University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	30/11/2023
Time	9:00 - 13:00
Location	Conference Room, Heartbeat/Microsoft Teams
Chair	Jenni Douglas-Todd
Apologies	Diana Eccles

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		**Patient Story** The patient or staff story provides an opportunity for the Board to reflect on the experiences of patients and staff within the Trust and understand what the Trust could do better.
3	9:15	**Minutes of Previous Meeting held on 28 September 2023** Approve the minutes of the previous meeting held on 28 September 2023
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	9:20	**Briefing from the Chair of the Finance and Investment Committee (Oral)** Dave Bennett, Chair
5.2	9:25	**Briefing from the Chair of the People and Organisational Development Committee (Oral)** Jane Harwood, Chair
5.3	9:30	**Briefing from the Chair of the Quality Committee (Oral)** Tim Peachey, Chair
5.4	9:35	**Chief Executive Officer's Report** Receive and note the report Sponsor: David French, Chief Executive Officer
5.5	9:55	**Performance KPI Report for Month 7** Review and discuss Sponsor: David French, Chief Executive Officer

5.6 **Finance Report for Month 7**

10:25 Review and discuss
Sponsor: Ian Howard, Chief Financial Officer

5.7 **People Report for Month 7**

10:35 Review and discuss
Sponsor: Steve Harris, Chief People Officer

5.8 **Break**

10:45

5.9 **Midwifery, Neonatal and Obstetric Anaesthetic Workforce Report**

10:55 Review and discuss
Sponsor: Gail Byrne, Chief Nursing Officer
Attendees: Emma Northover, Director of Midwifery/Marie Cann, Maternity/Neonatal Safety Lead/Alison Millman, Safety & Quality Assurance Matron

5.10 **Learning from Deaths 2023-24 Quarter 2 Report**

11:10 Review and discuss
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Jenny Milner, Associate Director of Patient Experience

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

11:20 Receive and discuss the report
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Diana Hulbert, Guardian of Safe Working Hours and Emergency Department Consultant

5.12 **Medicines Management Annual Report 2022-23**

11:30 Receive and discuss the report
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: James Allen, Chief Pharmacist

5.13 **Infection Prevention and Control 2023-24 Quarter 2 Report**

11:40 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

5.14 **Annual Ward Staffing Nursing Establishment Review 2023**

11:50 Discuss and approve the review
Sponsor: Gail Byrne, Chief Nursing Officer
Attendee: Rosemary Chable, Head of Nursing for Education, Practice and Staffing

5.15 **Freedom to Speak Up Report**

12:00 Review and discuss the report
Sponsor: Gail Byrne, Chief Nursing Officer
Attendee: Christine Mbabazi, Equality & Inclusion Adviser/Freedom to Speak Up Guardian

6 STRATEGY and BUSINESS PLANNING

6.1 Board Assurance Framework (BAF) Update

12:15 Review and discuss the update
Sponsor: Gail Byrne, Chief Nursing Officer
Attendees: Craig Machell, Associate Director of Corporate Affairs and Company Secretary/Lauren Anderson, Corporate Governance and Risk Manager

7 CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

7.1 Annual Assurance for the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)

12:30 Review and discuss the report
Sponsor: Joe Teape, Chief Operating Officer
Attendees: John Mcgonigle, Emergency Planning & Resilience Manager/ Danielle Sinclair, Deputy Emergency Planner

8 Any other business

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

9 Note the date of the next meeting: 30 January 2024

10 Items circulated to the Board for reading

10.1 CRN: Wessex 2023-24 Q2 Performance Report

Note the report
Sponsor: Paul Grundy, Chief Medical Officer

11 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.

12 Follow-up discussion with governors

12:45

University Hospital Southampton
NHS Foundation Trust

Minutes Trust Board – Open Session

Date	28/09/2023
Time	9:00 – 12:45
Location	Microsoft Teams
Chair	Jenni Douglas-Todd (JD-T)
Present	Dave Bennett, NED (DB) Gail Byrne, Chief Nursing Officer (GB) Diana Eccles, NED (DE) Keith Evans, Deputy Chair and NED (KE) David French, Chief Executive Officer (DAF) Paul Grundy, Chief Medical Officer (PG) Steve Harris, Chief People Officer (SH) Jane Harwood, NED/Senior Independent Director (JH) Ian Howard, Chief Financial Officer (IH) Femi Macaulay, Interim NED (FM) Tim Peachey, NED (TP) Joe Teape, Chief Operating Officer (JT)
In attendance	Craig Machell, Associate Director of Corporate Affairs and Company Secretary (CM) Marie Cann, Maternity/Neonatal Safety Lead (MC) (item 5.8) Jane Fisher, Head of Health and Safety Services (JF) (item 6.2) Sarah Herbert, Deputy Chief Nursing Officer (SHe) (items 5.9-5.11) Corinne Miller, Named Nurse for Safeguarding Adults (CMi) (item 5.10) Alison Millman, Interim Safety & Quality Assurance Matron (AM) (item 5.8) Emma Northover, Director of Midwifery (EN) (item 5.8) Julie Walters, Consultant Midwife (JW) (item 5.8) Vickie Purdie, Patient Safety Specialist and PSIRF Implementation Lead (VP) (item 5.11) Christina Rennie, Medical Lead for Safety (CR) (item 5.11) Laura Cross, Inspector, CQC (observing) 1 member of the public (item 2) 5 governors (observing) 2 members of staff (observing) 1 member of the public (observing)
Apologies	Martin De Sousa, Director of Strategy and Partnerships (MDeS)

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

The Chair welcomed attendees to the meeting. There were no interests to declare in the business to be transacted at the meeting.

The Chair provided an overview of her activities since July 2023, including visits to hospital departments, meetings with peers and other key stakeholders.

2. Patient Story

Carol Alstrom was invited to speak about her experience as a patient when she attended the Emergency Department in March 2023 due to a then undiagnosed complication with a pituitary tumour. It was noted that:

- The patient received surgery within a matter of hours and was very positive regarding the care provided and the kind, compassionate and caring workforce.
- The patient was previously a senior NHS leader, but did not inform staff of this.
- The importance of the people who make up the Trust's staff was highlighted as being key.

3. Minutes of the Previous Meeting held on 27 July 2023

The draft minutes tabled to the meeting were agreed to be an accurate record of the meeting held on 27 July 2023.

4. Matters Arising and Summary of Agreed Actions

There were no matters arising or actions due for completion.

5. QUALITY, PERFORMANCE and FINANCE

5.1 Briefing from the Chair of the Finance and Investment Committee

The chair of the Finance and Investment Committee was invited to provide an overview of the meeting held on 25 September 2023. It was noted that:

- The committee reviewed the Finance Report (item 5.5) and noted the pressure on the system and likely need to submit a reforecast for 2023/24.
- The committee also noted that it could be advantageous to bring forward capital expenditure due to a potential under-run of £7m in capital expenditure for the year.
- The committee reviewed the draft financial recovery plan produced by the Hampshire and Isle of Wight Integrated Care Board (ICB). There were considered to be significant risks in the plan due to risk of under- and non-delivery of transformation programmes.
- The committee received a quarterly update from Estates, including a report on reinforced aerated autoclave concrete at the Trust.

5.2 Briefing from the Chair of the People and Organisational Development Committee

The chair of the People and Organisational Development Committee was invited to provide an overview of the meeting held on 20 September 2023. It was noted that:

- The committee reviewed the People Report (item 5.6) and workforce plan, noting that the Trust was 74 whole-time equivalents over plan and that sickness and turnover rates were relatively low.
- The committee discussed methods to encourage staff to complete the staff survey.
- The committee approved the objectives for year two of the Trust's People Strategy.

5.3 Chief Executive Officer's Report

David French was invited to present the Chief Executive Officer's Report, the content of which was noted. It was further noted that:

- There had been the first simultaneous industrial action by both junior doctors and consultants between 20 and 22 September 2023 and 19 and 20 September 2023 respectively. Further strikes between 2 and 4 October 2023 by both groups had been announced.

- It was estimated that industrial action had resulted in the cancellation of one million appointments nationally. The participation in industrial action varied significantly across the country with 4-7% of consultants striking at the Trust, but other trusts saw c.50% strike. It had been noted that staff were becoming less inclined to inform the Trust whether they were planning to participate in upcoming industrial action, which made planning difficult.
- There had been no further information received regarding whether Elective Recovery targets would be adjusted to reflect the latest industrial action. Despite the disruption, the Trust's Elective Recovery performance was at 114% compared to 2019/20.
- The additional winter funding for 2023/24 announced by the Government on 14 September 2023 was being held centrally by NHS England.
- A meeting was scheduled to take place on 29 September 2023 with NHS England regarding the recovery support programme and the associated exit criteria.
- The Trust had been informed that the bid for a University Technical College in Southampton had been accepted by the Government. This was a good example of local organisations and politicians collaborating.
- Hampshire and Isle of Wight ICB had not yet made a decision in respect of specialised commissioning. It should be noted that Dorset had decided to delay the introduction until 2025. It would be necessary to carry out analysis of the financial impact and a delay until 2025 would be beneficial.

5.4 Performance KPI Report for Month 5 including Outpatient Transformation

Joe Teape was invited to present the Performance KPI Report for Month 5, the content of which was noted. It was further noted that:

- The Trust's performance was in the top quartile in respect of six out of nine measures and the top half in eight out of nine measures when assessed against comparator organisations.
- There had been a high demand for urgent care during September 2023 and there had been record numbers of patients with no criteria to reside which was impacting performance due to delays in discharging patients.
- The Trust's cancer performance was now in the top quartile and the backlog of patients waiting more than 62 days following a diagnosis had been reduced.
- A report on the significant increase in the number of elective caesarean sections was to be brought to the Quality Committee.

The Board noted the spotlight on the Emergency Department. It was further noted that:

- The Emergency Department continued to face unprecedented pressure with average attendances of over 365 per day and increasing numbers of patients presenting with or because of mental health concerns.
- A number of actions were being taken to support the Emergency Department, including to prevent inappropriate attendances, increasing diagnostic efficiency, streamlining clinical decision-making and improving patient flow.
- The state of local authority finances had meant that it had not been possible to provide services to enable patients with no criteria to reside to be discharged.
- The General Practitioner (GP) village trial carried out previously had shown that one third of 'walk-ins' to the Emergency Department could be dealt with by a GP. However, this programme had a significant financial cost associated with it.

The Board noted that spotlight on Diagnostics and noted that the Trust was performing reasonably well and continued improvement was expected.

On 4 August 2023, the Trust had been requested to carry out a review of its current annual plan for outpatient recovery by NHS England and for the Board to review and approve a self-certification by 30 September 2023. The Board reviewed the draft self-certification response and provided feedback to Joe Teape, particularly in respect of the explanation of the Trust's approach to out-patient follow ups.

Decision:
The Board approved the self-certification response, subject to incorporation of the feedback provided at the meeting, and authorised the Chair and Chief Executive Officer to sign the completed response and send it to NHS England.

5.5 Finance Report for Month 5

Ian Howard was invited to present the Finance Report for Month 5, the content of which was noted. It was further noted that:

- The Trust's year-to-date deficit was £20.8m, which was £4.1m adverse to the planned level. The main causes of this were the unfunded elements of the 2022/23 and 2023/24 pay awards. It was expected that at year-end, the unfunded pay awards would result in approximately £9m of additional cost. There was no indication of any further financial assistance to address this issue.
- The Trust had been good at identifying Cost Improvement Programme opportunities amounting to £80m, but, following assessment, it was anticipated that £54m of these were deliverable and that much of this amount was non-recurrent.
- News was awaited regarding adjustment of the Elective Recovery Fund target due to the impact of industrial action. Every 1% movement in the target was worth £4.5m per annum to the Trust.

The Board discussed the Trust's underlying financial position, noting that the underlying year-to-date deficit was £29.1m, averaging £5.8m per month. The Board asked what the plan was when the Trust reached its minimum cash balance. It was noted that the Trust had set a higher minimum cash balance than other organisations (£30m). If it proved necessary to request additional funding, the Trust would be required to bid for this funding one quarter in advance and that this funding could not be used for additional capital expenditure.

5.6 People Report for Month 5

Steve Harris was invited to present the People Report for Month 5, the content of which was noted. It was further noted that:

- The Trust was 74 whole-time-equivalents over the plan submitted to NHS England. There had been significant growth in substantive staff during August 2023 due to the annual junior doctor rotation.
- Use of temporary staff increased during August 2023, which was typical during the month due to the higher rate of staff absence due to annual leave. However, overall use of temporary staffing remained broadly flat with an intention to reduce use.
- Industrial action continued to impact staff and had resulted in the cancellation of 'We are UHS week'.

- Delivery of the Trust's leadership programmes was very important in terms of promoting diversity and training strategic leadership.
- There was continued benefit from the participation by representatives of the Finance team at People and Organisational Development Committee meetings.
- A number of important elements in relation to staff morale and wellbeing were not measurable. To gain insight into these areas the Trust's senior leadership undertook regular walkabouts and met with staff and staff groups. In addition, the Trust's nursing leadership 'went back to the floor' on Fridays.

5.7 Break

5.8 Maternity Safety 2023-24 Quarter 2 Report

Emma Northover, Alison Millman and Julie Walters were invited to present the Maternity Safety 2023-24 Quarter 2 Report, the content of which was noted. It was further noted that:

- The Care Quality Commission had published its report in respect of maternity services at the Trust and had rated the Trust overall as 'Good'. A number of areas for improvement were identified and an action plan was in place with appropriate oversight by Executive Directors.
- The Trust's current performance was reflective of operational pressures.
- The level of elective work had increased, particularly with respect to the number of elective caesarean sections.
- The Trust's performance in terms of continuity of carer was due to difficulties in terms of recruitment. Accordingly, a more flexible approach to recruitment was being considered.
- The information required to be reported to NHS Resolution was significant and additional information might need to be included in the reports to the Board over the coming months.

5.9 Events in the Neonatal Unit in Countess of Chester NHSFT

Sarah Herbert was invited to present the paper 'Events at the Neonatal Unit in Countess of Chester NHSFT', the contents of which were noted. It was further noted that:

- Lucy Letby had been convicted of murdering seven babies and attempting to kill six others at the neonatal unit at the Countess of Chester NHS Foundation Trust between 2015 and 2016 and was sentenced to imprisonment for life. A statutory inquiry was due to commence.
- NHS England had sent a letter to all ICBs, NHS Trusts and primary care networks on 18 August 2023 requesting assurance of proper implementation and oversight of governance arrangements and in respect of strengthening patient safety and Freedom to Speak Up arrangements.
- A Trust Board Study Session had been held on 12 September 2023, which reflected on the issues arising from the case and examined the Trust's patient safety and Freedom to Speak Up arrangements.
- NHS England and the Trust were also reviewing current controls and culture in terms of access to medicines.

- The statutory inquiry had the potential to have a significant impact, such as in terms of regulation of NHS senior leaders.
- There were 52 Freedom to Speak Up Guardians at the Trust, covering all of the divisions, but wider coverage was sought.

The Board challenged how quickly the Trust would have detected a similar situation and noted that during the period when these events occurred, the Independent Medical Expert Group (IMEG), which had started at the Trust and then been rolled out nationally, did not exist. IMEG would involve patient safety teams and information from the Patient Advice and Liaison Service and complaints would also be examined. The curiosity of the Trust's leadership would be key in detecting such an issue.

The Board challenged whether an annual report on Freedom to Speak Up would be sufficient and noted that this was driven by the availability of the staff survey results. It was suggested that appropriate questions could be added to pulse surveys to facilitate more frequent reporting. It was further noted that this matter was broader than just Freedom to Speak Up arrangements and it was necessary to embed a culture where staff feel comfortable to speak with their managers.

5.10 Safeguarding Annual Report 2022-23

Sarah Herbert and Corinne Miller were invited to present the Safeguarding Annual Report 2022/23, the content of which was noted. It was further noted that:

- The Trust had experienced increased safeguarding activity with increasing numbers of complex cases requiring input from the Trust's legal advisers.
- There had been issues due to the need to carry out tasks within the hospital environment, which had previously been the responsibility of other organisations. The Trust was working with the ICB to address this.
- There had been significant changes to a number of national policies and associated guidance, which had required new and revised policies at the Trust.
- It was recognised that training required improvement and a strategy to address this was due to be launched.

5.11 Patient Safety Incident Response Framework (PSIRF) Policy and Plan

Vickie Purdie and Christina Rennie were invited to present the paper 'Patient Safety Incident Response Framework (PSIRF) Policy and Plan', the content of which was noted. It was further noted that:

- The Trust had agreed a transition date of 2 October 2023 for the transition from the Serious Incident Framework to PSIRF.
- The Trust's policy and plan had been presented to the Quality Committee on 21 August 2023 and was subsequently approved by the Quality Governance Steering Group and by the Hampshire and Isle of Wight ICB.

The Board discussed the transition to PSIRF and noted that there remained an issue with increasing regulation conflicting with the open culture sought through PSIRF. There was also potential for challenges where it was decided not to investigate an event.

Decision:
Having reviewed the document 'University Hospital Southampton NHS Foundation Trust (UHS) Patient safety incident response policy' tabled to the meeting, the Board approved the document.

6. CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

6.1 Register of Seals and Chair's Actions Report

The paper 'Register of Seals and Chair's Actions Report' was presented to the meeting, the content of which was noted.

Decision:
The Board agreed to ratify the application of the Trust Seal to the documents listed in the 'Register of Seals and Chair's Actions Report'.

6.2 Health and Safety Annual Report 2022-23

Jane Fisher was invited to present the 'Health and Safety Annual Report 2022-23', the content of which was noted. It was further noted that:

- The Health and Safety team continued to provide support and training to staff.
- There was a planned reduction in the number of staff supporting FFP3 mask fit testing, which would impact the service provided.
- There had been 2,575 health and safety related adverse events reported during 2022/23, the majority of which related to slips/trips/falls (1,487) and violence and aggression (764). The number of events was higher than prior years, although was similar to the level seen prior to the COVID-19 pandemic.
- Where incidences of violence and aggression were reported, Employee Relations were involved in all incidences of staff-on-staff violence/aggression and the Trust had implemented a 'yellow' and 'red' card system for patient-on-staff violence/aggression. In addition, the Trust provided support for criminal investigations where appropriate and had invested heavily in security staff and body-worn cameras.

Actions:
Jane Fisher agreed to look at the violence and aggression incidents data for the specialist medicine care group to explain the number.

Gail Byrne, Steve Harris and Craig Machell agreed to schedule a further update in respect of violence and aggression at a future Trust Board Study Session.

6.3 People and Organisational Development Committee Terms of Reference

It was noted that the People and Organisational Development Committee had reviewed its terms of reference at its meeting held on 20 September 2023.

Decision:
Having reviewed the People and Organisational Development Committee terms of reference tabled to the meeting, it was agreed to approve these terms of reference.

7. Any other business

There was no other business.

8. Note the date of the next meeting: 30 November 2023

9. Items Circulated to the Board for reading

The items circulated to the Board for reading were noted.

10. Resolution regarding the Press, Public and Others

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

The meeting was adjourned.

University Hospital Southampton NHS Foundation Trust

List of action items

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 27/07/2023 5.16 Annual Complaints Report 2022-23				
1013.	Demographics	Milner, Jenny	30/11/2023	Completed
	Explanation action item Ellis Banfield agreed to ask the team to investigate the demographics of complainants to identify any trends. Update from JM, Associate Director of Patient Experience: We can review our demographics from complainants to a certain extent, our equality monitoring enables us to capture: Ethnic group; Language; Country; Gender; Marriage/civil; Sexual orientation; Religion/belief; Disability When the complainant is not the patient (for example a relative complaining on behalf of a patient) we do not capture that data. The PALS/Complaints team support with alerts to Learning Disabilities/Communication needs and will ensure that this patient has a flag if not already on UHS systems, the action to review themes instigated a review of the feedback forms sent to complainants, this showed that the predominant characteristics of complaints are white middle aged women. This indicates that there is targeted work required within our patient involvement workstreams to review our community engagement, this will be added as Quality Priority 2024/25.			
Trust Board – Open Session 28/09/2023 5.8 Maternity Safety 2023-24 Quarter 1 Report				
1031.	Letter from the Board	Douglas-Todd, Jenni	29/09/2023	Completed
	Explanation action item It was agreed to send a letter from the Board to Emma Northover and the team congratulating them for all their hard work and on achieving a ‘Good’ rating in the recent CQC inspection. Update: Letter sent 29/09/2023.			

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 28/09/2023 6.2 Health and Safety Annual Report 2022-23				
1032.	Violence and aggression incidents	• Fisher, Jane	30/11/2023	Pending
	Explanation action item Jane Fisher agreed to look at the violence and aggression incidents data for the specialist medicine care group to explain the number. Update: The data is currently being compiled and reviewed.			
Trust Board – Open Session 28/09/2023 6.2 Health and Safety Annual Report 2022-23				
1041.	Violence and aggression update	• Byrne, Gail • Harris, Steve • Machell, Craig	29/02/2024	Pending
	Explanation action item Gail Byrne, Steve Harris and Craig Machell agreed to schedule a further update in respect of violence and aggression at a future Trust Board Study Session.			

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:	**30 November 2023**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	My report this month covers updates on the following items: • Autumn Statement • CQC's New Approach to Assessment • Covid-19 Inquiry • Targeted Lung Health Check Programme			
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.			

Autumn Statement

On 22 November 2023, the Chancellor of the Exchequer delivered his autumn statement. The statement focused on three key areas: progress made on the Prime Minister's economic priorities; growing the UK economy; and making work pay.

There were no specific announcements concerning the health and care sector included, but the Chancellor outlined his ambition to increase productivity growth in the public sector by 0.5% per year as part of the Public Sector Productivity Programme. The Chancellor did refer to the NHS Long-Term Workforce Plan, which is underpinned by an assumed labour productivity growth of 1.5%-2% annually. It is intended that this will be achieved through moving towards a more preventative model of care, by doubling the size of the community workforce, and harnessing technology.

The Government announced £5m to support formation of the Fleming Centre to tackle anti-microbial resistance and is also providing £51m to the UK's largest health research programme to recruit volunteers and genotype the first one million participants.

As part of its reforms to welfare to reduce the number of long-term sick and disabled people out of work, the Government has announced the expansion of access to employment support services within community mental health teams and access to NHS Talking Therapies in England. In addition, it is proposed to develop a voluntary minimum framework to set out minimum level of occupational health intervention employers can adopt to improve health and work. The Government also announced an intention to reform the fit note process.

The Office of Budget Responsibility's (OBR) forecast assumes that spending in the NHS in England will increase in real terms by 3.6% per year, in line with the long-run average real terms growth rate for the service between 1949/50 and 2022/23. However, this will only be possible if major improvements in public sector productivity materialise. Public sector productivity is currently 5% below 2019/20 levels. In addition, the OBR expects that whilst inflation will continue to fall to 2% by the end of 2024, public services inflation is expected to average 7% growth over 2023 and should then sharply fall in 2024.

In terms of revenue and capital budgets, these have been updated to reflect the outturn position for 2022/23 and to include some adjustments for additional expenditure, e.g. the NHS Long-Term Workforce Plan, Agenda for Change pay deal and additional 'winter' support previously announced.

Revenue Funding:

	2022/23 (outturn)	2023/24 (forecast)	2024/25 (forecast)
DHSC revenue budget (£bn)	171.8	174.6	177.2
Of which, NHSE (£bn)	155.1	161.1	162.5

Capital Funding:

	2022/23 (outturn)	2023/24 (forecast)	2024/25 (forecast)
DHSC capital budget (£bn)	9.9	12.1	12.6

CQC's New Approach to Assessment
On 21 November 2023, the Care Quality Commission (CQC) commenced its roll out of its new single assessment framework in the South region.

Under the new framework, the central pillars of the existing framework – the five key questions (are services 'safe', 'effective', 'caring', 'responsive' and 'well-led') and the ratings scale will remain as before. The most significant change is the departure from reliance on a single inspection at a point in time to more continuous assessment. Importantly, the CQC will have powers to change a provider's rating at any point based on their assessment of evidence about quality and safety, without those changes being linked to an inspection.

The CQC has replaced the previous system of Key Lines of Enquiry and prompts with a series of 'quality statements' relating to 34 topic areas across the five key questions. To assess services against these quality statements, the CQC will use six categories of evidence: people's experiences of health and care services; feedback from staff and leaders; feedback from partners; observation; processes; and outcomes.

These quality statements will be scored from 1 (significant shortfalls) to 4 (exceptional standard), which will in turn generate a rating for each of the key questions, which when aggregated will give an overall rating.

Between 21 November and 4 December 2023, the CQC will be carrying out a small number of planned assessments with 14 early adopter providers. It is intended that the new framework will be rolled out across England by the end of March 2024.

Covid-19 Inquiry
The UK Covid-19 Inquiry public hearings for module 2 began on 3 October and will conclude on 14 December 2023. The second module of the Inquiry is focused on the core political and administrative governance and decision-making for the UK. It seeks to examine the initial response, central government decision-making, political and civil service performance as well as the effectiveness of relationships with the devolved administrations.

The Inquiry has heard evidence about concerns that the NHS was going to be overwhelmed, the discharge of patients into care homes, decisions about lockdowns and the Department of Health and Social Care's role in drafting regulations. It has heard from witnesses including the former Cabinet Secretary, senior advisers to the then Prime Minister, the Chief Medical Officer and the Chief Scientific Adviser.

Targeted Lung Health Check Programme
On 15 November 2023, Abi Desouza, Programme Manager for Targeted Lung Health Checks (TLHC) (Wessex) and Treatment Variation, and Edwin Woo, Consultant Thoracic Surgeon, attended a reception for the TLHC at the Houses of Parliament where Abi Desouza gave a speech to an audience from the charity sector, pharmaceuticals, clinicians, alliances and Members of Parliament on the Southampton TLHC programme and how it is helping to tackle health inequalities.

The national TLHC programme has identified (as of August 2023) 2,705 cases of lung cancer, of which 74% were stages one or two. Hampshire and Isle of Wight detected 224 cases of lung cancer over the same period, of which 80% were stages one or two.

The Trust invited 33,685 people to participate and performed 9,514 lung health checks under the TLHC programme between January 2020 and September 2023. These checks identified 181 cases of lung cancer, of which 148 were stage one or two cancers.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Performance KPI Report 2023-24 Month 7**			
Agenda item:	**5.5**			
Sponsor:	**David French, Chief Executive**			
Author	**Sam Dale, Associate Director of Data and Analytics**			
Date:	**30 November 2023**			
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 Performance KPI 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 performance metrics. 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.			

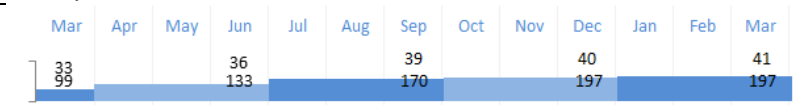
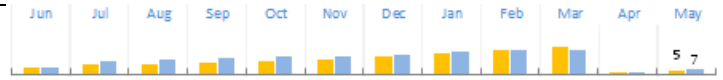
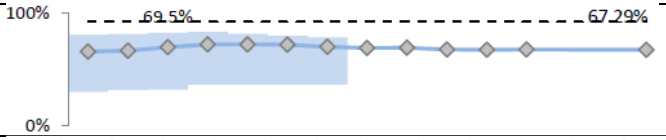
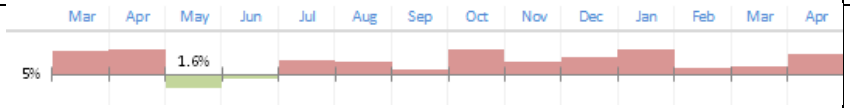
University Hospital Southampton NHS
NHS Foundation Trust

Performance KPI Board Report

Covering up to
October 2023

Sponsor – David French, Chief Executive Officer
Author – Sam Dale, Associate 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 is 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 Performance KPI 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, the following changes have been made to the report.

- Data Omission. The data to enable accurate percentage reporting for virtual outpatient appointments in October was not available at the time of publication

Summary

This month the 'Spotlight' section contains an update on the recent performance of the Accident and Emergency Department.

The ED spotlight highlights that:

- October performance for patients spending less than four hours in ED was 57.5% for Type 1 attendances and 61.1% for all types. This is below the trust's 23/24 in month planning trajectory that committed to reaching 76% by March 2024. The hospital performance for October however ranks in the top half when compared to other teaching hospitals.
- Current pressures are driven by the volume of attendances to the emergency department, subsequent speed of decision making and flow into beds for those patients who need to be admitted.
- Ambulance Handovers are a current focus area for NHS England and is also one of the key priority areas within the national priorities for 2023/24. UHS has constantly performed very well in relation to measures of timely ambulance handover and continues to do so compared to peers.
- The Trust has agreed a series of actions to improve timely decision to admit or discharge within the Emergency Department. In addition, four key initiatives have been requested to support the Emergency Department and are being led by the Deputy Medical Director and Director of Urgent and Emergency Care. Details of the schemes are documented in the report.

Areas of note in the appendix of performance metrics include:

1. Overall there have been positive trajectories in our cancer performance statistics since last publication: -
    a. Following validation, the 62 day standard performance for September increased to 69.%. This places UHS as the highest ranked teaching hospital for the month. Similarly the Trust's performance on 28 day faster diagnosis improved to 83.3% for September which again places the Trust at the top of the rankings for comparative teaching hospitals.
    b. However, the position worsened to 70.9% for 31 day subsequent treatments of cancer leaving the Trust in the bottom quartile when compared with Teaching hospitals. The performance is significantly impacted by an increase in the volume of tertiary referrals received by the Trust. Actions being explored to address the decline include extensive validation of the 31 day patient treatment list, exploring additional capacity with Spire for robotic surgery, reviewing theatre capacity allocation through the Trust's Clinical Priority Review Panel and progressing a radiotherapy service improvement plan.
2. The diagnostic waiting list continues to decrease every month within this financial year and now stands at 8,188 with 19% of patients waiting over six weeks.
3. The Trust reported one patient waiting over 104 weeks. This patient's treatment has been delayed due to the national availability of corneal tissue but will be treated in November. The Trust reported 23 patients waiting over 78 weeks and 378 waiting over 65 weeks.

4. The increased incidence in C. difficile cases continues to be reported both nationally and locally across the Hampshire and Isle of Wight integrated care system. An enhanced focus on reducing C.difficile is in place at national, regional and system level and an improvement plan has been developed at UHS which includes a new review process to enable timely identification of learning, actions and interventions. The review of cases in quarter two highlighted: -
    a. That the majority of patients had one or more risk factors for developing C. difficile diarrhoea including prior or current exposure to antibiotics or other high-risk medications, comorbidities, advanced age, impaired immune status.
    b. All patients had received antibiotics prior to developing CDI
    c. A proportion of cases (29%) were linked to a period of increased incidence (PII) on a ward indicating potential exposure, acquisition or transmission on the ward
5. The usage of Watch and Reserve antibiotics shows an in-month increase aligning it with the previous high in October 2022. This dataset is linked to a provisional calculation for number of admissions and will be reviewed in more detail when the confirmed number is calculated.
6. The bounce back in the October metric for Research and Development income reflects that the previous decision to defer Biomedical Research Centre funding from the National Institute of Health Research has now been reversed.

Ambulance response time performance

The latest unvalidated weekly data is provided by the South Coast Ambulance Service (SCAS). In the week commencing 6th November 2023, our average handover time was 17 minutes 22 seconds across 816 emergency handovers, and 24 minutes 22 seconds across 47 urgent handovers. There were 65 handovers over 30 minutes, and 5 handovers taking over 60 minutes within the unvalidated data.

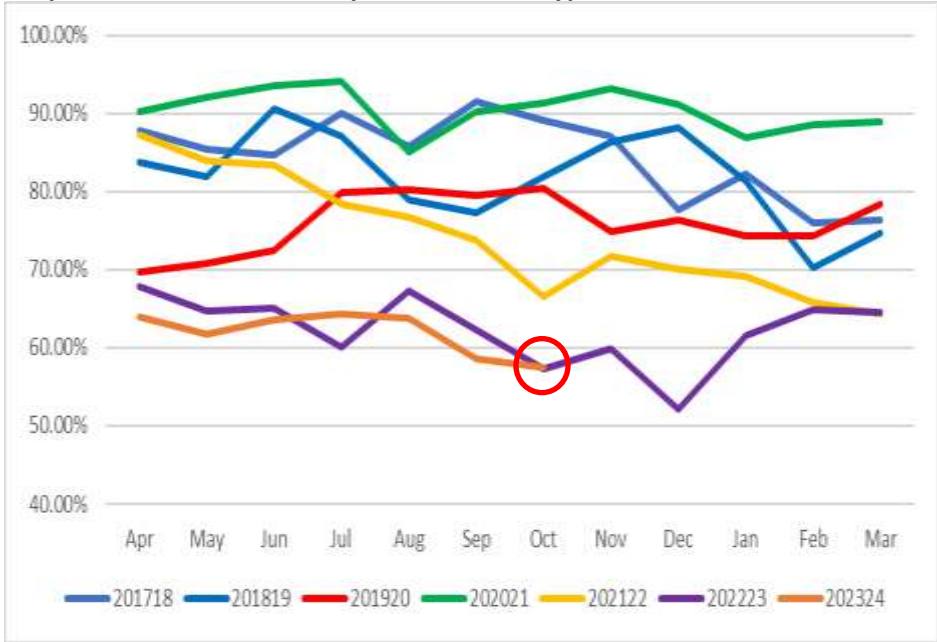
Spotlight: Emergency Department (ED) Performance

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

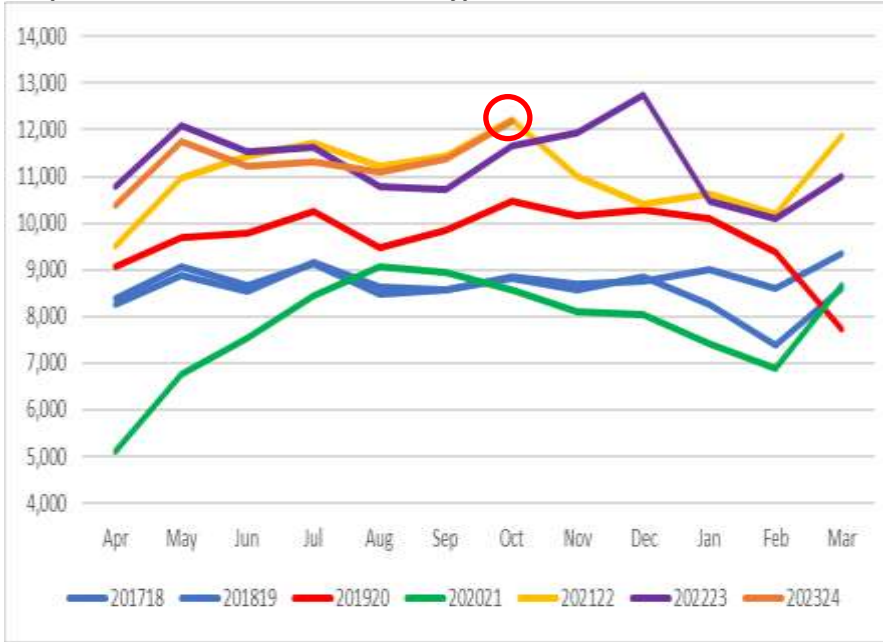
UHS is not currently meeting the national ED target and stood at 57.5% (Type 1) of patients seen within 4 hours in October 2023 (graph 1). We recognise that this performance is lower than in previous years, and this is partly attributed to Type 1 attendances to ED continuing to be higher compared to pre-COVID levels.

From April 2023 to October 2023 we averaged over 370 attendances per day (graph 2), compared to an average of 316 per day for the same time-period in 2019/20 (a 17% increase).

Graph 1: Trended ED 4 hour performance – Type 1



Graph 2: Trended ED attendance – Type 1



From September 2023 the Trust's 4hr performance (Type 1) started to dip below the plan for 23/24 (graph 3). This position continued in October where we were 5.5% off plan for the month. Achieving 76% in March 2024 will be a significant challenge. However, our aspiration remains to do so, subject to further support in achieving better flow and discharge.

Graph 3: Main ED (Type 1) performance vs plan 23/24

Graph 4: All Types performance vs plan 23/24

Current pressures are driven by the volume of attendances to the Emergency Department, subsequent speed of decision making and flow into beds for those patients who need to be admitted. Mental health attendances, with patients often staying prolonged periods waiting for an admission to a mental health facility, further increase the pressure.

Admission rates via the Emergency Department remain below 30% and whilst this is comparable to previous years, the impact from the rise in demand (based on a 7-day average length of stay) requires an extra 30-40 non-elective beds per day across the Trust. This challenge is alongside a backdrop of the Trust having an additional 25-30 non-criteria to reside patients on some days when compared to last year.

The newly appointed Deputy Chief Medical Officer and Director Urgent and Emergency Care is supporting a renewed focus on processes within the Emergency Department. To support this we have requested a visit from the regional Emergency Care Improvement Support Team (ECIST) in the coming weeks. Meanwhile, the focus of the inpatient flow programme is to reduce length of stay, increase timeliness of discharge (home before lunch) and an

increase in weekend discharge rates, which are key to supporting the ED. An equal focus on timeliness of decisions from senior decision makers at the front door of the hospital is ongoing via recruitment programmes, support from other specialties (AMU, MOP & Cardiology) and help with ambulatory care pathways.

Graph 5: Teaching Hospital Performance Comparison (7/20) – Type 1

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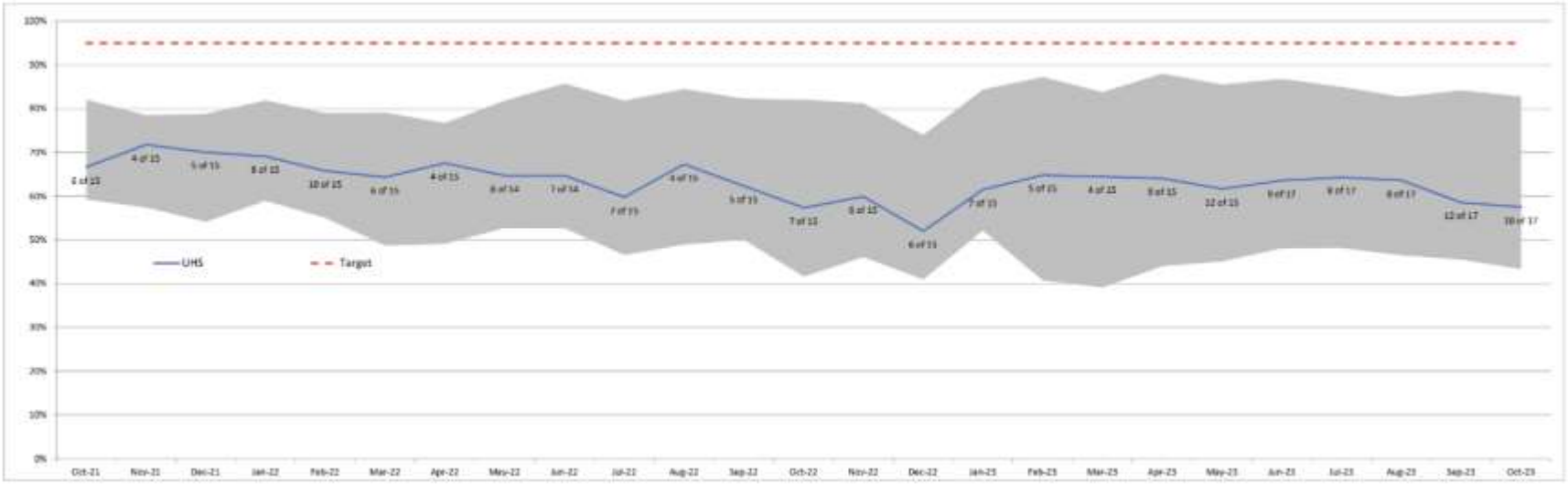
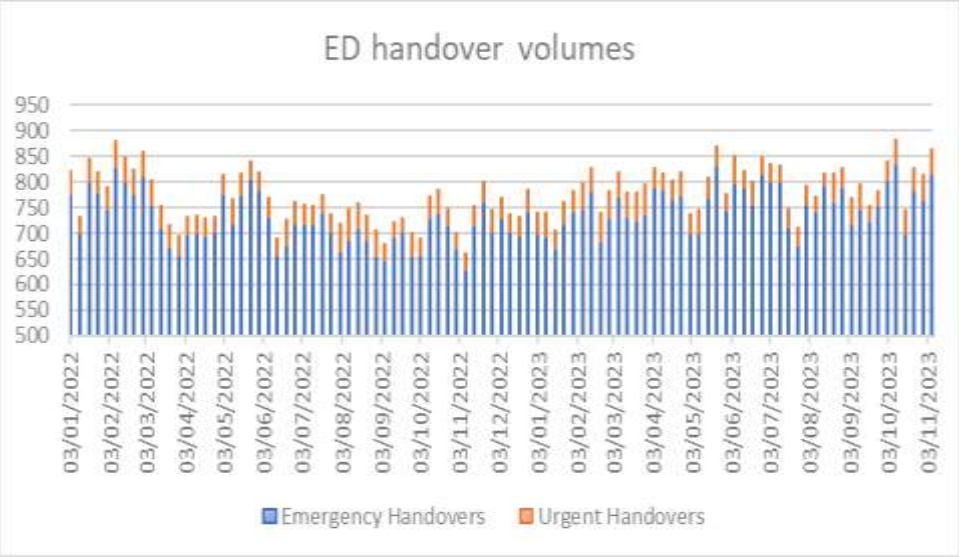


Ambulance Handover Performance Target "All handovers must take place within 15 minutes with none waiting more than 30 minutes"

Ambulance Handovers are a current focus area for NHS England and is also one of the key priority areas within the national priorities for 2023/24. UHS has constantly performed very well in relation to measures of timely ambulance handover and continues to do so compared to peers.

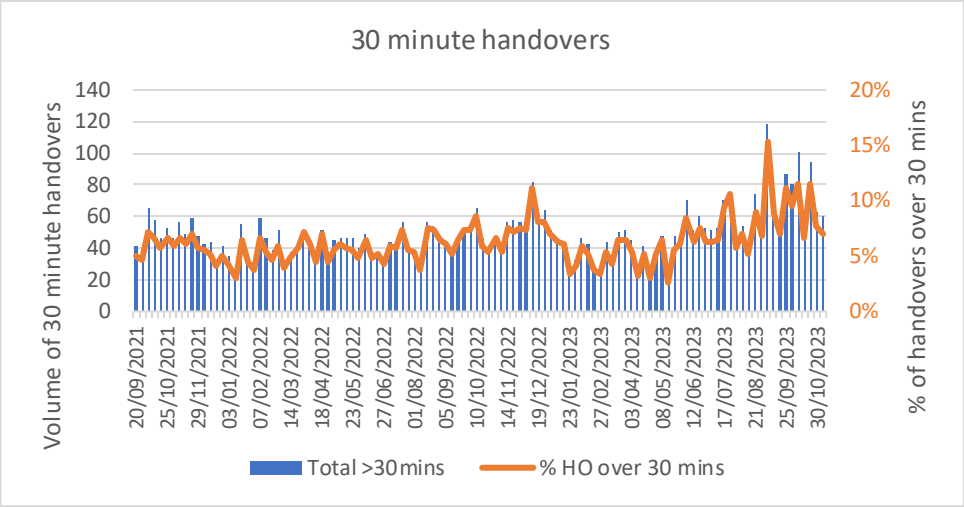
Graph 7: Ambulance handovers to ED (unvalidated)



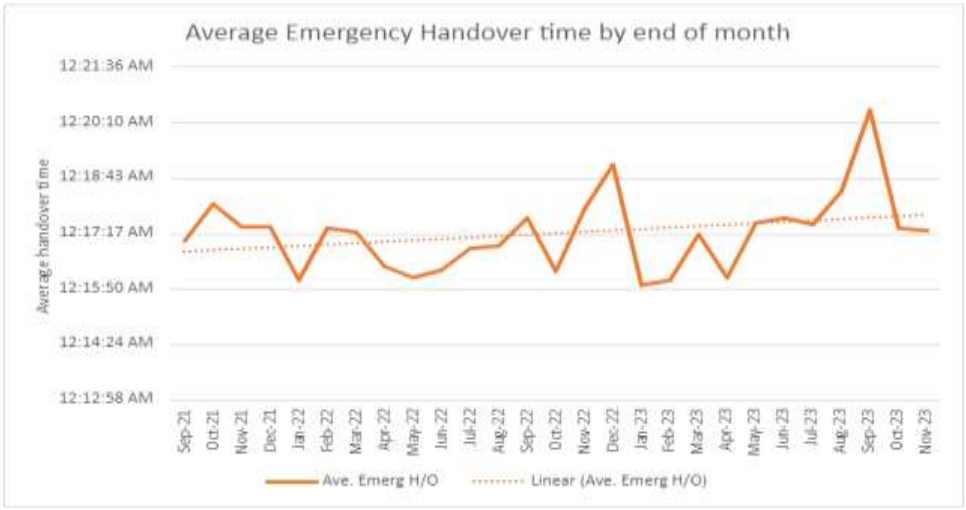
Total ambulance handover volumes into the Emergency Department per week from September 2021 to October 2023.

- There has been a continual increase in the weekly average handovers of patients being conveyed to ED in Ambulances as seen in graph 5.
  - Q2 2023/24 = 875 per week
  - Q1 2023/24 = 810 per week
  - Q4 2022/23 = 773 per week
  - Q3 2022/23 = 744 per week
  - Q2 2022/23 = 732 per week
- Acuity is increasing generally across the board and within the department.
- With increased acuity more work has focussed on the internal queue over past 6-12months with call buzzers being installed along corridor and testing of safety.
- Plan to develop a clear Standard Operating Procedure for the Hospital Ambulance Liaison Officer is being worked on in collaboration with SCAS.
- Increased focus on the pitstop processing model internally at UHS to ensure it remains pitstop and as efficient as possible.
- Written internal escalation plan has provided structure for how we queue patients, focus on ambulance turnarounds remains as it always has, but the balance of safety is of equal focus.

Graph 8: Ambulance handovers to the ED within 30 minutes



Graph 9: Average Emergency Ambulance handover time to the ED



Ambulance handovers into the Emergency Department taking longer than 30 minutes as a volume and percentage, per week, from September 2021 to October 2023.

- UHS ED 30 minute handover performance remains strong.
- In October 2023, 9% of handovers were greater than 30mins. This compares to 7% as at the end of August 2023.
- We are seeing a deterioration in total ambulance handover delays linked to a rise in demand and acuity which has triggered the need for an agreement between ED & SCAS to "cohort" patients in ED.
- Cohorting does not lead to UEC "reported" lost ambulance time however, the reality is only one ambulance (& crew) is held at UHS whilst they are supporting with ED demand and over-crowding.
- Equally our performances versus 60 minute handover delays continue to hold-up compared to other trusts in the South East and South West regions.
- Average emergency handover time week commencing 30th October 2023 was 17mins, compared to 18mins at the end of August 2023 and 17mins at the end of March 2023.
- Average urgent ambulance handover time for week 30th October 2023 was 21 minutes, compared to 22mins at the end of August and 18mins at the end of March 2023.
- We are also working closely with SCAS to support validation of daily handover data as we have provided examples of inaccuracies.

What are we currently doing about the challenges at the front door of the hospital?

Focus on improving Emergency Department performance falls broadly into three areas: improvements within the Emergency Department, additional support from staff outside the Emergency Department and improved flow and discharge.

Improvements Within the Emergency Department

Actions to improve timely decision to admit or discharge within the Emergency Department include:

- Appointing a Director of Urgent and Emergency Care to provide greater clinical support and oversight
- Requesting a visit from the regional Emergency Care Intensive Support Team to provide a 'critical friend' review
- Continued to review the possibility of restarting a GP at within the Emergency Department
- Focus on the workforce by reducing rota gaps, profiling attendances to resource available using national tools
- Continuing with consultant of the day workshops and the completion of an SOP to support ongoing review
- Resetting of 1 hr standard to support flow out of the Emergency Department
- Review of pathways in and out of the Emergency Department to ensure they are being used effectively and develop were appropriate, include review of the directory of service
- Continue with Same Day Emergency Care focus at the front door and back door. Front door strategy being worked on to support medical flow and timely admission discussions pulling from the Emergency Department
- Focus on pitstop processing model internally at UHS to ensure it is as efficient as possible

Organisation-wide changes

Four key actions have been requested to support the Emergency Department. These improvements are being led by the Deputy Chief Medical Officer and Director for Emergency and of Urgent. The key focuses are:-

1. Where patients are referred for admission/assessment, ensure that CT scans and clinical reviews occur in admission areas, rather than waiting for these to be completed in ED.
2. Where patients require admission from home/community, they should only come to ED if emergency life-saving treatment (resus facility) is required, otherwise patients should be admitted to specialty assessment areas/wards. All services will need to work up options for assessment

surge capacity supported by a risk assessment. We must avoid ED remaining as the default admission area. Where patients present to ED with a referral letter to a specialty service, we will expect that these patients are transferred directly to the relevant admission/assessment area rather than staying in ED.

3. Admitting specialties will need to provide early access to a senior decision maker via bleep or phone. In the event that the senior decision maker is unable to speak on the phone an alternative plan needs to be in place such that patients are not waiting unnecessarily in ED.
4. We need to have a careful focus on ward discharges (7 days a week), with patients leaving ward areas much earlier in the day. This will require support from the MDT, with full utilisation of the discharge lounges and identification of a 'golden patient' to be discharged by 10am each day.

Flow and Discharge

Improving inpatient flow and discharge will help to reduce over-crowding in the Emergency Department by allowing patients to be admitted more quickly. The programme is focused on:

- Increasing the number of patients discharged before midday
- Standardised Board Rounds, with appropriate clinical input
- Simplifying HMRs
- Better use of bed states
- Criteria led discharge
- Creating a culture of 'why not home today?'

Plans across the local system are also being developed, to support admission avoidance or improved discharge. However, the number of patients not meeting the criteria to reside remains high.

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

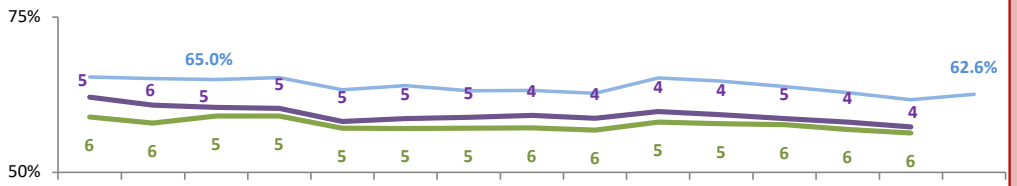
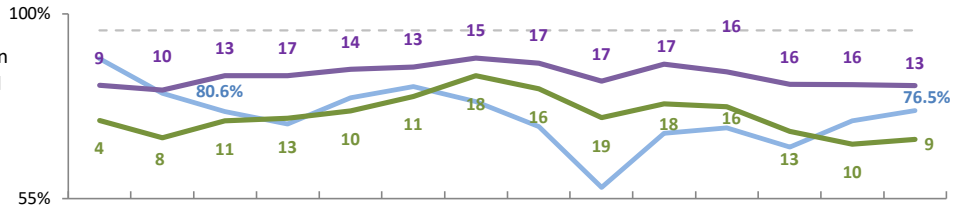
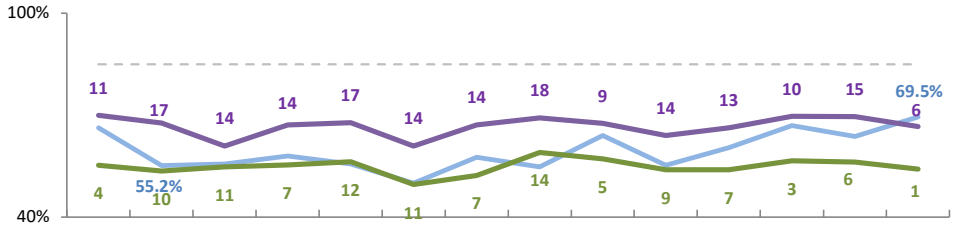
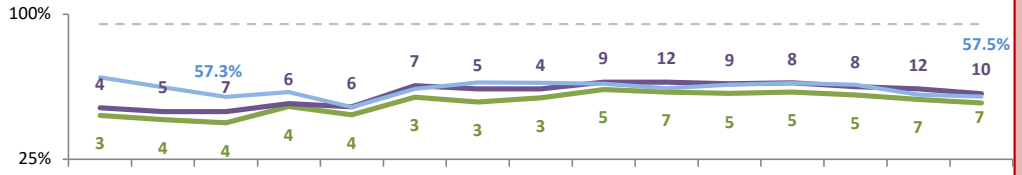
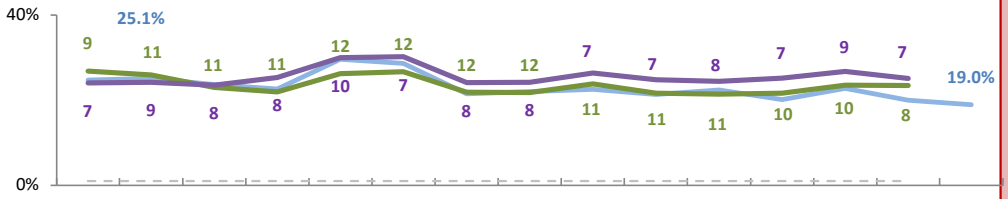
The NHS pledges to provide convenient, easy access to services within the waiting times set out in the Handbook to the NHS Constitution

- 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
31	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)																≥92%	63.4%
38	% 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)																≥93%	69.8%
39	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)																≥85%	63.3%
28	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 16) South East average (& rank of 16)																≥95%	59.9%
37	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching Hospital average (& rank of 20) South East Average (& rank of 18)																≤1%	21.2%

Outcomes		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
1	HSMR - UHS HSMR - SGH	89.34												85.77			≤100	86.5	≤100
		87.67												84.27					
2	HSMR - Crude Mortality Rate	2.9%												2.8%			<3%	2.7%	<3%
3	Percentage non-elective readmissions within 28 days of discharge from hospital	11.9%												12.1%			-	12.4%	
		Q3 22-23			Q4 22-23			Q1 23-24			Q2 23-24			Q3 23-24			Quarterly target		
4	Cumulative Specialties with Outcome Measures Developed (Quarterly)	68			71			72			72			72			+1 Specialty per quarter		
5	Developed Outcomes RAG ratings (Quarterly) Red Amber Green	38			35			34			37			41					
		79			81			82			75			67					
		317			336			340			333			337					

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
6	Cumulative Clostridium difficile **Most recent 12 Months** vs. **Previous 12 Months**	49	55	56	65	64	73	71	77	74	84	9	4	11	12	18	27	24	35	28	49	35	60	47	66	≤5	66	≤35
7	MRSA bacteraemia	0	0	1	1	1	0	0	0	0	0	0	1	0	0	1	0	2	0
8	Gram negative bacteraemia	17	22	14	24	16	17	14	32	14	19	27	16	21	15	25	≤16	137	≤83
		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
9	Pressure ulcers category 2 per 1000 bed days	0.40	0.30	<0.3	0.39	<0.3
10	Pressure ulcers category 3 and above per 1000 bed days	0.50	0.52	<0.3	0.45	<0.3
11	Medication Errors (severe/moderate)	3	4	≤3	19	≤21
12	Watch & Reserve antibiotics, usage per 1,000 adms **Most recent months** vs. **2018*95.5%**	2,746	2,867	2,992	2,519	19,385	17,882

12 - For 2022/23 and forward, 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).

Safety		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
13	Serious Incidents Requiring Investigation (SIRI) (based upon month reported as SIRI, excluding Maternity)			5												1	-	25	-
14	Serious Incidents Requiring Investigation - Maternity			1													-	4	-
15	Number of falls investigated per 1000 bed days			0.15												0.07	-	0.09	-
16	% patients with a nutrition plan in place (total checks conducted included at chart base)			93.9%												96.8%	≥90%	95%	≥90%
		750	719	676	669	711	1624	780	1600	844	871	788	806	798	772	770			
17	Red Flag staffing incidents			62												12	-	84	-

Maternity		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
18	Birth rate and Bookings Birth Rate - total number of women birthed Bookings - Total number of women booked	426 / 417	460 / 438	463 / 416	412 / 498	440 / 363	436 / 453	383 / 432	387 / 513	416 / 449	402 / 477	418 / 450	417 / 382	400 / 424	400 / 442	467 / 446	-	-	-
19	Staffing: Birth rate plus reporting / opel status - number of days (or shifts) at Opel 4.	2	0	3	1	5	1	0	2	1	1	4	6	1	3	3	-	-	-
20	Mode of delivery % number of normal birthed (women) % number of caesarean sections (women) % other	36.4% / 51.2%	38.7% / 48.9%	36.9% / 47.1%	35.7% / 48.5%	37.5% / 48.2%	37.2% / 49.3%	36.0% / 54.8%	36.7% / 48.8%	40.6% / 46.9%	32.6% / 53.0%	43.3% / 43.3%	43.7% / 38.6%	44.8% / 44.8%	43.0% / 43.5%	43.5% / 44.3%	-	-	-

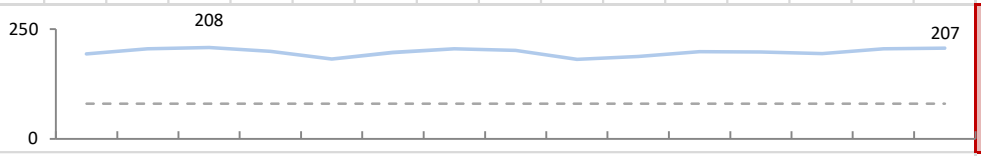
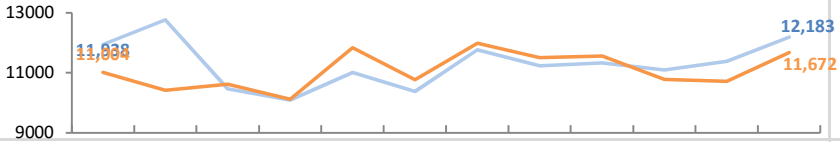
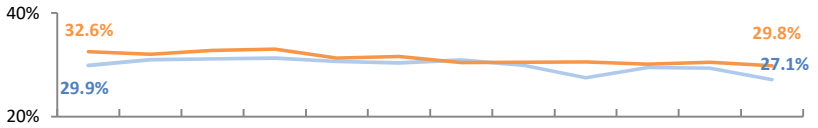
Patient Experience		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
21	FFT Negative Score - Inpatients			0.2%												0.4%	≤5%	0.6%	≤5%
22	FFT Negative Score - Maternity (postnatal ward)			1.8%												1.9%	≤5%	2.5%	≤5%
23	Total UHS women booked onto a continuity of carer pathway			46.5%												12.0%	≥35%	14.4%	≥35%
24	Total BAME women booked onto a continuity of carer pathway			82.0%												21.7%	≥51%	34.7%	≥51%
25	% Patients reporting being involved in decisions about care and treatment			89.0%												87.6%	≥90%	86.8%	≥90%
26	% Patients with a disability/ additional needs reporting those needs/adjustments were met (total number questioned included at chart base)			87.0%												88.7%	≥90%	90.8%	≥90%
26 - Performance is a scored metric with a "Yes" response scoring 1, "Yes, to some extent" receiving 0.5 score and other responses scoring 0.																			
27	Overnight ward moves with a reason marked as non-clinical (excludes moves from admitting wards with LOS<12hrs)			62												76	-	424	-

Access Standards		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
28	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 16) South East average (& rank of 16)	57.3%														57.5%	≥95%	59.9%	≥95%
		4	5	7	6	6	7	5	4	9	12	9	8	8	12	10			
		3	4	4	4	4	3	3	3	5	7	5	5	5	7	7			
29	Average (Mean) time in Dept - non-admitted patients	03:28														03:33	≤04:00	03:29	≤04:00
30	Average (Mean) time in Dept - admitted patients	06:10														06:24	≤04:00	05:48	≤04:00
31	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	65.0%														62.6%	≥92%	63.4%	≥92%
		5	6	5	5	5	5	5	4	4	4	4	5	4	4				
		6	6	5	5	5	5	5	6	6	5	5	6	6	6				
32	Total number of patients on a waiting list (18 week referral to treatment pathway)	53,913														59,151	-	59,151	-
33	Patients on an open 18 week pathway (waiting 52 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	2,340														1,877	≤2,011	1,877	≤2011
		5	5	5	5	5	5	5	4	4	4	4	3	3	3				
		13	13	12	12	12	12	12	11	11	11	9	8	8	8				

		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
34	Patients on an open 18 week pathway (waiting 65 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	6	6	6	6	6	6	5	5	4	4	4	4	5	5	1043 / 378	-	378	-
		14	14	13	13	12	13	12	12	11	11	10	9	9	9				
35	Patients on an open 18 week pathway (waiting 78 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	7	7	7	7	7	7	6	4	4	5	8	8	7	6	271 / 23	0	23	0
		15	15	15	15	15	15	15	12	10	11	12	11	10	9				
35a	Patients on an open 18 week pathway (waiting 104 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	6 / 6	7 / 6	5 / 1	1 / 0	1 / 0	1 / 0	1 / 0	1 / 0	1 / 0	8 / 1	14 / 4	17 / 5	15 / 2	16 / 2	1	0	1	0
		14	14	10	1	1	1	1	1	1	13	13	17	13	14				
36	Patients waiting for diagnostics	10,544														8,188	-	8,188	-
37	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	9 / 7	11 / 9	11 / 8	23.7% / 8	11 / 10	12 / 7	12 / 8	12 / 8	7 / 11	7 / 11	8 / 11	7 / 10	9 / 10	7 / 8	19.0%	≤1%	21.2%	≤1%
38	% 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)	9 / 4	10 / 8	13 / 11	17 / 13	14 / 10	13 / 11	15 / 18	17 / 16	17 / 19	17 / 18	16 / 16	16 / 13	16 / 10	13 / 9	80.6% / 76.5%	≥93%	69.8%	≥93%

		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
39	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 20) South East average (& rank of 17)	11	17	14	14	17	14	14	18	9	14	13	10	15	69.5%	6	≥85%	63.3%	≥85%
		4	55.2%	10	11	7	12	11	7	14	5	9	7	3	6	1			
40	Cancer 28 day faster diagnosis Percentage of patients treated within standard UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	6	77.9%	3	4	8	8	7	8	7	7	6	3	83.3%	1		≥75%	79.3%	≥75%
		8	4	2	5	9	5	5	8	7	5	3	2	1					
41	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 20) South East average (& rank of 17)	17	89.0%	16	16	16	16	18	16	15	17	15	13	13	11		≥96%	89.1%	≥96%
		16	17	12	13	13	12	14	20	12	10	14	11	5	9	6			
42	31 day cancer wait performance - Subsequent Treatments of Cancer (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	14	91.8%	14	14	7	15	16	15	17	16	16	17	16	17		≥96.0%	73.4%	≥96.0%
		12	11	9	13	6	16	16	15	15	18	19	18	18	20				

R&D Performance		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
43	Comparative CRN Recruitment Performance - non-weighted	5	6	7	7	14	15	15	13	14	17	19	19	21	17	17	Top 10	-	-
44	Comparative CRN Recruitment Performance - weighted	7	7	8	10	10	10	11	9	9	6	12	14	15	12	11	Top 5	-	-
45	Study set up times - 80% target for issuing Capacity & Capability within 40 Days of Site Selection										25%	47%	59%	64%	46%	60%	67%	-	-	-
46	Achievement compared to R+D Income Baseline Monthly income increase % YTD income increase %	93.7%	48.2%	23.5%	71.4%	79.2%	166.3%	69.5%	35.6%	50.7%	32.6%	28.2%	26.0%	9.2%	118.7%	17.0%	≥5%	-	-

Local Integration		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
47	Number of inpatients that were medically optimised for discharge (monthly average)																≤80	192	-
48	Emergency Department activity - type 1 This year vs. last year																-	79,338	-
49	Percentage of virtual appointments as a proportion of all outpatient consultations This year vs. last year																≥25%	29.0%	≥25%

Digital		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
50	My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month)	136,043														178,011	-	170,987	-
51	My Medical Record - UHS patient logins (number of logins made within each month)	27,154														33,060	-	31,462	-
52	Average age of IT estate Distribution of computers per age in years	0	0	16	37	81	132	331	845	1077	1160	2480	3070	1740	454		-	-	-
		13	12	11	10	9	8	7	6	5	4	3	2	1	0				
53	CHARTS system average load times - % of pages loaded under 5s																		
53	Data only available from April 2023 onwards																		
		Q3 22-23			Q4 22-23			Q1 23-24			Q2 23-24			Q3 23-24					
54	Cyber attacks / phishing / incidents blocked Average # Malware attempts blocked per month (10s) Average # Phishing emails blocked per month (100s) Average # Ransomware attempts blocked per month	1222	346	1	3673	262	7	1005	114	5	1005	61	38	2479	71	2	-	-	-
55	Inpatient noting progress Left axis: IP Noting data recorded (100s) IP Noting unique user views Right axis: IP pages scanned (1000s)	NEU go live				EYE go live		CV&T go live		T&O go live			Med go live		Sur go live		-	-	-
55	IP Noting went live in Oct-22. CGs going live are marked on green line.																		

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Finance Report 2023-24 Month 7**			
Agenda item:	**5.6**			
Sponsor:	**Ian Howard – Chief Financial Officer**			
Author:	**Philip Bunting – Director of Operational Finance** **David O'Sullivan – Assistant Director of Finance – Financial Performance**			
Date:	**30 November 2023**			
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:

Report for Trust Board:

Finance and Investment Committee reviewed a detailed monthly finance report, including a review of forecast outturn and a spotlight on capital prioritisation for 2024/25 and 2025/26. The full report is available to Trust Board members for background reading. The key highlights of the report are:

Half 2 Financial Planning

At an exceptional meeting in November, Trust Board approved the submission of a revised financial trajectory for M8-M12. Additional funding of £12.6m has been confirmed to cover the impact of industrial action, partially as additional block funding and partially as a reduction in our ERF target of 2%.

This resulted in a revised formal forecast of £31.5m deficit, which is a £5.5m deterioration from the original plan. This is as a result of shortfalls in national funding for the impact of pay awards. The revised forecast does include a number of risks, notably:

- There will be no further industrial action (as per national assumptions).
- As a result, ERF funding will deliver at 120% in M8-12.
- Staffing growth will not increase in M8-12, arresting the current trend (increased substantive recruitment will be off-set by reductions in temporary staffing levels).
- A further £5m CIP stretch will be delivered above the values delivered in H1.

We will need to monitor progress against this challenging plan closely, and our reporting will be adapted accordingly.

M7 Financial Position

UHS reported a deficit of £2.4m, compared with a deficit plan of £2m. The in-month position does however include non-recurrent benefits. In-month we have received confirmation that non-NHS organisations with contracts dynamically linked to Agenda for Change will receive funding directly for non-consolidated pay awards. This has enabled UHS to release £1m set aside for contracts with suppliers.

YTD the deficit is £25m compared to a plan of £21m, £4m adverse to plan. The variance is due to nationally agreed pay award costs remaining above the level of funding received, with a £4m pressure to date and a full year anticipated financial pressure of £5.5m.

ERF and Industrial Action

In month ERF performance was below target at 108%. This is due to a combination of the highest target month of the year and the impact of industrial action, with junior doctors and consultants taking action over four days concurrently.

An underperformance of £0.4m was therefore accounted for in month bring the YTD ERF overperformance position to £4.4m. This equates to achievement of 115% against the target of 111%. National data has now been received for months 1-4 confirming the level of income UHS will receive. Months 5-7 are currently estimated and subject to revision.

None of the above has yet been adjusted for the further 2% reduction to target confirmed within the H2 financial settlement.

Estimates value the loss of activity due to industrial action at over £5.3m YTD as shown in the table below with a further £1.5m incurred in additional premium backfill costs.

Industrial Action Financial Impact Assessment (£m)

Month	Estimated Loss of Income	Direct Cost Impact (Backfill less strike pay reductions)	Total Financial Impact
April	0.75	0.30	1.05
May	0.00	0.00	0.00
June	0.75	0.10	0.85
July	1.30	0.30	1.60
August	1.10	0.30	1.40
September	0.75	0.20	0.95
October	0.70	0.30	1.00
Total	5.35	1.50	6.85

Please note the above table has been reviewed in October and amended for prior months previously estimated.

Underlying Position

The underlying reported position of the Trust has been reassessed as to the position the Trust would have achieved should industrial action not have occurred. This now includes an element of ERF of £1.5m per month having removed this from the underlying position analysis. This results in a revised underlying position in H1 of £4.5m deficit per month.

Deficit Drivers

The underlying deficit continues to be driven by a number of underlying system pressures seen in 22/23, for which we have not been able to recover to date:

- Non-pay inflation beyond funded levels
- Impact of energy prices (with gas prices impacting UHS particularly hard)
- High-cost drugs spend (previously pass-through)
- Number of patients not meeting criteria to reside, impacting capacity (opening expensive “surge” capacity / bed capacity restricting elective activity)

In 23/24, we are now seeing further pressures, notably:

- Unfunded elements of pay awards - £0.4m per month.
- Workforce pressures as substantive recruitment is not offset with temporary staffing reductions - £0.7m per month.

	• Covid testing funding reductions not immediately offset with cost reductions - £0.2m per month. • Mental health nursing pressures - £0.2m per month. • Tariff efficiency reductions not offset by recurrent CIP delivery - £0.7m per month. • Further growth in the number of patients not meeting the criteria to reside. These have been consistently at 200 with some weeks peaking at over 240. Unfunded additional activity is a further pressure for UHS where we are YTD providing activity above block funded level for free in the following areas: • £7.4m of outpatient follow up appointments • £5m of non-elective • £4.3m of other treatments **Cost Improvement Plans** Whilst £71m of CIP opportunities have been identified, the most-likely risk assessed position sits at £59m. Whilst we have made good progress with CIP performance, it is heavily supported by non-recurrent delivery that cannot be relied upon for underlying financial improvement. **Capital** We remain on track to deliver in full against our CDEL target following a capital review and spotlight report in M6. However, there remains some risk of slippage in building programmes which are being monitored closely. **Cash** The cash balance decreased by £6.5m to £61.7m in October. The reduction in year has been driven primarily by the underlying deficit. The position remains consistent with previous projections which are currently forecasting reaching our minimum cash holding position of £30m by the end of the financial year. This is equivalent to 9 days of Operating Expenditure. We are hopeful that the recent updates to the financial position will deliver an improved cash position at the end of the year.
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) and the risk of a reducing internal CDEL allocation for 2024/25 due to the forecast deficit for 2023/24.
Summary: Conclusion and/or recommendation	Trust Board is asked to: • Note the finance position.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**People Report 2023-24 Month 7**			
Agenda item:	**5.7**			
Sponsor:	**Steve Harris, Chief People Officer**			
Author:	**Workforce Team**			
Date:	**30 November 2023**			
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 critical metrics in the strategy. It is provided monthly to Trust Executive Committee and People and OD Committee. The information is based on October 2023 data (M7).			
Response to the issue:	**Progress against pillars of the UHS People Strategy:** THRIVE (Workforce Capacity) Our workforce plan for 23/24 aims to deliver a flat position with no overall growth in the size of our total WTE. This included continued recruitment to vacancies and new expansions offset by decreases in the use of agency and bank, CIP, and other targeted reductions. We continue to report against our NHSE workforce plan, in addition, the Finance and Workforce team have created an internal UHS trajectory to reflect the phasing of new budgeted planned service developments (and associated staffing) that has not yet fully opened. For October we can report: • Our total workforce is over the NHSE plan by +270 WTE, and also over our internal trajectory by 349 WTE. The total size of the workforce (substantive and temporary) grew by 93 WTE in a month driven by factors including newly qualified nurses still within the supernumerary period, increased temporary staffing fill rate, and a small upturn in sickness. A breakdown is contained in the People Report.			

	• Mental health nursing (RMH and HCA) continues to drive temporary workforce utilisation (50 WTE above plan), despite some reductions in October. • Rolling **turnover** continues to track below the Trust target of 13.6% at 11.8%. Turnover in month has increased slightly in October. • Rolling **sickness** absence remains below our Trust target of 3.9%, however there was an in-month uptick from 3.8% to 4.0% attributed to higher levels of COVID in the community and other seasonal illness. Excel (Capability, Reward, Wellbeing) • **The NHS staff survey launched on 18 September** and will run through to the 25 November. Unfortunately, this year the current participation rate lower than previous years and currently at 40%. Last year a return rate of 55% was achieved. The HR team have supported a number of clinics and drop in sessions with laptops for staff who do not have readily available access to PCs. Promotion is taking place about the benefits of completing the survey, and we are running a prize draw to support participation. • **Appraisal completion** remains below target at 77%. This has been discussed through partnership review meetings with Divisions during October. Emphasis is being placed on ensuring that appraisals are reported in a timely fashion on ESR. It is believed there is some level of underreporting due to assessments not being recorded on ESR. • **A refreshed UHS wellbeing plan** was agreed at People Board and is being delivered through the wellbeing group. This focuses on the continued delivery of the support mechanism available to staff (TRiM, Psychology, practical support) Belong (Culture, inclusion, leadership) • November was the start of **Disability Awareness Month** and was marked with a flag-raising ceremony at UHS**. An** event is taking place on 4th December focused on adjustments and also using participants' lived experience to shape the next version of our attendance management policy.
Implications: (Clinical, Organisational, Governance, Legal?)	Implications are for good governance, meeting legal requirements, and providing safe clinical and organisational delivery (as this report includes intelligence on current and future workforce challenges).

Risks: (Top 3) of carrying out the change / or not:	We need to meet our strategic objectives as set out in the business assurance framework for UHS. Specifically: a) We fail to deliver 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 2023

THRIVE EXCEL BELONG

Narrative – 2023/24 M7 (October 2023)

The WTE overall **total workforce** growth from September 2023 to October 2023 was **+93 WTE** and is explained in the below table.

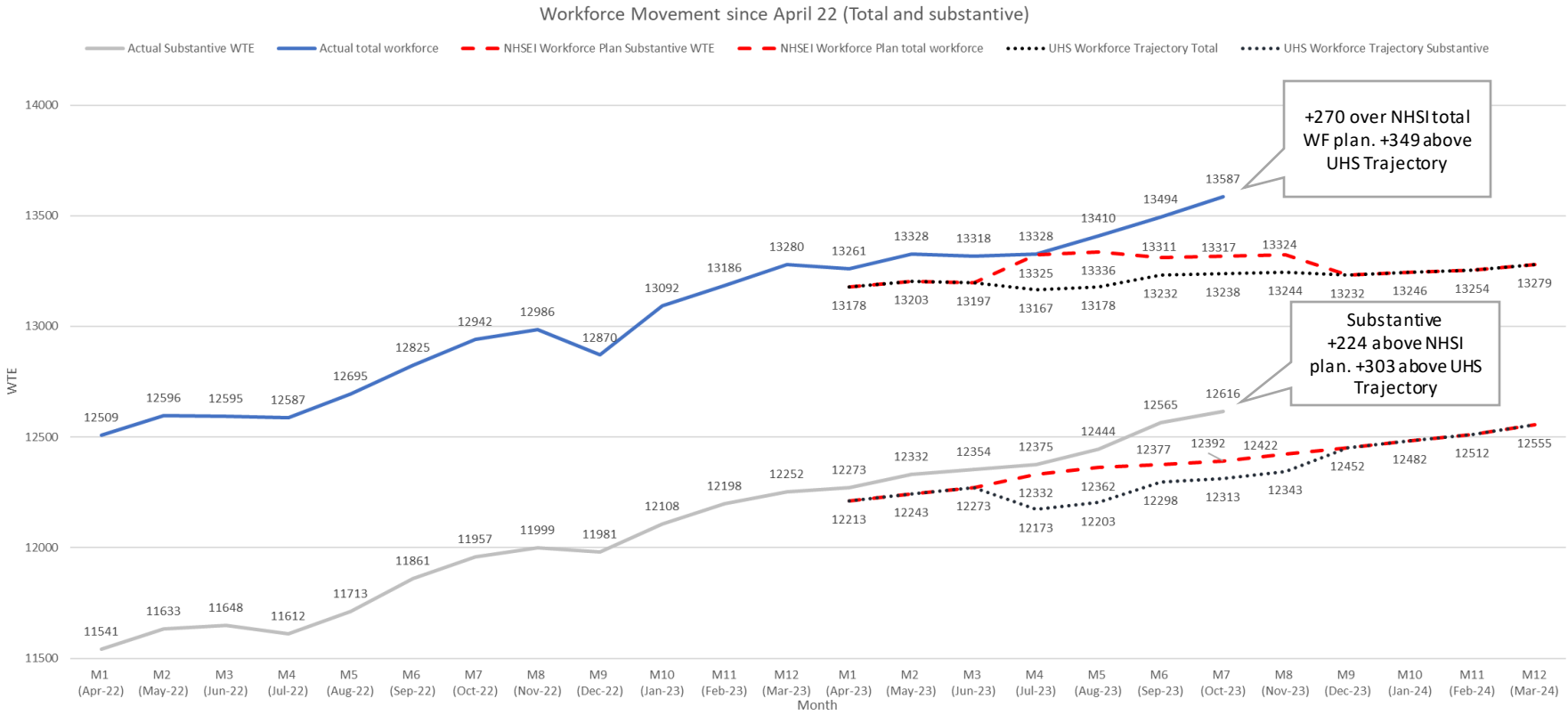
Category	WTE	Comments
Newly Qualified Nurses	29	Staff start as supernumery. Should reduce future bank spend.
Temp Staffing Fill Rate Increase	28	Increase from 88% to 91% fill rate
Sickness (+0.2%)	18	Temporary Staffing due to sickness increase by 0.2%
Medical Rotation	13	Should be offset by future locum spend reductions
Sci, Prof Tech Recruitment	13	Recruitment in underestablished areas (ODPs, OTs, Radiography)
Surge Capacity Increase	12	AMU, ED, SDU, Cath Labs
Mental Health Nursing	(20)	This remains 50 wte above the 22/23 average despite reductions
WTE Growth (Month on Month)	93	

Agency usage decreased from September to October by 3.1% (164 to 159 WTE)

Bank usage increased from September to October by 6% (765 to 811 WTE)

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

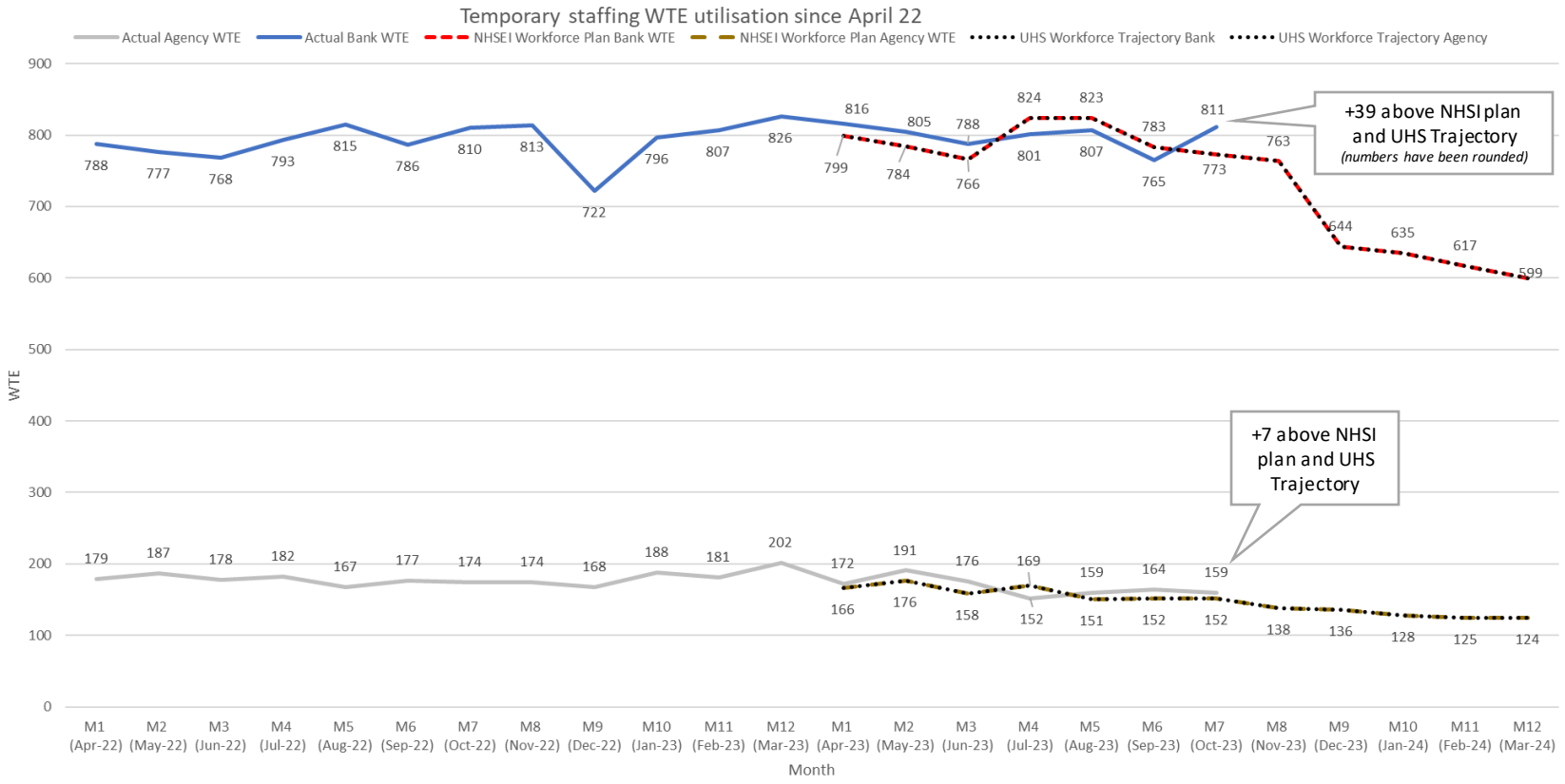


NB: UHS trajectory is based on revised service development timescales; i.e. new ward openings

Source: ESR substantive staff and bank & agency workforce as of 31 October 2023

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY



Source: NHSP Bank + THQ Medical Bank & Agency (NHSP Agency & 247 Agency) as of 31 October 2023

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

Division	Plan WTE	Actual WTE	Variance WTE	Variance %
Division A	2552	2566	14	1%
Division B	3492	3664	172	5%
Division C	2784	2867	83	3%
Division D	2455	2477	22	1%
THQ (inc EFCD and R&D)	1871	1895	25	1%
Other	83	118	34	41%
Total	13238	13587	348	3%

Staff Group	Plan WTE	Actual WTE	Variance WTE	Variance %
Add Prof Scientific and Technic	404	402	(2)	-0.5%
Additional Clinical Services	2477	2593	115	5%
Administrative and Clerical	2357	2379	22	1%
Allied Health Professionals	672	741	69	10%
Estates and Ancillary	406	408	2	0.5%
Healthcare Scientists	481	498	17	4%
Medical and Dental	2097	2185	87	4%
Nursing and Midwifery Registered	4343	4380	38	1%
Total	13238	13587	348	3%

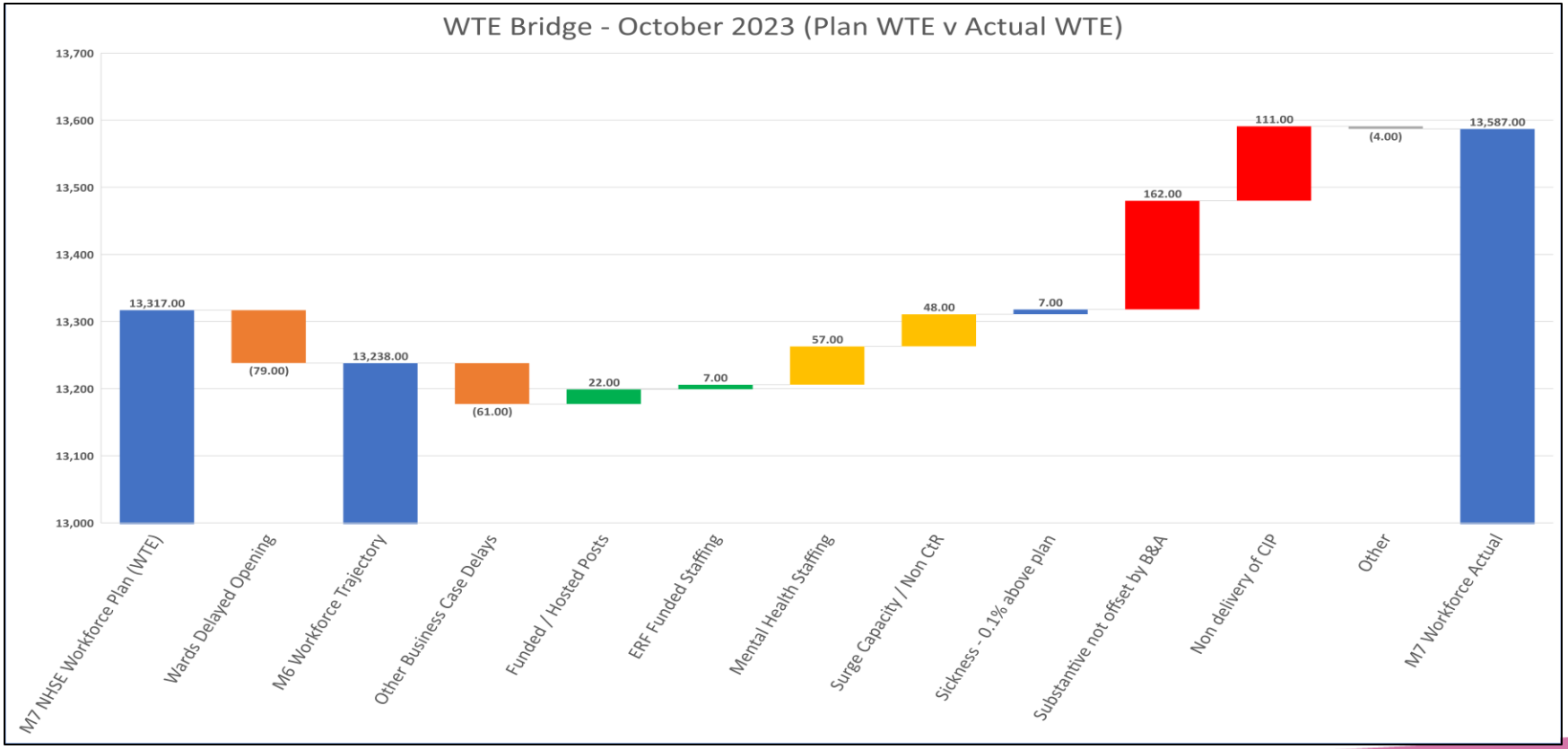
Growth (All Staff) versus plan since April:

- Additional Clinical Services (HCA) continued recruitment to vacancies and reduced turnover
- Medical growth in Junior doctors and additional externally hosted posts
- Continued pressure in Emergency Medicine (Div B) due to mental health and enhanced care requirements.
- Allied Health professional growth due to filling vacancies in Occupational Therapy (OT), ODPs and radiographer staffing groups.

Variance is against internal UHS trajectory since April.
Total workforce (substantive, bank, agency).
October 2023

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY



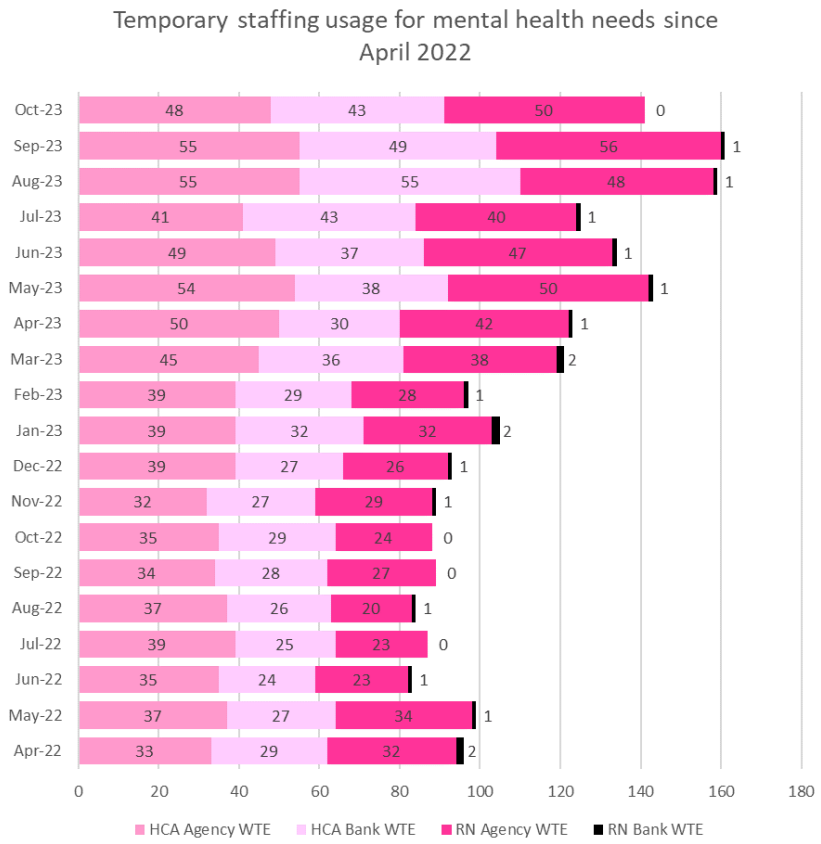
Note: Industrial Action impact is within WLI/Overtime/Excess Hours which is excluded from the above

Narrative – 2023/24 M7 (October 2023) cont.

Narrative – Mental Health:

- Mental Health (October 2023):
  - Total of 141 WTE of temporary staffing needed for MH needs (nursing and HCAs)
  - 50 WTE of which is MH Nursing, all (50) of whom were agency
  - 91 WTE HCAs (48 agency & 43 bank). Nursing workforce initiatives have seen reduced demand in month.

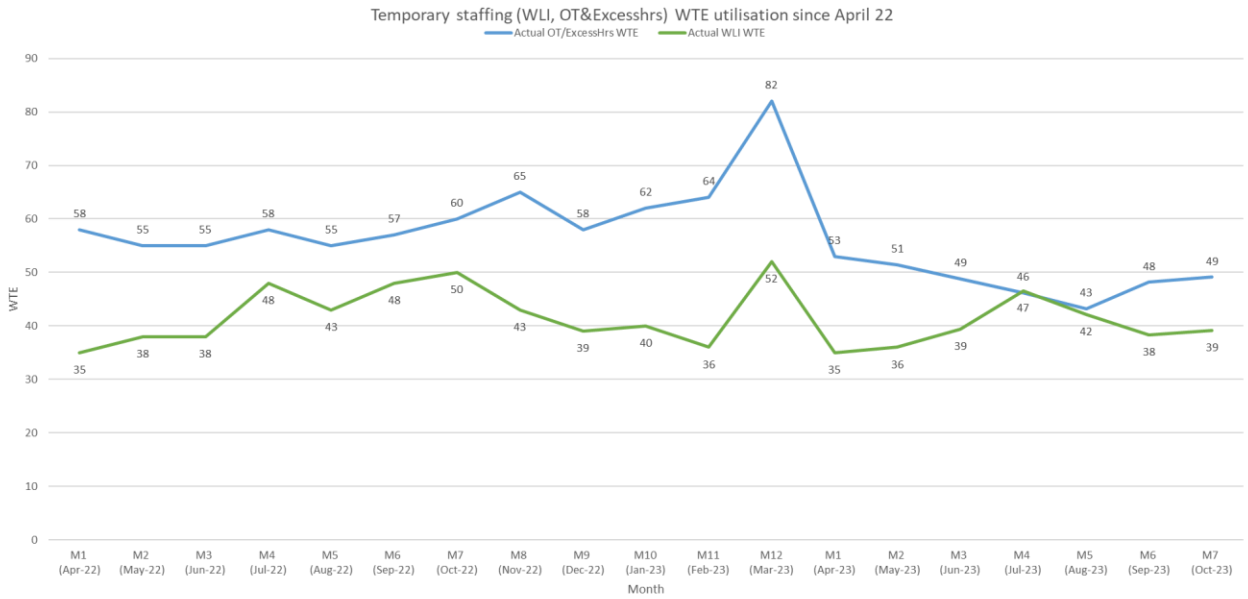
- The continued mental health pressures present a safety, quality, and financial challenge to the Trust. UHS continues to escalate to the ICB and press for more comprehensive system solutions to this issue.



People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

	M11 – M12	M12 – M1	M1 – M2	M2 – M3	M3 - M4	M4 – M5	M5 – M6	M6 – M7	M11 – M7 Total
WLI Movement	16	-17	1	3	8	-5	-4	1	3



OT and Excess hours peaked in March 2023 and has seen a steady decline to the lowest numbers in August 2023 since April 2022 in the 2023/24 period. This increased by 5 WTE in September and a further 1 in October 2023.

Whilst WLI also peaked in March 2023, numbers have been more balanced

Source: HealthRoster as of October 2023
Retrospective WLI figures have updated from April 2023

Delivering our financial controls on workforce: Working in partnership, Workforce teams, finance, and CIP teams can report the following:

Area	Action taken forward
Reporting	• Weekly reporting on WF (substantive, bank, agency) internally and to the ICB including quantification of mental health pressure • Divisional WF trajectories completed for all divisions and THQ included in the People Report to TEC. • Weekly joint finance and workforce team meeting to review data quality, trends, and reporting.
Divisional Review Meetings	Executive review meetings with each division (June and September) to review: • Divisional grip and control • Substantive growth and CIP delivery • Temporary staffing opportunities
WF Controls	• Expansion of the weekly recruitment control panel (RCP) process in April to include a significantly wider number of posts to review • Increased temporary staffing controls through the temporary resourcing team and Ward Staffing hub • Executive sign-off for all A&C bank and agency
Supporting Leaders	• Temporary staffing agency calculator for ward areas introduced to support booking process • Finance rolling out new budget training, including new rostering guidance.
Targeted action	• The CNO is leading a specific nursing group focused on bank demand supported by Finance and Workforce. This is also focused on reductions in bank when the supernumerary periods of the new starters end • The Deputy CNO is leading a review of use of mental health nursing agency, including reviewing opportunities for safe reduction • The CMO is leading work with the DCDs to convert WLI to substantive consultants where the business case is viable. • The CPO is leading the launch of a MARS programme aimed at targeted reductions in admin, clerical, and leadership infrastructure.

Nursing Workforce Spotlight

The Nursing workforce group meets biweekly with a focus on controls to reduce demand for bank and agency whilst maintaining patient safety and quality. The following initiatives are being implemented and in the process of being quantified for ongoing monitoring.

- Mental Health Care Support Worker (CSW03) now require 'golden key' approval from matron / DHN (effective from mid-November).
- Matrons reviewing all bank requests to ensure appropriateness offering additional oversight and challenge
- A "guide to manage bank requests" has been launched for bleep holders including a flowchart for managing short term absence
- The rollout of good roster hygiene training continues offering focused support by the workforce team. This includes actions to ensure nights, weekends, and bank holidays are rostered first leaving weekday shifts to be put out to bank in addition to ensuring the bank/agency calculator is used before putting shifts out.
- Bank shift times have been amended for early and late shifts to ensure cover is only for key hours (i.e. early shift to finish at 1300 rather than 1500)
- Weekly review meetings are in the process of being launched which will review staffing levels and compliance to budget. These will have Divisional Head of Nursing oversight. Budget surgeries also continue to take place monthly.
- Housekeeping process to be completed for supernumery periods to ensure they are compliant with the agreed timescales.

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

Substantive Monthly Staff in Post (WTE) for 2023/24

	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M7 (Oct)	M8 (Nov)	M9 (Dec)	M10 (Jan)	M11 (Feb)	M12 (Mar)	YTD Growth	Sparkline Trend
Add Prof Scientific and Technic	379	383	381	380	386	393	402						25	
Additional Clinical Services	2106	2113	2118	2129	2124	2153	2143						49	
Administrative and Clerical	2256	2271	2284	2287	2282	2295	2298						46	
Allied Health Professionals	682	673	681	690	691	699	703						31	
Estates and Ancillary	383	381	385	386	380	380	382						-1	
Healthcare Scientists	486	484	486	491	494	493	490						4	
Medical and Dental	2087	2074	2065	2061	2109	2120	2134						55	
Nursing and Midwifery Registered	3850	3910	3912	3908	3935	3987	4009						144	
Students (Apprentices)	43	43	43	43	43	43	54						11	
Grand Total	**12273**	**12332**	**12354**	**12375**	**12444**	**12565**	**12616**						**364**	

Substantive increase is due to improved vacancy fill and new approved business cases. Students increase is due to new courses starting.

Source: ESR substantive staff as of 31 October 2023; includes consultant APAs and junior doctors' extra rostered hours, excludes Wessex AHSN, UEL and WPL. Numbers relate to WTE, not headcount.

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TRUST-WIDE TURNOVER (October 2023)

Staffing group	Leavers (WTE) in month	Turnover 12m rolling %
Add Prof Scientific and Technic	2.8	9.0%
Additional Clinical Services	27.4	17.3%
Administrative and Clerical	32.5	14.4%
Allied Health Professionals	6.0	11.7%
Estates and Ancillary	3.7	13.0%
Healthcare Scientists	10.8	10.0%
Medical and Dental	4.0	5.0%
Nursing and Midwifery Registered	31.3	9.1%
UHS total	**118.5**	**11.8%**

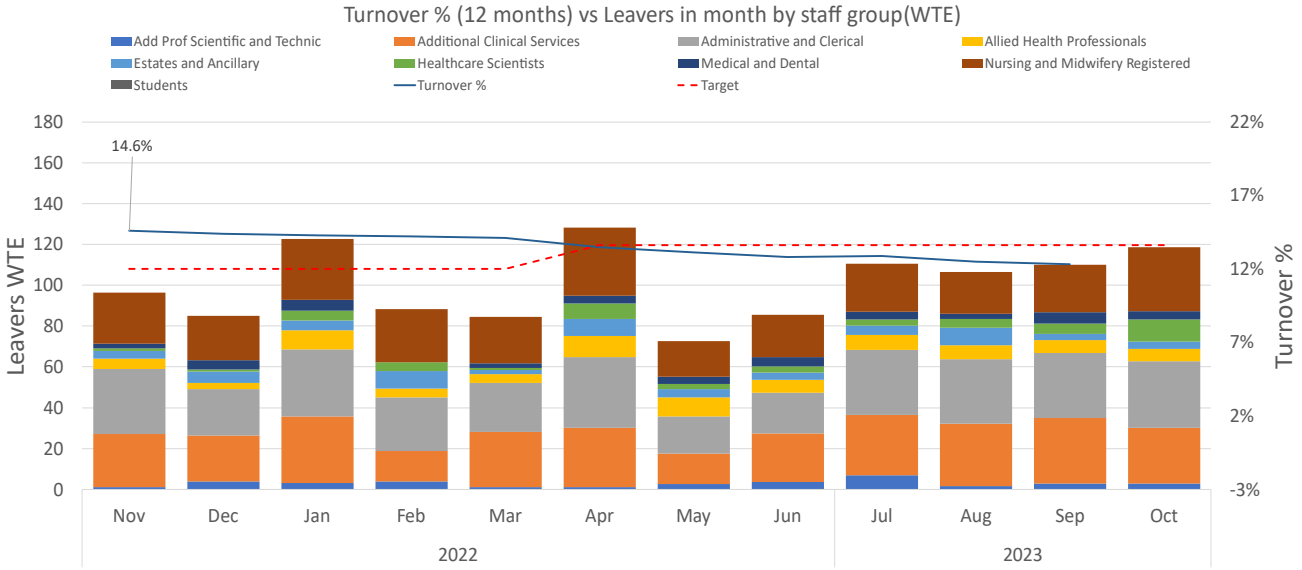
Source: ESR leavers October 2023 (excludes junior doctors)

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TURNOVER BY STAFF GROUP

Turnover (12 month rolling) downtrend continues and remains below the new target of 13.6%; in October 2023 there were 118.5 WTE leavers, which is slightly higher than September 2023. Turnover is currently 11.8% (rolling 12-month average) which is lower than the trust-wide target of <13.6% and is a reduction of -2.8% from 12 months ago.



Top reasons for leaving by staff group	
Add Prof Scientific & Technic	Excessive workload or pressure
Additional Clinical Services	Further education/training; Relocation within the UK
Admin & Clerical	Not feeling valued/recognised; Retirement
Allied Health Professionals	Relocation within the UK
Estates & Ancillary	Bullying, harassment or discrimination; Lack of job satisfaction; Pay, Senior leadership; Promotion; Relationship with line manager
Healthcare scientists	Relocation within the UK
Medical & Dental	Further education/training
Nursing & Midwifery	Excessive workload or pressure

- This data is from respondents to the exit survey (now via Microsoft Forms)
- The data above is for quarter 2 (July, August, September 2023).
- During the quarter 1,067 exit survey invites were sent out, 106 leavers completed the survey (and informed the below table).
- The exit survey is also sent to internal movers (so it is not as simple as 106/1067 is the response rate %, as some of those are internal movers not leavers).
- The table above covers those that left UHS only (leavers).

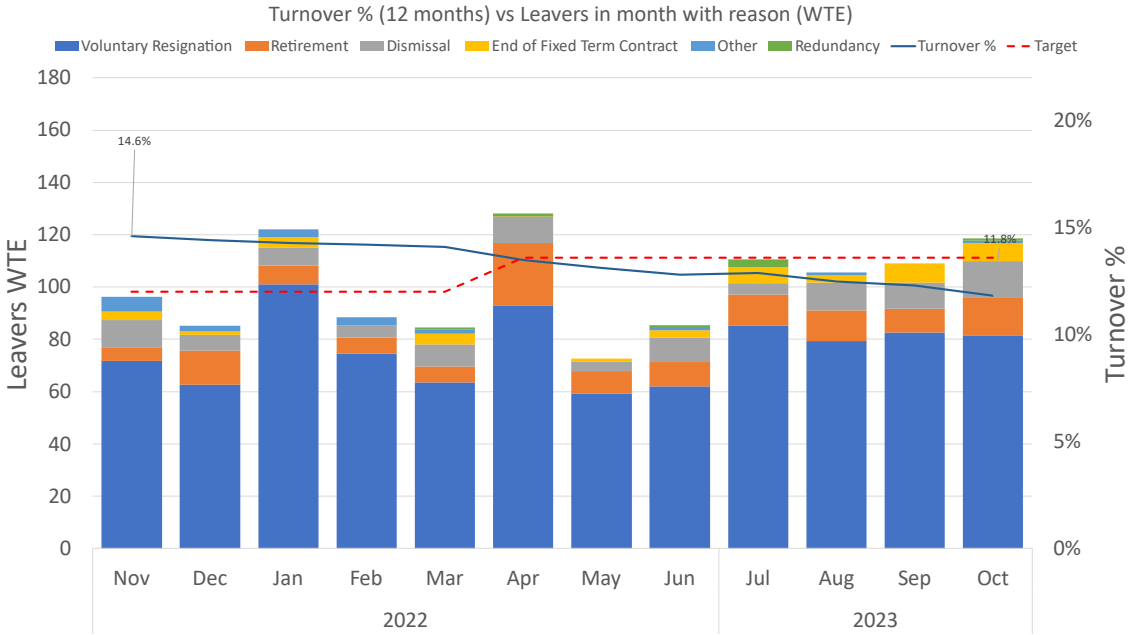
Source: ESR – Leavers Turnover WTE, HRBPs

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TURNOVER BY LEAVING REASON

In October 2023, a total of 118.5 WTE employees left the organisation. Most of the leavers were voluntary resignations, accounting for 81.6 WTE (69%). Retirement accounted for 14.2 WTE (12%), while dismissal and end of a fixed term accounted for 14.2 (12%) and 6.8 WTE (6%) respectively.



Source: ESR; Reason for Leaving: Leavers Summary Q1

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

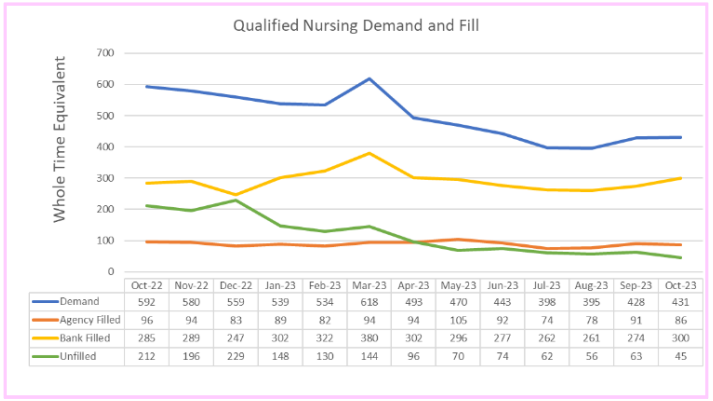
TEMPORARY RESOURCING

Status

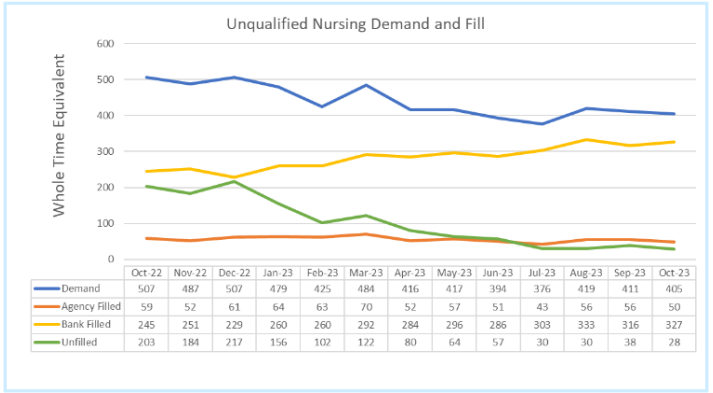
- Qualified nursing demand/fill (WTE): Demand increased from 428 September to 431 in October, of which, bank filled 300 (26 up on last month), agency filled 86 and 45 remained unfilled.
- Bank fill for qualified nursing increased slightly from 64.07% in September to 69.57% October.
- Demand for October 2023 is 161 WTE lower than October 2022.
- HCA demand/fill (WTE): Demand decrease from 411 in September to 405 in October, of which, bank filled 324, agency filled 50 WTE (48 WTE were MH HCA's) and 28 remained unfilled.
- Bank fill for HCA increased from 77.06% in September to 80.75%.
- Demand for HCA's is 102 WTE lower than in October 2022

Actions

- Nursing and Midwifery workforce working group set up to review further measures to reduce bank and agency spend.
- Thornbury removed from agency cascade – leading to zero TNS spend in October.
- CSW03 working group set up to look at reducing demand for mental health care support workers – demand decreasing by 15 FTE in October compared to September.
- Theatre bank rates will reduce by 10% on 13th November 2023.



	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Demand	592	580	559	539	534	618	493	470	443	398	395	428	431
Agency Filled	96	94	83	89	82	94	94	105	92	74	78	91	86
Bank Filled	285	289	247	302	322	380	302	296	277	262	261	274	300
Unfilled	212	196	229	148	130	144	96	70	74	62	56	63	45



	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Demand	507	487	507	479	425	484	416	417	394	376	419	411	405
Agency Filled	59	52	61	64	63	70	52	57	51	43	56	56	50
Bank Filled	245	251	229	260	260	292	284	296	286	303	333	316	327
Unfilled	203	184	217	156	102	122	80	64	57	30	30	38	28

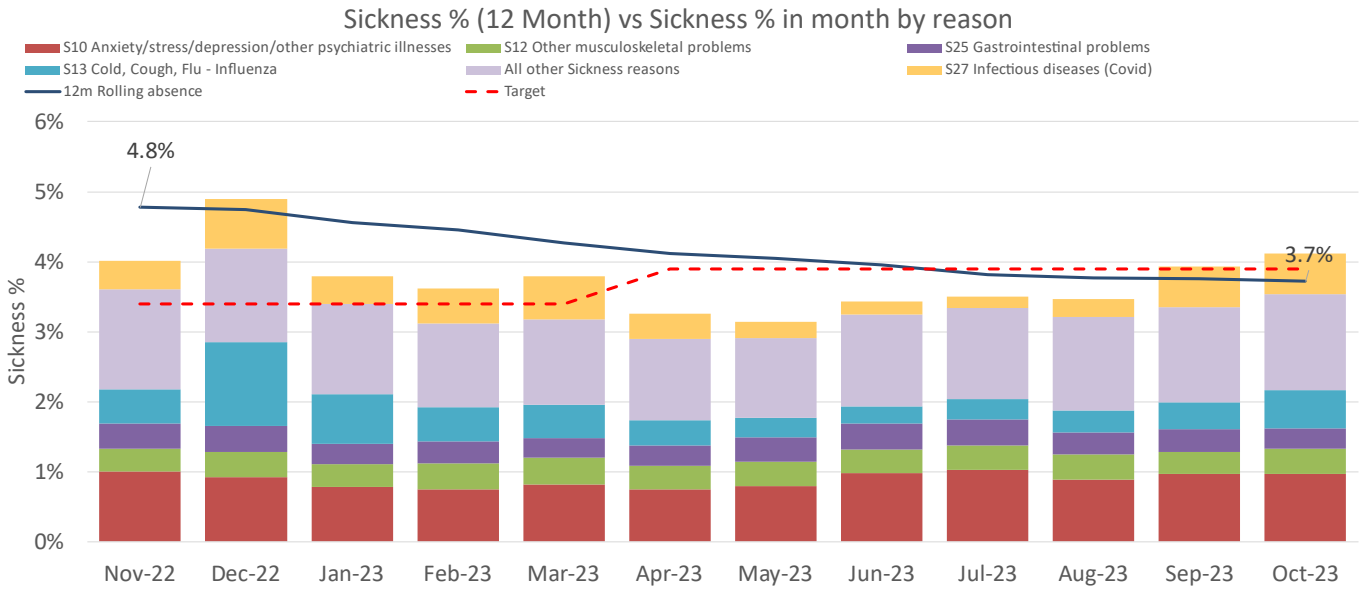
Source: NHSP October 2023

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

SICKNESS

The current rolling sickness rate of 3.7% is lower than 12 months ago (4.8%), and this has continued the downtrend from December 2022. October in-month sickness is 4.0%, 0.2% higher than September. The sickness target for 23/24 is 3.9% with the YTD figure at 3.5%. Covid prevalence and, to a lesser extent, other respiratory illnesses, are increasing.



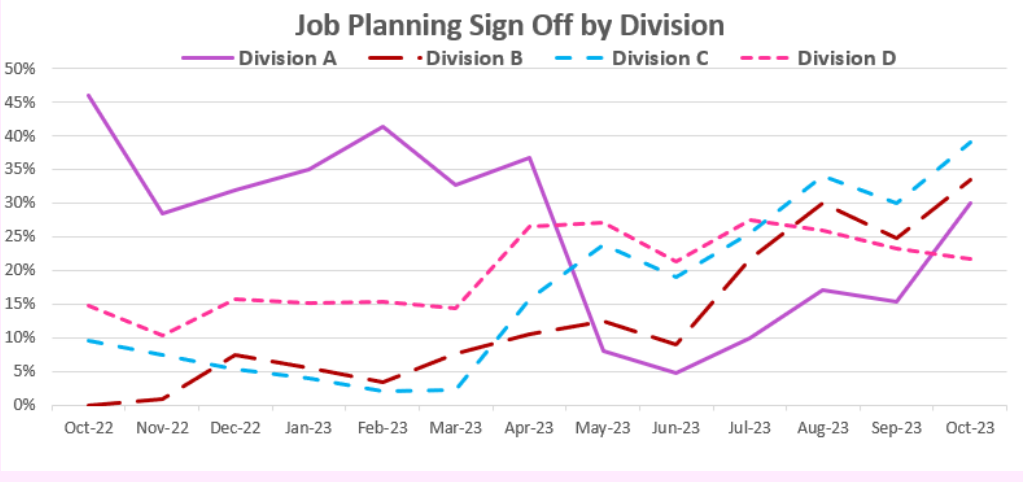
Source: ESR – Sickness data

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

Job Planning – October 2023

- Job planning sign off levels have increased from 26% in September to 31% at the end of October
- Active Job Plans dropped 0.1% to 88.4% in October
- Reminders sent to Inactive individuals and their Clinical Leads
- 30 Seconds of Job Planning News – Non-Working Time and Medic Rostering

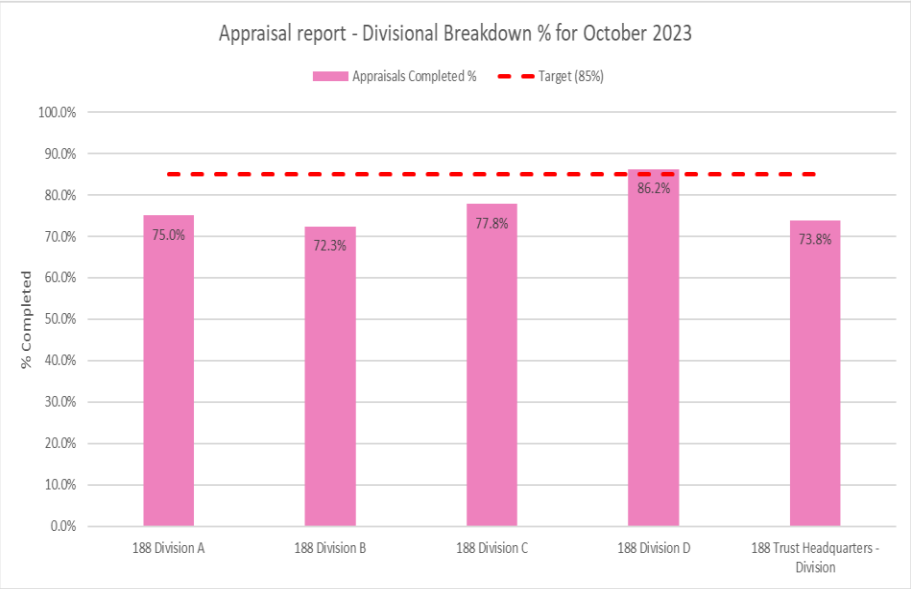


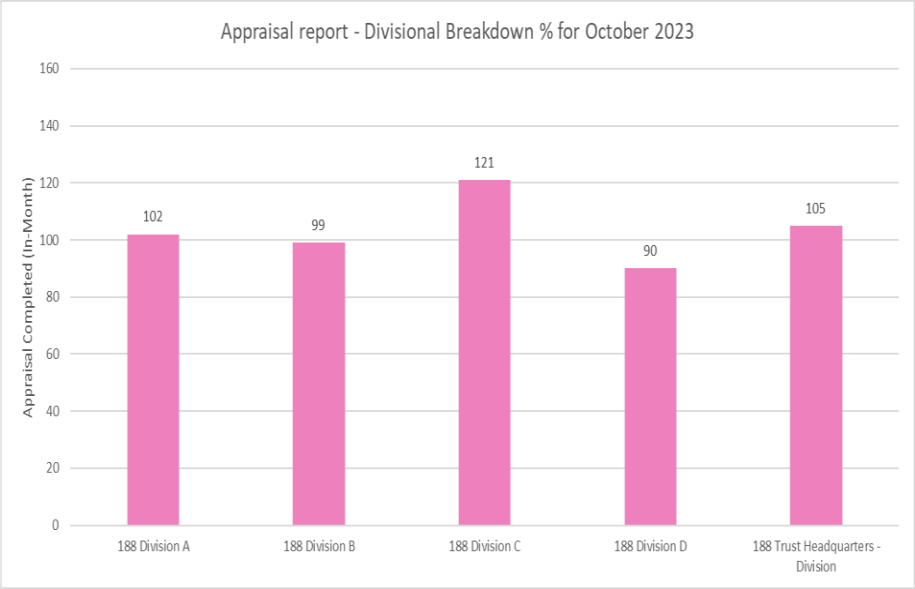
People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

APPRAISALS

A total of **517** appraisals **(76.8%)** were completed in M7 (October 2023). Appraisal completion has been affected by a combination of factors including annual leave, sickness absence, Industrial Action, and the use of ESR.





Source: ESR – Appraisal data for Divisions A, B, C, D and THQ only

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

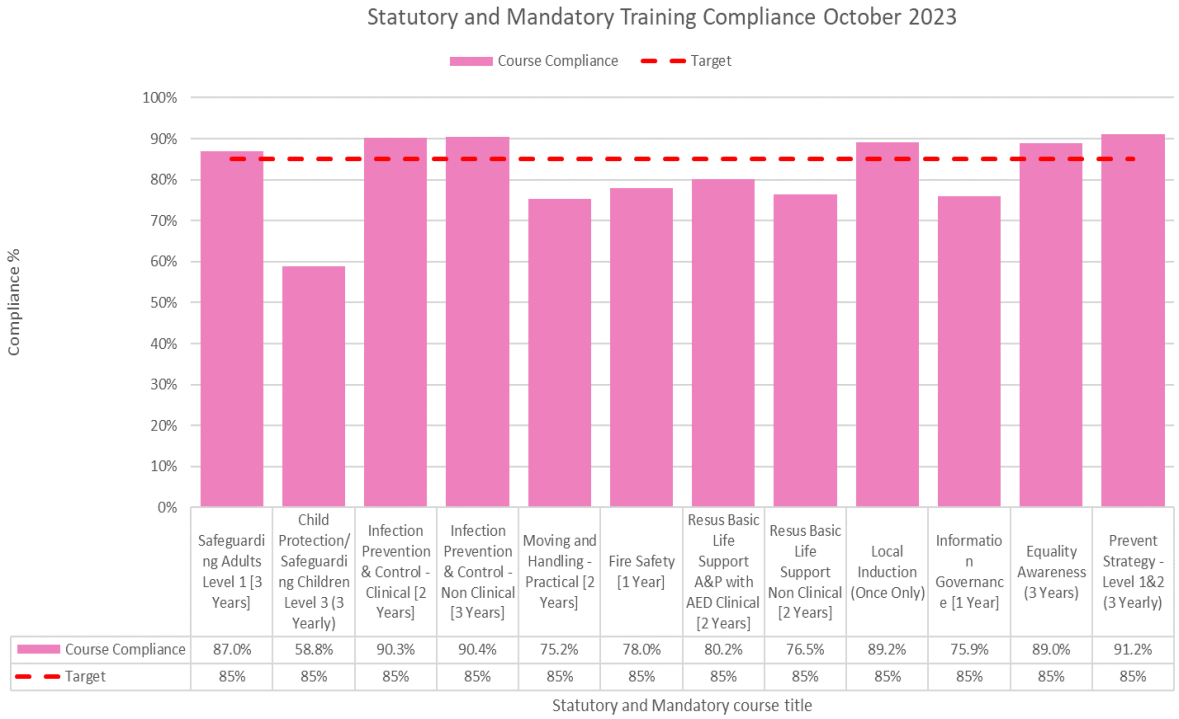
Statutory and Mandatory Training

Work is continuing on the revised VLE platform for launch in Q3

Recommendations were accepted to change Stat & Mand matrix to just be statutory (legal) and mandatory (core skills training)

Other current courses such as trust essential (e.g., Allyship) and role essentials (e.g., blood transfusion) to be split into separate matrices, and subject matter experts to be responsible for planning, delivery, and compliance

Revised reporting to be provided to Divisions and THQ



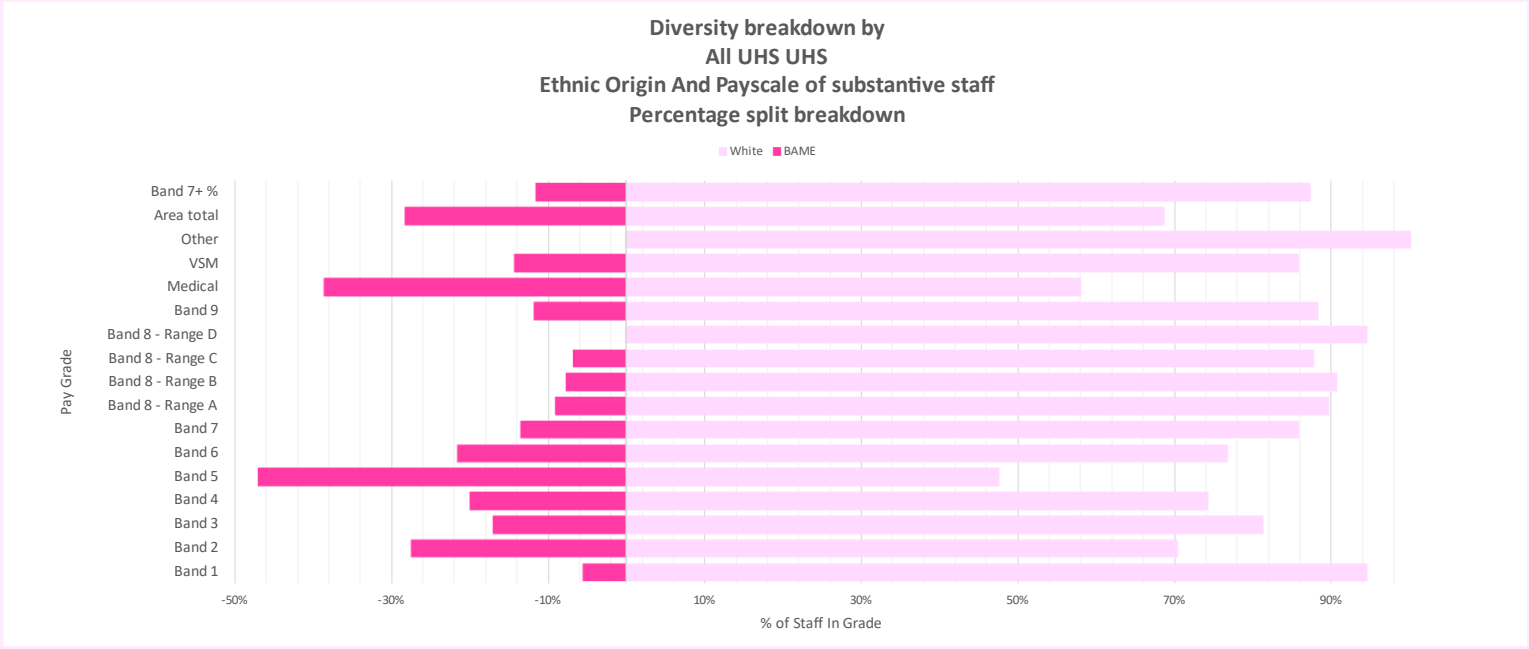
	Safeguarding Adults Level 1 [3 Years]	Child Protection/ Safeguarding Children Level 3 (3 Yearly)	Infection Prevention & Control - Clinical [2 Years]	Infection Prevention & Control - Non Clinical [3 Years]	Moving and Handling - Practical [2 Years]	Fire Safety [1 Year]	Resus Basic Life Support A&P with AED Clinical [2 Years]	Resus Basic Life Support Non Clinical [2 Years]	Local Induction (Once Only)	Information Governance [1 Year]	Equality Awareness (3 Years)	Prevent Strategy - Level 1&2 (3 Yearly)
Course Compliance	87.0%	58.8%	90.3%	90.4%	75.2%	78.0%	80.2%	76.5%	89.2%	75.9%	89.0%	91.2%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Source: Virtual Learning Environment (VLE)

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

STAFF IN POST – ETHNICITY

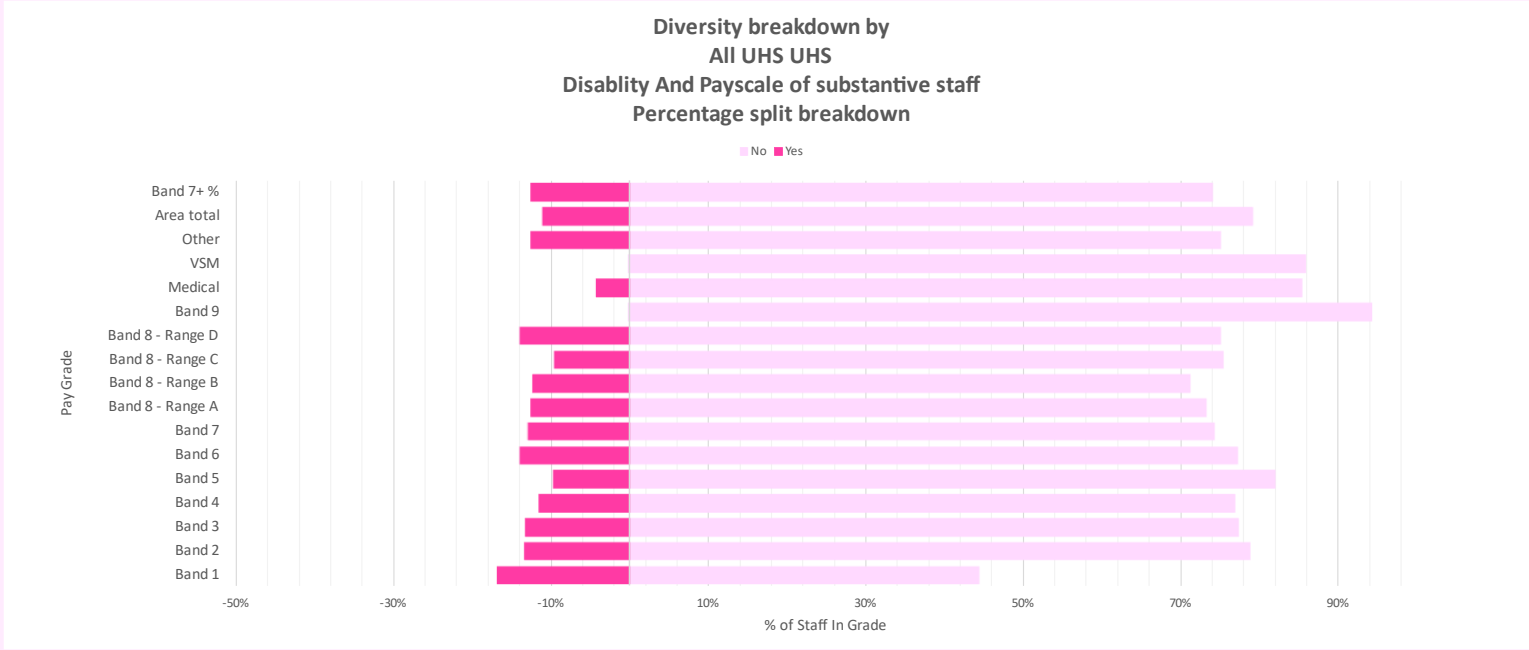


Source: ESR

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

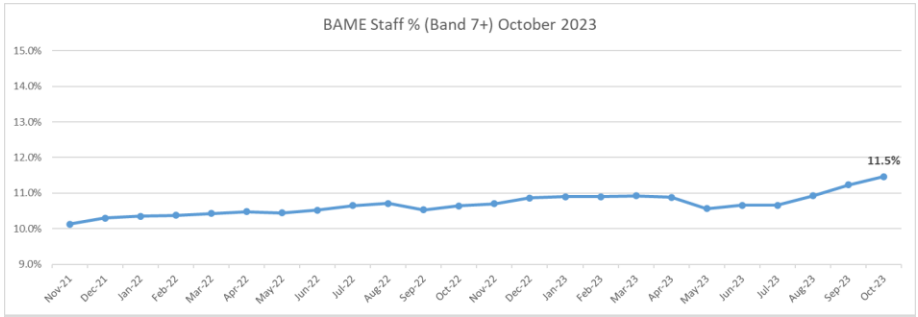
STAFF IN POST – DISABILITY STATUS

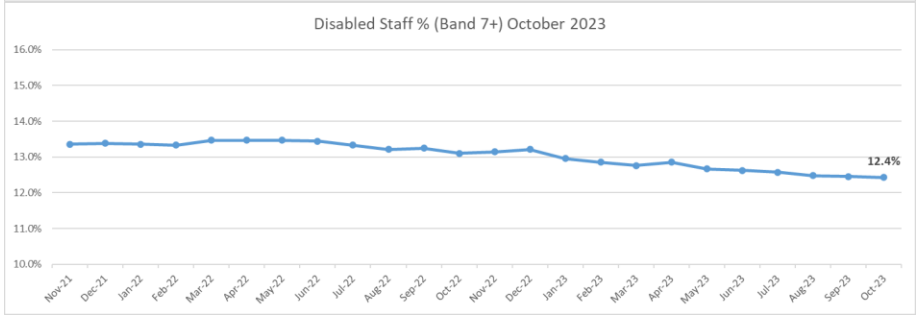


Source: ESR

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY





STAFF IN POST – ETHNICITY and DISABILITY

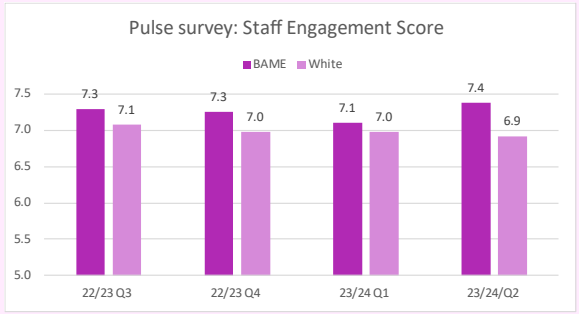
- Nursing Positive Action Programme with Florence Nightingale Foundation is mid-way through with the final celebration event on 5th December.
- Results for Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) at UHS have been published showing disparity levels between those with disability and those without at UHS has increased, feedback has been received that experiences for people working at UHS who have disabilities has declined. A group senior leads has been convened, with input from LID network, to agree the actions required to address the situation and will update progress to EDI Committee.
- WeAreUHS week held in October, saw high levels of engagement and involvement from across UHS. Feedback from staff was very positive.
- 0.3% increase for B7+ BAME staff from M6 to M7 equates to 6.
- The decrease of B7+ Disabled staff % is due to the increase of new recruits without disclosure. The number remains the same at 296.

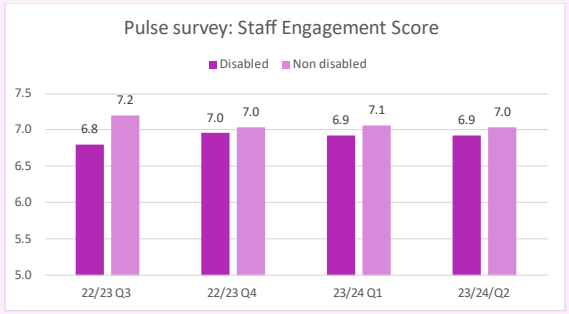
Source: ESR

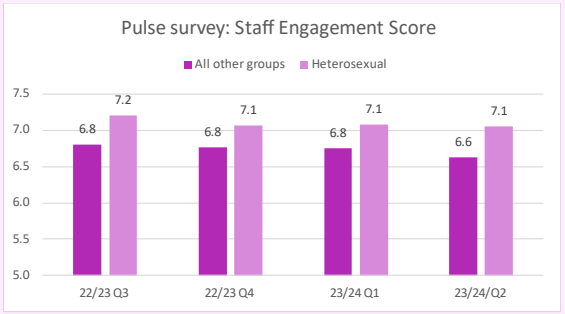
People Report

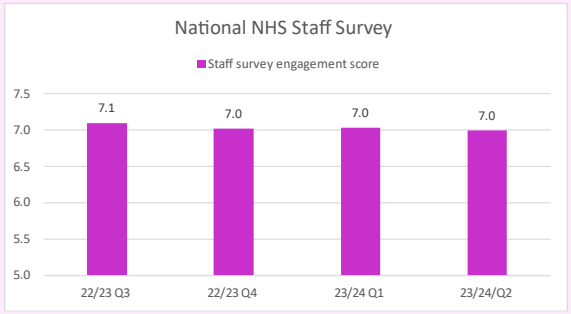
THRIVE | EXCEL | BELONG | PATIENT SAFETY

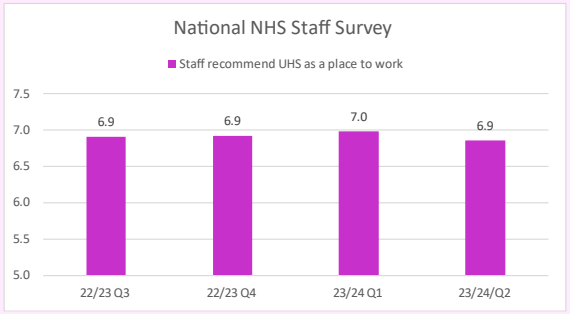
Pulse Survey – October 2023











Q3 is the annual staff survey which is live currently and closes on the 24th November. Results will be available between December-February 2024

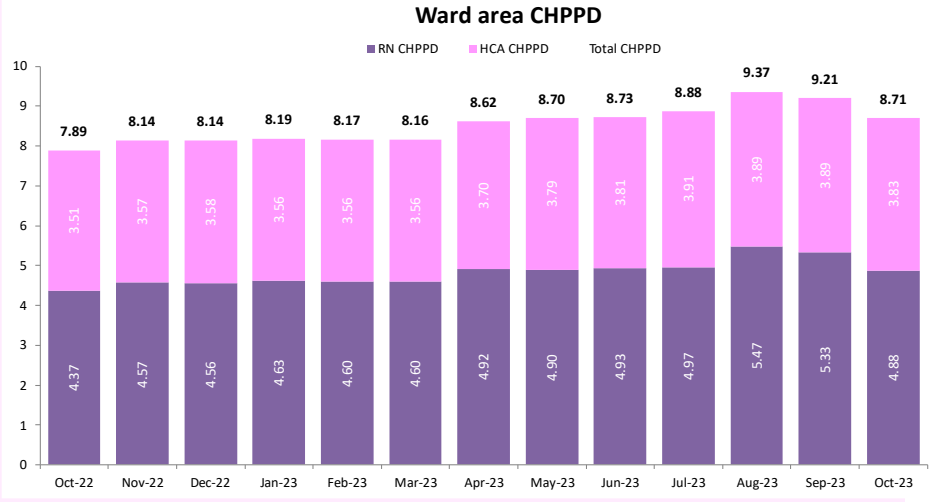
Source: Picker (Qualtrics)

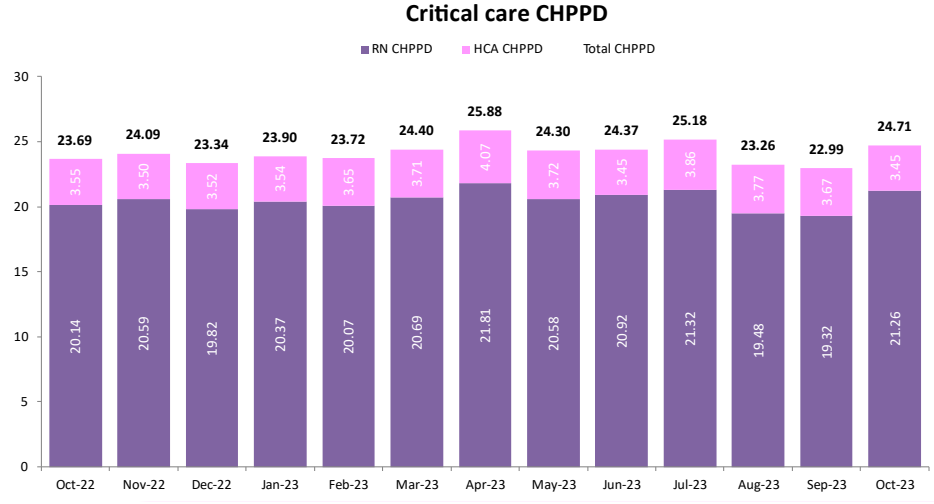
People Report

THRIVE | **EXCEL** | BELONG | PATIENT SAFETY

CARE HOURS PER PATIENT DAY
October 2023

The Ward areas CHPPD rate in the Trust has decreased from last month to RN 4.9 (previously 5.3), HCA reduced from 3.9 to 3.8.





The CHPPD rate in Critical care has increased overall from last month. RN 21.3 (previously 19.3), HCA 3.5 (previously 3.7), and overall, 24.7 (previously 23). 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.

Source: HealthRoster & eCamis

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Midwifery, Neonatal and Obstetric Anaesthetic Workforce Report**			
Agenda item:	**5.9**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Emma Northover, Director of Midwifery and Professional Lead for Neonatal Services** **Carly Springate, Head of Midwifery** **Victor Taylor, Lead Matron - Neonates** **Mark Johnson, Consultant Neonatologist**			
Date:	**30 November 2023**			
Purpose:	**Assurance or reassurance** **x**	**Approval**	**Ratification**	**Information** **x**
Issue to be addressed:	This report is being presented to the members of the Trust Board in order to provide information relating to Midwifery, Neonatal and Obstetric Anaesthetic Workforce. The reports and associated action plans are a requirement to demonstrate compliance with NHS Resolutions (NHSR) Safety Actions 5 - Midwifery Workforce, and Safety Action 4 - Neonatal and Obstetric Anaesthetic Workforce. The report provides an overview of future workforce planning and actions to mitigate our current challenges. The Obstetric Medical Workforce report requirement is significant with ongoing audit and will be shared with Trust Board in December 2023.			
Response to the issue:	**1. An Effective System of Midwifery Workforce Planning** **1.1 A clear breakdown of BirthRate Plus (BR+) or equivalent calculations to demonstrate how the required establishment has been calculated** In line with national drivers for assurance in relation to safe staffing levels within maternity services, UHS Maternity Services currently utilise BirthRate Plus (BR+) as a system and framework for workforce planning and strategic decision making. The last assessment of UHS Maternity Services by BR+ in 2018 suggested an overall clinical establishment based on a midwife V birth ratio of 1:24, calculated against an annual birth rate of 5500 births. At the time, the required total establishment as calculated by BR+ to ensure safe staffing levels equated to **226.55** WTE which was inclusive of support staff contribution. **1.2 In line with Midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations** Over the last 3 years, UHS Maternity Services have at times been working with midwife V birth ratios that are more suggestive of 1:26. Indeed, this has felt uncomfortable but with contingency frameworks in place (on-call midwives and the authorised use of temporary staffing against vacancy levels) the service has remained manageable and safe.			

With a vacancy rate of 25.95 WTE currently for registered staff we are presently operating a 1:29 midwife V birth ratio. This situation is further compounded by short-term sickness, an increased demand for education and training and a high maternity leave rate of 8%. This inevitably results in a workforce that is significantly overstretched. As we head into the winter months, stringent planning and mitigations are being actioned to aid and reduce staff burnout, increase support and the enhance retention of the workforce.

Whilst the annual birth rate at UHS has seemingly stabilised over the last 3 years at around 5200 births, the complexity of cases is vastly increasing. In July 2023, 91% of women / birthing people delivered on our labour ward. This is the first time the rate of births on labour ward has exceeded 90% and we have seen this trend continue each month since only falling to 88% in October. Whilst we have seen a slight increase in our normal birth rate in comparison to recent months, our caesarean section rate continues to rise with October showing a rate of 44%.

1.3 Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls

In support of the BR+ acuity tool, UHS Maternity Services have developed a systematic process for workforce planning in the form of a monthly dashboard. This live data is reflective of total staff unavailability to include vacancy rates, sickness ratios, maternity leave, and study time, all of which is compared alongside the budgeted versus actual staffing establishment overall. The data recorded within the monthly dashboard is lifted directly from maternity E-rostering and ESR systems. As such the staffing ratios are recorded in real time and will represent staffing levels in their most accurate form.

The monthly dashboard not only records an accurate position for midwifery staffing at the current time but also offers a projected forecast for staff unavailability in the months going forward. This ensures and supports an ongoing process for rolling recruitment, involving both qualified and unqualified staff groups. Utilising the dashboard in this way will see the Maternity Service reduce the current vacancy rate down to 13.35WTE as of 1 February 2024.

The recording of monthly maternity dashboard data dictates that effective measures are continued to be taken in ensuring an accurate account of midwifery staffing at any one time. This will enable vacancies and gaps within the workforce to be accounted for and managed accordingly.

Whilst we observe a rolling recruitment process within UHS Maternity Services, over the summer months we very successful recruited 14 newly qualified midwives. This cohort of midwives have recently begun their first few weeks with us, and they will be spending their first 6 months gaining confidence whilst working in the intrapartum environments. We have introduced additional supportive measures to aid them in their transition and we hope that these measures will be reflected in future recruitment and retention rates.

1.4 Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing

When considering clinical staff contribution, BR+ identify several budgeted leadership / specialist roles that should be excluded from total calculations. The recommendation from BR+ is that this "non-clinical establishment" should equate to **22.66** WTE. Current UHS workforce calculations for this cohort of staff sit in line with these recommendations with a full establishment of **22.66** WTE. Whilst these members of the team are otherwise exclusive from contributing clinically, they absolutely sit as part of the contingency framework for additional staffing during periods of escalation. If activated, the expectation would see these individuals supporting all areas across the service within a clinical capacity.

For 2022/23, the total number of funded clinical midwives for UHS Maternity Services is **207** WTE. At UHS however, the caseload model (NEST team) provides intrapartum care within PAH, as well as antenatal and postnatal care in the community, to vulnerable women as part of their model of care. It is recognised that the workload from women with significant safeguarding needs requires higher than average midwife hours within this care package and therefore any forward workforce planning should consider this additional midwife time.

1.5 Maternity Workforce Development – Next Steps/Way Forward

Over the last year, an extensive listening exercise has taken place to help inform the future direction and structure of the Maternity Service workforce. To align with current service needs, and with staff wellbeing as a central focus, the Director of Midwifery and Midwifery Senior Leadership Team are reviewing the way the service is delivered with the potential of a workforce restructure. Drivers around flexible working, retention and restorative practice will all underpin the direction and future of the way in which we work.

In terms of strategic workforce planning, there is currently a significant focus around the issue of supply and demand for maternity staff, particularly registered midwives. UHS Maternity Services currently host the regional midwifery lead for workforce development who has been incremental in establishing a collaborative working group across the LMNS and has made an impressive start into exploring and implementing a variety of recruitment pipeline opportunities.

Some of these options for workforce development see alternative training pathways for health care workers who previously may not have benefitted from such openings and include shortened midwifery conversion courses for registered nurses, return to practice midwifery courses, midwifery apprenticeship models and foundation programmes for aspiring maternity support workers.

It is anticipated that by broadening the gateway into careers within maternity services, whilst allowing training and education to be both accessible and affordable, a wider audience of prospective candidates will be achieved.

In these current times where maternity workforce tensions are so prominent, we recognise that succession planning is of prime importance, and therefore are busy creating new opportunities for staff upskilling and professional

development. UHS Maternity Services are committed to investing in their people and as such have dedicated programmes for career development starting at band 2 and progressing to band 9. Our prime focus is to consider new ways in which we can future proof our maternity services going forward.

2. Neonatal Nursing Workforce

2.1 Nursing Workforce

Currently the Neonatal nursing workforce does not meet the required standard as calculated by the CRG workforce tool (2020). Action plans for NHS Resolutions Year 4, progress against this action plan and a MIS Year 5 action plan can be seen in appendices 2, 3 and 4. The following information demonstrates requirement, budget and fill based on data acquired between September 2022-23.

2.2 Southampton Neonatal Services cot occupancy and nursing requirement

The information included in the table below outlines the nursing requirement recommended by the workforce tool, the current WTE and fill rates local to Southampton.

Care level	Cots	Cot occupancy (days) Sept 22-23
Intensive Care	12	3458
High Dependency	11	3013
Special Care	14	5052

Nursing requirement	WTE for cot occupancy	WTE in post	Fill %
Total QIS	68.48	48.51	70.83%
Total Non- QIS	31.37	37.77	120.4%
Total Non- registered	25.29	16.71	66.07 %

2.3 Local Breakdown of Nursing workforce – direct care only

Band	Budget	Contracted	Vacancy	Fill
Band 7	10.4	7.09	3.31	68%
Band 6	33	26	7	78.70%
QIS B5	31.99	15.42	16.57	48.20%
Band 5	31.99	37.77	-5.78	118%
Band 4	24.68	11.09	13.59	44.90%
Band 3	7.8	5.62	2.18	72.05%
Total	139.86	102.99	36.87	73.54%

There continues to be a significant gap in our Qualified in Specialty (QIS) nursing workforce. This is an issue that is nationally recognised by other level 3 neonatal units.

There have been several recruitment and retention initiatives over the past 4 years inclusive of R&R payment alongside re-location and rolling band 6 adverts, but these have not translated to improved QIS recruitment. The table below shows the amounts of shifts that we have met BAPM standards for QIS Nurses September 2022/23.

QIS Toolkit Standard	Number of Shifts	Percentage
Toolkit standard met/ exceeded	68	9.31%
1 x QIS below	46	6.30%
2 x QIS below	52	7.12%
3 x QIS below	74	10.13%
+3 x QIS below	490	67.12%

The shifts where we have met the required BAPM standard were at a time where there was a temporary decrease of demand on the service. The data largely shows we are significantly below the required standard, and this is indicative of the feeling felt by the neonatal team.

2.4 Bank and Agency use

Shifts Requested	Shifts Filled	Total (%)
5514	4467	81.01%

Substantively employed staff choose to work additional hours on NHSP to substitute gaps in the workforce. We almost exclusively use Bank to fill this gap with a negligible agency spend at 2.0 WTE in the previous YTD. This spend is because of agency staff being redeployed to NNU not booked by us.

NHSP spend offset by vacancy. Currently we are using on average 10.34 WTE per month to supplement our substantive workforce. It is evident from the information provided above that despite good fill rates we are still unable to fully staff the unit. We are working with the Temporary Resource Team to support the fill of vulnerable shifts out of hours.

2.5 Risk Mitigation

In line with the National Quality Board (2018) recommendations for neonatal staffing, professional judgement can be used to assess nurse to patient ratio according to the clinical needs of individual patients. It can be safe and appropriate to nurse some ITU babies 1:2. This way to working forms our locally adjusted nursing standards. There are also QIS nurses in non-direct care quality roles which are regularly utilised to support the safety of the department.

Role		Contracted	Vacancy
Family Care Nurse	1 x Band 7	1	0
Education Lead	1 x Band 7	0.92	0.08
Clinical Facilitators	3 x Band 6	2.08	0.92
Surgical CNS	2.2 x Band 6	2.2	0
SONeT Lead	1 x Band 7	1	0
Transport Nurse	5.5 x Band 6	5.5	0

2.6 Recruitment and Retention strategy

- Train more QIS nurses than we have previously as we recognise this as the best way to fill our QIS vacancy.
- Fill band 6 vacancy.
- Have well recruited non-QIS RN workforce to develop in readiness for QIS qualification. Talent management for those who wish to develop.
- Regularly advertise for external QIS nurses and target IEN workforce with neonatal experience.
- Strong focus on wellbeing.
- Education and training opportunities to retain staff.
- Leadership development to improve unit culture.

2.7 Implications

The implications of sub-optimal neonatal nurse staffing are a risk to the safety and quality of care delivered at UHS and the ability for UHS to remain a trusted referral centre for ITU, surgical and specialty care.

During the period covered by this report, the Neonatal Unit has escalated to opel 4 status on 11 occasions during the period September 2022 to September 2023 due to a lack of staffing or capacity. This has resulted in a lack of ability to accept intensive care babies from within the network for variable periods of time. Furthermore, this has impacted the maternity service's ability to accept high risk ante-natal mothers, resulting in women being transferred to other units for ongoing care.

Every period of opel 4 greater than 24 hours has undergone an RCA with the published reports reviewed by both the Trust Board and Quality Committee as part of quarterly reporting, and these are required to be notified to the CQC.

2.8 In Conclusion

The Neonatal Unit nurse staffing **does not** meet the required standards as set out by the NHSR and service specification requirements. Not meeting these requirements for NHSR can be mitigated by presenting progress against last year's action plan (Appendix 3) and presenting an action plan in MIS Year 5 (Appendix 4).

Understaffing is supplemented and mitigated by using NHSP, other agency, overtime, and the use of non-clinical staff to support cot side nurses. Neonatal staff are reassigned from their support roles – e.g., surgical nurses and education team, to ensure safe staffing numbers are met. Support is also sought from across the Child Health Division for appropriately trained and experienced staff from PICU and HDU to support the Neonatal Unit when required. As well as caring for babies under locally agreed mitigated standards, plans are in place to increase our QIS workforce, but this will run over 2 or 3 years. Our staffing is on the Trust's risk register and regularly reviewed to assess onward risk to clinical care. When reviewing staffing against last year it is evident that we have maintained our numbers within QIS and increased our non-QIS nurses with plans to develop this group. Overall, our vacancy rate has reduced but the skill mix has remained the same.

3. Neonatal Medical Workforce

In 2022 Southampton Neonatal Unit delivered 3136 ITU care days. Medical staffing meets the BAPM recommendations for units delivering >2500 ITU care days as follows:

- All consultants are on the specialist register and dedicated only to the neonatal unit and only have primary duties here.
- As a minimum on both day and night shifts there are two tier 1 doctors or ANNPs and two experienced junior doctors ST4-8 or appropriately trained specialty doctor or ANNP covering the neonatal unit.
- During normal working hours, there are 2 consultant-led teams covering the neonatal unit.
- On site consultant cover is provided for more than 12 hours a day (0830-2300) Monday to Friday and 0830-1700 at the weekend.

3.1 Current Risks

- At night (2030-0830) one of the tier 2 staff covers the regional transport service so may be called away from the unit, leaving only 1 dedicated tier 2 medical team member.
- On-site consultant cover does not extend to 12 hours at the weekend as recommended by BAPM (though consultants are on-call and available on site within 30 minutes).

3.2 Risk mitigation

- Due to minimum staffing of both two tier 1 and two tier 2 doctors on all shifts, even if the tier 2 doctor/ANNP covering the transport service is called out overnight, there will still be 3 medical staff on the unit. In addition, as well as the on-call consultant (who will be on site till 2300) there is a second consultant available on-call at home if needed. Furthermore, the number of transport referrals requiring medical cover at night are minimal.

- Funding has recently been provided from the Neonatal Network to extend on site consultant cover to 2300 at the weekend. This will commence in 2024 once additional consultants have been recruited to cover these extra hours.

3.3 Recruitment and Retention strategy

- Whilst a number of junior doctors at both tier 1 and 2 are often in short supply, both from the local deanery as trainees and through external recruitment, we have a good track record of ensuring our junior doctor rotas at both tiers are filled and compliant. We have done this through innovative approaches including a highly successful medical training Initiative v(MTI) scheme run through the RCPVH, and continuous training and recruitment of ANNPs and fellows. Whilst not having enough junior medical staff is always a risk, we are confident that we can continue to fill our rotas and have a history of doing this successfully each year.

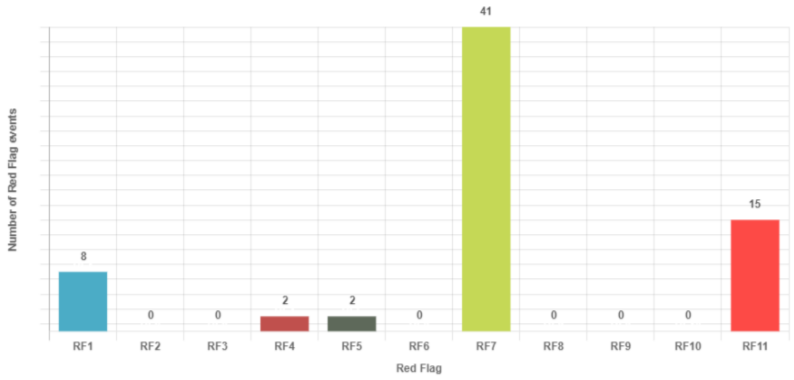
	• A business case is currently in progress for the appointment of additional substantive consultants as funding is available from both the Neonatal Network and as a result of a recent funded expansion of the neonatal unit, it is highly likely these posts will be approved. There are 2 existing locum consultants in place so it is anticipated that there will be enough interest in the substantive posts such that they will be successfully appointed to. **3.4 Conclusion** Medical staffing essentially meets BAPM recommendations, though there is a need to increase consultant cover on site at the weekends and there is a plan and funding in place to achieve this in 2024. **4. Obstetric Anaesthetic Workforce** A duty anaesthetist is immediately and exclusively available for the obstetric unit 24 hours a day. There are clear lines of communication to escalate for assistance (see Appendix 5). A consultant anaesthetist is available every weekday, additionally obstetric theatre lists are covered by specific obstetric anaesthetists.
Risks: (Top 4) of carrying out the change / or not:	The risk implications for UHS Maternity include: • **Reputational** – Safety concerns can be raised by the public to both NHS Resolution and the CQC. The CQC can undertake reviews of services who they believe have safety concerns. • **Financial** – Compliance with NHS Resolution Maternity Safety Actions to meet all ten standards is an expectation for many maternity safety requirements. • **Governance** – Safety concerns can be escalated to the Care Quality Commission for their consideration and to NHS England, the NHS Improvement Regional Director, the Deputy Chief Midwifery Officer, the Regional Chief Midwife and DHSC for information. • **Safety** - Non-compliance with requirements or recommendations would have a detrimental impact on the women and their families leading to increased poor outcomes and staff wellbeing.

Appendix 1 – BirthRate Plus Report

UHS Maternity Services have had no occasions where the Labour Ward Coordinator has not been able to maintain a supernumerary status across the reportable period. Additionally, one to one midwifery care for those in active labour was maintained. This evidence is taken directly from BirthRate + to provide assured compliance with this standard.

Number of Red Flags Recorded

From 01/05/2023 to 14/11/2023



Download

Number & % of Red Flags Recorded

From 01/05/2023 to 14/11/2023

RF1	Delayed or cancelled time critical activity	8	12%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief > 30 minutes	2	3%
RF5	Delay between presentation and triage Delay of 30 minutes or more	2	3%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process Delay of 2 hours or more	41	60%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Coordinator not able to maintain supernumerary/supervisory status	0	0%
RF11	Unable to facilitate women's choice of birth place	15	22%
	Total	68	

Safety Action 4: Can you demonstrate an effective system of NNU clinical* workforce planning to the required standard?

Recommendation complete	
Recommendation within timescale for completion	

Recommendation	Assurance and Evidence	Action Plan	Action Owner	Target for Completion	Status
Band 6 Nurses to ensure compliance with British Association of Perinatal Medicine (BAPM)	Band 6 WTE budget 46.91, WTE 33.41 in post (71.22% fill)	RVP approval for 5 x WTE Band 6 posts on NN. Premium rates for NHSP shifts negotiated to incentivise staff to work extra shifts Post recently advertised and 5 staff appointed. Awaiting clearance for start dates.	Angie Ansell Matron NNU	Successful candidates to start as soon as reasonably possible, following references and personnel checks. **April 2023**	Recruitment complete and starting as soon as pre-employment checks complete. When full employment checks completed this will bring Band 6 fill to 38.41 WTE = 81.88%
Band 5 Nurses Qualified In Speciality (QIS) to ensure compliance with British Association of Perinatal Medicine (BAPM)	Band 5 QIS budget 31.99 WTE 22.53 in post (70.42%)	Rolling advert for Band 5 QIS nurses. External advert placed for 3 months at a time and renewed as required. Premium rates for NHSP shifts negotiated to incentivise staff to work extra shifts. Funding secured for 10 WTE QIS course places for internal staff, 5 staff undertaking the course from November 2022 with an additional 10 places requested in the TNA for 2023/2024.	Angie Ansell Matron NNU	Ongoing until vacancies filled. October 2023.	October 2023
Band 4 staff to ensure compliance with British Association of Perinatal Medicine (BAPM)	Band 4 WTE budget 24.68 WTE 14.67 in post (59.44% fill) RVP approval received for 4 WTE	Recruit to band 4 4 WTE Advert to go out November 2022	Angie Ansell Matron NNU	Successful candidates to start as soon as reasonably possible following references and personnel checks.	Start date to be confirmed
Band 5 Nurses (non QIS) to ensure compliance with British Association of Perinatal Medicine (BAPM)	Band 5 WTE budget 31.99 WTE in post 31.44 (98.28% fill)	Over recruit to Band 5 non-QIS 12.17 WTE recruited with pending start dates	Angie Ansell Matron NNU	To start January 2023	

		To train to QIS level to meet the requirement of BAPM standards. Develop interim training and competency package to allow non-QIS Nurses with experience to take care of high dependency and lower level ITU (non-ventilated babies)			

Safety Action 4: Can you demonstrate an effective system of NNU clinical* workforce planning to the required standard?

Recommendation complete	
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Band 5 Nurses Qualified In Speciality (QIS) to ensure compliance with British Association of Perinatal Medicine (BAPM)	Band 5 QIS budget 31.99 WTE 22.53 in post (70.42%)	Rolling advert for Band 5 QIS nurses. External advert placed for 3 months at a time and renewed as required. Premium rates for NHSP shifts negotiated to incentivise staff to work extra shifts. Funding secured for 10 WTE QIS course places for internal staff, 5 staff undertaking the course from November 2022 with an additional 10 places requested in the TNA for 2023/2024.	Angie Ansell Matron NNU	Ongoing until vacancies filled. October 2023.	Rolling advert continues for this vacancy. We have less in post for this role this year than last year (currently 48.2% fill). We have a strategy with approved funding, for increasing QIS training rates in house and talent management in recruiting the right personal for the non-QIS role. Premium rates for NHSP continue with B7 being offered for this vacancy level.
Band 4 staff to ensure compliance with British Association of Perinatal Medicine (BAPM)	Band 4 WTE budget 24.68 WTE 14.67 in post (59.44% fill) RVP approval received for 4 WTE	Recruit to band 4 4 WTE Advert to go out November 2022	Angie Ansell Matron NNU	Successful candidates to start as soon as reasonably possible following references and personnel checks.	Rolling advert continues for this vacancy. We have less in post for this role this year than last year (currently 44.9% fill). We are actively working with the Trust recruitment team to

					manage this vacancy appropriately. We have revised the opportunities across the service for this role, which now extends across Transitional Care to meet the needs of a variety of applicants.
Band 5 Nurses (non QIS) to ensure compliance with British Association of Perinatal Medicine (BAPM)	Band 5 WTE budget 31.99 WTE in post 31.44 (98.28% fill)	Over recruit to Band 5 non-QIS 12.17 WTE recruited with pending start dates To train to QIS level to meet the requirement of BAPM standards. Develop interim training and competency package to allow non-QIS Nurses with experience to take care of high dependency and lower level ITU (non-ventilated babies)	Angie Ansell Matron NNU	To start January 2023	We are over recruited for this role in the unit as part of the talent management and QIS development programme. Current fill of 118% for this role.

Appendix 4

Action Plan for NHS Resolution 2023 MIS Year 5

University Hospital Southampton NHS
NHS Foundation Trust

Safety Action 4: Can you demonstrate an effective system of NNU clinical workforce planning to the required standard?

Recommendation	Action Plan	Action Owner	Target for Completion
Increase further the numbers for inhouse QIS training .	We have a strategy with approved funding for increasing QIS training rates in house and talent management in recruiting the right people for the training positions. Full recruitment to non-QIS vacancies to support their development prior to starting the course.	Victor Taylor Neonatal Services Matron	Review March 2024 but expectation is that this is a 2-3 year plan. Cohort from Sept 23 expected to complete in May 24.
Development of neonatal nurse education team	Appointment of B7 education lead and consultant neonatal nurse. Investment completed into education team to support theory and practical learning. Provision of shared SIM space with maternity services for learning experiences.	Victor Taylor Neonatal Services Matron	Completed September 2023
Continue rolling advert for B5 and 6 QIS nurses	Rolling advert continues. Engagement with recruitment team to promote this hard to recruit cohort.	Victor Taylor Neonatal Services Matron	Ongoing recruitment into B5 and 6 QIS posts Review March 2024
Incentivise NHSP for QIS nurses	Continue NHSP incentive (B7 for this vacancy level) Flexibility in hours offered additional to contract, for example the evening shift to complete specific clinical tasks.	Victor Taylor Neonatal Services Matron	Review March 2024
Continue to recruit at Band 4	Rolling adverts Internal development for promotion. Link to Trust international recruitment team to identify those with appropriate experience for neonatal services.	Victor Taylor Neonatal Services Matron	Ongoing Review March 2024
Strong focus on wellbeing and culture	Improve staff facilities for rest and breaks Ensure leaders at all levels are appropriately developed to improve unit culture Education and Training Opportunities to improve unit culture and retention Engagement with staff survey and “you said, we did” feedback to teams on outcomes with specific action plan linked to feedback results. Increased variation in contracts for staff with flexible working requirements.	Victor Taylor Neonatal Services Matron	Ongoing Review March 2024

Appendix 5

OBSTETRIC ANAESTHESIA ESCALATION PATHWAY

08:00-20:30 Mon-Fri and 08:00-18:00 Sat/Sun

If Labour ward Anaesthetic trainee (bleep 2410) is undertaking a clinical activity and another anaesthetist is required, bleep 2372 to contact the Consultant Obstetric Anaesthetist

20:30-08:00 Mon-Fri and 18:00-08:00 Sat/Sun

If Labour ward Anaesthetic trainee (bleep 2410) is undertaking a clinical activity and another anaesthetist is required then escalation should occur. Work down this pathway.

Coordinating midwife to bleep 2410 to check they are not close to finishing their case. If they are not, request a second anaesthetic trainee to attend by bleeping 2050.

If the 2050 anaesthetic trainee is not free to attend;

Coordinating midwife to bleep 2265 (ST6/7) and request second anaesthetic trainee to attend. If they are not free to attend;

At this point, if a category 1 or 2 Caesarean section is required and the 2410/2050 are undertaking an epidural insertion, this should be abandoned in favour of them managing the Caesarean delivery.

If no resident anaesthetist is able to attend having bleeped all three numbers above, phone the consultant anaesthetist on call for:

- Category I and II Caesarean deliveries
- An acutely deteriorating patient
- Epidural insertion where the 60 minute target will not be met in patients with **specific indications (confirmed by the coordinating anaesthetist 2265):**
    - Increased risk of operative delivery e.g. twin/triplets, BMI >40

Report to the Trust Board of Directors				
Title:	**Learning from Death 2023-24 Quarter 2 Report**			
Agenda item:	**5.10**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Author:	**Jenny Milner, Associate Director of Patient Experience** **Debbie Watson, Head of Patient and Family Relations** **Alex Woodhead, Mortality and Data Insight Coordinator**			
Date:	**30 November 2023**			
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:	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.			
Implications: (Clinical, Organisational, Governance, Legal?)	• Q2 UHS deaths have decreased from previous year's Q2, year on year Q2 deaths have fallen by 10%. • Overall SHMI (Summary Hospital Mortality Indicator) remains lower than expected and values show no features of concern. • Medical Examiners referred 5 cases into M&M feeling there were potential issues with patients care. The outcomes were fed back to Associate Director of Patient Experience, no themes and main learning identified was delay in palliative referrals and communication with patient and family. • End of Life complaint received due to multiple delays across the death processes which ended in a delayed funeral. AERs from End of Life relate to equipment availability in community. • 8 LeDeR reviews in Q2, to note the areas of good practice identified with communication and shared decision making, area for improvement identified for flagging LD and ASD patients.			

	• MEO and Bereavement team have been moved into the same structure to enable cohesive work surrounding death administration and support to families. Lead Medical Examiner Officer role now in process for recruitment. • Action outstanding from Q1 Report: Outcome from a patient safety review following on from a suicide now concluded and learning related to enhanced care observations noted.
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: Conclusion and/or recommendation	This paper is provided for assurance and approval.

1. Introduction

The learning from deaths report sets out to satisfy the requirements within the NHS Learning from Deaths framework. Data is presented from UHS data sources, NHS England and data collected by Medical Examiners Southampton.

In addition to the quantitative data presented, learning is presented from UHS sources such as 'adverse event reports,' complaints and mortality review bodies.

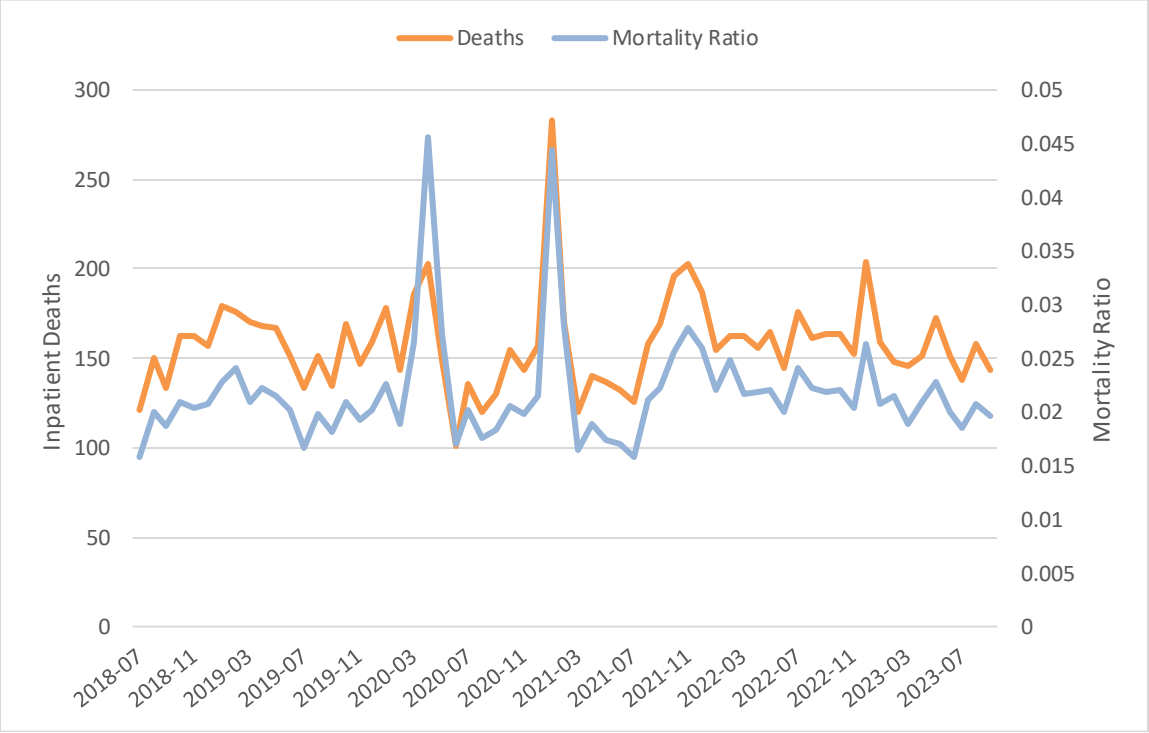
Morbidity and mortality meetings remain a focus for the improvement of data capture and availability, such that learning identified in these meetings can be shared both in this report and across the trust.

2. Analysis and Discussion

2.1 Deaths at UHS

Quarter	2019-2020	2020-2021	2021-2022	2022-23	2023-24
Q1	485	540	483	504	512
Q2	416	516	591	526	471
Q3	474	599	651	565	-
Q4	506	644	537	489	-
Total	1881	2299	2262	2084	983

The first quarter of 2023-24 saw 512 deaths at UHS sites, compared to 471 in Q2 2023-24. Year on year Q2 deaths have fallen by 10%.



Gross mortality numbers remain steady with no significant trends present in the monthly aggregated data. The crude mortality ratio (admissions/deaths) remains consistent with monthly values between 0.02 & 0.03.

2.2 **SHMI (replacing HSMR)** (Calculated by NHSE)

SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated here.

SHMI remains in the 'lower than expected' range at 0.82 for the 12 months to June 2023.

SHMI values are calculated on a diagnosis level for the following diagnosis groups:

Diagnosis Group	SHMI Value	SHMI Banding
Septicaemia (except in labour), Shock	0.8299	As Expected
Cancer of bronchus; lung	0.7576	Lower than Expected
Secondary malignancies	0.525	Lower than Expected
Fluid and electrolyte disorders	0.4762	Lower than Expected
Acute myocardial infarction	0.8672	As Expected
Pneumonia (excluding TB/STD)	0.9308	As Expected
Acute bronchitis	0.7295	As Expected
Gastrointestinal haemorrhage	0.7563	As Expected
Urinary tract infections	0.6635	Lower than Expected
Fracture of neck of femur (hip)	0.7645	Lower than Expected

For the 12 months to June 2023 5 diagnosis level values are in the 'As Expected' range, 5 are in the 'Lower than Expected' range.

Overall, SHMI values show no features of concern.

2.3 Medical Examiner Reviews

In Q2 the Medical Examiner Service reviewed 670 deaths of which 431 occurred at UHS acute sites, 239 occurred in the community. This compares to 592 in Q1 2022/23 of which, 492 were acute, 100 community: a 120% increase in community reviews year on year.

18 deaths from acute settings were referred for further internal review, of these 2 were to LeDeR, 3 to Patient Safety, 1 to Mental Health Disorder Case Note Review and 12 to clinical M&M.

Of the 12 cases referred to clinical M&M meetings 5 were due to the medical examiner feeling there were potential issues with the patient's care.

Of the 3 cases referred to Patient Safety this quarter, 2 are currently under investigation.

The third related to a patient with a fractured neck of femur. The Medical Examiner was concerned that there was undue delay in diagnosis of the fracture. Following investigation in conjunction with the clinical team it was found that the delay in identifying the fracture was not unreasonable given the circumstances of the case.

One investigation was ongoing at the time of the Q1 report being published; this investigation has now been completed. The investigation was in relation to the death of an inpatient by suicide and made the following recommendations:

- Main recommendations related to the root cause:
    - Enhanced observation policy to be re-launched within T&O with support from the Enhanced Care Mental Health Team and Lead Matron for Mental Health.
    - Review of Enhanced observation training included on Trust HCA inductions.

- Recommendations linked to contributory factors:
    - Consideration to be given to the employment of a mental health practitioner based on the T&O unit to assist with training, review of management plans and liaising between teams.
    - In conjunction with the Lead Matron for Mental Health and the Education team for T&O to map all available mental health, suicide and self-harm training provided in the Trust and provide staff with information on which training is pertinent to their role.
    - Mental health education programme in conjunction with Liaison Psychiatry Team being implemented in T&O.

2.4 UHS AERs relating to the Patient Deaths

5 AERs relating directly to patient deaths were recorded in quarter 2.

Following investigations, no issues with the care provided were found in any of these cases.

2.5 UHS 'End of Life' Incident Reports

Two incidents were entered with the 'End of Life Care' Cause Group in quarter 2.

The first incident was regarding difficulties arranging appropriate equipment and care support to enable the patient to be discharged home for end-of-life care. The incident was escalated to both the ICB and the Hampshire Equipment Library for response.

The second incident regarded the lack of out of hours Church of England chaplaincy.

2.6 UHS Complaints relating to End-Of-Life Care

Three complaint cases relating to end-of-life were received in quarter 2.

After investigation, 2 of these found issues with the service delivered by external organisations.

The third found that delay in referral by the clinical team to Medical Examiners Southampton following the patient's death, in conjunction with delay in referring the patient to the coroner, caused undue delay from the patient's death to an MCCD being issued. This in turn delayed the patient's funeral and caused significant stress to the bereaved family.

2.7 LeDeR Reviews

8 LeDeR reviews were completed in quarter 2.

Recurring areas of good practice were identified as:

- Communication with patient families
- Involvement of both patients and families in care planning and decision making.

In 2 cases the PAS Alert was found to not have the patient's LD or ASD diagnosis correctly flagged.

3. Morbidity and Mortality Process

A group of M&M meetings have been recruited to participate in a trial of the M&M outcomes recording application that has been developed.

The trial will commence in quarter 3.

4. Medical Examiner Service

MES as a hosted service continues to move toward being a statutory requirement in April 2024, to achieve the anticipated c5600 reviews per year the service is actively recruiting to its NHSE budget., a key objective is to ensure Trust administration supports this.

Some delayed engagement is being experienced from the community prior to the statutory status.

Work in progress to pilot out of hours service across the region.

5. Conclusion

No features of concern are identified in UHS mortality data.
Medical Examiners Southampton continues to review an increasing number of community cases.
Morbidity and Mortality governance is an area of focus for development.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Guardian of Safe Working Hours Quarterly Report**			
Agenda item:	**5.11**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Author:	**Dr Diana Hulbert** **Emergency Medicine Consultant & Guardian of Safe Working Hours**			
Date:	**30 November 2023**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** ✓
Issue to be addressed:	Exception Reporting continues to be steady but recently we have received 7 exception reports which have constituted a breach incurring a financial penalty and 2 of those included an immediate safety concern. Thus, UHS has been fined for the first time since implementation of the Junior Doctor contract in 2016. This is obviously a cause for concern, and we are meeting the relevant teams to ensure that we can learn from their rota challenges. The vacancy rate for doctors in training is currently 9.2%. The money spent on internal bank for locums continues to be reasonably high, relating to covering both short-term vacancies and longer-term gaps in the rotas. The tighter controls put into the locum request process reflect the need for clear financial governance around staffing spending and is seen in all NHS trusts. It is important to continue to support the doctors during strike actions. The significant work done by the Executive and senior clinical leaders at UHS to ensure that all available information was widely shared via several open events and to ensure that help and support was available to all was appreciated. We still await the outcome of negotiations between the Government and the BMA.			
Response to the issue:	See main report below.			

Implications: (Clinical, Organisational, Governance, Legal?)	There needs to be ongoing monitoring of exception reporting and appropriate support given to the Consultant/Clinical Rota Leads (CRL). 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 the working patterns of doctors in training. The doctors training now 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 there is any perception that UHS fails to fulfil the basic needs of doctors in training; to this end the new Trainee Doctor Pastoral Group has been set up to ensure that these doctors' needs are understood and met.
Summary: Conclusion and/or recommendation	The Board is invited to note the report and the concerns regarding work intensity, exception reporting, fines, rota gaps, locum expenditure and the working lives of doctors in training. The next quarterly report will be submitted to Trust Board in March 2024.

Executive Summary

Employment

There are 956.65 doctors in training or doctors employed in non-training posts employed by the Trust, and they either work on the 2016 contract (including lead employer hosted placements) or mirror that of the 2016 contract.

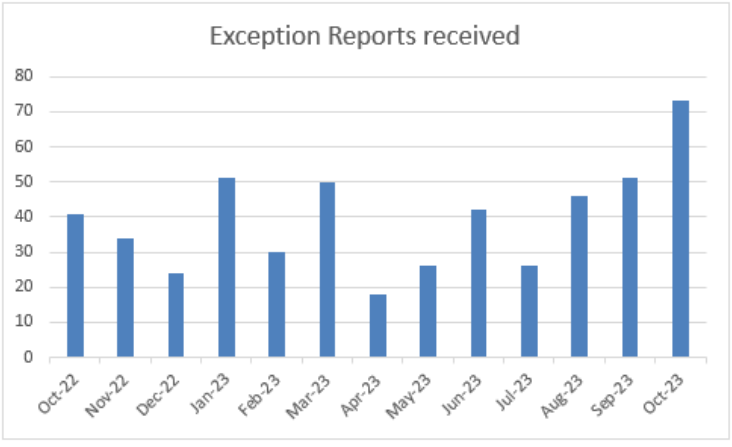
Recruitment continues for current vacancies and Medical HR are working with departments to plan for future gaps. (Appendix1)

Exception reporting

In total 3389 exception reports have been received at UHS since the implementation of the Junior Doctor Contract in October 2016

Since the last report in July 2023 there have been 219 exception reports

Total exception reports received over last 12 months:



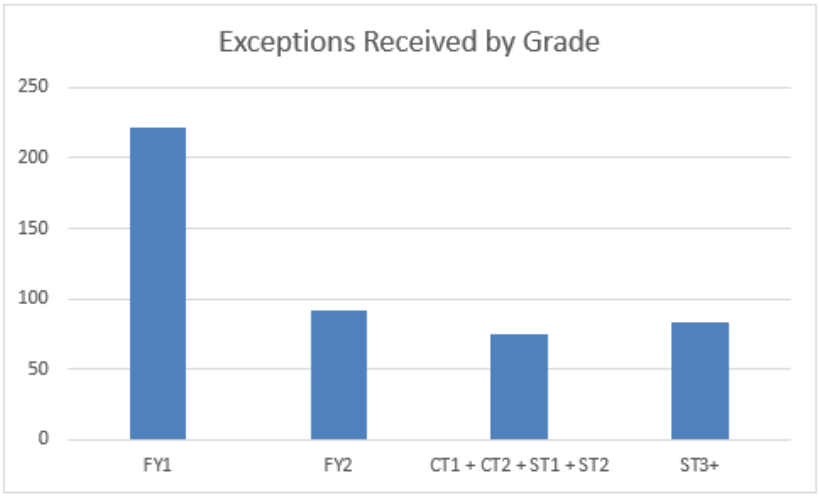
The most common reason for the submission of an exception report is additional working hours and the most common resolution is additional payment for the additional hours worked.

7 recent exception reports have been considered a breach of the maximum 13 hour shift length incurring a financial penalty to General Surgery of the total cost of £688.01. This fine is divided to the doctors concerned receiving in total £271.05 and the Guardian of Safe working receives £416.97.

All 7 reports were received from FY1 grade, working long days during October.
2 of these 7 also included immediate safety concerns, which was responded to in due process with Supervisor and Clinical Lead. The 2 cases were during the combined doctor strike period in October.

The cost of exception reporting to UHS continues to remain low even in despite of the recent breaches of hours which are clearly important, we shall continue to ensure transparent scrutiny of the rotas, exception reporting and working practices in conjunction with support for all the clinical teams.

Majority of the exception reports received are by FY1 doctors



Self Development Time (SDT)

All doctors in training are required to be given two hours of dedicated 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 10 exception reports stating missed SDT

We are working towards a streamlined approach to the provision of SDT across the Trust. We currently have 450 doctor in training rotas and approximately 72.58% have SDT embedded in the rota; the remaining rotas use HealthRoster to record SDT as rota unavailability. We would like to ensure that the best system used for each team.

Activity

The Junior Doctor Executive Committee is led by the chief registrar and meets quarterly with representation from all the specialties. This meeting brings together the Chief Registrar, the doctors in training representatives, the mess presidents, the Guardian and members of the UHS Executive

The Junior Doctor Forum is led by the Chief Registrar meets monthly and acts as an open and informal meeting to allow easy communication between the doctors in training, the Chief Registrar, the Guardian and the Medical Workforce Team.

Both these meetings now take place in the Doctors' Mess and via Teams to encourage wider participation

The new Chief Registrar, Dr Ellie Starkey (a senior doctor in training in oncology) began her term this month and we have set out an ambitious program of projects for her year in post.
We would like to thank Dr Ahmed Daoud, the previous UHS Chief Registrar, very much for his enthusiastic and effective work during a time of significant challenge. Ahmed stayed in his role informally for an extra three months which was invaluable, and he was highly effective in ensuring that there was broad representation of the doctors in training across all clinical groups.

The Guardian and Medical Workforce Team attend monthly Trust induction to ensure that all the doctors in training and the non-training fellows who join UHS feel connected to the team and are able to ask for help and advice.

We are hoping to hold an open forum event in December for all rota leads.

Challenges

There are ongoing concerns over the issue of rota gaps in several areas of the hospital. There are certain specialties where recruitment and retention is particularly challenging including acute medicine, emergency medicine, general surgery and trauma and orthopaedics.
Exception reporting has been high in acute medicine, general surgery and obstetrics and gynaecology in the last six months.
For the first time UHS has incurred fines for exception reports which highlight immediate safety concerns.

Work intensity remains high and the ongoing impact of the covid pandemic on patient behaviour and the rather stuttering recovery of the NHS generally has been significant.

In the last year the impact of staff rather than patient sickness has also 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 doctors in training work patterns as the hospital becomes inefficient and doctors take on tasks usually carried out by other members of the MDT. Of note the reduction of night cover by ACPs in several specialties (a consequence of workforce gaps) still significantly impacts the out of hours work burden for some doctors in training.

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 can help alleviate the problem of annual leave and the introduction of the new Medical Locum Bank system has led to more efficient and timely coverage of short-term rota gaps. In addition, specialties with significant challenges are becoming easier to identify earlier, allowing more effective intervention.

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.

There remains a need to discuss the evolution of the workforce. Work is being carried out around the role of doctors in training, advanced nurse practitioners, physician assistants and a range of non-clinical roles. The is controversy surrounding many of these roles and we at UHS must actively engage in the debate to get the best solutions.

The UHS locum rates change has ensured greater transparency, more consistency, and a better understanding of the differences between specialties. It is important to recognise that there are some particularly hard-pressed specialties including Emergency Medicine and Paediatrics and this is reflected in the locum pay rates.
I am hopeful that these pay agreements will continue to 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.

The recent doctor strikes have been challenging for all. The doctors in training have informally told us that they feel supported although there have been instances of peer pressure both to strike and not to strike. Emotions run high in these situations and the most important support we can give is up to date information, support, advice and judicious rotas which offer patient care and safety. The five-day July strike was harder for obvious reasons, not least because more colleagues were away and more strike fatigue was felt. We fervently hope that a settlement can be reached so that we can all move on.

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.
Recent discussions with the FY1s and FY2s have been invaluable and highlight system challenges and their potential solutions. To this end M-Edison's lab has been set with Dr Mark Wright to generate practical answers to tricky questions.

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 training and non-training doctor workforce.
These issues are the subject of the work that I do with the trainee doctors, the Chief Registrar, the Medical Workforce Team led by Becci Mannion, the Executive and other colleagues.
I am delighted to be a part of the Trainee Doctor Pastoral Care group led by Dr Kristina May; all our meetings with the F1s and the F2s convince us that we need to get the basics right.

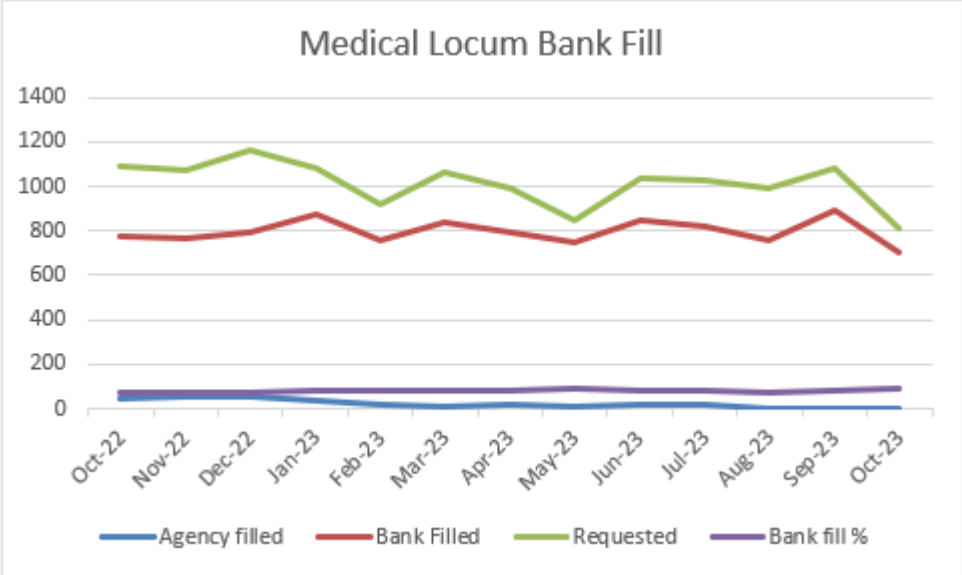
The concerns include new post induction, provision of non-clinical space, IT provision, the availability of reasonably priced hot meals overnight, free tea and coffee and the presence of sleep rooms after night shifts.
We are introducing a new sleep room provision method and I am optimistic that this will be successful.
There is a piece of ongoing work which will scope the office space available to doctors in training which we hope to review in early 2024.
I am delighted that the new DME, Kate Nash has taken on the challenge of local induction for the Trust as this is regularly highlighted as an area of concern by the doctors in training.

A significant challenge for UHS is the understanding of the different expectations of different generations of doctors.
In a big teaching hospital trust with more than 1000 doctors in training and more than 1000 consultants it can be difficult to fully understand how people feel. It is only by walking in peoples' shoes that we can understand how to create a happy workforce who give their best to UHS.
Many doctors at UHS embark on a new career in an unfamiliar city (sometimes in an unfamiliar country) in a big Trust where they know no one, have no support system and may be working an antisocial shift system. Some of the doctors in training in this situation may only have 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 successful doctor workforce are in place in UHS.

Medical Locum Bank

Month	Agency filled	Bank Filled	Requested	Bank fill %
October 22	48	774	1093	70.81
November 22	58	762	1076	70.82
December 22	54	795	1163	68.36
January 23	40	873	1081	80.76
February 23	20	753	916	82.21
March 23	12	835	1063	78.55
April 23	16	796	993	80.16
May 23	12	745	849	87.75
June 23	19	848	1039	81.62
July 23	16	816	1023	79.77
August 23	0	755	991	76.19
September 23	0	893	1077	82.92
October 23	0	704	810	86.91



Month	**Number of escalated bank duties – Pay flags**
September 22	6
October 22	23
November 22	12
December 22	45
January 23	22

February 23	24
March 23	34
April 23	21
May 23	30
June 23	29
July 23	50
August 23	58
September 23	60
October 23	42

Appendix 1: Summary of doctor in training vacancies - November 2023

Division	Care Group	Cost centre	No of posts	No of vacancies (1Nov23)	Fill rate @ 1 Nov 23
A	Critical Care	Anaesthetics	67	6	91.04%
A	Critical Care	CICU	12	2	83.33%
A	Critical Care	GICU	47	4	91.49%
A	Critical Care	NICU	14	1	92.86%
A	Critical Care	SHDU	8	0	100.00%
A	Ophthalmology	Ophthalmology	27	1	96.30%
A	Surgery	ENT	17	1	94.12%
A	Surgery	General Surgery	48	3	93.75%
A	Surgery	OMFS	10	1	90.00%
A	Surgery	Urology	13	1	92.31%
B	Cancer Care	Clinical Oncology	19	0	100.00%
B	Cancer Care	Haematology	21	3	85.71%
B	Cancer Care	Medical Oncology	21	2	90.48%
B	Cancer Care	Palliative Care	8	0	100.00%
B	Emergency	Acute Med	23	1	95.65%
B	Emergency	Acute Med OOH	6	1	83.33%
B	Emergency	ED	68	10	85.29%
B	Emergency	PHEM	3	0	100.00%
B	MOP	MOP	43	1	97.67%
B	Pathology	Chemical Pathology	2	0	100.00%
B	Pathology	Histopathology	22	8	63.64%
B	Pathology	Microbiology	12	3	75.00%
B	Specialist Med	Allergy/Respiratory	29	2	93.10%
B	Specialist Med	Clinical Genetics	4	0	100.00%
B	Specialist Med	Dermatology	7	0	100.00%
B	Specialist Med	Endo/Diabetes	4	0	100.00%
B	Specialist Med	General Medicine	22	1	95.45%
B	Specialist Med	GI Renal	31	0	100.00%
B	Specialist Med	Rheumatology	4	0	100.00%
C	Child Health	Paediatric Cardiology	14	2	85.71%
C	Child Health	Paediatrics	54	8	85.19%
C	Child Health	Paeds ED	16	0	100.00%

C	Child Health	PICU	16	1	93.75%
C	W&N	Neonates	30	5	83.33%
C	W&N	O&G	35	2	94.29%
D	CV&T	Cardiology	37	3	91.89%
D	CV&T	Cardiothoracic Surgery	28	4	85.71%
D	CV&T	Vascular Surgery	11	2	81.82%
D	Neurosciences	Neurology	20	3	85.00%
D	Neurosciences	Neurophysiology	2	0	100.00%
D	Neurosciences	Neurosurgery	26.5	4	84.91%
D	T&O	Spinal Surgery	3	0	100.00%
D	T&O	T&O	52	2	96.15%
		Total	**956.5**	**88**	90.80%

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Medicines Management Annual Report 2022-23**			
Agenda item:	**5.12**			
Sponsor:	**Paul Grundy – Medical Director**			
Authors:	**James Allen - Chief Pharmacist**			
Date:	**30 November 2023**			
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 outlined 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 and Trust Executive Committee 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 requested to acknowledge the report and continue to support the UHS Medicines Management 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 2.7 million prescriptions are written, and 7 million doses are administered each year.

1.3. There were 2,463 safety incidents involving medicines reported in 2022/23 of which 33% resulted in some level of harm. There have been fewer no-harm incidents reported when compared to 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 2022/23 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. The UHS Chief Pharmacist was elected to the National Acute Providers Pharmacy Collaborative, a forum to support national policy development and legislative change across secondary care organisations. In addition, several members of the department are supporting the National Aseptic Transformation Programme.

2.1.2. 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 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. These have been paused for 23-24 Q3 to allow time for implementing the learning and following good adoption of the change in *c.difficile* prescribing guidelines. In addition, the ward-based pharmacy teams continue to monitor and audit antimicrobial prescriptions monthly. This is expected to provide detailed prescribing data to further develop our antimicrobial stewardship strategy. The combined challenge of stewardship and delivering the COVID medicines and vaccine programme has now subsided, and the team is focusing more on antimicrobial stewardship. A significant focus of this work is leading the rollout of the timely intravenous to oral switch of antibiotics project, which has numerous benefits, including a reduction in length of stay, saving of nursing time, reductions in healthcare-associated infection and line-related adverse reactions.

2.1.3. UHS continues to be a national leader in transferring medicines-related information to patient's community pharmacies. The ward-based pharmacy team referred over 2,400 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.

2.1.4. Public health promotion in relation to smoking and alcohol advice continues to be provided on admission by the Medicines Management Team. 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). The development of UHS towards becoming a Smoke-Free Site has included members of the pharmacy team and pharmacists supporting the Tobacco Dependency Advisors on a daily basis by adding nicotine replacement therapy to the electronic prescribing system so that use can be documented and included on discharge paperwork.

2.1.5. 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 the pharmacy to improve its identification of shortages and the timeliness of escalations where necessary. Nevertheless, medication shortages remain an enormous and growing national issue for 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.

2.1.6. 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 the management or use of controlled drugs across the Trust or other organisations/agencies involved. All occurrence reports have been completed and submitted for 22/23 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 23.

Medicines Finance

2.1.7. In 2022/23, UHS expenditure on medicines was £180.1m. This is a 12% increase on the £161.5m in 2021/22, which reflects lower growth than observed in previous years. The key drivers for this increase remain similar to previous years and were:

- A £17.2 million increase in NHS England commissioned medicines. As per previous years, growth was concentrated in cancer care (+£6million), cystic fibrosis (+£4 million) and neurology (+£2.5 million) and can be attributed to newly commissioned therapies or the widening of eligible patient cohorts in these areas.
- Expenditure on Integrated care systems (ICSs) commissioned therapies has increased by +£3.9 million due to newly commissioned therapies and increased patient numbers.

Data from the national medicines data repository (Rx-Info) continues to place UHS just inside the top 25% of trusts for medicine spend. Given the range and depth of specialist services, this is to be expected and aligned with peer organisations of Cambridge (£167m), Bristol (£157m) and Nottingham (£184m).

2.1.8. At the end of 22-23 the established ICB block contract resulted in an accumulated financial cost pressure of £6.3 million. This was due to year-on-year growth in the use of newly commissioned biologics medicines that had not been captured in calculating the baseline. This growth has now stabilised, and with a further detailed review combined with new biosimilar opportunities, UHS is expecting to realise a saving compared to the block allocation in 23-24.

2.1.9. Throughout 22/23, 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 of which £918,268 was realised. These were achieved through homecare schemes and our focus on switching to new generic or biosimilar medicines. UHS Pharmacy continues to develop comprehensive models for identifying and reporting savings incorporating volume analysis and the new commissioning landscape. Over £1.3m of in-tariff or block medicine savings have been identified in 23-24. Work is underway to develop a more intuitive system for budget holders to support divisions in financial planning.

Workforce and Training

2.1.10. High-quality training and development remain a mainstay of the pharmacy department with a 100% success rate for trainees in 22/23. The pharmacy team continue to be commissioned by NHSE WTE 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.

2.1.11. Following significant recruitment challenges in previous years, the department is has operated with a level of vacancies which constrained the pharmacy service we aspire to offer and periodically impacts on the safety of our patients. This is particularly pertinent in our ward-based pharmacy teams. Through the latter stages of 22-23 and in the first half of 23-24 we are now seeing improvements 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, and efforts have been made to improve the experience and, therefore, support the retention of Trainee Pharmacists when they qualify. The recruitment status for pharmacy technicians and pharmacy support workers is where we see the largest recruitment challenges. Over 22-23 and into 23-24 this is beginning to improve, subsequently improving the department's operational resilience and our ability to safely manage medicines.

2.1.12. The number of non-medical prescribers (NMPs) within UHS continues to rise. Currently, 313 active/in-training NMPs are 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 can include prescribing. The new undergraduate pharmacy course includes prescribing, students graduating in 2026 will be qualified as independent prescribers.

Research & Development

2.1.13. The pharmacy team's clinical trial activity has now begun to recover, with 87 studies opened in 22-23, representing continued stability when compared to the 80 in 21-22. The team remains on track to deliver a similar number for 23-24 with over 42 studies already opened. The focus of improvement work has now shifted to the ongoing challenge of approving oncology and advanced therapy studies.

2.1.14. Advanced Therapeutic Medicinal Products (ATMP) workload has also begun to increase, with 3 additional studies opened in 22-23. 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 will likely 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.

2.1.15. Two pharmacy team members have successfully entered the UHS Research Leadership Program (RLP). In addition, we continue our collaborative arrangements with the University of Southampton with our Consultant Pharmacist for Critical Care awarded an Associate Professorship.

Medication Incidents

2.1.16. The number of medication incidents reported this year decreased slightly by 36 to 2463. This reduction in reporting has been seen across all incident types. The proportion of incidents resulting in harm has increased due to a reduction in reports relating to no harm. The medicines safety team review all incidents and provides learning on a weekly basis via Workplace.

2.1.17. Demand for the patient Medicines Helpline remains high at around 150 calls per month during 2022/23. 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 and 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. The Helpline is now advertised and contactable via My Medical Record, enabling rapid access to medication-related advice via this patient portal.

2.1.18. 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

2.1.19. A new national assessment framework for unlicensed aseptic units came into force in March 2023 (iQAPPs). This system focuses on monthly unit-submitted quality assurance reports alongside the established inspection schedule. The framework places greater emphasis on continued timely evidence of safety rather than the historical intermittent inspection schedule. A similarly timed update to the legal and governance framework associated with unlicensed aseptic units provides commissioners and Regional Quality Assurance (QA) with greater powers to enforce

the closure of units felt to be operating outside safe limits, including those working above their established operating capacity. All units within UHS have submitted the required information with no concerns highlighted by the regional QA team.

2.1.20. The operational performance of the oncology pharmacy unit has continued to improve, leading to the removal of the unit from the Cancer Care risk register. The key oversight metrics are referenced below.

Category	Oct-21	Mar-22	Sep-23
Prepared in advance	21.5%	34.2%	40.6%
Not delayed	12.1%	28.4%	45.7%
0 - 1 hr delay	40.4%	29.7%	11.7%
1 - 2 hrs delay	18.5%	6.1%	1.0%
2 - 3 hrs delay	5.6%	0.9%	0.6%
3 - 4 hrs delay	1.3%	0.3%	0.1%
Over 4hrs delay	0.6%	0.4%	0.2%
Item Total	2107	2184	2197

Primarily, this has resulted from significant recruitment efforts and collaboration with cancer care to enable a greater proportion of products to be prepared in advance. The ability to utilise pre-prepared products will be critical to the utilisation of Adanac Park and remains a consistent workstream with Cancer Care.

2.1.21. The pharmacy oncology aseptic unit (Platinum House) has undergone all the remedial estate design work required by the Quality Assurance inspection in 2022. A repeat inspection occurred in Nov 2023, recognised the significant operational improvement, and accepted those works. The unit has been assessed and rated as in the lowest risk category on the new national iQAPPs inspection framework.

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. Patient numbers have increased to 7300 in 22-23. The pharmacy homecare and clinical pharmacy teams received additional critical investment at the start of 23-24 to ensure we can meet the demands and quality requirements of the organisation. This investment has been critical to support the appropriate oversight of homecare services, many of which have faced significant operational challenges over the course of the last 12 months.

2.1.23. The UHS pharmacy department and leadership team have continued to work with UPL to support their service during periods of pressure, most notably during their recent capital expansion and robot works. Assurance regarding previous medication error rates and patient experience remains in place with formal reporting mechanisms into the Quality Safety and Governance Group (QGSG) in place to continue our oversight and divisional assurance.

Medicines Policy & Governance

2.1.24. The UHS pharmacy team have developed and continued to lead on the amalgamated Hampshire and Isle of Wight ICS medicines formulary. The development of one key formulary across the ICS is expected to significantly improve the transition of patients at interfaces of care and reduce duplication of effort in appraising the addition of new medicines.

2.1.25. The UHS Drugs Committee met monthly throughout 22/23, 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 55 policies and procedures/clinical guidelines

2.1.26. 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 instruction from a prescriber. The pharmacy team have worked hard to significantly reduce the number of expired PGDs 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 utilising technology to streamline the overall PGD process. The PGD committee has:

- reviewed and approved 30 PGDs
- reviewed and approved 2 occupational health work instructions for staff vaccination
- removed a further 22 unnecessary PGDs from use

2.1.27. 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, operational, ethical, and financial risks. The Drugs Committee continues to provide governance and oversight to these schemes using newly updated policy guidance based on national guidance released in Aug 2023. These schemes remain essential to patient care as a major teaching hospital with regional specialities. An expansion in the number of individual requests for compassionate use was observed in 22/23, with the Drugs Committee reviewing 21 schemes for their suitability for use in UHS.

2.1.28. Individual Funding Requests (IFRs) are requests for medicines in patients that are not commissioned. In 22-23, applications remain reduced 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 22-23 is below:

	Total Last year in parentheses	ICB	NHSE
Submitted	17 (16)	12	6
Approved	12 (11)	12	3

During 22-23 three rejected cases were considered by the UHS IFR panel comprising of the requesting clinician, the Chief Pharmacist and the Medical Director. These cases were all approved on the basis of clinical need at a total cost of £60.2k to UHS.

Digital

2.1.29. 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. A pilot of the next phase regarding our Central Intravenous Additives Service (CIVAS) in also underway. Work to progress the external funding for Medcura is paused while the team concentrates on the capital programme for Adanac Park. The Pathfinder sites are not yet in a position to

consider their digital infrastructure, and so it is expected there will be an opportunity to revisit this nationally recognised system once the hub has become operational.

2.1.30. 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 implementing the system to improve governance, data integrity and record-keeping across the rest of the pharmacy department.

2.1.31. Drug chart view (view-only version of the JAC EPMA system) has undergone an extensive rewrite with a new and improved user interface and clinical safety profile. The new version has been approved, and released in October 2023.

2.1.32. Triscribe, our data warehouse project, continues to offer various data warehouse opportunities for UHS. Development work continues in areas such as anticholinergic burden, Parkinson's medicines, pharmacy on-call utility, stock shortages, order tracking and medicines savings. The partnership has the potential to generate collaborative commercial arrangements.

2.1.33. The replacement program for the original EPMA project drug trolleys has replaced 69 out of the 129 in use. There is an ongoing risk with the outstanding original trolleys (60), with urgent replacement required due to failures to meet medicine storage requirements (19) and electrical components required to use any computer equipment for administering medicines (7). Continual identification of funding resources is being overseen by the Digital Medicine Optimisation group.

2.1.34. A new App (TTO Pick up) has been developed with UHS Digital, to support the medicine discharge process and increase efficiencies and patient flow. The dashboard allows the ward teams to request discharge document review via the whiteboard and Pharmacy to identify staff processing the order and the order status. The system also requests the discharge status on the whiteboard to be updated, which gives more accurate data to the Hospital Site Team and the Service Improvement Team.

Integrated Care Board and Regional Medicines Optimisation

2.1.35. The UHS Chief Pharmacist co-chairs the HIOW ICS 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.

2.1.36. The formation of the ICB has led to the amalgamation of the medicines management processes across HIOW. The newly formed Area Prescribing Committee has been in function throughout 22-23 with representation provided by the Chief Pharmacist. Sub-committees covering high-cost drugs, medication risk, shared care and guideline development are now well established. These committees are expected to reduce duplication of effort, reduce inequity of medicine provision and support block finance arrangements across the system.

2.1.37. The planned development of an offsite aseptic unit at Adanac Park remains on track for commissioning in March 2025. The design of the unit and equipment schedules have been finalised and the outline shell of the unit looks likely to completed in Jan 24. 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 supra-regional unit and provide much-needed aseptic resilience to the local and neighbouring systems.

2.1.38. The UHS Digital Pharmacy team are now integrated with PUH and IOW to ensure we realise the benefits of a shared EPMA system across the ICS. Continual cross-site collaboration supports projects like the EPMA upgrade and OpenEyes system deployment by reducing the duplication of validation and system build work.

2.2. Key areas requiring action/improvement

Medicines Policy & Governance

2.2.1. The overarching medicines policies for UHS (storage, prescribing and controlled drugs) now need updating and refreshing to take new legislation and developments in practice. Work has already begun to engage with key stakeholders in these policies, including training and education teams, to deliver a refresh that provides appropriate safeguards while supporting the development of new roles. A key objective of this update is to make the policies more readily accessible to support staff across the organisation.

2.2.2. The recent high-profile media events relating to the misappropriation of medicines have brought access to medicines and safe storage into sharp focus. The pharmacy team routinely collect information about unlocked cupboards and medicines that are not stored securely for each ward that receives a pharmacy-led stock top-up. Ward leaders use this information as part of the accreditation process. The data will soon be available across UHS on our digital platform, Triscribe.

2.2.3. In March 2023, NHSE published guidance on minimising time-weighted exposure to nitrous oxide in healthcare settings. At that time, work to assess and mitigate exposure to maternity staff was already underway. A formal programme of works, including an assessment of other areas that use nitrous oxide, is being led and developed by the Medical Gasses Committee.

Digital

2.2.4. An upgrade to the pharmacy stock control and ward-based e-prescribing system (JAC/CareFlow Medicine Management) remains outstanding. Validation has been completed, but a critical clinical issue has been identified, and a resolution from System-C is outstanding, which has delayed the ability to deploy the upgrade.

At present, these delays are prohibiting progress with other strategic projects, including:

- Regional procurement hub
- Closed loop supply (Omnicell cabinets on AMU) ePrescribing interface
- Additional Outpatient Deployment

2.2.5. The uptake and utilisation of electronic prescribing in outpatients remains low (13,500 prescriptions in the last 6 months). Additional work with System-C is required to improve the prescriber experience and realise the potential benefits.

2.2.6. The regional chemotherapy and prescribing system (Aria) must be updated within the next 6 months to ensure continuity of service provision from the vendor and system stability. The system remains unstable due to the ageing system version and server architecture. An upgrade case and implementation plan is being led by the regional host (PUH) supported by a regional steering group.

2.2.7. The medication transfer between IT systems remains a risk when patients move between clinical areas that have JAC/CareFlow Medicine Management and MetaVision ePrescribing systems. 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. HHFT have been in a

development project with System-C and are looking to validate the system and process flow by March 2024, which could allow UHS to deploy the same system and mitigate our current risk.

2.2.8. A variety of different drug libraries are used across different electronic systems in UHS. To achieve complete interoperability and comply with DAPB 4013, each drug and allergy library requires review and amendment in line with international SNOMED standards, i.e. DM+D. When assessed, the primary drug database in UHS (JAC/CareFlow MM) continues to have a high (>98%) level of conformity with DM+D, however this is not being achieved in other systems. All current or new drug libraries are being developed to ensure compliance and readiness for connection to GPConnect which will enable a link between our prescribing systems and GP prescribing systems.

2.2.9. Three Omnicell cabinets have been implemented as standalone systems since Nov 20. However, we have yet to implement the full link between our ePrescribing system and the cabinets, limiting several of the expected benefits of the cabinets. The link will be available after the planned upgrade of the JAC/CareFlow MM System and further work on usage and management of the cabinets will support the delivery of expected benefits.

Operational and Infrastructure

2.2.10. Progress in implementing the regional medicines procurement hub has stalled, pending the availability of the digital architecture. It has been confirmed that this will not be available until March 2024. This project was the primary mitigation for the ageing pharmacy logistics robot. A replacement robot is now required, and work is underway with procurement and estates to take this forward.

2.2.11. 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 continue to work 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.

2.2.12. 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 the pharmacy to deliver a solution for UHS.

Research & Development

2.2.13. 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 the Research and Development Steering Group (RDSG) and Cancer Board. As we enter 2024, the primary actions (recruitment and training) had started to realise improvements however, recent significant operational challenges linked to our radiopharmacy have led to fewer studies being approved and this is expected to continue until Jan 2024. There remains a significant level of fragility in this area due to the ongoing national shortages of trained oncology and aseptic specialist pharmacists.

Workforce and Development

2.2.14. The Pharmacy workforce strategy needs to be updated in light of the NHS Long-Term Workforce Plan and in light of the aforementioned areas of fragility in service

provision. This plan has been deferred to ensure that it can be approached from an integrated system perspective and to cover critical changes in pharmacy training and education. The most notable change is that all pharmacists will graduate as prescribers in 2026. The UHS pharmacy team expect to play a significant role as a training centre over the coming years, both for prescribing practitioners and in regard to the regional aseptic workforce.

Sustainability and UHS Green Plan

2.2.15. Several important areas linked to sustainability have seen improvements in 22-23. Work to reduce the usage of the anaesthetic gas desflurane continues to be successful, and there are active projects underway linked to the reduction of Nitrous Oxide usage. However, UHS remains an outlier in the proportion of metered dose inhalers issued compared to the more sustainable varieties. The pharmacy team are actively working toward the actions contained within the Royal Pharmaceutical Society's (RPS) Greener Pharmacy Guide (published Sept 23) and will report these programmes of work to the Sustainability Board alongside developing any new initiatives as 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 2023/24 Medicines Management Report.

4. Recommendation

4.0 The Trust Executive Committee and Trust Board are 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 2022/23

	Action	Outcome	Additional information
1	Extend implementation of Medcura within UHS to fully realise safety benefits and provide evidence for national adoption	Complete	Full deployment of Medura across UHS sites has been completed
2	Ensure the new aseptic unit based at Adanac Park delivers on the organisation's investment and strategic requirements	Complete	• The design of the unit is complete with input from estates and specialist cleanroom manufacturers. • Additional expertise regarding MHRA licensing requirements has been secured. • Submission for funding to National Aseptic Review (Oct 22) – completed and pathfinder funding (£6.4m) approved • Workforce plan and associated timelines completed.
3	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.
4	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
5	Submit Medcura for national consideration as part of the newly formed National Aseptic Review panel	Paused	The five pathfinder sites are not at a stage to consider their aseptic preparative management systems. The UHS Pharmacy team plan to concentrate on the build and the MHRA validation of the Adanac Hub with a view to developing Medcura once the unit is operational.
6	Transition the UHS medicines procurement and distribution service to the Solent Acute Alliance hub	Paused until March 24	Validation of the JAC system upgrade required for all these projects was completed in August 23 and then further testing for newer (patched) version was completed in Oct 23. This work highlighted several critical issues that have delayed deployment. Confirmation from the vendor leadership team that these issues are not planned to be rectified until March 2024.
7	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 regarding the system usability.		
8	Electronic outpatient prescribing – objectively increase the proportion of outpatients prescribed digitally from baseline (10%).		

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	Timeline	Lead
1	20/21	Develop the nurse discharge checklist for paediatric areas & work with nurse leaders to improve utilisation in adult ward areas.	Local audit evidence confirms that ward areas using the checklist have reduced discharge error rates and that it reduces 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 the full benefits of the checklist across adult ward areas.		Q1 24-25	Nicola Howarth - Deputy Chief Pharmacist
2	21/22	Ensure the new aseptic unit based at Adanac Park delivers on the organisation's investment and strategic requirements	• Ongoing discussions are occurring at ICS and South East/South West regional level regarding the commercial and capacity plan. • An oversight and delivery group will be created with regular reporting requirements to NHSE and UHS Executive Committees.		Q4 24-25	Chief Pharmacist – James Allen & Deputy Chief Pharmacist – Mark Pepperrell
3	21/22	Update the pharmacy workforce strategy in light of the new NHS Long-Term Workforce 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 complete in preparation for Adanac aseptics		Q3 23-24	Chief Pharmacist – James Allen

	Identified	Actions	Progress / Update	RAG Status	Timeline	Lead
4	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 reduce desflurane from UHS have been completed. Newly updated guidance on sustainable medicines was published in Sept 2023 and will form the basis of the planning programme.		Q3 23-24	Chief Pharmacist – James Allen
5	22/23	Upgrade the regional electronic chemotherapy prescribing (Aria) to ensure to ensure ongoing stability for chemotherapy provision and cancer scheduling	Regional upgrade optional appraisal has been developed by PUH and shared with key stakeholders across the system. The vendor (Varian) is supporting the upgrade planning process.		Q4 23-24	Chief Pharmacist – James Allen
6	New - 23/24	Develop and deliver an action plan to reduce Nitrous Oxide exposure to staff	Initial actions post maternity audit underway led by the Medical Gases Committee in collaboration with estates and occupational health. Work to assess the risks across the wider trust footprint is also underway		Q4 23-24	Deputy Chief Pharmacist - Andy Fox
7	New - 23/24	Refresh Medicines Management policies and safe storage audit programme. Ensure these are aligned with the relevant CQC and regulatory frameworks and include formal reporting arrangements within the organisation	Extensive assessment of areas that require update has been undertaken in conjunction with stakeholders.		Q4 23-24	Chief Pharmacist – James Allen

Report to the Trust Board of Directors				
Title:	**Infection Prevention and Control 2023-24 Quarter 2 Report**			
Agenda item:	**5.13**			
Sponsor:	**Gail Byrne, Chief Nursing Officer/Director of Infection Prevention & Control**			
Author:	**Julie Brooks, Consultant Nurse Infection Prevention & Control and Deputy Director of Infection Prevention & Control** **Dr Julian Sutton, Lead Hospital Infection Control Doctor**			
Date:	**30 November 2023**			
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 2023/24 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	Performance in Q2 2023/24 in relation to HCAIs has again been challenging with target thresholds in a number of HCAI indicators and antimicrobial usage exceeded for the quarter. Improvements are required to ensure that fundamental standards of infection prevention and control practice and prudent antimicrobial prescribing are consistently applied by all staff to reduce risk of transmission of infection and antimicrobial resistance. Members of Trust Board are asked to: 1. Review the report and the identified actions detailed in each section and ensure these are addressed via the Divisional Governance processes, with relevant teams and staff groups. 2. Support the proposed actions/ measures to facilitate improvements in practice relating to reduction of C.difficile and Gram-negative bloodstream infections and measures to improve standards of infection prevention & control practice, including hand hygiene and cleanliness of equipment. 3. Note the significant ongoing outbreak of *Candida auris* on D4 vascular ward and the concerns relating to the ward environment impacting on the ability to prevent and control infection.			

1.Introduction

Category		Q2	Annual Limit	Action /Comment
National Thresholds (as set by NHSE)	MRSA bacteraemia (Threshold = 0)	G	G	0 MRSA BSI attributable to UHS in Q2 2023/24 (0 cases YTD)
	Clostridioides difficile infection (Threshold = 60)	R	A	33 cases in Q2 2023-24 against an internal limit of 15. (60 cases YTD).
	E coli Bacteraemia (Threshold = 120)	R	G	31 cases in Q2 2023/24 against an internal limit of 30 (71 cases YTD)
	Klebsiella Bacteraemia (Threshold = 56)	R	G	16 cases in Q2 2023/24 against an internal limit of 14 (30 cases YTD)
	Pseudomonas Bacteraemia (Threshold = 33)	G	G	5 cases in Q2 2023/24 against an internal limit of 9 (12 cases YTD)
Other	MSSA			13 cases in Q2 2023/24 (26 cases YTD)
	VRE			3 cases in Q2 2023/24 (5 cases YTD)
Antimicrobial Stewardship	Prudent antibiotic prescribing	R	G	NHS standard contract requires a reduction in the use of broad-spectrum antibiotic usage of 10% for 2023/24 (against a 2017 baseline)
Provide assurance of basic infection prevention practice:	Assurance of Infection Prevention Practice Standards	A	G	Analysis of Q1&2 IP&C audits show 52% of areas are currently not meeting requirements needed to achieve full accreditation at year end in March 2024

2. Analysis

2.1 Healthcare Associated Infection

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

MRSA Bloodstream infection (MRSA BSI)

0 Healthcare Associated MRSA BSI attributed to UHS in Q2 2023/24 & 0 cases year to date.

Reporting trusts are now asked to provide information relating to prior healthcare exposure -whether patients had been admitted to the reporting trust within one month prior to the onset of the current case. This allows a greater granulation of the healthcare association of cases. Cases are split into one of five groups:

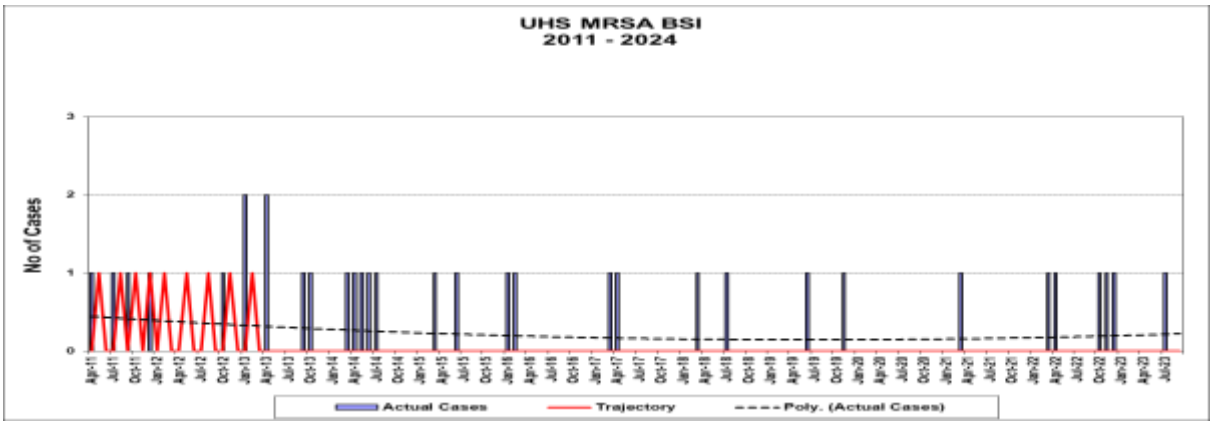
**Hospital-onset, healthcare associated (HOHA) - Specimen date is ≥3 days after the current admission date (where day of admission is day 1)*

**Community-onset healthcare-associated (COHA) - Is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)*

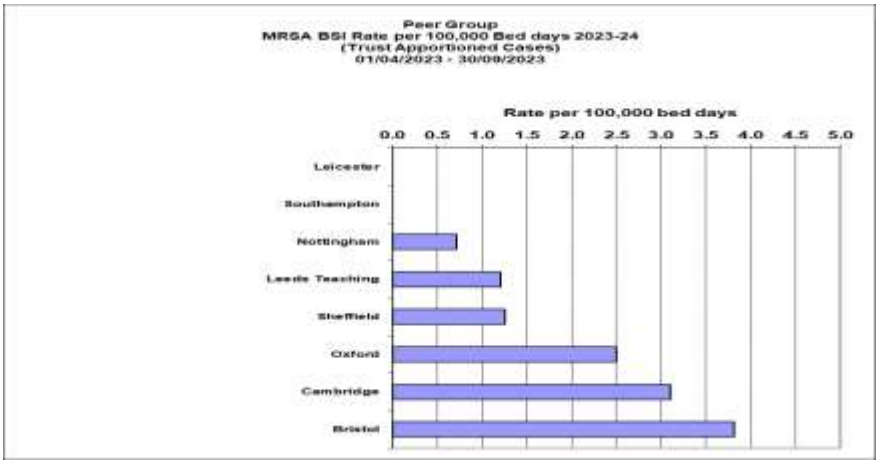
**Community-onset, community associated (COCA) - Is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 28 days prior to the specimen date (where day 1 is the specimen date)*

** Unknown - The reporting trust answered "Don't know" to the question regarding previous discharge in the month prior to the MRSA case.*

** No information - The reporting trust did not provide any answer for questions on prior admission.*



UHS has an attributable MRSA BSI rate of 0 cases/100,000 bed days and ranks equal first of 8 self-selected peer hospitals. Top quartile, median and lower quartile marker rates are 0.0, 0.8 and 1.5 cases/100,000 bed days.



Clostridioides difficile (C.difficile)

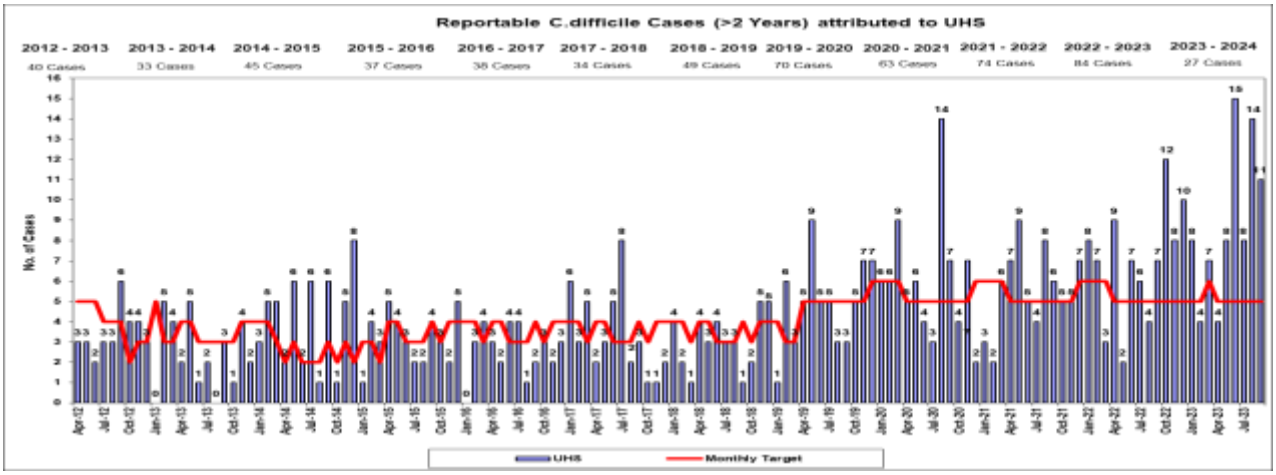
Trusts are required under the NHS Standard Contract 2023/24 to minimise rates of C. difficile so that they are no higher than the threshold levels set by NHS England and Improvement (NHSEI). Trust-level thresholds comprise total healthcare-associated cases i.e. Hospital-onset healthcare associated (HOHA) and Community-onset healthcare associated (COHA). UHS have been set a national performance threshold of 60 cases for 2023/24.

2023/24 progress:
33 cases in Q2 2023/24. 60 cases year to date (Q1 & Q2) against a nationally set annual threshold of 60.

Q2 cases:

- 25 Hospital Onset – Healthcare associated (HOHA)
- 8 Community Onset – Healthcare associated (COHA)

2023/24	July	August	September	Total
HOHA	5	11	9	**25**
COHA	3	3	2	**8**



The increased incidence in C. difficile cases continues to be reported both nationally and locally across the Hampshire and Isle of Wight integrated care system (HIOW ICS). Reasons for this ongoing national trend are still not fully understood but are undoubtedly multifactorial. The increased trend continues to be reflected in UHS case numbers with 33 cases reported in Q2 2023/24 compared to 17 cases in the same period in 2022/23 (52% increase).

An enhanced focus on reducing C.difficile is in place at national, regional and system level. Within UHS a C.difficile improvement plan has been developed with 4 key areas of focus (see Appendix 1 for detail). Delivery of this plan is overseen by the Infection Prevention Committee. As part of this plan, a new review process has enabled timely identification of learning, actions and interventions. Findings and learning from case reviews undertaken in Q2 have remained similar to those identified in Q1.

<u>Key themes and learning from C.difficile Infection (CDI) case reviews undertaken July – September 2023</u>
34 concise reviews were completed (33 cases reportable and 1 case not reportable as considered ongoing colonisation not infection).

- The majority of patients had one or more risk factors for developing C. difficile diarrhoea including prior or current exposure to antibiotics or other high-risk medications, comorbidities, advanced age, impaired immune status.
- All patients had received antibiotics prior to developing CDI, 32 of which had received broad spectrum antibiotics. Whilst in most cases prescribing was appropriate and in line with UHS prescribing guidelines, for a small number of cases indication for antibiotic treatment was not clear (9%) and choice of antibiotics (6%) was not in line with UHS guidelines.
- A proportion of cases (29%) were linked to a period of increased incidence (PII) on a ward indicating potential exposure, acquisition / transmission on the ward.

83 C. difficile IP&C Practice reviews were undertaken with key themes identified as:

- Isolation risk assessments 42% not completed.

- Commodes (31%) were found to be visibly soiled with body fluids including faeces.
- Incorrect isolation sign on patient isolation room (19%) – a green isolation sign should be displayed when a patient has infective diarrhoea, including C. difficile, indicating that hand hygiene must be undertaken with soap and water.
- 16% of patients with suspected infectious diarrhoea not isolated with 2 hours from onset of loose stools.
- Incorrect cleaning products used in 13% of cases for cleaning of equipment being used on patients in isolation with confirmed or suspected infectious diarrhoea/C.difficile.

Actions and interventions to support improvements in practice and improved outcomes for patients have continued in Q2 and have included:

- Ongoing focus on appropriate antibiotic prescribing with documented indication, duration, and review.
- Actions to improve infection prevention and control practice and cleaning standards, including cleanliness of commodes.
- IPT ward rounds which include a focus on isolation care, equipment cleanliness.
- Ensuring appropriate treatment of CDI cases and reducing risk of relapse.
- Commencement of the national point prevalence survey (PPS) for healthcare associated infection and antimicrobial use which will provide further data on antimicrobial prescribing practices across the Trust.

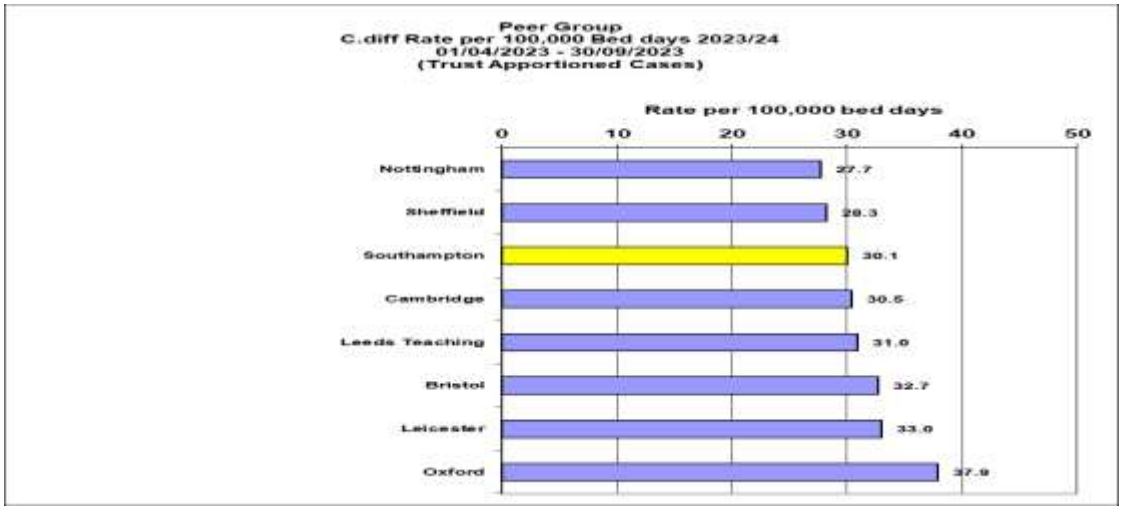
Whilst good progress has been made in the delivery of actions within the C. difficile improvement plan in Q2, further enhanced focus will be undertaken in Q3 specifically relating to:

1. Antimicrobial stewardship and application of the principles of prudent antimicrobial prescribing – including completion of the national PPS and initial analysis of antimicrobial use to identify areas for improvement; education/awareness during World Antimicrobial Awareness week.
2. Cleanliness standards, particularly cleanliness of commodes
3. Improving IP&C practices including standards of isolation care.

Focused actions continue to be taken at a system level within HIOW ICB including focus on antimicrobial prescribing practice, use of PPI's, education and awareness within health and social care settings.

During Q2 2023/24 an outbreak of C.difficile was declared on 1 ward within UHS, involving 4 patients, with an additional 6 wards having periods of increased incidence (PII) declared (due to having two or more new cases of C. difficile on the ward in a 28 day period). As per the agreed PII process actions were implemented in response which included enhanced cleaning of the whole ward with Sochlor/Actichlor plus; increased activity on the ward by the IPT (including a formal weekly review of the ward/observations of practice) review of isolation procedures; request for review of antibiotic usage; enhanced communications with all parties and staff. In a ward outbreak and in PIIs, the C. difficile isolates undergo strain typing (ribotyping) at the national reference laboratory.

UHS ranks third out of 8 self-selected peer acute trusts, with a rate of 30.1 cases/ 100,000 bed days. Comparative data needs careful interpretation because of differences in test selection, methodology and reporting criteria between trusts.



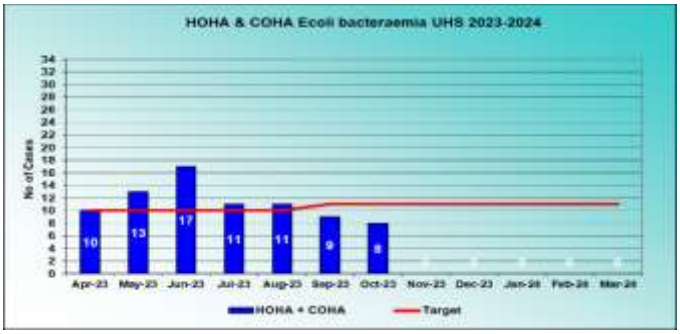
Healthcare Associated Bloodstream infection (excluding MRSA)

Trusts are required under the NHS Standard Contract 2023/24 to minimise rates of Gram-negative bloodstream infections (BSI) so that they are no higher than the threshold levels set by NHS England and Improvement. 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 &Q2 2023-24	2022-23	2021-22	2020-21
E coli	71	154 (127)	138 (151)	67
Klebsiella	30	51 (73)	64 (64)	40
Pseudomonas	12	35 (36)	30 (34)	13
MSSA	26	45	43	36
VRE	5	4	9	7

(Annual National thresholds in brackets)

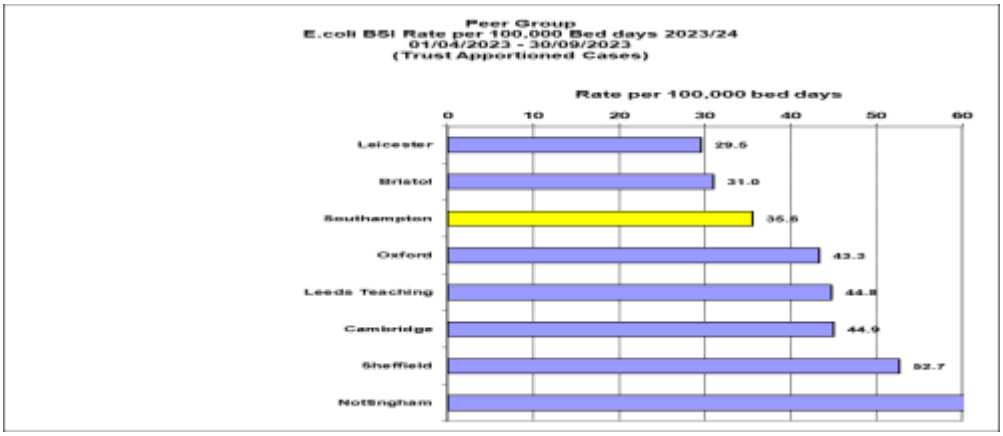
E coli BSI: 71 cases year to date (Q1 & Q2) against a nationally set annual threshold of 120 cases for the year.



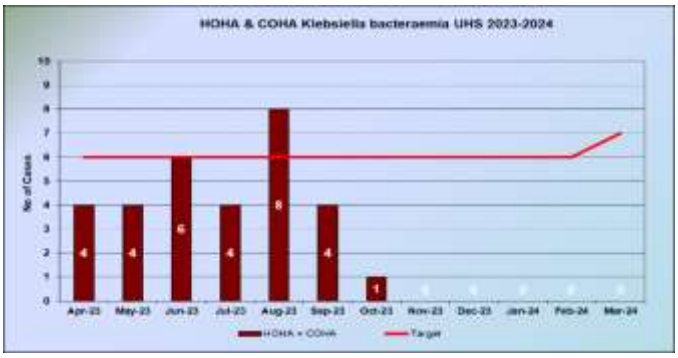
Q2 Progress:
31 cases

- 11 Community Onset – Healthcare Associated (COHA)
- 20 Hospital Onset – Healthcare Associated (HOHA)

13 concise case reviews undertaken.



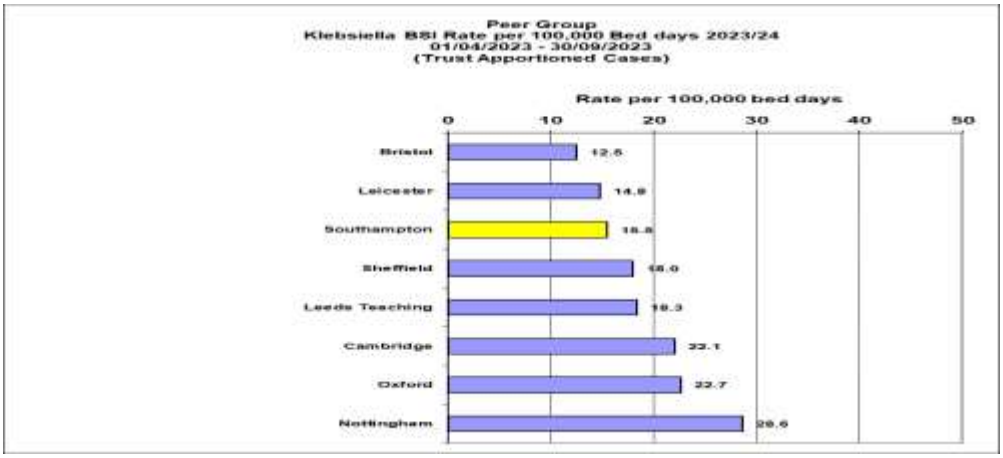
Klebsiella BSI: 30 cases year to date (Q1 & Q2) against a nationally set annual threshold of 56 Cases for the year.



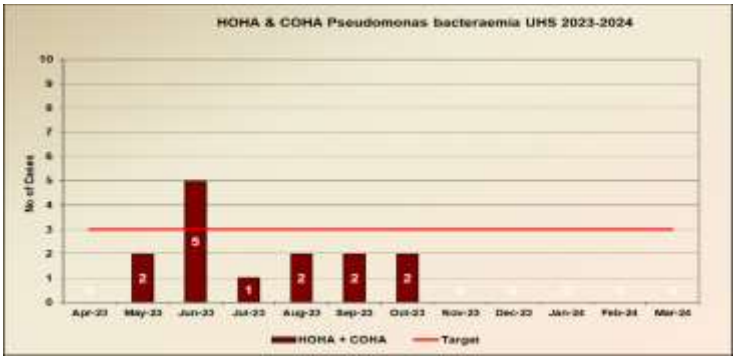
Q2 Progress
16 cases:

- 5 Community Onset – Healthcare Associated (COHA)
- 11 Hospital Onset – Healthcare Associated (HOHA)

6 concise case reviews undertaken.



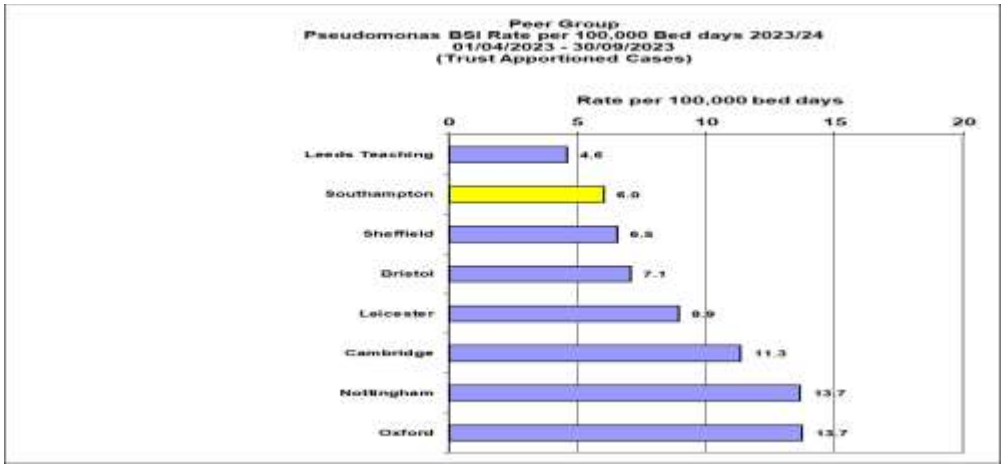
Pseudomonas Bacteraemia: 12 cases year to date (Q1 & Q2) against a nationally set annual threshold of 33 cases for the year.



Q2 Progress:
5 cases:

- 2 Community Onset – Healthcare Associated (COHA)
- 3 Hospital Onset – Healthcare Associated (HOHA)

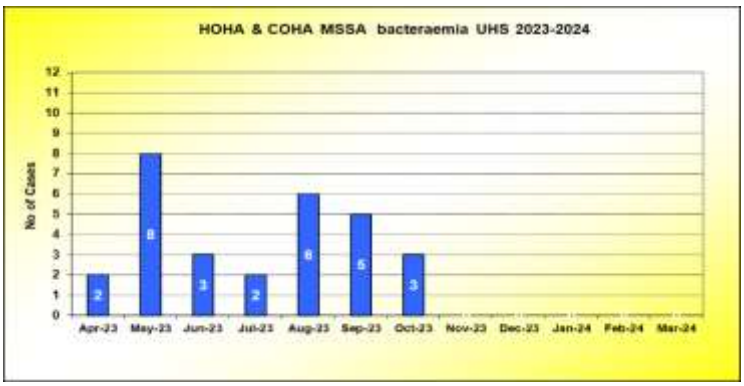
0 concise case reviews undertaken.



MSSA Bacteraemia

26 cases year to date

No nationally set threshold level but ongoing focus to minimise MSSA bloodstream infections.



Q2 Progress:
13 cases:

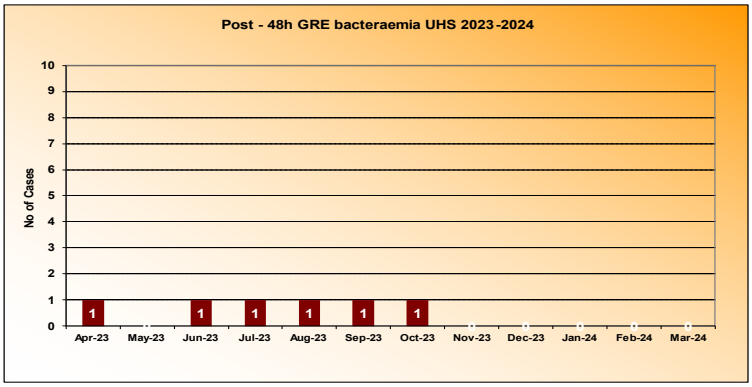
- 4 Community Onset – Healthcare Associated (COHA)
- 9 Hospital Onset – Healthcare Associated (HOHA)

4 concise case reviews undertaken.

VRE Bacteraemia

6 cases year to date

No nationally set threshold level but ongoing focus to minimise VRE bloodstream infections.



Q2 Progress:

3 cases:

- 0 Community Onset – Healthcare Associated (COHA)
- 3 Hospital Onset – Healthcare Associated (HOHA)

2 concise case reviews undertaken.

Summary of case reviews

A total of 68 cases of healthcare associated BSI (gram negative, MSSA & VRE) were reviewed in Q2. The likely source of infection was determined as:

Intravascular Device (Including pacemaker / peripheral or central venous access device)	16% (n=11)
Lower urinary tract (no catheter)	14% (n=10)
Lower urinary tract (urinary catheter associated)	13% (n=9)
Lower Respiratory Tract (pneumonia, VAP, bronchiectasis, exac COPD etc)	12% (n=8)
Unknown	10% (n-7)
Gastrointestinal/intrabdominal collection (excluding hepatobiliary)	10% (n=7)
Skin or soft tissue (including ulcers, cellulitis, diabetic foot infection without osteomyelitis)	9% (n=6)
Hepatobiliary	6% (n=4)
Bone and Joint (no prosthetic material)	3% (n=2)
Upper Respiratory Tract and ENT	1% (n=1)
Lower Respiratory Tract (NOT Ventilated)	1% (n=1)
Cardiovascular or Vascular (with prosthetic material e.g. EVAR, stent, valve, prosthetic fistula)	1% (n=1)
Unclear source.	2% (n=2)

For cases that were deemed as likely to be associated with indwelling urinary catheters, intravascular devices, ventilator associated pneumonia or surgical site infection, a concise case review and IP&C practice review was undertaken by the IPT. Findings and learning from case reviews undertaken in Q2 remained similar to those identified in Q1.

25 concise case reviews were undertaken in Q2. Key themes/learning from reviews:

- Intravenous device (IV) insertion and ongoing care-gaps in documentation and assurance regarding daily review and care.
- Urinary catheter insertion and ongoing care- gaps in documentation/assurance regarding daily review and care including ongoing requirement for the catheter; no planned dates/criteria for removal of the catheter potentially resulting in catheters staying in longer than necessary.
- Hand hygiene practices not meeting expected standards.
- Gaps in documentation / assurance relating to preventing surgical site infection (pre and post operative care).

An improvement plan to reduce healthcare associated BSI has been developed for 2023/24 (Appendix 2). Actions and interventions to support improvements in practice have continued in Q2 including:

1. Continued focus on reducing risk of catheter associated UTI (CAUTI) through management of urinary catheters, avoiding unnecessary catheterisation and appropriate early removal of catheters
    - Ongoing project work in T&O to reduce the duration of catheterisation & development of a flowchart for the early removal of catheters with pilot of a nurse led TWOC protocol.
2. Improving IV device care and management
    - Ongoing quality improvement project to reduce the length of time that IV devices are in place.
    - Ongoing education and awareness activities related to hand hygiene, principles of aseptic non-touch technique and the insertion and management of invasive devices.
3. Ongoing development and implementation of UHS Fundamental Care standards e.g. nutrition & hydration, mouth care, promoting mobility, maintaining skin integrity, bladder and bowel care, personal hygiene., led by the Deputy Chief Nurse.
4. IPT ward rounds with a focus on invasive device care and management.

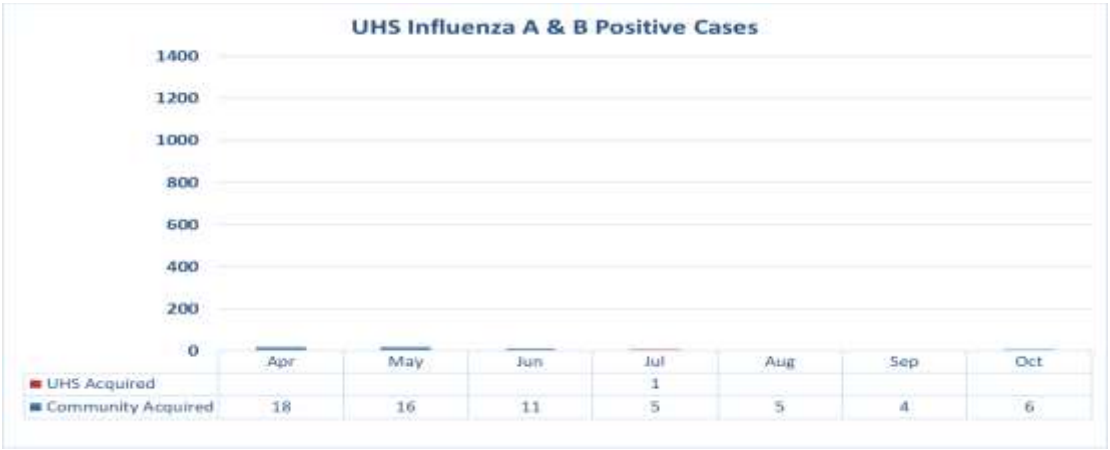
Whilst progress is being made in the delivery of actions within the BSI improvement plan in Q2, enhanced focus is required in Q3 specifically relating to:

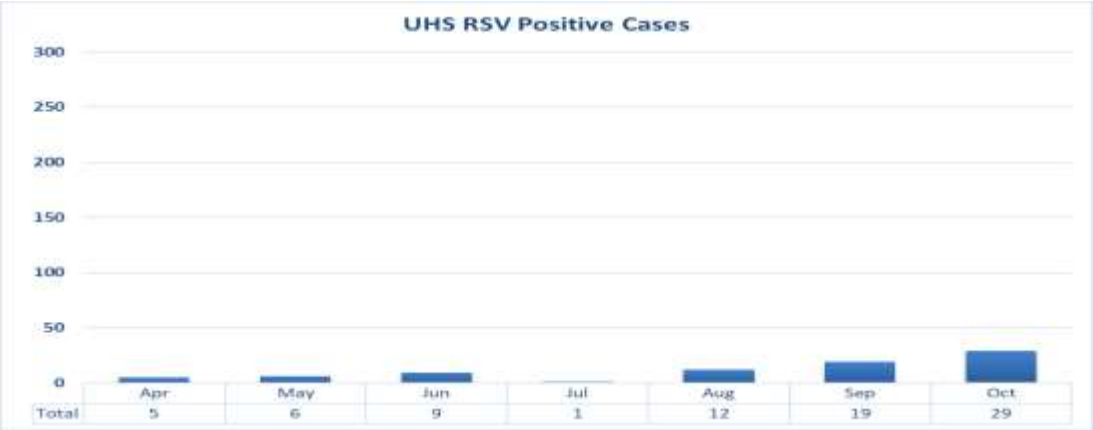
- Documentation of invasive device care and management, including review of the forms on the electronic Inpatient Noting system.
- Improving hand hygiene practices.

2.2 Respiratory Viruses

Influenza & RSV

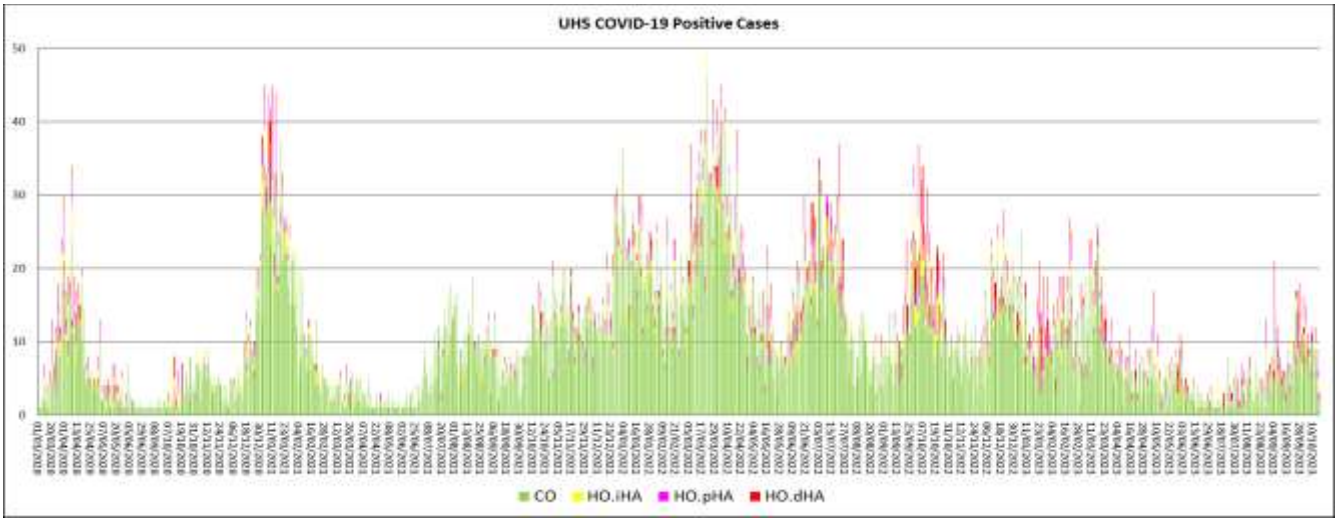
Prevalence of influenza and RSV remained low in Q2 with one hospital acquired influenza case and no reported outbreaks.





COVID-19

Prevalence of COVID-19 has fluctuated during Q2. Increasing case numbers seen within UHS in September were associated with an increasing prevalence in the community, in-hospital transmission and outbreaks occurring.



Cases identified in UHS: July 2023 to September 2023

	Community Onset (CO)	Indeterminate (HO.iHA)	Probable (HO.pHA)	Definite (HO.dHA)
Q2	342	35	48	63

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.*

A number of measures remain in place to support early identification of cases and reduce risk of in-hospital transmission, including testing of patients with symptoms and quarantining of patients exposed to a positive case

At the end of Q1, due to a significant reduction in national funding for COVID-19 testing, COVID-19/respiratory point-of-care testing (POCT) in AMU and AOS was replaced by rapid in-lab tests carried out in the Microbiology/Virology laboratory, with results available around one hour from sample receipt in the laboratory. The overall real-world turnaround time (TAT) for a result being available for these urgent respiratory swab samples from ED/AMU and AOS is now 2-4 hours. This is due to the use of the pneumatic pod system for delivery of samples from these areas to level D Pathology specimen reception. There is subsequent regular (scheduled every 30 minutes) manual collection of samples by Microbiology/Virology lab staff on level B, from specimen reception, two floors above.

Currently the Trust does not have a formal process to monitor and record the operational impact of the longer time to result for these respiratory virus tests. However, it is self-evident that the consequences on individual patient flow are either an increased time spent in the emergency assessment area awaiting the results, or patients move and are placed in the downstream area before their respiratory virus status in known.

During last year's winter flu surge, ~1,000 patients were diagnosed with Influenza via the ED/AMU POC testing in a six-week period. As we expect an increase in community prevalence of respiratory viruses this winter, the overall increase in the time to result will not only increase wait time in the emergency assessment area or increase risk of nosocomial transmission in downstream wards but will also impact on timely decisions to discharge non-frail/elderly patients at the front door whose presentation is explained by a confirmed respiratory virus infection that does not require inpatient management. Any measures that decrease overall time to result in the in-lab respiratory virus diagnostic pathway will impact positively on emergency admissions patient flow and reduce the risk of nosocomial transmission. This means swabbing the patient at the earliest opportunity in the admissions pathway and optimising time to delivery from the admission area to the Microbiology/Virology lab. In-lab TAT on receipt of the urgent sample is already optimised with a 24/7 service in place and is invariably only a few minutes longer than the actual assay run time for the diagnostic platform.

Outbreaks & Periods of Increased incidence (PII) of COVID-19 infection

UHS surveillance data continues to be used to facilitate early warnings of increased rates of infection enabling us to identify both outbreaks and PIIs/clusters (detection of unexpected, potentially linked cases) of infection amongst patients. Close liaison between the Infection Prevention Team and clinical/non-clinical teams remains in place to support identification, investigation and management of increased incidence of infection.

	Number of Covid Outbreaks	**Total Number of Positive Patients**
Q2	12	81

All outbreaks have been managed by the Infection Prevention Team with ongoing monitoring until 28 days following the last confirmed case.

Key themes/ learning from outbreaks and PIIs.

As a result of changes to testing and other IP&C measures as part of the transition to living with COVID-19 it is often now often difficult to determine specific factors that have resulted in acquisition or outbreaks occurring. The virus itself remains highly transmissible and key themes/learning remain unchanged from 2022/23 including:

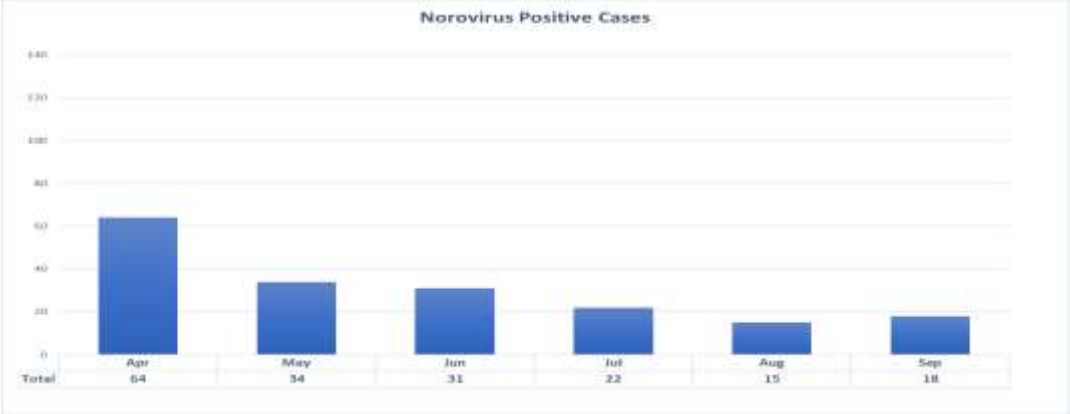
- Risks associated with the physical environment, particularly lack of mechanical ventilation and difficultly in achieving good airflow by natural ventilation (due to lack of windows/ inability to open windows in some areas) and risks related to the physical environment (including the lack of bathroom/toilet facilities on some wards resulting in a high number of patients sharing

facilities or difficulty in allocating dedicated facilities for patients with known or suspected infection).

- 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.
- Visitors attending the hospital/visiting wards with respiratory virus symptoms or reporting symptoms/positives tests a short period after visiting indicating that they may have been incubating the virus at the point of visiting.

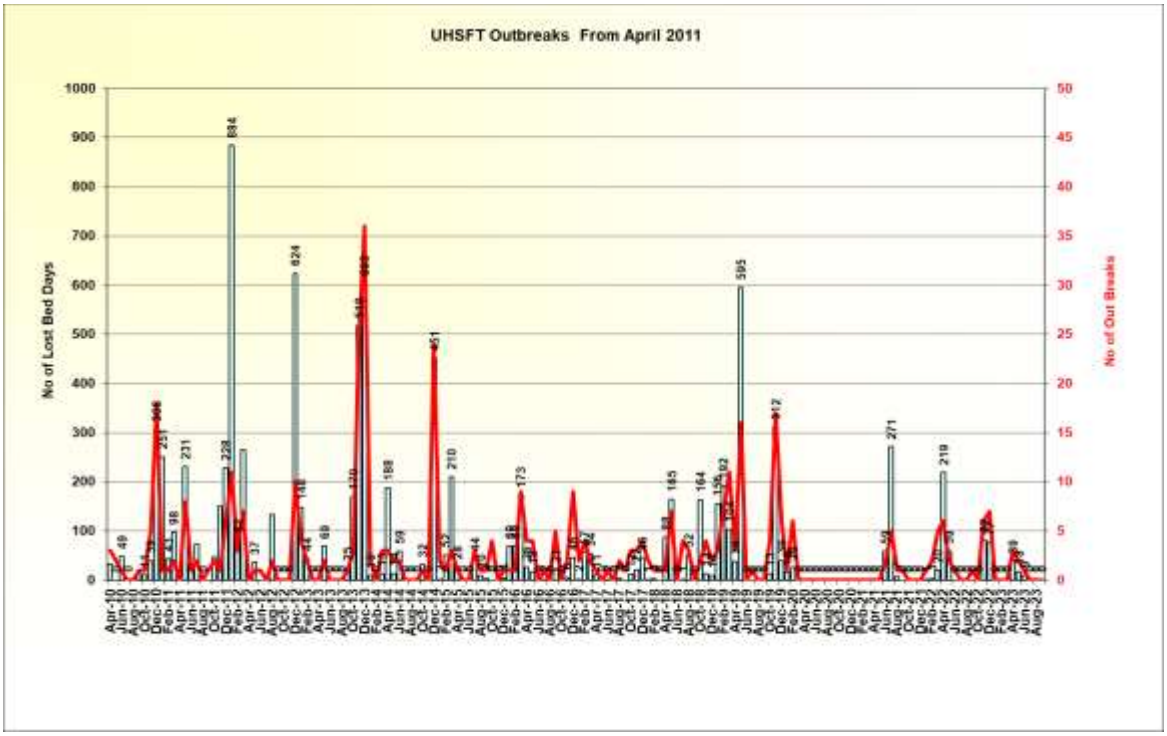
2.3 Viral Gastroenteritis including Norovirus.

0 outbreaks in Q2



	No. of outbreaks	Cause	No of Bed Days Lost	No of Pts	No of Staff	No of Bays Closed	Wards closed
Q2	0	Norovirus	9	7	0	7	0

During Q2, 7 bays were closed each with 1 patient testing positive for Norovirus. This resulted in 9 lost bed days. The positive patients were isolated resulting in no further transmission or outbreaks. In addition, there were 14 occasions where a patient was symptomatic with suspected infectious diarrhoea and/or vomiting in a bay but a rapid test GI test returned a negative result, enabling the bay to be re-opened in a timely manner without any lost bed days.



Year	Bed days lost due to bay/ward closures
2019-20	1039
2020-21	0
2021-22	361
2022-2023	503
Q1 & Q2 2023-2024	75

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.

The ongoing use of rapid in-lab diagnostic testing for gastrointestinal (GI) pathogens (including Norovirus and *C. difficile*) for symptomatic patients (those with potentially infective diarrhoea) on admission in AMU and, led by the IPT within ward bays throughout the hospital, has almost certainly made a significant contribution to the reduced number of ward closures and bed days lost due to Norovirus outbreaks. Prior to the introduction of rapid GI testing in AMU, delayed diagnosis of Norovirus in medical/MOP emergency admissions led to unrecognised transmission to other patients in AMU and subsequent seeding of infection to downstream wards in the Trust.

For rapid GI testing in existing inpatients in open bays, faster diagnosis or exclusion of an infectious GI pathogen within 2-3 hours of a rectal swab sample being taken rather than 24-48hrs if waiting for a standard laboratory test result on a stool sample, results in rapid implementation of targeted control measures to reduce transmission to other patients. These include prompt isolation of patients with infective gastroenteritis and quarantine of contacts where required (e.g., for Norovirus), reduced

unnecessary bed moves in patients without an infective cause for their diarrhoea, optimised use of limited side-room resource and significantly reduced bay closure time. For IPT-led in hours (Mon-Fri, 8am – 5pm) rapid GI testing of patients with new onset diarrhoea in ward bays where the patient tests negative for infective gastroenteritis (the majority of tests) the median bay closure is now 3 hours.

Currently, routine access to rapid GI-testing is limited to emergency medical admissions in AMU, medical patients being assessed (e.g. for a flare of inflammatory bowel disease) in SDEC and in-hours IPT-directed testing for inpatients in open bays. Increasing access to other patient groups notably acute surgical admissions and permitting out-of-hours testing of inpatients under strict criteria and with appropriate senior-level test authorisation would extend the benefits currently experienced in AMU and in-hours when there is IPT presence. During the Emergency Care Village pilot in AMU when ASU had 24/7 access to rapid GI testing, rapid diagnosis of cases of infectious gastroenteritis (e.g., Campylobacter) as a cause of acute abdominal pain prevented unnecessary investigations (e.g., CT abdomen) and even diagnostic surgical procedures (laparoscopy) and led to markedly shorter LOS in certain patients.

2.4 Key actions required to minimise the risk of in-hospital transmission and outbreaks associated with respiratory viruses and Norovirus.

Actions and strategies to reduce the risk of in-hospital transmission of respiratory viruses and Norovirus, along with planning for potential increase in cases, particularly over the winter period, remain in place and under ongoing review. Key actions to support effective management and control of all infections include:

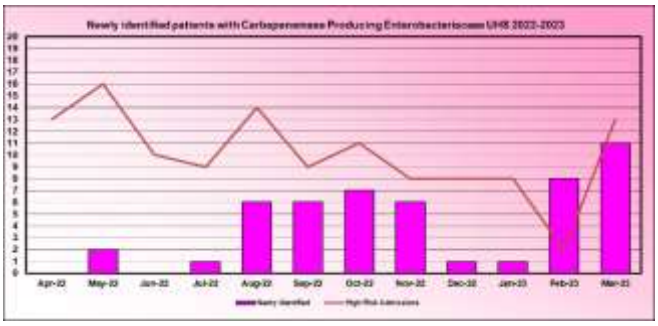
- The use of local & national prevalence data to facilitate early warnings of increased rates of infection in the local community/area and ongoing use of local UHS surveillance data to facilitate early warnings of increased rates of infection.
- The development of a centralised informatics system to provide accurate real-time infection data (inpatients and admissions) and to support operational planning in relation to placement and management of cases.
- 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.
- Increasing & expanding the capacity for rapid diagnostic testing (result within 2 hours) for gastrointestinal pathogens (including Norovirus) for symptomatic patients (those with potentially infective diarrhoea to all admission pathways (i.e. not just limited to AMU) and expansion of its use for bay closures (currently in-hours Monday-Friday).
- 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.
- Ongoing focus on more effective management and optimal use of single room capacity to facilitate rapid isolation of patients presenting with suspected infections and increasing isolation/single room capacity as part of new builds/ward refurbishment.
- Ongoing review and work to improve ventilation standards in clinical areas.
- Limiting patient movement (bay and ward moves) as far as possible.
- Promotion of the Flu vaccination and COVID booster vaccination in Autumn 2023.
- Winter Virus awareness campaign in Q3 2023/24.
- Further improving communication cascades and internal alerts/escalation.
- Ongoing monitoring and focus on infection prevention and control practices in clinical and non-clinical spaces.
- Development of a programme of work to ensure that there are sufficient patient bathroom/toilet facilities in wards.
- Working with partners regarding admission avoidance where appropriate e.g. hydration management in care homes/the home.
- Further enhancing processes/practices to support prevention of outbreaks occurring including rapid assessment, identification, and isolation of suspected cases.
- Enhancing practices/processes to support management and control of outbreaks when they

occur.

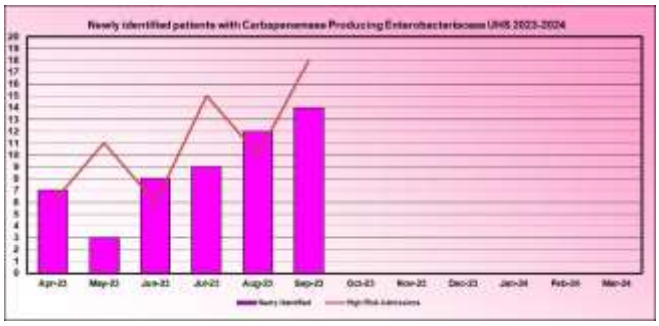
- Work with partners and local/national agencies, e.g., ICB/UKHSA/local Health Protection Teams, to improve intelligence and communication relating to community infection activity.

2.5 Carbapenemase-producing Gram-negative bacteria.

2022/23



2023/24



- 35 Newly Identified CPE cases in Q2 2023/24 compared to 13 in Q2 2022/23
- 43 High Risk patients admitted to UHS in Q2 2023/24 compared to 32 on Q2 2022/23

CPE (carbapenemase-producing Enterobacterales) 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).

Key actions to reduce risk and transmission from CPE:

- Enhanced focus on antimicrobial stewardship to reduce use of broad-spectrum antibiotics especially carbapenem group of antibiotics (e.g. Meropenem).
- To continue to undertake extensive screening for CPE including patients admitted that meet the high-risk criteria for CPE carriage and patients on carbapenems.

2.6 Other infections

A wide range of infections (single cases, clusters and outbreaks), outside of those already detailed in the report have continued to be seen within UHS in Q2. These have been identified through laboratory reporting, UHS surveillance systems, national notifications, notifications from clinical teams. All have required a combination of investigation, implementation of infection prevention and control measures, ongoing monitoring and assurance.

Ongoing *Candida auris* outbreak associated with UHS Vascular Ward

Since March 2023 there has been an ongoing D4 *Candida auris* outbreak, centred on D4 Vascular ward at UHS and the effect on Trusts within the region whose patients access the UHS Vascular service.

Candida auris is a fungal pathogen first identified as a novel species in 2009. This yeast can colonise the skin and cause infection in both adult and paediatric populations. *C. auris* is readily transmitted between patients, and the clinical environment, including via multi-use equipment.

To date 37 cases of *Candida auris* have been confirmed in patients who have spent some time as an inpatient on D4 ward. Many of the patients have complex vascular problems including diabetic foot ischaemia and/or infection, with care shared across UHS, Hampshire Hospitals (HHFT) and Portsmouth Hospitals University Trust (PHU). Whilst the large majority of patients have been identified via surveillance screening within UHS, a small number have subsequently tested positive after discharge from D4 ward, at other hospitals in the region.

Extensive investigation remains ongoing with a wide range of control measures implemented which are under regular and ongoing review, with guidance and support from regional and national colleagues from UKHSA.

- Ongoing review, monitoring and focus on IP&C practice and cleanliness standards on ward D4.
- Enhanced PPE (long sleeve gown and gloves) with hand hygiene, after contact with the patient and patient's environment, with soap and water, followed by alcohol gel.
- IPC alerts for individual patient 'C. auris' cases and 'C. auris contacts' created on Camis.
- Isolation in side-rooms or quarantine in *C. auris* designated positive bay(s) on D4 for all confirmed positive cases for the duration of their admission and for any subsequent re-admission.
- Isolation in side-rooms or quarantine of *C. auris* contacts (patients who have shared a bay with a confirmed case, for any time, no matter how short).
- Implementation of enhanced cleaning on ward D4.
- Use of additional terminal disinfection measures on ward D4 – hydrogen peroxide disinfection of all rooms/bays on ward D4 in April 2023.
- Routine use of UVC disinfection technology following terminal clean of single rooms/bays occupied by confirmed *C. auris* cases.
- Switch from Chlorine based liquid cleaning product, to use of Clinell Universal Cleaning wipes for multi-use patient equipment.
- *Candida auris* screening programme (all inpatients tested via axilla, groin and wound swabs on admission, weekly and on discharge) adopted by UHS, HHFT, PHU and Isle of Wight.
- Review and monitoring of IP&C practices and cleanliness standards in other linked areas e.g. cardiac catheter labs.
- Extensive environmental sampling of equipment/surfaces on D4 and other linked areas. Thus far, *C. auris* has been detected (cultured) from two environmental swabs on inner windowsills, (accessible touch surfaces for patients and staff). This merely confirms that the organism can persist, remain viable in the ward environment and is potentially transferrable from any fomite (inanimate surface or piece of equipment) to the hands or other body areas of an individual touching that fomite.
- Review of antimicrobial usage on ward D4.
- Review and monitoring of the general environment on D4.

<u>Factors which may be contributing to the ongoing outbreak</u>

- D4 ward environment
    - high ambient temperature.
    - poor ventilation.
    - aging and deteriorating ward infrastructure (e.g. floor and ceiling tiles) compromising the ability to clean the ward environment.
    - limited space, cluttered and crowded ward environment making effective cleaning challenging.
    - internal building works causing further disruption.
    - recurrent and frequent sewage leaks affecting predominantly D4's limited number of side rooms including leading to their closure on multiple occasions.
    - extensive and prolonged external building works immediately outside the ward (close to the external windows, which can and are opened at times). Building materials stored close to external ward windows.
- Patient group - national experts have noted that vascular patients in diabetic foot clinics have been a part of other *C. auris* outbreaks in the UK, so this may be a relevant risk factor for acquiring *C. auris* and consideration should be given to reviewing/monitoring IPC practice in outpatient diabetic foot/podiatory clinics including those in the community. These patients, particularly when admitted and receiving inpatient care for complications of diabetic foot, frequently require antibiotics (often broad spectrum) to treat severe polymicrobial skin and soft tissue infection and/or osteomyelitis. Prolonged antibiotic courses (e.g. 6 weeks for osteomyelitis) may be indicated. It is possible that antibiotic exposure may lead to a higher colonisation bioburden of yeasts, including *C. auris* on the skin of an already colonised

individual, potentially increasing the likelihood of transmission to the environment or directly to other individuals.

- There is no defined intervention e.g. antimicrobial decolonisation regimen that results in clearance of colonisation with this organism. There is no robust evidence as to the prevalence of asymptomatic colonisation with this organism either in the UK or internationally. There is limited evidence on the usual duration of colonisation with *C. auris*; an individual may remain colonised for many months, and expert opinion is that colonisation may potentially persist for years or even lifelong. Expert opinion also points to the possibility that skin colonisation with *C. auris* may fluctuate between being detectable on screening swabs and undetectable. Hence, cryptic undetectable ongoing low-level colonisation may be a confounder in IPC management of *C. auris* outbreaks. This includes the potential for ongoing but unidentified risk of transmission to other patients and challenges in confidently de-alerting and declaring individual patients formally cleared of colonisation.

Regular outbreak/incident meetings remain in place to review the situation and control measures, with representation from HHFT, PHU, IOW, HIOW ICB and UKHSA.

2.7 Surgical Site Infections

Continuous surgical site infection (SSI) surveillance (using UKHSA SSI modules) continues to be undertaken for elective hip and knee replacement surgery. The UHS surveillance system process includes the monitoring of SSIs before discharge, use of 30-day post discharge patient questionnaires and on readmission.

Period	UHS INCIDENCE SSI HIP REPLACEMENT	UHS INCIDENCE SSI KNEE REPLACMEENT
Q2 2023 - 2024	(0) 92 – 0.0% Other participating hospitals with PDQ – 0.2%	(2) 61 – 3.3% Other participating hospitals with PDQ – 0.2%. A root cause analysis (RCA) was undertaken on the 2 cases: <u>Patient 1:</u> All NICE guidance followed, patient recovered well post-operatively and was discharged home. Subsequent traumatic falls and patient factors following discharge resulted in wound dehiscence and deep infection. Infection was considered as not healthcare acquired. SSI was unavoidable. <u>Patient 2:</u> High BMI = 48.5. Re-admitted 2 months post operatively with deep infection. Wash out and debridement carried out. According to the Consultant Microbiologist the microorganisms were not healthcare acquired and it was concluded that the SSI was unavoidable.

2.8 Assurance of Infection Prevention & Control Practice standards, including environmental cleaning

Infection Prevention Practice standards

The Trust annual infection prevention audit programme remains in place for 2023/24 to monitor infection prevention and control practice standards in clinical and non-clinical areas.

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

	Month	Element	% Standards met
Surgical Site Infection Audit	August 2023	Pre-Operative	98%
		Peri-Operative	93%
		Post-Operative	98%
Ventilated Patients Audit	August 2023		100%

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 2023/24 will consist 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 2023	92%	
Outpatient areas (self-assessed)	July 2023	98%	
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 = 58%. Overall trust median score following re-audits = 61%	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. Audits undertaken in Q1, identified 5 inpatient areas scoring below 30%. All five areas have been re-audited in Q2 with all areas recording results of over 60%.

Miscellaneous Audits

Audit	Month	% Standards met
PPE Audit	September 2023	98%
Cleaning and Decontamination Audit - Non-Contaminated	September 2023	92%
Cleaning and Decontaminated Audit - Contaminated	September 2023	95%

Infection Prevention Accreditation – Mid Year Review April 2023 – Sept 2023

Target**:** All areas to achieve full accreditation at year end 2023/24.

Accreditation status for each clinical area is calculated based on self-reported performance in audits undertaken as part of the Infection Prevention Audit Programme (high impact intervention audits hand

hygiene, miscellaneous audits), IPN Hand Hygiene Audits and Clinical Cleaning scores as detailed below:

- Self-assessed Audits: scores achieved across all audits. Non submission of an audit scores 0
- IPN hand hygiene audits -score achieved across both audits in the year.
- Clinical cleaning scores: scores consistently achieved against national cleaning standards.

Progress: April to Sept 2023 midyear review, based on self-assessed audit scores only, a total of 52 areas were fully accredited (35%) and 20 areas partially accredited (13%). 78 areas did not achieve accreditation (52%).

- 21 areas rated Red (54%) in Division A
- 23 areas rated Red (57%) in Division B
- 21 areas rated Red (64%) in Division C
- 14 areas rated Red (37%) in Division D

Reasons why areas have not achieved full accreditation is mainly due to non-submission of audits.

Summary of actions to improve accreditation status

1. The Infection Prevention Team continues to work with areas to support achievement of full accreditation by the end of 2023/24.
2. In order to improve audit submissions a number of actions have been implemented:
    - An email reminder on the audits due for submission is sent on the 1st working day of each month to all ward leaders, theatre leads, matrons and infection prevention link staff.
    - Audit reports detaining non submissions are sent to all ward leaders, theatre leads and matrons and uploaded to staffnet.
    - A midyear ward accreditation report has been collated detailing all areas and non-submissions to date.
    - Infection prevention nurses are linking with the ward leaders within their divisions to highlight audit non submissions.
    - Commencing November 2023 a list of areas that have not submitted the previous months audits will be communicated via our Infection Prevention Link Staff Microsoft Teams Group.

Environmental Cleaning

Monitoring of environmental cleaning standards (domestic and clinical) continued to be undertaken by the environmental monitoring team (EMT) and Serco in 2023/2024. During this period, the EMT have established a new team, and are now able to maintain the required level of audits, ensuring all areas of the hospital are being assured for cleanliness. EMT now have a dedicated Clinical Quality auditor and lead educator. Serco. Since the failure of the KPI and meeting national standards in June we have seen an improvement on levels being maintained.

There has been a slight improvement in clinical cleaning quality since last quarter, notes, drugs and sharps trolleys and patient fans being the main themes.
Over the last 12 months a total of 20,249 terminal cleans have been completed at an average of 1,687 per month.

2.9 Antimicrobial Stewardship.

See Appendix 3 - Pharmacy Anti-infectives Team Report.

2.10 Estates & the Built Environment

The design, planning, construction, refurbishment and ongoing maintenance of the healthcare facility has an important role to play in the prevention and control of infection. The physical environment should assist, not hinder, good practice. It is important that healthcare buildings are designed with appropriate consultation, and the design facilitates good infection prevention and control (IPC) practices and has the quality and design of finishes and fittings that enable thorough access, cleaning and maintenance to take place. Good standards of basic hygiene, cleaning and regular planned maintenance will assist in preventing healthcare-associated infection (HCAI).

Within UHS, the EFCD team overall have effective processes in place to ensure that consideration of IPC practices occurs throughout the planning, design, construction and refurbishment phases of a project. Effective working relationships have developed with the IPT, involving regular consultation.

Concerns continue to be highlighted in relation to the existing environment in some areas of our hospital sites (e.g. ventilation, lack of toilet/bathroom facilities, lack of isolation facilities, general repair of ward/outpatient environments) and the impact on preventing & controlling infection. A specific example of this relates to Ward D4 as outlined in section 2.6 of this report.

IPT spotlight reviews of the environment, cleanliness and practice were re-introduced in Q2 , initially in outpatient areas on SGH, PAH & RSH sites and maternity inpatient areas. These reviews have highlighted a wide range of issues associated with the general fabric/repair of the environment in many of the areas reviewed to date and a process is in place to report these back to the EFCD team to address and action.

Progress continues to be made in addressing concerns in some areas e.g. work ongoing on D4 vascular ward to improve the support spaces; work nearing completion in the maxillo-facial outpatient department to improve the environment. Refurbishment work on G3 commenced in Q2 along with enabling works to support the Neonatal unit expansion/refurbishment.

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 cause significant morbidity and mortality to vulnerable patients, can delay discharge and increase length of stay in addition to increasing the need to use broad spectrum antibiotics.

The Trust Water Safety Group continues to meet on alternate months with a remit to:

- Provide clear direction and oversee the strategic and operational implementation of water safety and hygiene management throughout the Trust.
- Support and steer action on water safety and hygiene to meet Trust objectives and local and national targets and statutory compliance.
- Ensure action is taken across the Trust to minimise the risk of infection emanating from water and 'wet' systems supporting the improvement in patient safety and the patient experience.
- Review of the programme and outcomes of monitoring of sampling for Legionella and Pseudomonas; review of risks and actions required/taken; review of water safety risk assessments for Legionella/Pseudomonas.

Air Quality/Ventilation

Providing a clean environment, including fresh air, is considered essential to the healthcare environment.

General ventilation across UHS wards, outpatient areas and offices is variable, with only a small number of areas having good ventilation. Many areas where ventilation is poor also experience high temperatures which affects both patient and staff wellbeing.

The COVID-19 pandemic further highlighted key areas within UHS where mechanical ventilation is lacking or does not meet current standards in clinical areas with many of the COVID-19 outbreaks within UHS occurring in areas of poor ventilation. Currently, the risk continues to be managed by the careful placement of portable air purifiers which are likely to play an essential role in risk mitigation. Air purifier units have been 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.

Actions remain ongoing to explore ways to improve the current state of ventilation in key areas of the hospital. 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. Long term solutions to install ductwork will be scheduled in line with future ward refurbishment programmes.

Options for a medium term solution to improve the ventilation on some of the highest risk wards on F Level East Wing (Orthopaedics) were identified by the Estates team in collaboration with the Infection Prevention Team in late 2022 and installation of wall mounted units into 8 bays within the T&O wards that were been assessed by the IPT/DHN/Matrons as highest risk for outbreaks (F2 &F1 trauma bays) commenced in May 2023. The impact of these is being monitored and an evaluation will be undertaken by the Estates Team and IPT to inform future planning/strategies for other areas of the Trust.

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, Influenza, 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 and treatment costs associated with healthcare associated infection e.g. C. difficile, contributes further to decreased operational productivity. A recent study has estimated the total annual cost of healthcare associated infection in the UK to be 774 million pounds.

4.0 Appendices

Appendix 1 : UHS C.difficile Improvement Plan (summary)
Appendix 2: UHS BSI improvement plan (summary)
Appendix 3: Pharmacy Anti-infectives Team Report (QX 2023/24)
Appendix 4 : Q2 Division A Matron and CGCL Report
Appendix 5: Q2 Division B Matron and CGCL Report
Appendix 6: Q2 Division C Matron and CGCL Report
Appendix 7: Q2 Division D Matron and CGCL Report

Appendix 1 UHS C.difficile Improvement Plan (Summary)

<table>
<tr><th>Learning & improving through investigation of C.difficile cases.</th><th>IP&C practices to prevent the risk of transmission of C.difficile.</th></tr>
<tr><td>
• Introduction of a concise After-Action Review process for HOHA to review risk factors, antimicrobial prescribing practices, IP&C practice gaps/areas of good practice.
• IP&C practice reviews of wards where HOHA/COHA cases are isolated for assurance on IP&C practice standards.
• C.difficile weekly case review panel
• C.difficile MDT review panel (including ICB IP&C leads) to review cases & identify themes, learning and actions to improve practice and patient management for UHS, primary care and community/social care providers.
• Sharing of learning with clinical/ward teams and across the healthcare system.
• Collaborative working across HIOW ICS – shared investigation/learning of COHA cases, sharing learning & good practice with other acute providers.
• Ensuring ongoing surveillance to rapidly identify any increased incidence/potential outbreaks.
</td><td>
IP&C practices to prevent the risk of transmission of C. difficile
Assessment & isolation:
• Continued focus on the early assessment and isolation of patients presenting with symptoms of diarrhoea.
• Optimising the management of isolation facilities and improving standards of isolation care.
Improving fundamental standards of IP&C practice:
• Hand hygiene improvement framework.
• 'Give up the gloves' campaign.
• Introduction of IPT ward rounds to review & support practice (incl. focus on isolation care, PPE, cleanliness).
• Re-introduction of the UHS IP&C ward accreditation framework.
• Education, training & awareness activities.
Cleaning & decontamination of the environment :
• Relaunch cleaning roles & responsibilities framework
• Further education & training on expected cleaning standards, products and process.
• Introduction of environmental walkabouts to review practice & the condition of the environment (Estates/IP&C/Cleaning services/Ward).
• Re-launch of the use of UVC technology for decontamination of isolation single rooms.
• Full implementation of national standards of healthcare cleanliness (2021).
• Re-introduction of IP&C spotlight reviews to review & support practice.
</td></tr>
<tr><th>Management & treatment of C. difficile to reduce risk of relapse/recurrence</th><th>Reducing risk factors for C. difficile - antimicrobial prescribing & stewardship.</th></tr>
<tr><td>
Management & treatment of C.difficile to reduce risk of relapse/recurrence
• Weekly Clinical C. difficile virtual ward round to review new cases of C. difficile to ensure appropriate treatment & management.
• Targeted education to medical staff to increase awareness of C. difficile treatment and management guidelines.
• Finalise faecal microbial transplant protocol
</td><td>
Reducing risk factors for C.difficile - antimicrobial prescribing & stewardship
• Increased antimicrobial stewardship activity targeted to areas not currently covered by microbiologist AMS ward rounds/ areas of concern – pilot of a combined pharmacy AMS/IP&C ward round in respiratory medicine/adult oncology.
• Ongoing programme of updates to antimicrobial prescribing guidelines.
• Rolling programme of education & awareness to clinical staff .
• Focus on prompt switching of intravenous to oral antibiotics (2023/24 CQUIN)
</td></tr>
</table>

Appendix 2 UHS improvement plan to reduce healthcare associated BSI (summary)

Learning & improving through investigation of cases	Improving standards of IP&C practice to reduce risk of infection
• Introduction of a concise After-Action Review process to review risk factors and practice to identify learning and actions for improvement. • Timely IP&C practice reviews for cases that are related to IV devices, indwelling urinary catheters, surgical site infection or ventilator associated to identify learning, good practice. • Fortnightly BSI review panel to review cases & identify themes, learning and actions to improve practice and patient management. • Sharing of learning with clinical/ward teams and across the healthcare system. • Collaborative working across HIOW ICS – shared investigation/learning of COHA cases, sharing learning & good practice with other acute providers.	• Quality improvement project - reducing risk of catheter associated UTI (CAUTI) through management of urinary catheters, avoiding unnecessary catheterisation and appropriate early catheter removal. • Quality improvement project to improve the care and management of IV devices & reduce the length of time that these devices are in place. • Introduction of focused IPT ward rounds to review & support practice related to IV devices and urinary catheters. • Pilot of combined IP&C invasive device & pharmacy antimicrobial stewardship ward rounds to review and support practice. • Improving standards of hand hygiene-hand hygiene improvement framework, education & awareness activities. • Re-focus on standards of aseptic technique - review, update and re-launch of ANTT practice guidelines, education & awareness activities. • Re-introduction of the UHS IP&C ward accreditation framework.
Focus on reducing risk factors that pre-dispose patients to infection	
• Development and implementation of UHS Fundamental Care standards e.g. nutrition & hydration, mouth care, promoting mobility, maintaining skin integrity, bladder and bowel care, personal hygiene. • Focus on health prevention and self-care measures on a wider community and system level in collaboration with HIOW ICS, Southampton City Health Protection Board and via the Southeast Regional IP&C network e.g. such as promoting hydration, good personal hygiene.	

Appendix 3

Pharmacy Anti-infectives Team Report to Infection Prevention Committee and TEC November 2023 (Covering Q2 2023)

Introduction

Antimicrobial stewardship (an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness) features in the Health and Social Care Act 2008. To comply with the terms of the code of practice the trust needs to ensure: Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.
Antimicrobial stewardship functions well when there is strong leadership across clinical specialities.

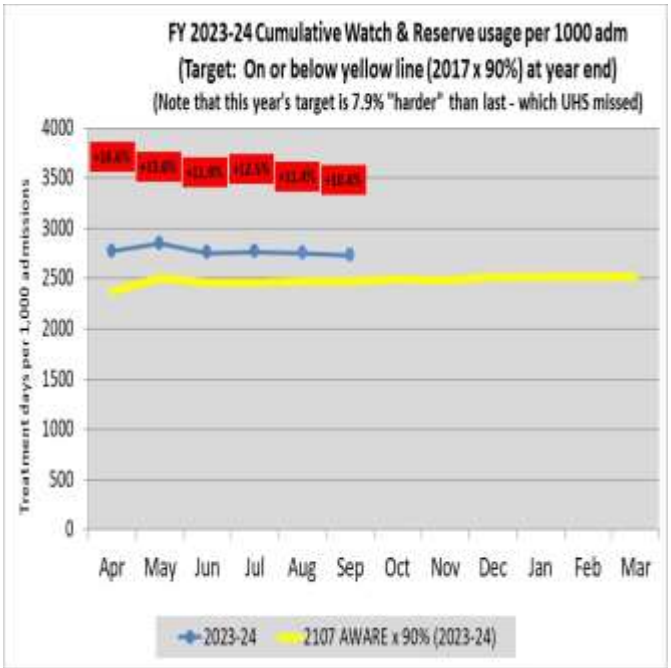
At UHS oversight is provided by the antimicrobial stewardship committee reporting via this medium to TEC. Stewardship work focuses on national targets and CQUIN schemes as well as review and update of antimicrobial guidelines. A full antimicrobial stewardship strategy is planned when resources allow. The medical microbiologists provide speciality-based stewardship rounds and advice although there are gaps in this provision.

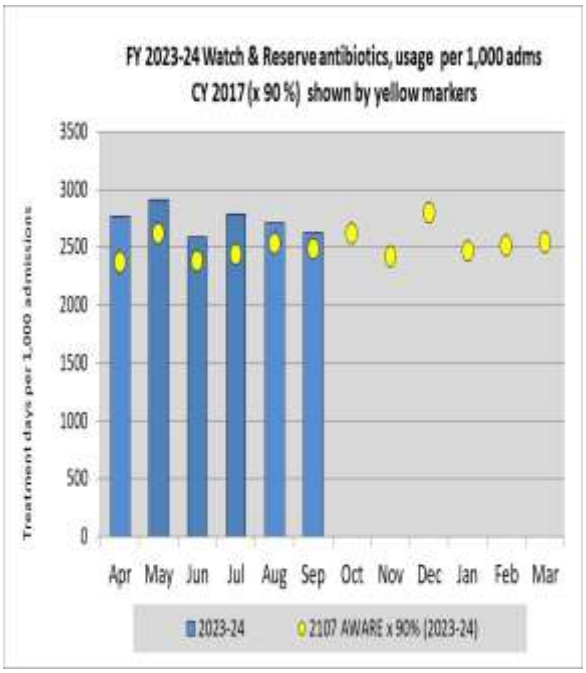
1. Total Antibiotic Consumption

a. Internal performance

The NHS standard contract 2023-24 requires a reduction of 10% in the use of WHO AWaRe programme "Watch" and "Reserve" antibiotics for FY 2022-23 when compared to Calendar year 2017 (watch and reserve antibiotics include as examples co-amoxiclav and piperacillin-tazobactam).

Consumption data is shown in the chart below. To meet the target the blue line needs to be on or below the yellow line. Data for quarters 1 and 2 strongly suggest that UHS is ***unlikely to meet this target***. To meet our contractual target there needs to be a wholesale change in practice surrounding use of antibiotics in the trust and even that would likely be insufficient for the current year.

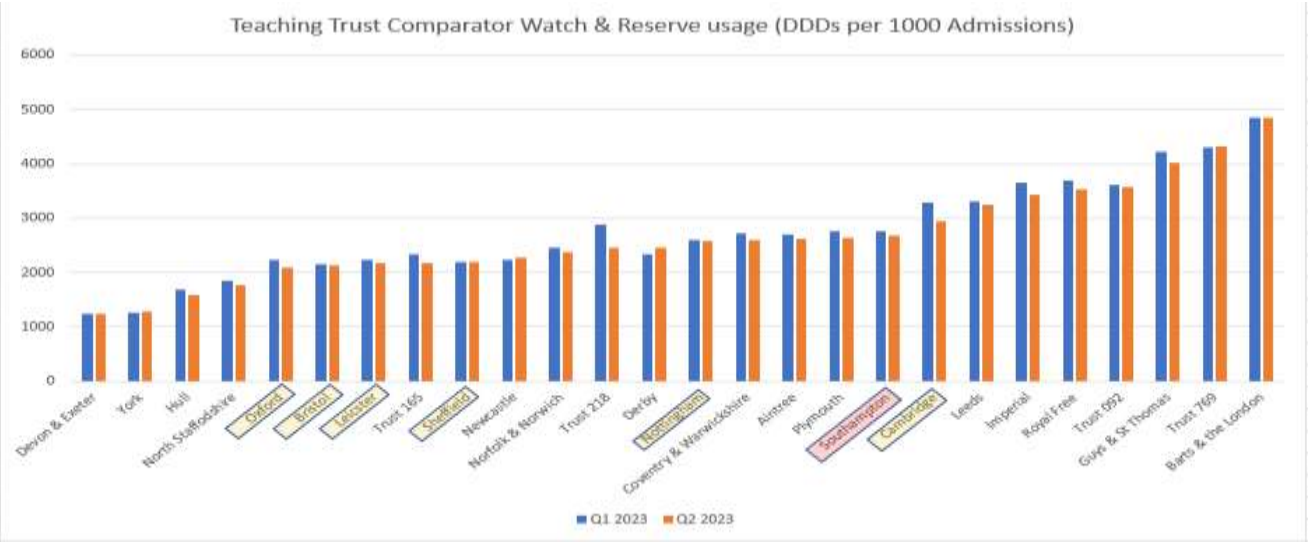




Ref: Internal reporting; source data from https://www.rx-info.co.uk/ (Refine)

b. National comparators

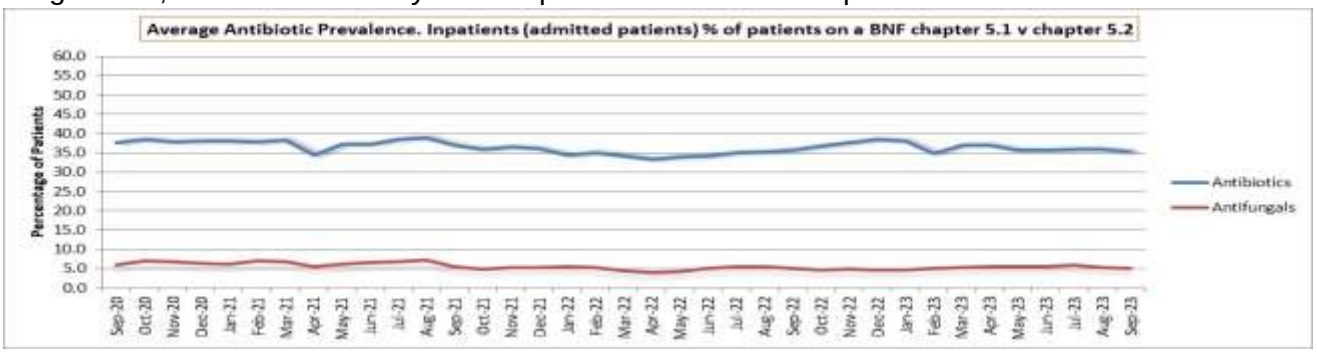
The following chart shows how UHS compares to other teaching trusts. We do not have full trust identifiers as seen with the codes; our peer comparator trusts are identified by the y-axis boxes. When the average of our peer comparator trusts is calculated Southampton usage is 10% (Q1) and 11% (Q2) respectively above the mean.



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

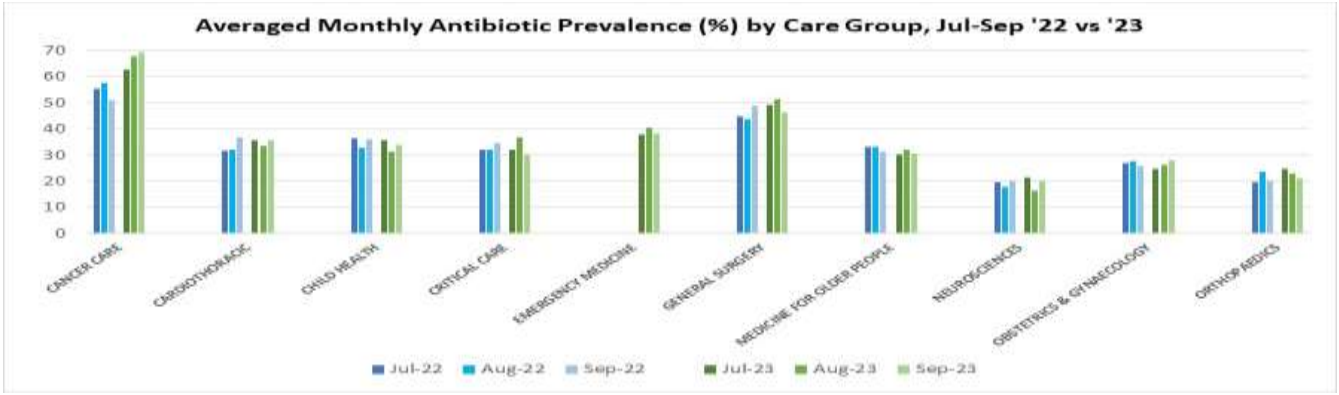
c. Proportion of Patients on Antibiotics

At UHS there continues to be approximately 35-38% of patients on antibiotics at any one time. A full-hospital Point Prevalence Survey has recently been completed at UHS as part of a national Programme; results will be analysed and presented in a future report.



Ref: Reporting data from JAC prescribing system

This can be broken down by speciality; Q2 usage for 22-23(blue) is compared to 23-24(green). The older specialist medicine (C5&D10 wards) and emergency care group specialities were combined in February 2023 to form the new Emergency Medicine care group.



Ref: Reporting data from JAC prescribing system

d. HAPPI Audits

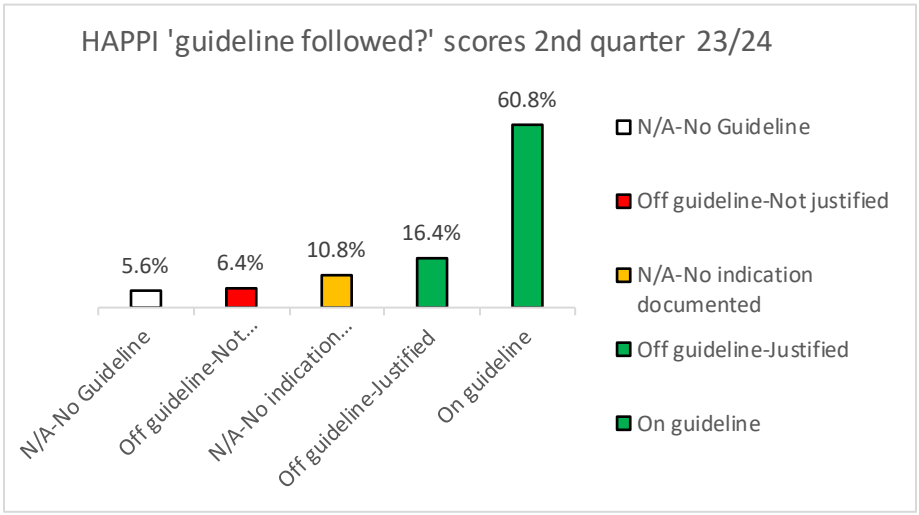
Hospital Antibiotic Prudent Prescribing Indicators (HAPPI) audits have been re-introduced (September '22) to gain information on appropriateness of antimicrobial prescribing. They allow UHS to fulfil its obligation as per the H&SC Act 2008 to monitor the use of antimicrobials to ensure inappropriate and harmful use is minimised.

The aim is for 5 audits to be completed each month for each ward by the ward pharmacists.

Numbers of audits are now below 40% of the target so we have instituted a training package particularly focussing on new pharmacists to encourage quality data collection.

Audit results for Q2 2023/4:

- Guidelines were followed (or justifiably deviated) in around 77% of cases, leaving 5.6% of infections with "no applicable guideline" and then 17.2% either NOT followed or not auditable due to having no stated indication, (image below). This data is largely unchanged from the previous summary.



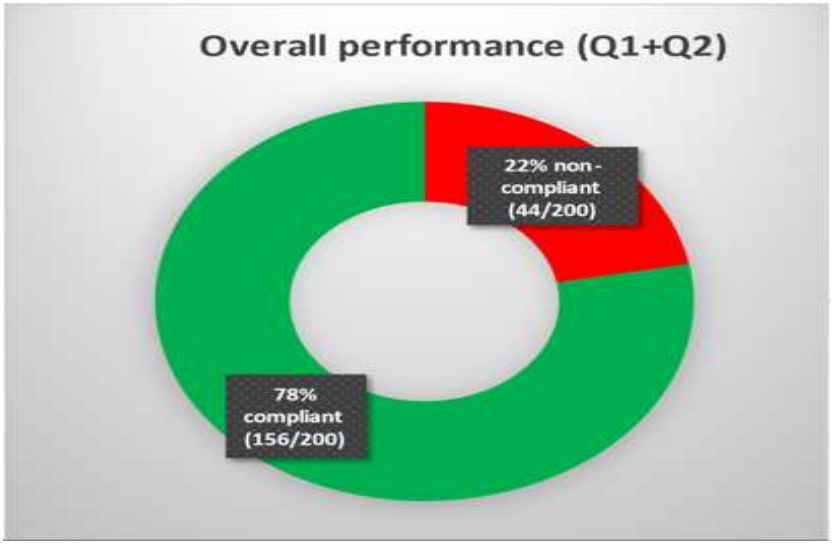
- Of 390 auditable cases, 16.9% did NOT have a documented indication at the time of prescribing, this is an increase from 13.8% in the previous quarter and 12.4% for the preceding quarter. This may be selection bias by the pharmacists carrying out the audit on patients which cause concern.

- Of auditable cases, a small reduction from 83% in the first quarter to 79% had a documented review and management plan at 48-72hr. This is concerning noting the focus on IVOS.

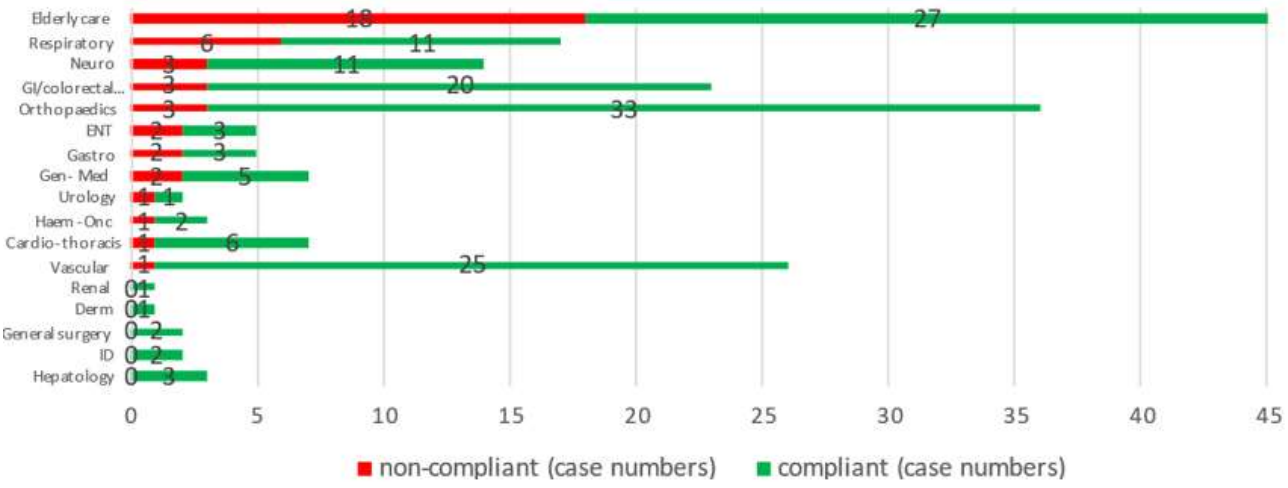
2. CQUIN: Timely IV to Oral Antibiotic Switching (IVOST)

Target: Of audited patients receiving IV antibiotics, fewer than 40% shall be found to have been eligible for oral switching at time of audit; this is a cumulative target for the year. One hundred patients are audited per quarter. Quarterly results are recorded in the table below:

	Non-compliant %	Compliant %	CQUIN target: ≤ 40% non-compliant
Q1 (April-June)	22	78	Met
Q2 (July-September)	22	78	Met



Further detail for individual specialities:



Although the CQUIN target has been met for the first half of the year there are opportunity benefits to be realised. Assuming that at any one time a fifth of patients could have been on oral therapy, national data indicates that this could result in a potential £250k saving in drug costs per annum and nursing time saved equating to 15 WTE. This does not include possible savings from a reduction in length of stay and spend on consumables. There is work to be done to realise as much of these benefits as possible. We are fortunate that Gail Byrne has agreed to chair a steering and oversight group to implement this. Although the CQUIN is for 2023-24 this quality improvement needs to be embedded into routine practice.

Appendix 4

Division A Q2 Matron and CGCL **Report to TEC**

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

Matrons: Kerry Rayner, Kate Stride, Jake Smokcum, Charlie Morris, Lisa Turnbull, Linda Monk, Michaela Jones. Ryan Bird, Leah Marriott, Tracy Richards, Mitzi Garcia, Raquel Domene Luque and Fretzie Condevillamar, Neil Sabarre.

Clinical Lead: John Knight, Aris Konstantopoulos and Aby Jacob

Date of Report: October 2023

Author: Colette Perdrisat

Performance Quarter 2 – 1st July to 30th September 2023

Key Indicator	Division A	Limit	Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 1** (COHA)
***Clostridium difficile* diarrhoea**	**6**	**Trust Limit 15**	**Trust Total 33** (HOHA + COHA)
E. coli (HOHA)	**2**	**Trust Limit of 30**	**Trust Total 31** (HOHA + COHA)
Pseudomonas (HOHA)	**0**	**Trust Limit of 9**	**Trust Total 3** (HOHA + COHA)
Klebsiella (HOHA)	**7**	**Trust Limit of 14**	**Trust Total 15** (HOHA + COHA)
MSSA Bacteraemia	**2**	**No Limit**	
GRE	**0**	**No Limit**	

	Cause	Comments
Incidents/ Outbreaks of Infection	NICU Pseudomonas	3 cases of Pseudomonas aeruginosa in ET secretions and x2 cases of pseudomonas citronellols colonisation (rectal swab) Sterile bottles without dates Hand Hygiene Cups of water and a mouthcare pink sponge sitting in trolley Grey dust found in some curtain rails and equipment pendants above patients
	GICU C.diff PII	C.diff PII GICU - 2 cases within 28 days. C.diff integrated care pathway not completed daily. Commodes soiled with faeces. Commodes and bed pans not always labelled with 'I am clean sticker'. Hand Hygiene with soap and water. Soiled linen being placed on the floor in cubicle. Diarrhoea and Vomiting proformas not always completed fully. Stool charts not updated daily when bowels not opened.

Performance Year to Date: 1st April – 30th September 2023

Key Indicator	Division A	Limit	Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 1** (COHA)
***Clostridium difficile* diarrhoea**	**8**	**Trust Limit 60**	**Trust Total 60** (HOHA + COHA)
E. coli (HOHA)	**9**	**Trust Limit of 120**	**Trust Total 70** (HOHA + COHA)
Pseudomonas (HOHA)	**1**	**Trust Limit of 33**	**Trust Total 10** (HOHA + COHA)
Klebsiella (HOHA)	**12**	**Trust Limit of 56**	**Trust Total 29** (HOHA + COHA)
MSSA Bacteraemia	**3**	**No Limit**	
GRE	**0**	**No Limit**	

Key Learning from Investigation of Infections and Deaths:

Critical Care

GICU (6) & CICU (2) – Cdiff (total 8) and PII on GICU in July although no related cases. Staff reminded to use Sochlor rather than Clinell wipes, type 5 is also considered a loose stool and when bowels are not open, the care plan should reflect this. Risk assessments should take into account PPI i.e. lansoprazole and Tazocin are higher risk for CDiff acquisition (an earlier risk assessment was considered not potentially infectious but later on the patient was identified as CDiff positive). All bed pans and commodes should be labelled with 'I am clean' stickers once clean. Good Practice Guide (proforma) and integrated care pathway documentation to be completed fully and daily for the latter once diagnosis confirmed.

GICU (1) & SHDU (1) E.Coli (total 2) and GICU Pseudomonas (1) - urinary catheter care related. Catheter was appropriately inserted and removed early on GICU however plan for TWOC should be reviewed daily and rationale provided as to why a catheter is still required. Urinary catheter care records to be completed at least daily. Bladder washout practice reviews are being investigated in liaison with nurse specialists.

CICU Klebsiella (2) and GICU Pseudomonas (1) – VAP related. Rationale to be clearly documented on care plan for any deviation from VAP care bundle.

NICU Pseudomonas PII in July. Nebuliser acorns are to be cleaned and dry before storing away, sterile water bottles should have a date and time when opened (and discarded after 24 hours). Hand wash basins should have a black bin next to it.

Progress and Success:

Ophthalmology

An Infection Prevention Spotlight Review was carried out on Eye outpatients on 18 09 2023 which received an overall score of 89 % (RAG rating of Amber. 5 Star cleaning audits across all areas of ophthalmology throughout the quarter

Surgery

Covid numbers increased recently, managed well within care group by utilising side rooms and cohorting in bays as necessary. No full ward closures experienced, only b

Theatres

Intraoperative: There were 10 audits and a total of 67 observations. · Overall, Trust score of 93% for Intraoperative care shows a 7% decrease in compliance compared to 100% in February 2023.

Ward	Overall Score		Ward	Overall Score		Ward	Overall Score
All Recovery	**100**		Colorectal Scrub	**100**		Neuro Scrub	**100**
Urology Scrub	**100**		Paediatric Scrub	**100**			

Isolation precautions in Recovery – 96% pass

Critical Care

CICU Klebsiella PII was closed (Sept). It appears the cases were linked to theatre as the patients tested positive within 24-48 hours of being in CICU and all patients were positive in respiratory secretions. Theatres have been visited, surfaces swabbed, practice observed, and recommendations made. No source has been identified but as there have been no further positives for over 28 days, the outbreak is now closed. We are awaiting an RCA from Theatres. Hand hygiene audits GICU 95% SHDU 100% NICU 100% CICU 90% Pre and post of SSI GICU 100%, SHDU 100%, CICU 100%, NICU 100% VAP 100% all 3 ICUs Cleaning and decontamination 100% in all 3 ICUS and SHDU Reaudits where results were 'amber' have demonstrated improvements particularly in documentation and hand hygiene.

Ongoing Challenges:

Ophthalmology

July Outpatient Hand Hygiene audit compliance. 100% in Eye Casualty, 80% in Eye OP July In Patient Hand Hygiene audit compliance. Eye Short Stay Unit, 65%

Surgery

CPE- 2x cases from E8- not linked- IPT seeing increase of CPE in community- likely related to antibiotic resistance.

1. incidental finding from CC (they screen everyone). Nothing we could have done.

2. Patient admitted from ASU- E8. Both areas missed opportunity to isolate (Patient recently admitted in Yeovil hospital).

Theatres

Result from August 2022, with improvement plans under way to be assessed by the IP team:

Cardiac paediatric theatres recommended to create improvement plan regarding use of iodine drapes. Due to the size of patients, this has been an ongoing challenge, and the team is exploring options. Re-audit and revisit to be arranged.

New suction canisters being rolled out in theatres. These new canisters are pre-filled with solidifying agents, to reduce/eliminate fluid leaks on disposal. There are concerns around intraoperative fluid management. Discussion to clarify, with further education and teaching to be disseminated. In addition, there is a new practice in disposal of the canisters. Previously, these are being disposed of in a carboard box, which has now changed into a larger plastic hard container. Theatres is clarifying with the IP team on appropriate disposal practice if large plastic container is unfilled. Outcome pending. Information to be disseminated once known.

Other challenges:

Standard precautions – 88% fail – 1 overfilled sharps bin in treatment room, staff not using eye shields when at risk of splash (removing LMAs), staff not knowing correct concentration of actichlor to clean blood spill. Re-audit within 1 month

Hand hygiene – 85% fail – 1 recovery staff not bare below the elbow (green jacket sleeves down whilst delivering patient care), 1 anaesthetic practitioner not bear below the elbow (green jacket sleeves down whilst delivering patient care) and hand hygiene not completed after contact with patient, 1 medical student hand hygiene not completed after contact with patient surroundings. Re-audit within 1 month

Critical Care

Encouraging staff to ensure aprons are worn for close contact patient care and encourage visor use when there is a risk of splash in GICU and CICU.

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

Ophthalmology

Focused work is taking place on education mornings to empower the teams to challenge poor hand hygiene compliance by various professions.

Surgery

Infection prevention to send out CPE flow charts again to share with all wards to ensure correct processes in place and increase vigilance.

Theatres

On 11 August 2023, IP team had a walkabout in theatres as part of investigating the concerns related to cases of Klebsiella Pneumoniae in cardiac patients. Some areas of improvement were recommended to the Anaesthetic practitioners (AP) team. Prompt improvement plan created and implemented by AP team within one week of recommendation.

Critical Care

Critical Care IP link sister continues to remain present on the units to carry out observations of practice and surveillance to ensure staff are following policy and providing assurance that infection prevention practices are adhered to. Information is cascaded via newsletter, emails and one to one education whilst in the clinical areas. Focus continues with hand hygiene, documentation and highlighting actions/ lessons learnt following blood stream infection reviews.

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
November 2023	November 2023

Appendix 5

Division B Q2 Matron and CGCL **Report to TEC**

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, Emma Chalmers, Susie Clarke, Erica Wallbridge, Steve Hicks, Gillian Lambert, Emma Lavelle, Sandra Souto, Nat Kinnaird, Samantha Brownsea and Kat Black

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

Date of Report: *October 2023*

Author: Suzy Pike

Performance Quarter 2 – 1st July to 31st September 2023

Key Indicator	Division B	Limit	Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 1** (COHA)
***Clostridium difficile* diarrhoea**	**14**	**Trust Limit 15**	**Trust Total 33** (HOHA + COHA)
E. coli (HOHA)	**10**	**Trust Limit of 30**	**Trust Total 31** (HOHA + COHA)
Pseudomonas (HOHA)	**1**	**Trust Limit of 9**	**Trust Total 3** (HOHA + COHA)
Klebsiella (HOHA)	**1**	**Trust Limit of 14**	**Trust Total 15** (HOHA + COHA)
MSSA Bacteraemia	**0**	**No Limit**	
GRE	**2**	**No Limit**	

	Cause	Comments
Incidents/ Outbreaks of Infection	C6 Mycobacterium	Mycobacterium chelone on blood cultures-PII on C6. Patient to have lines covered when using the shower. Shower heads are changed every 3 months. Patient had placed used urine in the sink.
	D3 C.difficile PII	2 x cases of C diff on D3 ward with 28 days. Dusty wall mounted fan in corridor. Equipment used by/ for patients is cleaned in between patient use. Commodes are clean, signed and dated with a cleaned label. Appropriate use of PPE. Staff are adhering to correct hand hygiene. Patients with type 6/7 stool have proforma done and are isolated immediately if required.

		Isolate patients in a side room on loose stool onset. If none available, barrier nurse in bay, inform infection control for potential rapid swab and complete AER
	D10 Candida Auris	Patient with Candida Auris discharged and room did not have a UV decontamination and next patient tested positive for Candida Auris.
	D9 C.diff Outbreak	4 patients tested positive for C.diff all with 005 Ribotype. Incorrect sign on the door No isolation risk assessment completed therefore correct precautions were not taken. Missed hand hygiene opportunities. Incomplete C-diff care pathways Patient with type 6,7 stools where there is a clear change in the stool pattern, not reviewed. Some gaps in stool charts Commodes were not cleaned. Some ward staff not cleaning equipment with actichlor.
	C6 C.diff PII	3 x cases of C diff in 28 days Dirty commodes found. Equipment dusty Waste streams -not being used correctly -blue pharmacy waste had gloves in the bins . Isolation signage incorrect and isolation risk assessment need updating

Performance Year to Date: – 1st April to 31st September 2023

Key Indicator	Division A	Limit	Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 1** (COHA)
***Clostridium difficile* diarrhoea**	**23**	**Trust Limit 60**	**Trust Total 60** (HOHA + COHA)
E. coli (HOHA)	**21**	**Trust Limit of 120**	**Trust Total 70** (HOHA + COHA)
Pseudomonas (HOHA)	**2**	**Trust Limit of 33**	**Trust Total 10** (HOHA + COHA)
Klebsiella (HOHA)	**5**	**Trust Limit of 56**	**Trust Total 29** (HOHA + COHA)
MSSA Bacteraemia	**3**	**No Limit**	
GRE	**3**	**No Limit**	

Key Learning from Investigation of Infections and Deaths:

Emergency Care: Nil related to above.

Medicine/MOP:

D9's hand hygiene compliance was poor, commodes often not fully clean, and loose stools not acted on as per policy (thought to be linked that loose stool was common in the gastro patients).

D10 communication issues between the team and SERCO. Additional pressure related to flow and rapid use of empty beds.

Specialist Medicine: Nil related to the above

Cancer Care:

Hand hygiene compliance previously poor, re-auditing has so far indicated improved compliance.

Bungs changed for all IV devices as found to be hard to clean ? contributing to increase in infections. Education regarding isolation signage and infection prevention locally on ward C6- reminders at handovers and Nic checks etc.

Progress and Success:

Emergency Care:

Some progression of minor works request to improve hand basis availability in majors to enhance hand hygiene compliance.

Hand hygiene audit improving. On going audits from peers. Challenging visitors and external teams for compliance.

Rectal POC supporting appropriate isolation and management of side rooms.

Medicine/MOP:

D9 have had post C.diff outbreak visits from IPT. Improvement seen across hand hygiene compliance, commode cleaning, general nursing cleaning and stool chart completion.

D9 leadership team have utilised huddles, to provide teaching about IPT.

D10 have put in a more robust room checklist before bed is given away that requires a senior nurse sign off.

Staff development day with the matrons covers the importance of infection prevention and control. Taught to all healthcare assistants, associate practitioners, and registered nurses.

Specialist Medicine: No significant infection prevention incidents to note. Spotlight audits completed in Endoscopy, Dermatology and Managed Care with action plans completed in timely manner.

Cancer Care:

Improved compliance noted in hand hygiene. Gels now in place more readily available in C6 outside patients' rooms/ in corridors.

IV bungs changed as harder to clean than the alternative (no cost impact) which should improve line infection risks

C2 treatment room extension works underway which will improve the environment and ensure compliance with medications management and storage as well as space for appropriate medications preparation.

Ongoing Challenges:

Emergency Care:

Sinks and plumbing work in ED. Continuous challenge results in lack of toilet availability within ED footprint and available hand wash basins.

Action: Working closely with estates, escalations through DMT/Estates monthly meeting. Await quote of long term solution.

Side room capacity due to volume of mental health patients in ED/AMU, timely isolation can be challenging due to this.

Action: Support from Mental health team to support patient pathway, discussion through ED huddles and divisional huddles to support decision making.

Hand hygiene compliance

Action: Peer audits, DMT hand hygiene walkabouts, monitoring through governance.

Medicine/MOP:

Side room capacity – competing demand infections/ end of life/ mental health.

Action: Daily side room review, support from Mental health team to support patient pathway, discussion through divisional huddles to support decision making.

Hand hygiene compliance.

Action: Peer audits, DMT hand hygiene walkabouts, monitoring through governance.

Specialist Medicine:

Endoscopy inpatient pathway for those with infective causes/suspected causes of diarrhoea. On occasion, patients have arrived to the department from isolation areas within the inpatient area. This has resulted in delays to the list whilst the patient is completed, and the rooms subsequently cleaned to allow for the next patient to proceed. Where possible, all patients with known infective status should be at the end of the list if clinically appropriate.

Action: for flow co-ordinators to attend wards (where possible) prior to inpatient procedures to allow for effective communication around the patients' needs/expectations when attending the department.

Cancer Care:

Overall bed capacity continues to be a challenge this includes the availability of side rooms for both infectious patients and patients who are neutropenic.

Action: Exploring isolation times and criteria for Rhino virus contacts currently.

Due to capacity patients in AOS have been waiting in the corridor at times to be seen and C bay has ran at 6 chairs rather than 4.

Action: aiming to mitigate risk by assessing infection status/likelihood of infection, use of curtains and screens and the use of filters and testing for all virus' so that they can be identified and we can act accordingly.

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

Emergency Care:

Continued focus on hand hygiene and peer reviews.

Medicine/MOP:

Current focus is to continue to manage multiple infections across multiple wards.

Hand hygiene focus ongoing.

Specialist Medicine:

Endoscopy spotlight review within the last month- 86% with some clear actions identified on the day of review between IPT and Unit lead. Action plan in place and shared with IPT, for review 17.11.23. Some good areas of practice identified to be shared with staff.

Endoscopy have failed 2 consecutive hand hygiene audits within the last quarter. Focus within the nursing team on correct hand hygiene process and local action plan to be generated.

Dermatology spotlight review within the last quarter- 83% action plan in place. 7x couches requiring replacement, the team are reviewing a plan for this with regards to finance/budget as likely cost £7k.

Managed Care spotlight review within the last quarter- action plan pending (due 31.10.23).

Cancer Care:

AOS staff room leak resolved and no further leaks.

C2 leaks from the ward above also resolved.

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

Emergency Care:

Long term resolution of plumbing/draining issues in ED.

Challenges to isolate some infections timely in crowded environment increases risk to patients and staff.

Medicine/MOP: Nil to add

Specialist Medicine: Nil to add.

Cancer Care: Nil to add

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 2023	Nov 2023

Appendix 6

Division C Q2 Matron and CGCL **Report to TEC**

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

Matrons: Karen Elkins (PAH), Victor Taylor (Neonates), Lucy Price (Maternity), Lorna St John (PICU), Felicity Oldman (Divisional) and Catherine Roberts (Child Health).

Clinical Lead: Balamurugan Thyagarajan and Charlie Keys

Date of Report: October 2023

Author: Louisa Green, Emma Northover

Performance Quarter 2 – 1st July to 30th September 2023

Key Indicator	Division C	Limit	Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 1** (COHA)
***Clostridium difficile* diarrhoea**	**2**	**Trust Limit 15**	**Trust Total 33** (HOHA + COHA)
E. coli (HOHA)	**4**	**Trust Limit of 30**	**Trust Total 31** (HOHA + COHA)
Pseudomonas (HOHA)	**1**	**Trust Limit of 9**	**Trust Total 3** (HOHA + COHA)
Klebsiella (HOHA)	**1**	**Trust Limit of 14**	**Trust Total 15** (HOHA + COHA)
MSSA Bacteraemia	**0**	**No Limit**	
GRE	**0**	**No Limit**	

	Cause	Comments
Incidents/ Outbreaks of Infection	G4 CPE	Patient with a CPE alert - OXA48 placed in a bay. Staff were aware of patient alert from 2022 and raised it to bed manager. Bed manager unaware of policy to continue to isolate if patient still has an alert on notes and until infection prevention have de-flagged. Advise given to nursing staff that the patient did not require isolation. Education given to bed managers and nursing staff to continue to check patients alerts, if alert is still in place the patient is to be treated as infectious until told otherwise by infection prevention team or micro. There was prompt isolation of positive patient and her contacts. CPE screening for contacts – one contact screened and was negative the second no screening completed as discharged soon after therefore needs to be screened on future admissions.

	G4 Rotavirus Outbreak	3x confirmed cases of Rotavirus and 2x discharged patients with symptoms. Review following this identified gaps present within stool charts and not all cases had a D&V good practice guide. In addition, some staff within SCH appeared to be unaware of Rapid gastro POC process. Clinical decision made to move a patient in double cubicle with patient who had unexplained loose stool with no stool result. Risk assessed at the time to be low risk and best option. Patient vomited in morning and moved to PICU due to high acuity therefore it does not appear patient was further screened.
	PMU C.diff PII	2 Patients tested positive for C.diff within 28 days. Review found there is learning required around incomplete stool charts, good practice guide and isolation risk assessments. It was also noted storerooms were dusty with equipment and boxes on floor. In the sluice a commode found to have poor cleaning technique under seat and footrest.

Performance Year to Date: 1st April 2023 – 30th September 2023

Key Indicator	Division C	Limit	Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 1** (COHA)
***Clostridium difficile* diarrhoea**	**6**	**Trust Limit 60**	**Trust Total 60** (HOHA + COHA)
E. coli (HOHA)	**6**	**Trust Limit of 120**	**Trust Total 70** (HOHA + COHA)
Pseudomonas (HOHA)	**3**	**Trust Limit of 33**	**Trust Total 10** (HOHA + COHA)
Klebsiella (HOHA)	**2**	**Trust Limit of 56**	**Trust Total 29** (HOHA + COHA)
MSSA Bacteraemia	**2**	**No Limit**	
GRE	**0**	**No Limit**	

Key Learning from Investigation of Infections and Deaths:

Southampton Childrens Hospital

G4 CPE – Education provided to bed management team and nursing staff to continue to check patients alerts, if alert is still in place the patient is to be treated as infectious until told otherwise by Infection Prevention team or microbiology.

G4 Rotavirus Outbreak – Education focus to be on good practice guide, rapid gastro POC, stool charts and isolation decisions.

PMU C.Diff - Education focus correct completion of stool charts, good practice guide and isolation risk assessment being in place and up to date. Focus on hygiene code including commode cleaning and regular spot checks to ensure it is implemented fully and consistently.

This provision will be rolled out across SCH and audited to ensure compliance and consistency.

Neonates - Rates of Klebsiella increasing. Confirmation received infection prevention team are coming to complete an assurance review on the respiratory care practices.
Domestic cleaning audit failed; it was highlighted the cleaners could not see well enough in the dimmed nurseries, and access to vents can be difficult. The nursing staff recognise the importance that the cleaning staff get good light and appropriate access and will adapt practices to support, including moving cots to clean under etc.

Progress and Success:

Children's Hospital - Refurbishment of G3 commenced in August 2023. CPAP masks education completed due to concerns how masks were being cleaned within different areas.

Maternity - Positive spotlight reviews were received in all maternity areas along with consistently good environmental and cleaning audit scores.

Neonates -There has been a focus on ANTT teaching including staff enrolling and staff undertaking train the trainer course, with additional staff booked on to future sessions. ANTT training is now included in staff inductions and a safety net has been developed that ad hoc teaching can also be provided to ensure all staff are captured.

The unit was not washing in-house linen at the correct temperature to be in line with trust policy. This has now been resolved and is now compliant with the temperature required.

Blunt needles are now used as standard practice on the unit and a lock has been fitted to sluice to secure used sharps bins away from public. These actions ensure we are now compliant.

Women's Health -PAH Outpatients **-** Environmental Cleaning Monitoring: Rated 5* and saving lives audits for hand hygiene 90% in October to be repeated. EPU/GAU, Colposcopy & Hysteroscopy and Urodynamics & Physio, Theatre and Bramshaw are also compliant.

Clinical Services
All on call respiratory physios competent for suctioning and competencies completed.

Ongoing Challenges:

Southampton Children's Hospital - Increased demand on isolation facilities due to high levels of paediatric patients requiring admission with RSV. Critical care isolation facilities within PICU have improved due to estates work last year to creating additional side rooms. The relocation of PHDU (adjacent to PICU) has added a further side level 2 side room.

However, demand for level 1 isolation facilities remains high to support flow from ED and paediatric critical care. Cohort bays are regularly being utilised to support this additional demand. Side rooms are required for isolation for infection prevention and CAMHS patients.

Estates/maintenance support being provided for 2 Side rooms not in use in E1 and Piam Brown, leaks from John Atwell Day Unit and G4 continue to cause disruption and attempts to repair are being addressed.

Audit Submission inconsistent affecting accreditation. Infection Prevention matron leading to address this - direct contact with link role representatives, highlight in Band 7 meeting, individual emails and check list once completed for each ward for each audit.

COVID contacts risk assessed and not required to be recognised in Paediatrics as children are not deemed at risk, the only exception is immune compromised children are not to be nursed with contacts.

Maternity - Recent spotlight on Labour Ward, Broadlands and F level identified estate challenges, these issues have been reported with Estates on Planet. Staff awareness of IP practice including audits and improvement plans. Low- and high-level dust found, escalated to Serco currently being monitored.

Neonates -Sluice updated since a case of Klebsiella on the unit. A new extended work surface for the housekeepers installed for more surface space when cleaning. Fluid waste disposal point is currently out of action in the sluice, a toilet has been isolated at the far end of the unit to dispose of contaminated water/ liquid waste on the unit. There is ongoing work to re-locate incubator de-contamination to re-commission the fluid disposal unit in the Sluice.

Insufficient space on NNU has been highlighted as an ongoing issue on the register since July 2015. This is compromising patient safety due to inadequate spacing between patient bedspaces in the clinical areas. The recommendation is 2 meters between incubators. NNU expansion plan has commenced and addresses this issue.

Water safety is a concern, especially as the coffee room tap is growing pseudomonas. A refurbishment for the staffroom is being considered, currently there are 'not drinking water' signs up in coffee room, milk kitchen and expressing room.

Theatres - Cleaning audits failed due to dirty bottom part of clinical equipment, tap not free from limescale, dusty vent, dust built up on skirting boards. Post Clinical Cleaning Audit failure Action Plan completed. Education and auditing to be carried out to ensure compliance.

Support Services - Infection Prevention are reviewing NP suction technique within Paediatrics with reference to the use of sterile gloves and concerns over double gloving.

Audits data not appearing with Infection prevention despite being completed currently showing as non-compliant, this is being investigated by infection prevention.

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

Southampton Children's Hospital - Promote Trust Infection Control processes including audits, correct isolation, good hand hygiene and ANTT and audit to ensure compliance. Continue to work with estates to support issues.

Maternity - Reminder to staff to check CPI alerts on admission. Planning to have theme of the week and maternity mail feature following Spotlight areas for improvement. Work with education team regarding IP training during new staff inductions.

Neonates - Working closely with domestic team to ensure a thoroughly cleaned environment, focusing on ANTT training to ensure compliance for all staff, and linen practices reviewed, and policy disseminated to all staff to ensure compliance with washing linen on the unit.

Key action plan to take forward:

- Review of environment and practices with the infection control team following increased Klebsiella rates on the unit
- Incubator cleaning SOP to be passed through governance.
- Expansion plans for special care to move and unit to be refurbished to start. This should help to improve the current situation.

Clinical Services - Reviewing NP suctioning technique to ensure meets Infection Prevention Guidelines and policy.

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

Maternity - Ongoing challenges regarding estates issues compromising infection prevention identified in recent spotlight reviews and reoccurring issue of mould growing on the walls and sealant around the windows that have not been replaced as part of the new windows scheme at PAH. Solutions are actively being sought.

Southampton Children's Hospital - Side room availability for level 1 capacity continues to be challenging this will improve with estates upgrading work (G3).

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 2023	October 2023

Appendix 7

Division D Q2 Matron and CGCL **Report to TEC**

Care Groups: Cardiovascular and Thoracic, Neurosciences, Trauma and Orthopaedics and Radiology

Matrons: Jenny Dove, Sonia Webb, Jean-Paul Evangelista, Sarah Halcrow, Beverley Ann Harris, Rebecca Tagg, Claire Liddell, Tracy Mahon, and Rebecca Tagg.

Clinical Lead: Edwin Woo, Boyd Ghosh, Jonathan Hempenstall, Nick Hancock, and Charles Peebles

Date of Report: October 2023

Author: Natasha Watts

Performance Quarter 2 – 1st July to 30th September 2023

Key Indicator	Division D	Limit	Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 1** (COHA)
***Clostridium difficile* diarrhoea**	**3**	**Trust Limit 15**	**Trust Total 33** (HOHA + COHA)
E. coli (HOHA)	**4**	**Trust Limit of 30**	**Trust Total 31** (HOHA + COHA)
Pseudomonas (HOHA)	**0**	**Trust Limit of 9**	**Trust Total 3** (HOHA + COHA)
Klebsiella (HOHA)	**2**	**Trust Limit of 14**	**Trust Total 15** (HOHA + COHA)
MSSA Bacteraemia	**0**	**No Limit**	
GRE	**1**	**No Limit**	

	Cause	Comments
Incidents/ Outbreaks of Infection	Radio pharmacy Sewage Leak	Sewage came rapidly up via shower drain and toilet adjacent to aseptic suite. Estates did not check after the leak had been controlled to assess what works were required and the quality of the cleaning. Lack of awareness there were issues with still needed to be resolved before unit could commence its revalidation process. When checks made leak/ mould found behind skirting. SSH cleaned inadequately. No signage on office door not to enter the office (staff assumed the carpet had been cleaned)
Period of increased incidence of MRSA	Not identified	Ward F1 (MTU) had 2 confirmed cases of hospital acquired MRSA within 28 days of admission. The first patient was admitted on 23/09/23 into Purple bay and was positive on 28/09/23. The second patient was admitted on 22/09/23 into Trauma 2 bay and was positive on 10/10/23. The 2 patients were not nursed in the same area before the positive results and their ribotyping was different which means there was no onward transmission. On the IPT monitoring visits, it was identified that though patients are screened when transferred from other care groups in UHS, reduction

		measures are not given as per policy. Action plan to educate staff has been agreed on by the IP link nurses.
Period of increased incidence of C. diff	Possible environmental contamination	Ward F1 (MTU) had 2 confirmed cases of hospital acquired *Clostridioides difficile* within 28 days of admission. The first patient was admitted on 12/09/23 and was positive on 21/09/23, was not nursed in the same bay with the second patient who was admitted on 08/09/23 and was positive on 03/10/23. The ribotyping for the C. diff results was found to be different. The IPT found dirty commodes on their monitoring visits. Action plans have also been agreed on by the IP link nurses to continue teaching staff how to clean commodes.
Covid-19 outbreak		This month several covid concerns. F3 Blue bay covid concern following a visitor stating they were positive followed by her mother who was the patient. Also a covid episode with one male patient which covered areas across F1 and Brooke ward. Unknown if these were outside or internal UHS outbreak. Currently watching nurse numbers on F3 after the initial cases were found.

Performance Year to Date: 1st April 2023 – 30th September 2023

Key Indicator	Division D	Limit	Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 1** (COHA)
***Clostridium difficile* diarrhoea**	**9**	**Trust Limit 60**	**Trust Total 60** (HOHA + COHA)
E. coli (HOHA)	**8**	**Trust Limit of 120**	**Trust Total 70** (HOHA + COHA)
Pseudomonas (HOHA)	**1**	**Trust Limit of 33**	**Trust Total 10** (HOHA + COHA)
Klebsiella (HOHA)	**3**	**Trust Limit of 56**	**Trust Total 29** (HOHA + COHA)
MSSA Bacteraemia	**2**	**No Limit**	
GRE	**2**	**No Limit**	

Key Learning from Investigation of Infections and Deaths:

CVT:

BSI D4 - line related infection (D4), concluded cannula insitu 4 days.

Neuro:

Two cases of Clostridium Difficile (C.diff) on DNU, post infection review was undertaken, key learning identified documentation not being completed.

Progress and Success:

Action plans were submitted from several wards that had performed inadequately on the hand hygiene audits. Wards have been re audited with a better result. However not all wards have seen an improvement and further education is being provided and the glow box is being circulated across throughout the unit.

Clostridium Difficile (C.diff) post infection review was undertaken on F4S, good areas of practice were highlighted, and all documentation was completed appropriately.

Ongoing Challenges:

Ventilation installed in F1 and F2 has not been completed. Now in its 5th month. F2 has now had some cased but waiting for switches to be re-installed to ensure this is able to be used.

F1 has not been activated since installation, which is a delay and for escalation, please.

Please note the F1 ventilation has therefore not been in use during these last outbreaks as work is not completed.

2 incident reports within 2 weeks on the failure to comply with the management of cannulas as per IPC guidance. Both reports were for cannulas that had been in situ for 9 days without any documentation on inpatient noting from admission to Ward F2. One of the cannulas was inserted in theatre and the paper insertion form was completed in theatre and the second cannula was inserted in ED Pitstop and the catheter insertion form was completed in ED. The root causes for the error of omission have been:

- ED and Theatre do not use inpatient noting so there is no continuation of the documentation process.
- Handing over of cannulas which should be done is not done routinely.

Candida Auris D4 vascular - total 41 pts, environmental swabs testing positive, decision made to not screen staff.

Difficulties with transport refusing to transport patients with candida and for Lymington Hospital to accept patients. Escalated and discussed at regional level – now resolved.

Delays to recruitment for CVT IFC lead post due to HR issue.

The poor environment within the neuro building has created issues when it is required to isolate patients. This was further highlighted on E Neuro when covid contact bay needed to be cordoned off by kwick screens.

Poor hand hygiene compliance in Interventional Radiology – further training provided for the team and ad hoc audits.

An infection control spotlight in radiology day unit highlighted lack of storage space resulting in boxes being stored on floor.

Recent infection control spotlight audits carried out on Radiology Day Unit and Neuro Outpatients highlighted some areas of concern with regards to cleaning, SERCO are aware and actions being put in place.

Catheter audits carried out in September highlighted some concerns relating to inpatient noting and as a result failed. Sisters across the unit have worked with the Infection Control and the inpatient noting team to ensure that this has been rectified but still poses a challenge.

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

Candida Auris:
UHS IFC team, D4 vascular ward and ICB regional teams (QA, HHFT) working together to monitor and review any new incidence.
ICB establishing a community working group
UHS IFC creating SOP

Ongoing support for IP ward links to provide education at ward level
Care group walkarounds, lunchtime teaching, ward study days to restart

Focus on hand hygiene, correct isolation processes and appropriate PPE for infections and cleaning
VIPS focus cannula removal within 72hrs

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

CVT:
Recurrent sewage leaks into bathrooms of all 6 D4 side rooms during summer and autumn. Risk of infection to patients and staff, however nil confirmed.

Investigated and inspected on numerous occasions by estates and external company. Patients were being evacuated twice weekly. Great stress and upset was caused to the ward team who were accused of deliberately flushing wipes blocking the plumbing system. However, leaks eventually resolved after removal of blockage in plumbing system caused by a 'card reader', following the commissioning of an external company to review the pipework. A report on the pipe work has since shown following further investigation that the configuration of the pipework is prone to blockages, and now further survey work is planned to determine what action is required to fix this.

Ventilation installed in F1 and F2 has still not been completed, this raises a risk to spread of infection.

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 2023	October 2023

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Ward Staffing Nursing Establishment Review August 2023 – October 2023**			
Agenda item:	**5.14**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Rosemary Chable, Head of Nursing for Education, Practice and Staffing**			
Date:	**30 November 2023**			
Purpose:	**Assurance or reassurance** ☑	**Approval**	**Ratification**	**Information**
Issue to be addressed:	Requirement to undertake systematic ward staffing establishment reviews. The systematic review of ward staffing presented annually to TEC since 2009 and 6 monthly to Trust board since 2014. Now reported annually to TB with 6 monthly light-touch reviews presented at divisional boards. Findings validated at Nursing and Midwifery Staffing Review Group on 31st October 2023 and discussed at TEC on 22nd November 2023			
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 2023 – October 2023. 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 TEC and 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: ○ UHS nursing establishments are set to achieve a range of 1:2 to 1:9 registered nurse to patient ratio in most areas during the day with the majority (47) set between 1:4 to 1:8. Differences relate to specialty and overall staffing model. ○ The majority of wards (38) 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 (2) are both higher intensity care areas requiring a higher registered skill. 35 wards (up from the 34 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 5.4 – 19.3 and average at 8.0 • To note the impact of budget setting on staffing levels for 2023/24 and Divisional requirements for consideration (with corporate overview) as part of budget setting 2024/25. • 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 support the continued Trust wide commitment and momentum on actions to fill ward based vacancies and further reduce the reliance on high-cost agency, against the backdrop of rising acuity and emergency and elective recovery. • To discuss the report at TEC and onward to 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 2023 – October 2023. 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 maternity, critical care, theatres and the emergency department have been reviewed separately.

1.3 Divisional 'light touch' 6 monthly staffing reviews took place in March/April 2023 for Divisions A, B and D and were reported to their relevant divisional boards. Division C were undertaking continuous reviews of their areas due to budget and establishment changes and therefore did not complete a formal review until just prior to the annual review. Emergent themes have therefore been incorporated into this annual review.

1.4 It should be noted that due to the ongoing COVID-19 recovery situation as well as challenges with capacity and service re-configurations all ward establishments and nurse staffing levels have continuously been reviewed as ward function, specialty and acuity/dependency levels have continued to fluctuate.

1.5 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.

1.6 This report fulfils expectation 1 and 2 of the National Quality Board requirements for Trusts in relation to safe nurse staffing 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). 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). Now incorporated into the Healthroster Safecare system
- 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

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 (October 2023) shows maintenance of compliance levels despite the ongoing recruitment, activity and financial challenges. 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.* Whilst there is some allowance within the 23% headroom, requirements for supervision are growing with revised initiatives around preceptorship, staff wellbeing and student supervision. Learner numbers (students, international and apprentices, preceptees) are increasing with limited additional supervisory support available. Timescale for completion extended to April 2024 the Trust continues to review headroom allowance overall.

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

2.2.3 In July 2014 NICE published *Clinical Guideline 1: Safe Staffing for nursing in adult inpatient wards in acute hospitals.* This guideline is made up of 38 recommendations. A detailed action plan was developed within UHS and is reviewed 4 monthly by the Nursing and Midwifery Staffing review group. The current assessment (October 2023) 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.

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 4), 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 remains 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 improved patient outcomes.

2.3 6 monthly Ward Staffing review August 2023 – October 2023 – Outcomes

2.3.1 The 6 monthly review was carried out from August 2023 – 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.

2.3.2 The detailed spreadsheet with ward-by-ward findings is included at Appendix 5. 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 capacity and service situation, including new ward build and ward moves. A number of rostering template reviews were therefore instigated as a result of the review discussions so some figures will have changed for individual wards since the review.

2.3.4 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 and is having a measurable impact on the reduction in high-cost agency bookings.

The value of this service, which is now funded recurrently post-covid, came out strongly in the reviews.

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.

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

- The ward establishments across UHS allow for registered nurse to patient ratios during the day to range from 1:2 (Eye short stay) to 1:9 (Bassett, D6, D7 and D8) depending on specialty and overall staffing model. This is a further slight increase

in the number of wards with lower RN: patient ratios (particularly noted in medicine) 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 (47 wards) with 38 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 (13 wards) are the medicine wards, Medicine for Older People (all MOP wards including Bassett), Brooke 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.
  - Wards are piloting different twilight shift patterns (within existing budget) to continue to support the demands at night.
  - Rising acuity of patients, more therapeutic activity taking place overnight and the impact of more geographically spread clinical areas has increased the pressure on the staffing resource at night.
- Following previous reviews there are now 3 in-patient ward areas with ratios higher than 1:11 (RN to patient) at night (an increase of 1 on last year). These are E3(G), Brooke and the Acute Oncology Service, where the ratios rise to 1:12 and 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 Brooke this is linked to the service model and is offset by a total nurse to patient ratio of 1:5. For AOS this is linked to the patient throughput, which is unpredictable and difficult to establish an actual nurse to patient ratio. The total nursing level in AOS at night is at 1:7.

2.3.6 ***Registered to unregistered ratios***

- UHS ward areas were reviewed against the benchmark of 60:40 registered to unregistered ratios as the level to which ward establishments should ideally not fall below unless planned as the model of care.
- 14 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.
- 35 wards (up from the 34 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.

- 7 wards (1 more than 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, 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.

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

- The Safer Nursing Care Tool (acuity/dependency model) has been used to model required staffing based on the national recommended nurse to patient ratios for each category of patient in all 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. During the review period, a Trust-wide rollout of a new version of the software took place which has seen a total refresh of the use and application of the safer nursing care tool to ensure this is being used consistently across the organisation.

2.3.8 ***Care Hours Per Patient Day***

- Planned total Care Hours Per Patient Day (CHPPD) range from 5.4 (G5 and G8) rising to 19.3 (Piam Brown) and average at 8.0. The average is slightly lower than the previous year and there are a higher number of wards in the lower range.
- Registered care hours per patient day range from 2.6 (Brooke) rising to 14.6 (Piam Brown) and average at 4.6. This average is slightly lower this year.
- Unregistered care hours per patient day range from 1.5 (E1) – 8.6 (G2 Neuro) and average at 3.3. This average is slightly lower than last year.

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

- All areas have 23% funding allocated to allow for additional headroom requirements arising from non-direct care time. The COVID-19 impact saw a significant rise in the headroom required due to increased sickness levels, this has reduced but there is still significant pressure on maintaining staffing within the allowed headroom. This is due to high training levels (resulting from the more junior workforce) and maternity/paternity levels that consistently exceed the allowance.
- 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.

2.3.10 ***Specific Divisional issues emerging***

Specific Divisional issues highlighted in the review are contained in Appendix 6.

2.4 Trust wide risks and issues considered in the review

2.4.1 ***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 as our patients are definitely presenting with a higher level of both acuity and dependency.

Information on the acuity and dependency of our patients 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 in some services. Outreach in particular have continued to be unable to support the wards out of hours creating additional pressure to the ward staffing model.

2.4.2 ***Increasing enhanced care needs***

Trust wide we have continued 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 continued to see a significant rise in the number of children requiring additional mental health support 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 but.

The numbers however remain unpredictable and are therefore managed in real-time as part of overall considerations around safe staffing. The staffing hub is now co-ordinating the requests for additional staff with additional mental health needs specifically linked to the mental health support team.

2.4.3 ***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.

New national guidance was issued in October 2022 and implemented within UHS during 2023 with additional requirements in relation to the provision of preceptorship for all staff new to registration. 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 23/24 to strengthen the education teams and clinical supervision support to the clinical areas. The designated HCSW support hub and 'welcome ward' concept has made a significant impact on the retention for this group of staff. Recurrent funding has not been identified for this initiative beyond the external funding and this will need further consideration as part of budget setting.

The capacity and capability within the education and support teams needs to be further reviewed for 24/25 to ensure they can continue to support the further increase in numbers which will be required for UHS to meet the challenging workforce targets set in the national plan - with nursing student placements set to increase by up to 230% in the southeast over the coming years.

2.4.4 *Vacancies*

Total reported nursing vacancies (registered and unregistered) across the inpatient areas at the time of the staffing review (September 2023) were running at 380 (10.3%) with registered nurse vacancies at 207 (9.2%) and unregistered at 152 (12.5%). Encouragingly both registered and unregistered nursing vacancies continue to gradually reduce with the continued range of recruitment and retention initiatives. Focus in now on managing the temporary resource use that has previously offset the vacancy position.

2.4.5 *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.

Hospitals with a high volume of critical care beds (providing 1:1 care) will have a higher CHPPD.

Table 1

Organisation/Group	Total CHPPD	Registered CHPPD	Unregistered CHPPD
UHS excl. Critical Care	8.0	4.6	3.3
UHS with Critical Care	10.6	6.7	3.9
Shelford Group	9.8	5.9	3.1
MHS Peer Group	8.6	5.4	3.3
Region	8.9	5.4	3.2
National	8.5	5.0	3.4

All data submissions (registered and unregistered) are averaged so will not necessarily equal the total CHPPD)

Data is from the MHS July 2023 (latest figure) and includes nursing and midwifery and ward AHP staffing. and the UHS excluding critical care is UHS reporting Sept 2023 just for nursing.

Following the TEC discussion there will be a further focus on gaining some additional benchmarking information for future review.

2.4.6 ***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 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.

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.

4.6 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 rising acuity and emergency and elective recovery.

4.7 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 2024.

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 hospital - 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.

V21 Reviewed at NMSRG 31st October 2023

NATIONAL QUALITY BOARD - JULY 2016

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

	Descriptor	No.	Recommendation	Current measures in place	Assessed UHS rating (October 2023) 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	Head of Nursing - staffing/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	Head of Nursing - staffing/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	Head of Nursing - staffing/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	Head of Nursing - staffing/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	Head of Nursing - staffing/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	Head of Nursing - staffing/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	Head of Nursing - staffing/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 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 which has not fallen significantly. Discussions ongoing to reflect accurate headroom levels as part of budget setting particularly in light of current financial challenges	Apr-24	Head of Nursing - staffing/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	Head of Nursing - staffing/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. Ensuring any N&M specific actions are also incorporated into the retention toolkit and action plan	ongoing through E & D	Chief Nurse/People Director
		2.3.2	The organisation has effective strategies to recruit, retain and develop their staff, as well as managing and planning for predicted loss of staff to avoid over-reliance on temporary staff.	Full retention and recruitment programme of work ongoing and a workforce project management office established to maintain the focus	C	Confident that there are effective strategies in place and remains an area for ongoing action. Continued focus and evaluation of the wide ranging streams of work in place to support retention and recruitment	ongoing through R & R steering group	People Director /DMT
		2.3.3	In planning the future workforce, the organisation is mindful of the differing generational needs of the workforce. Clinical leaders ensure workforce plans address how to support staff from a range of generations, through developing flexible approaches to recruitment, retention and career development	Generational work starting to be incorporated into projects for retention and recruitment and specifically around preceptorship.	C	Research partnership with Burdett and Birmingham to review self rostering. Flexibility sub group established as part of R & R actions to review different approaches to flexibility for generational needs. Joined RePAIR work on flexibility and NHSI retention collaborative	ongoing through R & R steering group	Associate Director of People/Director of TD&W/DMT
	Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board, if concerns arise. Directors of nursing, medical directors, directors of finance and directors of workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.	**3.1 Productive working and eliminating waste**							
		3.1.1	The organisation uses 'lean' working principles, such as the productive ward, as a way of eliminating waste.	Transformation work incorporates lean techniques and productive ward techniques applied as appropriate including reviews of care hours, safety crosses, knowing how we're doing boards and patient status at a glance	C	Lean techniques used systematically as part of transformation	complete	Head of transformation/DMT
		3.1.2	The organisation designs pathways to optimise patient flow and improve outcomes and efficiency e.g. by reducing queuing.	Incorporated into all service redesign	C	Clear focus on flow and avoiding bottle-necks in service design.	complete	Head of transformation/DMT
		3.1.3	Systems are in place for managing and deploying staff across a range of care settings, ensuring flexible working to meet patient needs and making best use of available resources.	Staff are employed to be fully flexible (skills and competence allowing).	C	Continued review as part of daily staffing meetings to maximise flexibility of staff	complete	Chief Nurse/DMT
		3.1.4	The organisation focuses on improving productivity, providing the appropriate care to patients, safely, effectively and with compassion, using the most appropriate staff.	Staff are employed to be fully flexible (skills and competence allowing).	C	Continued review as part of daily staffing meetings to maximise flexibility of staff	complete	Chief Nurse/DMT
		3.1.5	The organisation supports staff to use their time to care in a meaningful way, providing direct or relevant care or care support. Reducing time wasted is a key priority.	Included as part of methodology of reviews of staffing. Direct care time monitored. Other roles utilised to maximise direct care	C	Continue with current approach	complete	Chief Nurse/DMT
		3.1.6	Systems for managing staff use responsive risk management processes, from frontline services through to board level, which clearly demonstrate how staffing risks are identified and managed.	Clear escalation processes in place and risk register and AER system used to record, review and learn from any staffing issues	C	Continue with current approach and monitor ongoing trends with staffing risks	complete	Chief Nurse/DMT

Expectation 3: Right place and time		**3.2 Efficient deployment and flexibility**						
		3.2.1	Organisational processes ensure that local clinical leaders have a clear role in determining flexible approaches to staffing with a line of professional oversight, that staffing decisions are supported and understood by the wider organisation, and that they are implemented with fairness and equity for staff.	Involvement of clinical leaders at all levels in setting establishment levels and rostering workforce. This is systemetically reviewed through 6 monthly staffing reviews reported to board	C	Continue with current approach	complete	Chief Nurse/DMT
		3.2.2	Clinical capacity and skill mix are aligned to the needs of patients as they progress on individual pathways and to patterns of demand, thus making the best use of staffing resource and facilitating effective patient flow.	Clinical speciality, acuity, dependency and pathways inlcuded as part of the systematic review of staffing levels	C	Continue with current approach	complete	Chief Nurse/DMT
		3.2.3	Throughout the day, clinical and managerial leaders compare the actual staff available with planned and required staffing levels, and take appropriate action to ensure staff are available to meet patients' needs.	Regular reviews of staffing levels planned and actual undertaken at care group, Division and trust wide level through daily stafifng meetings linked to site.	C	Continue to strenghten the daily staffing meetings and utilise safecare information	complete	Head of Nursing - staffing/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	Head of Nursing - staffing/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	Head of Nursing - staffing/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

V26 May 2023 - Reviewed at NMSRG 31st October 2023

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

UHS FT self-assessment and action plan

	No.	Recommendation	NICE category Must (M) Should (S) Consider (C)	Current measures in place	Initial Assessed UHS rating (July 2014) C = compliant A = Actions required	Identified actions required (24 compliant, 14 action)	Timescale	Lead	October 2023 compliance	October 2023 (37 compliant, 1 requiring action)
	Organisational strategy - Recommendations for hospital boards, senior management and commissioners in line with NQB expectations									
Senior management and commissioners in line with NQB expectations	1.1.1	Ensure patients receive nursing care they need regardless of ward, time, day.	M	Specialty and sub-specialty ward system in place Outlying/inlying patients monitored through site	C	Continued monitoring of compliance	Maintain	Clinical teams/DMT	C	Continued monitoring of compliance. Reconfiguration of ward specialties and skills occurring due to COVID-19 and ongoing review of skills taking place as part of staffing allocations.
	1.1.2	Develop procedures to ensure ward staff establishments are sufficient to provide safe nursing care for each patient	M	6 monthly establishments reviews in place led by DoN team with DHN/Matron/ward leaders as appropriate.	C	Continued development of staffing review methodology linked to NICE guidance		Chief Nurse/Head of Nursing - staffing/ 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/Head of Nursing - staffing/ 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/Head of Nursing - staffing/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	Head of Nursing - staffing/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		Head of Nursing - staffing/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	Head of Nursing - staffing/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	Head of Nursing - staffing/DHN/safety team	C	Red flag information now routinely captured through safecare (real-time) and reviewed through staffing hub. AER's also capture red flag information and this is reviewed systematically monthly and reported to board for trends. Included in staffing establishment reviews.

Organisational strategy - Recommendations for hospital boards, se	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	Head of Nursing - staffing/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	Apr-24	Head of Nursing - staffing/DHN	A	Management of trustwide staffing deficits via the staffing hub have minimised the risk of this however continued vacancy position and capacity situation does not enable assurance that wards are not compromised by staff movements.
	1.1.12	Ensure there is a separate contingency and response for patients requiring continuous presence 'specialling'	M	Specialling processes in place and agreed escalation process within divisions.	C	Review the process for requesting specialling support.	Maintain	Head of Nursing - staffing/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	Head of Nursing - staffing/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	Head of Nursing - staffing/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	Head of Nursing - staffing/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	Head of Nursing - staffing/DHN/ Education leads	C	Continue to strengthen and evidence the process
	1.1.17	Ensure there are sufficient registered nurses who are experienced and trained to determine day-to-day staffing needs in 24 hour period	M	Bleep-holder role includes requirement to assess and review staffing and risk assess	A	Review to ensure all bleep-holders are competent and capable in staffing assessment and risk management	Maintain	DHN/Matron	C	Additional education put into bleep holding as part of winter pressure oversight arrangements. Now in place with bleep holding and band 7 weekend review
	1.1.18	Organisation should encourage staff to take part in programmes to assure quality of nursing care and care standards	S	Nursing staff involved in range of quality improvement programmes e.g. essence of care, nursing practice, turnaround, clinical accreditation scheme	C	Continue to involve staff at all levels in nursing quality standard development	Maintain	DHN/Head of Quality and Clinical Assurance	C	Continue to involve staff at all levels in nursing quality standard development
	1.1.19	Involve nursing staff in developing nursing policies which govern nursing staff requirements such as escalation policies	S	Nursing staff involved in developing policy through groups and consultation	C	Continue to involve staff at all levels in nursing policy development	Maintain	DHN/Head of Quality and Clinical Assurance	C	Continue to involve staff at all levels in nursing policy development
etermining nursing staffing commendations for registered of individual wards or shifts	**Principles for determining nursing staffing requirements -** Recommendations for registered nurses in charge of individual wards or shifts who should be responsible for assessing the various factors used to determine nursing staff requirements									
	1.2.1	Use systematic approach to determining nursing staff requirements when setting nursing establishments and on day to day	M	Professional judgement and SNCT embedded for use within the Trust. Clear 'established levels' identified on eRoster	C	Continue to support staff at local ward level to understand establishments and staffing models	Maintain	DHN/Matrons/Ward Leaders	C	Continue to support staff at local ward level to understand establishments and staffing models. Staffing hub has strengthened the understanding of staff at different levels
	1.2.2	Use a decision support toolkit endorsed by NICE to determine nursing staff requirements		Not yet available through NICE but UHS already uses nationally validated Safer Nursing Care Tool (SNCT) as part of methodology for reviewing staffing levels	C	Review NICE endorsed tools as they emerge	Continuous review of emerging national guidance	Head of Nursing - staffing	C	Review NICE endorsed tools as they emerge. Continue to use endorsed SNCT and incorporate into safe care module.

Principles for de requirements - Rec nurses in charge	1.2.3	Use informed professional judgement to make a final assessment of nursing staff requirements	M	Professional judgement used as mainstay of methodology for reviewing establishments and day to day staffing	C	Continue to support staff at local ward level to understand establishments and staffing models	Maintain	DHN/Matrons/Ward Leaders	C	Continue to support staff at local ward level to understand establishments and staffing models. Stregnthened through the staffing hub
	1.2.4	Consider using nursing care activities included in guidance as a prompt to help inform professional judgement (see separate tab)	C	Already considered routinely as part of professional judgement and methodology	C	Continue to support staff at local ward level to understand establishments and staffing models	Maintain	DHN/Matrons/Ward Leaders	C	Continue to support staff at local ward level to understand establishments and staffing models
Setting the ward nursing staff establishment - Recommendations for senior registered nurses responsible for determining nursing staff requirements or those involved in setting the nursing staff establishment	**Setting the ward nursing staff establishment -** Recommendations for senior registered nurses responsible for determining nursing staff requirements or those involved in setting the nursing staff establishment of a particular ward									
	1.3.1	Setting ward establishments should involve designated senior registered nurses at ward level experienced and trained in determining nursing staff requirements using recommended tools	S	Ward sisters already involved in ward establishment reviews but approach needs strengthening. Competency for establishment review included in ward leader competencies	A	Strengthen involvement and training of ward leaders and other nurses through staffing master classes	Maintain	Head of Nursing - staffing/DHN/Workforce Systems	C	Current staffing review has full representation from ward leaders
	1.3.2	Routinely measure the average amount of nursing time required throughout a 24 hour period for each patient expressed as nursing hours per patient.	S	Methodologies not previously based on nursing hours per patient but safe nursing care tool and professional judgement	A	Include nursing hours per patient as a methodology in the staffing reviews from November 2014 Introduce next version of eRostering which has functionality to convert data into hours per patient	Maintain Maintain	Head of Nursing - staffing/Workforce Systems Head of Nursing - staffing/Workforce Systems	C C	Care hours per patient day now embedded as part of monthly reporting and included in safecare module of eRoster. Used as part of 6 monthly review from July 2016. reviewed as a metric in the staffing hub Safe care rollout complete
	1.3.3	Formally analyse the average nursing hours required per patient at least twice a year when reviewing the ward nursing staff establishments	S	Methodologies not previously based on nursing hours per patient but safe nursing care tool and professional judgement	A	Include nursing hours per patient as a methodology in the staffing reviews from November 2014	Maintain	Head of Nursing - staffing/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	Head of Nursing - staffing/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	Head of Nursing - staffing/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	Head of Nursing - staffing/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	Head of Nursing - staffing/DHN	C	Continued consideration at establishment reviews. Continued monitoring of 23% headroom through eRostering
aff available on the day meet ecommendations for registered s on wards	**Assessing if nursing staff available on the day meet patients' nursing needs -**Recommendations for registered nurses on wards who are in charge of shifts									
	1.4.1	Systematically assess that the available nursing staff for each shift or at least each 24 hour period is adequate to meet the actual nursing needs of patients on the ward	S	Daily spreadsheet used in site to review safe staffing - Matrons expected to link with all wards to determine staffing levels	C	Continued review of staffing levels included as a key responsibility in the ward leader and matron role	Maintain	Ward Leaders/ Matrons/ DHN	C	Continued review of staffing levels included as a key responsibility in the ward leader and matron role. Oversight from the staffing hub now enhancing the 24 hr view
	1.4.2	Monitor the occurrence of the nursing red flag events throughout a 24hour period	M	Escalation processes in place through bleep-holders through to site. Matrons responsible for reviewing staffing daily and this should include red flags	A	Care groups/Divisions to develop processes for review, reporting and capture of red flags through escalation processes	Maintain	Ward Leaders/ Matrons/ DHN	C	Monitoring of red flags on ongoing basis and key metric considered at staffing hub huddles. Reflected in AER reporting

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

Appendix 4

RCN Nursing Workforce Standards – May 2021

Overview

Appendix 5

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

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

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

					Finance budgeted			Staffing Numbers						Planned on Template (long day factor applied)				Actual demand average in Sept 2023 (In Safe Care)	Actual average (Calculated on actual hours provided and average patient numbers at midnight)
Division	**Care Group**	**Unit Name**	**Shift**	**Total Beds**	**Budgeted Total 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)**	**Planned Registered (CHPPD)**	**Planned Unregistered (CHPPD)**	**Total Planned CHPPD**	**Safe Care**	**Total Actual Demand CHPPD**	**Total Actual CHPPD**
Division A	Surgery	SUR Acute Surgical Admissions	Early	30	40.0	23.8	16.2	6	3	9	67 : 33	1 : 6	1 : 4	3.5	2.0	5.5	6.03	9.2	6.9
		SUR Acute Surgical Admissions	Late	30				6	2	8	75 : 25	1 : 6	1 : 4						
		SUR Acute Surgical Admissions	Night	30				3	3	6	50 : 50	1 : 11	1 : 6						
		SUR Acute Surgical Unit	Early	12	24.9	16.3	8.6	3	2	5	60 : 40	1 : 5	1 : 3	5.8	3.9	9.7	9.91	6.6	12.5
		SUR Acute Surgical Unit	Late	12				4	1	5	80 : 20	1 : 4	1 : 3						
		SUR Acute Surgical Unit	Night	12				2	3	5	40 : 60	1 : 7	1 : 3						
		SUR E5 Lower GI	Early	18	30.3	18.7	11.7	4	3	7	58 : 42	1 : 5	1 : 3	4.1	3.2	7.3	7.52	7.7	7.9
		SUR E5 Lower GI	Late	18				3	2	5	64 : 36	1 : 6	1 : 4						
		SUR E5 Lower GI	Night	18				2	2	4	52 : 48	1 : 9	1 : 5						
		SUR E5 Upper GI	Early	18	30.5	17.4	13.1	4	3	7	59 : 41	1 : 5	1 : 3	4.2	3.1	7.3	7.43	7.5	7.8
		SUR E5 Upper GI	Late	18				2	1	3	68 : 32	1 : 9	1 : 7						
		SUR E5 Upper GI	Night	18				2	2	4	52 : 48	1 : 9	1 : 5						
		SUR E8 Ward	Early	26	53.9	34.2	19.7	7	4	11	64 : 36	1 : 4	1 : 3	5.4	3.1	8.4	9.23	7.1	8.6
		SUR E8 Ward	Late	26				7	4	11	64 : 36	1 : 4	1 : 3						
		SUR E8 Ward	Night	26				5	3	8	63 : 37	1 : 6	1 : 4						
		SUR F11 IF	Early	17	29.8	20.3	9.4	4	2	6	67 : 33	1 : 5	1 : 3	5.1	2.8	7.9	7.43	9.9	7.3
		SUR F11 IF	Late	17				2	1	4	68 : 32	1 : 7	1 : 5						
		SUR F11 IF	Night	17				3	2	5	61 : 39	1 : 6	1 : 4						
		SUR F5 Ward	Early	28	36.7	22.7	14.0	5	3	8	65 : 35	1 : 6	1 : 4	3.6	2.0	5.6	5.23	6.4	6.2
		SUR F5 Ward	Late	28				3	2	5	60 : 40	1 : 10	1 : 6						
		SUR F5 Ward	Night	28				3	2	5	60 : 40	1 : 10	1 : 6						
	Emergency Care	ECM Acute Medical Unit	Early	60	136.4	76.0	60.5	12	9	20	57 : 43	1 : 6	1 : 3	4.5	3.8	8.2	10.90	13.2	11.5
		ECM Acute Medical Unit	Late	60				11	10	20	52 : 48	1 : 6	1 : 3						
		ECM Acute Medical Unit	Night	60				12	9	20	57 : 43	1 : 6	1 : 3						
	Cancer Care	CAN Acute Onc Services	Early	12	32.7	19.1	13.6	3	3	6	52 : 48	1 : 5	1 : 3	4.5	3.3	7.8	8.83	6.8	15.5
		CAN Acute Onc Services	Late	12				2	0	2	100 : 0	1 : 6	1 : 6						
		CAN Acute Onc Services	Night	12				1	1	2	50 : 50	1 : 13	1 : 7						
		CAN C2 Haematology	Early	27	55.9	39.3	16.6	8	3	11	73 : 27	1 : 4	1 : 3	5.8	2.6	8.4	8.44	8.7	8.9
		CAN C2 Haematology	Late	27				8	3	11	73 : 27	1 : 4	1 : 3						
		CAN C2 Haematology	Night	27				6	3	9	67 : 33	1 : 5	1 : 4						
		CAN C4 Solent Ward Clinical Oncology	Early	23	39.7	23.6	16.1	5	3	8	63 : 38	1 : 5	1 : 3	4.0	2.4	6.4	6.37	7.6	9.1
		CAN C4 Solent Ward Clinical Oncology	Late	23				5	3	8	63 : 38	1 : 5	1 : 3						
		CAN C4 Solent Ward Clinical Oncology	Night	23				3	2	5	60 : 40	1 : 9	1 : 5						
		CAN C6 Leukaemia/BMT Unit	Early	21	47.5	38.5	9.0	8	2	10	80 : 20	1 : 3	1 : 3	7.5	1.6	9.1	9.20	7.3	10.5
		CAN C6 Leukaemia/BMT Unit	Late	21				8	2	10	80 : 20	1 : 3	1 : 3						
		CAN C6 Leukaemia/BMT Unit	Night	21				6	1	7	86 : 14	1 : 4	1 : 4						
		CAN C6 TYA Unit	Early	6	16.2	14.7	1.5	3	1	4	75 : 25	1 : 3	1 : 2	9.3	2.2	11.6	10.82	6.5	9.9
		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 D12	Early	24	0.0	0.0	0.0	5	3	8	63 : 38	1 : 5	1 : 4	3.8	1.8	5.7	5.73	6.6	8.1
		CAN D12	Late	24				5	2	7	71 : 29	1 : 5	1 : 4						
		CAN D12	Night	24				3	2	5	63 : 37	1 : 9	1 : 6						
Division B	Medicine	MED Bassett Ward	Early	26	43.0	17.3	25.7	3	6	9	33 : 67	1 : 9	1 : 3	3.0	4.4	7.4	6.79	12.6	7.0
		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	29.5	12.0	17.6	2	4	6	34 : 66	1 : 8	1 : 3	3.4	5.2	8.6	8.45	7.8	12.0
		MED C5 Isolation Ward	Late	14				2	4	6	34 : 66	1 : 8	1 : 3						
		MED C5 Isolation Ward	Night	14				2	2	4	50 : 50	1 : 8	1 : 4						
		MED D10 Isolation Unit	Early	18	33.7	14.6	19.0	3	4	7	43 : 57	1 : 7	1 : 3	3.2	3.6	6.8	6.65	5.3	9.0
		MED D10 Isolation Unit	Late	18				3	3	6	50 : 50	1 : 7	1 : 4						
		MED D10 Isolation Unit	Night	18				2	2	4	50 : 50	1 : 10	1 : 5						
		MED D5 Ward	Early	28	40.4	19.9	20.5	4	5	9	44 : 56	1 : 8	1 : 4	2.9	3.0	5.9	5.88	8.0	8.1
		MED D5 Ward	Late	28				4	5	9	44 : 56	1 : 8	1 : 4						
		MED D5 Ward	Night	28				3	2	5	60 : 40	1 : 10	1 : 6						
		MED D6 Ward	Early	24	38.9	17.3	21.7	3	5	8	38 : 63	1 : 9	1 : 4	2.9	3.4	6.3	6.28	7.9	9.0
		MED D6 Ward	Late	24				3	4	7	43 : 57	1 : 9	1 : 4						
		MED D6 Ward	Night	24				3	3	6	51 : 49	1 : 9	1 : 5						
		MED D7 Ward	Early	16	26.4	12.0	14.4	2	3	5	40 : 60	1 : 9	1 : 4	2.9	3.6	6.4	6.64	8.4	8.3
		MED D7 Ward	Late	16				2	3	5	40 : 60	1 : 9	1 : 4						
		MED D7 Ward	Night	16				2	2	4	50 : 50	1 : 9	1 : 5						
		MED D8 Ward	Early	24	38.9	17.3	21.7	3	5	8	38 : 63	1 : 9	1 : 4	2.9	3.5	6.3	6.35	8.0	6.8
		MED D8 Ward	Late	24				3	4	7	43 : 57	1 : 9	1 : 4						
		MED D8 Ward	Night	24				3	3	6	51 : 49	1 : 9	1 : 5						
		MED D9 Ward	Early	28	40.4	19.9	20.5	4	5	9	45 : 55	1 : 7	1 : 4	2.9	3.0	5.9	5.97	9.3	6.9
		MED D9 Ward	Late	28				4	4	8	51 : 49	1 : 7	1 : 4						
		MED D9 Ward	Night	28				3	3	6	50 : 50	1 : 10	1 : 5						
		MED E7 Ward	Early	20	37.7	17.3	20.5	3	5	8	37 : 63	1 : 8	1 : 3	2.8	3.9	6.7	5.02	10.8	8.8
		MED E7 Ward	Late	20				3	4	7	42 : 58	1 : 8	1 : 4						
		MED E7 Ward	Night	20				2	2	4	46 : 54	1 : 11	1 : 5						
		MED F7 Ward	Early	20	32.3	14.6	17.6	3	4	7	43 : 57	1 : 7	1 : 3	2.9	3.7	6.6	6.79	6.2	6.9
		MED F7 Ward	Late	20				3	4	7	42 : 58	1 : 7	1 : 3						
		MED F7 Ward	Night	20				2	2	4	49 : 51	1 : 11	1 : 6						
		MED G5 Ward	Early	28	36.9	17.3	19.6	4	4	8	50 : 50	1 : 8	1 : 4	2.9	2.5	5.4	5.32	8.4	6.3
		MED G5 Ward	Late	28				4	4	8	50 : 50	1 : 8	1 : 4						
		MED G5 Ward	Night	28				3	2	5	60 : 40	1 : 10	1 : 6						
		MED G6 Ward	Early	26	36.9	17.3	19.6	4	4	7	48 : 52	1 : 8	1 : 4	3.0	2.7	5.6	5.66	7.7	6.3
		MED G6 Ward	Late	26				4	4	7	48 : 52	1 : 8	1 : 4						
		MED G6 Ward	Night	26				3	2	5	60 : 40	1 : 9	1 : 6						
		MED G7 Ward	Early	14	22.9	11.6	11.4	2	3	5	40 : 60	1 : 8	1 : 3	3.2	3.4	6.6	7.05	7.8	9.2
		MED G7 Ward	Late	14				2	3	5	41 : 59	1 : 8	1 : 3						
		MED G7 Ward	Night	14				2	2	4	50 : 50	1 : 8	1 : 4						
		MED G8 Ward	Early	28	38.7	17.3	21.4	4	4	8	50 : 50	1 : 8	1 : 4	2.9	2.5	5.4	5.37	8.0	5.9
		MED G8 Ward	Late	28				4	4	8	50 : 50	1 : 8	1 : 4						
		MED G8 Ward	Night	28				3	2	5	60 : 40	1 : 10	1 : 6						
		MED G9 Ward	Early	26	38.7	17.3	21.4	4	4	8	50 : 50	1 : 7	1 : 4	3.1	2.6	5.8	5.74	8.4	6.9
		MED G9 Ward	Late	26				4	4	8	50 : 50	1 : 7	1 : 4						
		MED G9 Ward	Night	26				3	2	5	60 : 40	1 : 9	1 : 6						
Division C	Child Health	CHI Paed Medical Unit	Early	18	55.0	39.1	15.9	5	2	7	71 : 29	1 : 4	1 : 3	7.4	2.8	10.2	8.84	8.1	11.4
		CHI Paed Medical Unit	Late	18				5	2	7	71 : 29	1 : 4	1 : 3						
		CHI Paed Medical Unit	Night	18				5	2	7	71 : 29	1 : 4	1 : 3						
		CHI Piam Brown Unit	Early	12	48.4	39.2	9.2	13	3	15	83 : 17	1 : 1	1 : 1	14.6	4.7	19.3	13.78	9.3	16.4
		CHI Piam Brown Unit	Late	12				5	2	7	71 : 29	1 : 3	1 : 2						
		CHI Piam Brown Unit	Night	12				4	2	6	66 : 34	1 : 4	1 : 3						
		CHI Ward E1 Paed Cardiac	Early	20	43.1	33.6	9.5	5	2	7	77 : 23	1 : 4	1 : 3	5.8	1.5	7.2	7.26	#N/A	13.7
		CHI Ward E1 Paed Cardiac	Late	20				5	2	6	75 : 26	1 : 5	1 : 4						
		CHI Ward E1 Paed Cardiac	Night	20				4	1	5	80 : 20	1 : 6	1 : 5						
		CHI Ward G2 Neuro	Early	6	12.6	12.6	0.0	2	2	4	50 : 50	1 : 4	1 : 2	8.1	8.6	16.8	17.94	8.2	9.5
		CHI Ward G2 Neuro	Late	6				2	2	4	50 : 50	1 : 4	1 : 2						
		CHI Ward G2 Neuro	Night	6				2	2	4	50 : 50	1 : 4	1 : 2						
		CHI Ward G3	Early	20	45.6	31.6	14.0	6	4	10	60 : 40	1 : 4	1 : 3	6.7	4.3	11.0	11.02	8.2	14.9
		CHI Ward G3	Late	20				6	4	10	60 : 40	1 : 4	1 : 3						
		CHI Ward G3	Night	20				5	3	8	63 : 38	1 : 5	1 : 3						
		CHI Ward G4 Surgery	Early	18	53.1	38.6	14.5	6	3	9	68 : 32	1 : 3	1 : 2	7.7	3.4	11.0	10.87	8.2	10.5
		CHI Ward G4 Surgery	Late	18				6	3	9	68 : 32	1 : 3	1 : 2						
		CHI Ward G4 Surgery	Night	18				5	2	7	71 : 29	1 : 4	1 : 3						

Appendix 5

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

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

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

					Finance budgeted			Staffing Numbers						Planned on Template (long day factor applied)				Actual demand average in Sept 2023 (In Safe Care)	Actual average (Calculated on actual hours provided and average patient numbers at midnight)
Division	**Care Group**	**Unit Name**	**Shift**	**Total Beds**	**Budgeted Total 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)**	**Planned Registered (CHPPD)**	**Planned Unregistered (CHPPD)**	**Total Planned CHPPD**	**Safe Care**	**Total Actual Demand CHPPD**	**Total Actual CHPPD**
Division D	Women & Newborn	W&N Bramshaw Womens Unit	Early	18	27.1	17.5	9.6	3	2	5	62 : 38	1 : 7	1 : 4	3.3	2.2	5.5	5.73	4.3	8.7
		W&N Bramshaw Womens Unit	Late	18				3	2	5	62 : 38	1 : 7	1 : 4						
		W&N Bramshaw Womens Unit	Night	18				2	2	4	53 : 47	1 : 9	1 : 5						
	Cardiovascular & Thoracic	CAR Coronary Care Unit	Early	22	64.1	44.6	19.5	7	3	10	71 : 29	1 : 4	1 : 3	7.5	3.2	10.7	10.64	7.2	12.8
		CAR Coronary Care Unit	Late	22				7	3	10	70 : 30	1 : 4	1 : 3						
		CAR Coronary Care Unit	Night	22				7	3	10	70 : 30	1 : 4	1 : 3						
		CAR Ward D2 Cardiology	Early	15	29.8	16.3	13.5	4	2	6	66 : 34	1 : 5	1 : 3	4.4	2.9	7.3	7.09	12.6	8.0
		CAR Ward D2 Cardiology	Late	15				3	2	5	60 : 40	1 : 6	1 : 4						
		CAR Ward D2 Cardiology	Night	15				2	2	4	51 : 49	1 : 8	1 : 4						
		CAR Ward D4 Vascular	Early	22	43.3	22.4	21.0	5	3	8	62 : 38	1 : 5	1 : 3	4.3	3.0	7.3	7.45	8.0	10.1
		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	33.4	19.9	13.4	4	3	7	60 : 40	1 : 5	1 : 3	4.3	3.0	7.3	7.20	8.0	7.5
		CAR Ward E2 YACU	Late	17				4	2	6	68 : 32	1 : 5	1 : 3						
		CAR Ward E2 YACU	Night	17				2	2	4	50 : 50	1 : 9	1 : 5						
		CAR Ward E3 Blue	Early	18	32.7	19.6	13.2	4	3	7	61 : 39	1 : 5	1 : 3	4.1	2.8	6.9	6.60	8.0	6.9
		CAR Ward E3 Blue	Late	18				4	2	6	68 : 32	1 : 5	1 : 4						
		CAR Ward E3 Blue	Night	18				2	2	4	52 : 48	1 : 9	1 : 5						
		CAR Ward E3 Green	Early	24	41.2	25.4	15.8	4	4	8	49 : 51	1 : 7	1 : 3	3.0	3.2	6.2	6.19	7.8	7.2
		CAR Ward E3 Green	Late	24				4	3	7	58 : 42	1 : 7	1 : 4						
		CAR Ward E3 Green	Night	24				2	3	5	40 : 60	1 : 12	1 : 5						
		CAR Ward E4 Thoracics	Early	20	44.1	23.9	20.2	4	3	7	54 : 46	1 : 6	1 : 3	4.1	3.0	7.1	7.17	7.6	9.0
		CAR Ward E4 Thoracics	Late	20				4	3	7	55 : 45	1 : 5	1 : 3						
		CAR Ward E4 Thoracics	Night	20				3	2	5	62 : 38	1 : 7	1 : 5						
	Neurosciences	NEU Acute Stroke Unit	Early	28	55.3	22.7	32.7	4	7	11	36 : 64	1 : 8	1 : 3	2.8	4.9	7.7	7.81	10.4	7.8
		NEU Acute Stroke Unit	Late	28				4	7	11	36 : 64	1 : 8	1 : 3						
		NEU Acute Stroke Unit	Night	28				3	5	8	38 : 63	1 : 10	1 : 4						
		NEU HASU	Early	10	33.2	25.3	7.9	4	1	5	80 : 20	1 : 3	1 : 3	9.5	2.1	11.6	9.09	10.3	13.4
		NEU HASU	Late	10				4	1	5	80 : 20	1 : 3	1 : 3						
		NEU HASU	Night	10				4	1	5	80 : 20	1 : 3	1 : 3						
		NEU Regional Transfer Unit	Early	10	26.2	17.9	8.3	3	1	4	75 : 25	1 : 4	1 : 3	6.1	3.5	9.6	9.63	9.0	15.0
		NEU Regional Transfer Unit	Late	10				3	1	4	74 : 26	1 : 4	1 : 3						
		NEU Regional Transfer Unit	Night	10				2	2	4	49 : 51	1 : 5	1 : 3						
		NEU Ward D Neuro	Early	27	61.6	28.8	32.8	5	5	10	48 : 52	1 : 6	1 : 3	4.0	4.3	8.2	8.25	8.2	9.4
		NEU Ward D Neuro	Late	27				5	5	10	49 : 51	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	52.4	26.5	25.9	5	4	8	57 : 43	1 : 6	1 : 4	4.1	3.2	7.2	7.98	8.0	8.7
		NEU ward E Neuro	Late	26				5	4	8	57 : 43	1 : 6	1 : 4						
		NEU ward E Neuro	Night	26				4	4	7	52 : 48	1 : 7	1 : 4						
	Spinal Service	SPI Ward F4 Spinal	Early	22	42.8	22.7	20.1	4	3	7	57 : 43	1 : 6	1 : 4	3.8	3.0	6.9	6.89	7.7	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 Trauma Admissions Unit	Early	8	26.7	13.2	13.6	3	2	5	57 : 43	1 : 4	1 : 2	6.5	5.5	12.0	11.76	10.9	18.3
		T&O Trauma Admissions Unit	Late	8				2	2	4	50 : 50	1 : 5	1 : 3						
		T&O Trauma Admissions Unit	Night	8				2	2	4	50 : 50	1 : 5	1 : 3						
		T&O Ward Brooke	Early	18	33.9	16.6	17.3	3	3	6	50 : 50	1 : 7	1 : 4	2.6	3.0	5.7	6.94	11.8	7.2
		T&O Ward Brooke	Late	18				3	3	6	50 : 50	1 : 7	1 : 4						
		T&O Ward Brooke	Night	18				2	3	5	41 : 59	1 : 10	1 : 4						
		T&O Ward F1 Major Trauma Unit	Early	32	65.5	34.9	30.6	6	5	11	55 : 45	1 : 6	1 : 4	4.2	3.5	7.7	7.71	9.9	8.8
		T&O Ward F1 Major Trauma Unit	Late	32				6	5	11	55 : 45	1 : 6	1 : 4						
		T&O Ward F1 Major Trauma Unit	Night	32				5	5	10	50 : 50	1 : 7	1 : 4						
		T&O Ward F2 Trauma	Early	26	52.3	22.7	29.6	4	5	9	44 : 56	1 : 7	1 : 3	3.3	4.0	7.2	7.31	8.3	9.5
		T&O Ward F2 Trauma	Late	26				4	5	9	45 : 55	1 : 7	1 : 3						
		T&O Ward F2 Trauma	Night	26				3	4	7	43 : 57	1 : 10	1 : 4						
		T&O Ward F3 Trauma	Early	24	52.8	22.7	30.2	4	6	10	40 : 60	1 : 7	1 : 3	3.6	4.9	8.5	8.47	7.1	9.6
		T&O Ward F3 Trauma	Late	24				4	5	9	44 : 56	1 : 7	1 : 3						
		T&O Ward F3 Trauma	Night	24				3	5	8	38 : 63	1 : 9	1 : 4						
		T&O Ward F4 Elective	Early	18	32.3	18.3	14.0	4	2	6	66 : 34	1 : 5	1 : 4	3.7	3.5	7.2	7.20	7.0	7.9
		T&O Ward F4 Elective	Late	18				3	3	6	50 : 50	1 : 7	1 : 4						
		T&O Ward F4 Elective	Night	18				2	3	5	40 : 60	1 : 10	1 : 4						

Appendix 6

Specific Divisional issues emerging - Ward Staffing Review 2023

Division A

The established staffing levels are appropriate in most wards and vacancy levels are low.
There has been an increase in the amount and complexity of patients requiring enhanced care, quite often due to patients presenting with mental health conditions.

Skill mix has been a noted challenge this year which has put extra pressure on both existing staff and the education team.

Whilst not part of the inpatient ward staffing review, it is worth noting that the SDU (Surgical Day Unit) is currently funded for 6 overnight inpatient beds.

Due to trustwide capacity challenges, this unit has continued to run with 18-24 patients overnight consistently, alongside the normal day-case schedule for the past 12 months. This is currently staffed by bank/agency. The unit needs to undergo a review regarding future use. If it is decided to accommodate an increased number of inpatients on a permanent basis this will require extra funding for a substantive workforce.

Areas to be put forward at budget setting post 2023 review – Division A:

F5 still have a slightly lower nurse/patient ratio than other surgical wards and this will need a further review based on the acuity of patients (major ENT ops). Their current ratio (whilst also staffing an ENT treatment area) sits at 1:7 with the rest of the surgical care group working on a 1:6 basis. To rectify this, F5 would need an uplift of 2.0 WTE RN.

A review of the staffing model in ASU has taken place to reflect the increased numbers of NEWS activations and fluctuant admissions (which can often lead to being outside of their budgeted footprint). A request for 2.7 WTE RN would be needed to respond to this increasing demand.

Division B

Medicine/MOP

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 has now been recognised recurrently in budget.

Medicine have been allocated 24 additional beds in the new ward build, opening on 11th December 2023. There has been successful recruitment into the required additional posts.

A skill mix review was undertaken and establishments have been realigned to reflect a standard approach across the care group of B6 sister/charge nurse posts, resulting in a reduction and conversion back to B5 posts, ensuring no impact to overall establishment.

Cancer Care

Cancer care have seen an increase of 2 beds since their move into the new ward D12 and have recruited into the required additional posts.

There is continued recruitment linked to the delivery of the CAR-T business case.

It should be noted that Division B has continued to see a rise in enhanced care requirements, mainly related to management of complex mental health patients and also 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 2023 review – Division B:

Medicine/MOP

G5 and G7 sit at the lower end of the national CHPPD scale and require a small increase in establishment to bring in line with other inpatient wards. We are currently achieving this through use of bank staff when clinically indicated.

Cancer Care

C6 have seen an increase in acuity and are requiring the use of bank staff to achieve safe staffing – likely need for increase in establishment which is being monitored.

Division C (excluding Midwifery)

Overall established staffing levels are appropriate in the majority of wards in Southampton Children's Hospital (SCH) and Women's Health.

There has, however, been an increase in demand for paediatric critical care capacity nationwide. The wards within SCH include paediatric high dependency beds, it is recognised that these beds support capacity and flow (for patients post operatively, from the emergency department and down streaming from PICU). If this demand continues it may have an impact on staffing requirements in the future. Appropriate staffing will enable the wards to be able to flexibly offer a high dependency level of care for complex patients.

The children's hospital is currently undergoing some refurbishment, and this will result in the reallocation of beds and staffing to ensure we are offering high-quality cost-effective care within current budget.

Piam Brown (Regional Paediatric Oncology Centre)

Due to the infrastructure of PB having both inpatient and complex day case services combined, the care hours per patient per day appear significantly higher than expected. The ward has received an up-lift for the increased acuity and activity through the day unit and is now recruiting into these vacancies, with a plan to reduce bank and agency. Healthcare workers are now embedded within the PB staffing requirements.

NHS England are reviewing the future Paediatric oncology services, as a result, this may increase patient numbers and have a direct impact on staffing requirements.

G3 (Regional Paediatric Trauma and Orthopaedic Unit)

Currently undergoing refurbishment, due to be completed end of December 2023. As a result of this G3 will be a 16 bedded unit with six HDU beds (an increase of two). The AWL for G3 remains unchanged.

G4 (Regional Paediatric Surgical, Urology and Nephrology Centre)

Due to the infrastructure of G4 having both complex inpatients and a regional haemodialysis unit, the care hours per patient per day are increased. It is felt that the current AWL meets the acuity needs of the patients.

PMU (Paediatric Medical Unit)

PMU has increased to a footprint of 18 beds, inclusive of 2 HDU spaces. This includes an admissions area to support flow from CED. The ward is supported by health care support workers on a 75:25 RN:URN ratio, due to the complex care needs of some of the patients within the medical unit. There are times where flexible staffing is utilised to increase the number of health care support

workers as required, this includes the additional support often required to care for complex CAMHS patients.

G2N (Regional Paediatric Neurosurgical Centre)

A six bedded neurosurgical ward that encompasses level 2 patients and has a bespoke Video Telemetry in-patient suite.

In January the development of Robbie's Rehab commences as an extension of G2Neuro. This is a re-assignment of beds (level 1b) to provide neuro rehab within the neurosurgical footprint. This means that G2Neuro will increase from 2 Trained nurses per shift to 3 trained nurses and 1 HCA per shift. These staff will be reallocated from within the Children's Hospital and therefore there is no further financial request.

E1 (Regional Paediatric Cardiology and Cardiac Surgery Centre)

E1 has had an uplift in staffing to increase cardiac HDU beds from four to six within the ward environment, recruitment and staff development is ongoing. We are also reviewing how we can accommodate additional activity that is currently required to support the ongoing paediatric cardiac waiting list. This may result in a requirement for additional staff.

Women's Health

Bramshaw have seen an increase in acuity and have undertaken a review of current staffing patterns to ensure staff available at appropriate times. This has currently been achieved within budget.

Areas to be put forward at budget setting post 2023 review – Division C:

No areas identified as part of the review.

Division D

Over the past year the Div D finance team have worked hard to align budgets with establishments. In some instances, this has required uplifts and moving funds from one cost centre to another. CVT was the area identified last year as having the greatest level of misalignment, this has now been corrected.

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

The pressure on staffing relating to the increasing number of patients admitted requiring specialist mental health nursing and enhanced care continues.

F1 ward had a 'never-event' in relation to mental health this year. As a result, T&O are working with the trust to look at establishing a model to offer cover, education and appropriate individual care planning.

A business case is currently being developed and is in discussion with the trusts MH leads. It is hoped that providing MH support directly within the care group will reduce current spend.

F4 spines continue to breach staffing establishments when they reach higher numbers of tetraplegic patients, as these patients require 1:1 continual support, this is currently not factored into their establishment.

Funding has been agreed through winter pressure monies to support supernumerary bleep holders in CVT and neuro, with plan to fund permanently next year. This is gratefully received as this has been a concern for some time now and it will support the bleep holder to be released from practice.

Staffing across all wards feels much better with the majority of wards almost fully recruited to for RN's. However, skill remains a concern with high numbers of new and junior staff across all care groups. Retention of HCA's has seen an improvement but recruitment to this staff group remains a focus. The welcome ward model has been working well and funding remains in place until April 2024.

CVT footprint has expanded with the opening of D3 ward in September. Recruitment and training of staff has been very successful.

Areas to be put forward at budget setting post 2023 review- Division D

Consideration for MH funding via business case proposal.

No budget was allocated this year to increase enhanced care funding, this remains an ongoing challenge.

Whilst not included in the inpatient ward staffing review, staffing discharge lounges is another requirement, which is essential to support flow.

Current budget allows it to be open for 7.5 hours a day, but this is often required to be open for extended lengths of time. Currently reviewing how longer hours can be achieved.

Report to the Trust Board of Directors				
Title:	**Freedom to Speak Up Report**			
Agenda item:	**5.15**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Christine Mbabazi, Freedom to Speak Up Guardian**			
Date:	**30 November 2023**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** ✓
Issue to be addressed:	Freedom to Speak Up at UHS			
Response to the issue:	To provide an update on the Freedom to Speak Up (FTSU) agenda, cases, themes and actions taken and lessons learnt from the concerns raised.			
Implications: (Clinical, Organisational, Governance, Legal?)	1. Mechanism to support a culture where staff feel safe and can speak up about concerns. 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. • Note the number of FTSU cases received to date. • Note the actions taken from the concerns raised as well as the self-assessment tool.			

1. Executive Summary

To provide an update following the last report written in May 2023. The last report reflected the comparative information from previous reports identifying trends, themes as well as available cases to the FTSU Guardian from 2017 (when appointed) to April 2023.

It also provided an evaluation of the FTSU service using the National Guardian's self-reflection and planning tool.

2. Purpose/Context/Introduction

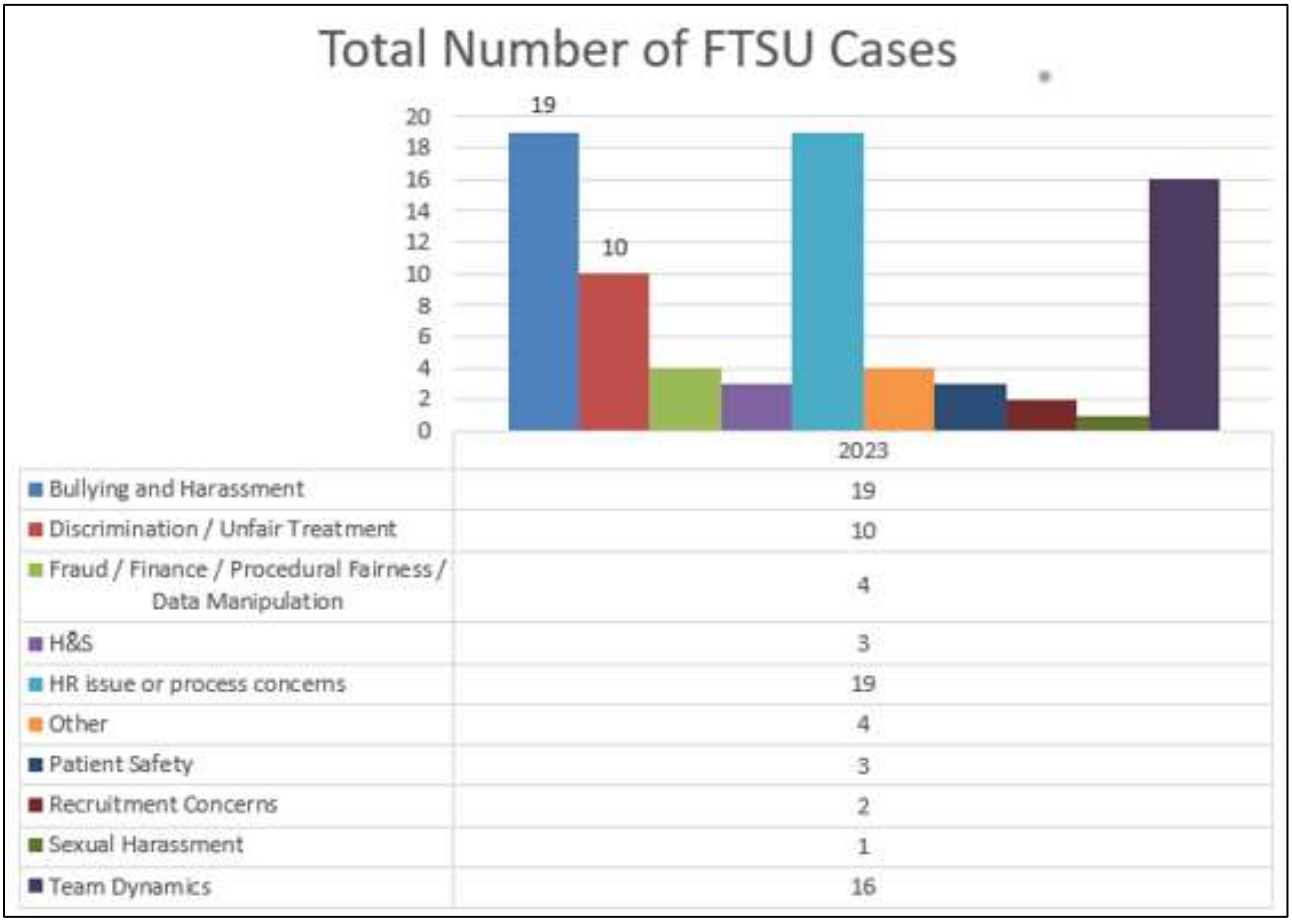
The purpose of this report is to update Trust Board on the FTSU agenda, noting the cases raised to the FTSU champion in the Trust and the actions taken to resolve the concerns.

3. Key Issues

Case Update

The Trust has received 81 FTSU cases in 2023 so far (see Table 1 for a thematic breakdown). From 12th May 2023 – 13th November 2023, the Trust received 65 FTSU cases compared to 29 cases received in the same period in 2022.

The key themes remain bullying and harassment, HR issues or process concerns, team dynamics, and unfair treatment/discrimination. An increased number of staff have contacted FTSU regarding HR processes that they are going through to seek advice or raise concerns about the HR process, or to request support from a FTSU Champion.



	2023
Bullying and Harassment	19
Discrimination / Unfair Treatment	10
Fraud / Finance / Procedural Fairness / Data Manipulation	4
H&S	3
HR issue or process concerns	19
Other	4
Patient Safety	3
Recruitment Concerns	2
Sexual Harassment	1
Team Dynamics	16

Table 1 – Total Number of FTSU Cases in 2023

4. Progress on the FTSU Agenda

Bullying and harassment

In June this year there were some comments shared on a closed NHS face book page regarding bullying and negative behaviours at UHS. Freedom to speak up was mentioned and was used as a vehicle to encourage staff to speak up and share their experiences about the issues raised and more. Following the above these are some of the actions that have been taken as Freedom to speak up:

- The Trust has commissioned an external learning review of its formal employee relations processes and for the way it manages Freedom to Speak Up. The is due to conclude at the end of November and the Trust will consider any recommendations on how policy and practice can be improved.
- Triangulation of staff survey, Freedom to speak up data and exit interviews to identify any specific team/ areas with the above concerns that require support.
- In July, we used the Raising concerns steering group as platform for staff to discuss the Facebook issues raised. This group has two executive board members, freedom to speak up champions, staff side unions and other members of the organisation. It is a good group to hear from all staff because it has representatives from all staff groups including FTSU champions.
- It was another opportunity to listen to what is going on in the organisation following the B&H concerns raised. We got a lot more from that group that helped shape the actions for HR and the OD team. When people feel that speaking up about poor behaviour is welcomed and encouraged as well as dealt with, this benefits the Trust but also encourages a speaking up culture. People's voices play a vital role in informing and driving improvement.
- We continued to listen to staff and in October as part of the National Freedom to Speak Up Month we set up a series of listening events chaired by senior leaders on the 30th October, 1st November and 3rd November. These listening events were to give a platform to staff to raise anything they wanted anonymously just like the closed Facebook page had given only this would be within the Trust with answers to those issues or questions. We received some issues raised anonymously and some were very personal due to the anonymity we were not able to address those individuals. However, the themes from the listening events were culture and behaviours, inclusion, experience of disabled staff and working together and not in silos. The HR &OD Teams are following up on these themes with various interventions.

Freedom to Speak Up Champions

In addition to the FTSU Guardian role, the Trust has 78 FTSU Champions who come from across the clinical divisions and THQ departments and the number is still growing. The network of FTSU Champions aims to promote open, honest, and patient/staff focused cultures across the organisation and support staff who wish to speak up about something they are worried about. The FTSU Champions are from various staff groups, backgrounds and staff levels.

- The FTSU champion role is not an advocacy service but more of a facilitative one that allows Trust policies on subjects such as bullying, harassment, discrimination, incident reporting and raising concerns (whistleblowing) to be explained and allows the staff member to have a sounding board for options available to them.
- A FTSU champion is an informed, non-judgemental "listening ear" and where necessary may provide practical and emotional support for any member of staff who has a concern and would direct them to the FTSU Guardian or to HR employee relations.
- Raises awareness of the FTSU agenda amongst staff and signposts them to the FTSU Guardian
- The role of the FTSU Champion is to explain the options available to the staff member and to provide assistance in guiding them to the appropriate Trust policies to help the staff member to decide which course of action to take, or how to report their concern.

Staff Survey Results

In the staff survey results for 2022, for the two questions relating to staff feeling secure about raising unsafe clinical practice and confidence in the organisation addressing those concerns, UHS scored in the top 20 Acute and Acute Community NHS Trusts:

- **Q19A: I would feel secure raising concerns about unsafe clinical practice.** 75% Strongly Agree / Agree (18th/124 Acute / Acute Community)
- **Q19B: I am confident that my organisation would address my concern.** 61% Strongly Agree / Agree (19th/124 Acute / Acute Community)

The Trust's FTSU Guardian has been targeting areas with low positive responses to these questions for FTSU Champion recruitment and to also engage with the management teams to consider what measures can be implemented to give staff more confidence in raising concerns about unsafe clinical practice and being assured that the Trust would address those concerns.

5. Next Steps / Way Forward / Implications / Impact

The FTSU Guardian and Champion network will continue to work with different teams to achieve the high-level development actions (see appendix A) from the self-assessment reflection tool that was explained in the last report. The importance of doing this is to ensure that we create a culture where patients and staff safety are at the centre of what we do, as has been noted by the National Guardian Office and CQC.

6. Recommendation

Trust Board is asked to:

- Note the number of FTSU cases received to date.
- Note the actions taken from the concerns raised as well as the self-assessment tool.

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Appendix A: Summary of High level actions from National Guardian self- assessment tool

SUMMARY OF HIGH-LEVEL DEVELOPMENT ACTIONS (6-24 MONTHS)

Action	Target Date	Action Owner
1. Look at ringfencing sometime to support champions	Dec 2023	CM
2. Promote FTSU to our staff and what we do in addressing concerns	Ongoing	CM
3. We need to tell positive stories about speaking up and the positives it can bring	Ongoing	CM
4. We measure the effectiveness of our communications strategy for FTSU	Jan 2024	CM & Communications team
5. Our HR and OD teams measure the impact of speaking up training	June 2024	OD Team
6. All managers and senior leaders have received training on FTSU	June 2024	OD Team

Appendix B – FTSU CASES 13/05/2023 – 10/11/2023

Year	Qtr	Date Concern Raised	Department	Contact Method (Internal / External)	Trust Board Summary
2023	Q1	13/05/2023	Division D	Internal	Discrimination / Unfair Treatment
2023	Q1	24/05/2023	Division B	Internal	Discrimination / Unfair Treatment
2023	Q1	29/05/2023	THQ	Internal	H&S
2023	Q1	06/06/2023	THQ	Internal	Patient Safety
2023	Q1	09/06/2023	THQ	External	Fraud / Finance / Procedural Fairness / Data Manipulation
2023	Q1	12/06/2023	Division B	Internal	Bullying and Harassment
2023	Q1	15/06/2023	THQ	Internal	Bullying and Harassment
2023	Q1	15/06/2023	Division C	Internal	HR issue or process concerns
2023	Q1	15/06/2023	Division C	Internal	HR issue or process concerns
2023	Q1	16/06/2023	Division B	Internal	HR issue or process concerns
2023	Q1	22/06/2023	Division B	Internal	HR issue or process concerns
2023	Q1	30/06/2023	THQ	Internal	Bullying and Harassment
2023	Q2	03/07/2023	THQ	Internal	Bullying and Harassment
2023	Q2	03/07/2023	Division A	Internal	Sexual Harassment
2023	Q2	14/07/2023	THQ	Internal	Team Dynamics
2023	Q2	14/07/2023	Division A	Internal	Other
2023	Q2	18/07/2023	Division B	Internal	Bullying and harassment
2023	Q2	19/07/2023	Division C	Internal	Fraud / Finance / Procedural Fairness / Data Manipulation
2023	Q2	24/07/2023	Division A	Internal	Bullying and harassment
2023	Q2	26/07/2023	Division C	Internal	H&S
2023	Q2	26/07/2023	Division C	Internal	Bullying and harassment
2023	Q2	26/07/2023	Division D	Internal	HR issue or process concerns

2023	Q2	01/08/2023	THQ	Internal	Team Dynamics
2023	Q2	08/08/2023	THQ	Internal	Discrimination / Unfair Treatment
2023	Q2	08/08/2023	THQ	Internal	HR issue or process concerns
2023	Q2	09/08/2023	Division C	Internal	H&S
2023	Q2	08/08/2023	Division B	internal	Discrimination / Unfair Treatment
2023	Q2	10.08.2023	Division B	internal	HR issue or process concerns
2023	Q2	11/08/2023	Division D	Internal	HR issue or process concerns
2023	Q2	11/08/2023	Division A	Internal	Team Dynamics
2023	Q2	18/08/2023	Division A	Internal	Bullying behaviour of manager
2023	Q2	18/08/2023	Division C	Internal	Bullying and harassment
2023	Q2	30/08/2023	THQ	Internal	Bullying and harassment
2023	Q2	30/08/2023	Division C	Internal	Team Dynamics
2023	Q2	01/09/2023	Division D	Internal	Patient Safety
2023	Q2	06/09/2023	Division A	Internal	Team Dynamics
2023	Q2	14/09/2023	Division D	Internal	Team Dynamics
2023	Q2	18/09/2023	Division C	Internal	HR issue or process concerns
2023	Q2	19/09/2023	Division B	Internal	Bullying and harassment
2023	Q2	19/09/2023	Division A	Internal	Bullying and harassment
2023	Q2	21/09/2023	Division B	Internal	Discrimination/Unfair treatment
2023	Q2	21/09/2023	Division A	Internal	Patient Safety
2023	Q2	26/09/2023	Division B	Internal	Bullying and harassment
2023	Q2	27/09/2023	Division C	Internal	Recruitment Concerns
2023	Q3	05/10/2023	THQ	Internal	HR issue or process concerns
2023	Q3	11/10/2023	Division B	Internal	HR issue or process concerns
2023	Q3	12/10/2023	THQ	Internal	Team Dynamics
2023	Q3	13/10/2023	Division C	Internal	Team Dynamics
2023	Q3	17/10/2023	Division D	Internal	Team Dynamics
2023	Q3	17/10/2023	Division D	Internal	Team Dynamics
2023	Q3	19/10/2023	Division B	internal	HR issue or process concerns
2023	Q3	20/10/2023	THQ	Internal	Other
2023	Q3	20/10/2023	THQ	Internal	Discrimination and unfair treatment
2023	Q3	24/10/2023	Division B	Internal	HR issue or process concerns
2023	Q3	25/10/2023	Division C	Internal	HR issue or process concerns
2023	Q3	30/10/2023	Division B	Internal	Bullying and harassment
2023	Q3	30/10/2023	Other	External	HR issue or process concerns
2023	Q3	29/09/2023	Division A	Internal	Bullying and harassment
2023	Q3	31/10/2023	Division C	Internal	Discrimination and unfair treatment
2023	Q3	31/10/2023	Division C	Internal	recruitment Concerns
2023	Q3	31/10/2023	Other	Internal	Discrimination and unfair treatment
2023	Q3	10/11/2023	Division B	Internal	HR issue or process concerns
2023	Q3	06/09/2023	THQ	Internal	HR issue or process concerns
2023	Q3	07/09/2023	THQ	Internal	Bullying and Harassment

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Board Assurance Framework (BAF)**			
Agenda item:	**6.1**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Lauren Anderson, Corporate Governance & Risk Manager** **Craig Machell, Associate Director of Corporate Affairs and Company Secretary**			
Date:	**30 November 2023**			
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. The report has been updated following discussions with the relevant executives and their teams.			
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 is asked to note the updated Board Assurance Framework.			

Appendix 1 – Board Assurance Framework

The risks are grouped according to the Trust's key strategic themes:

1: **Outstanding patient outcomes, safety and experience**

- 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.
- 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.
- 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.

2: **Pioneering research and innovation**

- 2a: We do not take full advantage of our position as a leading University teaching hospital with a growing, reputable, and innovative research and development portfolio, attracting the best staff and efficiently delivering the best possible treatments and care for our patients.

3: **World class people**

- 3a: We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles.
- 3b: We fail to develop a diverse, compassionate and inclusive workforce, providing a more positive staff experience for all staff.
- 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.

4: **Integrated networks and collaboration**

- 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.

5: **Foundations for the future**

- 5a: We are unable to deliver a financial breakeven position, resulting in: Moving into NHS Outcomes Framework segment 4, which leads to entering into the Recovery Support Programme and additional controls / undertakings; A reducing cash balance, impacting both The Trust's ability to invest in line with its capital plan and estates / digital strategies, and the Trust's ability to invest in transformation initiatives.
- 5b: We do not adequately maintain, improve and develop our estate to deliver our clinical services and increase capacity.
- 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.
- 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.

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 plans for surge beds and specific seasonal planning. Patient flow programme to reduce length of stay and improve discharge. Outpatient transformation programme focused on reducing follow up demand. Theatre transformation programme to improve theatre utilisation / treat more patients. Urgent and Emergency Care Board established to drive improvements across UEC pathways. Weekly divisional performance meetings with a particular focus	Excess demand in community and social care combined with cuts to Hospital Discharge Funding may further increase the number of patients in hospital not meeting the criteria to reside. Limited funding, workforce and estate to address capacity mismatch in a timely way. Lack of local delivery system 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. Weekly performance meetings to monitor key access targets. Rapid Improvement Plans to support improvements across cancer pathways. UEC recovery plan to support improvements across UEC pathways. Monitoring and reporting of waiting times. Harm reviews identifying cases where delays have caused harm.	Limited capacity within the Local Authority to support for patients without a criteria to reside. Lack of granular plans at specialty level to support reduction in outpatient follow ups. Ongoing industrial action through 22-23 and into 23-24 presents significant risk to the Trust's ability to meet ongoing demand on our services.	Outpatient theatres and inpatient flow transformation programmes. Review of ED workforce model against national workforce tool has been completed resulting in an uplift to nursing staff Review of local delivery system plan for reducing delays throughout the hospital. Deliver target of 113% of 19/20 baseline activity to secure additional funding and address waiting lists. Deliver plans to hit the trajectory of no patients waiting over 65 weeks by March 2024. Open additional wards (Cancer Care D12 opened in August 2023 and a medical ward is planned to open in December 2023) Community Diagnostic Hub opening in Q4 2024/5 to provide additional diagnostic capacity.Previously scheduled for 2023/4 however this has been delayed following redesign. Engagement in the NHSE Further Faster programme for elective care.	4 x 3 12 Apr-25

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.						
on cancer and long waiting patients.	Challenges in staffing ED department during periods of extreme pressure.				Improvement work on flow focussing on 3 key areas: home before lunch, clinical standards, and Urgent & Elective Care (UEC). New appointments to the leadership team (TS as Clinical Director of the UEC and JP as Operational Manager). Implementation of cardiology pathway within ED.	

Outstanding patient outcomes, safety and experience	Monitoring Committee: Quality Committee Executive Leads: COO, CMO, CNO

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. Delivery of 23/24 Always Improving Programme aims.	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	Negative outlier on follow-ups for outpatients. Ongoing industrial action through 22-23 and into 23-24 presents significant risk to the Trust's ability to meet ongoing demand on our services	**Introducing a robust and proactive safety culture:** Implement plan to enable launch of PSIRF in Q3 2023/24. Embed learning from deaths lead & lead medical examiner roles (primary and secondary care) and develop objectives and strategy. Introduce thematic reviews for VTE. Implement the second round of Ockenden recommendations – completed. **Empowering and developing staff to improve services for patients** Ongoing completion of SDM project, data analysis and formulate plan for ongoing roll-out, predominantly focussed on specialist services. Engagement and rollout within adult congenital heart disease, head and neck cancer, and also orthoapedics across the iCS.To embed as business as usual from April 2024. Baseline assessments and two quarters' submissions have completed and this will form part of the CQINN this year.	3 x 2 6 Mar-24

Outstanding patient outcomes, safety and experience			Monitoring Committee: Quality Committee Executive Leads: COO, CMO, CNO			
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.						
Involvement of patients and families through our Quality Patient Safety Partners (QPSPs) in PSSG, SISG and Quality Improvement projects. Patient Involvement and engagement in capital build projects Working with communities to establish health inequalities and how to ensure our care is accessible and equitable.			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. Performance reporting. Patient Safety Strategy Oversight Committee Transformation Oversight Group (TOG) including TOG dashboard to oversee impact. Established governance oversight and escalation from ward to board through care group and divisional governance groups, as well as the Quality Governance		**Always Improving programme** Delivery of 23/24 aims of patient flow, outpatient and optimising operating services programmes and associated quality, operational and financial benefits (incl. Outpatient follow-up reduction). Further development of our continuous improvement culture to ensure a sustained focus on quality and outcomes. Increase specialties contributing to CAMEO We are developing 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. Always Improving self assessment against NHSE guidance to be taken to Trust Board in December. Fundamentals of care programme roll out across all wards. **Patient experience initiatives** Roll out of SMS and other feedback mechanisms, offering clinical teams targeted response surveys to ensure	

Outstanding patient outcomes, safety and experience					Monitoring Committee: Quality Committee Executive Leads: COO, CMO, CNO	
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.						
			Steering Group and the Quality Committee (sub committee of the board). Providing other avenues of FFT feedback that suits the needs of our demographic, or example SMS surveys, ensuring our care is informed by ours patients voice		specific care needs are not only identified they are also addressed. Experience of Care team to provide meaningful patient feedback to individual services through Div Gov and local level groups to disseminate and support service improvement through codesin and patient experience. We are Listening events – held in local community areas to capture protected characteristic patients that may not explore traditional complaint routes into the Trust.	

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	Transmissibility of Covid and other infections such as norovirus, RSV and influenza. Non-compliant patients and lower uptake of vaccinations due to 'vaccine fatigue'. 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,	None	Ongoing campaigns 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'. Completed work 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. Focussed education on catheter associated urinary tract infection (CAUTI) prevention through Trust wide newsletter August 2023	3 x 2 6 Apr-24

access, etc. to ensure patient safety.			cleanliness, fire safety, medical devices, etc.).			

Pioneering research and innovation					**Monitoring Committee: Trust Board** **Executive Lead: Chief Medical Officer**	
2a) We do not take full advantage of our position as a leading University teaching hospital with a growing, reputable, and innovative research and development portfolio, attracting the best staff and efficiently delivering the best possible treatments and care for our 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)**
Research strategy, approved by Board and fully funded. Always improving strategy, approved by the board and detailing the UHS improvement methodology.	Operational pressures, limiting time for staff to engage in research & innovation. Limited capacity to support new studies and	3 x 3 9	Governance structure surrounding University partnership. Board to Council meetings. Joint Senior operational group.	Limited corporate approach to supporting innovation across the Trust.	Staff survey to test staff engagement and understanding of innovation at UHS. Deliver R&I Investment Case. Ongoing work to review investment and return.	3 x 2 6

Pioneering research and innovation					Monitoring Committee: Trust Board Executive Lead: Chief Medical Officer	
2a) We do not take full advantage of our position as a leading University teaching hospital with a growing, reputable, and innovative research and development portfolio, attracting the best staff and efficiently delivering the best possible treatments and care for our 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)**
Partnership working with the University and other partners. Clinical academic posts and training posts supporting strategies. Secured grant money. Host for new regional research delivery network, supporting regional working. Local ownership of development priorities, supported by the transformation team.	research areas, relating to hard to recruit areas, turnover, and existing clinical priorities. Research priorities with partners not necessarily led by clinical or operational need. No overarching strategy to support innovation.		Joint Research Strategy Board. Joint executive group for research. Joint executive group for innovation. Joint Innovations and Commercialisation Group – UHS/UoS. Monitoring research activity funding and impact at R&D steering group. MHRA inspection and accreditation. Strategy and transformation process. CQC review of well-led criteria, including research and innovation.	National benchmarking: previously ranking was below optimal although improvements are being seen since September 2023. Action plan underway.	International Development Centre, attracting external funding to support staff in pursuing innovation. Execute an agreed joint programme of work with partners through establishing executive group for education. Maximise the benefits of the newly established Wessex Health Partnership as a founding member. Supporting departments in increasing recruitment and retention through work with R&D to create innovative roles. Review the Trust's approach to corporate-wide innovation.	Jan-25

World class people	Monitoring Committee: People and Organisational Development Committee
	Executive Lead: CPO

3a) We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles.

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 Year2 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 including a reduced level of nurse vacancies. Recruitment campaign. Apprenticeships. Recruitment control process to ensure robust vacancy management against budget. Workforce reviews to respond to specific	Ability to fully manage demand on workforce requirements due to external factors such as patient needs, criteria to reside, industrial action. Complete data reviews to ensure alignment of HR and Finance information. Completion of divisional workforce plans to ensure local ability to track progress. Differential pay grading across the ICS leading to retention difficulties. Full workforce CIP identification for 2023/24.	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. Joint finance and Workforce working group on data assurance. Temporary staffing collaborative	Improving forecasting of WF position at year end. Universal rostering roll out including all medical staff. Full review of new national workforce plan(published July) for impacts at UHS.	Approval of Year 2 objectives supporting delivery of the Trust's People Strategy. Deliver workforce plan for 22/23 including increasing substantive staff in targeted areas offset by reducing temporary agency spend. To develop and implement Divisional Workforce Plans. To deliver specific plans to reduce reliance on temporary workforce. To focus on delivery of workforce CIP in partnership with finance and the Divisional teams. To improve data reporting on workforce to support decision making, and alignment with finance reporting. To improve workforce prediction and forecasting. To implement a range of programmes to reduce turnover to 13.6%. To implement a range of measures to reduce our staff absence to 3.9%. To implement a range of measures to improve medical deployment. Ensure	4 x 3 12 Mar-25

World class people					Monitoring Committee: People and Organisational Development Committee	
					Executive Lead: CPO	
3a) We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles.						
recruitment and retention issues (e.g. the ACP review).			diagnostic analysis on effectiveness.		accuracy of leave allocation and recording for medical staff via Health roster for all care groups. Increase use of Health roster across medical staff groups. Continued management of industrial action to mitigate patient impact, and continue to support staff motivation, morale and wellbeing.	

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 UHS wellbeing plan developed. Guardian of Safe Working Hours. Re-launched appraisal and talent management programme.	To recruit to the new network leads for the Trust and re-energise the network capacity and capability. Coverage of allyship training. Embedded responsibility for	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.	Maturity of staff networks Maturity of datasets around EDI, and ease of interpretation	**Building an inclusive and compassionate culture** Deliver year 1 objectives of the new Inclusion and Belonging strategy by March 2024: This includes • 50% of UHS staff to have participated in Allyship training by 31 March 2024	4 x 2 8

Building an inclusive and compassionate culture Inclusion and Belonging Strategy signed off at Trust Board. Creation of a divisional steering group for EDI. FTSU guardian, local champions and FTSU policies. Diversity and Inclusion Strategy/Plans. Collaborative working with trade unions. Launch of the strategic leaders programme with a cohort of 24 across UHS. Senior leader programme launched. Positive action programme completed. Nurse specific positive action programme also launched.	all leaders on inclusion.		Wellbeing Guardian and wellbeing champion. **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. Listening events with staff, regular executive walkabouts, talk to David session. Insight monitoring from social media channels. Allyship Programme. Gender Pay Gap reporting. External freedom to speak up and employee relations review.		• Completing the inclusive recruitment review • Strengthening the role of the staff networks • Embed the belonging blue print • Deliver another cohort of positive action programmes • To improve the quality and dept of EDI data to support decision making, • Ensuring all Board members objectives include a focus on EDI. To deliver an enhanced staff recognition and reward programme including: • Delivery of the new We are UHS Awards • Deliver We are UHS week in September 2023 • New in-person monthly staff spotlight meetings • Refreshed weekly news to keep staff up to date • Peer to peer thankyous which are easy to enact	Mar-25

					refresh the underpinning behaviours of our Trust Values and produce a new behaviours framework. This will underpin future leadership development and OD interventions.	

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 New leadership development framework, 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 Leadership development talent plan 2023-2024 Executive succession planning	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 core training, due to capacity and demand Releasing staff to engage in personal development and training opportunities Limited succession planning framework, consistently applied across the Trust.	4 x 3 12	Annual Trust training needs analysis reported to executive Trust appraisal process GMC Survey Education review process with Health Education Wessex Utilisation of apprenticeship levy Talent development steering group People Board reporting on leadership and talent, quarterly	Need to develop quantitative and qualitative measures for the success of the leadership development programme Full review of new national workforce plan(published July) for impacts at UHS.	To increase the proportion of appraisals completed and recorded to 85%, and increase staff quality perceptions on appraisal by March 2024. Take specific targeted action to improve areas of low satisfaction in the GMC survey. Building strategic partnerships with new Southampton UTC and the new FE colleges alliance, increasing our overall usage of the apprentice levy (March 2024) 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? Implement the leadership development and talent plan throughout 2023 and 2024 Strategic leadership programme and positive action programmes	3 x 2 6 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)
	Areas of concern in the GMC training survey					

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. Vacancies and movement within the	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	Trusts all under significant operational and financial pressure which is challenging prioritisation on elective networking. Specialised Commissioning budget delegation deferred until April 2024.	**ICS and PCNs** Priority networks reviewed and updated against UHS network maturity framework; and agreed by trust board for 2023/24. **Integrated Networks and Collaboration** Urology Area Network plan agreed and proceeding at pace Continue 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 Q3 of 2023/24. 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. Clinical leaders ICS forum has been started, this group is an opportunity to gain clarity on board level agreement on network opportunities and ways forward.	3 x 2 6 April-24

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)**
	senior leadership team has slowed pace.				NHSE has approved the business case for the Elective hub, this is a significant step forward and now moving ahead. Tim Briggs, National Director of Clinical Improvement, and team engaged to support HIOW on 'Further Faster' programme. ICS agreement on clinical specialty focus including dermatology, ophthalmology, UGI and pelvic floor. Funding for dermatology AI pathway secured.	

Foundations for the future	Monitoring Committee: Finance and Investment Committee Executive Lead: CFO

5a) We are unable to deliver a financial breakeven position, resulting in:

- Moving into NHS Outcomes Framework segment 4, which leads to entering into the Recovery Support Programme and additional controls / undertakings
- A reducing cash balance, impacting both The Trust's ability to invest in line with its capital plan and estates / digital strategies, and the Trust's ability to invest in transformation initiatives

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Internal Financial strategy and Board approved financial plan. Trust Savings Group (TSG) oversight of CIP programme (£69m). Transformation Oversight Group (TOG) overseeing delivery of 23/24 transformation programmes including financial benefits Tightened 2023/24 business rules Robust controls over recruitment via the Recruitment Control Panel Enhanced workforce controls including workforce review meetings Weekly executive oversight of workforce numbers Robust business planning and bidding processes Engagement in revised ICB financial architecture	**Internal** Remaining unidentified and high-risk schemes within CIP programme Ability to control and reduce temporary staffing levels **System wide/external** Elements of activity growth unfunded via block contracts Grip of system wide initiatives and assurance	4 x 5 20	Regular finance reports to Trust Board & F&IC Divisional performance on cost improvement reviewed by senior leaders – quarterly. Trust Savings Group oversight of financial recovery plan and CIP programme actions F&IC visibility and regular monitoring of detailed savings plans Transformation Oversight Group (TOG) Operating plan based on cash modelling to ensure affordability of capital programme	Current short-term nature of operational planning Lack of confidence in system-wide initiatives – for example impact of reduced Hospital Discharge Programme funding on Non-Criteria to Reside patients in UHS.	Deliver the planned financial deficit. Improve the underlying financial run-rate back to break-even by April 2024 *(to be reviewed in planning for 24/25)* Improve identification of CIP and reduce value of high-risk schemes Work across health system partners to deliver system initiatives (e.g., planned care, urgent care, criteria to reside etc.) Support the organisation to understand the current financial environment, whilst balancing performance, quality and staff morale Full engagement in Recovery Support Programme, including supporting	Interim target: 4 x 4 16 Apr-24 Longer term target: 4 x 3 12 Apr-25

Foundations for the future	Monitoring Committee: Finance and Investment Committee
	Executive Lead: CFO

5a) We are unable to deliver a financial breakeven position, resulting in:

- Moving into NHS Outcomes Framework segment 4, which leads to entering into the Recovery Support Programme and additional controls / undertakings
- A reducing cash balance, impacting both The Trust's ability to invest in line with its capital plan and estates / digital strategies, and the Trust's ability to invest in transformation initiatives

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Robust controls over investment decisions via the Trust Investment Group and associated policies and processes Monthly reporting processes from Care Groups to Trust Board level. Monthly VFM meetings with each CG **System wide/external** Financial Recovery Programmes / Transformation Programmes: • Planned Care • Urgent & Emergency Care • Discharge • Local / Primary Care • Staffing Improved "grip and control" measures with consistent application across all organisations.	of delivery e.g., Criteria to Reside Shortfall in funding from the pay award		Involvement in development of ICS Recovery Plan		development of the ICS Recovery Plan. Quantify and monitor delivery of financial productivity benefits from 23/24Transformation programme	Apr-24

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. Clear line of sight to Trust Board for all risks identified	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 HTM / HBN 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 Identify future funding options for additional capacity in line with the site development plan Delivery of 2023/24 capital plan Implement the HOIW elective hub. Deliver £5m of critical infrastructure backlog maintenance Agree plan for remainder of Adanac Park site Site development plan for Princess Anne hospital. CAFM System to be presented to November 2023 Trust Investment Group Estates Strategy currently being developed alongside the ICB Infrastructure Plan	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, supported by chief clinical information officers and chief nursing information officers, and safeguarded by clinical safety officers Digital strategy incorporating: • technology programme • clinical digital systems programme • data insight programme	Hampshire and Isle of Wight ICS digital strategy yet to be fully finalised, 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. Ability to implement workforce plan to retain staff needed to underpin strategy Cyber security and recovery capability requires investment and development Development of a non-clinical/business systems strategy	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	Funding to cover the development programme, improvements, and clinical priorities Difficulties in understanding benefits realisation of digital investment. ICB outline business case funding for EPR	Ongoing recruitment of key Digital resource to mitigate operational risk. Cyber security and leadership roles have been recruited to. Achieve 200,000 My Medical Record (MMR) accounts and 30% paper switch-off Inpatient noting for nursing has been rolled out to all appropriate wards Digital ophthalmology system project 'open eyes' to be implemented Identify opportunities for funding for digital transformation and programmes. Robust programme prioritisation in line with available funding. Develop benefits realisation calculations across whole digital programme, linked to other Trust transformation programmes 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: 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)
					Implementation of new Emergency Department patient flow and vital signs systems via Alcidion. Joint delivery of Outpatient, Inpatient and Operating Efficiency programmes with Transformation team through single programme governance	

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 improvements to the Trust's estate and energy supply, including use of funding from the Public Sector Decarbonisation Scheme. Develop metrics and establish governance processes in respect of the Trust's Green Plan and other related strategies. Review green energy ambitions following extreme rises in electricity costs. Forward plans to review energy contract.	2 x 2 4 Dec-24

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Emergency Preparedness, Resilience and Response Delivery Group (EPRR-DG) – Assurance Report**			
Agenda item:	**7.1**			
Sponsor:	**Joe Teape, Chief Operating Officer**			
Author:	**John Mcgonigle, Emergency Planning**			
Date:	**30 November 2023**			
Purpose:	**Assurance & reassurance** **Section 1**	**Approval**	**Ratification**	**Information** **Section 2 - 4**
Issue to be addressed:	This report seeks to provide an update the Trust Board on the UHS EPRR-Assurance submission 2023 / 2024. This report covers: 1. EPRR Assurance 2023 / 2024 2. EPRR Delivery 2024 3. Command Exercising 4. Risks			
Response to the issue:	**1. EPRR Assurance 2023 / 2024** • The Annual Assurance requirement 2023 assessed UHS preparedness within ten domains covering sixty-two core standards, and multiple performance indicators within each. • UHS is fully complaint with sixty of those sixty-two standards and thus awarded a grading of 'substantially compliant'. Whilst this award matches year 2022 / 2023, the actual performance within the range has improved six percentage points (from 91% to 97%). • Notable developments throughout 2023 include the following: ○ **Incident Response Plan:** Complete re-write of UHS approach to mirror national, regional and ICB structure. Scalable command protocols. Includes Critical Incident Protocol, and Protocol for Gold and Silver Command (escalation and responsibilities). Consultation completed and being presented to Emergency Preparedness, Resilience and Response Delivery Group (EPRR-DG) on 7th December for acceptance. 209 members of UHS Incident Command cohort have received training / support / accreditation on the national occupational standards. CPD command portfolios have			

been designed and these, together with new Incident / Decision logs, and are scheduled for release across UHS. Incident Commanders will be supported by further CPD and training January – March 2024.

- Rewrite of following plans ready for presentation to EPRR-DG on 7th December:
  - CBRN
  - Severe Weather
  - EPRR Policy
  - Business Continuity Policy
  - New / emerging pandemics
  - Lockdown (interim – for further review 2024)
  - VIP / Protected Persons

- There are two core standards requiring improvement, and these each are subject of an Action Plan. They are:

Duty to maintain plans – Mass Casualty:

- Following redesign of the Incident Response Plan, this necessitated a thorough revision of our Major Incident and Mass Casualty plan. This update incorporated several significant changes, including operational enhancements, an evolved role for the Incident Control Centre (ICC), specific procedures for P3 and P4 casualties, adjustments for paediatric cases, integration of MTC clinical guidance, refined traffic management strategies, and enhanced staff welfare measures.

- UHS identified several critical risks in this process, including patient clearance, resource allocation during out-of-hours periods, expansion of critical care services, considerations of bed capacity and spatial constraints, ensuring medication availability, and optimising resource and equipment management.

- The governance structure overseeing these arrangements will be operating under the aegis of the Mass Casualty Operational Planning Group. This assembly of Subject Matter Experts will convene bi-annually and will actively steer the development, testing, and exercises associated with the UHS plan.

- The intent is to establish a well-defined testing and evaluation program, intended for launch in January 2024, with scheduled activities commencing in April of the same year. This initiative will serve to facilitate the integration of the NHS Mass Casualty Concept of Operations (CONOPS) and the NHS Major Incident Triage Tool (MITT), which was officially published in April 2023 and is stated for adoption across the healthcare sector in June 2024.

- This plan is scheduled for formal consultation at the end of February 2024.

Duty to maintain plans – Evacuation and Shelter

- The UHS Evacuation Plan has undergone comprehensive revision to bring in line with NHSE doctrine, although it is pending release as we await a decision concerning protocols, processes and procedures across the county and region. Our Assurance Action plan has evolved to encompass not only the whole UHS evacuation but also to ensure compliance with fire regulation requirements pertaining to evacuation plans at the ward and department levels, in addition to adherence to annual testing mandates. These latter points will be driven through EPRR-DG (see section 2 below).

- To enhance our evacuation preparedness, an Evacuation Operational Planning Group is set to be established, and this group will directly contribute to the EPRR-DG's activities.

- Efforts are ongoing to develop a system for holding, evacuation clearing, and patient dispersal teams, with refinements to be made in collaboration with the HIOW ICB (Hampshire and Isle of Wight Integrated Care Board) in line with regional requirements.

- Regarding shelter arrangements, UHS is actively collaborating with the local authority to secure three locations for shelter (Southampton Football Club, Docks, and a local church / sports centre) to cater to evacuation scenarios that fall short of a major incident involving many patients and staff. Negotiations are presently underway.

- UHS will independently advance its evacuation and shelter plan early 2024, a decision articulated to the ICB during the Local Health Resilience Partnership (LHRP) meeting in October 2023. Following this, a UHS-wide training program will ensue. This training program will blend a Virtual Learning Environment (VLE) with area-specific testing, in strict accordance with our Fire Policy, mandating an evacuation plan test or exercise every 12 months.

- This plan is scheduled for formal consultation at the end of February 2024.

2. **EPRR Delivery 2024**

- The EPRR-DG replaces Major Incident Planning Group (MIPG) and will first sit on 7th December. The key difference is in the requirement for delivery of performance outputs / outcomes as articulated within the Terms of Reference. EPRR-DG will:

    - Ensure that the EPRR system aligns to Trust business and delivers a measurable performance output against key performance indicators related to statutory requirement and across the spectrum of Business

	Continuity planning. Attendees have strategic accountability for delivery in their area of business. ○ Subgroups are to be formed and required to sit twice annually to feed into (proposed) EPRR-DG. These are: ▪ CBRN Operational Planning Group (OPG) ▪ Major Incident / Mass Casualties OPG ▪ Pandemic Preparedness Group (PPG) ▪ Evacuation OPG 3. **Command Exercising** • **Cyber exercise**. A cyber-crisis exercise is scheduled for 29 November 2023. Facilitated by UHS Cyber Security Team (Informatics), the exercise will include elements of senior leadership, digital, IT, CyberSec, Information Governance, EPRR & switchboard teams to exercise our incident response knowledge and test responses. • **Command and Control:** UHS Actions and Decisions logs are scheduled for delivery December 2023. Several refresher dates have been arranged for UHS Gold / Silver Commanders to revisit National Occupational Standards for command, and test effectiveness at individual level utilising a table-top scenario. This will occur January – March 2024 and contribute towards individual's command CPD portfolios.
Implications: (Clinical, Organisational, Governance, Legal?)	This report provides internal assurance to Trust Executive Committee and Trust Board that UHS continues to drive improvement through appropriate scrutiny, inspection, and performance management. The formal requirement is that the Trust continues to meet EPRR Core Standard requirements and maintain our assurance levels for Emergency Planning, Resilience and Response.
Risks: (Top 3) of carrying out the change / or not:	4. **Risks** • The EPRR team are two full-time staff working to a challenging agenda and timescales. The year 2023 has seen a significant re-write of whole approach to EPRR planning and response. The work delivery programme has met 2023 Assurance timescales but that, together with operational delivery whether industrial action or electrical resilience, has come at cost to training and exercising. Improvement in this domain forms a significant part of the 2024 EPRR work-plan. • The Trust Business Continuity Management System is occasionally opaque and fragmented, and this has been observed both within preparation for large EFCD work programmes (electrical) and in operational / incident scenarios. The EPRR-DG will oversee the business improvement

	supported by Deputy Emergency Planner, Danielle Sinclair, who embarks of a Business Continuity Lead Assurer course November 2023. The intent is that through 2024, UHS strengthens its Business Continuity arrangements through support, governance, and oversight. • The 2024 Evacuation and Shelter action plan is a critical area of business with a higher probability of enactment than Mass Casualty. Increased focus required on internal arrangements to evacuate at Ward-to-Trust level to assure processes. This will be driven through EPRR-DG. The Evacuation Plan(s) across HIOW Acute Trusts are misaligned requiring drive, oversight and governance at ICB / Regional level. In the event of significant movement of patients across Trusts, tracking and tracing of patients would present difficulties presently.
Summary: Conclusion and/or recommendation	**Recommendations** Trust Board is asked to note the report.

Report to the Trust Board of Directors				
Title:	**CRN Wessex: 2023-24 Q2 Performance Report**			
Agenda item:	**10.1**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Author:	**Clare Rook, Chief Operating Officer, CRN Wessex** **Graham Halls, Business Intelligence Manager, CRN Wessex**			
Date:	**30 November 2023**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **x**
Issue to be addressed:	• This report covers Clinical Research Network (CRN) Wessex's performance in quarters one to two of the 2023/24 financial year (April to September 2023) against the Department of Health and Social Care's (DHSC) high level objectives (HLOs) for research and other local metrics.			
Response to the issue:	• The Wessex region is meeting the DHSC requirements to work with local research sponsors to ensure that their studies are achievable and are recruiting within ninety days of their planned start date. • The Wessex region is performing above or close to DHSC ambitions to ensure studies recruit to their planned timelines and deliver sufficient responses to the National Institute of Health and Care Research's (NIHR) Participant in Research Experience Survey (PRES). Performance on these objectives has improved since the end of quarter one and research participants are reporting a generally positive experience. • All care settings have recruited to NIHR-supported studies so far this financial year, with a record 61 per cent of GP practices in Wessex participating in research. • Wessex provided 8.5 per cent of the national recruitment to commercial studies in the first two quarters, with 5 per cent of the UK population. Commercial studies offer novel tests or treatments to Wessex patients and generate income for reinvestment in infrastructure.			
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 and grant funding to facilitate research activity within Wessex. Therefore, CRN Wessex and its partner organisations must ensure the funding is used effectively.			
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 are: ○ Winter pressures ○ End of LCRN contract September 2024 ○ Strike actions. *Please review the risk register in Appendix One for details of the already underway or planned responses.*			
Summary: Conclusion and/or recommendation	• In quarter one it was flagged that recruitment has decreased in Wessex relative to previous years and other regions. This report demonstrates the breadth of studies that have taken place in 2023/24 to-date, as well as the quality of both the delivery and participants' experiences. • There is evidence that interventions taken in collaboration with partner organisations is resulting in larger studies, that have a high potential for patient benefit, opening and recruiting well in Wessex. The effect of this will be demonstrated further in later reports this financial year but can already be seen in improving high level objective results and increased commercial activity. • The Board will continue to be updated on performance quarterly.			

NIHR | Clinical Research Network Wessex

CRN Wessex Q2 2023/24 Performance Report

Clare Rook, Chief Operating Officer
Graham Halls, Business Intelligence Manager

November 2023

Introduction

This report informs the UHS Board of Directors of the clinical research activities within the Wessex region. The report covers the performance against the National Institute of Health and Care Research's (NIHR) high level objectives, as well as general research activity in Wessex. This report focuses on quarters one to two of the 2023/24 financial year (April 2023 to September 2023), unless otherwise stated.

Key issues

National areas of strategic focus for health research

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 seven areas of strategic focus for the NIHR (Figure 1). These focus areas guide how the CRN, and its partner organisations deliver NIHR-supported research activities in Wessex.

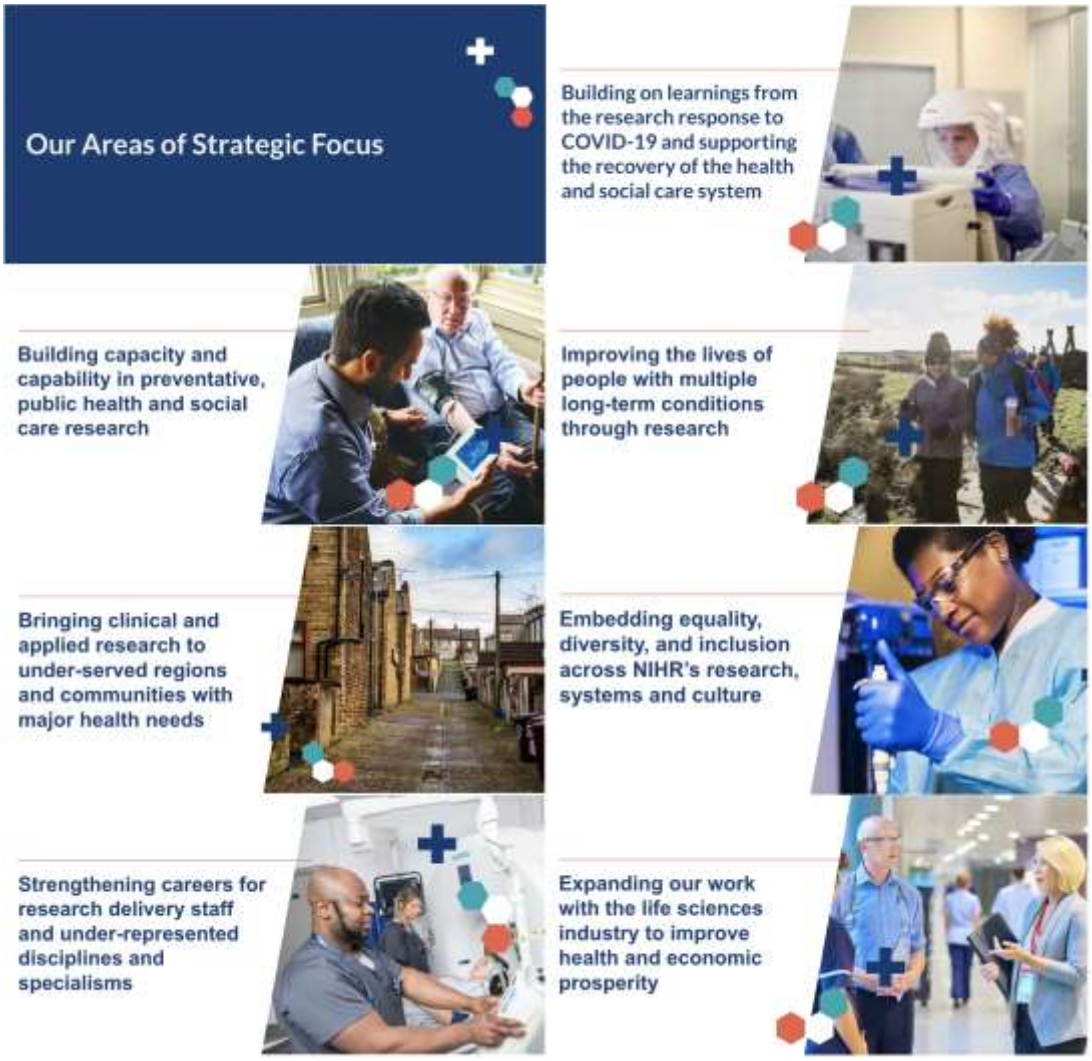

Figure 1 - NIHR Areas of strategic focus from Best Research for Best Health: The Next Chapter.

Recovery and growth of the research system following the COVID-19 pandemic

Led by the Department of Health and Social Care (DHSC), the NIHR's focus at the start of the 2023/24 financial year was on resetting and recovering health and care research. Local sponsors and CRN Wessex supported the DHSC's 'Research Reset' programme (Research Recovery and Reset | NIHR). The programme aimed to make CRN research portfolio delivery achievable within planned timelines and sustainable within the resources and capabilities the UK currently has in the NHS.

The Research Reset program successfully rebuilt the UK's clinical research ecosystem after the pandemic, achieving the national ambition of 80% on-time delivery for open studies by June 2023. The program's completion marked the transition to the maintenance or 'business as usual' phase, reducing study delays, and sustaining overall recruitment levels. The NIHR CRN, including CRN Wessex, has adopted the Research Reset approach as a standard process for managing the clinical research portfolio, ensuring the UK's clinical research growth remains sustainable.

As of November 2023, less than four per cent of studies led from the Wessex region were awaiting a response from the sponsor (Figure 2). Local clinical research networks are asked to review studies more than ninety days past their planned opening date with no recorded activity and Wessex currently has no studies in this category.

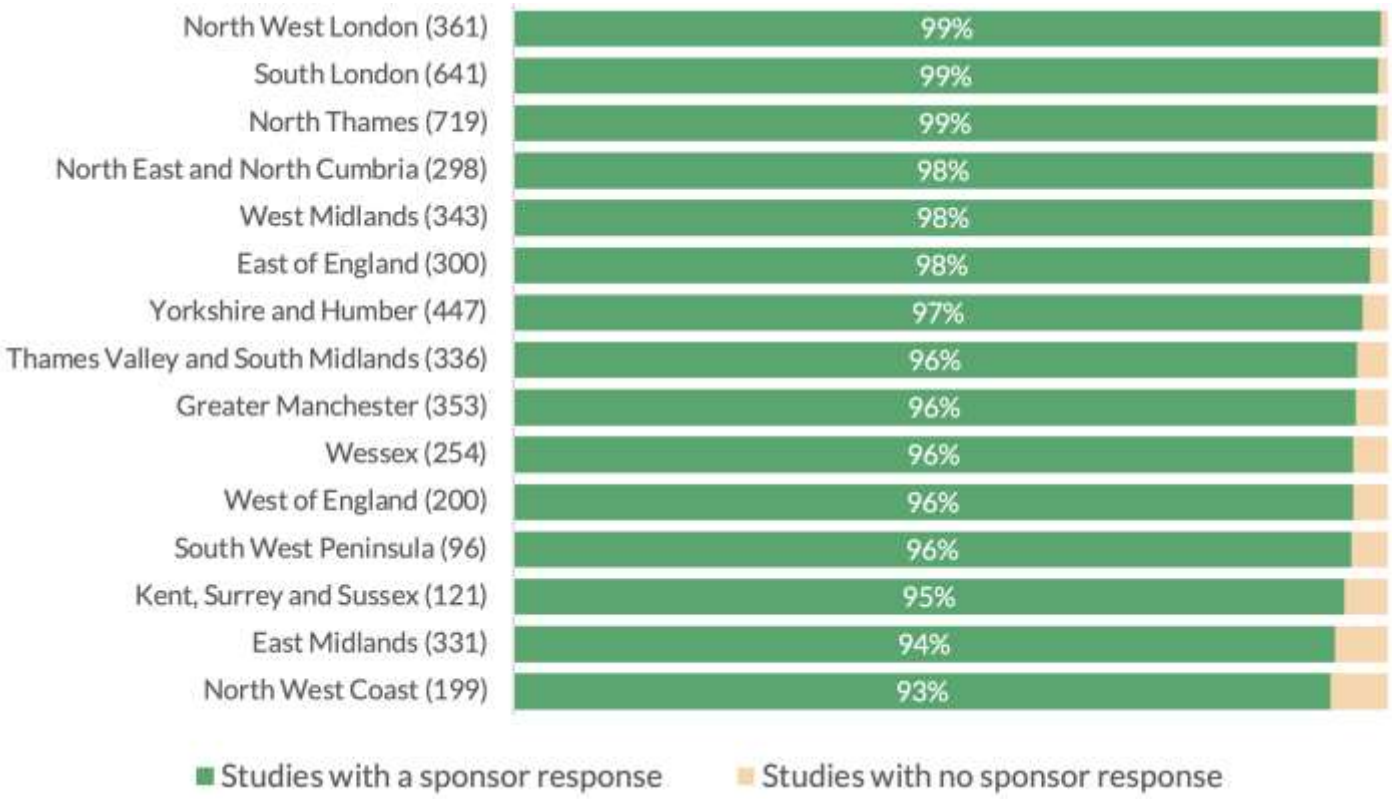

Figure 2 - Summary of DHSC Reset programme responses from study sponsors by local clinical research network region - updated 9 November 2023. Numbers in brackets are studies led from each region.

DHSC & NIHR Clinical Research Network high level objectives (HLOs) for 2023/24

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. In addition, the NIHR CRN should demonstrate to NIHR-supported research participants that their input is valued by gathering their feedback and using it to improve research delivery. The performance of the NIHR CRN in meeting these purposes is measured using the HLOs. These are outlined in Figure 3, with current Wessex and English (all local CRNs combined) performance linked to ambitions agreed with the DHSC.

Objective		Measure	Ambition	Wessex	England
Study delivery	Support sponsors to deliver NIHR CRN Portfolio studies to recruitment target	Percentage of **open to recruitment commercial** contract studies which are predicted to achieve their recruitment target	80%	78% (28/36 open Wessex-led studies)	82%
		Percentage of **open to recruitment non-commercial** studies which are predicted to achieve their recruitment target	80%	72% (100/138 open Wessex-led studies)	79%
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	678 (55%)	18,000 ambition (total national responses received to date is TBC)

Figure 3 – Local and national performance for the DHSC & NIHR CRN High Level Objectives for quarters one to two of the 2023-24 financial year.

At the end of quarter two, Wessex was not meeting the ambition value of 80 per cent for the two measures under the *Study delivery* objective. These measures apply to studies that are 'led' from Wessex, where the chief investigator or sponsor is located in the region. Both measures have improved since quarter one, when 71 and 70 per cent of open commercial and non-commercial studies, respectively, were predicted to meet their recruitment targets. This improvement has been both due to better performance, as well as studies closing to recruitment and being excluded. Performance is regularly discussed with the partner organisations sponsoring these studies in the region. A new business intelligence dashboard aimed at monitoring Wessex-led studies has been developed and made available to sponsors. Research and delivery departments in Wessex partner organisations have also requested regular reports from CRN Wessex to help them monitor their performance, as well as the performance of research sites supporting their studies in other regions.

The *Participant Experience* objective has an ambition for Wessex of 1,237 completed surveys during 2023/24 (Figure 4). Nearly seven hundred responses had been received, four per cent above the anticipated responses as of 3 October 2023. By comparison, at the end of quarter one Wessex was one per cent behind the expected responses at that stage. Figure 5 demonstrates the predominantly positive responses received. The lowest values are for respondents feeling that they have been kept updated and knowing how they would receive their results. These communications are predominantly the responsibility of the study sponsor team and have to be approved by an ethics committee. CRN Wessex has a PRES working group who will explore how the local teams can help to improve these values.

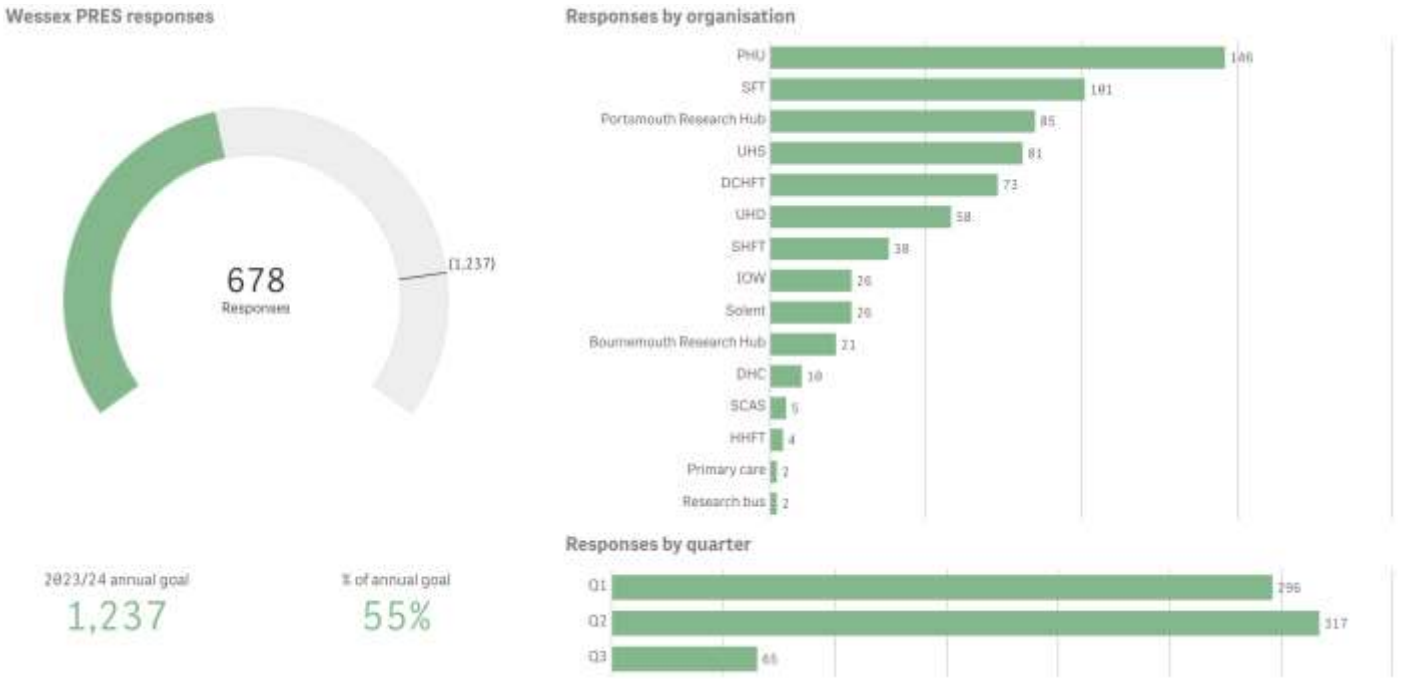

Figure 4 - Participant in research experience survey responses in Wessex in the 2023/24 financial year (updated 3 October 2023). The glossary in appendix two contains expanded acronyms.

Figure 5 - Summary of the Participant in research experience survey results in Wessex in the 2023/24 financial year (updated 3 October 2023).

Research activity in Wessex

All research activity in Wessex

Recruitment has been benchmarked against England's activity over the eighteen months leading to the end of quarter two (Figure 6). In the last twelve months the recruitment trend remained relatively stable in Wessex, with a small fall in activity in September across both Wessex and England.

Recruitment is affected by the opening and closure of large and lower intensity studies, such as surveys or those that require a single visit. CRN Wessex has been working with partner organisations to open championed studies that give patients in the region a greater opportunity to take part in research, or for other strategic criteria. For example, the 'Newborn screening for SMA' spinal muscular atrophy study has opened in quarter two and has since recruited over 1,750 participants at four sites in Wessex (includes quarter three recruitment). This study was recently reported on the ITV Meridian news (YouTube link: https://youtu.be/VuZiI5PztcA) given its high potential to improve the lives of participants. This and other large or strategically important studies are starting in the final two quarters of this financial year, with monthly recruitment expected to rise as a result.

Figure 6 - Wessex research recruitment benchmarked against England for the eighteen months leading to the end of quarter two of the 2023/24 financial year.

In the first half of the 2023/23 financial year, research activity took place in all care settings (Figure 7) including acute, ambulance, care and mental health trusts as well as non-NHS and primary care sites. 61 per cent of GP practices have recruited at least one participant, against a local ambition based on previous NIHR objectives of 45 per cent. This is the highest level of participating ever in Wessex. Figure 8 demonstrates that this activity has happened across the region, with the majority centred around the largest cities and towns in the region.

It is important to ensure that research reaches all communities to ensure everyone can access its benefits. CRN Wessex supports small-grant initiatives, with a total of £200,000 of funding this financial year. These initiatives operate in collaboration with local charities and organisations to boost research in underserved communities. They aim to address challenges such as limited access, greater healthcare needs under-served by research, or decreased involvement, as outlined in the NIHR INCLUDE project.

Organisation type	No. trusts	No. sites	Recruitment	% of organisations recruited this year
Acute	7	26	9,219	**100%** *(ambition 100%)*
Ambulance	1	1*	371	**100%** *(ambition 100%)*
Care	1	8	172	**100%** *(ambition 100%)*
Primary care	*N/A*	158	4,880	**61%** *(ambition 45%)*
Mental Health	2	25	830	**100%** *(ambition 100%)*
Non-NHS	*N/A*	11	76	*N/A*

*Activity happens across Wessex but is recorded at the SCAS Trust Headquarters in Oxfordshire.

Figure 7 – Research activity in Wessex by organisation type during quarters one to two of the 2023/24 financial year.

Figure 8 – Recruiting research sites in Wessex by organisation type in quarters one to two of the 2023/24 financial year.

Figure 9 provides quarterly recruitment grouped by type of organisation since October 2022.

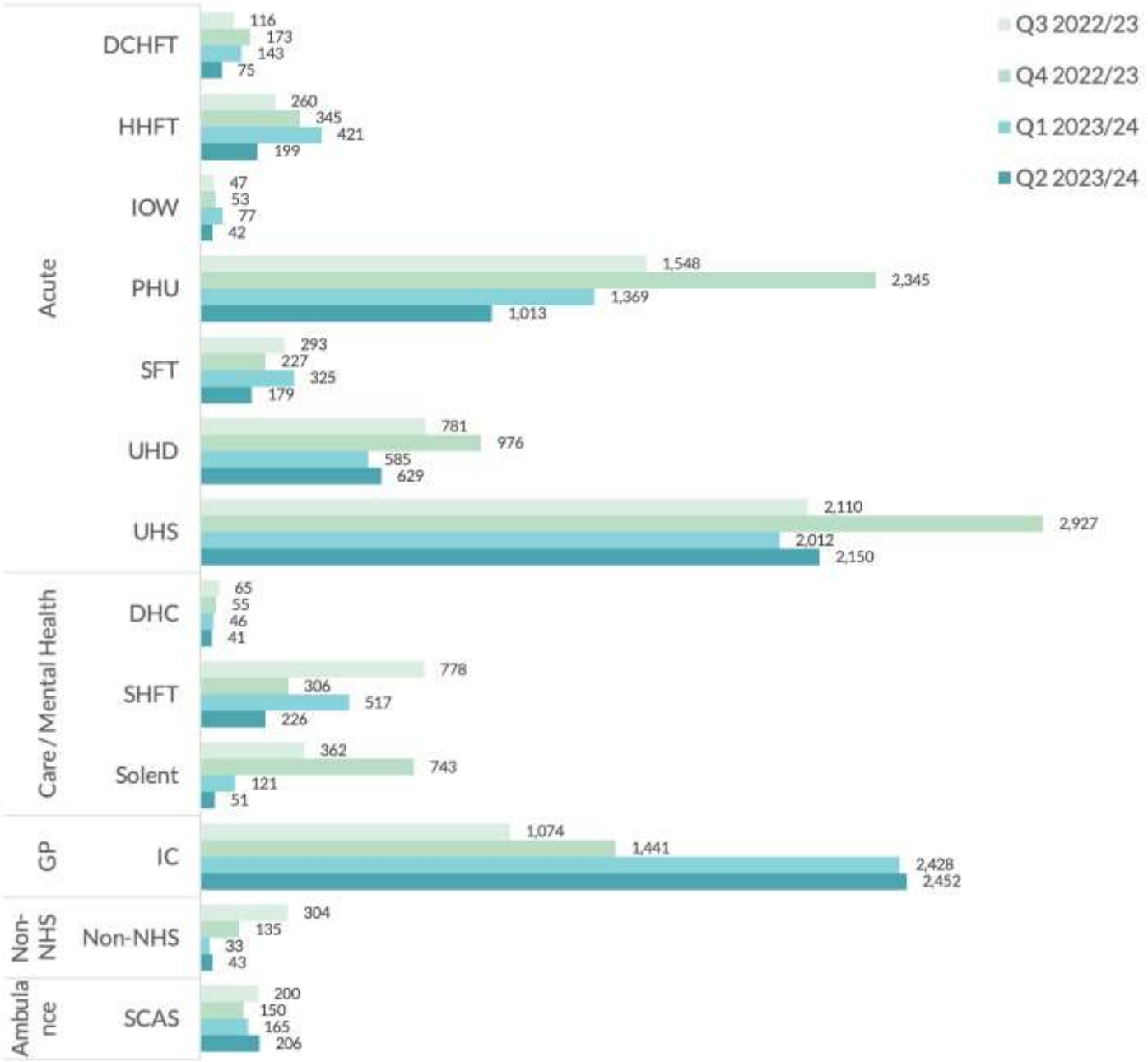

Figure 9 – Quarterly CRN Portfolio study recruitment by organisation type in Wessex since October 2022.

The number of studies that have recruited in Wessex each quarter since April 2019 is provided in Figure 10. There is a slight downwards trend evident in the total recruiting studies over the last twelve months. Participation in commercial studies has increased over this same period and is approaching levels seen before the COVID-19 pandemic. After the pandemic the DHSC Research Reset programme led to the closure of studies that were not recruiting as expected. An average capacity of around 400 recruiting studies appears to be the region's new 'normal' within the current infrastructure.

Figure 10 - Recruiting studies in Wessex by funding type in the last five financial years.

Commercial research activity in Wessex

Commercial research, funded and sponsored by the life sciences industry, is important to the Wessex region and is a priority area for the DHSC. It provides novel treatment options for patients, supports the expansion of research infrastructure and often generates savings on treatment costs for participating organisations.

Figure 11 - Percentage of Wessex sites on commercial studies that closed each financial year meeting their recruitment target assigned by the sponsor.

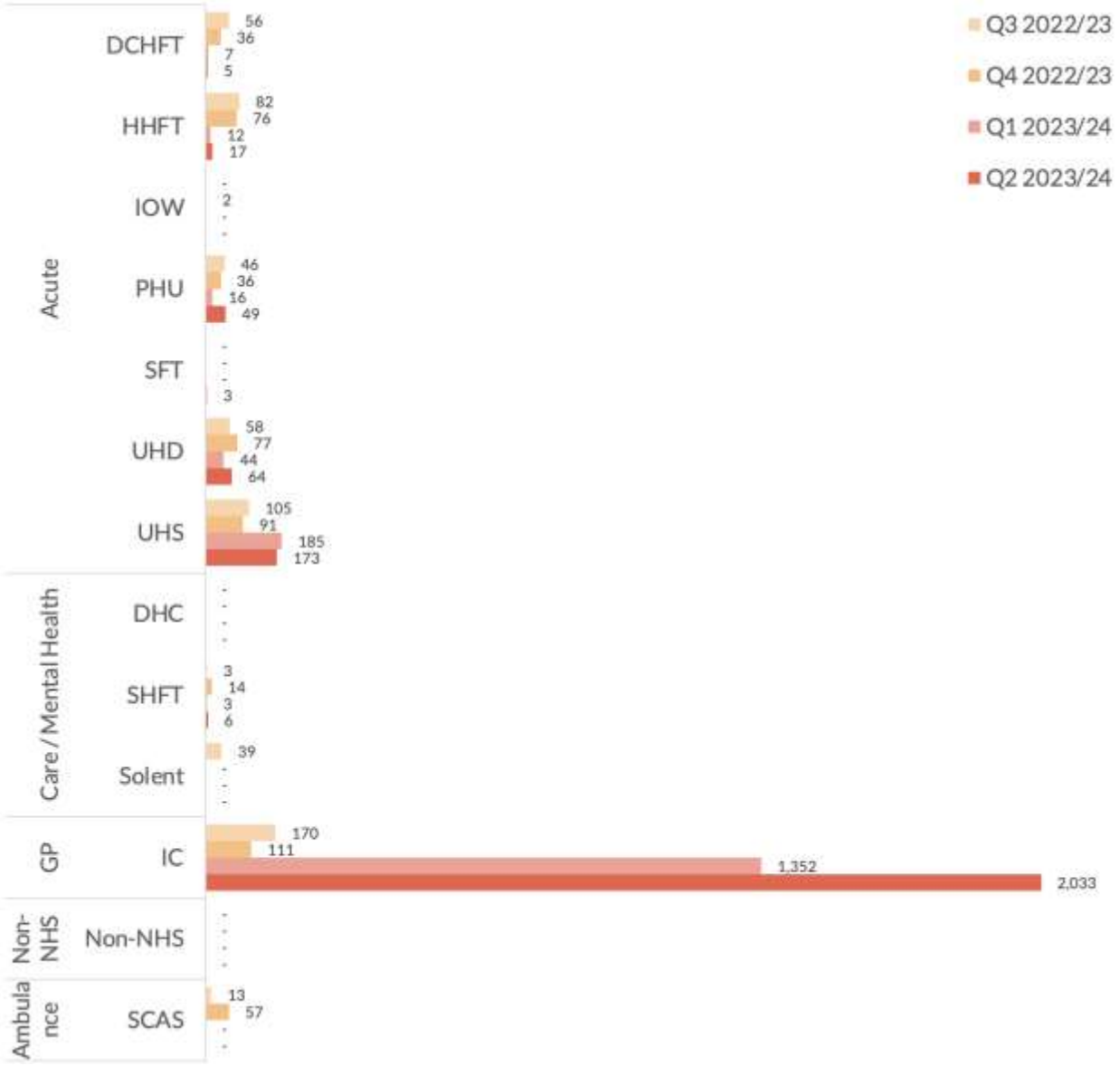

Figure 12 – Quarterly commercial CRN Portfolio study recruitment by organisation type in Wessex since October 2022.

Wessex provided 8.5 per cent of the United Kingdom's recruitment to commercial studies in the first two quarters, with five per cent of the population. The largest studies included a health and genetics study in primary care (Discover Me), with over 3,342 participants, and a Moderna COVID-19 vaccine trial (NextCOVE) with 221 recruited at the four Wessex research hubs.

The high level objectives focus on studies led by each region, but site performance on commercial studies led from any region is also monitored by CRN Wessex (Figure 11). Wessex sites remained above the local eighty per cent ambition in quarters one to two; over four out of five study sites closed having met their recruitment target. Figure 12 provides quarterly recruitment grouped by type of organisation since October 2022.

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 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.	3	3	9	Current	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 two-weekly calls with POs 5. Core team returning to 40/60 split of office/home January 2022	WFD Lead / COO / SSS Lead	All - ongoing	3	2	6	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	Current	1. Talent management within team 2. PDPs with identified training needs and subsequent provision of appropriate learning opportunities 3. Job shadowing opportunities 4. Succession planning, e.g deputy COO role 5. Strongly embedded workforce wellbeing initiatives	COO / CD	All - ongoing	2	2	4	Open	Decreased
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**	3	4	12	Current	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	2	2	4	Open	Decreased
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**	2	3	6	Current	1. Ongoing recruitment to the direct delivery team 2. Reinvestment of hub income to increase head count	WFD/COO	All - ongoing	2	2	4	Open	Decreased
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**	2	3	6	Current	1. DDT based nearer hub locations could pick up some work 2. Look for opportunities for remote trial delivery	COO/DCOO	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 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**	2	3	6	Current	1. Raise locally and nationally for advice on prioritisation of key activities/studies	COO/DCOO	All - ongoing	2	3	6	Open	Decreased
CRN 10	Workforce	Sep-22	CDs/COO	**Cause: End of LCRN contract September 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	Current	1. Raise locally and nationally for advice on prioritisation of key activities/studies 2. Implement staff transition survey to gather opinions and suggestions 3. Involve staff in wellbeing initiatives to support through the transition 4. Work with UHS transition leads and HR to keep staff up to date with process to support transition to new roles and services	COO/DCOO	All - ongoing	3	4	12	Open	Static
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	Current	1. Raise locally and nationally for advice on prioritisation of key activities/studies	COO/DCOO	All - ongoing	4	4	16	Open	Static
CRN 14	Performance	March	CDs/COO	**Cause: Junior doctor strike action** **Event: Redeployment of clinical staff to cover emergency care leading to lack of staff to deliver clinical trials**	4	3	12	Current	1. Raise locally and nationally for advice on prioritisation of key activities/studies	COO/DCOO	All - ongoing	4	3	12	Open	Static
CRN 15	Performance	March	CDs/COO	**Cause: Consultant strike action** **Event: Redeployment of clinical staff to cover emergency care leading to lack of staff to deliver clinical trials**	4	3	12	Current	1. Raise locally and nationally for advice on prioritisation of key activities/studies	COO/DCOO	All - ongoing	4	3	12	Open	Static

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 2023/24 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