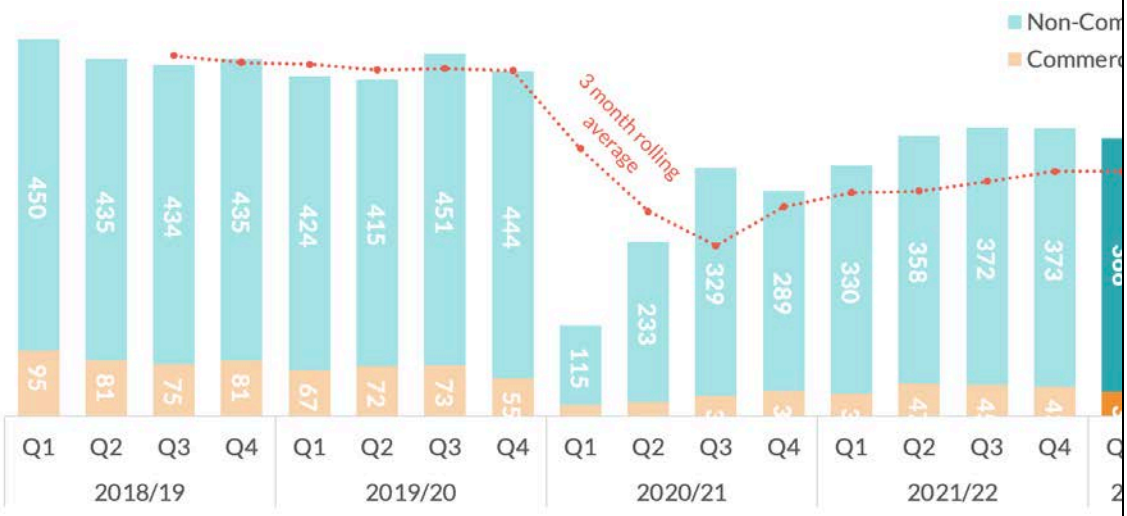


Figure 11 – Total NIHR CRN portfolio studies that have recruited within Wessex by quarter since April 2018 (1 April 2018 – 30 September 2022).

Commercial research activity in Wessex

Commercial research, funded and sponsored by the life sciences industry, is important to the Wessex region. It provides novel treatment options for patients, funds the expansion of research delivery and often savings on treatment costs for participating organisations.

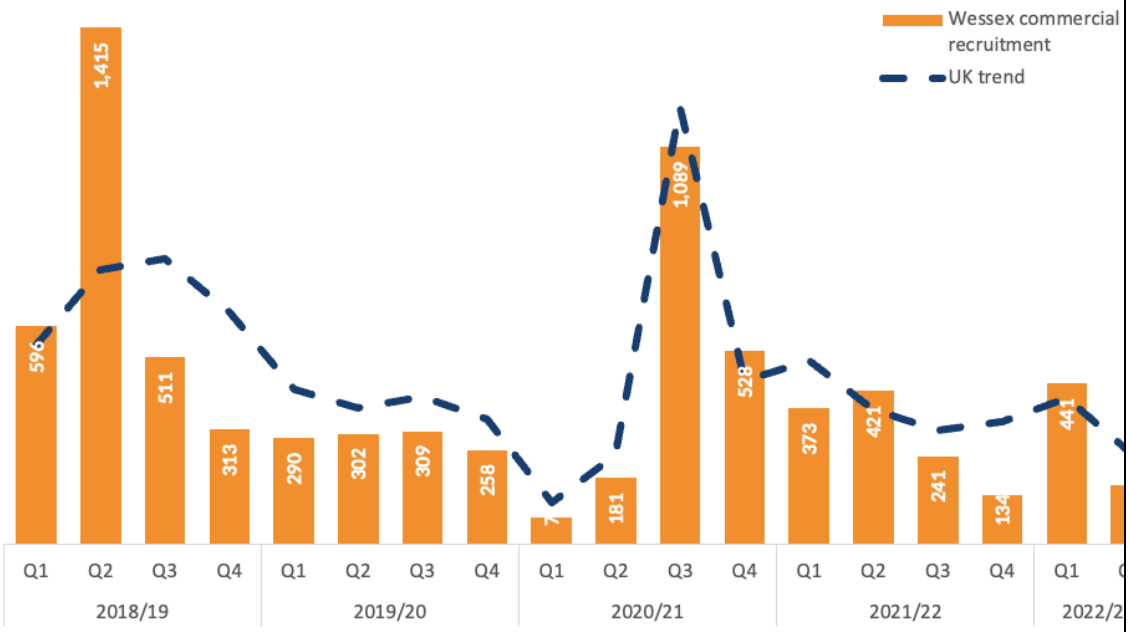


Figure 12 - Wessex commercial study recruitment benchmarked against the UK (20:1 scale) by quarter for the 2018/19-2022-23 financial year period: 1 April 2018 – 30 September 2022.

Wessex's commercial activity has been benchmarked against the UK's in Figure 12 using the same twenty to one population-scaled approach used for non-commercial recruitment. Wessex had a good first quarter, with the delivery of a Moderna mRNA trial that enrolled two hundred and seventy-one participants. Recruitment fell in quarter two with the closure of this trial.

In quarters one to two, Wessex was tenth among the fifteen regions in England (Figure 13) for recruitment. This increases to eighth when the population size in each region is factored in. Wessex partner organisation recruitment over the same period is shown in Figure 14)

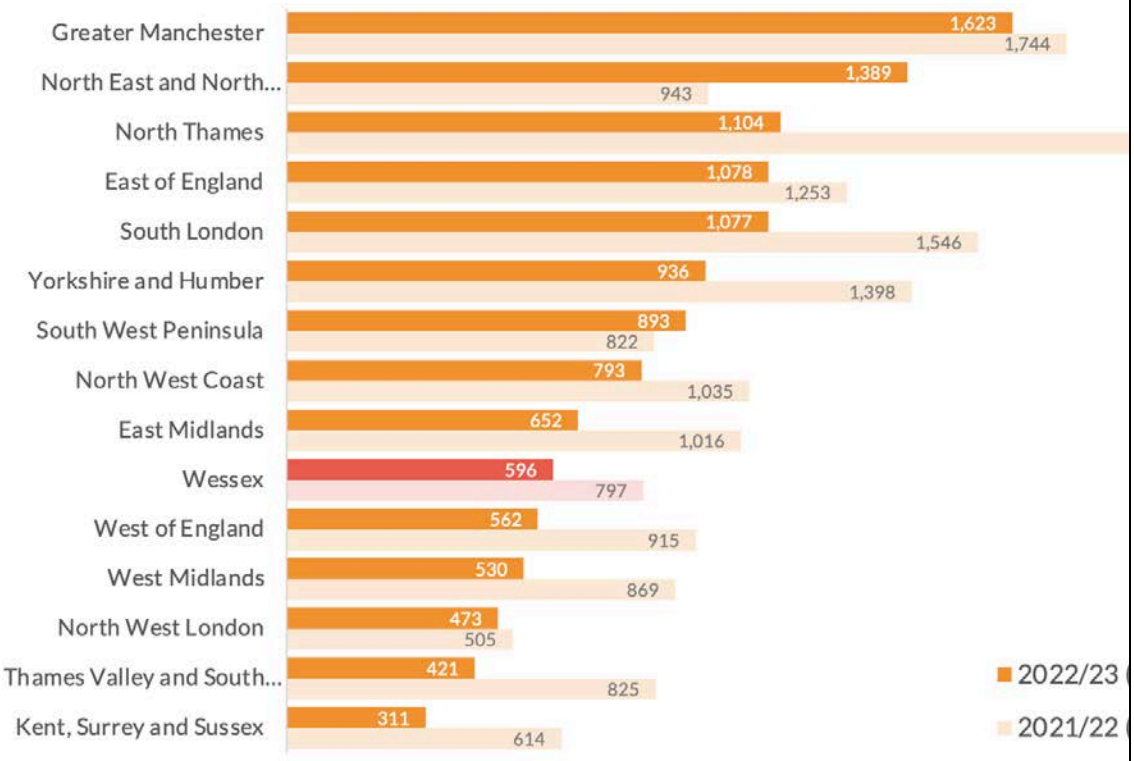


Figure 13 - Wessex commercial study recruitment by local clinical research network in quarters one to two of the 2022/23 financial year compared to the same period in 2021/22. Regional population sizes can be found in appendix two.

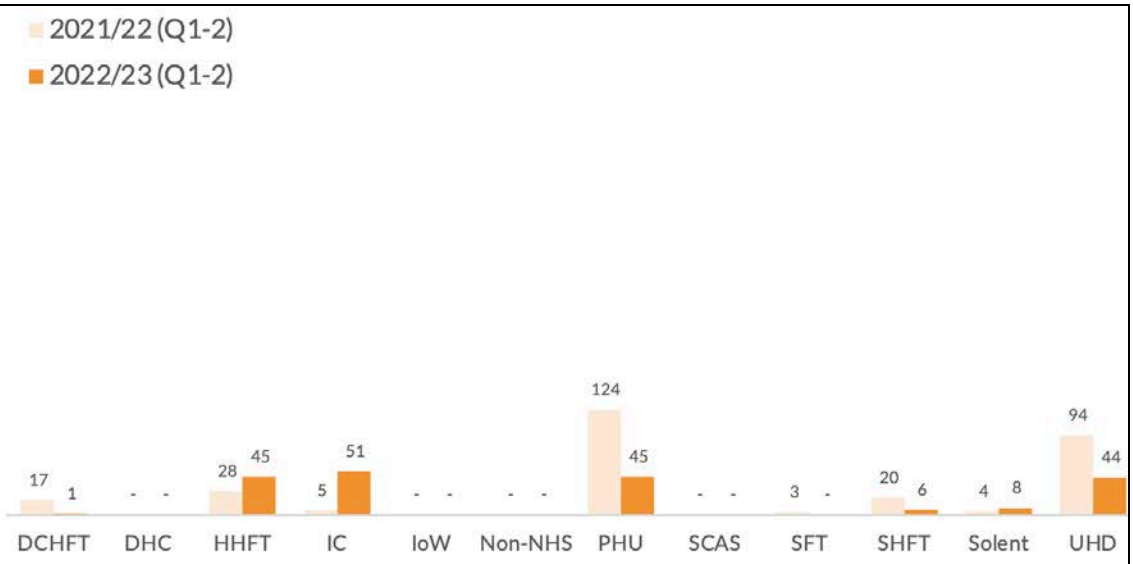


Figure 14 - Wessex commercial study recruitment by organisation in quarters one to two of the 2022/23 financial year, compared to the same period in 2021/22.

One of the commercial studies identified as key by CRN Wessex is being led from the region - the Sanofi HARMONIE respiratory syncytial virus (RSV) trial. With a sample size of 9,620 infants, the randomised trial aims to provide evidence of whether Sanofi's nirsevimab drug prevents hospitalisations due to RSV. The trial is taking place across England (Figure 15) and is expected to account for a significant proportion of the region's commercial activity for the remainder of this financial year.

Figure 15 – Wessex-led HARMONIE RSV vaccine trial recruiting sites in England during quarters one to two of the 2022/23 financial year: 1 April 2022 – 30 September 2022.

Implications: (Clinical, Organisational, Governance, Legal?)	All NHS organisations have a duty to their local population to participate in and support health and care research. The NIHR provides service support funding to facilitate research activity within Wessex. Therefore, CRN Wessex and its partner organisations must ensure that this is used effectively during the pandemic response and subsequent recovery, resilience, and growth of other studies.
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. Staff burnout. 2. Fuel prices/fuel shortage. 3. Supply chain issues. Please review the risk register for details of the responses that are already underway or planned.
Summary: Conclusion and/or recommendation	Research recruitment within the Wessex region in quarter two has fallen from quarter one. However, the number of recruiting studies has not dropped, nor the geographical spread of the research offering to patients. National and local initiatives described in this report are underway to ensure that the existing portfolio recruits to its targets through releasing capacity and that new studies prioritised by the clinical leadership open at more sites. The start of the Wessex-led HARMONIE RSV vaccine trial has already led to more vulnerable patients being able to participate in research while also improving the regions' performance against the DHSC's High Level Objectives for commercial studies. The UHS Board of Directors will continue to be updated on performance quarterly.

Appendix

Appendix 1 – CRN Wessex Risk Register

PRE-RESPONSE (INHERENT)									POST RESPONSE (RESIDUAL)								
Risk ID	Primary category	Date raised	Risk Owner	Risk Description (to include cause/event, and effect)	Probability	Impact	Value (Pxl)	Proximity	Response Actions	Action owner(s)	Action status	Probability	Impact	Value (Pxl)	Risk status (open or closed date)	Trend (since last reviewed)
CRN 02	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 prrogramme and managed national recovery workstreams 8. Close working with secialty group leads to share commercial opportunities with all partners 9. Develop research hub operating model to provide opportunities for all trusts to support commercial trials	Commercial Lead	All - ongoing	4	3	12	Open	Static
CRN 04	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 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 capacty 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
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.	5	4	20	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 January 2022	WFD Lead / COO / SSS Lead	All - ongoing	5	2	10	Open	Decreased
CRN 05	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 opportunties 3. Job shadowing opportunities 4. Succession planning, e.g deputy COO role 5. Strongly embedded workforce wellbeing initiatives	COO / CD	All - ongoing	2	2	4	Open	Decreased

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 (Pxl)	Proximity	Response Actions	Action owner(s)	Action status	Probability	Impact	Value (Pxl)	Risk status (open or closed date)	Trend (since last reviewed)
CRN 06	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 7	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	WFD/COO	All - ongoing	4	4	16	Open	Increased
CRN 8	Performance	Mar-22	CDs/COO	**Cause: Fuel prices/fuel shortage** **Event: Cost of fuel becomes prohibitively expensive/fuel shortages prevent core delivery team travel across the region to deliver trials** **Effect: Meaning that fewer clinical trials are delivered**	3	4	12	Now	1. DDT based nearer hub locations could pick up some work 2. Look for opportunities for remote trial delivery	COO/DCOO	All - ongoing	4	4	16	Open	Increased
CRN 9	Performance	Mar-22	CDs/COO	**Cause: Supply chain issues** **Event: Cost of fuel becomes prohibitively expensive/fuel shortages impact on supply chain for drugs and consumables required for trial delivery** **Effect: Meaning that fewer clinical trials are delivered**	3	4	12	Now	1. Raise locally and nationally for advice on prioritisation of key activities/studies	COO/DCOO	All - ongoing	4	4	16	Open	Increased
CRN 10	Workforce	Sep-22	CDs/COO	**Cause: End of LCRN contract March 2024** **Event: Exisiting staff may leave for other roles in the system to avoid uncertainty, leading to a depleted team and difficulty delivering to the POF. Difficulty recruiting into vacant posts for the final 'transition' year (2023/24)**	4	4	16	Now	1. Raise locally and nationally for advice on prioritisation of key activities/studies	COO/DCOO	All - ongoing	4	4	16	Open	
CRN 11	Performance	Oct-22	CDs/COO	**Cause: Winter pressures** **Event: Staff shortages due to sickness impacting on delivery, pharmacy, imaging: redeployment of research staff to clinical services**	4	4	16	Now	1. Raise locally and nationally for advice on prioritisation of key activities/studies	COO/DCOO	All - ongoing	4	4	16	Open	
CRN 12	Performance	Nov-22	CDs/COO	**Cause: Nurses strike action** **Event: Lack of research nurses to deliver clinical trials due to strike action and redeployment to cover emergency care**	5	4	20	December	1. Raise locally and nationally for advice on prioritisation of key activities/studies	COO/DCOO	All - ongoing					

Appendix 2 - Glossary

Partner organisation abbreviations used by CRN Wessex:

- DCHFT – Dorset County Hospital NHS Foundation Trust
- DHC - Dorset HealthCare
- 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 their 2021/22 financial year population:

- East Midlands – EM - 4,605,206
- East of England – EoE - 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 – WoE - 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