

## Agenda Trust Board – Open Session

<b>Date</b>	30/03/2023
<b>Time</b>	9:00 - 12:30
<b>Location</b>	Conference Room, Heartbeat/Microsoft Teams
<b>Chair</b>	Jenni Douglas-Todd
<b>Apologies</b>	Diana Eccles
<b>Observing</b>	Chris Lake, Integrated Development

- 1 Chair's Welcome, Apologies and Declarations of Interest**  
9:00 Note apologies for absence, and to hear any declarations of interest relating to any item on the Agenda.
- 2 Minutes of Previous Meeting held on 31 January 2023**  
Approve the minutes of the previous meeting held on 31 January 2023
- 3 Matters Arising and Summary of Agreed Actions**  
To discuss any matters arising from the minutes, and to agree on the status of any actions assigned at the previous meeting.
- 4 QUALITY, PERFORMANCE and FINANCE**  
Quality includes: clinical effectiveness, patient safety, and patient experience
- 4.1 Briefing from the Chair of the Audit and Risk Committee (Oral)**  
9:15 Keith Evans, Chair
- 4.2 Briefing from the Chair of the Finance and Investment Committee (Oral)**  
9:20 Jane Bailey, Chair
- 4.3 Briefing from the Chair of the People and Organisational Development Committee (Oral)**  
9:25 Jane Harwood, Chair
- 4.4 Briefing from the Chair of the Quality Committee (Oral)**  
9:30 Tim Peachey, Chair
- 4.7 Chief Executive Officer's Report**  
9:35 Receive and note the report  
Sponsor: David French, Chief Executive Officer
- 4.8 Integrated Performance Report for Month 11**  
10:05 Review and discuss the Trust's performance as reported in the Integrated Performance Report.  
Sponsor: David French, Chief Executive Officer

- 4.9 Finance Report for Month 11**  
10:35 Review and discuss the finance report  
Sponsor: Ian Howard, Chief Financial Officer
- 4.10 People Report for Month 11**  
10:45 Review and discuss the people report  
Sponsor: Steve Harris, Chief People Officer
- 4.11 Break**  
10:55
- 4.12 UHS Staff Survey Results 2022 Report**  
11:10 Discuss and note the report  
Sponsor: Steve Harris, Chief People Officer  
Attendees: Ceri Connor, Director of OD and Inclusion/Sophie Limb, HR Project Manager
- 4.13 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
- 4.14 Learning from Deaths 2022-23 Quarter 3 Report**  
11:30 Review and discuss the report  
Sponsor: Paul Grundy, Chief Medical Officer  
Attendee: Ellis Banfield, Associate Director of Patient Experience
- 5 STRATEGY and BUSINESS PLANNING**
- 5.1 UHS Smoke Free Site Model**  
11:40 Review and approve the proposal  
Sponsor: Paul Grundy, Chief Medical Officer  
Attendee: Lucinda Hood, Head of Medical Directorate
- 5.2 Board Assurance Framework (BAF) Update**  
11:50 Review and discuss the update  
Sponsor: Gail Byrne, Chief Nursing Officer  
Attendees: Craig Machell, Associate Director of Corporate Affairs and Company Secretary/Kyle Lacoste, Trust Documents Manager
- 6 CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL**
- 6.1 Register of Seals and Chair's Actions Report**  
12:00 Receive and ratify  
In compliance with the Trust Standing Orders, Financial Instructions, and the Scheme of Reservation and Delegation.  
Sponsor: Jenni Douglas-Todd, Trust Chair

**7** **Any other business**  
12:05 Raise any relevant or urgent matters that are not on the agenda

**8** **Note the date of the next meeting: 25 May 2023**

**9** **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.

**10** **Follow-up discussion with governors**  
12:15

## Minutes Trust Board – Open Session

<b>Date</b>	31/01/2023
<b>Time</b>	9:00 – 13:00
<b>Location</b>	Heartbeat Education Centre/Microsoft Teams
<b>Chair</b>	Jenni Douglas-Todd (JD-T)
<b>Present</b>	Jane Bailey, Non-Executive Director (NED) (JB) Dave Bennett, NED (DB) Gail Byrne, Chief Nursing Officer (GB) Jenni Douglas-Todd, Chair (JD-T) 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) Tim Peachey, NED (TP) Joe Teape, Chief Operating Officer (JT)
<b>In attendance</b>	Cyrus Cooper, Associate NED (CC) Femi Macaulay, Associate NED (FM) Craig Machell, Associate Director of Corporate Affairs and Company Secretary (CM) Christine McGrath, Director of Strategy and Partnerships (CMcG) Marie Cann, Senior Midwifery Manager (MC) (item 5.10) Ceri Connor, Director of OD and Inclusion (CCo) (item 6.1) Emily Heron, Trainee Advanced Nurse Practitioner (item 2) Kyle Lacoste, Trust Records Manager (KL) (item 6.3) Hannah Leonard, Consultant Midwife (HL) (item 5.10) Alison Millman, Interim Safety & Quality Assurance Matron (AM) (item 5.10) Emma Northover, Director of Midwifery (EN) (item 5.10) Four Governors (observing) Six members of staff (observing) One member of the public (observing)
<b>Apologies</b>	Diana Eccles, NED (DE)

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

The Chair welcomed attendees to the meeting. It was noted that there were no interests to declare in the business to be transacted at the meeting.

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

### 2. **Staff Story**

Emily Heron, a nurse and now trainee Advanced Nurse Practitioner was invited to present a staff story based on her experience working on an intensive care unit during the COVID-19 pandemic and subsequent impact on her mental health, leading to a diagnosis of late-onset post-traumatic stress disorder.

### **3. Minutes of the Previous Meeting held on 29 November 2022**

The draft minutes tabled to the meeting were agreed to be an accurate record of the meeting held on 29 November 2022.

### **4. Matters Arising and Summary of Agreed Actions**

It was noted that all actions due had been completed or would be addressed through the business of the meeting. It was agreed that action 878 should be deferred until the next meeting.

## **5. QUALITY, PERFORMANCE and FINANCE**

### **5.1 Briefing from the Chair of the Audit and Risk Committee**

The chair of the Audit and Risk Committee was invited to provide an overview of the meeting held on 16 January 2023. It was noted that:

- The committee reviewed a self-assessment of the Trust's financial governance, which had also been reviewed and agreed with internal audit.
- The committee reviewed the Trust's compliance with the NHS Foundation Trust Code of Governance, noting that, bar a few minor exceptions, the Trust was fully compliant.
- Internal audit had carried out a review into data security.
- The committee reviewed the fraud, bribery and corruption work plan, noting that the main area of concern was the level of compliance with the Trust's declaration of interests policy.

### **5.2 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 30 January 2023. It was noted that:

- The committee had reviewed the Trust's latest financial position.
- The committee had reviewed the Trust's activities in the areas of Always Improving and Digital.
- The committee had reviewed the strategic risks within its remit.
- The committee had reviewed the outputs of a review of its effectiveness.

### **5.3 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 25 January 2023. It was noted that:

- National funding for the Health Care Assistant Hub would end in April 2023.
- The committee had reviewed the Trust's sickness absence level, noting that this remained above the Trust's target.
- The committee had reviewed the Trust's workforce planning activities for 2023/24.

### **5.4 Briefing from the Chair of the Quality Committee**

The chair of the Quality Committee was invited to provide an overview of the meeting held on 30 January 2023. It was noted that:

- There was no capacity to operate on P2s in neuro-oncology, which would require significant intervention, possibly involving national or private sector assistance to resolve.
- The committee had reviewed serious incidents and never events.
- The committee had reviewed the Maternity Safety Report.
- The committee had reviewed progress against the Trust's clinical strategy.
- The committee had reviewed the outputs of a review of its effectiveness.

- The Trust was likely to miss some of its targets due to clinical priorities with c.150 long-waiting patients forecast to be missed by the end of March 2023. It was noted that the Trust cannot continue to accept referrals who will not be seen within the 78-week target. In addition, health inequalities needed to be considered in respect of long-waiting patients, i.e. those unable to afford private alternatives.

## 5.5 Chief Executive Officer's Report

David French was invited to present the Chief Executive Officer's Report. It was noted that:

- There had been industrial action by the Royal College of Nursing (RCN) on 18 and 19 January 2023 with further industrial action expected to take place on 6 and 7 February 2023. The strike had added c.2,000 people to the Trust's waiting lists and was very disruptive.
- NHS England had published guidance in respect of the circumstances under which it would seek to make an order under the Health and Care Act 2022 to impose limits on capital expenditure by an NHS Foundation Trust.
- Both the Southampton Clinical Trials Unit and Southampton's Experimental Cancer Medicine Centre has been awarded further funding.
- There was a national ambition to recover the position with respect to emergency care. As a result, there would be increased pressure, but without additional funding.

## 5.6 Integrated Performance Report for Month 9

Joe Teape was invited to present the Integrated Performance Report for Month 9, the content of which was noted. It was further noted that:

- There had been significant pressure on the Emergency Department during the period with over 430 attendances some days and double the normal level of attendance in paediatrics due to (suspected) streptococcus A cases.
- The Trust had, along with the rest of the region, declared a critical incident on 20 December 2022 due to the significant pressures on the Emergency Department.
- A deep-dive had been carried out into falls. The risk of falls had increased due to the increasing number of frail patients awaiting discharge, but unable to be discharged due to the lack of care provision in the community.
- It was agreed that the Trust's performance metrics should form the basis of the monthly spotlights.
- It was noted that cancer performance could not be effectively understood at an aggregate level, as each area had different pressures and, consequently, performance.
- The Trust had a high turnover in terms of staff.
- Work was being carried out to investigate the reasons why women and BAME members of staff were under-represented above Band 7.

### Action:

GB agreed to consider whether the increased number of falls was an indicator of safety issues as opposed to a consequence of the changing profile of the patients, and to work with Jason Teoh in terms of obtaining relevant data.

Christine McGrath was invited to provide an update in respect of research and innovation. It was noted that:

- The Trust was rated 14<sup>th</sup> in the country in terms of research and innovation.
- The Trust carried out research across a number of specialities. However, recruitment of volunteers for trials was proving more difficult than was the case prior to COVID-19.
- The Trust had been successful in obtaining funding where applied for due to the quality of research produced.
- It was agreed that there should be improved links between areas of research and the Trust's key clinical areas and strategy.
- Delivery of research and innovation projects was challenging due to the operational pressures on the Trust.

## **5.7 Finance Report for Month 9**

Ian Howard was invited to present the Finance Report for Month 9, the content of which was noted. It was further noted that:

- The Trust's deficit for 2022/23 was forecast as being £20.2m (1.7%), equating to an underlying deficit of approximately £3.5-4m per month. The main causes of this deficit were considered to be unfunded elective activity and the increase in energy costs.
- The Trust's elective performance for the month was 105% of 2019/20 activity with an average for the year of 106%. This was above the national target.
- The Trust was on track to deliver its cost improvement programme.
- The Integrated Care Board (ICB) had committed to an overall deficit of £74m with a stretch target of £55m. It was considered that the stretch target was not possible and that the £74m target was at risk due to pressures on the prescriptions budget in the ICB driven in part by the significant increase in cases of streptococcus A over the winter.
- The Hampshire and Isle of Wight Integrated Care System (ICS) was one of the worst performing in England from a financial perspective.

*[Post-meeting note: The Board discussed the matters raised in the Finance Report (and associated discussion) at the closed session of the Trust Board held immediately after this meeting.]*

## **5.8 People Report for Month 9**

Steve Harris was invited to present the People Report for Month 9, the content of which was noted. It was further noted that:

- The Trust's plan was to increase its substantive workforce, which should lead to a reduction in the reliance on agency and temporary staff. However, whilst the substantive workforce had increased, the Trust remained reliant on bank and agency staff.
- In the aftermath of COVID-19, staff were keen to develop and transform, however, the operational pressures on the organisation made this difficult.
- The Trust's staff turnover was comparable to similar university teaching hospitals.

- It continued to prove difficult to recruit Health Care Assistants, but, following investment, there had been some improvements. However, this investment was possible due to national funding, which would cease in April 2023.
- The Trust's 'cost of living' support initiatives had resulted in c.£150k of savings for staff through the subsidising of meals in the staff canteen.
- The allyship programme had proven popular, although roll out had been slowed due to availability of personnel.
- It was necessary to ensure that the Trust's financial, workforce and recruitment plans were aligned for 2023/24.

## 5.9 Break

### 5.10 Maternity Safety 2022-23 Quarter 3 Report

Emma Northover, Marie Cann and Hannah Leonard were invited to present the Maternity Safety 2022-23 Quarter 3 Report, the content of which was noted. It was further noted that:

- The NHS Resolution Maternity Incentive Scheme Board Declaration approved at the meeting held on 20 December 2022 had been signed off and was awaiting formal approval.
- The quarter had seen significant activity coupled with difficulties in staffing.
- The most significant issue remained staffing, but it was noted that sickness rates were reducing and additional staff had been recruited.
- There had been an increase in the number of elective caesareans to c.180-190, whereas the Trust's capacity was 157. This rate was expected to increase due to the public's concerns in respect of maternity services. As a result, there had been increased pressure on other services owing to the need for additional theatre capacity.
- The Trust appeared to be an outlier in terms of post-partum haemorrhages.
- The Trust's Apgar rate was linked to the nature of the unit, as it dealt with more complicated cases. In addition, the complexity and acuity of patients had increased, including in terms of higher Body Mass Index patients, the age of patients and early pre-term births.
- In order to support staff, additional Speak Up, Wellbeing, Safety and Mental Health champions had been appointed.

#### **Action:**

Emma Northover agreed to investigate whether the relatively high post-partum haemorrhage rate was linked to the increase in births at the Trust.

## 6. STRATEGY and BUSINESS PLANNING

### 6.1 Inclusion and Belonging Strategy

Ceri Connor was invited to present the Trust's Inclusion and Belonging Strategy. It was noted that:

- The strategy had been developed over the previous ten months and had been reviewed and approved by the Equality, Diversity and Inclusion Committee, People and Organisational Design Committee and the Trust Executive Committee.



- As a result of feedback, the strategy would also incorporate hidden disabilities, the impact of hierarchies, Speak Up and increased detail in terms of the various programmes and initiatives.
- It was expected that the strategy would be refreshed annually.
- The launch of the strategy would be accompanied by a communications plan.
- Consideration was given to incorporating equality, diversity and inclusion related objectives into the objectives of senior leaders.
- It was noted that staff members would be encouraged to declare disabilities and that further information would be provided in terms of support available. It was noted, however, that setting a target for percentage of members of staff with a declared disability was likely inappropriate.
- It was important that the strategy be embedded across the organisation, rather than simply being part of the People directorate.
- Representation of women, BAME and disabled members of staff at Band 7 and above was low compared to the overall workforce.

**Action:**

Ceri Connor agreed to define the measures to demonstrate 'Belonging'.

**Decision:**

Having considered the proposed Inclusion and Belonging Strategy, the Board agreed to approve the strategy for launch according to the engagement plan and for it to then be implemented. Furthermore, the Board agreed to adopt a proactive approach to support the content and ethos of the strategy.

**6.2 Corporate Objectives 2022-23 Quarter 3 Review**

Christine McGrath was invited to present the Corporate Objectives 2022-23 Quarter 3 Review, the content of which was noted. It was further noted that:

- The Trust had achieved 64% of the quarter 3 objectives in full and 30% were currently delayed. Cumulatively, across the year, 80% of targets had been achieved and 14% partly achieved or delayed.
- Areas of concern were integrated networks and collaboration and foundations for the future.

**6.3 Board Assurance Framework (BAF) Update**

The Board Assurance Framework was presented to the meeting, the content of which was noted. It was further noted that:

- Risk 5a required amendment following feedback provided by the Finance and Investment Committee.
- The wording of risk 3a was to be updated based on feedback provided by the Board.

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

**7.1 Feedback from the Council of Governors' (CoG) meeting on 25 January 2023**

The Chair provided an overview of the Council of Governors' meeting held on 25 January 2023. It was noted that:

- The CoG had received an update from the Chief Executive Officer.
- The CoG discussed and agreed a proposal to appoint two young people as 'associate' governors to improve engagement with this demographic.
- The matters relating to the Audit and Risk Committee terms of reference referred to in item 7.3 were supported by the CoG.

## 7.2 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'.

## 7.3 Audit and Risk Committee Terms of Reference

It was noted that the Audit and Risk Committee had reviewed its terms of reference at its meeting held on 16 January 2023. It was noted that:

- It was proposed to amend paragraph 3.2 of the terms of reference to permit the deputy chair to act as chair of the committee.
- The Code of Governance for NHS Provider Trusts, applicable from April 2023, includes provisions (B.2.5 and D.2.1), which state that the deputy chair should not be chair of the audit committee.
- However, the key concern is that the audit committee chair should be independent, and where the deputy chair is expected to act as chair of the board, there is potential for the director's independence to become compromised over time.
- It was proposed to include the proviso in the Audit and Risk Committee terms of reference, that should the deputy chair have to act as Chair of the Board for an extended period of time, they will resign as Committee Chair in order to preserve the independence of the Committee Chair.

### Decision:

Having reviewed the Audit and Risk Committee terms of reference tabled to the meeting, it was agreed to approve these terms of reference. It was considered that the non-compliance can be justified under the 'comply or explain' principle and that the underlying concern in respect of independence will be mitigated through the proviso referred to above.

## 7.4 Finance and Investment Committee Terms of Reference

It was noted that the Finance and Investment Committee had reviewed its terms of reference at its meeting held on 30 January 2023.

### Decision:

Having reviewed the Finance and Investment Committee terms of reference tabled to the meeting, it was agreed to approve these terms of reference.

**7.5 Quality Committee Terms of Reference**

It was noted that the Quality Committee had reviewed its terms of reference at its meeting held on 30 January 2023.

**Decision:**

Having reviewed the Quality Committee terms of reference tabled to the meeting, it was agreed to approve these terms of reference.

**8. Any other business**

There had been an external review of the Trust as a trauma centre, which placed the Trust's outcomes ahead of the mean for the country.

**9. Note the date of the next meeting: 30 March 2023**

**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.

List of action items

Agenda item	Assigned to	Deadline	Status	
Trust Board – Open Session 26/05/2022 5.6 Freedom to Speak Up Report				
704.	Comparative information	● Byrne, Gail	25/05/2023	■ Pending
<p><i>Explanation action item</i> It was requested that future FTSU reports included comparative information from previous years in order to identify trends and also identified cases from previous reporting periods that had not yet been closed.</p> <p>Update: This will be included in the May 2023 report.</p>				
Trust Board – Open Session 29/09/2022 5.4 Integrated Performance Report for Month 5				
826.	My medical record	● Teape, Joe	25/05/2023	■ Pending
<p><i>Explanation action item</i> JT noted that there was a business case that was overdue for my medical record around how we industrialised it across the Trust which should provide some huge benefits and would bring a timeline back as to when this would happen.</p> <p>Update: Business case due May 2023.</p>				
Trust Board – Open Session 29/09/2022 5.4 Integrated Performance Report for Month 5				
827.	Digital change and indicators	● Teape, Joe	25/04/2023	■ Pending
<p><i>Explanation action item</i> JT noted that there was some big digital change happening with the rolling out of speech recognition and some E tools. In addition it would be helpful to look at the indicators to understand whether they were the right ones and review them as part of the digital updates which could be discussed at F&amp;IC.</p> <p>Update: New indicators for digital being developed for new financial year.</p>				

Agenda item	Assigned to	Deadline	Status
Trust Board – Open Session 29/11/2022 5.1 Briefing from the Chair of the Charitable Funds Committee (Oral)			
872.	Cap and collar fee	● Howard, Ian	30/03/23 <span style="background-color: yellow;">■</span> Pending
<p><i>Explanation action item</i>            General money received was often sat in small funds, waiting to be spent and the charity was working with divisions to encourage them to consolidate their funds, to have nominated fund holders and more effective spending plans. IH noted that the charity should consider a cap and collar fee that rewarded consolidation.</p> <p>Update: The charity is working through an options appraisal process which will be considered at the next Charitable Funds Committee scheduled for 21/02/2023.</p>			
Trust Board – Open Session 29/11/2022 13 Freedom to Speak Up Report			
878.	FTSU Champions	● Byrne, Gail	30/03/2023 <span style="background-color: yellow;">■</span> Pending
<p><i>Explanation action item</i>            The importance of being visible around the Trust and listening to staff was noted and it was suggested that it may be helpful for the Board to meet with the Freedom to Speak Up Champions.</p> <p>It was agreed that GB would contact CMb as there had been some technical issues with the Teams link.</p> <p>TB 31/01/23: It was agreed to defer the action to the next meeting.</p>			
Trust Board – Open Session 31/01/2023 5.6 Integrated Performance Report for Month 9			
915.	Increased number of falls	● Byrne, Gail	30/03/2023 <span style="background-color: yellow;">■</span> Pending
<p><i>Explanation action item</i>            GB agreed to consider whether the increased number of falls was an indicator of safety issues as opposed to a consequence of the changing profile of the patients, and to work with Jason Teoh in terms of obtaining relevant data.</p>			

Agenda item	Assigned to	Deadline	Status
Trust Board – Open Session 31/01/2023 5.10 Maternity Safety 2022-23 Quarter 3 Report			
916.	Post-partum haemorrhage rate	<ul style="list-style-type: none"> <li>● Northover, Emma</li> <li>● Byrne, Gail</li> </ul>	30/03/2023 <span style="float: right;">■ Pending</span>
<p><i>Explanation action item</i> Emma Northover agreed to investigate whether the relatively high post-partum haemorrhage rate was linked to the increase in births at the Trust.</p>			
Trust Board – Open Session 31/01/2023 6.1 Inclusion and Belonging Strategy			
917.	Belonging	<ul style="list-style-type: none"> <li>● Connor, Ceri</li> <li>● Harris, Steve</li> </ul>	30/03/2023 <span style="float: right;">■ Pending</span>
<p><i>Explanation action item</i> Ceri Connor agreed to define the measures to demonstrate 'Belonging'.</p>			

Report to the Trust Board of Directors				
<b>Title:</b>	Chief Executive Officer's Report			
<b>Agenda item:</b>	4.7			
<b>Sponsor:</b>	David French, Chief Executive Officer			
<b>Date:</b>	30 March 2023			
<b>Purpose:</b>	Assurance or reassurance	Approval	Ratification	Information  X
<b>Issue to be addressed:</b>	My report this month covers updates on the following items: <ul style="list-style-type: none"> <li>• Industrial Action – British Medical Association</li> <li>• National Pay Negotiations on Agenda for Change</li> <li>• Pension Reforms</li> <li>• OBE for Southampton Doctor</li> <li>• UTC Southampton</li> </ul>			
<b>Response to the issue:</b>	The response to each of these issues is covered in the report.			
<b>Implications:</b> (Clinical, Organisational, Governance, Legal?)	Any implications of these issues are covered in the report.			
<b>Summary: Conclusion and/or recommendation</b>	The Board is asked to note the report.			

### Industrial Action – British Medical Association

There was a 72-hour period of industrial action by junior doctors which commenced on 13 March 2023 and concluded on 17 March 2023. The Trust undertook a comprehensive planning process to manage the industrial action, involving its most senior medical leadership.

The aims of the planning process were as follows:

- To provide tactical command and control for the Trust across all areas of business in relation to the industrial action by junior doctors (the **Strike**).
- To minimise disruption to Trust services caused by the Strike.
- To ensure a continued safe and caring environment for patients and staff.
- To ensure coordination of response with external agencies.
- To ensure a robust communications strategy was in place both prior to and during the Strike.

The objectives set were as follows:

- To consider the impact on service delivery and ensure close liaison with Divisional Tactical Command Cells / Operational Commanders.
- To ensure communications with staff, patients, partners, and public were accurate, timely and consistent.
- To ensure situation reporting was conducted in a timely manner in line with timetables set by NHS England.
- To ensure appropriate representation of the Trust at any external decision-making bodies.
- To ensure that records and logs were kept of tactical command decisions and actions.
- To consider the financial impacts on the Trust of the Strike and, where necessary, make appropriate arrangements to maintain the financial integrity of the Trust.
- To maintain patient and staff safety throughout the Strike, ensuring the risk to patients and staff was considered in all command decisions.

The industrial action by junior doctors was expected to have a significant impact on the Trust's clinical delivery and services. Therefore, to provide direction, control, and clarity to the planning effort, we also agreed the following services that, as a minimum, should be protected and delivered:

Minimum Service Delivery:

- Emergency Department
- Critical Care including GICU, CICU, NICU, PICU, HDU
- Operating Theatres for emergency surgery patients - CEPOD, Trauma, Cardiac – adult and paediatrics, Neurosurgery, Paediatric CEPOD, Vascular, Spinal, Obstetrics & Gynaecology, 1 cardiac cath lab (for PCI and pacing), 1 neuroradiology lab (for mechanical thrombectomy and coiling aneurysms), INR lab, 1 interventional radiology lab (for abdominal, urology, vascular etc.) emergency endoscopy rooms
- Pre-screening and Pre-op assessment – emergency patients
- Maternity – delivery suite, Obstetrics Theatre, Neonatal and PICU
- Cardiac, Neurosurgery, Major Trauma, Paediatric and other regional services
- All inpatient ward areas, including paediatrics
- Transfusion and blood products for urgent and emergency patients
- Resuscitation service 24/7
- Stroke service
- PPCI service
- Chemotherapy, radiotherapy, SACT service
- Urgent diagnostic services to support inpatient care and emergency surgery
- Patient discharge services



- Child protection, child- and adult safeguarding
- Urgent outpatients by exception
- Same-day emergency care units

Activities leading up to the industrial action included:

- Preparing rosters and operating plans (including appropriate 24-hour cover) for the industrial action period for all clinical services across the Trust.
- Standing down elective activity which could not be delivered without junior doctor input or where other staff members were redeployed (e.g. consultants) to cover junior doctor gaps.
- Determining resource availability for the period.
- Ensuring robust clinical prioritisation of the surgical operating programme.
- Negotiating pay rates with the local negotiating committee to ensure pay conditions for those covering were clarified in advance of the industrial action.
- Providing additional training the week before the industrial action to ensure appropriate competences for those covering (e.g. access to electronic systems).
- Seeking System support to increase capacity where possible over the period of industrial action to mitigate the increased pressure.
- Developing a clear communications strategy for the patients and the public in relation to the strike.
- Undertaking listening events with junior doctors, consultants and other staff groups.
- Establishing incident management structures and senior cover for the duration of the industrial action.

Demand for emergency activity remained high during the period of industrial action, but our planning for the event held up well and we navigated the 72 hours safely. We are very grateful for our colleagues who worked differently or took on additional responsibilities in response to managing this period.

The final numbers related to the industrial action are as follows:

- Over the three days we rescheduled 119 Day Cases/Inpatients (the majority of which were endoscopy) and 1,241 Outpatient appointments (most of which were review appointments).
- 13 March: 421 out of 741 doctors took industrial action (57%)
- 14 March: 431 out of 746 doctors took industrial action (58%)
- 15 March: 408 out of 766 doctors took industrial action (53%)

A full debrief and lessons learned exercise has taken place and will be reported in due course. Once again, I wanted to thank everyone at the Trust for their fantastic efforts to keep patients safe, particularly those willing to do different work and those offering to work additional hours, sometimes at anti-social times of the day. Whilst we had to stand down some out-patient appointments and elective surgery, we did manage to retain much activity and, crucially, the wards were kept safe throughout.

### **National Pay Negotiations on Agenda for Change**

On 16 March 2023, Agenda for Change (AfC) trade union members of the NHS Staff Council formally agreed to suspend industrial action to consider an offer of settlement made by the Government.

The AfC trade unions will now consult with their membership on the 'in principle offer' made by the Government. It is anticipated that this consultative process being run by the AfC trade unions will take approximately three to four weeks. During this period of consultation, and pending any final decisions from their members, the AfC trade unions have agreed to pause all planned industrial action.

The proposed deal includes consolidated and non-consolidated payments and a commitment to a work programme to improve AfC wider terms.

The offer in principle includes 3 key aspects:

2022/23	<p>One-off <b>Non-Consolidated payment</b> including:</p> <ul style="list-style-type: none"> <li>• A flat payment of 2% for all AfC staff</li> <li>• A tiered 'COVID Backlog payment' averaging 4%</li> </ul> <p>The total value of the combined payment will be between £1,655 and £3,789, dependent on pay band</p>
2023/24	<p>A <b>flat consolidated payment</b> of 5% for all Agenda for Change bands</p> <p>Entry level pay for the NHS would start at £22,270, equivalent to £11.45 per hour. The national living wage is currently £10.90 per hour.</p>
2023/24	<p><b>A series of non-pay measures</b> to be worked through the NHS Staff Council including:</p> <ul style="list-style-type: none"> <li>• A specific focus on nursing career development and progression</li> <li>• Publication of a national workforce plan</li> <li>• Improvements to wider support in the terms and conditions to aid development (apprenticeships etc.)</li> <li>• A review of the pay review body process</li> <li>• More support to tackle violence and aggression against NHS staff</li> <li>• Further changes to pension abatement</li> <li>• Consideration of a cap on redundancy costs over £100k</li> </ul>

Nealy all the AfC trade unions are recommending acceptance of the offer as the best that can be negotiated. The reception through social media to the offer has been mixed, and it is not certain whether union members will vote to accept the proposals.

The Chief People Officer at the Trust has recently joined the NHS Staff Council and was present at the meeting where the offer was formally made to the unions and the motion to suspend industrial action was passed. Membership of this group as one of the employer representatives for the South East places the Trust well for the next phase of work.

### Pension Reforms

Significant changes to pension taxation were announced in the Budget on 15 March 2023.

Pension taxation on the value of annual and lifetime allowances has been a significant issue for NHS medical capacity, causing a reduction in hours, refusal to undertake extra-contractual duties, and, in some cases, retirement from the service. The existing rules, coupled with a lack of flexibility in the scheme, have been a source of frustration and anger for many senior medical staff over the last four years. Where individuals breach either allowance limit, taxation is applied at a rate of up to 45%, creating significant tax bills.

The Chancellor's announcements are welcomed and include:

- An increase in annual allowance tax free limit from £40k to £60k
- An abolition of the lifetime allowance
- Changes to the tapering rules by increasing the threshold income value from £240k to £260k to extend the earnings at which tapering begins. Earnings above this point reduce the annual allowance value by £1 for every £2 earned above £260k

- Increasing the minimum post-tapering annual allowance to £10k (previously £4k)

The Department of Health and Social Care also concluded its consultation on pension scheme reforms and has agreed to enact a series of further flexibilities to support senior NHS staff. This includes the ability for older eligible staff to take benefits from the 1995 scheme and continue to work and contribute to the 2015 scheme. Changes to the way inflation is calculated for the value of annual allowances will also be made to further mitigate the potential of people breaching.

Generally, the combination of taxation and scheme changes are welcomed and should help a majority of the consultant and senior manager bodies. There has been significant service-wide lobbying for change. The Trust has been strong in its voice that major overhaul was needed so we are pleased that some reforms will be made. It is recognised, however, that the changes will not fully mitigate taxation issues for all senior medics or senior managers. The highest earners will still likely incur taxation issues, critically with the *marginal* rate of tax for additional earning still making that work unattractive, albeit with a reduction in the total tax burden compared to before.

### **OBE for Southampton Doctor**

Professor Saul Faust, a consultant paediatrician at the Trust, has received an OBE from the Prince of Wales. This was in recognition of his leading role in the national COVID-19 vaccination programme, including in the COV-BOOST programme, which looked at the safety, immune responses and side-effects of seven vaccines when used as a third booster jab. We are delighted and proud that Professor Faust's work has been rightly recognised in this way.

### **UTC Southampton**

University Technical Colleges (UTCs) are state funded specialist secondary schools with a sponsor university and with close ties to local business and industry. These university and industry partners support the curriculum development of the UTC and guide students on to industrial apprenticeships or tertiary education. Pupils transfer to a UTC at the age of 14, part-way through their secondary education.

There is a successful UTC in Portsmouth which focuses on STEM subjects and which is heavily over-subscribed.

In late 2021, I was approached by UTC Portsmouth to determine whether we would be willing to support development of a bid for the establishment of a UTC in Southampton. Given our commitment to the development and success of the city, combined with a shortage in the availability of local youngsters with the skills we need across the hospital, we could see significant benefits from a local UTC and we have been heavily involved in the development of the bid.

The bid has been submitted to the DfE, the body which approves UTC applications, and the bid has successfully cleared several hurdles already. The next and final stage in the application process is a face-to-face interview (3 April) with DfE officials, which I have been invited to attend as a key sponsor. Should the bid be successful, we will engage closely with the development of the curriculum and the overall leadership / oversight of the UTC for the benefit of the students, the hospital and the wider city.

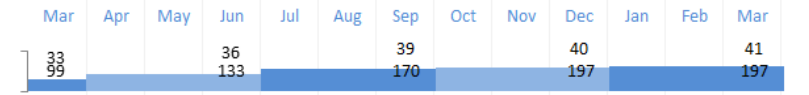
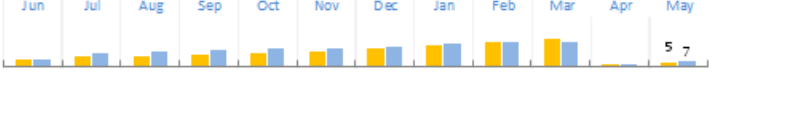
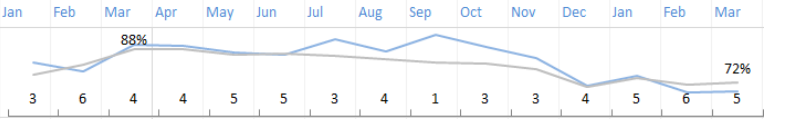

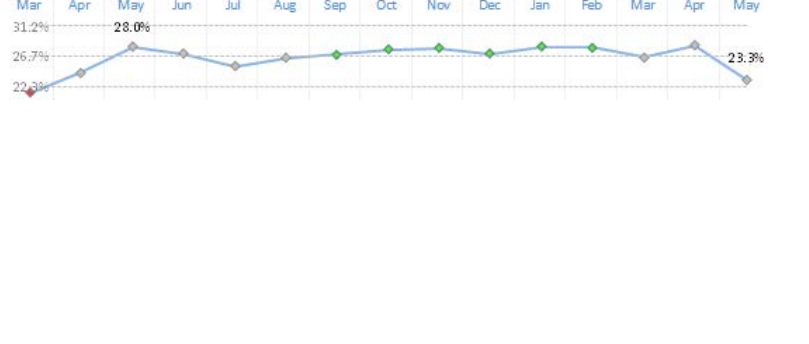
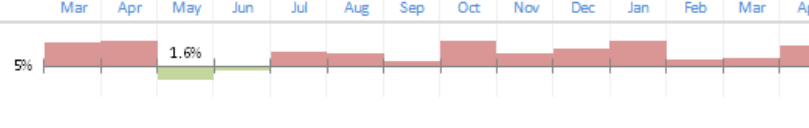
Report to the Trust Board of Directors				
<b>Title:</b>	<b>Integrated Performance Report 2022-23 Month 11</b>			
<b>Agenda item:</b>	<b>4.8</b>			
<b>Sponsor:</b>	<b>David French, Chief Executive</b>			
<b>Author</b>	<b>Jason Teoh, Director of Data and Analytics</b>			
<b>Date:</b>	<b>30 March 2023</b>			
<b>Purpose</b>	<b>Assurance or reassurance</b> Y	<b>Approval</b>	<b>Ratification</b>	<b>Information</b>
<b>Issue to be addressed:</b>	<p>The report aims to provide assurance:</p> <ul style="list-style-type: none"> <li>• Regarding the successful implementation of our strategy</li> <li>• That the care we provide is safe, caring, effective, responsive, and well led</li> </ul>			
<b>Response to the issue:</b>	The Integrated Performance Report reflects the current operating environment and is aligned with our strategy.			
<b>Implications: (Clinical, Organisational, Governance, Legal?)</b>	This report covers a broad range of trust services and activities. It is intended to assist the Board in assuring that the Trust meets regulatory requirements and corporate objectives.			
<b>Risks: (Top 3) of carrying out the change / or not:</b>	This report is provided for the purpose of assurance.			
<b>Summary: Conclusion and/or recommendation</b>	This report is provided for the purpose of assurance.			

# Integrated KPI Board Report

Covering up to  
February 2023

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

## Report guide

Chart type	Example	Explanation
Cumulative Column		<p>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.</p>
Cumulative Column Year on Year		<p>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.</p>
Line Benchmarked		<p>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).</p>
Line & bar Benchmarked		<p>The line shows our performance, and the bar underneath represents the range of performance of benchmarked trusts (bottom = lowest performance, top = highest performance)</p>
Control Chart		<p>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).</p>
Variance from Target		<p>Variance from target charts are used to show how far away a variable is from its target each month. Green bars represent the value the metric is achieving better than target and the red bars represent the distance a metric is away from achieving its target.</p>

## Introduction

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

The report aims to provide assurance:

- regarding the successful implementation of our strategy; and
- that the care we provide is safe, caring, effective, responsive, and well led.

The content of the report includes the following:

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

This month the following changes have been made to the report.

- Data correction: It has been identified that due to a database issue, last month's UT6 Cumulative Clostridium difficile, UT7 Healthcare acquired COVID infection, and UT8 Probable hospital-associated COVID infection metrics undercounted the number of cases. The data for January 2023 has now been corrected in this month's report.

## Summary

This month the 'Spotlight' section contains an update on Cancer and Diagnostic performance.

The Cancer spotlight highlights that:

- UHS cancer performance has been under significant pressure in recent months due to higher referrals and difficulty in treating cancers within 31 days. This has affected all three of the key cancer metrics, and our position relative to other teaching hospitals has worsened in recent months.
- There are some early indications of recovery, with reductions in the overall size of the waiting list and 62 day breaches which have been in line with the action plans that Care Groups have developed by tumour site. As we enact these plans to reduce the patient backlog, this does unfortunately mean that there will be a period of deteriorating cancer performance.

The Diagnostic spotlight highlights that:

- UHS has been delivering strong levels of diagnostic activity, and when adjusting for holiday periods, we are delivering approximately 25% more activity compared to pre-pandemic levels. However, we continue to see high volumes of referrals, and alongside an increase in non-elective diagnostic demand, this has led to a higher waiting list, with around 10,300 patients awaiting a diagnostic test at the end of February 2023.
- We continue to work to prioritise the most clinically urgent diagnostic tests, as well as looking to ensure that longer waiting patients are seen first. This has resulted in a reduction in breaches, with 78.5% of all diagnostic waiters seen within six weeks.
- Care Groups are continuing to develop their operational plans to ensure that we retain the right levels of activity to meet ongoing diagnostic demand.

Areas of note in the appendix of performance metrics include:

1. Cancer performance in January 2022 (the latest available validated month) has continued to be under a sustained level of pressure, and our performance is not at the level that we would expect both at an absolute level or relative to our peers. Part of this is a "flow through" of some of the poor results from previous months; however, it also reflects the ongoing high demand for cancer services. Regular meetings with all tumour sites are in place.
  - a. Two week wait (2WW) performance improved three percentage points to 82.3%, although we have slipped into the third quartile when compared against other teaching hospitals. At a tumour site level, Breast saw a small performance uplift to 40.9% as additional capacity has been added to the service, while Head and Neck performance (44.6%) has been the other tumour site under significant challenge in January 2023 due to high volumes of referrals.



- b. 31 day performance dipped to 82.3%, although we remain in the third quartile when compared against other teaching hospitals. The most challenged pathway continues to be Skin (53%), mainly due to the higher volume of patients requiring surgical intervention. Urology performance (66%) was also challenged due to increased prostate demand as well as tertiary referrals.
  - c. 62 day performance dropped to 50%, and we remain in the third quartile compared to other teaching hospitals. Performance has been impacted by our historic 2WW and 31 day performance in previous months. There are considerable ongoing improvement efforts across our cancer tumour sites, with actions in place to improve performance.
2. Emergency Department (ED) four hour performance improved to 65% in February 2023 (from 61.5% in January 2023). There were just over 10,000 ED attendances in February, which was lower than the corresponding month in 2022, and believed to be partly due to the start of the GP streaming trial which has diverted some attendances away from being counted within the UHS ED attendance numbers.
3. There has been a good progress in treating the longest waiting patients in the Trust, and we have seen a reduction in the number of 78 week breaches reported at month end, with 150 reported as breaching in February 2023 (compared to 271 in January 2023). Our latest forecast is for around 15-20 patients to be waiting over 78 weeks at the end of March 2023; this is a significant improvement on our previous forecast of more than 100 patients.
4. There has been an improvement in our diagnostic performance. The total number of patients waiting has reduced to just over 10,300 patients, and there has been a good reduction in the number of patients awaiting diagnostic procedures for more than six weeks, with performance improving seven percentage points to 21.5% in February.
5. The National NHS Staff Survey results, and the Q4 National Quarterly Pulse Survey results have now been released. They both show declining trends (comparing national to national, and quarterly to quarterly results), which is likely to reflect the challenging environment that staff are working in, and some of the wider industrial relation issues. However, we continue to benchmark well relative to other hospitals, and this demonstrates that this is a wider national challenge.

### **Ambulance response time performance**

Utilising the latest unvalidated weekly data provided by the South Coast Ambulance Service (SCAS), it can be seen that UHS does not significantly contribute to ambulance handover delays. In the week commencing 13 March 2023, our average handover time was 15 minutes 31 seconds across 732 emergency handovers, and 16 minutes 43 seconds across 47 urgent handovers. There were 33 handovers over 30 minutes, and 1 handover (still to be confirmed) taking over 60 minutes within the unvalidated data. This is in line with historic performance.

## Spotlight: Cancer performance

UHS has seen significant pressures on its cancer services particularly in the second half of 2022/23. As a specialist teaching hospital, we treat some of the more complex cancer cases from the region. However, all cancer services are under pressure from higher demand. This trend continues to be replicated nationally. UHS has historically benchmarked in the upper quartile, relative to our teaching hospital peers. Our position slipped in the face of operational challenges in October and November 2022. To help to correct this, we have held a series of focused meetings with each service to understand the position, address any barriers to improved performance and agree clear action plans to support recovery. This coincides with signs of recovery and an upward performance trajectory in both December 2022 and January 2023. The Trust is focussed on progressing the action plans with support from the ICB and Wessex Cancer Alliance.

### Cancer 2 week wait (2WW) referrals volumes

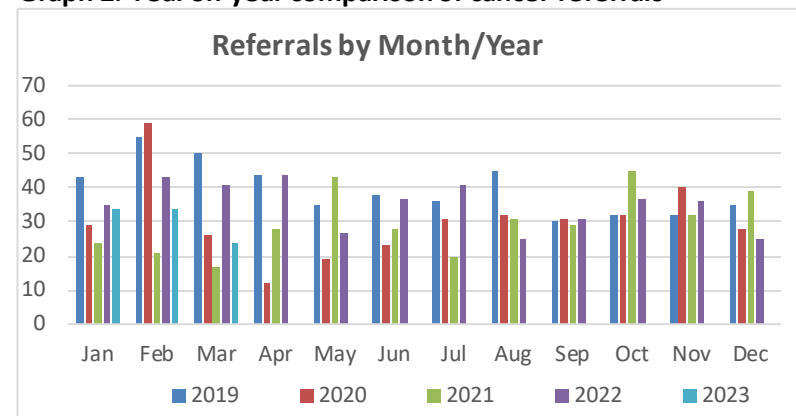
Cancer referrals volumes continue to see significant month on month volatility, with comparatively low volumes of referrals between December 2022 to February 2023 compared to the referrals seen through May to November 2022 (graph 1). Historically, we see lower referrals over winter months, so this is likely to be linked to seasonality.

This volatility in referral volumes also occurs week on week making capacity management to meet a 14 day target challenging. Overall, referral volumes in 2022 average 2,030 patients per month, which is 12.5% higher than 2021 (which was partly Covid impacted), and 23.3% higher when compared with 2019 volumes. For January and February 2023, referrals are still higher than 2019 by 9.3% (graph 2).

**Graph 1: Monthly cancer referrals**



**Graph 2: Year on year comparison of cancer referrals**



**2 week wait (2WW) performance** (seen by UHS within 14 days of referral – target 93%):

The 2WW performance is closely related to the volume of referrals received, and higher referrals have impacted on our 2WW performance. Our validated reported performance for January 2023 was 82.3%, an improvement from 79.5% in December 2022.

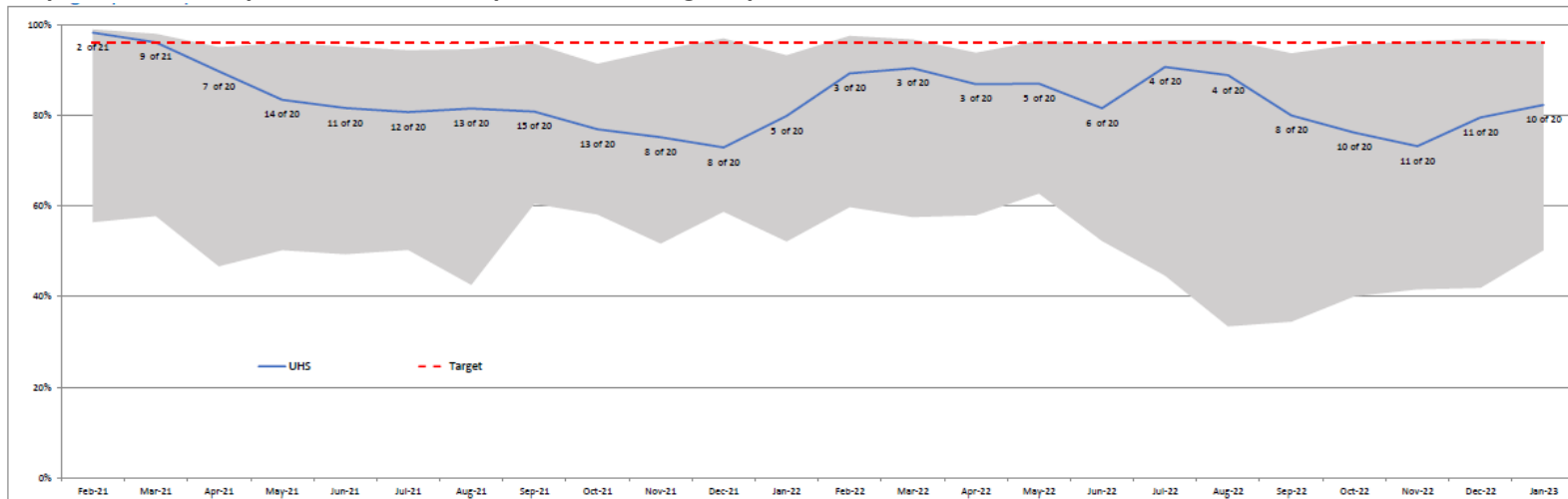
In order to maintain capacity for increased referrals, teams have been actively managing clinic capacity between 31 day treatment and 2WW assessment. However, because referrals are, broadly, seen in the order they are received, spikes in demand cause bottlenecks in the pathway which can be challenging to mitigate. Different tumour sites have seen varying levels of referral volume pressure through the year, and some specific impacts are outlined below:

- Gynaecology, which saw challenged performance in 2022, has significantly improved with a provisional result of 96% for February 2023. Although lower referrals in December 2022 and February 2023 helped, performance was improved due to additional locum capacity within the service.
- Breast had recovered through Summer 2022 but has again been significantly challenged in recent months, with provisional performance at 57% in February 2023. This has been due in part to consultant sick leave and attrition which has reduced capacity in the face of higher demand. In addition, there has also been a review which necessitated a change in the breast screening pathway, further reducing current capacity.
- Head and Neck referrals in 2022 have been approximately 44% higher than 2019 (249 versus 173 referrals per month), with February 2023 particularly high with 267 referrals. Performance demonstrated an improved position due to the new associate specialist starting, however this failed to keep pace with sustained increased in referrals.
- Skin has also seen as seen significantly higher demand in 2022 compared to 2019 (462 versus 367 referrals per month). The revised Dermatology pathway which will help to divert referrals started in January 2023 with one Primary Care Network (PCN) and the Alliance are working with other PCNs to ensure process and equipment is available for expanded rollout. The aim for all PCNs to be following the new pathway this year.

Other factors which are impacting cancer performance include delays in diagnostic reporting capacity in both radiology and pathology. We have seen an increase in 2WW radiology requests alongside higher inpatient demand (particularly for CT and MRI scans), and this has led to some delays on our 2WW pathway. This was particularly pronounced over December 2022 and January 2023 – partly due to scanner downtime – and the radiography team have been prioritising cancer patients where appropriate, and running extended hours where required.

When benchmarking against teaching hospital peers, we remain “mid pack” and in the second quartile (graph 3). The national pressure can be seen in the graph, as the spread of 2WW performance (shown by the grey area) between teaching hospitals widened in July / August 2022, which corresponded with UHS’s own 2WW performance challenges. We have started to see some improvement in 2WW performance at UHS, and the continuation of this will be partly dependent on referral volumes in coming months.

**Graph 3: UHS 2WW performance vs comparator teaching hospitals**



**28 Day Faster Diagnosis** (diagnosed, or cancer ruled out, within 28 days of referral – target 75%):

This measure was introduced in Q3 21/22 as a replacement for the 2WW measure and is intended to ensure that patients have a timely diagnosis, or “all clear” within 28 days of being referred to the hospital. UHS has always met this measure since its introduction, but for the first time has missed this target in January 2023 – delivering 69.9% against a target of 75%. This is due to our 2WW performance and patients taking longer to be seen, and then diagnosed or cleared. However, unvalidated figures for February and March 2023 are showing that UHS performance has returned to above target for this metric.

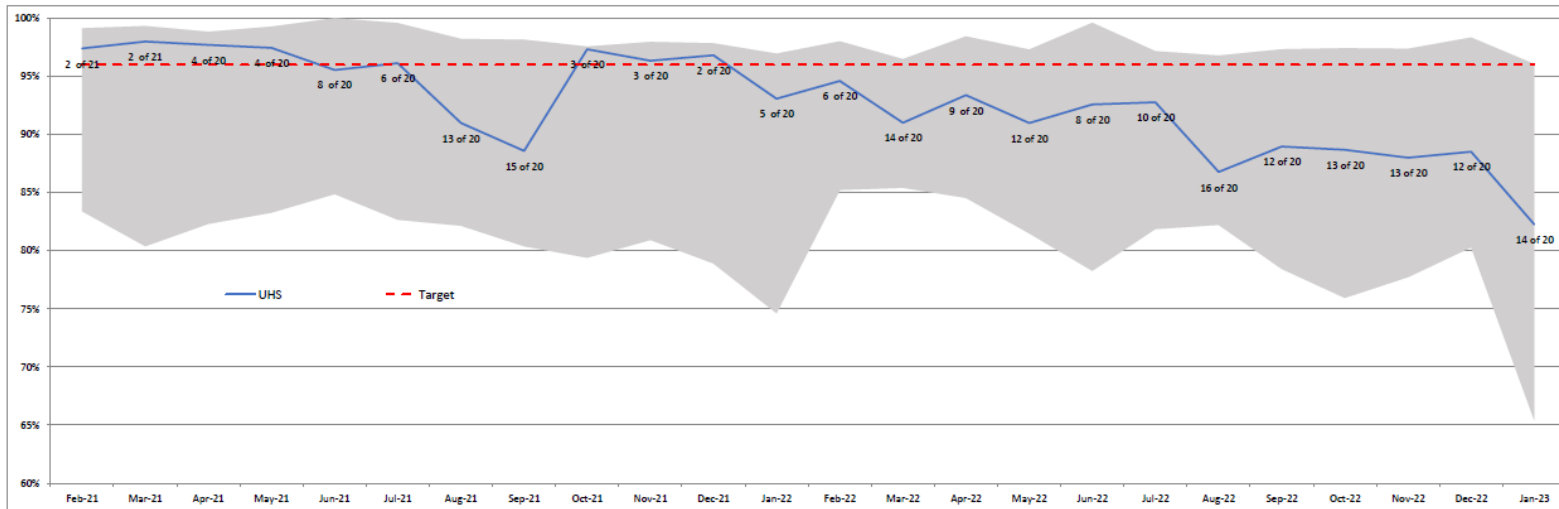
**31 Day Performance** (start treatment within 31 days of a diagnosis – target 96%):

UHS is currently struggling to achieve the target, with particular areas of challenge being the Skin and Urology tumour sites which have seen particularly high demand. Our performance in January 2023 was 82.3%, compared to 89.5% in December 2022. The Q4 predicted performance is presently 82.5%.

In the past the Trust was heavily reliant on waiting list initiatives to provide additional work, particularly to manage spikes in referrals. Over the past few years this has become increasingly difficult, because of the well-rehearsed tax and pension implications. We are therefore heavily reliant on plans that involve either increased productivity or substantive recruitment, both of which have significant challenges. However, Care Groups have developed action plans to drive improvements in performance across key tumour sites which can be seen in the appendix.

Looking at our comparative performance (graph 4), our position has fallen relative to other teaching hospitals. However, other hospitals have been equally challenged as the spread of performance to the 31 Day standard has also significantly broadened. As our action plans clear the backlog of patients waiting for treatment, it is likely that we may see a further deterioration in 31 Day performance in the short term.

**Graph 4: UHS 31D performance vs comparator teaching hospitals**

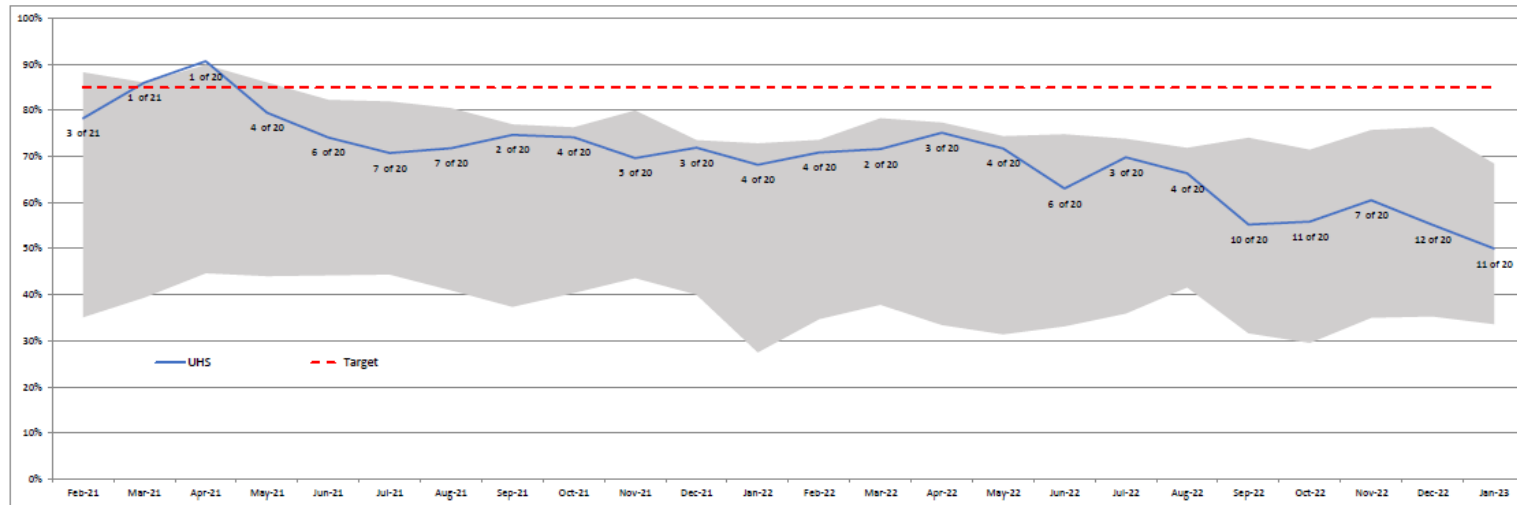


**62 Day performance (treatment within 62 days of referral – target 85%):**

62 day performance has worsened in January 2023, standing at 50%, compared to 55.6% in December 2022. This measure is directly linked to our performance against our 2WW and 31 Day performance and reflects the challenges we have for seeing and treating patients in time due to the reasons outlined above. Overall, we have fallen to third quartile on 62 day performance compared to other teaching hospitals (graph 5). As our action plans clear the backlog of patients waiting for treatment, it is likely that we may see a further deterioration in 62 Day performance in the short term. However, we then expect performance to improve as our backlog clears, and 2WW and 31D metric performance improves.

In addition, as a tertiary centre, our performance has been impacted by more complex cancer patients who are transferred from other hospitals. Patients who are transferred from other hospitals often create an additional pressure on our performance, and the gap between UHS and tertiary referrals has increased in recent months. When looking at 62 day performance, our current predicted Q4 performance (January and February 2023) is 55.5% (85% target) for all UHS patients, compared to our performance on tertiary referrals alone, which is at 32.8%.

**Graph 5: UHS 62D performance vs comparator teaching hospitals**



**Overall cancer waiting list**

In recent months, through an increase in activity, UHS has managed to reduce the cancer waiting list (or PTL – Patient Treatment List), despite the current referral pattern volatility. Unfortunately, the PTL remains at levels that are significantly higher than pre-pandemic levels (graph 6). In recent weeks, through the interventions put in place by the Trust, there has been a reduction in both the overall waiting list (blue line) and the breaches (pink line), and we are confident that we will see further reductions in the coming weeks and months.

Supporting this, each Care Group has put in place actions to reduce the number of patients waiting beyond 62 days or their diagnosis and cancer treatment alongside their expected performance glide, and this can be found within the appendix.

**Graph 6: UHS Cancer Waiting List and 62 day breaches**

**Overall PTL Trend**

● Grand Total ● Over 62 Days



**Appendix: Actions in place to improve cancer performance**

A sample of some of the key actions that Care Groups have put in place to improve cancer performance is listed below. Although over time this will reduce the waiting list size and breach volumes, in the short to medium term this will cause a deterioration in the cancer performance statistics as the backlog is cleared.

Tumour site	Actions
General	<ul style="list-style-type: none"> <li>• Dr Caroline Marshall has supported an in-depth review of our cancer pathways to identify and support further opportunities for improvement which could be implemented.</li> <li>• We are working with the ICB to assist GPs with the direct ordering of cancer diagnostics. This should help to reduce the waiting time for a diagnostic test.</li> </ul>
Pathology	<ul style="list-style-type: none"> <li>• Locum consultant position being advertised while business case for 2 substantive consultant posts are being developed.</li> <li>• WLI being offered to cellular pathology consultants to add additional reporting capacity to dermatopathology.</li> <li>• Selected dermatopathology cases being outsourced to relieve pressure on inhouse capacity.</li> <li>• Outsourcing of GI and Gynaecology samples (450-500 blocks now outsourced per day - equivalent to 3 lab microtomists). Freeing up lab capacity to support cancer pathways</li> </ul>
Breast	<ul style="list-style-type: none"> <li>• Appointment of a new breast surgeon locum</li> <li>• Reviewing breast pain pathway piloted at HHFT</li> </ul>
Skin	<ul style="list-style-type: none"> <li>• The introduction of tele-dermatology to assist in responding to the increasing 2ww referrals remains on track for Q2 2023 implementation. Primary Care will be asked to send a photo with a referral to UHS. This will facilitate early transfer to routine pathway or discharge and allow a straight to surgery model to be introduced.</li> <li>• Insourcing capacity obtained until February 2023 which has enabled the waiting list to be reduced in size by c30%. Business case for permanent additional dermatologist currently going through approval.</li> <li>• Reviewing booking processes to minimise cancellations and wasted slots</li> <li>• Reviewing staffing models in place and appropriate upskilling of HCAs and nurses combined with a dedicated surgical lead to support actions and drive change</li> </ul>
Colorectal	<ul style="list-style-type: none"> <li>• Working with primary care on Faecal Immunochemical Test (FIT) to reduce referrals and speed up diagnostic time for patients.</li> <li>• Reviewing different pathway approaches across Dorset and Hampshire</li> </ul>
Lung	<ul style="list-style-type: none"> <li>• Ongoing Work to reduce delays due to PET CT and Genomic testing (both outside UHS's direct control).</li> <li>• Reviewing in-house processing for molecular markers</li> <li>• Supporting early identification of patients who only have palliative treatment options</li> <li>• Improved streamlining and bundling of sequential test requests</li> </ul>
Urology	<ul style="list-style-type: none"> <li>• Agreed funding for additional nurse led clinics.</li> <li>• Recruitment of an additional ANP post to increase capacity targeting 2 week wait patients.</li> <li>• WLI work to reduce the backlog in diagnostics, but treatment capacity is still a challenge</li> <li>• In discussions with Guildford about support for Winchester cohort of patients</li> <li>• Exploring surgical support from retired surgeons</li> <li>• "Super Saturday" all day urology lists run to clear backlog</li> </ul>

## Spotlight: Diagnostic performance

The following information is based on the validated February 2023 submission.

### Background

The national target for diagnostic performance is for at least 99% of patients waiting for an elective diagnostic test to have waited less than six weeks. The latest Elective Care guidance from NHS England and Improvement (NHSE/I) states that the "ambition is that 95% of patients needing a diagnostic test receive it within six weeks by March 2025".

The target applies to 15 different diagnostic tests, although performance is measured at a Trust level. These tests are broadly divided into three groups:

- endoscopy (e.g. gastroscopy, cystoscopy);
- imaging (e.g. CT, MRI, barium enema); and
- physiological measurement (e.g. echocardiogram, sleep studies).

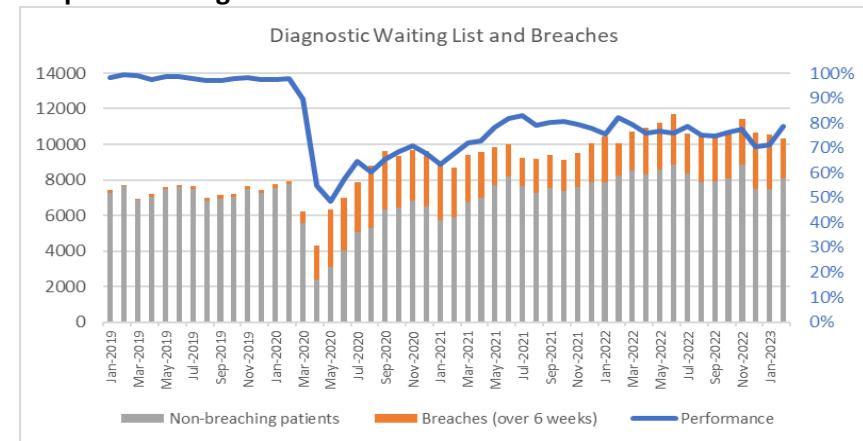
As with many other waiting lists within the Trust, we have seen increases in diagnostic demand post lockdown which is affecting our performance. This is both from GP referrals, as well as inpatient demand. Therefore, despite overall diagnostic activity being higher than the pre-COVID period in 2019/20, the waiting list has been growing, and diagnostic performance has been adversely impacted. In 2023/24, diagnostic activity will be paid on a block basis, and this is likely to create a financial challenge for the Trust.

### Waiting list and breaches

Diagnostic referrals from GPs has grown from around 1,700 referrals per week in H1 2021/22, to around 2,000 per week. This has been alongside an increase in inpatient referrals for diagnostic procedures; this demand is not shown in the waiting list, but the impact is reflected in the waiting list size. Consequently, the elective diagnostic waiting list is nearly 45% larger in February 2023 (10,400 patients – graph 1) compared to April 2019 (7,200 patients). However, this still represents a reduction from the 11,600 highs seen in June 2022.

The total number of breaches within the diagnostic waiting list has reduced to 2,600 patients. The proportion of breaches within the waiting list has remained broadly consistent post-COVID, with current performance at 78.5% (after recovering a post-Christmas dip in performance).

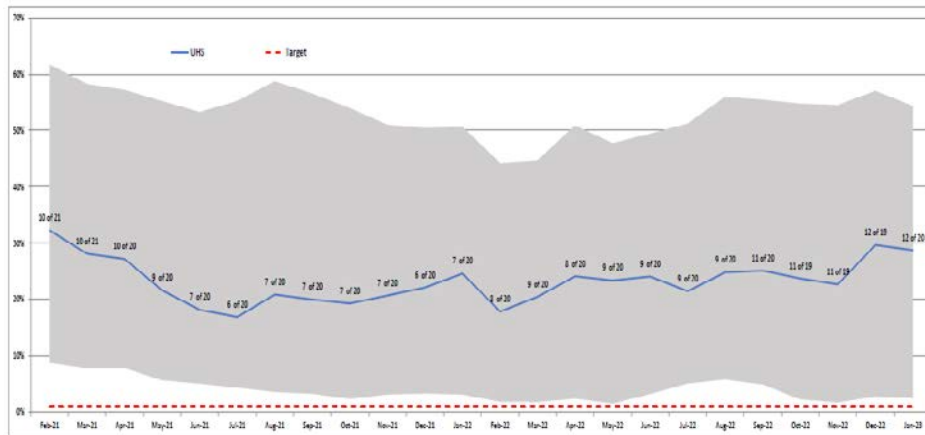
Graph 1: Waiting list and breaches



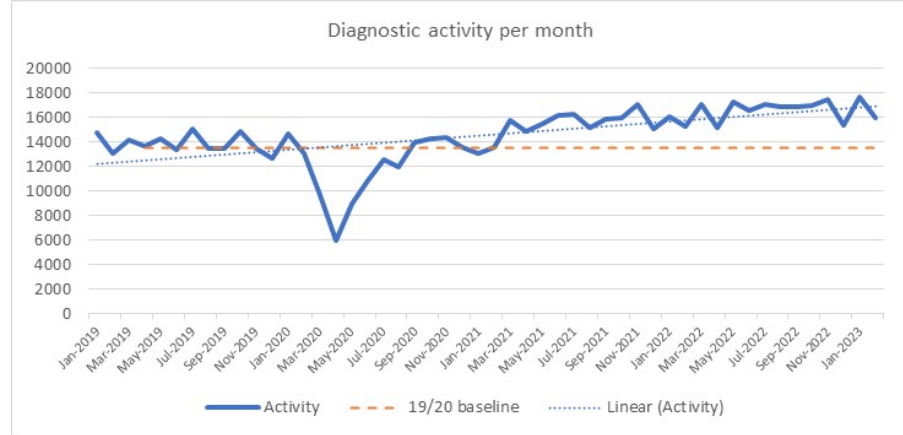


When benchmarking our performance with other peer teaching hospitals (graph 2), our diagnostic performance has deteriorated and since the second half of 2022/23, we have been in the third quartile. There is a wide spread of diagnostic performance – with some trusts delivering fewer than 50% of tests within the six-week target. At UHS, diagnostic performance is particularly sensitive to inpatient demand, which has been high in recent months. This has also been coupled with some scanner availability / reliability issues which has impacted on elective diagnostic performance.

**Graph 2: Benchmark diagnostic performance versus teaching hospitals**



**Graph 3: Monthly diagnostic activity**



**Diagnostic activity**

Elective diagnostic activity at UHS has been increasing through 2022/23 which has helped UHS to meet the increased growth in referrals. Graph 3 illustrates how recent diagnostic activity is approximately 29% higher than the 2019/20 baseline (approximately 17,380 procedures per month vs baseline of 13,200). Despite this, we are still unable to make significant reductions in the overall size of the waiting list.

The Care Groups are developing plans to ensure that they can maintain, and where possible increase, diagnostic activity into 2023/24 to meet demand, and to enable UHS to move progressively closer to NHS England’s 95% target by March 2025. Some specific areas of note include:

- Working with the ICB to expand the community diagnostic centre capacity in Southampton and South West Hampshire,
- New MRI suite at UHS
- Additional locum and weekend lists, in particular to support non-obstetric ultrasound.
- ongoing radiographer recruitment.

### Diagnostic breaches and prioritisation

Our teams continue to ensure that they prioritise diagnostic procedures based on clinical urgency. Alongside prioritising urgent diagnostics (for example for patients with cancer), we continue to prioritise the longest waiting diagnostic patients. Breaches have decreased from 3,500 in August 2020, to 2,500 in September 2022, and to 2,200 in February 2023. At the time of writing, there remained a small number of undated long waiting patients (just over 200), who had waited more than 13 weeks for a diagnostic procedure. While some of these are due to patient choice, other breaches sit within sleep studies and neurophysiology – both areas which have historically required additional infection prevention processes and have limited capacity – as well as paediatric endoscopies (which need to be conducted under general anaesthetic and are reliant on theatre capacity).

At this point in time, we do not have a clear line of sight to returning diagnostic breaches to pre-pandemic levels, given the levels of demand. Our short-term intention is to ensure that we continue to make progress in reducing the absolute number of breaches.

Internally, we track performance against a wider set of diagnostic activity (i.e. beyond the 15 modalities reported to NHS England). Graph 4 shows the total 6 week breaches, by week, and the improvement trajectory set in September 2022. We are broadly in line with our forecast performance, despite a more challenging Christmas 2022 period than expected.

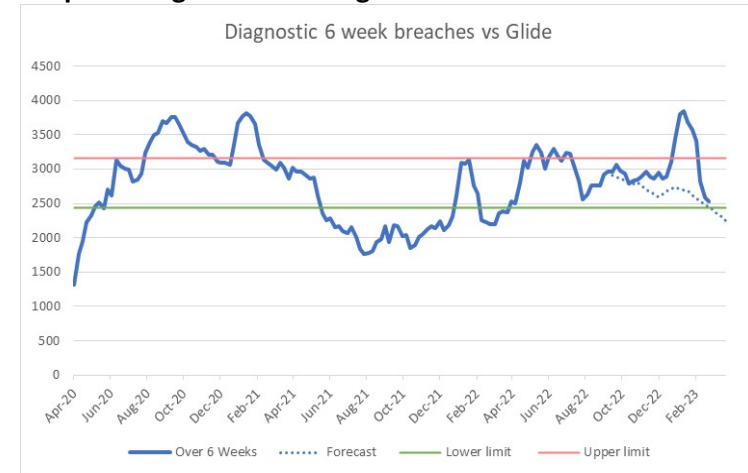
### Modality detail

For reference, we also provide a short commentary on some of the challenges between the modalities.

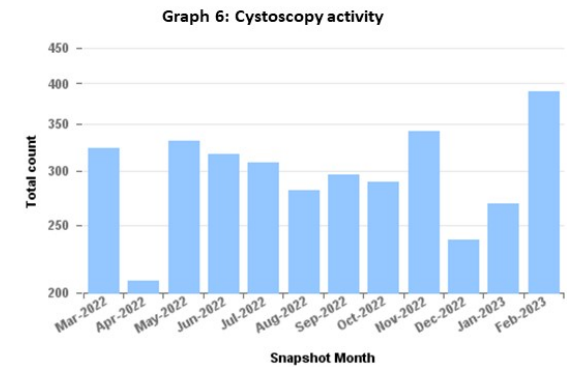
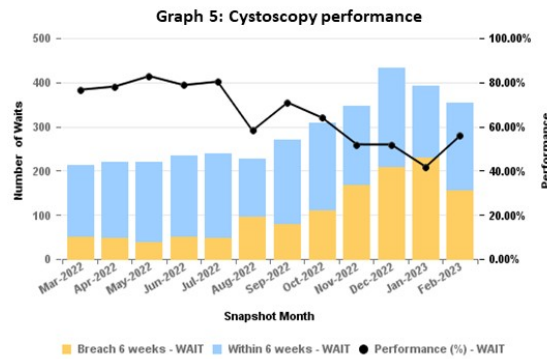
**Endoscopy** performance has been in the range of 80-83% which is comparable with Q4 2019/2020 when was 86%. Demand has remained high, and the additional endoscopy capacity has helped to maintain, rather than reduce, the overall waiting list level. The service position has also been challenged by surveillance patients that are exceeding their APD (Approximate Planned Date – a rough date when the patient needs their next diagnostic procedure), as requested by NHS England, these are being converted to an active waiting list entry and are drawn into the diagnostic wait time and increasing the diagnostic breach position.

Overall, adult endoscopy services have seen an improvement and are performing in the 87% range. The two areas which have been particularly challenged are paediatric endoscopy and adult cystoscopies. Paediatric endoscopy performance has been in the mid-30s due to the need for these to be performed under general anaesthetic, and the ongoing pressure on theatre capacity.

**Graph 4: Diagnostic breach glide**

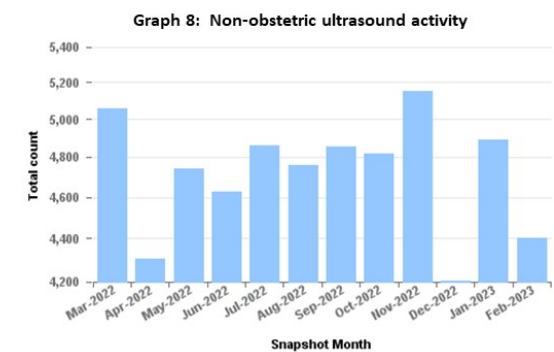
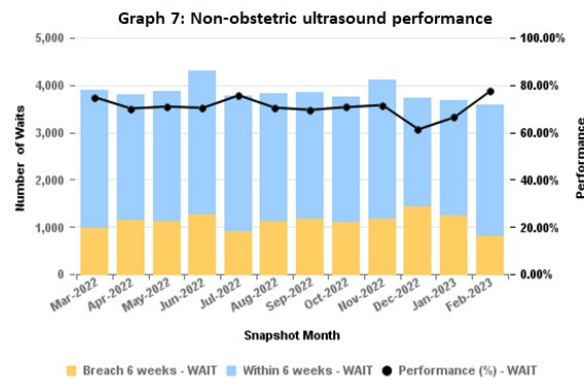


Cystoscopies has seen extremely high demand, and despite record levels of activity (graph 6), the waiting list and breaches have been under pressure (graph 5). In particular, the Care Group have needed to balance demand from Two Week Wait haematuria patients who take priority. Capacity in the service will increase from the next financial year by an additional seven lists per week, and we expect performance to improve.



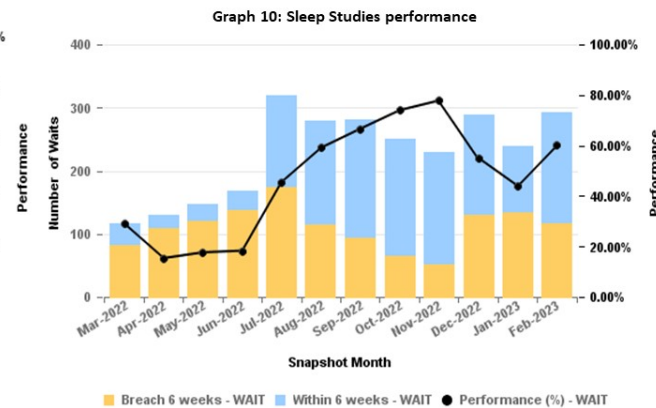
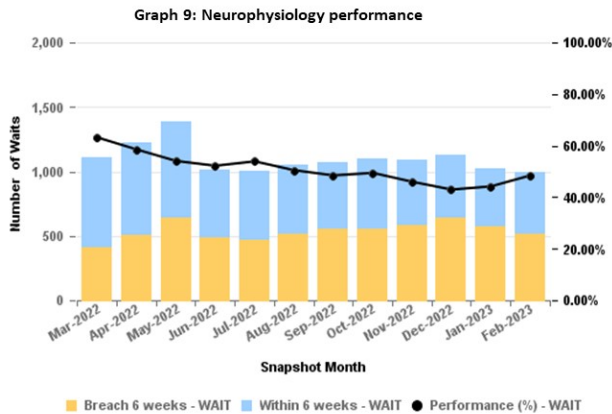
**Imaging performance** has seen some good improvements through the Christmas and New Year periods, with performance at 81.8% in February 2023. Radiographer recruitment continues to be a challenge for CT and MRI, and the Care Group continues to balance the CT and MRI capacity by moving radiographers between the services as required to meet demand.

However, the biggest improvement in non-obstetric ultrasound. Despite the significant increases in demand (which had caused the waiting list to increase by nearly a third in a year), the Care Group have delivered additional capacity through weekend sessions, NHSP and locums (graph 8) to bring performance back closer to 80% (graph 7).



**Physiological measurements** performance has been broadly stable at around 70%. Performance continues to be impacted by breaches in peripheral Neurophysiology and Sleep Studies, both of which had historic challenges with a higher level of infection prevention measures which impacted on the activity which could be delivered. Sleep Studies performance was impacted over the Christmas and New Year period due to lower capacity (graph 10), but the service should see further improvements through 2023.

For Neurophysiology, the Care Group are developing service transformation plans to improve performance. In the short term, some of the diagnostic reporting has been outsourced and a locum has been recruited to increase service capacity. As part of the longer term plan, the team are undertaking a full pathway review to improve processes, developing autonomous reporting to reduce consultant pressure, and are working with NHS England on national benchmarking of neurophysiology diagnostic performance to compare with other trusts. Although these plans will take time to fully deliver, there are already some small signs of improvement (graph 9).



## 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>

		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD
UT28-N	% Patients on an open 18 week pathway (within 18 weeks ) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	9	8	67.4%	5	5	3	4	4	5	6	5	5	5	5	5	≥92%	68.7%
CN1-N	% Patients following a GP referral for suspected cancer seen by a specialist within 2 weeks (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	16	12	13	13	13	15	14	8	9	9	13	17	14	13	82.3%	≥93%	82.8%
UT34-N	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	13	13	11	12	7	11	14	10	10	16	14	14	17	14	50.0%	≥85%	62.6%
UT25-N	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 16) South East average (& rank of 16)	5	8	65.8%	6	4	8	7	7	4	5	7	6	6	7	65.0%	≥95%	61.8%
UT33-N	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching Hospital average (& rank of 20) South East Average (& rank of 18)	6	7	17.8%	8	9	9	9	9	9	11	11	11	10	7	21.5%	≤1%	24.4%

Outcomes		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target			
UT1-N	HSMR - UHS HSMR - SGH	82.8	81.9										88.1	86.6			≤100	93.2	≤100			
UT2	HSMR - Crude Mortality Rate	2.8%											2.8%				<3%	2.7%	<3%			
UT1-N / UT2: At time of IPR publication, the latest information available in Doctor Foster was from Nov 2022. Metrics are 12 month rolling. YTD is for financial year for UHS up to Oct 2022 as the contract with Dr Foster has ended and is being replaced by HED.																						
UT3	Percentage non-elective readmissions within 28 days of discharge from hospital			12.0%													-	11.5%				
		Q3 21-22	Q4 21-22	Q1 22-23	Q2 22-23	Q3 22-23	Q4 22-23													Quarterly target		
UT4-L	Cumulative Specialties with Outcome Measures Developed (Quarterly)	63	63	64	64	68											+1 Specialty per quarter					
		383	393	419	403	430																
UT5	Developed Outcomes RAG ratings (Quarterly)	77%	76%	74%	74%	74%																
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		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target									
UT6-N	Cumulative Clostridium difficile <i>Most recent 12 Months vs. Previous 12 Months</i>	57	71	63	74	7	9	16	11	21	18	25	24	33	28	39	35	44	47	49	55	56	65	64	73	71	77	≤55
UT7	Healthcare-acquired COVID infection: COVID-positive sample taken >14 days after admission (validated)	35	20	14	43	36	23	49	48	2	30	92	2	35	56	40	-	413	-									
UT8	Probable hospital-associated COVID infection: COVID-positive sample taken >7 days and ≤14 days after admission (validated)	0	18	11	32	38	12	32	37	3	16	50	3	15	29	19	-	254	-									
UT9	Pressure ulcers category 2 per 1000 bed days																<0.3	0.34	<0.3									
UT10	Pressure ulcers category 3 and above per 1000 bed days																<0.3	0.41	<0.3									
UT11-N	Medication Errors (severe/moderate)																≤3	24	≤33									



		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target
UT12	Watch & Reserve antibiotics, usage per 1,000 adms <b>Most recent months vs. 2018*95.5%</b>	2,847	3,051											2,847	3,231		2,847	25,738	24,294
UT12 - For 2022/23, a new requirement is applied: Reduction of 4.5% from calendar year 2018 usage in combined WHO/NHSE AWaRE subgroups for “watch” and “reserve” agents. The performance data relate to successive FINANCIAL years, however the comparator denominator remains CALENDAR year 2018 (we are not using 2020 or 2021 due to the disruptive effect of COVID on both usage and admissions). Data is reported 3 months in arrears.																			
UT13	Serious Incidents Requiring Investigation (SIRI) (based upon month reported as SIRI, excluding Maternity)			2													-	99	-
UT14	Serious Incidents Requiring Investigation - Maternity			1													-	10	-
UT15	Number of falls investigated per 1000 bed days			0.14													-	0.14	-
UT16	% patients with a nutrition plan in place (total checks conducted included at chart base)	397					53	742	572	750	719	676	669	711	1624	780	≥90%	94%	≥90%
UT16 - monthly audit was paused due to pressure on all ward areas between Dec 2021 to May 2022. The audit was partially restarted in some ward areas in May 2022, and fully restarted in June 2022.																			
UT17	Red Flag staffing incidents			16													-	380	-

<b>Patient Experience</b>		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target
UT18-N	FFT Negative Score - Inpatients																≤5%	1.0%	≤5%
UT19-N	FFT Negative Score - Maternity (postnatal ward)																≤5%	2.6%	≤5%
UT20	Total UHS women booked onto a continuity of carer pathway																≥35%	43.7%	≥35%
UT21	Total BAME women booked onto a continuity of carer pathway																≥51%	81.0%	≥51%
UT22	% Patients reporting being involved in decisions about care and treatment																≥90%	88.1%	≥90%
UT23	% Patients with a disability/ additional needs/adjustments were met (total number questioned included at chart base)																≥90%	88.2%	≥90%
UT23 - Performance is a scored metric with a "Yes" response scoring 1, "Yes, to some extent" receiving 0.5 score and other responses scoring 0.																			
UT24	Overnight ward moves with a reason marked as non-clinical (excludes moves from admitting wards with LOS<12hrs)																	567	-

Access Standards		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target	
UT25-N	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 16) South East average (& rank of 16)	5	8	10	6	4	8	7	7	4	5	7	6	6	7	4	≥95%	61.8%	≥95%	
UT26	Average (Mean) time in Dept - non-admitted patients																≤04:00	03:20	≤04:00	
UT27	Average (Mean) time in Dept - admitted patients																≤04:00	05:52	≤04:00	
UT28-N	% Patients on an open 18 week pathway (within 18 weeks ) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	9	8	67.4%	5	5	3	4	4	5	6	5	5	5	5	5	63.2%	≥92%	68.7%	≥92%
UT29	Total number of patients on a waiting list (18 week referral to treatment pathway)																-	54,692	-	
UT30	% Patients on an open 18 week pathway (waiting 52 weeks+ ) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	7	7	7	7	7	7	5	5	5	5	5	5	5	5	5	2,032	2,011	2,151	2,011

		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target
UT31	Patients on an open 18 week pathway (waiting 104 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	8	8	8	6	8	5	6	6	6	7	5	1	1	1	0	0	0	0
UT31a	Patients on an open 18 week pathway (waiting 78 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	7	8	8	7	7	7	7	7	7	7	7	7	7	7	150	150	150	150
UT32	Patients waiting for diagnostics			10,058												10,329	-	10,329	-
UT33-N	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	6	7	8	9	8	9	9	9	9	11	11	11	10	7	21.5%	≤1%	24.4%	≤1%
UT34-N	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	13	13	11	12	7	11	14	10	10	16	14	14	17	14	50.0%	≥85%	62.6%	≥85%
UT35-N	31 day cancer wait performance - decision to treat to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	11	14	16	14	16	15	15	17	16	16	16	16	16	16	82.3%	≥96%	89.3%	≥96%
UT36-N	31 day cancer wait performance - Subsequent Treatments of Cancer (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	16	15	14	15	13	9	12	13	13	13	13	14	14	7	81.9%	≥96.0%	90.2%	≥96.0%

<b>R&amp;D Performance</b>		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target	
PN1-L	Comparative CRN Recruitment Performance - non-weighted	8	9	8	9	1	1	3	4	5	6	7	7	14	15	15	Top 10	-	-	
PN2-L	Comparative CRN Recruitment Performance - weighted	3	4	4	3	6	8	11	7	7	7	8	10	10	10	11	Top 5	-	-	
PN3-L	Comparative CRN Recruitment - contract commercial	7	8	9	10	2	1	3	2	3	4	4	8	8	8	8	Top 10	-	-	
PN4-L	Achievement compared to R+D Income Baseline Monthly income increase % YTD income increase %	29.0%	-234.0%	143.0%	359.0%	63.0%	74.0%	56.0%	177.0%	94.0%	48.0%	23.0%	71.0%	79.0%	166.0%	69.0%	84.0%	≥5%	-	-
PN4-L	Note – Monthly and YTD Income are affected by a permanent change in accounting treatment implemented in M10 (Jan) 2021/22 in order to improve accuracy. Prior to M10, R+D open and ongoing studies/ grants in credit had anticipated future costs accrued. From M10 onwards, income received is deferred where costs have not yet been incurred/ invoiced. This change results in an adjustment of -£5m to monthly and YTD income which has been applied in M10. (An equivalent adjustment to the costs accounted for means that the balance of income and expenditure is not affected).																			

		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target	
<b>Thrive</b>																				
WR1-L	Substantive Staff - Turnover -R12M turnover % -Leavers in month (FTE)																	R12M <= 12.0%	14.7%	-
WR2-L	Staff Vacancies -Nursing vacancies (registered nurses only in clinical wards) -All Staff vacancies																	-	-	-
WR3-L	Workforce Numbers -Planned substantive WTE -Actual substantive WTE -Including - Month-end contracted staff in post (ESR), Consultant APAs, Junior doctors Extra Rostered Hrs -Excluding - Bank and agency; honorary contracts; career breaks; secondments; hosted services; WPL; Chilworth; Vaccination Hub																	11,900 WTE by March 2023	-	-
WR4-L	Staff - Sickness absence -R12M sickness % -Sickness in month %																	R12M <= 3.4%	4.7%	-
<b>Excel</b>																				
WR5-L	Non-medical appraisals completed -R12M appraisal % -Appraisals in month																	R12M >= 92.0%	73.6%	-
WR6-L	Medical staff appraisals completed - Rolling 12-months																	-	-	-

		Q3 21-22	Q4 21-22			Q1 22-23			Q2 22-23			Q3 22-23			Q4 22-23			Quarterly target			
WR7-L	Staff recommend UHS as a place to work score: National Quarterly Pulse Survey (NQPS) National NHS Staff Survey	8.0	7.1	7.24			7.05			6.96			6.91			6.92	-	-	-		
WR8-L	Staff survey engagement score National Quarterly Pulse Survey (NQPS) National NHS Staff Survey	8.0	7.2	7.17			7.08			7.03			7.1			7.02	-	-	-		
<b>Belong</b>			Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target	
WR9-L	% of Band 7+ staff who are Black and Minority Ethnic	12%	10.4%															10.9%	19% by 2026	10.7%	-
WR10	% of Band 7+ Staff who have declared a disability or long term health condition	13.7%	13.3%															12.9%	-	-	-
		12.5%																			

		Q3 21-22	Q4 21-22	Q1 22-23	Q2 22-23	Q3 22-23	Q4 22-23	Quarterly target											
WR11	Staff recommending UHS as a place to work: White British staff compared with all other ethnic groups combined -White British -All other ethnic groups combined	7.36 7.14	7.44 7.12	7.3 7.02	7.14 6.97	7.29 7.07	7.25 6.98	-	-	-									
WR12	Staff recommending UHS as a place to work: Non disabled /prefer not to answer compared with Disabled -Non disabled /prefer not to answer -Disabled	6.9 7.3	7.02 7.18	6.9 7.09	6.91 7.06	6.8 7.2	6.96 7.04	-	-	-									
WR13	Staff recommending UHS as a place to work: Sexuality = Heterosexual compared with all other groups combined -Sexuality = Heterosexual -All other groups combined	7.00 7.2	6.87 7.19	6.81 7.08	6.62 7.05	6.80 7.2	6.76 7.06	-	-	-									
		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target
FN6	Percentage of staff living locally (inside the Southampton City boundaries)															-	-	-	
FN7	Percentage of staff residing in deprived areas (lowest 30% - national Index of Multiple Deprivation)															-	-	-	



<b>Local Integration</b>		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target
NT1	Number of inpatients that were medically optimised for discharge (monthly average)																≤80	205	-
NT2	Emergency Department activity - type 1 <i>This year vs. last year</i>																-	0	-
NT3	Percentage of virtual appointments as a proportion of all outpatient consultations <i>This year vs. last year</i>																≥25%	30.4%	≥25%

<b>Digital</b>		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target
FN1	My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month)																-	148,029	
FN2	My Medical Record - UHS patient logins (number of logins made within each month)																-	290,674	
FN3	Patients choosing digital correspondence - Total choosing paperless in the month - Total offered but not yet choosing paperless in the month - % of total My Medical Record service users who have chosen paperless (cumulative)																-		

Report to the Trust Board of Directors				
Title:	Finance Report 2022-23 Month 11			
Agenda item:	4.9			
Sponsor:	Ian Howard – Chief Financial Officer			
Author:	Philip Bunting – Director of Operational Finance David O’Sullivan – Assistant Director of Finance – Financial Performance			
Date:	30 March 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:	<p><b><u>M11 Financial Position</u></b></p> <p>UHS has this month received confirmation of an additional £5.4m of income in 22/23 relating to Elective Recovery Fund over-performance on HIOW ICS activity. This had previously been flagged as being at risk, but national funding has now been issued to the HIOW ICS to make payment to UHS for this.</p> <p>As a result, a revised forecast position of <b>£11m deficit (0.9%)</b> has been agreed with HIOW ICB subject to any further income flowing into the system. This is down from £16.4m reported the previous month.</p> <p>Due to the additional income being received in M11, UHS reported a surplus of £5m in February 2023, which is now a £11.3m deficit YTD. A surplus of £0.3m is therefore required within March to deliver the forecast position. There is confidence in the achievability of this.</p> <p><b><u>Underlying Position</u></b></p> <p>The underlying position for January is £4.3m deficit which is an increase of £0.7m from the previous month. This was driven by an increase in energy costs of £0.4m in addition to clinical supplies increases which are known to be volatile. The overall position remains increased in comparison to Q1 and Q2 due to significant operational pressures requiring further spend on unfunded capacity and an overall increase in energy costs vs prior periods.</p> <p><b><u>Key drivers</u></b></p> <p>The key drivers for the underlying position remain consistent with previous monthly reports and are listed in the table below. Most of these are classed as uncontrollable with UHS having limited ability to directly influence the level of cost pressure being experienced in some areas. These have been partly offset by planned CIP and further to that additional CIP or additional income being achieved. This has helped UHS report a lower deficit number than the underlying position of £39.6m deficit YTD.</p>			

Cost Driver	Rationale	Controllable / Uncontrollable	Underlying Variance to Breakeven (YTD £m)
Covid Costs	Covid volumes in excess of 'low covid environment' assumed within plan	Uncontrollable	5.0
Pay Inflation	Pay award funding does not cover costs in full	Uncontrollable	2.2
Non Pay Inflation	Rates of inflation are in excess of planned expectations	Uncontrollable	11.6
Energy Costs	Energy costs have increased beyond that expected.	Uncontrollable	10.5
Criteria to Reside	Medically optimised patients still residing leading to flex bed costs.	Uncontrollable	3.6
Additional Bank Holiday	One off costs were incurred relating to bank holiday enhancements	Uncontrollable	0.2
Drugs and devices expenditure in excess of block funding	Drugs and devices costs have been in excess of the block funded level due to additional NICE approvals and new treatments approved.	Uncontrollable	9.4
Emergency Department	ED costs are in excess of planned levels due to activity and workforce pressures.	Controllable	5.5
CIP	Planned CIP Offset	Controllable	(8.4)
<b>Underlying Deficit YTD</b>			<b>39.6</b>
Additional CIP Achievement / Additional Income / Other One Offs			(28.3)
<b>Reported Deficit YTD</b>			<b>11.3</b>

### ERF Position

UHS achieved 103% in February which is an improvement from January which was 100%. This is however consistent with January once industrial action is normalised for.

UHS is reporting achievement of 105% YTD ahead of the national 104% target and consistent with that planned. Indicatively UHS has achieved £5.4m of income relating to ERF however this is probably an underestimate as national data has tended to suggest internal estimates marginally understate actual performance.

Both H10W ICS and Specialised Commissioning have now agreed non recurrent financial settlements for elective recovery fund overperformance.

### CIP

The Trust has achieved delivery of £38.7 YTD, £1.2m below the target of £39.9m. Identification of CIP schemes has improved to £44.8m of the £45.4m target (98%) and equates to an overall achievement of 3.5% of income. We are looking to commit to achievement of the full target within March 2023 and close the remaining gap within the Financial Recovery Plan.

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

	<p><b><u>Financial Recovery</u></b></p> <p>Financial recovery remains a significant priority for the trust. Progress continues to be made via the Trust Savings Group and Transformation Oversight Group following on from the finance summit held in December. Actions completed since the December F&amp;IC:</p> <ul style="list-style-type: none"> <li>• Outsourcing spend has reduced in Q4 after enacting stricter controls on its usage</li> <li>• Revised financial governance and controls have been discussed and agreed at the Trust Executive Committee</li> <li>• A review of the trusts balance sheet has taken place with HIOW ICS and NHSE Regional colleagues</li> <li>• Tightened agency spend controls continue to report reduced spend on high-cost agency</li> <li>• The Transformation Oversight Group (TOG) is in the process of setting priorities for 23/24</li> </ul> <p><b><u>Capital</u></b></p> <p>The Trust has reported capital expenditure of £9.3m in month and has spent £63.7m YTD. Within the remaining weeks of 2022/23 the trust has £24m still to spend in order to deliver internal CDEL spend in full and externally funded commitments in full.</p> <p>Due to the risk of slippage, we have identified a number of schemes to bring forward expenditure from 2023/24, including increasing in year spend on the wards development. This is mitigating the risk of underspend at the end of the year. The amount left to spend has been circulated to responsible owners in month to ensure clarity, with progress and risks reported regularly at the Trust Investment Group.</p> <p>Although this represents a significant step change feedback from project managers is that there is confidence in delivery. Due to the level of risk however further mitigations are being explored as slippage into 2023/24 will cause a problem as future projects may need deferring in order to contain costs within CDEL allocations.</p> <p><b><u>Cash</u></b></p> <p>The cash position has improved £11.5m from the previous month increasing to £104.4m. This was predominantly due to PDC drawdowns in month that have not yet been offset by equivalent capital expenditure. The underlying downward trend remains consistent with the previous forecast however although recent cash injections of non-recurrent funding will help short term liquidity and boost cash reserves. Cash is anticipated to reduce in March 2023 as there is £24m of capital expenditure to be incurred in addition to the continuation of the underlying deficit.</p> <p>We are continuing to have a current-account deficit, which is being funded by our capital investment savings account.</p> <p><b><u>HIOW ICB Position</u></b></p> <p>A verbal update on the latest position will be provided.</p>
<p>Implications:</p>	<ul style="list-style-type: none"> <li>• Financial implications of availability of funding to cover growth, cost pressures and new activity.</li> <li>• Organisational implications of remaining within statutory duties.</li> </ul>
<p>Risks: (Top 3) of carrying out the change / or not:</p>	<ul style="list-style-type: none"> <li>• Financial risk relating to the underlying run rate and projected potential deficit if the run rate continues.</li> </ul>

	<ul style="list-style-type: none"><li>• Investment risk related to the above</li><li>• Cash risk linked to volatility above</li><li>• Inability to maximise CDEL (which cannot be carried forward) and the risk of a reducing internal CDEL allocation for 2023/24 due to the forecast deficit for 2022/23.</li></ul>
Summary: Conclusion and/or recommendation	Members of Trust Board are asked to: <ul style="list-style-type: none"><li>• Note the update to the financial position.</li></ul>

**Finance Report Month 11**

<b>Report to:</b>	<b>Board of Directors and Finance &amp; Investment Committee</b>  <b>February 2022</b>
<b>Title:</b>	<b>Finance Report for Period ending 28/02/2023</b>
<b>Author:</b>	<b>Philip Bunting, Director of Operational Finance</b>  <b>David O'Sullivan, Assistant Director of Finance</b>
<b>Sponsoring Director:</b>	<b>Ian Howard, Chief Financial Officer</b>
<b>Purpose:</b>	<b>Standing Item</b>
	<b>The Board is asked to note the report</b>

**Executive Summary:****In Month and Year to date Highlights:**

1. In Month 11, UHS reported a surplus position of £5.0m which was £3.5m favourable to the planned £1.5m surplus. The YTD position is £11.3m deficit which is £9.9m adverse to the planned deficit target of £1.5m.
2. The underlying position is however £39.6m deficit YTD with one off benefits helping improve the in year reported position. Estimates of the forecast indicate an intermediate projection of £11m after accounting for non recurrent costs and benefits. This is heavily influenced by largely uncontrollable costs relating to covid, inflation, MOFD numbers and energy expenditure.
3. CIP YTD delivery is £38.7m, an increase from the £33.3m achieved at M10. CIP forecast now stands at £44.8m, just £0.6m short of the target of £45.4m. Of the £44.8m delivered YTD £18.7m has been transacted by Divisions and Directorates and £26.1m has been transacted through Central Schemes.
4. The main income and activity themes seen in M11 were:
  1. UHS has delivered 103% of Elective Recovery activity in M11.
  2. Indicative ERF income totals £5.4m year to date.
  3. At M11 the unfunded pressure for ICB block funded drugs and devices is £9.4m of which £6.6m is from drugs.
5. The underlying deficit of £4.3m in month is driven by:
  1. Drugs & Devices (£0.9m per month) – partly offset with CIP
  2. Energy costs – (£0.9m per month) – Inflationary pressure increasing – partly offset by CIP
  3. Covid related staff costs – (£0.6m per month) – continued sickness absence costs and covid spend which has not reduced as per planning assumptions
  4. Inflationary and pay award pressures (£1.2m per month) – costs are unfunded
  5. Activity and MOFD related pressures (£0.7m per month) – ED costs above plan as a result of significant operational pressure.

**Finance: I&E Summary**

A surplus position of £5.0m was reported in February favourable to the planned position of £1.5m surplus.

The YTD position of £11.3m deficit is £9.9m adverse to the planned £1.5m deficit target.

The in month favourable position is largely driven by receipt of £5.0m Elective Recovery Fund income relating to UHS clinical activity performance for the year.

Pay expenditure continues to run at a high rate across the organisation with a further increase of £0.2m in month.

Overspends are being experienced across the majority of expenditure categories which are partially offset by income overachievement.

The Trust has formally revised its reported outturn forecast for 2022/23 to £11m.

	Current Month			Cumulative			Plan		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
NHS Income: Clinical	69.7	82.0	(12.2)	767.3	790.9	(23.6)	837.0	862.8	(25.8)
Pass-through Drugs & Devices	11.2	9.6	1.7	123.4	140.1	(16.7)	134.6	152.8	(18.2)
Other income Other Income excl. PSF	10.6	19.6	(9.1)	116.0	166.1	(50.0)	126.6	181.2	(54.6)
Top Up Income	0.6	0.5	0.1	7.8	7.1	0.6	8.3	7.8	0.6
<b>Total income</b>	<b>92.1</b>	<b>111.6</b>	<b>(19.5)</b>	<b>1,014.5</b>	<b>1,104.1</b>	<b>(89.7)</b>	<b>1,106.6</b>	<b>1,204.5</b>	<b>(97.9)</b>
Costs Pay-Substantive	50.1	51.8	1.7	541.3	557.7	16.4	591.6	608.4	16.9
Pay-Bank	2.1	4.0	1.9	31.2	43.1	12.0	33.2	47.1	13.9
Pay-Agency	0.7	1.4	0.7	11.3	13.5	2.2	12.0	14.8	2.7
Drugs	4.7	5.9	1.1	55.0	56.6	1.6	59.7	61.8	2.1
Pass-through Drugs & Devices	11.2	9.6	(1.7)	123.4	140.1	16.7	134.6	152.8	18.2
Clinical supplies	5.2	7.3	2.2	69.5	74.3	4.8	74.6	81.1	6.4
Other non pay	15.6	26.2	10.6	174.0	221.4	47.3	189.6	238.9	49.2
<b>Total expenditure</b>	<b>89.7</b>	<b>106.1</b>	<b>16.4</b>	<b>1,005.7</b>	<b>1,106.7</b>	<b>101.1</b>	<b>1,095.3</b>	<b>1,204.8</b>	<b>109.4</b>
<b>EBITDA</b>	<b>2.4</b>	<b>5.5</b>	<b>(3.1)</b>	<b>8.8</b>	<b>(2.6)</b>	<b>11.4</b>	<b>11.2</b>	<b>(0.2)</b>	<b>11.5</b>
<b>EBITDA %</b>	<b>2.6%</b>	<b>4.9%</b>	<b>(2.3%)</b>	<b>0.9%</b>	<b>-0.2%</b>	<b>1.1%</b>	<b>1.0%</b>	<b>0.0%</b>	<b>1.0%</b>
Non operating expenditure/income	(0.9)	(1.4)	(0.5)	(10.2)	(9.5)	0.7	(11.1)	(11.1)	0.0
<b>Surplus / (Deficit)</b>	<b>1.5</b>	<b>4.1</b>	<b>(2.6)</b>	<b>(1.4)</b>	<b>(12.1)</b>	<b>10.7</b>	<b>0.1</b>	<b>(11.4)</b>	<b>11.5</b>
Less Donated income	(0.1)	(0.6)	0.4	(1.3)	(2.0)	0.7	(1.4)	(2.0)	0.6
Profit on disposals	-	-	0.0	-	(0.0)	0.0	-	(0.1)	0.1
Gain/ Loss on absorption	-	-	0.0	-	(0.4)	0.4	-	(0.9)	0.9
Add Back Donated depreciation	0.1	0.2	0.1	1.2	1.8	0.6	1.3	2.0	0.7
Impairments	-	1.3	1.3	-	1.3	1.3	-	1.3	1.3
<b>Net Surplus / (Deficit)</b>	<b>1.5</b>	<b>5.0</b>	<b>(3.5)</b>	<b>(1.5)</b>	<b>(11.3)</b>	<b>9.9</b>	<b>0.0</b>	<b>(11.0)</b>	<b>11.0</b>

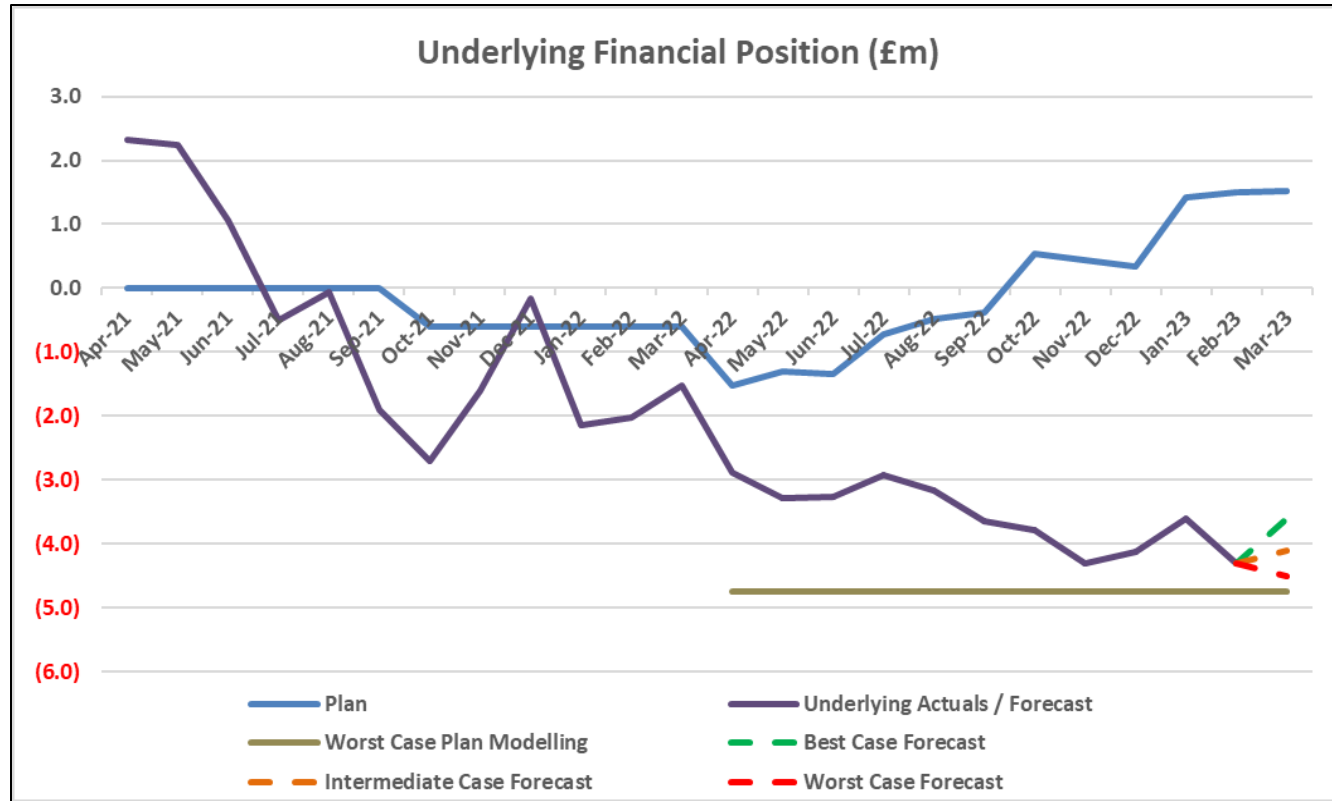


Monthly Underlying Position

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

This differs from the reported financial position as it has been adjusted for non recurrent items (one offs) and also had any necessary costs or income rephased by month to get a true picture of the run rate. The underlying position is £4.3m deficit in M11 up from £3.6m in M10.

The run rate from month 1 to month 11 is on average £3.6m deficit per month due mainly to energy cost pressures (seasonality impact also), continuing covid pressures, inflationary pressures and the unfunded pay award pressures. This is in addition to activity related operational pressures especially within ED and related to delayed discharges. A range of deficit scenarios have been modelled which are shown on the graph and are shown within the table overleaf.



Financial Risks

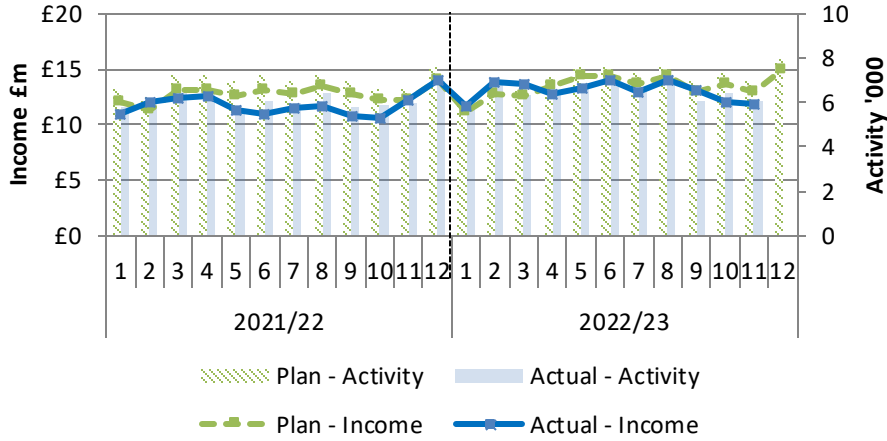
The table illustrates the key variables driving the underlying deficit position.

This illustrated an underlying forecast between £41.7m deficit and £44.7m deficit with an intermediate forecast assessment of £43.2m deficit before non recurrent CIP is added and any additional income or stretch applied. This remains consistent with the previous month.

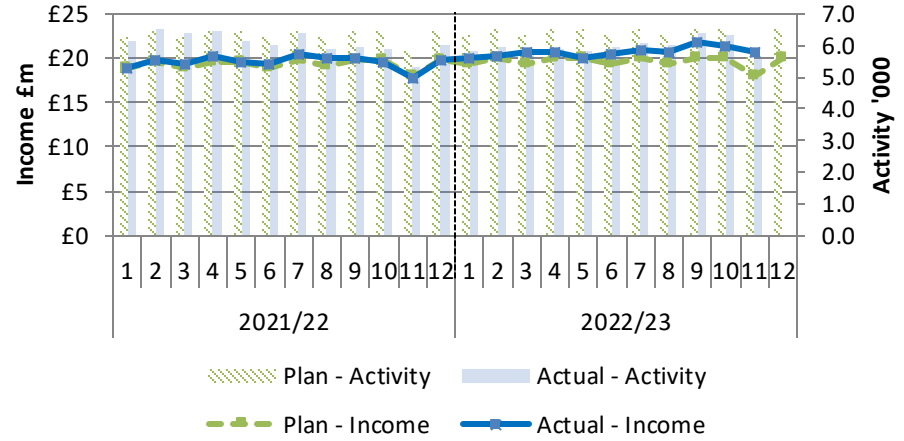
Risk Variable	Controllable / Uncontrollable	Original Worst Case Assessment (£m)	Forecast Assessment		
			Best Case (£m)	Intermediate Case (£m)	Worst Case (£m)
Cost Improvement Plans not fully delivered	Controllable	(28.9)	0.0	0.0	0.0
Covid 19 remains at above 'background' levels meaning costs don't reduce	Uncontrollable	(17.0)	(4.9)	(5.1)	(5.3)
Inflationary pressures impacting the price of goods and services (including stockouts)	Uncontrollable	(11.3)	(12.0)	(12.2)	(12.4)
Energy Cost prices continue to rise	Uncontrollable		(11.0)	(11.3)	(11.6)
Block drugs and devices costs continue to overspend	Uncontrollable	0.0	(11.1)	(11.6)	(12.1)
Medically optimised for discharge numbers do not reduce and flex beds remain open	Controllable	0.0	(2.9)	(3.1)	(3.3)
Emergency Department	Controllable	0.0	(5.2)	(5.3)	(5.4)
Pay Award Funding Gap	Uncontrollable	0.0	(2.3)	(2.3)	(2.3)
Additional Bank Holiday Costs	Uncontrollable	0.0	(2.9)	(2.9)	(2.9)
Cost Improvement Plans Offsetting (Within Plan)	Controllable	0.0	10.6	10.6	10.6
<b>Underlying Deficit Subtotal</b>		<b>(57.2)</b>	<b>(41.7)</b>	<b>(43.2)</b>	<b>(44.7)</b>
Non Recurrent CIP (Within Plan)			5.0	5.0	5.0
Additional Income / Stretch Achievement			27.2	27.2	27.2
<b>Reported Deficit Total</b>		<b>(57.2)</b>	<b>(9.5)</b>	<b>(11.0)</b>	<b>(12.5)</b>

Clinical Income

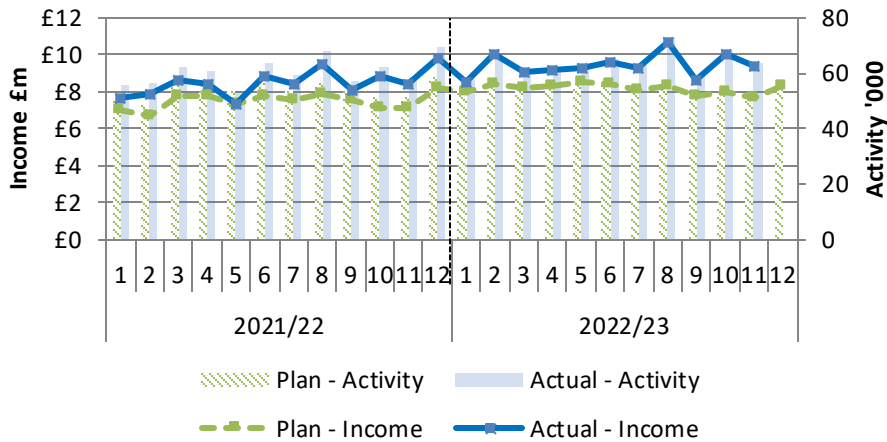
### Elective spells



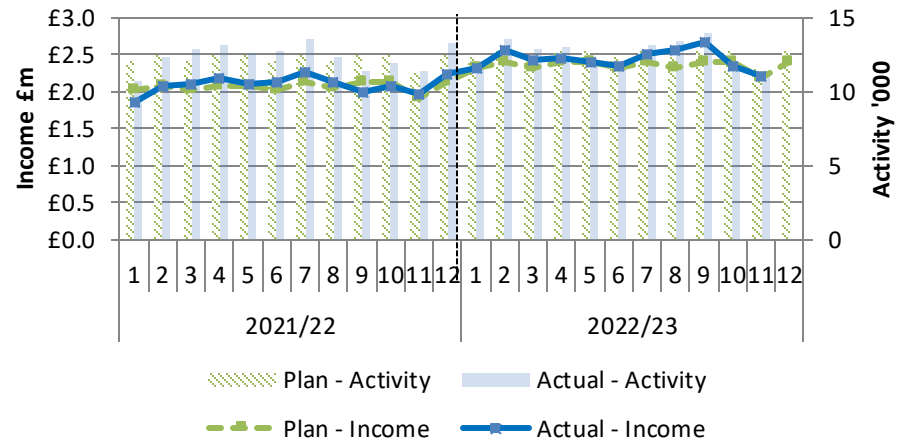
### Non elective spells



### Outpatients Total

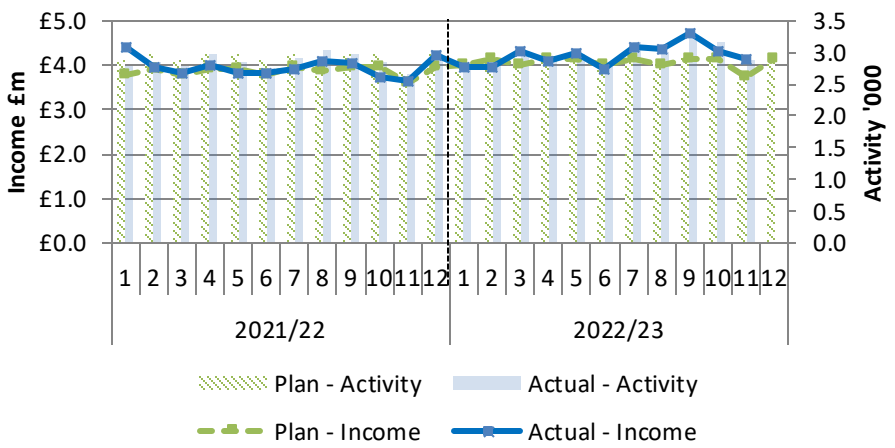


### A&E

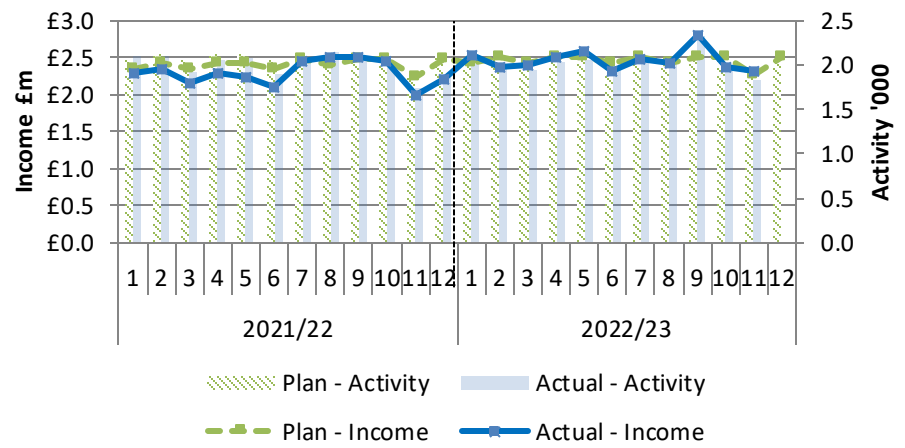


Clinical Income

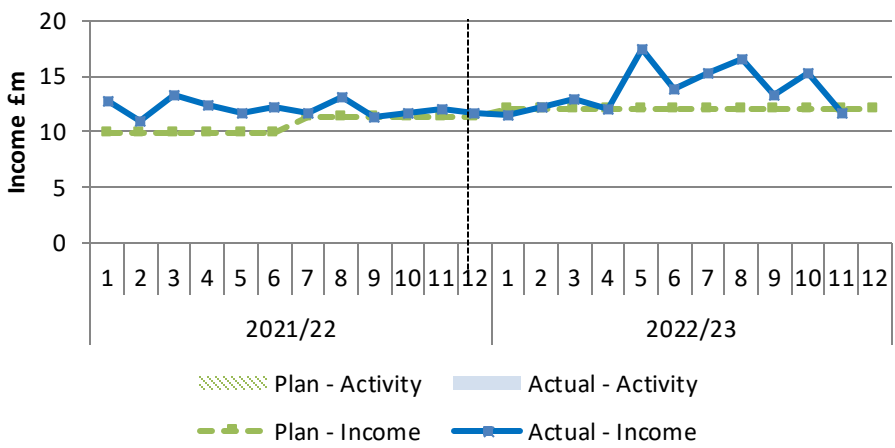
Adult critical care



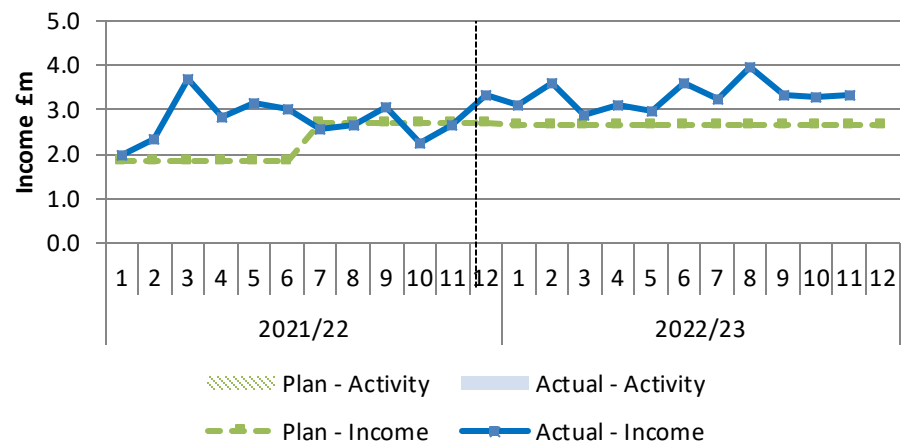
Neonatal & paediatric critical care



Tariff excluded drugs



Tariff excluded devices



Elective Recovery Fund 22/23

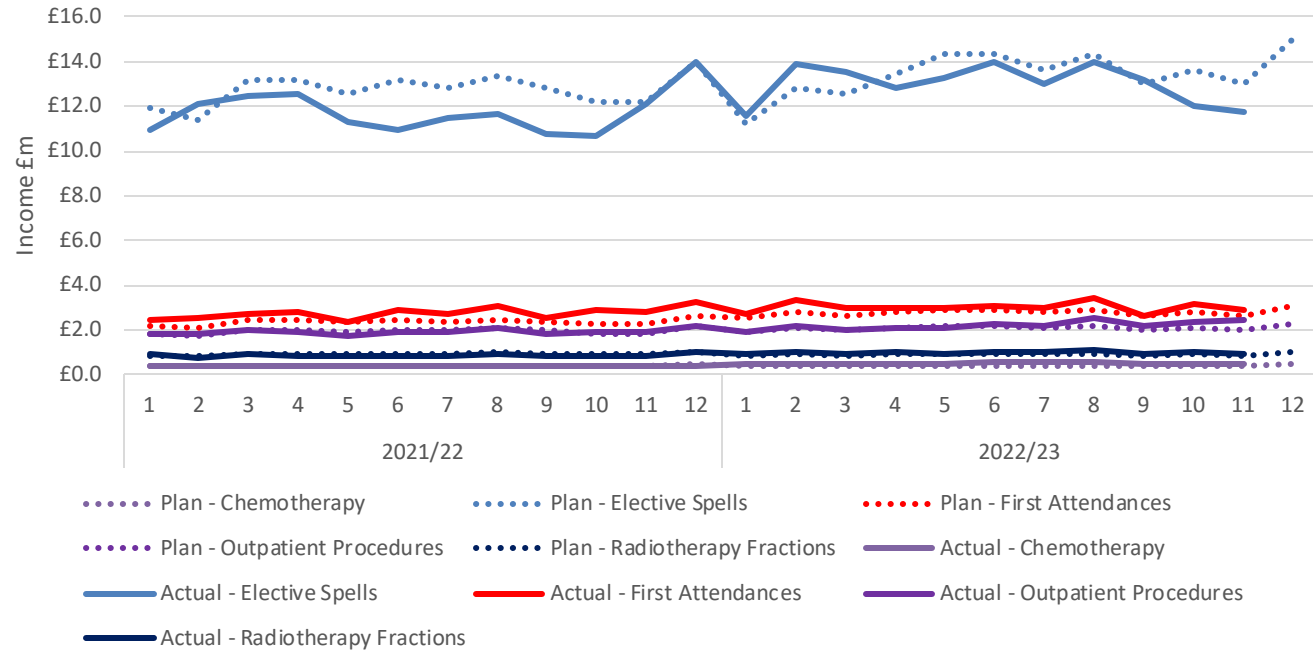
The graph shows the ERF performance for 22/23 as well as a trend against plan for 21/22.

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

The table highlights overall performance against the 19/20 pre-Covid baseline, highlighting M11 performance of 103% and 105% YTD. Indicatively this has generated £5.4m in ERF income YTD. This most likely understates the true position as national data has tended to reflect a higher reported position.

Both specialised commissioning and H10W ICS (via additional national funding) have now made non recurrent payments in support of achievement of ERF in year.

ERF 104% performance



Elective Recovery Framework Performance	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	YTD
Elective performance	99%	107%	110%	99%	98%	103%	101%	104%	107%	93%	96%	102%
Outpatient first and procedures performance	109%	117%	112%	108%	104%	109%	111%	120%	107%	117%	120%	112%
Chemotherapy performance	146%	127%	142%	127%	128%	133%	142%	140%	139%	133%	136%	136%
Radiotherapy performance	119%	112%	114%	116%	104%	113%	112%	117%	114%	119%	114%	114%
<b>Overall ERF performance</b>	<b>104%</b>	<b>111%</b>	<b>112%</b>	<b>103%</b>	<b>101%</b>	<b>106%</b>	<b>104%</b>	<b>109%</b>	<b>108%</b>	<b>101%</b>	<b>103%</b>	<b>105%</b>
Anticipated ERF payment (incl. A&G)	£826	£1,673	£1,502	£125	£409	£337	£172	£876	£723	£383	£8	£5,434
Outpatient follow up performance	130%	137%	130%	125%	120%	125%	126%	139%	123%	137%	129%	129%

Cost Pressures 2022/23

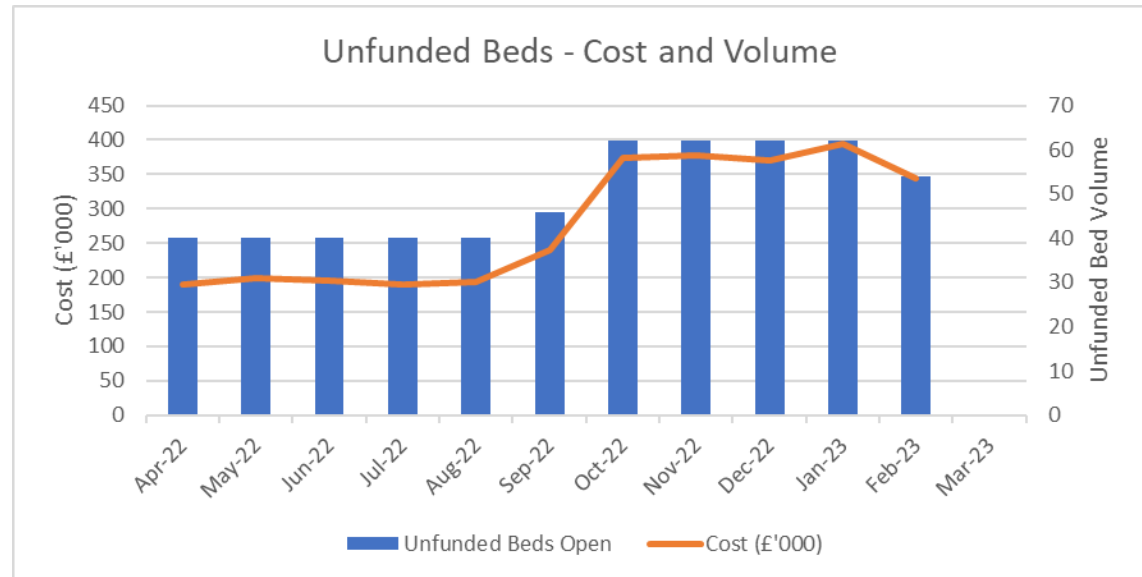
The top tables show the performance for block funded and pass-through drugs in 22/23. The majority of NHS England Specialised Commissioned drugs and devices are being funded on a cost and volume (C&V) basis but all those which are ICB commissioned are subject to a fixed block payment.

At M11 the unfunded pressure for these block funded drugs and devices is £9.4m of which £6.6m is from drugs. Long term conditions form one of the key areas of cost growth particularly within gastroenterology, rheumatology and ophthalmology. These services are seeing disproportionate growth in patient numbers and significant impact from NICE technical appraisals particularly around biologics.

The graph shows the costs of 'unfunded beds' open within UHS. These are required due to increasing numbers of patients (c200) not meeting the criteria to reside. Flex bed pressures have increased over recent months with costs increasing to £345k in month (£3.1m YTD).

Block	YTD Plan	YTD Actual	Unfunded performance
Drugs	£33,739,083	£40,327,992	£6,588,910
Devices	£5,381,295	£8,234,968	£2,853,673
<b>Total</b>	<b>£39,120,378</b>	<b>£48,562,961</b>	<b>£9,442,583</b>

C&V	YTD Plan	YTD Actual	Funded performance
Drugs	£99,560,386	£111,887,112	£12,326,726
Devices	£23,845,775	£28,164,645	£4,318,870
<b>Total</b>	<b>£123,406,161</b>	<b>£140,051,757</b>	<b>£16,645,596</b>



**Finance Report Month 11**

**Substantive Pay Costs**

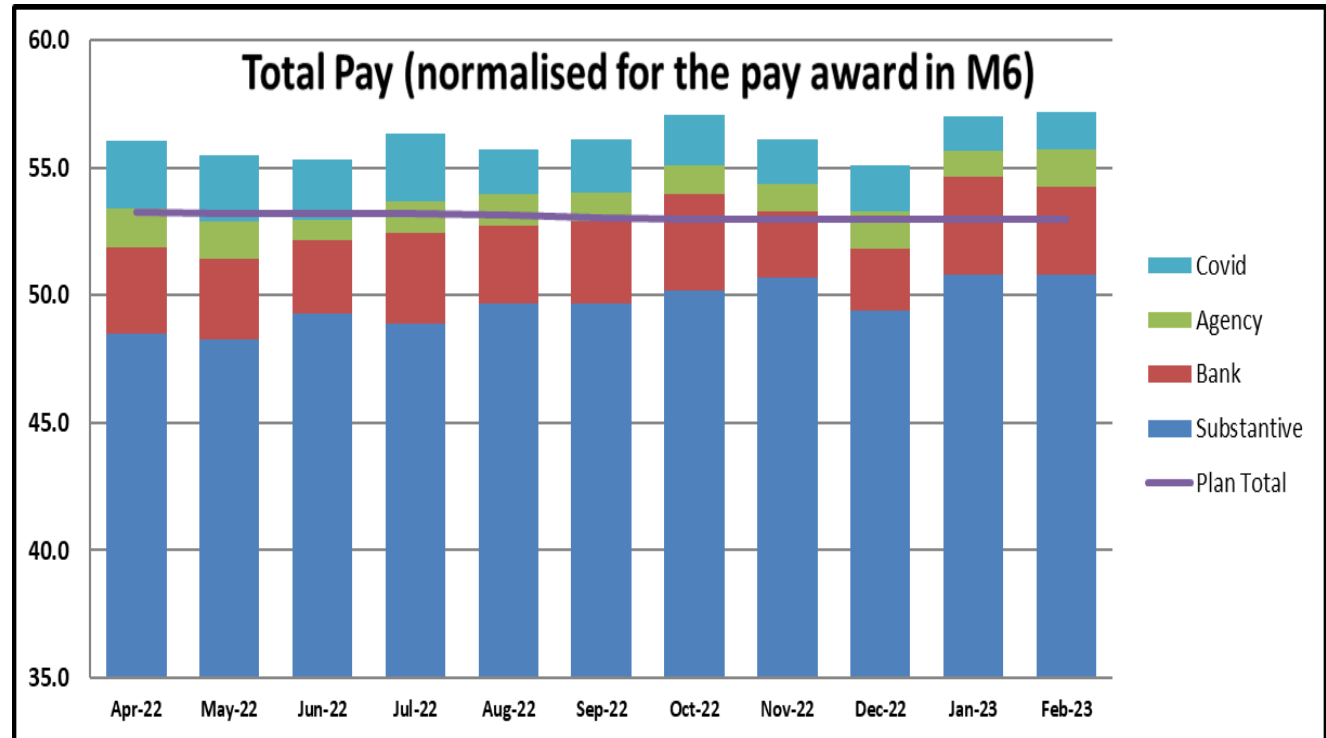
Total pay expenditure in February was £57.2m, up from January's £57.0m.

Substantive staffing payments have been flat in month, continuing at a rate consistent with two of the last three months.

The in month increase in costs has been driven by increased Agency expenditure (partly offset by reductions in Bank spend) and covid related costs.

Despite the higher fill rate of substantive staffing across the organisation, a commensurate drop in temporary staffing has not materialised at an equivalent level.

Staff costs are over plan £29.3m YTD for which £16m relates to pay award costs not within plan but largely funded. The residual £13m is due mainly to operational and covid related pressures meaning temporary staffing costs have remained even though substantive costs have increased over the year.

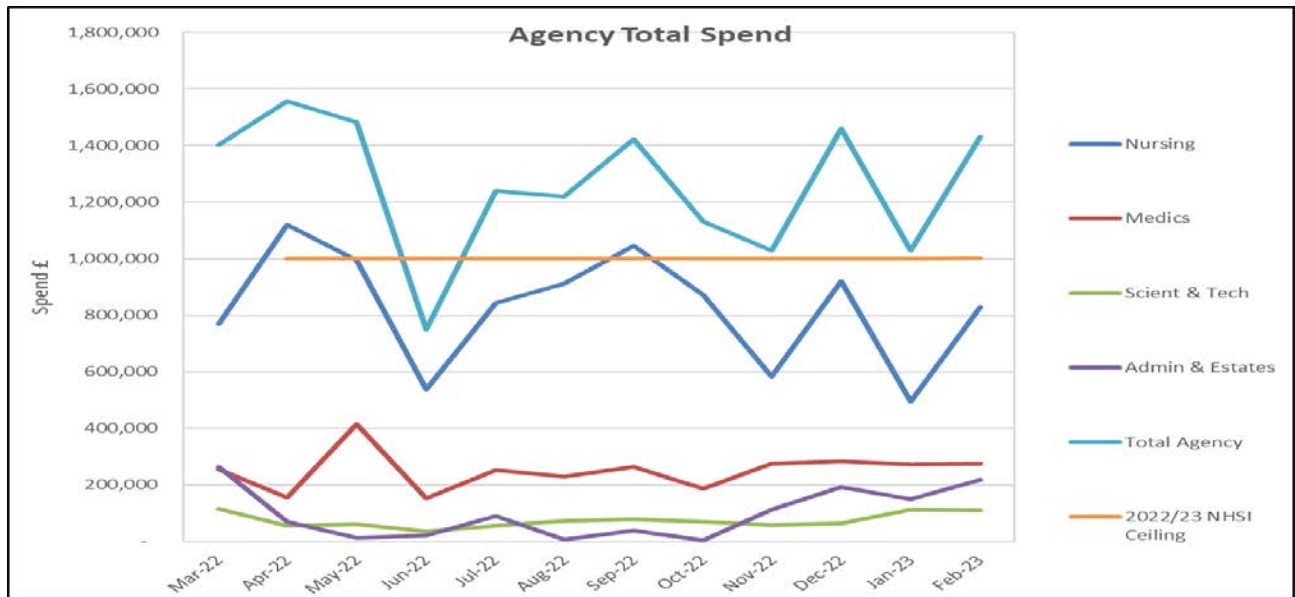
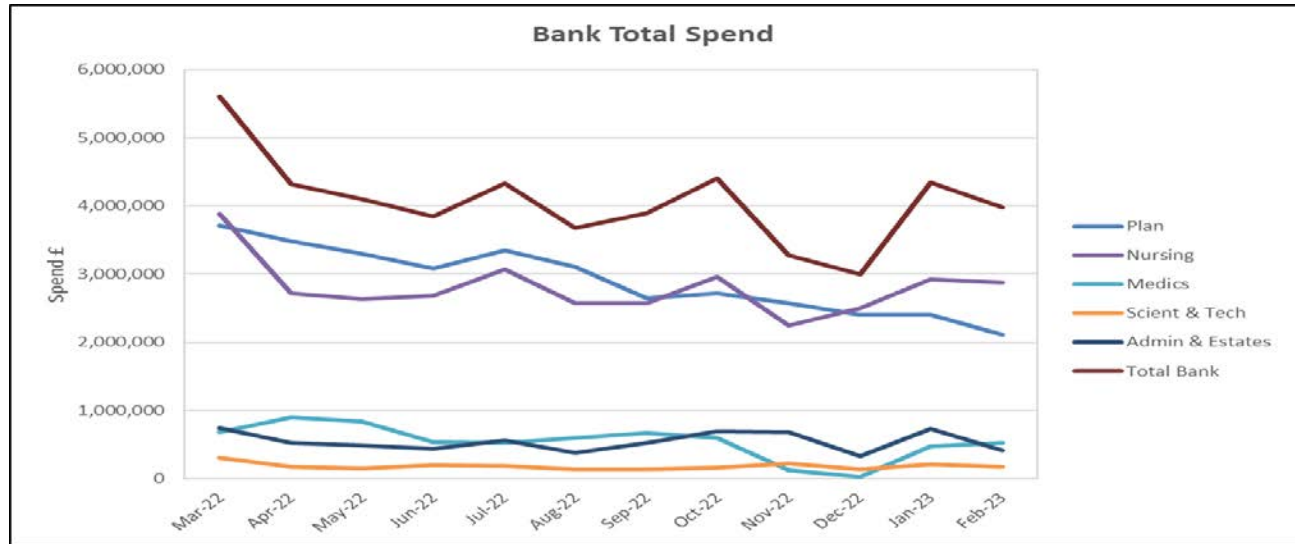


Temporary Staff Costs

Expenditure on Bank staff reduced by £0.4m from January to £4.0m in month. The decrease was driven predominantly by reductions in administrative and estates staffing in month of £0.3m. In month spend is £58k above the average YTD, with Nursing being £189k above its average run rate.

Agency spend increased by £0.4m. The majority of the change related to increased nursing agency spend of £0.3m in month. In month spend is £0.2m above the average run rate, with administrative and estates driving the increase by £147k above its average.

Spend is above the 22/23 agency ceiling, however remains comparably lower than other similar sized trusts. Reducing agency spend remains a focus area for the Trust Savings Group (TSG).





## Covid Costs 22/23

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

YTD costs are £24.0m which is £5.0m ahead of plan. This is due to Critical Care and ED additional capacity and costs which are reporting £7.5m of costs in excess of plan.

All areas of spend are under continuous review especially those associated with national guidance changes.

Alternatively for some areas where an ongoing need has been identified discussions with commissioners have taken place to explore recurrent funding sources. Critical care is the main example of this with NHSE supporting £1.5m in recurrent funding increase from 22/23.

ED remains a particular concern as demand remains much higher than pre-Covid levels.

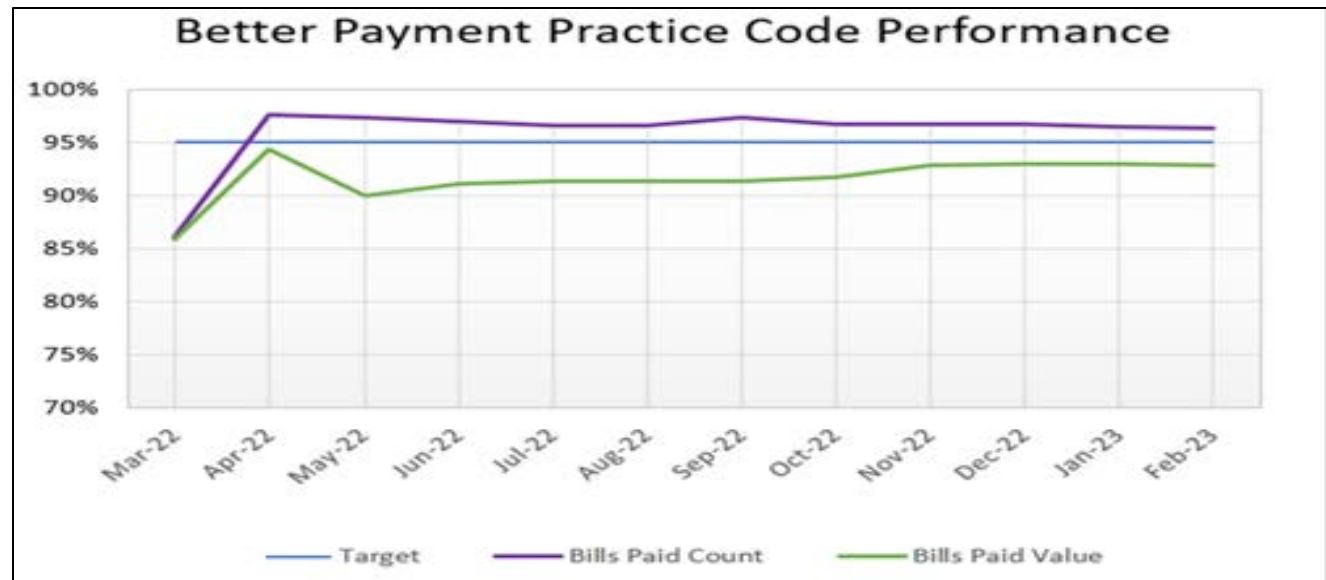
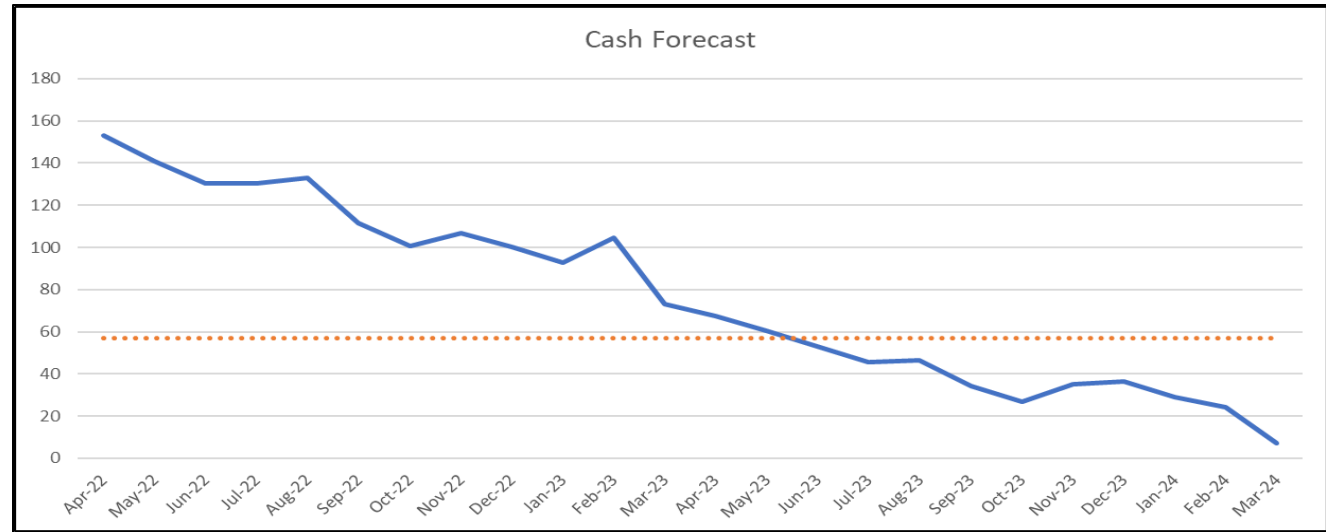
Description	2022/23 Annual Plan (£'000)	2022/23 YTD Plan (£'000)	2022/23 YTD Actual (£'000)	2022/23 YTD Variance (£'000)
Covid Related Staff Sickness / Absence	9,123	8,363	7,016	1,347
Critical Care Additional Capacity	4,914	4,505	8,150	(3,646)
Emergency Department Additional Costs	1,800	1,650	5,542	(3,892)
Car Parking Income - Patients / Visitors	1,320	1,210	1,210	0
Additional Cleaning / Decontamination	812	744	773	(29)
C5 uplift to L2 facility for 12 beds for Covid	480	440	440	0
Staff / High Risk Patient Covid Testing	500	458	210	248
PPE / Perso Hoods and Consumables	320	293	12	281
Staff Psychology Support	200	183	41	142
Car Parking Income - Staff	183	168	168	0
Clinical Engineering	138	127	0	127
Covid Medical Model (Div B)	115	105	105	0
PAH Theatres social distancing	108	99	0	99
Infection Control Team	107	98	18	80
Other (sub £100k plans)	694	636	358	278
<b>TOTAL</b>	<b>20,813</b>	<b>19,079</b>	<b>24,042</b>	<b>(4,964)</b>

Cash

The cash balance increased by £11.5m in February to £104.4m and is analysed in the movements on the Statement of Financial Position.

A cash forecast has been completed for the next 12 months projecting a material decline in cash driven by an underlying deficit and sizeable internally funded capital programme of £48m per annum. This is currently based on the draft plan submission for 2023/24.

BPPC in month for February is over the 95% target at 96.48%, (January 96.49%) for count of invoices and now below target for value at 93.02% (January 93.03%). With a small decrease in February our YTD position still shows a similar stable position with improvement needed to reach the 95% target for value.



Capital Expenditure

(Fav Variance) / Adv Variance

Expenditure on capital schemes was £63.7m for the year to Month 11. The total expenditure in the month was £9.3m. In month expenditure was high in informatics, where large hardware orders were delivered (£3.2m), the construction of the two new wards (£2.6m) and the refurbishment of theatres 10 & 11, as this nears completion (£2.3m).

£24.0m needs to be spent in March in order for the trust to hit it's forecast target. £11.3m of this relates to the Siemens Managed Service contract where 5 MRI scanners are being acquired. Notably, £2.6m remains to be spent on the strategic maintenance budget, £2.5m on informatics and £2.2m on other equipment.

To ensure UHS spends its agreed allocation for the year, arrangements have been made to bring forward the purchase of equipment that would have been purchased in the 2023-24 financial year into the current financial year.

Scheme	Month			Year to Date			Full Year Forecast		
	Plan £000's	Actual £000's	Var £000's	Plan £000's	Actual £000's	Var £000's	Plan £000's	Actual £000's	Var £000's
<b>Internally Funded Schemes</b>									
<b>Estates</b>									
Strategic Maintenance	1,266	1,078	188	6,891	4,309	2,582	7,185	6,958	227
Refurbish of neuro theatres 1 & 2	0	77	(77)	730	3,409	(2,679)	1,800	3,409	(1,609)
Decorative Improvements/Small Projects/Fire/DDA	144	6	138	733	115	618	950	568	382
General Refurbishment Fund	352	0	352	805	160	645	1,097	1,135	(38)
NICU Pendants	0	(36)	36	528	703	(175)	528	703	(175)
Theatres 10 & 11/F level Fit Out	965	2,291	(1,326)	4,035	5,187	(1,152)	5,000	5,277	(277)
Oncology Centre Ward Expansion Levels D&E	1,585	2,587	(1,002)	6,389	8,431	(2,042)	8,000	10,195	(2,195)
Fit out of C Level VE (MRI) Capacity	0	(1)	1	6,592	3,655	2,937	6,592	4,045	2,547
PICU Side Rooms	0	(32)	32	1,203	1,201	2	1,203	1,201	2
Donated Estates Schemes	63	569	(506)	3,759	1,577	2,182	5,327	4,671	656
<b>Information Technology</b>									
Information Technology Programme	550	1,316	(766)	4,500	5,000	(500)	5,000	5,000	0
Pathology Digitisation	42	26	16	393	416	(23)	448	448	0
<b>Equipment</b>									
IMRI	0	0	0	1,300	323	977	1,300	358	942
Medical Equipment panel (MEP)	375	263	112	1,875	2,105	(230)	2,500	3,341	(841)
Purchased Equipment / Lease Buyouts	37	132	(95)	430	512	(82)	500	760	(260)
Divisional Equipment	37	116	(79)	429	334	95	500	523	(23)
Donated Equipment	53	0	53	265	0	265	350	50	300
Subsidiaries Equipment	17	0	17	187	11	176	200	461	(261)
Surgical Robot	0	590	(590)	0	590	(590)	0	590	(590)
<b>Other</b>									
Other	0	72	(72)	691	1,415	(724)	691	2,072	(1,381)
Slippage	(1,000)	0	(1,000)	(4,780)	0	(4,780)	(4,681)	0	(4,681)
Donated Income	(158)	(596)	438	(5,017)	(1,993)	(3,024)	(6,760)	(5,379)	(1,381)
<b>Total Trust Funded Capital excl Finance Leases</b>	<b>4,328</b>	<b>8,457</b>	<b>(4,129)</b>	<b>31,938</b>	<b>37,461</b>	<b>(5,523)</b>	<b>37,730</b>	<b>46,386</b>	<b>(8,656)</b>
<b>Leases</b>									
Medical Equipment Panel (MEP) - Leases	37	0	37	429	309	120	700	309	391
Equipment leases	105	0	105	525	197	328	500	300	200
IISS	0	0	0	785	167	618	3,115	1,370	1,745
Fit out of C Level VE (MRI) Capacity	0	0	0	0	0	0	5,619	2,969	2,650
<b>Total Trust Funded Capital Expenditure</b>	<b>4,470</b>	<b>8,457</b>	<b>(3,987)</b>	<b>33,677</b>	<b>38,134</b>	<b>(4,457)</b>	<b>47,664</b>	<b>51,334</b>	<b>(3,670)</b>
Disposals	0	0	0	0	(217)	217	0	(217)	217
Capital to Revenue Adjustment	0	0	0	0	0	0	0	332	(332)
Transfer to external Schemes	0	0	0	0	0	0	0	(3,785)	3,785
<b>Total Including Technical Adjustments</b>	<b>4,470</b>	<b>8,457</b>	<b>(3,987)</b>	<b>33,677</b>	<b>37,917</b>	<b>(4,240)</b>	<b>47,664</b>	<b>47,664</b>	<b>0</b>

Capital Expenditure

(Fav Variance) / Adv Variance

M11 expenditure against the £26.8m of capital schemes that are funded by additional (external) capital awards by NHSI related to informatics funding streams (mainly frontline digitisation). Expenditure against the externally funded equipment will be accounted for in month 12.

Scheme	Org	Month			Year to Date			Full Year Forecast		
		Plan £000's	Actual £000's	Var £000's	Plan £000's	Actual £000's	Var £000's	Plan £000's	Actual £000's	Var £000's
Maternity Care System (Wave 3 STP)	UHS	0	0	(0)	89	89	(0)	89	89	0
Digital Outpatients (Wave 3 STP)	UHS	50	193	(143)	542	374	168	592	472	120
Oncology Centre Ward Expansion Levels D&E	UEL	0	0	0	0	10,000	(10,000)	0	10,000	(10,000)
Neonatal Expansion	UHS	0	119	(119)	0	199	(199)	0	249	(249)
Targeted Lung Health Checks CT Scanner	UHS	0	0	0	0	0	0	0	0	0
Pathology Digitisation	UHS	0	20	(20)	0	211	(211)	0	250	(250)
Community Diagnostic Centre Phase 2	UHS	0	0	0	0	0	0	0	3,200	(3,200)
Asceptic Pharmacy Building	UHS	0	0	0	0	0	0	0	1,000	(1,000)
Frontline Digitisation	UHS	0	1,648	(1,648)	0	1,648	(1,648)	0	3,945	(3,945)
Cyber Security	UHS	0	0	0	0	0	0	0	118	(118)
MRI Scanner	UHS	0	0	0	0	0	0	0	2,000	(2,000)
Nasendoscopy system for Cancer ENT/Head & Neck	UHS	0	0	0	0	0	0	0	88	(88)
CT Scanner	UHS	0	0	0	0	0	0	0	1,560	(1,560)
Breast Screening Equipment	UHS	0	0	0	0	0	0	0	36	(36)
Transfer from schemes within CDEL	UHS	0	0	0	0	0	0	0	3,785	(3,785)
<b>Total Externally Funded Schemes</b>		<b>50</b>	<b>1,980</b>	<b>(1,930)</b>	<b>631</b>	<b>12,521</b>	<b>(11,890)</b>	<b>681</b>	<b>26,792</b>	<b>(26,111)</b>
<b>Total CDEL Expenditure</b>		<b>4,520</b>	<b>10,451</b>	<b>(5,931)</b>	<b>34,308</b>	<b>50,438</b>	<b>(16,130)</b>	<b>48,345</b>	<b>74,456</b>	<b>(26,376)</b>
<b>Outside CDEL Limit</b>										
Adanac Park Car Park	UHS	0	(1,378)	1,378	0	13,022	(13,022)	0	13,022	(13,022)
Surgical Robot Lease Element	UHS	0	265	(265)	0	265	(265)	0	265	(265)
<b>Total Capital Expenditure</b>		<b>4,520</b>	<b>9,338</b>	<b>(4,818)</b>	<b>34,308</b>	<b>63,724</b>	<b>(29,416)</b>	<b>48,345</b>	<b>87,743</b>	<b>(39,398)</b>

Statement of Financial Position

(Fav Variance) / Adv Variance

The January statement of financial position illustrates net assets of £544.6m, an increase of £16.2m.

The underlying cause of the increase is cash of £11.5m and fixed assets of £6.3m.

£5.0m cash has been received in month relating to Elective Recovery Fund clinical income. Additionally £13.2m of PDC funding has been received relating to externally funded capital for which much of the spend has yet to be incurred.

Movements in fixed assets are in line with the capital program activity for the organisation, as investment is made in the Trust infrastructure.

There are movements with receivables and payables, with a net decrease of £1.1m which is due to the timing of invoice receipts and payments.

Statement of Financial Position	2021/22 YE Actuals £m	2022/23		
		M10 Act £m	M11 Act £m	MoM Movement £m
Fixed Assets	471.9	553.0	559.3	6.3
Inventories	17.0	17.1	16.8	(0.4)
Receivables	53.1	73.5	93.2	19.7
Cash	148.1	92.9	104.4	11.5
Payables	(204.2)	(196.1)	(216.9)	(20.8)
Current Loan	(1.7)	(1.7)	(2.0)	(0.2)
Current PFI and Leases	(9.1)	(10.3)	(10.2)	0.1
<b>Net Assets</b>	<b>475.0</b>	<b>528.4</b>	<b>544.6</b>	<b>16.2</b>
Non Current Liabilities	(23.0)	(20.5)	(21.5)	(1.0)
Non Current Loan	(6.8)	(5.6)	(5.6)	0.0
Non Current PFI and Leases	(33.6)	(95.9)	(93.8)	2.2
<b>Total Assets Employed</b>	<b>411.6</b>	<b>406.4</b>	<b>423.8</b>	<b>17.4</b>
Public Dividend Capital	261.9	273.0	286.2	13.2
Retained Earnings	115.6	99.3	103.4	4.1
Revaluation Reserve	34.1	34.1	34.1	0.0
Other Reserves				
<b>Total Taxpayers' Equity</b>	<b>411.6</b>	<b>406.4</b>	<b>423.7</b>	<b>17.4</b>

**UHS Total** - £44.8m identified, 98% of the total 22/23 requirement which = £45.4m

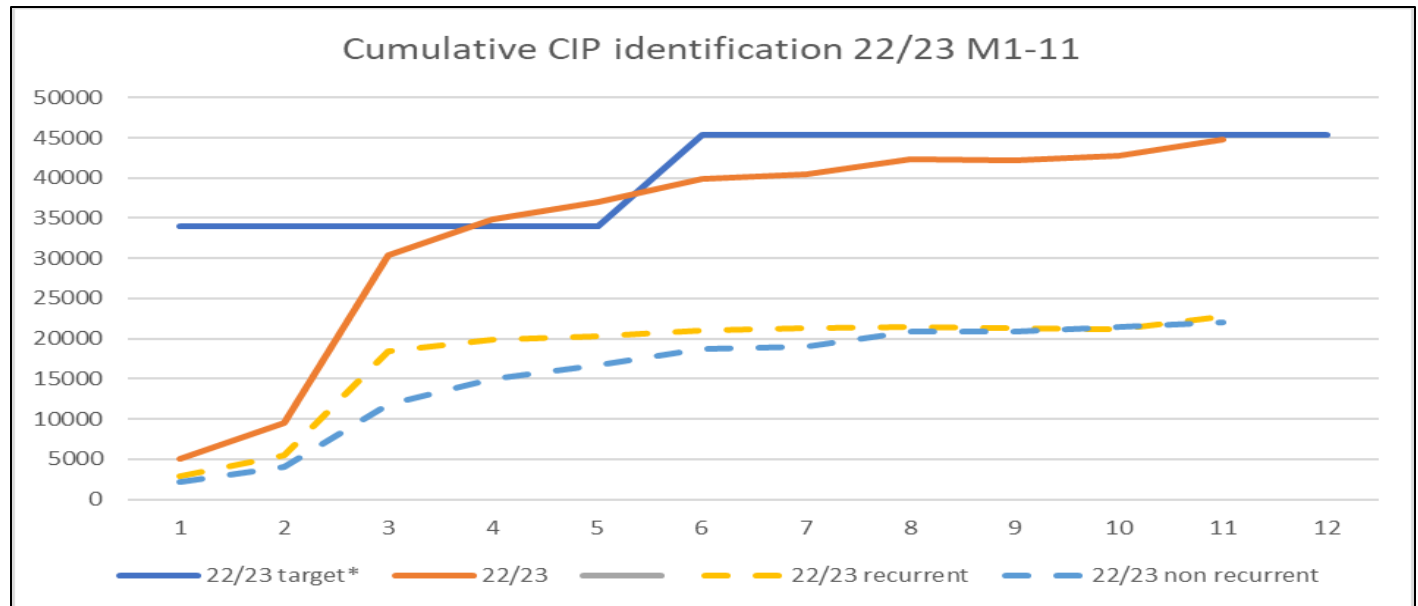
**Divisions and Directorates** - £18.7m of CIP schemes identified. This represents 94% of it's 22/23 target which = £20m

**Central Schemes** - £26.1m of CIP schemes identified. This represents 103% of the 22/23 target which = £25.4m

Of the identified UHS total, £9.1m is Pay, £28m is Non-Pay, and £7.7m is Income

Divisional identification varies from 81% to 100%

Month 11 CIP Identification	Non Recurrent ('000s)	Recurrent ('000s)	Total ('000s)	Target ('000s)	% Identified
Division A	£2,785	£1,482	£4,267	£4,260	100%
Division B	£2,386	£2,042	£4,481	£5,535	81%
Division C	£3,170	£673	£3,843	£3,938	92%
Division D	£1,228	£2,261	£3,489	£3,573	98%
THQ	£977	£1,653	£2,630	£2,695	98%
Central Schemes	£11,422	£14,675	£26,097	£25,400	103%
<b>Grand Total</b>	<b>£21,968</b>	<b>£22,786</b>	<b>£44,807</b>	<b>£45,400</b>	<b>98%</b>



M11 Trust YTD delivery is £38.7m, an increase from the £33m achieved at M10

Our £38.7m delivery YTD is below our planned YTD activity of £39.9m

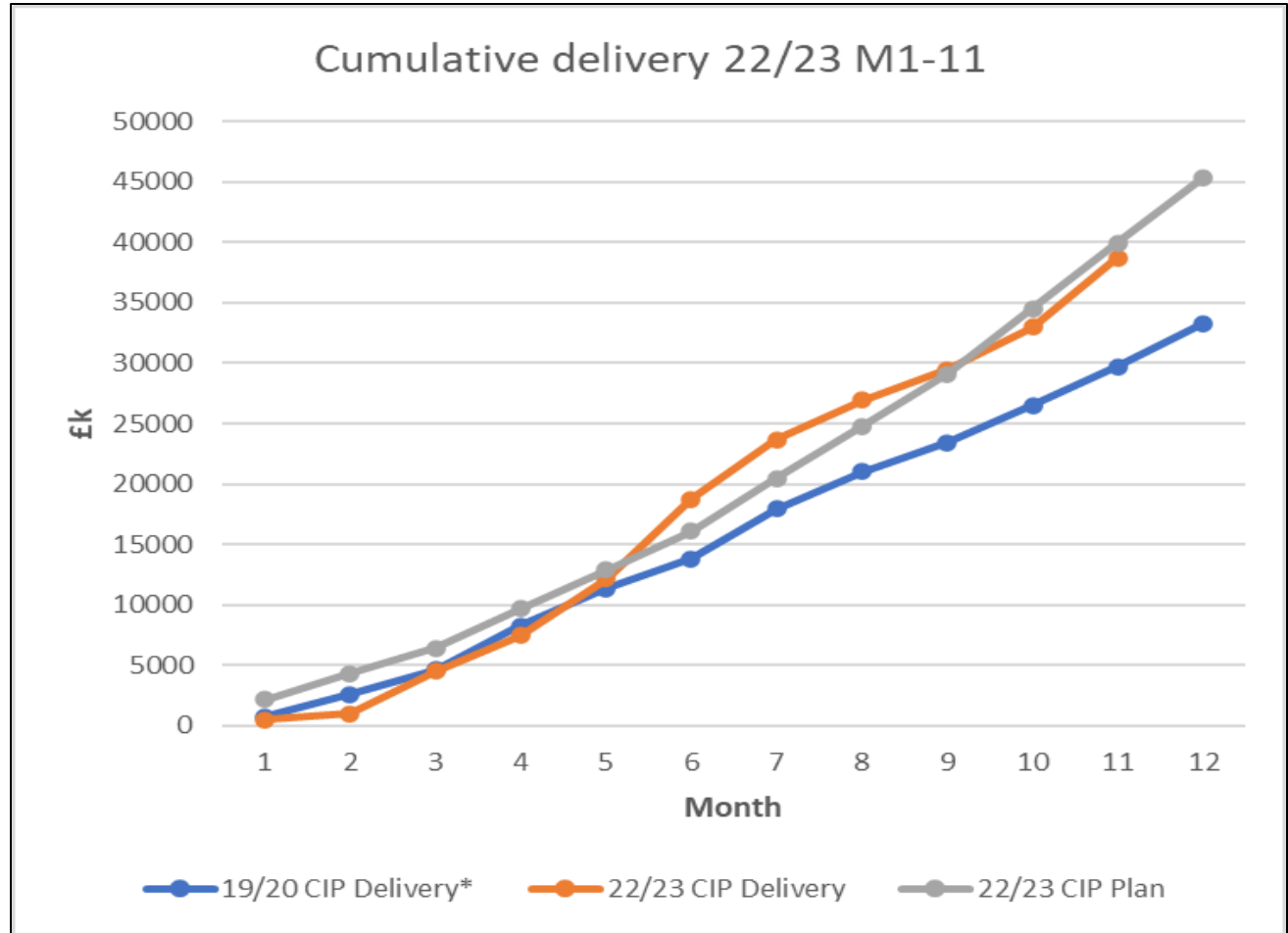
Of the £38.7m delivered YTD:

- £16.6m has been transacted by Divisions and Directorates

- £22.1m has been transacted through Central Schemes

Of the trust YTD achievement, £20m is non-recurrent.

This includes £10.5m of non-recurrent Central Schemes.



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

Report to the Trust Board of Directors				
<b>Title:</b>	<b>People Report 2022-23 Month 11</b>			
<b>Agenda item:</b>	<b>4.10</b>			
<b>Sponsor:</b>	<b>Steve Harris, Chief People Officer</b>			
<b>Author:</b>	<b>Workforce Team</b>			
<b>Date:</b>	<b>30 March 2023</b>			
<b>Purpose</b>	<b>Assurance or reassurance</b> X	<b>Approval</b>	<b>Ratification</b>	<b>Information</b> X
<b>Issue to be addressed:</b>	<p>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.</p> <p>Its key areas of THRIVE, EXCEL, and BELONG shape the work of people focus across UHS.</p> <p>The Monthly People report summarises progress against the delivery of the key metrics in the strategy. It is provided monthly to Trust Executive Committee and People and OD committee. The report is based on February 2023 data.</p>			
<b>Response to the issue:</b>	<p>The Chief People Officer can report the following to the Board.</p> <p>It should be noted the style of the report is due to be refreshed once our new workforce plan is agreed upon and target metrics established for 2023/24.</p> <p><b>THRIVE (Our workforce supply)</b></p> <p>Our overall workforce (Temp and Perm) continues to be above our planned workforce levels. Our overall total workforce is currently 13,243 WTE, which is 816 WTE above plan.</p> <p>Specifically:</p> <ul style="list-style-type: none"> <li>• <b>The substantive workforce has grown by +685 WTE YTD.</b> This is +365 WTE over plan at Month 11.</li> <li>• This is as a result of successful recruitment to vacancies (existing gaps and funded capacity growth)</li> <li>• <b>However temporary staffing has not fallen in line with plan.</b> Overall temporary staffing usage has remained broadly static.</li> <li>• During 22/23 temporary workforce demands have been driven by:</li> </ul>			



- **COVID** impact beyond planned activity.
- **Higher levels of sickness absence** (4.44% rolling 12 month) than anticipated and still above pre-covid levels
- **Significant unfunded capacity demands** from staffing surge capacity and from the 200 or so MOFD patients we are unable to discharge.
- Consistent **higher emergency demand** during the year.
- Other operational pressures to deliver reductions in our **weight times for elective patients**
- Impact of **Industrial Action** in January, February and March
- The Board have been advised that, due to these factors, **we will not hit our overall workforce plan** for 22/23.
- Our workforce planning for 23/24 aims **to deliver a flat position with no overall growth** in the size of our total WTE. This will include continued recruitment to vacancies and new expansions offset by decreases in the use of agency and bank and other targeted reductions.
- Our workforce planning aligns with our financial position and also with the clear directions from national, regional, and ICB leadership on overall workforce growth.
- Our efforts on workforce will focus in 2023/24 on:
  - Targeted recruitment to key vacancies with sensible controls on non-clinical replacements and new posts
  - Review of our overall establishment levels to ensure affordability.
  - Efforts to further reduce sickness absence through improving prevention measures, a range of wellbeing measures, and appropriate review of low levels of attendance.
  - The recruitment and retention committee will continue to lead on efforts to reduce attrition.
  - Targeted discrete reductions in posts through CIP plans.

### **EXCEL (Career growth, reward, well-being)**

In a future-challenged financial environment, it remains critical as part of our people strategy to ensure we still focus on helping our staff to excel in post.

- In the month recorded appraisal completion **has increased slightly again in Feb.** The overall rate is at 76% (rolling 12 months). The importance of a quality conversation on development, progress, well-being and career remains a critical part of our people strategy. It is still felt that appraisals are not always being logged on ESR in a timely manner, under stating our overall appraisal position.
- We have fully recruited to a **new senior Leadership programme commencing in May 2023.** 24 Senior leaders from across the Trust will be given access to a high quality

	<p>development programme to support the continued growth of compassionate inclusive leadership across the Trust</p> <ul style="list-style-type: none"> <li>• The OD team have <b>launched a leadership framework</b> which brings together all of our management and leadership development interventions. This provides support to our leaders at first line and operational, and senior management level.</li> <li>• A leadership development day has been run for our Care Group Managers, a critical part of our UHS family.</li> </ul> <p><b>BELONG (Equality, Diversity, Inclusion, Culture)</b></p> <p>Driving a culture of compassion and inclusion remains critical at UHS. We continue to strive for a place where everyone feels they belong. Specifically, we can report that:</p> <ul style="list-style-type: none"> <li>• <b>Our national staff survey results place</b> us well for 'recommendation as a place to work'. We are 1<sup>st</sup> in the South East and 7<sup>th</sup> Nationally. This is despite a decline at UHS broadly in line with overall national trends. The report is subject to discussion at People and OD committee and is on the Agenda for Board</li> <li>• Our <b>new positive action programme</b>, aimed at improving our diversity of leadership in senior positions, has been fully recruited and commences on 31 March 2023.</li> <li>• The number of staff at <b>Band 7 from non-white backgrounds</b> has continued to grow this year. However, our level of people at Band 7 and above who have made a declaration of a long-term illness and/or disability continues to fall slowly.</li> <li>• We have completed our <b>Gender pay gap reporting</b>. The mean gender pay gap is 23.33% The report shows a small reduction in our pay gap which has fallen by 4.8% in 5 years. The critical difference remains in senior medical positions. There is little difference in gender pay in Agenda for Change or in Junior Medical staff. The full report will be reviewed at our EDI committee with action included in our annual Inclusion and Belonging plan.</li> </ul>
<p>Implications: (Clinical, Organisational, Governance, Legal?)</p>	<p>Implications are for good governance, meeting legal requirements, and the provision of safe clinical and organisational delivery (as this report provides intelligence on current and future workforce challenges).</p>
<p>Risks: (Top 3) of carrying out the change / or not:</p>	<p>There is a risk that we fail to meet our strategic objectives as set out in the business assurance framework for UHS.</p> <p>Specifically:</p> <ul style="list-style-type: none"> <li>a) We fail to increase the UHS workforce to meet service demands</li> <li>b) We fail to develop a diverse, compassionate, and inclusive workforce providing a more positive staff experience for all staff</li> </ul>

	<p>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.</p>
Summary: Conclusion and/or recommendation	<p>Trust Board is required to:</p> <ul style="list-style-type: none"><li>• Note the feedback from the Chief People Officer and the People Report</li></ul>

# UHS People Report

March 2023



**WORLD CLASS PEOPLE**



## View from Chief People Officer



The month of February has seen fewer **appraisals** being completed compared with January 2023, and February last year, due to a combination of factors including winter pressures, annual leave, and recent industrial action. Strike action took place in February where we saw over 1300 nursing staff members and 85 physiotherapy staff members rostered for strike action. The **BMA industrial action** for junior doctors also takes place in March and we are so far seeing about 60% of our rostered junior doctors participating in strikes.

February has seen some positive outcomes. Our **sickness levels** in February were 3.5% compared to nearly 6% over a year ago, and they are at the lowest levels seen in the last 12 months. And our **substantive workforce** grew in February (by +92 WTE) compared with January due to higher levels of new starters. February also saw the fewest number of **HCA leavers** in over twelve months. Our overall **turnover** remained stable, and our **vacancies** in February have reduced from January, but we are still seeing greater than planned **temporary resourcing** usage.



**Steve Harris**  
Chief People Officer

## Workforce Summary

### HCA Supply

Currently at 19% vacancy. HCA SIP increased by +35 WTE in February

### Turnover

Fewer leavers in Feb-23 (91 WTE) compared with Jan 23 (123.5 WTE)

### Sickness

Sickness has reduced marginally to 4.4% (r12M); Flu prevalence decreased in February

### Covid-19

Over 6500 boosters have been delivered

### THRIVE

In 2022/23 YTD as of Feb, we had a substantive SIP growth of +685 WTE (Compared with Apr 22 baseline)

### EXCEL

398 appraisals were recorded in February; the lowest monthly total in 12 months

### BELONG

Proportion of our staff of BAME backgrounds at B7+ is nearly 11%

### Levels of attainment

Job plan sign off has reduced to 14%  
Medic eJP is LoA 1; close to 2

### Patient Safety

69 incident reports in February 2023 cited staffing; similar to January's 70. This is a significant decrease from the 117 in December 2022

### Other contextual updates

Establishment and budget review commenced in March 2023 via Trust Savings Group

### NHS England and Improvement Operational Planning Update

Penultimate workforce numerical return submitted on 9 March; final submission due 16 March

# People Report

THRIVE

EXCEL

BELONG

PATIENT SAFETY



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

## 1. THRIVE

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

Relevant information:

**Staff in Post | Workforce Plan 2022/23 | Temporary resourcing | Turnover | Sickness absence**

# People Report

THRIVE

EXCEL

BELONG

PATIENT SAFETY

## Staff in Post Commentary

Month 10 to 11 (January to February) 2022/23 saw an increase of substantive employed staff (+92 WTE), and a reduction of bank staff (-107 WTE) and agency staff (-7 WTE).

The substantive staffing continues to increase this financial year by +685 WTE staff. The staff groups with most growth are Admin and Clerical due to strong domestic recruitment activity, Medical and Dental due to increased numbers of Junior doctors allocated from HEW and consistent consultant SIP growth, HealthCare scientists due to a TUPE of Salisbury staff to UHS, and Nursing and Midwifery staff due to the successes of the overseas nursing and apprenticeship programmes during the last year. This growth has filled existing vacancies within budgets with only a moderate increase in establishment of (~300 WTE), leading to a decrease in our vacancy position (pg. 14).

Bank and agency usage has remained constant throughout the year (with a dip in December) but planned decreases in reliance on this resource have not been realised, whilst demand for this remains high, driving the continue high usage. The temporary resourcing team continue to target areas of high usage and off-framework agencies breaches.



# People Report

THRIVE

EXCEL

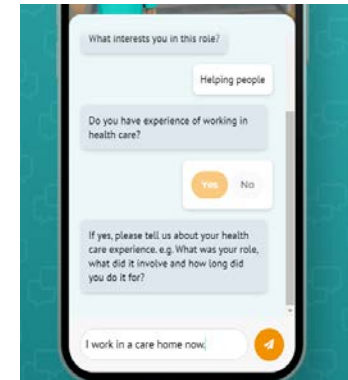
BELONG

PATIENT SAFETY

## Spotlight on... Recruitment

We have recently been adopting technology to attract and recruit talent to UHS. One example of this is the 'Talk and Job' app, which is a unique application process being trailed for HCA recruitment. It is optimised for mobile phones, there are elements of gamification, and it is aligned to our essential personal specification criteria.

We have also been hosting virtual career events branded with UHS, with social advertising linking to our unique landing pages. Our NQN event had over 130 attendees with positive feedback.



# People Report

THRIVE

EXCEL

BELONG

PATIENT SAFETY

## Monthly Staff in Post (WTE) for 2022/23

	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M7 (Oct)	M8 (Nov)	M9 (Dec)	M10 (Jan)	M11 (Feb)	M12 (Mar)	YTD Growth	Sparkline Trend
Add Prof Scientific and Technic	392	395	377	372	369	380	384	385	380	380	381		-11	
Additional Clinical Services	2009	2029	2055	2047	2053	2042	2052	2066	2052	2071	2098		88	
Administrative and Clerical	2119	2149	2164	2156	2152	2175	2182	2194	2203	2239	2249		129	
Allied Health Professionals	622	624	624	617	622	643	640	649	647	656	663		41	
Estates and Ancillary	394	391	394	399	401	406	416	416	416	417	417		23	
Healthcare Scientists	392	397	400	403	408	420	481	478	481	483	480		88	
Medical and Dental	1963	1969	1966	1961	2030	2052	2046	2043	2032	2066	2070		107	
Nursing and Midwifery Registered	3649	3682	3676	3667	3693	3762	3769	3781	3787	3815	3859		211	
Students	30	29	29	29	29	29	35	37	37	37	37		7	
Grand Total	11570	11664	11684	11651	11757	11907	12006	12050	12034	12163	12255		685	

Source: ESR substantive staff as of 28 Feb 2023; includes consultant APAs and junior doctors' extra rostered hours, excludes hosted services. Numbers relate to WTE, not headcount

# People Report

THRIVE

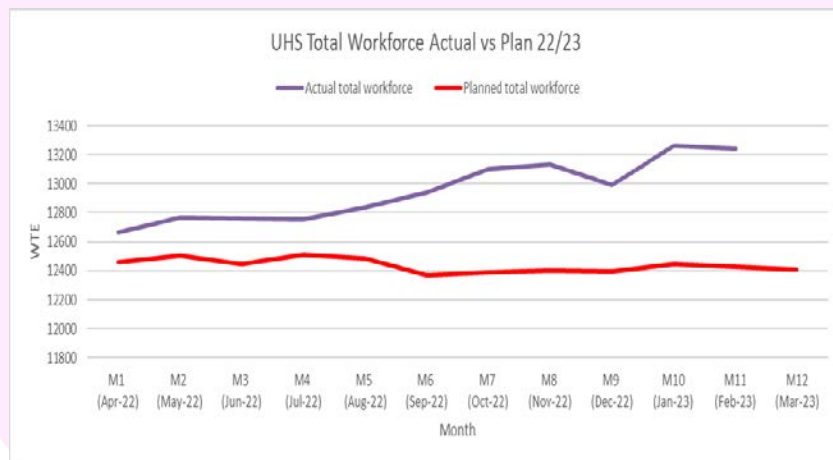
EXCEL

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PATIENT SAFETY

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

	M1 (Apr-22)	M2 (May-22)	M3 (Jun-22)	M4 (Jul-22)	M5 (Aug-22)	M6 (Sep-22)	M7 (Oct-22)	M8 (Nov-22)	M9 (Dec-22)	M10 (Jan-23)	M11 (Feb-23)	M12 (Mar-23)
Actual WTE	12664	12770	12764	12757	12819	12944	13105	13137	12993	13265	13243	
Planned WTE	12458	12506	12445	12510	12485	12371	12391	12399	12398	12446	12427	12409
Deviation from Plan	+206	+264	+319	+247	+356	+573	+714	+738	+595	+819	+816	



### Inclusions:

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

### Exclusions:

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

Source: ESR substantive staff as of 28 February 2023; ESR (Overtime & Excess Hours, WLI); NHS Professionals (bank and non-medical agency); 247 Time; HealthRoster; MedicOnline (medical bank)

# People Report

THRIVE

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## Total substantive Workforce – performance to date

	M1 (Apr-22)	M2 (May-22)	M3 (Jun-22)	M4 (Jul-22)	M5 (Aug-22)	M6 (Sep-22)	M7 (Oct-22)	M8 (Nov-22)	M9 (Dec-22)	M10 (Jan-23)	M11 (Feb-23)	M12 (Mar-23)
Actual WTE	11570	11664	11684	11651	11757	11907	12006	12050	12034	12163	12255	
Planned WTE	11570	11664	11659	11657	11688	11693	11695	11741	11785	11834	11890	11900
Deviation from Plan	+0	+0	+25	-5	+69	+214	+311	+309	+249	+329	+365	



### Inclusions:

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

### Exclusions:

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

Source: ESR substantive staff as of 28 February 2023; consultant APAs and junior doctors' extra rostered hours

# People Report

THRIVE

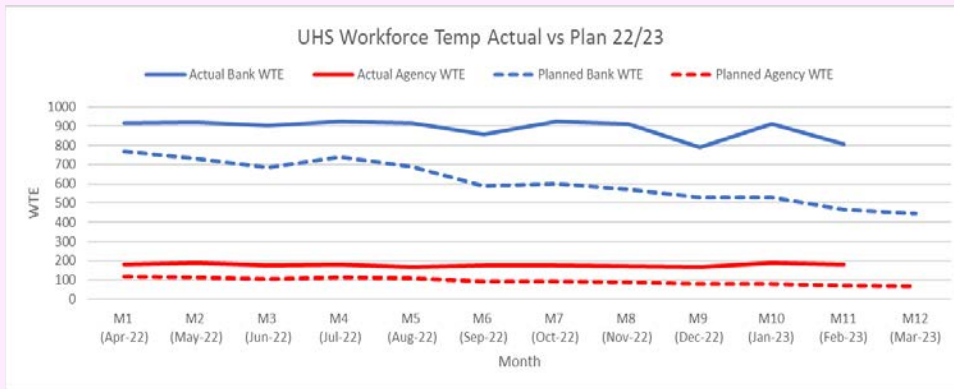
EXCEL

BELONG

PATIENT SAFETY

## Temporary Staffing – performance to date (bank and agency)

	M1 (Apr-22)	M2 (May-22)	M3 (Jun-22)	M4 (Jul-22)	M5 (Aug-22)	M6 (Sep-22)	M7 (Oct-22)	M8 (Nov-22)	M9 (Dec-22)	M10 (Jan-23)	M11 (Feb-23)	M12 (Mar-23)
Actual Bank WTE	914	920	902	924	917	859	924	913	791	914	807	
Planned Bank WTE	770	731	684	741	688	587	602	570	532	532	467	444
Deviation from Plan	+144	+189	+219	+184	+229	+273	+322	+343	+259	+382	+339	
Actual Agency WTE	179	187	178	182	167	177	174	174	168	188	181	
Planned Agency WTE	118	111	103	112	109	91	93	88	81	80	69	65
Deviation from Plan	+61	+76	+75	+70	+58	+86	+81	+86	+87	+108	+112	



### Inclusions:

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

Source: ESR (Overtime & Excess Hours, WLI); NHS Professionals (bank and non-medical agency); 247 Time; HealthRoster MedicOnline (medical bank) as of 28 February 2023

# People Report

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## TRUST-WIDE VACANCIES (February 2023)

Staffing group	Vacancy WTE	Vacancy %	
Add Prof Scientific and Technic	103.1	21.5%	↑
Additional Clinical Services	218.0	9.1%	↓
Administrative and Clerical	80.8	3.5%	↓
Allied Health Professionals	67.8	9.3%	↓
Estates and Ancillary	81.6	17.3%	↑
Healthcare Scientists	43.2	8.3%	↑
Medical and Dental	-0.5	0.0%	↓
Nursing and Midwifery Registered	401.0	9.7%	↑
<b>UHS total</b>	<b>994.9</b>	<b>7.7%</b>	↓

# People Report

THRIVE

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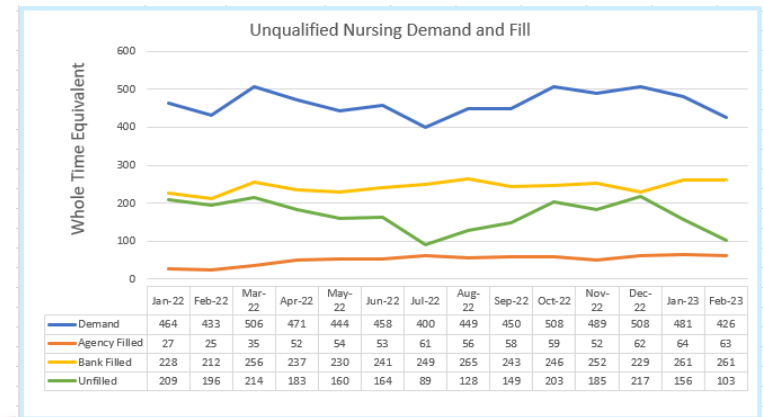
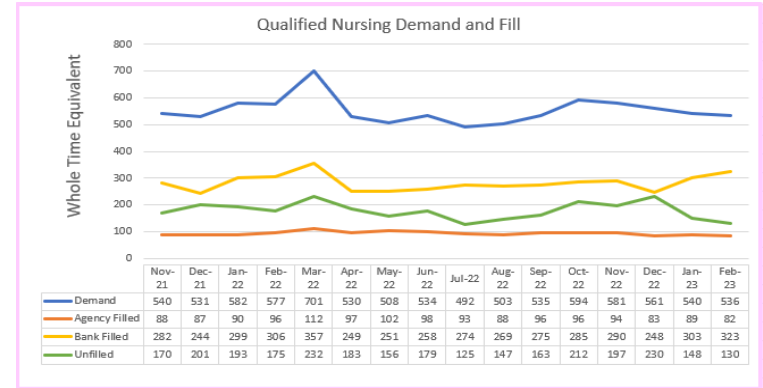
## TEMPORARY RESOURCING

### Status

- Qualified nursing demand/fill (WTE): Demand decreased from 540 WTE in January, to 536 in February, of which, bank filled 323 (20 up on last month), agency filled 82 and 130 remained unfilled
- Bank fill for qualified nursing increased from 56.10% in January to 60.33% in February.
- Demand for February 2023 is 41 WTE lower than February 2022
- HCA demand/fill (WTE): Demand decreased to 426 WTE in February, of which, bank filled 261, agency filled 63WTE (39WTE were MH HCA's) and 103 remained unfilled
- Bank fill increased from 54.22% in January, to 61.12% in February.
- Demand for HCAs 7 WTE lower than in February 2022

### Actions

- Agency switch off from HCA agreed 31<sup>st</sup> March 2023 – Agency Migration project to migrate all workers by this date.
- Winter Incentive covering January and February for all General Bank codes will not continue in to March.
- Continued demand management work to concentrate bank and agency fill to the areas with the greatest need.
- Adult Mental Health shifts centralised to the staffing hub from 1<sup>st</sup> April 2023



# People Report

THRIVE

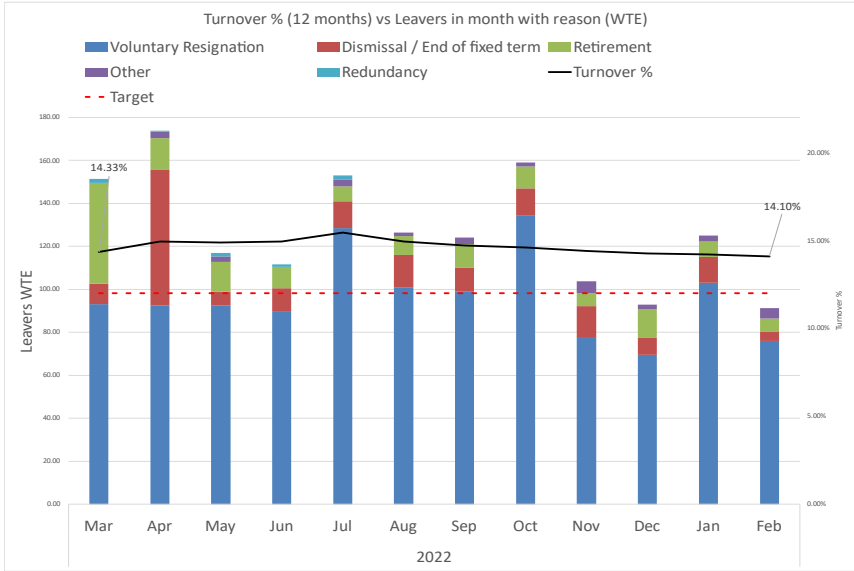
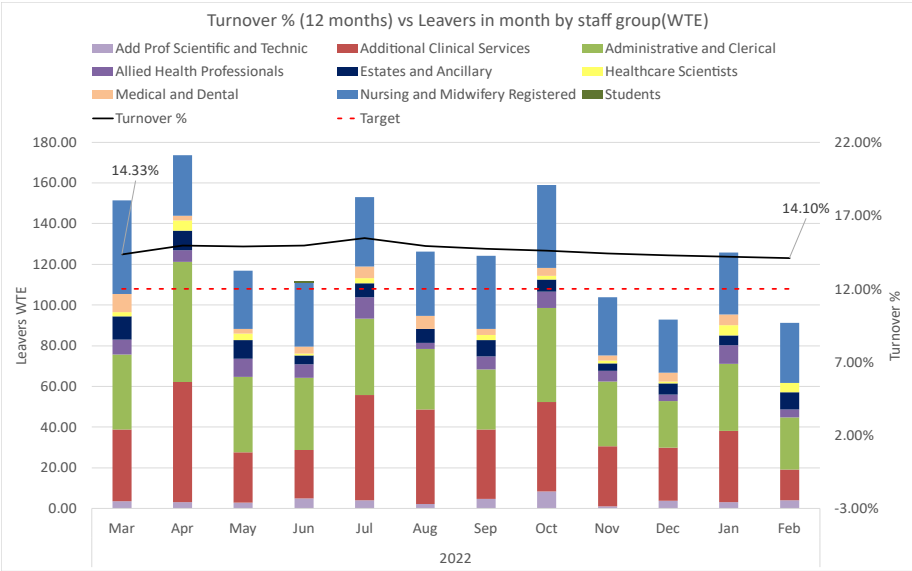
EXCEL

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## TURNOVER

Turnover has been decreasing since July 2022; in February 2023 there were 91.18 WTE leavers, which is less than in November to January. Turnover is currently 14.1% which remains higher than the trust-wide target of <12%.



Source: ESR – Leavers Turnover WTE



# People Report

THRIVE

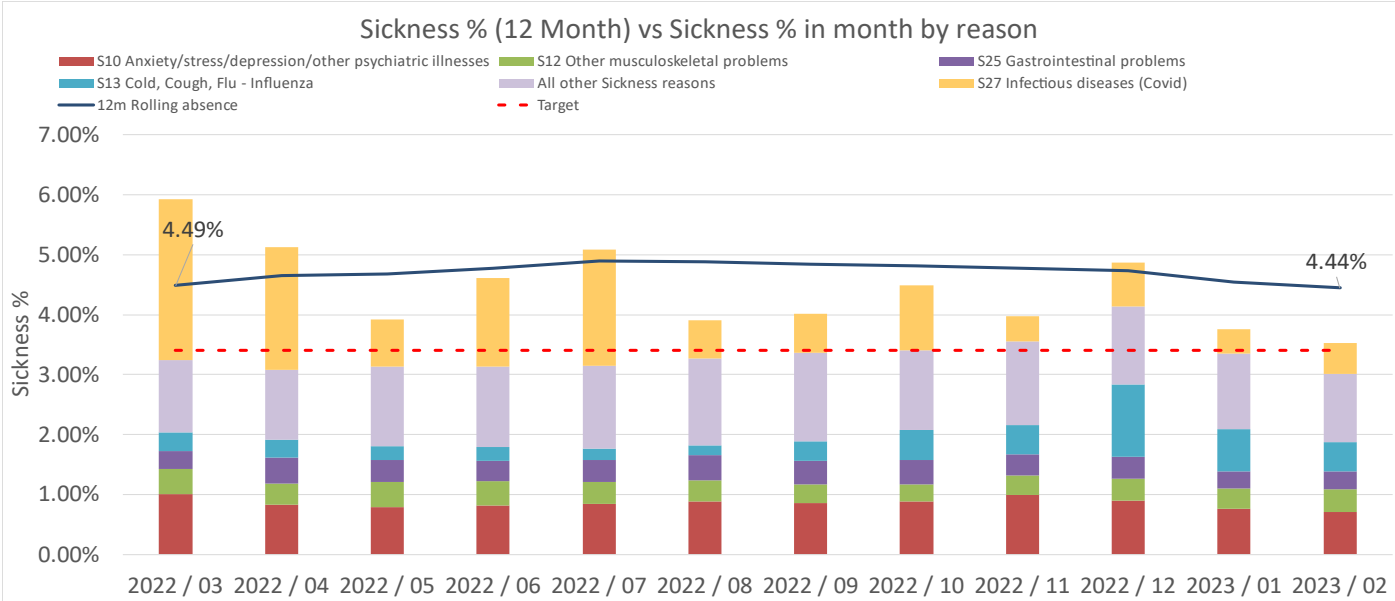
EXCEL

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## SICKNESS

The rolling sickness rate (4.44%) is lower than 12 months ago (4.49%); however, this has been reducing gradually since July 2022. The reasons for this include COVID-related sickness, flu, mental health, gastrointestinal and MSK. February in-month sickness is 3.53%. The target is being reviewed for 23/24



Source: ESR – Absence data

# People Report

THRIVE

EXCEL

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

## 2. EXCEL

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

Relevant information:

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

# People Report

THRIVE

EXCEL

BELONG

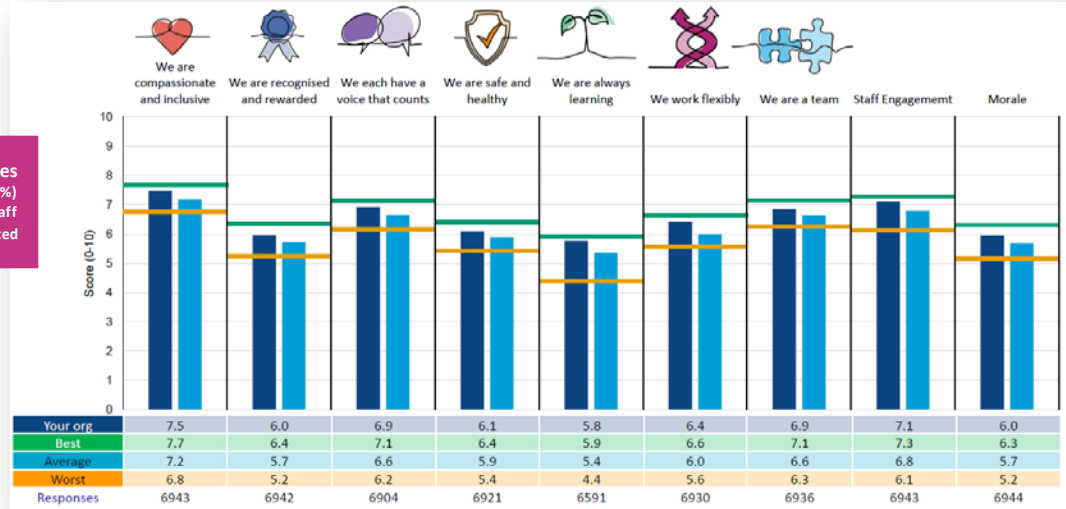
PATIENT SAFETY

## The Annual Staff Survey

- The Annual Staff Survey for 2022 opened from 28 September to 25 November 2022.
- UHS results across the People Promise themes, plus engagement and morale, can be found on the right, with a comparison to the average, best and worst trust. UHS consistently scored above average.
- UHS scored **above or the same as average** for 100 out of 111 questions (the average for 124 Acute and Acute Community trusts).
- UHS scored the highest out of all 124 Acute and Acute Community Trusts for there being opportunities to develop your career in the organisation (63.6%)



Responses  
7,023 (54.7%)  
of our staff  
participated



## Next Steps

Publish  
timeline for  
results and  
action  
planning within  
teams.  
Feb-23

Analysis of  
results and  
preparation of  
Care group  
packs.  
Feb-23

Present at  
TEC and Trust  
Board  
Mar-23

Publish results  
when embargo  
has lifted  
Mar-23

Divisional  
action  
planning takes  
place  
Apr-23  
onwards

Arrange  
Divisional  
presentations  
Jul-23

# People Report

THRIVE

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## APPRENTICESHIPS

A total of 392 staff are currently partaking in an apprenticeship programme.

There are a total of 51 different apprenticeships with 54 different training providers. These include staff working in clinical apprenticeships in nursing, ODP, Occupational Therapy and Diagnostic Radiology, Pharmacy, and non clinical including early years educator, senior leader, operations manager and HR.

The apprenticeship levy remains at £5M, with average monthly spend of £145K, and monthly contributions of £220K. We transfer some of our levy to four different small businesses to support the local community apprentices.

Division	Headcount
Division A	69
Division B	95
Division C	78
Division D	76
THQ	72
CLRN	2
<b>Grand Total</b>	<b>392</b>

# People Report

THRIVE

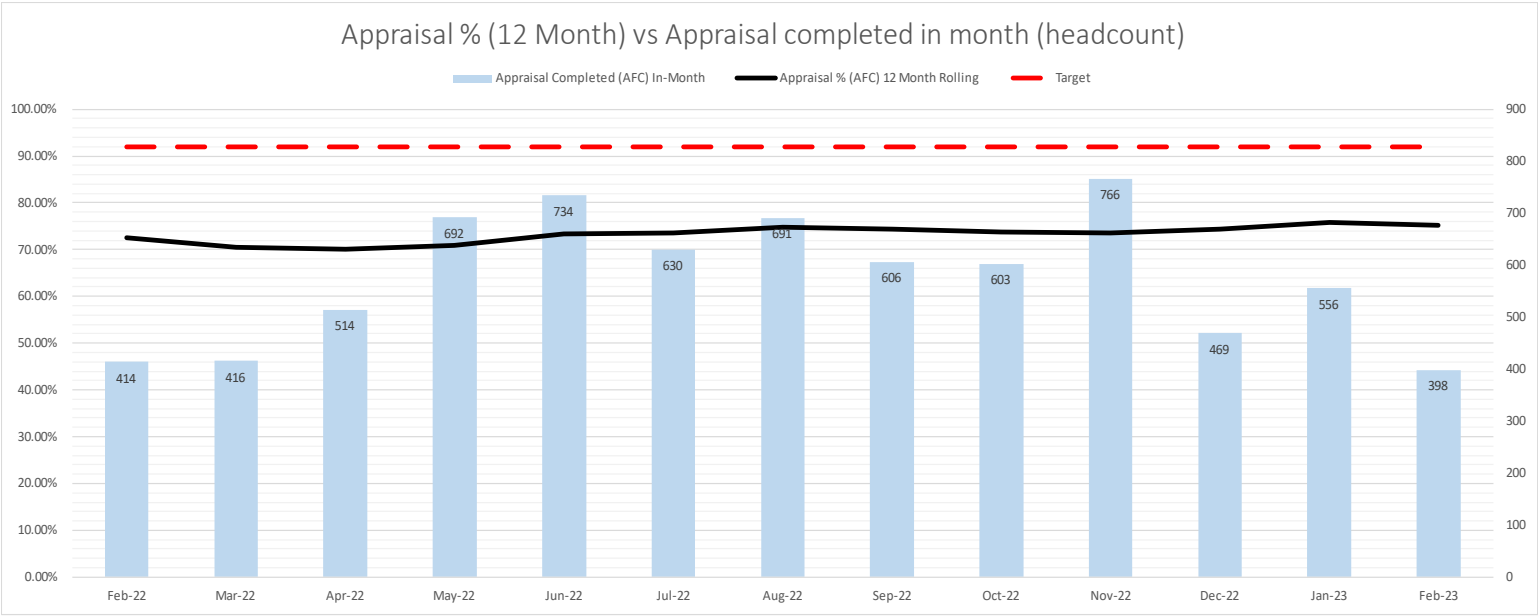
EXCEL

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## APPRAISALS

In February 2023, 398 appraisals were completed. This is lower than February 2022, and is the lowest over the last 12 months. Low appraisal completion is due to a combination of factors including winter pressures, annual leave, sickness absences, and recently Industrial Action.



Source: ESR – Appraisal data

# People Report

THRIVE

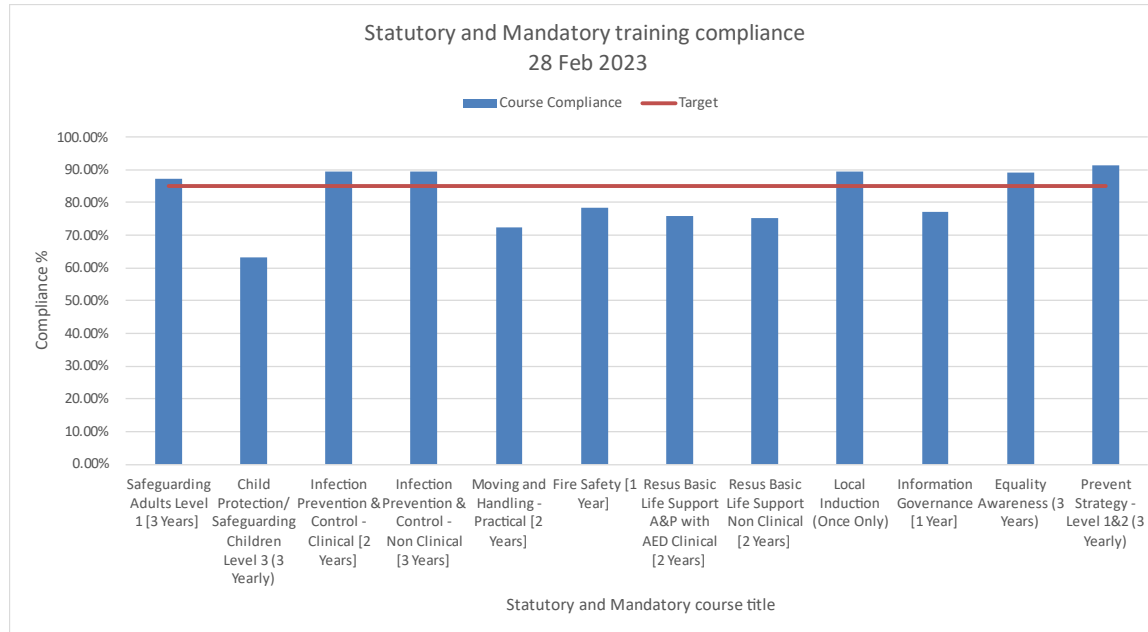
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## STATUTORY AND MANDATORY TRAINING

Statutory and Mandatory training and compliance is devolved to the clinical divisions with oversight being held by divisional education leads and flagged at the divisional governance meetings. Benchmarking statutory and mandatory training compliance with other NHS organisations is being carried out, and we are monitoring against the National Core Skills Training Framework



# People Report

THRIVE

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## BELONG

Compassionate  
and inclusive  
culture for all

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

### 3. BELONG

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

Relevant information:

**Percentage of staff employed at AfC B7+ from non-white backgrounds | Percentage of staff employed at AfC B7+ with a disability or long-term condition | Gender Pay Gap 2022**

# People Report

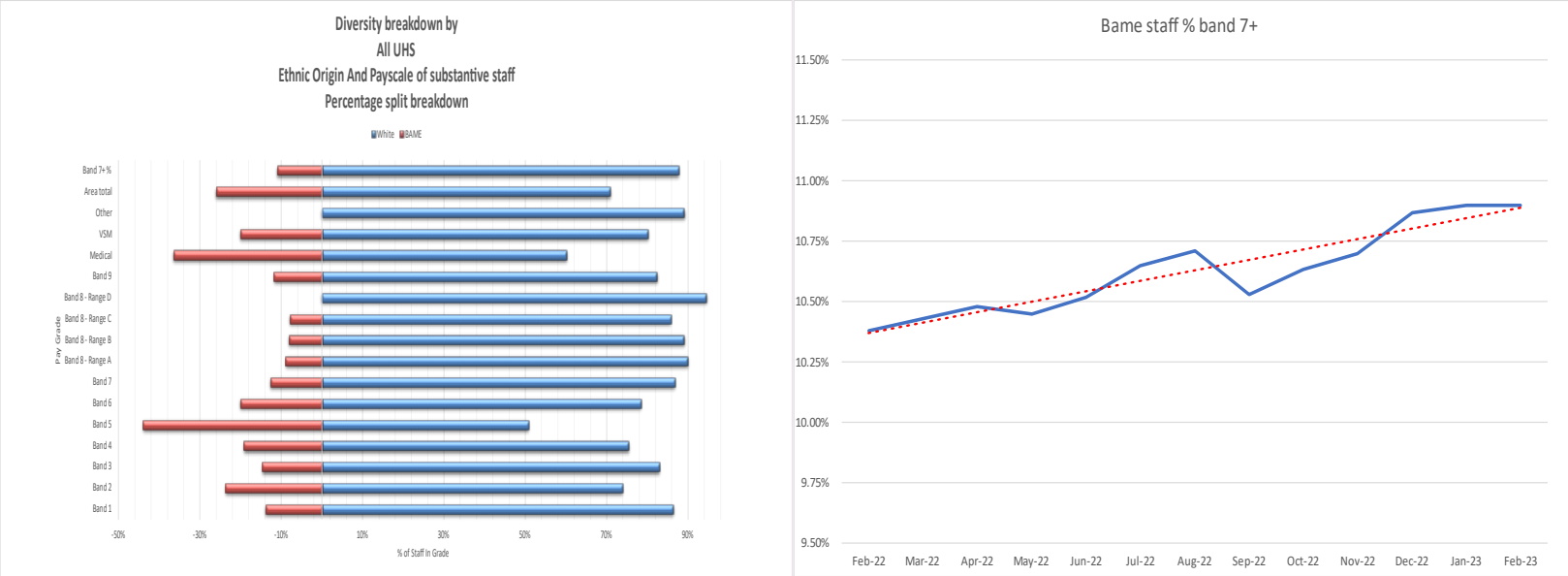
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EXCEL

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## STAFF IN POST - ETHNICITY





# People Report

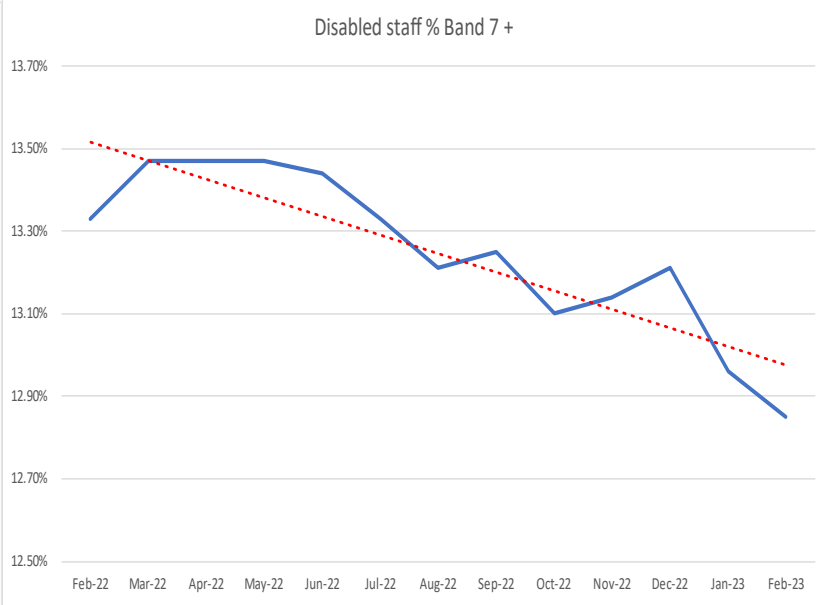
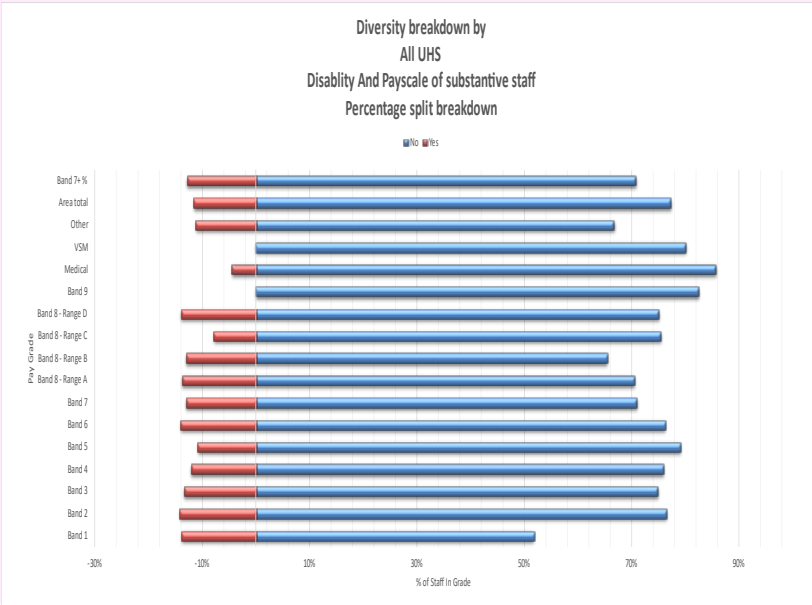
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## STAFF IN POST – DISABILITY STATUS



# People Report

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**Gender pay reporting aims to show the difference in average pay and bonus payments\* between male and female staff.**

This is the sixth year of reporting our Gender Pay Gap. We have been working hard to support the development of our people in their chosen roles, and we continue to work on our recruitment processes to ensure they are fair, inclusive and transparent.

Our Gender Pay Gap is decreasing, and over the last five years it has reduced by 4.8%. Agenda for change and junior doctor contracts Gender pay remains broadly equal. The overall gender pay gap is still primarily driven by our senior consultant workforce. This will be discussed through our EDI committee. Full report available [here](#)

## GENDER PAY GAP



25.04% 74.96%

### Our Workforce

People who identify as female make up the majority of our workforce



23.33% (£5.55 p/h)

### Our Mean Gender Pay Gap

This is an average of the difference between the female and male hourly rate of salary. This has decreased from 24.18% the year before.



11.42% (£2.13 p/h)

### Our Median Gender Pay Gap

This is the middle value of the difference between the female and male. This has decreased slightly from 11.48% the year before.



### Full time staff

64.25% of staff are full time

Of our full time staff  
33.69% identify as male  
66.31% identify as female



### Part time staff

35.75% of staff are part time

Of our part time staff  
9.49% identify as male  
90.51% identify as female

### Our Mean Bonus Pay Gap



30.71%

The difference between the mean bonus pay between males and females. (For those eligible)

### Our Median Bonus Pay Gap



33.33%

The difference between the median bonus pay paid to males and females. (For those eligible)

# People Report

THRIVE

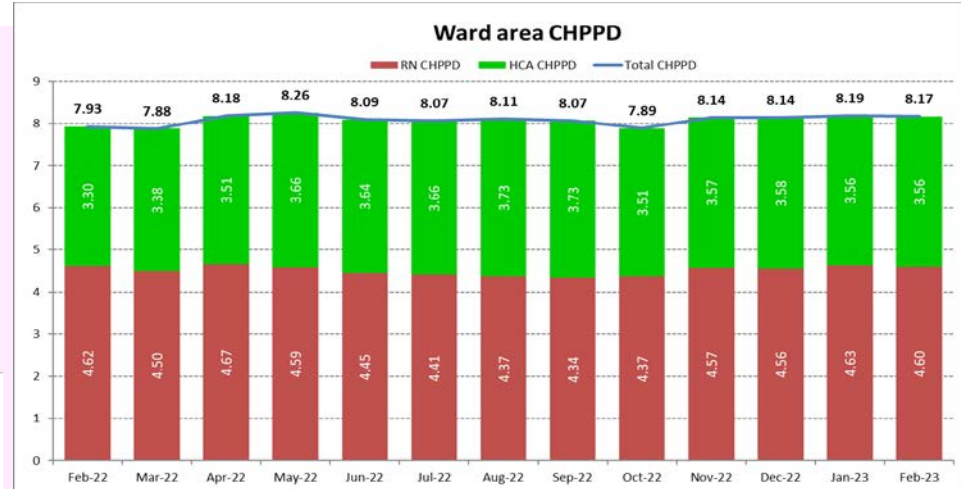
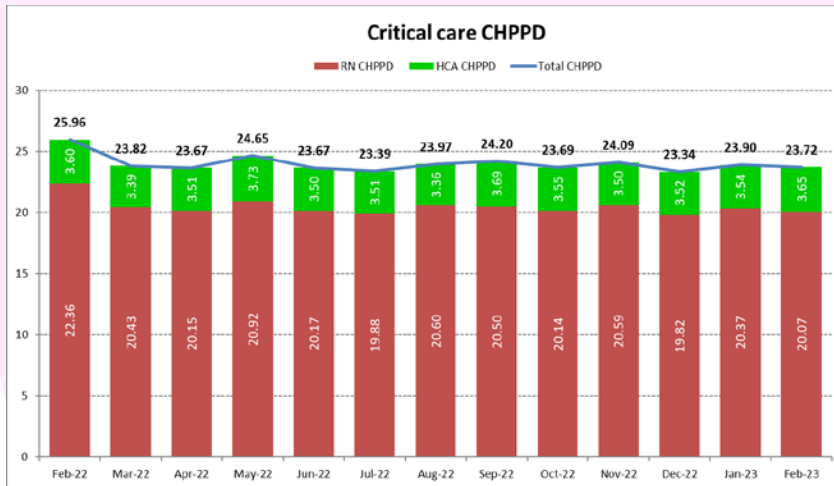
EXCEL

BELONG

PATIENT SAFETY

## CARE HOURS PER PATIENT DAY

The Ward areas CHPPD rate in the Trust has decreased from last month to RN 4.60 (previously 4.63), HCA 3.56 (previously 3.56) overall 8.17 (previously 8.19). Factors affecting CHPPD is linked to increasing patient numbers and the budgets of additional winter pressure areas available to include in the report this month (THR F10, Eye SSU, Bursledon House).



The CHPPD rate in Critical care has decreased overall from last month. RN 20.07 (previously 20.37), HCA 3.65 (previously 3.54) overall 23.72 (previously 23.90). Staffing on intensive care and high dependency units is always adjusted depending on the number of patients being cared for and the level of support they require. Therefore, the numbers will fluctuate considerably across the month when compared against our planned numbers..

Report to the Trust Board of Directors				
Title:	Staff Survey Results 2022 Report			
Agenda item:	4.12			
Sponsor:	Steve Harris, Chief People Officer			
Author:	Ceri Connor, Director of Organisational Development and Inclusion			
Date:	30 March 2023			
Purpose	Assurance or reassurance  x	Approval	Ratification	Information  x
Issue to be addressed:	<ol style="list-style-type: none"> <li>1. To review the feedback and experiences of our staff in the 2022 national NHS Staff Survey against the existing UHS People Strategy 2022-26, and wider UHS strategies.</li> <li>2. To consider the current challenges in the healthcare environment, identify which are outside our control, and assess our ability to return staff satisfaction and engagement to pre pandemic levels.</li> <li>3. To optimise elements of staff experience we <b>can</b> control, and in turn continue to sustain or improve our staff experience given the complex environment we are operating in.</li> <li>4. Compare our results to the national average and other like for like Trusts.</li> <li>5. Summarises the main action to take forward into people objectives for 2023/24.</li> </ol>			
Response to the issue:	<p>The report highlights the following:</p> <ul style="list-style-type: none"> <li>• A headline summary of our 2022 survey results (p3); Summary of our participation rate. We achieved <b>54.7% participation</b>, equating to 7023 staff against a national average of 44%.</li> <li>• Areas of success (p4): We were <b>rated the top</b> in the acute and acute community category in the Southeast region, <b>and 7<sup>th</sup> nationally</b>. We have sustained our “above average” position on <b>all</b> the national People Promise themes. We have scored <b>significantly above the national average</b> on many indicators.</li> <li>• Areas of further focus (p5): Specifically related to <b>wellbeing, violence and aggression and discrimination at work</b>.</li> <li>• Our engagement, morale and advocacy scores (p6); Our staff <b>engagement score is has declined at 7.1</b>, our morale scores have remained unchanged on many indicators but notably indicators relating to enough people in the organisation to do my job, and those that are thinking of leaving, declined by 3% from 2021.</li> <li>• The indicators in relation to <b>Inclusion and belonging (p7), showing some improvements</b> in relation to how people believe UHS respects individual differences at 77%, but people are still experiencing discrimination, and incidences of <b>violence and aggression from patients, service users</b>, relatives and members of the public, and this has worsened from 2021. Over</li> </ul>			

	<p>70% of staff said they felt valued at UHS and respected by colleagues.</p> <p>The UHS People Strategy aims to address many outcomes of the staff survey, alongside our other existing strategies and work programmes. The results of the 2022 survey results have not altered our course, but provides the opportunity to undertake focused planning for 2023/24 objectives, specifically in the context of the financial challenges we face, and the work we need to do to support the action on demand and capacity – “the hamster wheel”.</p>
<p>Implications: (Clinical, Organisational, Governance, Legal?)</p>	<p>The following implications should be noted:</p> <ul style="list-style-type: none"> <li>• <b>Culture:</b> Actions to continually improve UHS survey results align to the three elements of the People Strategy; <i>Thrive, Excel and Belong</i> and is a central part of the UHS 5 Year Strategy. Feedback relating to staff experience, sentiment and advocacy forms a critical part of delivery plans to strengthen organisational culture.</li> <li>• <b>CQC:</b> The annual staff survey and specifically the engagement score is a leading indicator of staff satisfaction and engagement with the CQC and will be used as evidence in terms of the Well Led domain. Organisations who are rated Outstanding have evidenced continual improvements in staff survey results and are rated “the best” in their benchmark groups.</li> <li>• <b>Organisational:</b> The staff survey actions are aligned to the programmes of work underpinning the UHS People Strategy and underpin the NHS People Strategy.</li> </ul>
<p>Risks: (Top 3) of carrying out the change / or not:</p>	<p>BAF risk</p> <p>3b) We fail to recruit, retain, and develop a diverse, compassionate, and inclusive workforce to meet our corporate strategy aims</p>
<p>Summary: Conclusion and/or recommendation</p>	<p>Trust Board are asked to receive and review the 2022 survey results and support the recommendations in the report (page 9).</p>

## 1. Introduction and purpose

- 1.1 The National NHS staff survey annually measures the satisfaction of employees across all parts of the NHS. It is a critical source of information that UHS can use to measure our employee experience and importantly to measure our progress against our UHS People Strategy. It is a key source of information that drives our annual objectives for People at UHS.
- 1.2 This paper sets out the details of our national staff survey results for 2022 and provides outlines of how we will respond during 23/24.

## 2. Context

- 2.1 Following on from the Covid Pandemic the NHS has struggled to recover. Staff are reporting high levels of burnout, dissatisfaction with working conditions, with pay, and workforce shortages impacting on their ability to care for patients. This is made worse by a capacity crisis in social care impacting on flow within hospitals and putting immense pressure on the whole system. In wider society, we have a cost-of-living crisis and a challenging labour market whereby jobs such as entry retail roles offer the same or better packages than entry health roles. For UHS this impacts on our ability to engage with staff, deliver the strategic objectives of our people and improvement strategies, and in turn improve staff experience, recruitment, and retention.
- 2.2 Given the context we are operating in, we must focus in on the elements **we can control**. We must acknowledge the elements outside of our control. For UHS, this is being **proud** about the purpose that unites us together - the amazing **work we do for our patients and families**, living our **values**, behaving with **kindness and compassion** to each other. Developing our leaders and managers to be the best they can be, developing a culture where people feel they **belong** at work, and feel included. A place where people feel **safe to speak up** and concerns are acted upon, people feel **supported**, a place where people have **opportunities for growth**, development, and people feel **valued for the work** they do.

## 3. Summary of 2022 Survey results

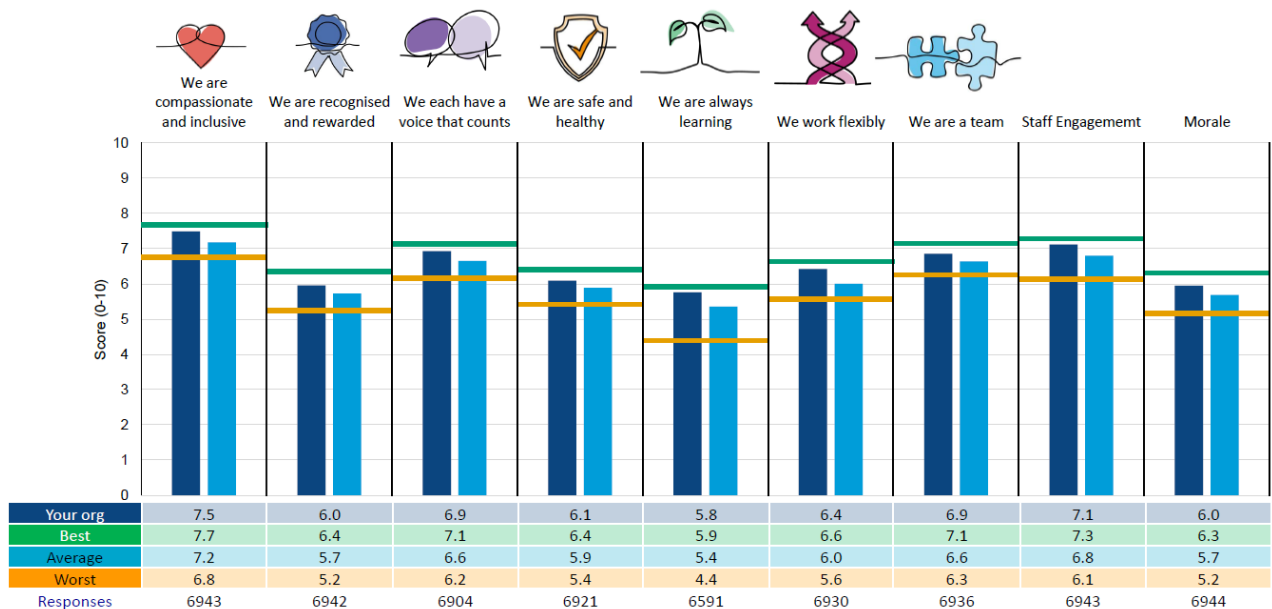
- 3.1 The annual NHS Staff Survey is the only mechanism where we hear feedback from over **50% (over 7000) of our people** on a range of indicators, the only tool we have which provides the mechanism to benchmark what it feels like to work at UHS against other trusts regionally and locally. The survey opens in September and closes in December each year, results start to come to us from January, and we receive the full picture by the end of February. For survey facts and how the survey is produced see Appendix 1.
- 3.2 There are indicators in the staff survey which have seen a decline **post pandemic** and have not yet recovered, these are:
- Satisfied with levels of pay
  - Not enough staff to do my job properly

- Experienced violence and aggression from patients, family members or members of the public. Although this saw an improvement in 2020 due to the covid restrictions on visiting.

3.3 2022 results show we have managed to **maintain or improve across most indicators**. Where we have declined there are workstreams in place under our UHS strategies to directly respond to the issues. Some workstreams need adequate time to embed across the organisation to see improvements in future surveys. We should be proud that despite the challenging environment we have sustained our position of “above average” on all People Promise themes, and in most of the individual questions.

3.4 Figure 1 shows our performance across the People Promise themes, including the Staff Engagement and Morale score benchmarked against the “Best”, “Worst” and “Average” in our category.

**Figure 1 – Scores by People Promise themes**



3.5 A summary of the Trust wide Key Survey Results for 2022 can be found in appendix 2.

### 3.6 Things to celebrate

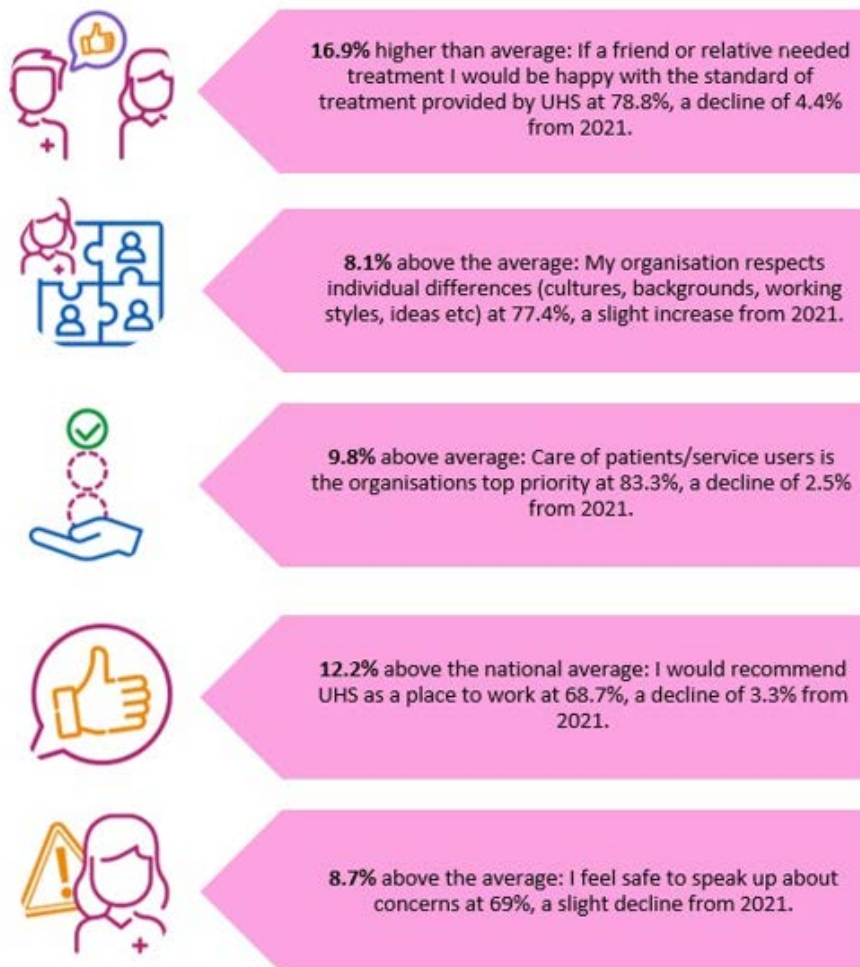
- 3.6.1 UHS was the 7<sup>th</sup> highest Trust for *recommendation as a place to work* nationally, out of 124 Trusts nationally. We held the same position as last year.
- 3.6.2 UHS is now the top rated acute Trust for *recommendation as a place to work* in the Southeast NHS region (17 Trusts) and the highest rated acute Trust in HIOW.

All South East - ranked in order of staff “agreeing” or “strongly agreeing” they would recommend it as a place to work

Trust	2019	2020	2021	2022	Change 2021 to 2022	Change 2019 to 2022
University Hospital Southampton NHS Foundation Trust	73%	77%	72%	69%	-3%	-4%
Royal Berkshire NHS Foundation Trust	70%	74%	67%	68%	1%	-2%
Maidstone and Tunbridge Wells NHS Trust	66%	75%	66%	64%	-2%	-2%
Royal Surrey County Hospital NHS Foundation Trust	70%	74%	70%	64%	-6%	-6%
Dartford and Gravesham NHS Trust	62%	70%	63%	63%	0%	1%
Surrey and Sussex Healthcare NHS Trust	79%	80%	72%	61%	-10%	-18%
Oxford University Hospitals NHS Foundation Trust	64%	70%	64%	61%	-3%	-3%
Buckinghamshire Healthcare NHS Trust	59%	65%	57%	59%	3%	0%
Frimley Health NHS Foundation Trust	67%	71%	63%	58%	-5%	-9%
Ashford and St Peter's Hospitals NHS Foundation Trust	67%	71%	63%	58%	-5%	-9%
Hampshire Hospitals NHS Foundation Trust	62%	68%	59%	57%	-3%	-5%
East Sussex Healthcare NHS Trust	63%	69%	61%	55%	-6%	-8%
Isle of Wight NHS Trust (acute sector)	47%	57%	57%	53%	-5%	6%
Portsmouth Hospitals University National Health Service Trust	64%	67%	58%	51%	-7%	-13%
Medway NHS Foundation Trust	51%	53%	49%	49%	1%	-2%
University Hospitals Sussex NHS Foundation Trust			54%	49%	-5%	-
East Kent Hospitals University NHS Foundation Trust	51%	48%	46%	44%	-3%	-7%

3.6.3 We have scored **above average** across all the NHS People Promise themes as shown in Fig 1. We performed most positively in the “*We are always learning*” theme with only 0.1 difference between UHS and “the best”. In the “*We are recognised and rewarded*” theme we scored UHS was 0.4 points from “the best” trust in our category.

3.6.4 It is pleasing that UHS scored significantly **above national average** on the following:

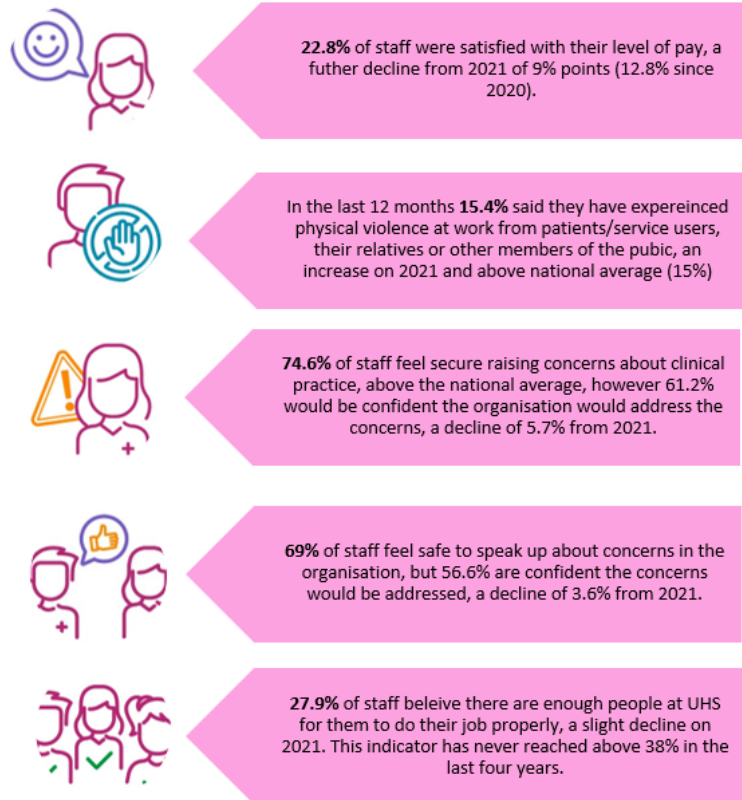




- 3.6.5 There were small improvements **relating to appraisal**, and how it helped people to do their job. People were more satisfied with line managers than in 2021. In particular, managers improved how they listen to personal challenges, undertook discussions on flexible working, and taking an interest in personal health and wellbeing.
- 3.6.6 Satisfaction also increased in relation to **access to learning and development**, and satisfaction relating to making reasonable adjustments for people with disabilities, both indicators increased by 2%.
- 3.6.7 **People working additional unpaid** hours reduced and therefore improved by 3%, as did teams meeting to discuss team effectiveness, also improved by 3%.

### 3.7 Areas of concern

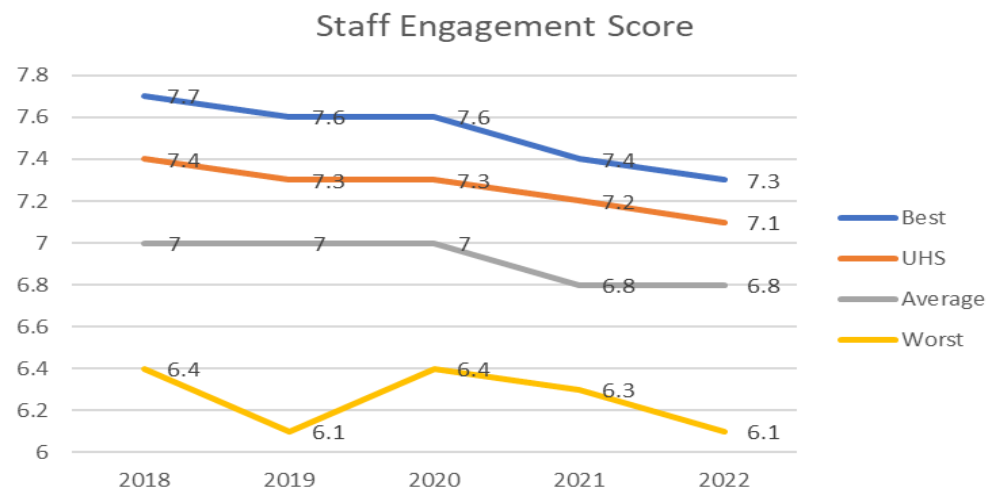
- 3.7.1 There are still causes for concern in terms of experience of physical violence from patients, service users, relatives or members of the public, and experience of harassment, bullying and abuse at work from patients, service users and members of the public, from colleagues and managers. All indicators have declined from 2021.
  - 3.7.2 The care groups that reported the most physical violence at work from patients, service users and members of the public in 2022 are: Medicine (53.6%), Emergency Care (53.3%), Critical Care (47.1%), Neuro (34.6%), Trauma and Orthopaedics (33.8%) and Cardiovascular and Thoracic (25.8%).
- 3.8 Reassuringly people have reported they feel safe and secure to raise concerns, but there is work to do to improve people's confidence that the concerns will be addressed.
- 3.9 Results in relation to burnout, health and wellbeing have remained largely unchanged since 2021. We know however that the rate of workload being experienced by our people is a challenge.
- 3.10 Satisfaction with level of pay has continued to decline, which is unsurprising in light of the cost of living crisis and widespread industrial unrest. Nursing and Midwifery has the lowest level of satisfaction with pay. Satisfaction was also low in additional clinical services, which includes entry level jobs such as Health Care Assistants. UHS is also an outlier, with below-average levels of pay satisfaction. This may well be linked to known challenges of banding comparison between other organisations, with Advanced Care Practitioners (ACPs) being a particular issue. In addition, the employment market has been buoyant fuelling competition for entry level jobs in other sectors.



#### 4. Staff Engagement, Morale, and advocacy

4.1 Our Staff Engagement Score, derived by the three measures of engagement (motivation, involvement, and advocacy) has declined from 2021 at 7.1. It is still however well above the national average, and in line with other Trusts in our category. Fig 2 below shows “the best” trust has declined at the same rate.

**Fig 2. Engagement Score comparison 2018-2022**

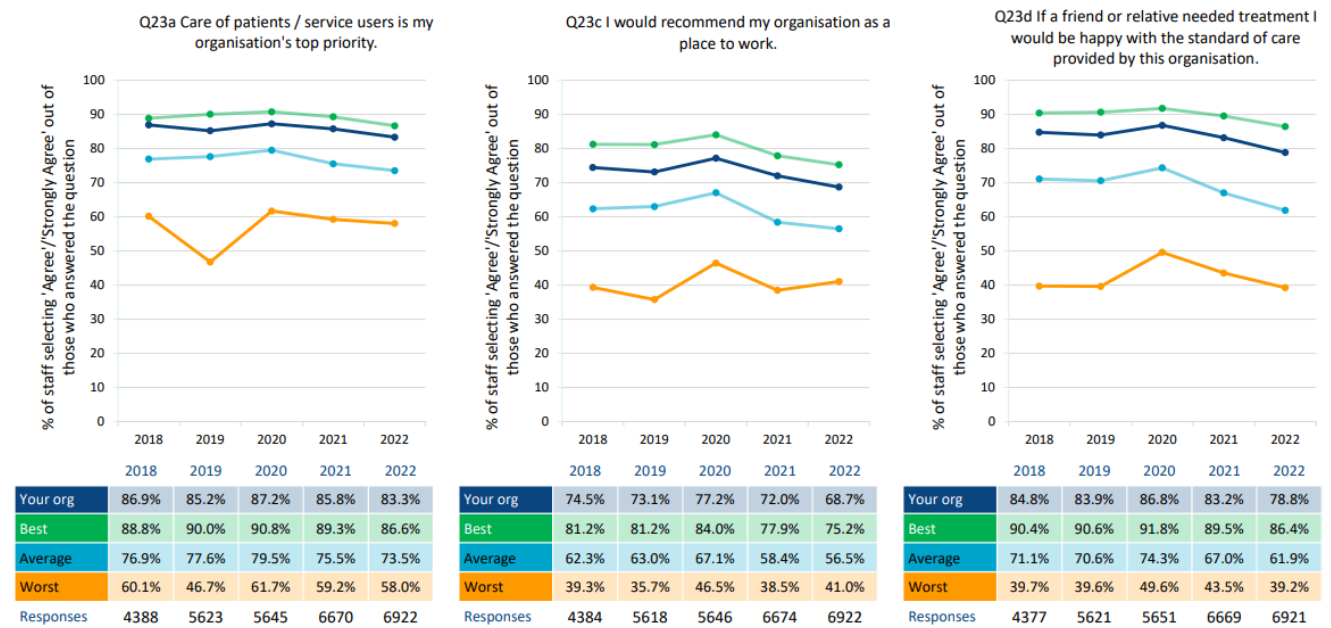


4.2 In terms of Morale, 27% of staff say they often think about leaving UHS, this has steadily increased over the last four years, rising by 3.1% since 2018.

4.3 20% of staff say they will probably look for a job in the next 12 months, an increase of 2% since 2018.

4.4 Advocacy scores have slightly declined, Fig 3 shows the comparison between UHS, best, average and worst since 2018.

**Fig. 3 – Advocacy scores comparison 2018-2022**



## 5. Inclusion and Belonging

5.1 It is positive to see we have improved in relation to how UHS respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc), this shows that we are moving towards our ambitions of creating a culture of inclusion and belonging.

5.2 However, people are still experiencing discrimination, bullying, harassment, and abuse on the grounds of ethnicity, gender, disability, religion, age and sexual orientation. Those that said **they had experienced discrimination** in the last 12 months, discrimination on the grounds of ethnicity was the highest, other characteristics as follows:

- Ethnicity – 54.5%
- Gender – 20%
- Age – 17%
- Disability or long term illness – 7.8%
- Sexual orientation – 4.6%
- Religion – 3.2%
- Other – 24.2%

5.2.1 Whilst we do not have information in terms of what is categorised under “other” within this indicator, we do have valuable information from the survey written comments. The reason

given that occurred most in the verbal comments was **discrimination based on “Role/Band”** which implies there is still work to do in terms of reducing hierarchy, recognising equity of voice, and valuing everyone’s view and experiences no matter your role or profession.

- 5.3 People are **still facing violence, aggression, harassment, bullying and** abuse at work. Despite our best efforts our indicators have declined, **15.4%** of staff said they had experienced at least one incident of physical violence from patients, service users, relatives or members of the public, and **24.4%** said they had experienced at least one incident of bullying, harassment or abuse at work from patients, service users, relatives or members of the public, both indicators increased from 2021.
- 5.4 62% of staff feel UHS acts fairly in relation to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age, this remains unchanged from 2021.
- 5.5 71.6% of staff said they feel **valued** by their team, and 74.8% said their immediate manager values their work. 73% said they receive the **respect** they deserve from colleagues at work.
- 5.6 27% of staff said they often think about leaving UHS, 20.7% said they will be looking for a job in a new organisation in the next 12 months, and **only 13.9%** said as soon as they find another job, they will leave UHS.

## 6. Trust wide, Divisional and Care Group response and actions.

6.1 The delivery workstreams of our UHS People Strategy will move into the 2<sup>nd</sup> year in 2023. The People Objectives 2023/24 and other UHS strategies will be informed by 2022 results. However, assurance is provided within this report that the work programmes remain the **correct ones** to respond to the feedback, and we continue as planned. People Strategy themes and goals can be found in Appendix 3.

### 6.2 Our Corporate Response

6.2.1 We will follow the communication model that we used for staff survey results in 2022 (results of 2021 survey) and launch trust wide communications on 9<sup>th</sup> March, when the national embargo is lifted. We will provide a high level summary of the UHS results overall, and highlight the work that is happening, within our control, to improve. This is outlined in Figure 4.

**Fig 4 – Actions are taken and continued areas of focus**



### 6.3 Our Local response

- 6.3.1 For Divisions, Care Groups and those who have team results; Divisional leaders received their results in January, to review and reflect on how 2021 plans should remain the same or need to alter. Divisional participation can be seen in Appendix 4, and examples of 2021 divisional action can be seen in Appendix 5.
- 6.3.2 It is important that staff survey feedback is seen as **continual improvement**, therefore action plans don't necessarily need to change year on year, so long as there is assurance the actions remain the correct ones to **sustain or make improvements**.
- 6.3.3 **Participation is key**, and whilst we were not able to improve percentage participation on 2021 we should still aim for year on year increases. To increase participation, it is crucial for team members to **see the results** and participate in thinking around some of the **potential solutions**, where possible, get **involved in creating them**. Local involvement, where changes are driven locally are more likely to be sustained, and people are more likely to participate in the survey in the future if they can see a **direct link** between their feedback and improvements in their individual experience, team or environment.
- 6.3.4 Divisions and key THQ areas will meet with the CEO, CPO and Director of OD and Inclusion to review ongoing local responses and progress to the staff survey during Q2.

## 7 Conclusions

- 7.1 We should consider our 2021 survey results a success given the complex environment we are operating in. We have managed to remain above average in all People Promise themes, and significantly above average on many indicators.
- 7.2 We have seen "green shoots" of improvement on those indicators where we have started work during 2022 – appraisal, management development, education and career development, and inclusion and belonging.
- 7.3 Where we have seen declines, these have been in line with the average, or "the best" trusts (indicating we are not outliers), and we have existing actions in place or in development to tackle these areas.
- 7.4 For those indicators where there is less internal control (pay, enough people to do my job) we may need to accept that our ability to improve experience is limited, and accept an informed risk around this, in line with the risks articulated in our Board Assurance Framework.

## 8 Recommendations

- 8.1 It is recommended that we continue to follow the agreed themes and workstreams in the UHS People Strategy 22-26 and bring forward specific areas noted in the feedback into the 2023 People Objectives. This includes:

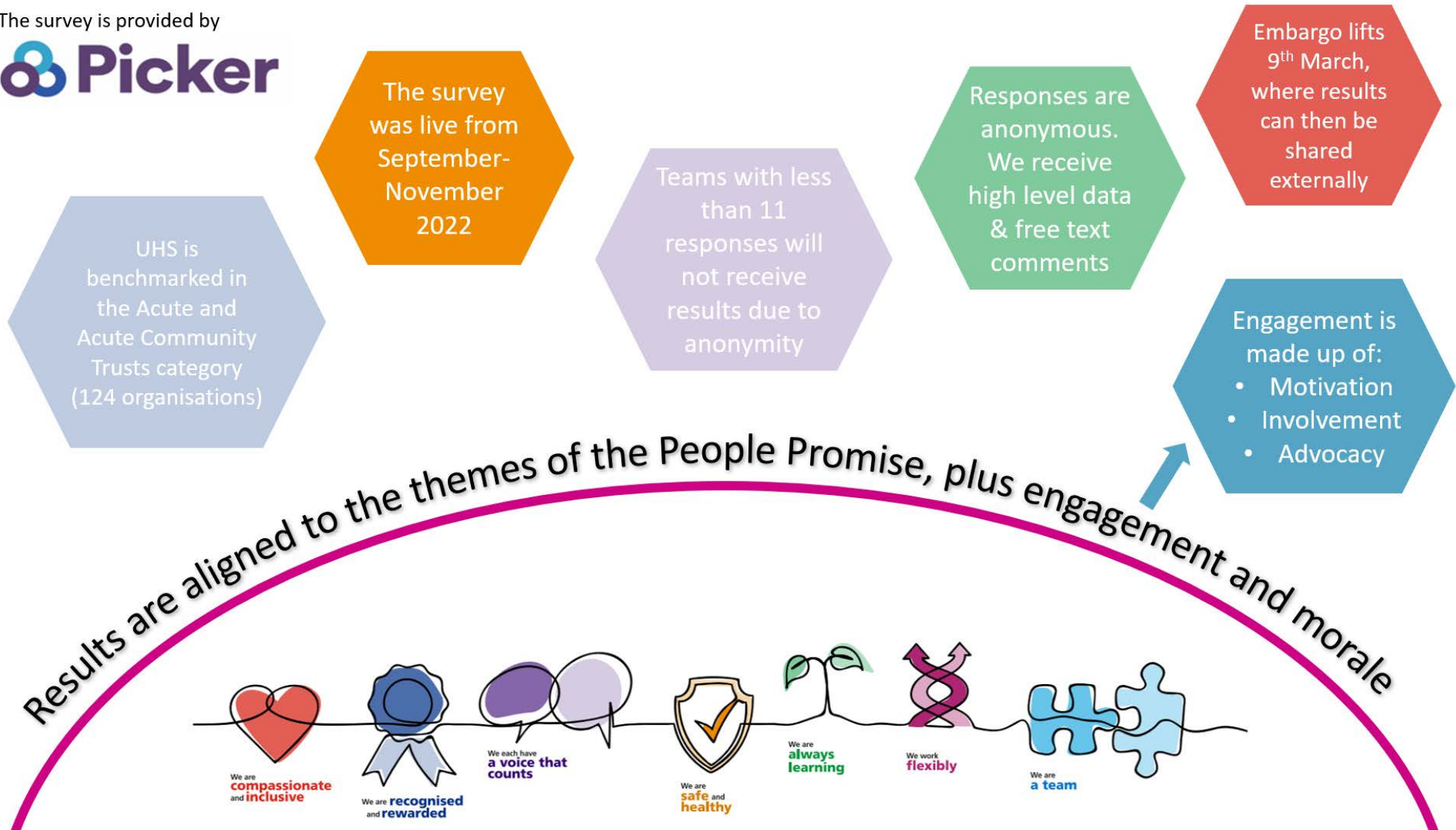
- Corporate objectives for the People Directorate based on Thrive, Excel and Belong
- Focus specifically on key staff groups and areas of concern
- Support Divisions to establish local plans to respond to local issues. Review through Chief Executive led meetings during Q2.

8.2 That we follow the model from 2021 for communications and engagement as set out in Appendix 6. We share actions from 2021 and continue to help people make connections between the people, transformation, patient safety, local workstreams, and the survey feedback.

**8.3** We pay particular attention to helping as many people as possible to see and engage in local survey results, and managers share as widely as they can to aid confidence that feedback is seen and acted upon.

**Appendix 1, NHS Annual Staff Survey: The Facts**

The survey is provided by





# Staff Survey Key Results 2022

54.7% participation  
7,023 staff

↓ a 1.5% decrease  
from 2021

UHS scored the highest out of all 124 Acute and Acute Community Trusts for there being opportunities to develop your career in the organisation (63.6%)

Our staff engagement score is 7.1.  
The national average is 6.8

In comparison to UHS scores in the 2021 survey

↑ 2%

When looking at themes where UHS have made the most improvement on the previous years scores line managers is one theme that stands out. Eleven questions regarding staff's line manager have improved from 2021. Some of these questions are:

Immediate manager listens to challenges I face – increased 2% from last year (74%).

↑ 1%

The other ten questions have increased by 1% on the previous year and cover topics such as, providing feedback on work, asking for opinion before making decisions, taking an interest in health and wellbeing, encouraging staff at work, valuing the work of their employees and being approachable to discuss flexible working.

↑ 3%

Not working any additional unpaid hours per week – 47% (up 3% on the previous year)

↑ 3%

Team members meeting to discuss the team's effectiveness – 58% (up 3%).

↑ 2%

Being able to access learning and development opportunities – 64% (up 2%).

↑ 2%

UHS made reasonable adjustments for disabilities – 81% (up 2%).

In comparison to the national average

UHS scored below average for 6 out of 103 questions

-0.4%

In the last 12 months have you personally experienced discrimination at work from patients/service users, their relatives or other members of the public? UHS scored 8.2% (up by 0.9% from 2021) and the average was 7.8%.

-2.3%

When asked whether staff were satisfied with their level of pay, 22.8% of UHS staff agreed (dropped from 31.8%), below the average of 25.1%.

-0.3%

The last time you experienced physical violence at work, did you or a colleague report it? UHS scored 0.3% below the average, with a score of 68.4% (Increased from 67.2% in 2021).

-1.8%

On reporting harassment, bullying or abuse at work 45.6% confirmed that they did (fell from 48.4% in 2021), in comparison to an average of 47.4%.

-0.4%

In the last 12 months 15.4% of UHS staff experienced physical violence at work from patients, service users, their relatives or members of the public (this was 14.3% in 2021), with a national average of 15.0%.

-0.2%

72.3% of staff agreed that time passes quickly when working. This has dropped slightly from the previous year (74.0%), below the average of 72.5%.


The most dissatisfied staff groups with their level of pay: nursing and midwifery (63%) and additional clinical services (62%)


The staff groups who were the most satisfied with their pay were healthcare scientists (33%) and medical and dental (36%).

The care groups that reported the highest incidences:  
Medicine (53.6%)  
Emergency Care (53.3%),  
Critical Care (47.1%)  
Neuro (34.6%)  
Trauma & Orthopaedics (33.8%)  
Cardiovascular & Thoracic (25.8%).

Area	Question	UHS 2022	UHS 2021	UHS Difference	Average 2022	Average 2021	Difference in average
Motivation	Often/always look forward to going to work	55%	56%	-1%	52%	52%	0%
	Often/always enthusiastic about my job	69%	70%	-1%	66%	67%	-1%
	Time often/always passes quickly when I am working	72%	74%	-2%	72%	73%	-1%
Involvement	Opportunities to show initiative frequently in my role	78%	78%	0%	72%	72%	0%
	Able to make suggestions to improve the work of my team/department	75%	74%	1%	70%	70%	0%
	Able to make improvements happen in my area of work	57%	57%	0%	54%	53%	1%
Advocacy	Care of patients/service users is organisations top priority	83%	86%	-3%	73%	75%	-2%
	Would recommend organisation as a place to work	69%	72%	-3%	56%	58%	-2%
	If a friend/relative needed treatment would be happy with standard of care provided by organisation	79%	83%	-4%	61%	67%	-6%
	Engagement score	7.1	7.2	-0.1	6.8	6.8	0

## Appendix 3 People Strategy themes and goals 2022-2026

AREA	OUR GOALS
 <p><b>THRIVE</b> Growing, deploying, innovating our workforce</p>	<p><b>Meeting demands through innovation, focus on people, and development of talent:</b></p> <ul style="list-style-type: none"> <li>• <b>PLAN AND INOVATE</b> – Design a workforce plan which aligns to the ambitions in our Digital Strategy and Always Improving Strategy, where we develop roles for the future, aligned to transformation and emerging clinical practice. As key collaborators with our ICS partners we will focus on workforce capacity, growth and sustainability now and in the future at scale.</li> <li>• <b>EDUCATE</b> – Work with the University of Southampton, our wider education partners, and ICS colleagues to grow our future professionally qualified workforce capacity, specifically through more qualified nurses, Allied Healthcare Professionals, scientific and technical roles, and junior doctors.</li> <li>• <b>ATTRACT</b> – Develop a comprehensive inclusive talent attraction plan which will: <ul style="list-style-type: none"> <li>• Expand our overseas recruitment.</li> <li>• Increase our apprenticeships with an ambition to grow our own.</li> <li>• Offer career pathways and progression routes.</li> <li>• Ensure succession plans for all leadership roles and critical/hard to recruit roles.</li> <li>• Work with people in local communities to attract future talent into UHS and the wider NHS.</li> <li>• Ensure a diverse and representative UHS leadership and workforce community.</li> <li>• Focus on a flexible employment offering to meet diverse needs.</li> <li>• Maximise our opportunities as a university teaching hospital.</li> </ul> </li> <li>• <b>INSIGHT</b> – We will develop our people analytics, creating insights and intelligent dashboards to enhance the rigour of decision making.</li> <li>• <b>LEARNING</b> – Transforming professional learning and development to a more inclusive, discovery-based approach, self-driven development of knowledge, skills and experience, supported by leading educational provision.</li> <li>• <b>AGILE DEPLOYMENT</b> – Agile deployment; maximising technology and workforce systems to ensure skills and experience are in the right place at the right time. Greater flexibility to work at UHS and through our partner organisations in the ICS seamlessly.</li> <li>• <b>CONTINGENT WORKFORCE</b> – Ensure maximum value and opportunity from our contingent workforce focusing on agency, bank and our volunteers.</li> </ul>

AREA	OUR GOALS
 <p><b>EXCEL</b> A great place to work, develop and achieve</p>	<ul style="list-style-type: none"> <li>• <b>HEALTH AND WELLBEING</b> – The health and wellbeing of our people is a top priority. We will ensure we consider the impact of wellbeing initiatives and activity to promote and sustain wellbeing and a healthy work environment. We will focus on what really makes a difference in supporting people to stay well and healthy, and strive to achieve these.</li> <li>• <b>THE UHS CAREER PROMISE</b> – Everyone has a career plan who wants it. We will refresh our appraisal and performance system to ensure continual feedback, and clarity of purpose for all roles, connecting people to The UHS Way. We will link our careers opportunities and support to diversity, including different parts of peoples life experience and expectations.</li> <li>• <b>LISTEN AND ACT</b> – We will listen to our diverse UHS family, integrated team members, partners and communities to develop a deep understanding of how they are treated and what it feels like to work at UHS, and to respond accordingly. We will seek to make year-on-year improvements in the annual NHS Staff Survey and continue to raise participation.</li> <li>• <b>REWARD AND CELEBRATE</b> – We will reward people for the amazing work they do. We will celebrate success and raise the profile of our people and teams regionally and nationally. We will ensure our reward and celebration reflect our amazing diversity with the UHS family.</li> <li>• <b>A WHOLE EMPLOYMENT APPROACH</b> – We will major on the “UHS experience”, we will delight people from our advert, to our induction, and right the way through their UHS journey. If they leave, we will ensure that is positive too.</li> <li>• <b>GREAT JOBS, WELL DESIGNED</b> – We want to get our job design right. We will simplify our processes and structures and ensure our jobs allow innovation and creativity.</li> <li>• <b>NURTURING TALENT</b> – we will grow and nurture diverse talent from all parts of the UHS family. We will enable this talent to flourish at UHS and across our partners in the ICS.</li> <li>• <b>OUR EMPLOYER BRAND</b> – We will generate a compelling offer for potential candidates through investment in our employer value proposition and brand.</li> <li>• <b>OUR ENVIRONMENT</b> – We will develop our physical estate to improve the working, learning and rest environments for our people, including meeting diverse needs.</li> <li>• <b>PARTNERSHIPS</b> – We will ensure those we commercially partner with, align with our values and our expectations on the importance of the people agenda.</li> <li>• <b>SAFETY</b> – We will continue to make every effort to ensure our staff are not harmed, injured or become ill whilst at work; we will develop and implement a safety competence framework of knowledge and skills for staff in order to reduce the number of injuries and ill-health that occur as a result of our activities.</li> <li>• <b>RESEARCH AND DEVELOPMENT</b> – We will develop roles across our organisation that support our research for all strategy.</li> </ul>

AREA	OUR GOALS
<div style="background-color: #2c4e64; color: white; padding: 10px; text-align: center;"> <b>BELONG</b>            Compassionate and inclusive culture for all         </div> 	<ul style="list-style-type: none"> <li>• <b>LIVING OUR VALUES</b> – We will aspire to live our values every day through our interactions and decision making. We will review the behaviours that underpin our values, and ensure they remain true to our strategies and the driving force behind our aspired culture.</li> <li>• <b>LEADING THE UHS WAY</b> – We will continue to invest in our leaders and managers, recognising the impact they have on our people. We will create a variety of leadership programmes, interventions and offerings which will enable leaders to develop their skills for the future and equip them to deal with current challenges. Our leaders will focus on improvement in all that they do.</li> <li>• <b>BEING YOU AT WORK</b> – We will focus on creating the conditions where people can thrive and be their best self at work, where difference is celebrated and respected. We will drive the ethos of inclusion and belonging through all our strategies, and leadership development and culture programmes. We will collaborate with external partners who will assist us in this ambition.</li> <li>• <b>JUST AND LEARNING CULTURE</b> – We will develop our culture of civility where people can confidently speak up, learn from errors and improve services. We will train more people in appreciative inquiry techniques so we can identify what works well and replicate success.</li> <li>• <b>REPRESENTING ALL OUR PEOPLE</b> – We will take positive action to develop people from underrepresented groups with an aim of diversifying leadership at all levels.</li> <li>• <b>OUR NETWORKS GUIDING US</b> – We will support our Staff Networks to grow and thrive, ensuring people can get involved, share their lived experiences, and input in to decision making.</li> <li>• <b>BELONGING FOR ALL</b> – We will tackle inequality in the workforce driven through a progressive and bold Diversity and Inclusion Strategy, and we will not tolerate bullying, harassment and discrimination towards our people.</li> <li>• <b>A FAMILY OF ALLIES AT UHS</b> – We will focus on allyship and offer bystander training for all our leaders and people.</li> </ul>

## Appendix 4

### Divisional participation rates

Division	Eligible	Respondents	Response Rate
Division A	2371	1343	56.6%
Division B	3178	1565	49.2%
Division C	2765	1517	54.9%
Division D	2313	1126	48.7%
Hosted Services	231	121	52.4%
THQ	1967	1351	68.7%

## Appendix 5

### Examples of Divisional actions plans and initiatives in response to 2021 survey

#### Appraisal action plan, Division C

#### Appraisal (particularly quality of appraisal) and training/development

Headline Theme	Headline Action	Action Summary
<b>Career development</b>	<ul style="list-style-type: none"> <li>Ask staff directly regarding career aspirations and frustrations to establish if there is a common theme. In discussion with line managers establish what can be put in place to support staff career progression.</li> </ul>	Discussions with line managers and action plan by end September
<b>Staff development</b>	<ul style="list-style-type: none"> <li>Remind staff that appraisal records should not be signed unless they feel useful and achievable objectives have been agreed.</li> <li>Re training and development: Invite teams to make their training and development updates visible to the whole Group</li> </ul>	<ul style="list-style-type: none"> <li>May 22</li> <li>Sep 22</li> </ul>
<b>Value of appraisals</b>	<ul style="list-style-type: none"> <li>Ensure all line managers undertake updated training on appraisals. Utilise new paperwork at future appraisals. Head of Service to ask line managers if there is anything they feel needs to change to help with the appraisal process.</li> <li>Learn from areas that are doing well - what makes people value appraisals?</li> <li>Team leaders/managers to discuss with teams - what do people want from appraisals? Why are they not finding them valuable?</li> <li>Appraisal training to be offered to staff</li> <li>Implement new appraisal paperwork</li> <li>Standardise supervision processes and documentation</li> <li>Implement new CPD process</li> <li>Pursue opportunities for new posts - university posts, secondments</li> <li>Continue to highlight opportunities and cascade via team meetings, IPRs and emails</li> <li>Suggested an implementation of post-appraisal feedback survey in pharmacy</li> </ul>	<ul style="list-style-type: none"> <li>Line managers to undertake updated training by end August</li> <li>Initial discussion with line managers by end June</li> <li>Monitoring appraisal feedback over the next 12 months (small team, not likely to generate insight more quickly than that)</li> <li>Sharing training approvals and any rejections across Group from now and monitoring our rejection rate</li> <li>To collect dept themes and evidence of whether changes are making a difference</li> </ul>

## Neuro 100 Bright ideas



### 24 ideas generated so far examples include:

#### Team building/development events and Training:

- Half a day every half year for the team to work on team building. [Regional WellFest event in June](#) but we appreciate that a Neuro specific event(s) would be a different thing.
- Education for Junior Doctors. [Regular teaching to start on Monday afternoons with longer sessions to compliment the regular sessions during educational half days.](#) Teaching will be for [SpRs, Juniors and ANPs.](#)

#### More staff/ shift changes:

- More staff in admissions. [Vacancy currently out to advert](#)
- A nurse specialist for Hydrocephalus service
- Twilight admin staff to do the scanning and folding of letters. [Will explore flexible working pattern for all admin to work lates and earlies \(covering 0800 am -1800 pm or later?\). This would enable uninterrupted working in the evenings when the phones aren't ringing constantly.](#)
- A regional bed manager or UHS repatriation manager who sits between the trust and the local hospitals. [The current neuro bed managers have very good relationships with the DGHs and communicate with them on a daily basis to negotiate transfers. Has been escalated to the trusts Flow Project for their comments.](#)
- Shift times change on the day shift would like to finish at 20:00 as most of the hospital does.

**Staff Survey Top 3 Priorities, Division A**

**Staff Survey feedback - Our top 3 improvement priorities**

Team name: Division A

Priority one	Action we will take	By when? How will we know it has made a difference?
<b>People</b> - Time pressures / Enough staff / conflicting demands - Job satisfaction / relationships / recognition	<ul style="list-style-type: none"> <li>Recruitment and retention focus</li> <li>Embedding of divisional monthly workforce meetings</li> <li>'Ideas for the future meetings'</li> </ul>	<ul style="list-style-type: none"> <li>Positive trends being demonstrated with HR turnover and vacancy metrics at monthly board and quarterly partnership meetings</li> <li>Quarterly ideas for the future meetings commenced August</li> <li>DHN and HRBP involvement in onboarding process from September</li> <li>R&amp;R Lead conducting supplementary exit interviews for those that chose not to say when leaving – commenced June</li> <li>Equality Diversity and Inclusion steering Group establishment first meeting September</li> </ul>
<b>Health Wellbeing and Safety at work</b> - Worn out/ burnt out / emotionally and physically exhausted	<ul style="list-style-type: none"> <li>Absence management training</li> <li>Appraisal training</li> <li>Ideas for the future meetings</li> <li>Annual leave booking and pre planning</li> </ul>	<ul style="list-style-type: none"> <li>Training sessions delivered by ER and HRBP between April and July</li> <li>First quarterly ideas for the Future meetings took place in August</li> <li>Positive trends being demonstrated with HR sickness, appraisal, and annual leave metrics at monthly board and quarterly partnership meetings – less annual leave carry over</li> </ul>
<b>Personal Development</b> - Appraisals helping me improve, feel valued, give clear objectives	<ul style="list-style-type: none"> <li>Introduction of progressive roles across the division</li> <li>Talent Management programme – leading on talent management pathways</li> <li>Align with transformation agenda to improve theatre productivity and enable culture change</li> </ul>	<ul style="list-style-type: none"> <li>Progressive roles introduced as and when needed – Progressive Nurse Practitioner, Ophthalmic Technician, Anaesthetic Associate roles, ACPs, ODPs, PNAs.</li> <li>Monthly divisional workforce meetings commencing September</li> <li>Positive trends being demonstrated with HR turnover metrics</li> </ul>

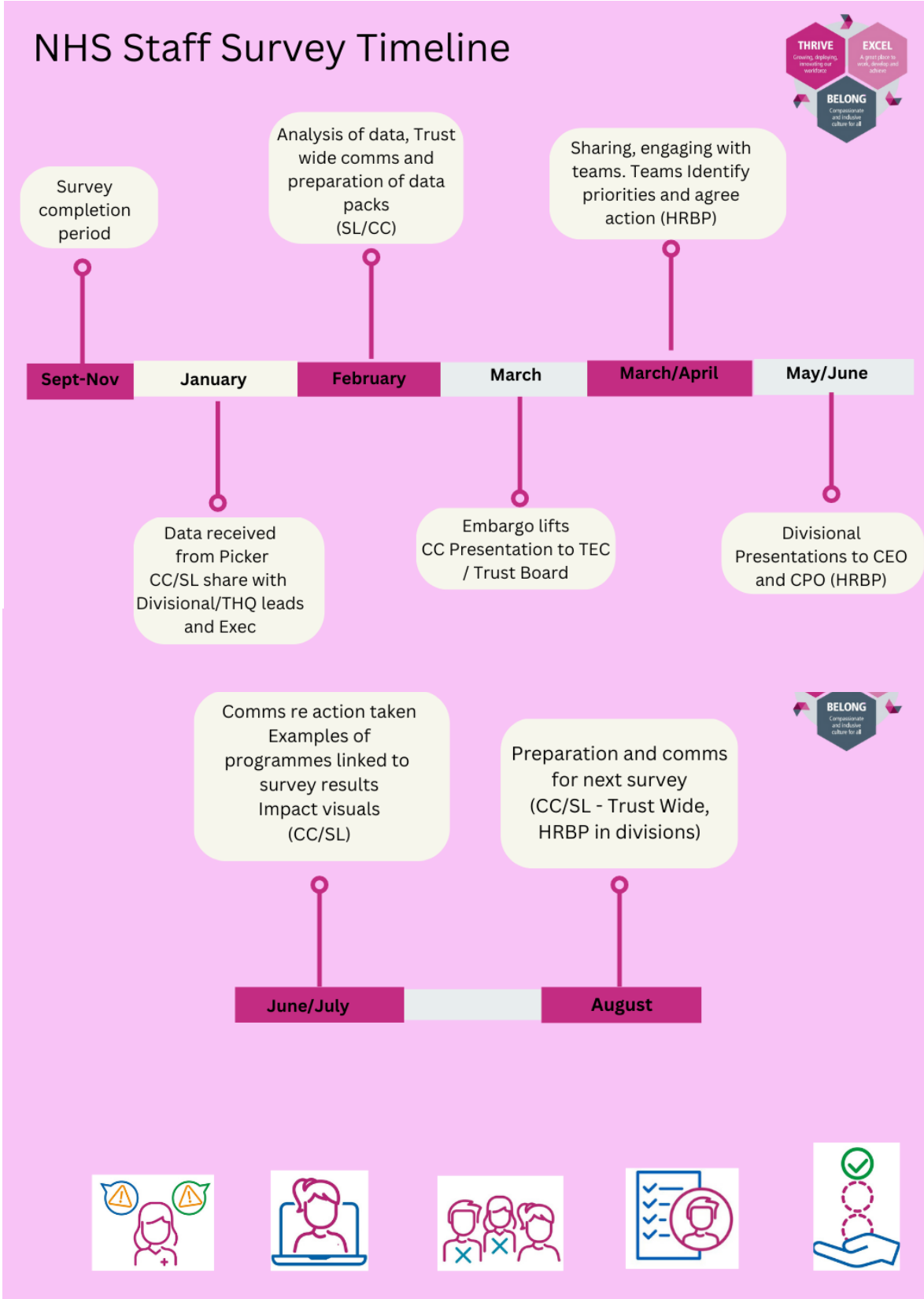
**3 Priorities ED**

**Staff Survey feedback - Our top 3 improvement priorities**

Team name: Emergency Medicine

Priority one	Action we will take	By when? How will we know it has made a difference?
<i>"Have we heard you?"</i>	Short 'sense check' survey for staff to ensure capture feedback accurately and for views going forwards using Trust Gthr platform	Survey out to all- will close end of September. Feedback will then be analysed to ensure appropriate interventions planned
<b>Pillars of belonging</b>	Link to Emergency Medicine 'Belonging' Strategy and 22/23 care group priorities initiatives underway - Wellbeing, Psychological Support, Communication, Career Pathways, Trust network groups, Freedom to Speak Up, Equality, Diversity and Inclusivity, Meaningful Appraisals, Education, FERF, Violence and Aggression strategy, Trim. Incorporation of NHS People Promise	Reduction in AER's, increase in FERF's, re survey staff, retention increase
<b>Power of appreciation</b>	AMU started a colleague appreciation award monthly, Dialogue tool to share information between MDT groups . to replicated in Adult and Paeds ED	Commenced in AMU June 2022- popular and creating a positive atmosphere. Dialogue tool to be published September -Both initiatives to be rolled out in ED by end of October.

**Appendix 6 – Timeline**



Report to the Trust Board of Directors				
<b>Title:</b>	<b>Guardian of Safe Working Hours Quarterly Report - March 2023</b>			
<b>Agenda item:</b>	<b>4.13</b>			
<b>Sponsor:</b>	<b>Paul Grundy, Chief Medical Officer</b>			
<b>Author:</b>	<b>Dr Diana Hulbert Emergency Medicine Consultant &amp; Guardian of Safe Working Hours</b>			
<b>Date:</b>	<b>30 March 2023</b>			
<b>Purpose:</b>	<b>Assurance or reassurance</b>	<b>Approval</b>	<b>Ratification</b>	<b>Information</b>  ✓
<b>Issue to be addressed:</b>	<p>Exception Reporting continues to be both low risk and low cost to the Trust.</p> <p>The vacancy rate for doctors in training is currently 8.42%; this equates to 74 vacancies.</p> <p>The spend on internal bank for locums continues to be high, relating to covering both short-term vacancies and longer-term gaps in the rotas.</p> <p>The changes in locum rates for doctors in training and subsequent communication have improved clarity for everyone involved and identified departments which have significant challenges in recruitment and retention. We are hopeful that there is improved communication with this group of doctors and that this will facilitate future negotiations.</p> <p>We were happy to support the Junior Doctors during the recent strike action. Significant work was 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. We await the outcome of negotiations between the Government and the BMA.</p> <p>From August 2023 we are hoping to streamline the provision of Self Development Time (SDT) across the Trust.</p>			
<b>Response to the issue:</b>				
<b>Implications:</b> (Clinical, Organisational, Governance, Legal?)	<p>There needs to be ongoing monitoring of exception reporting and appropriate support given to the Consultant Rota Leads.</p> <p>Additional support needs to be given to promote exception reporting across the medical workforce.</p> <p>Medical recruitment must remain a high priority for the Trust.</p> <p>There must be continued vigilance around rotas, sickness, and sustainability of the working patterns of doctors in training.</p> <p>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.</p>			



<p>Risks: (Top 3) of carrying out the change / or not:</p>	<p>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 junior doctors; to this end the new Trainee Doctor Pastoral Group has been set up to ensure that these doctors' needs are understood and met.</p>
<p>Summary: Conclusion and/or recommendation</p>	<p>The Board is invited to note the report and the concerns regarding work intensity, exception reporting, rota gaps, locum expenditure and the working lives of doctors in training.</p> <p>The next quarterly report will be submitted to Trust Board in June 2023</p>

**Executive Summary**

**Employment**

There are 751 Doctors in Training employed by the Trust and they all work on the 2016 contract (including lead employer hosted placements).

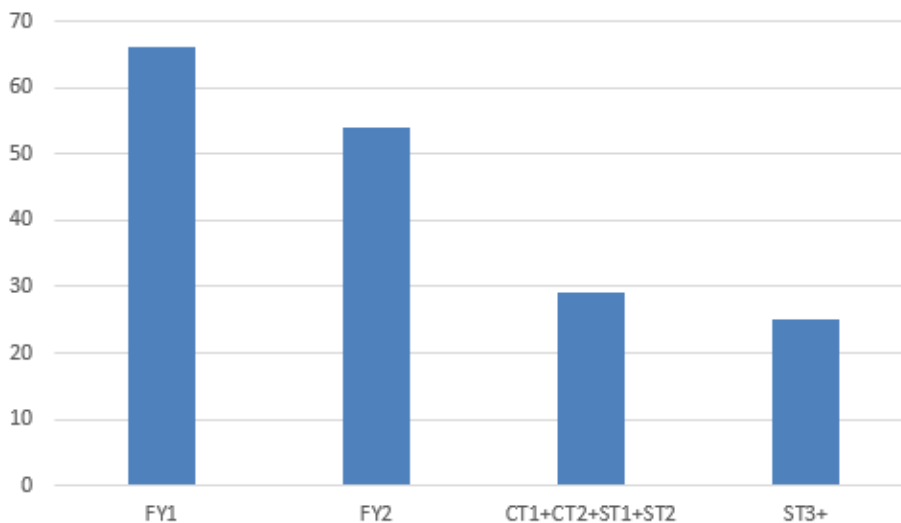
There are 375 Junior Doctors employed in non-training posts; all these doctors work on UHS local terms and conditions which mirror the 2016 contract

The current vacancy rate is 8.42% which equates to 74 wte vacant posts. Recruitment continues for current vacancies and Medical HR are working with departments to plan for future gaps.

**Exception reporting**

Since November 2022 (the last Board Paper) there have been 174 exception reports

The majority of exception reports are submitted by F1 and F2 doctors



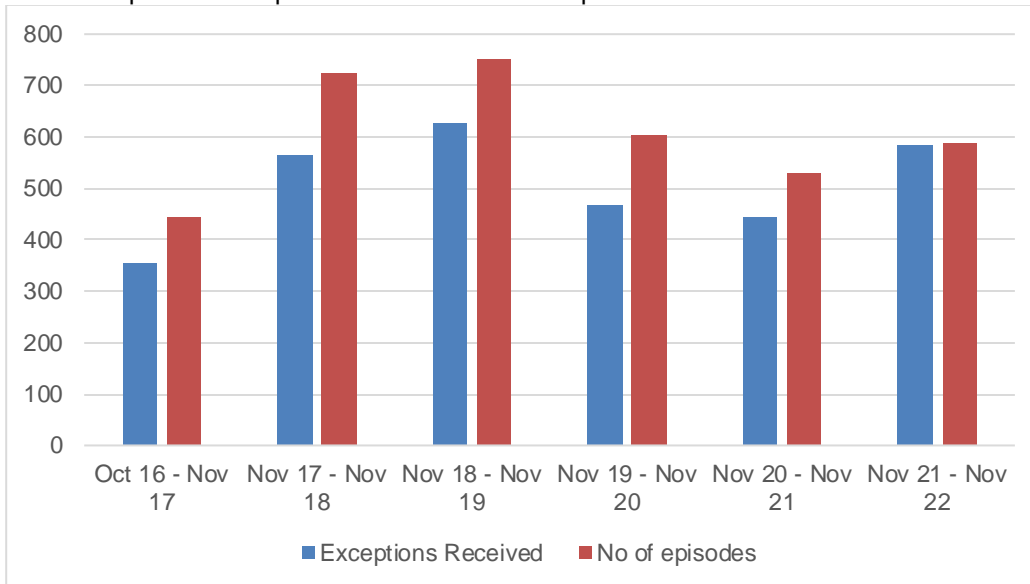
In total 3074 exception reports have been received at UHS since the implementation of the Junior Doctor Contract in October 2016

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

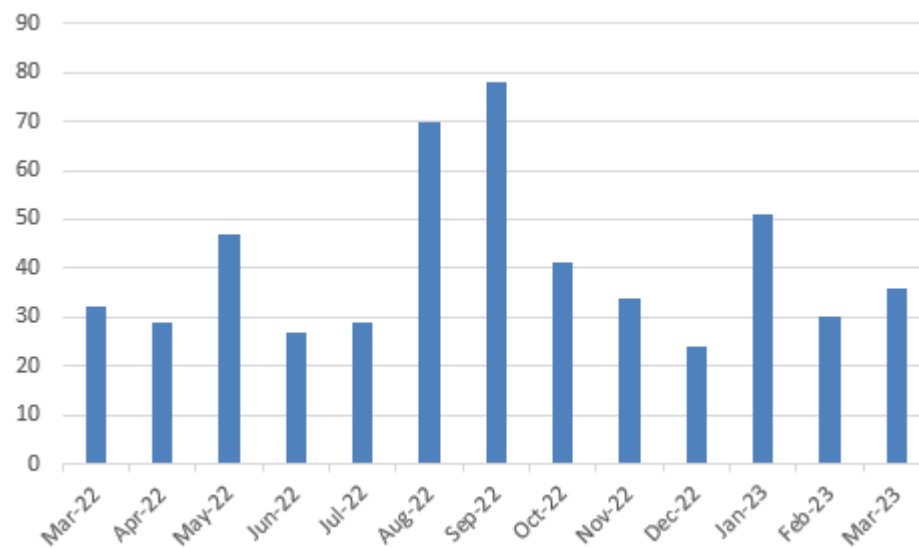
To date no exception report has been a breach incurring a financial penalty

The cost of exception reporting to UHS continues to remain low

Total exceptions and episodes received since implementation of contract:



Total exception reports received over last 12 months:



**Self Development Time**

All doctors in training and trust appointed are required to be given two hours of dedicated self development time (SDT) per week to complement that already available for training and is a requirement to be recorded in the doctors’ work schedules.

To enable doctors to take SDT UHS encourages the use of the exception reporting mechanism to raise concerns when SDT has been missed on at least 25% of occasions over a 12-week period. This allows us to review and adjust rotas.

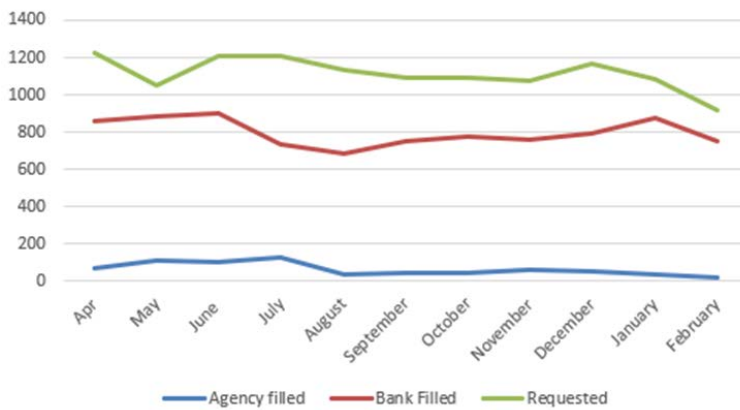
In the last 12 months we have only received 5 exception reports stating missed SDT

**Medical Locum Bank**

**Junior M&D shifts**

Month	Agency filled	Bank Filled	Requested	Bank fill %
Apr	72	863	1223	70.56
May	112	884	1048	84.35
June	102	901	1206	74.71
July	131	736	1207	60.98
August	34	687	1133	60.64
September	46	750	1090	68.81
October	48	774	1093	70.81
November	58	762	1076	70.82
December	54	795	1163	68.36
January	40	873	1081	80.76
February	20	753	916	82.21

**Junior Doctors fill**



Month	Number of payflags
September	6
October	23
November	12
December	45
January	22
February	24

### **Activity summary**

The Junior Doctor Executive Committee is led by the chief registrar and meets quarterly with increasing representation from across the specialties. This meeting brings together the Chief Registrar, the junior doctor representatives, the Mess presidents, the Guardian and members of the UHS Executive

The Junior Doctor Forum meets monthly and remains an informal method of communication between the junior doctors, the chief registrars, the Guardian and the Medical Workforce Team.

Both these meetings now take place in the Doctors' Mess and we are exploring a hybrid option to encourage wider participation

Dr Ahmed Daoud is the UHS Chief Registrar; he took up this post in August 2022 and will be with us for one year.

I aim to meet the rota leads and the workforce managers regularly to share good practice and discuss current issues in recruitment, retention and training.

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

### **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 and trauma and orthopaedics

Work intensity remains high and the ongoing impact of the covid pandemic, the rather stuttering recovery and the appearance of new variants coupled with a large number of flu cases has been significant.

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

These problems are national; I am confident that the divisional management and executive teams are aware of these issues and seeking improvement plans.

Rota annualisation can help alleviate the problem of annual leave and the introduction of a new locum 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.

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 F1s and F2s have highlighted some problems within the system which I believe we can fix.

There remains a need to discuss the evolution of the workforce. Work is being carried out around the role of junior doctors, advanced nurse practitioners, physician assistants and a range of non-clinical roles.

The significant expenditure on locums suggests that a review of medical and non-medical staffing is required to increase our baseline staffing which should lead to a decrease in the locum spend. An uplift in the workforce will need innovative solutions for staffing patterns and recruitment but would undoubtedly help retention.

The UHS locum rates change 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. There was a concern that many junior doctors (particularly those in the hard-pressed specialties) would be paid less for locum shifts; this has largely not been the case. UHS has taken on the concerns raised by several groups and there will be regular meetings between the junior doctors and members of the Executive. There is an absolute understanding that safety and risk will not be compromised and there will be close monitoring of both. I am hopeful that these pay agreements will be successful and acceptable to all. There will be regular review of the agreements. It will be particularly important to review the needs of the most hard-pressed specialties by assessing the regularity with which exceptional payments are requested, the number of unfilled locums and the number of exception reports.

In addition to the challenges of providing rotas which are sustainable and promote high quality work alongside an attractive life/work balance there are other issues that are important to the training and non-training doctor workforce. These issues are the subject of the work that I do with the Junior doctors, the Chief Registrar, the Medical Workforce Team led by Becci Mannion, the Executive and other colleagues. I am delighted to be a part of the new Trainee Doctor Pastoral Care group led by Dr Kristina May via Deanery support. Following my recent meetings with the F1s and the F2s I am convinced that we need to get the basics right. The concerns include provision of non-clinical space, the 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 work which will scope the office space available to junior doctors which we hope to review in July 2023.

A larger challenge for me is the realisation of the different expectations of different generations of doctors. I am hoping to embark on some open forum discussions around a more shared understanding. When a doctor embarks on a new career in an unfamiliar city (sometimes in an unfamiliar country) in a big Trust where she or he knows no one, is working a shift system and only has four months to understand, assimilate and succeed before moving on it is the provision of support in all its forms that determines the ability to thrive.

We are determined to ensure that the building blocks for a successful junior doctor workforce are in place in UHS.

**Appendix 1: Summary of junior doctor training vacancies March 2023**

<b>Cost centre</b>	<b>No of posts</b>	<b>No of vacancies (1Mar23)</b>	<b>Fill rate @ 1 Mar23</b>
<b>Vascular Surgery</b>	8	0	100.00%
<b>Cardiothoracic Surgery</b>	28	3	89.29%
<b>Cardiology</b>	43	5	88.37%
<b>Neurology</b>	21	0	100.00%
<b>Neurosurgery</b>	23	4	82.61%
<b>Neurophysiology</b>	2	0	100%
<b>Spinal Surgery</b>	3	1	66.67%
<b>T&amp;O</b>	48	1	97.92%
<b>Neonates</b>	35	10	71.43%
<b>O&amp;G</b>	38	1	97.37%
<b>Paediatric Cardiology</b>	14	0	100.00%
<b>Paediatrics</b>	56	6	89.29%

<b>PICU</b>	21	1	95.24%
<b>Paeds ED</b>	17	0	100.00%
<b>Chemical Pathology</b>	2	0	100.00%
<b>Microbiology</b>	12	2	83.33%
<b>Histopathology</b>	20	4	80.00%
<b>Palliative Care</b>	8	1	87.50%
<b>Medical Oncology</b>	24	6	75.00%
<b>Haematology</b>	21	1	95.24%
<b>Clinical Oncology</b>	18	3	83.33%
<b>Dermatology</b>	8	0	100.00%
<b>General Medicine</b>	11	2	81.82%
<b>Endo/Diabetes</b>	5	0	100.00%
<b>Clinical Genetics</b>	3	1	66.67%
<b>Rheumatology</b>	6	0	100.00%
<b>GI Renal</b>	30	1	96.67%
<b>Allergy/Respiratory</b>	27	0	100.00%
<b>MOP</b>	48	5	89.58%
<b>Acute Med</b>	25	2	92.00%
<b>Acute Med OOH</b>	6	0	100.00%
<b>PHEM</b>	3	2	33.33%
<b>ED</b>	68	9	86.76%
<b>Anaesthetics</b>	57	6	89.47%
<b>GICU</b>	40	3	92.50%
<b>SHDU</b>	9	2	77.78%
<b>NICU</b>	14	1	92.86%
<b>CICU</b>	12	1	91.67%
<b>Ophthalmology</b>	28	2	92.86%
<b>ENT</b>	11	1	90.91%
<b>Urology</b>	11	3	72.73%
<b>OMFS</b>	10	0	100.00%
<b>General Surgery</b>	48	0	100.00%
<b>Total</b>	<b>942</b>	<b>90</b>	<b>90.45%</b>

Report to the Trust Board of Directors				
<b>Title:</b>	Learning from Deaths 2022-23 Quarter 3 Report			
<b>Agenda item:</b>	4.14			
<b>Sponsor:</b>	Paul Grundy, Chief Medical Officer			
<b>Authors:</b>	Ellis Banfield, Associate Director of Patient Experience; Alex Woodhead, Mortality data and insight coordinator			
<b>Date:</b>	30 March 2023			
<b>Purpose:</b>	Assurance or reassurance x	Approval	Ratification	Information
<b>Issue to be addressed:</b>	<p>This report ensures that mortality reporting in relation to deaths, reviews, investigations, and learning is regularly provided to the board.</p> <p>The report also provides an update on the development and effectiveness of the medical examiner service.</p>			
<b>Response to the issue:</b>	<p><b>Summary</b></p> <ul style="list-style-type: none"> <li>• Q3 deaths failing under medical examiner review have increased slightly from previous year.</li> <li>• 97% of deaths reviewed found no evidence of avoidability</li> <li>• 3 deaths were reviewed and found to be possibly or probably avoidable.</li> <li>• 97% of cases were deemed good care or better by the medical examiner review</li> <li>• HSMR still sits within the low range and has decreased slightly since the last report.</li> </ul>			
<b>Implications:</b>	<p>The National Guidance on Learning from Deaths sets out expectations that:</p> <p><i>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.</i></p> <p>This paper sets out a plan to meet these requirements more fully.</p>			
<b>Risks:</b>	<ol style="list-style-type: none"> <li>1. The Trust does not reduce avoidable deaths in our hospitals.</li> <li>2. The Trust does not promote learning from deaths, including relating to avoidable deaths and good and poor quality of care.</li> <li>3. The Trust does not promote an open and honest culture and support for the duty of candour.</li> </ol>			
<b>Summary:</b>	This paper is provided for assurance.			

## 1. Introduction

In 2016 the CQC found that Trusts in England were unable to demonstrate best practice across all aspects of identifying, reviewing, and investigating deaths and capturing and actioning learning identified from these reviews. The CQC's report and recommendations was that mortality governance should be a key priority for Trust boards.

At UHS, IMEG was started in the Trust in September 2014 and has scrutinised all inpatient deaths since. Following national developments, the service has transitioned into the Medical Examiner Service, working to national guidelines, requirements, and expectations. Scrutiny starts with the electronic patient record's being reviewed by a Medical Examiners Officer (MEO) who looks at the pre-hospital care, presentation, and case history to be able to flag any potential issues to the Medical Examiner and identify cases for coronial referral. A doctor (of any grade) from a clinical team will come down and discuss the case with a trained Medical Examiner (ME) and offer a cause of death. This is either agreed upon or discussed further. If any further questions arise from the scrutiny or a potential issue is picked up the case will then be sent for an in-depth mortality review. These reviews can come in the form of questions directed to the speciality Morbidity and Mortality meeting, or an Urgent Case Review with the Patient Safety Team.

## 2. Analysis and Discussion

### 2.1 Total Deaths

Q3 deaths have increased from the previous year, though it is important to note the increase in community cases reviewed by the Medical Examiners' Service in this quarter:

Quarter	2022-23	2021-2022	2020-2021	2019-2020
Q1	578	504	564	606
Q2	653	429	511	541
Q3	651	639	529	589
Q4		531	634	620
Total	1882	2103	2238	2356

### 2.2 Mortality Reviews

In addition to medical examiner scrutiny other additional or more detailed levels of scrutiny may be applied. Some review processes are subject to national guidelines and directives such as the reviews for learning disability, paediatric and neonatal deaths. Others such as Morbidity & Mortality (M&M), Scoping and serious adverse event case review are locally managed governance processes, although they may feed into other national reporting processes.

The table below lists the total number of case referrals from the medical examiner service into the additional and more detailed scrutiny groups:

Quarter	M&M	Scoping	Paediatric	Neonates	LeDeR
Q1	15	2	17	3	1
Q2	19	7	-	-	2
Q3	13	8	-	-	4
Q4					
Total	47	17	17	3	7



As the table illustrates, in addition to Medical Examiner scrutiny, Q3 saw:

- 13 deaths sent to sub-speciality Morbidity and Mortality groups (M&M) for further clarification / questions
- 8 cases were sent for an urgent serious adverse event Case review (commonly known as a scoping meeting within the Trust) with the Patient Safety Team because the reviewing medical examiner felt that death probably avoidable with different or better care
- 4 LeDeR referrals were also made
- Information on paediatric and neonate reviews not available at time of writing

Most cases get assigned an initial avoidability and quality rating which then gets adjusted accordingly if they are sent for further review:

The table below outlines outcomes from Medical Examiner Service:

Avoidability	Q4	Q1	Q2	Q3
1. Definitely Avoidable	1			
2. Strong Evidence of Avoidability				
3. Probably Avoidable (>50:50)	1		2	1
4. Possible Avoidable (<50:50)		2	2	2
5. Slight Evidence of Avoidability	2	3	6	6
6. Definitely not avoidable	611	573	638	633
Quality of care				
1. Very Poor				
2. Poor care	2		2	1
3. Adequate Care	3	1	7	7
4. Good Care	611	575	617	589
5. Excellent Care	2	2	18	43

### ***Avoidable deaths***

Above, 2 deaths were reviewed and categorised as ‘possibly’ avoidable and 1 as ‘probably’ avoidable.

- Possibly Avoidable Case 1: Coroner referral and concerns raised about medical management of the patient, in particular whether diagnosis of Metastatic Squamous Cell Carcinoma could have been earlier and avoided multiple surgeries.
- Possibly Avoidable Case 2: Coroner referral and cause of death was a rapid decline from overwhelming sepsis. Internal scoping review due to delay in admission to ITU from ED- did not affect mortality but earlier monitoring would have been preferential.
- Probably Avoidable Case: patient with learning disabilities and other vulnerabilities died suddenly. Family had raised some concerns about care and case referred to coroner.

## **2.3 Paediatric and neonatal mortality review**

A full paediatric and neonatal mortality update will be included in the Q4 / year review report.

## **2.4 HSMR**

- 2.5.1. Our contract with Dr Foster recently finished and the BI are in the process of swapping over to HED (run by UH Birmingham), who have HSMR, albeit ever so slightly different.
- 2.5.2. The HSMR in the most recent 12 months of data (Dec21-Nov22) from Dr Foster has reduced compared to the previous update and was 88.1.

## **3. Medical Examiner Service Update**

- 3.1 A new substantive lead medical examiner for UHS has been appointed in Dr Harnish Patel. Dr Patel will oversee the scrutiny and review of all deaths referred into the service from the Trust.
- 3.2 Dr Paul Wharton has been appointed the lead medical examiner for the community side of the service and is prioritising onboarding Southampton's PCNs and refining the referral and review process.
- 3.3 Substantive recruitment for remaining available medical examiner PA sessions has been completed.

## **4. Conclusion**

- 4.1 UHS continues to demonstrate low levels of avoidable mortality and overall good quality of care for most patients who die during their admission. HSMR has declined and is within 'low' range and overall mortality rate remains lower than pre-Covid levels.
- 4.2 New joint lead medical examiner appointed which will provide substantive clinical leadership of the Medical Examiner Service going forward as the scope of its reviews increase (due to become statutory April 2023).

Report to the Trust Board of Directors				
<b>Title:</b>	<b>UHS Smoke Free Site Model</b>			
<b>Agenda item:</b>	<b>5.1</b>			
<b>Sponsor:</b>	<b>Mr Paul Grundy, Chief Medical Officer</b>			
<b>Author:</b>	<b>Katie Lovely &amp; Annabel Shawcroft, Clinical Programme Officers Luci Hood, Head of Medical Directorate</b>			
<b>Date:</b>	<b>30 March 2023</b>			
<b>Purpose:</b>	<b>Assurance or reassurance</b> ✓	<b>Approval</b> ✓	<b>Ratification</b>	<b>Information</b>
<b>Issue to be addressed:</b>	<p>Tackling the issue of smoking across UHS is universally in our best interest with smoking accounting for 1 in 6 deaths in Southampton and costing our Trust £10.8million annually. The NHS is increasingly looking after people with long-term health conditions, and we need to do more in creating an environment where people are supported to make healthier decisions.</p> <p>In September 2022, the Trust Board approved a consultation piece to establish how best to achieve a smoke free site. The consultation involved all members of the UHS community (staff, patients and public) which allowed the steering group to develop an evidence-based model that will engage and support staff, patients and visitors. To achieve the recommended model non reoccurring costs have been identified and outlined within this paper.</p> <p>Shouldering the Smoke Free initiative lies with the Inpatient Smoking Cessation Service which has been temporarily funded by the ICB to achieve the mandated requirement outlined within the NHS Long Term Plan. Since the implementation of this service the team has seen great success and currently reporting a 36% quit rate. (10% higher than other well-developed services). However, to continue this level of success the service needs recurrent funding.</p>			
<b>Response to the issue:</b>	<ul style="list-style-type: none"> <li>• Tobacco dependency steering group initiated to oversee delivery of:               <ul style="list-style-type: none"> <li>-patient smoking cessation services,</li> <li>-UHS smoking policy,</li> <li>-Smoke free site</li> </ul> </li> <li>• Trust board approval for move to smoke free site September 2022</li> <li>• Six month consultation period to agree smoke free model at UHS</li> <li>• UHS Smoke free site model proposed to TEC and Trust board for approval, March 23.</li> <li>• Review of costs to achieve smoke free, with considerations of cost efficiency where possible.</li> </ul>			
<b>Implications: (Clinical, Organisational, Governance, Legal?)</b>	<ul style="list-style-type: none"> <li>• Our Values: pledging to this initiative and completing a consultation with staff and service users reflects our three core values and allows us to grow strong collaborative working across all areas of UHS as we implement a smoke free site.</li> <li>• National NHS Strategy: a pledge and strategy links to the objectives of the national NHS Smoke-free pledge.</li> </ul>			

	<ul style="list-style-type: none"> <li>• CQC Ratings: It aims to support the delivery of an authentically 'Outstanding' NHS organisation under CQC ratings, and specifically to support Outstanding in the Well Led Domain.</li> <li>• Financial Impact: The strategy will require appropriate investment which is outlined within this document.</li> <li>• System Collaboration: The strategy will require collaboration with staff, service users and partners to UHS.</li> </ul>
<p>Risks: (Top 3) of carrying out the change / or not:</p>	<ul style="list-style-type: none"> <li>• National reputation: If UHS does not adopt the national 'smoke-free' stance it could be perceived as not supporting our local population to avoid long-term health conditions and failing to support health equality.</li> <li>• Local reputation: Comms review 2022 showed negative feedback within the trust and on social media to smoking on the UHS site. Staff and patient survey completed supported the move to smoke free site.</li> <li>• Stakeholder Engagement: The Steering group recognise that the trust could go smoke free by putting up signs and removing shelters, however through learning from other trusts this method has proven to not be successful alone. Move to smoke free must be adequately managed to enable success.</li> </ul>
<p>Summary: Conclusion and/or recommendation</p>	<ul style="list-style-type: none"> <li>• The Board is asked to review and approve the smoke free site model proposed at UHS.</li> <li>• Approve proposal to sign the NHS smoke free pledge after the 1st April, committing to taking actions to go smoke free</li> <li>• Review associated costs for both smoke free site and smoking cessation and support process to identify funding streams (internal and external) as required.</li> </ul>

# UHS smoke free site model



Trust board

Annie Shawcroft and Katie Lovely,  
Project officers, Clinical Programme

Paul Grundy, Chief Medical Officer

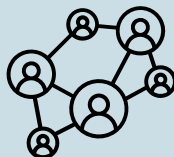
Luci Hood, Head of Medical Directorate

# Purpose

- This paper aims to:



Gain approval of recommended smoke free model



Provide assurance consultation has been completed



Provide an overview of current recommendations and implementation plan



Gain approval for UHS to sign National Smoke free pledge

# Executive summary

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Tackling the issue of smoking across UHS is universally in our best interest with smoking accounting for 1 in 6 deaths in Southampton and [costing our Trust £10.8million annually](#). The NHS is increasingly looking after people with long-term health conditions, and we need to do more in creating an environment where people are supported to make healthier decisions.

In September 2022, the Trust Board approved a consultation piece to establish how best to achieve a smoke free site. The [consultation involved all members of the UHS community \(staff, patients and public\)](#) which allowed the steering group to develop an [evidence-based model](#) that will engage and support staff, patients and visitors. To achieve the recommended model non reoccurring costs have been identified and outlined within this paper.

Shouldering the Smoke Free initiative lies with the Inpatient Smoking Cessation Service which has been temporarily funded by the ICB to achieve the mandated requirement outlined within the NHS Long Term Plan. Since the implementation of this service the team has seen great success and currently reporting a [36% quit rate](#). (10% higher than other well-developed services). However, to continue this level of success the service needs recurrent funding (outlined below).

Therefore, the Trust Board is asked to [approve the recommended smoke free model and review associated costs](#) as well as the reoccurring costs to support our patients to quit smoking. We also ask the Board to [sign the Smoke Free Pledge on 1st April 2023](#) to publicise our commitments going forward.

# Content



## Introduction

- Current state
- Case for change

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5-7



## UHS smoke free site model

- Governance
- Consultation
- The model
- Decisions/ discussions
- Costs
- Implementation plan
- Risks/ issues

Slides  
8-20



## Smoking cessation services

- Model and impact
- Costs

Slides  
21-23



## Recommendations

- NHS smoke free pledge
- Recommendation overview

Slides  
24-26



## Appendices

- Detail by workstream
- Literature review

Slides  
27-37  
Enclosure  
A

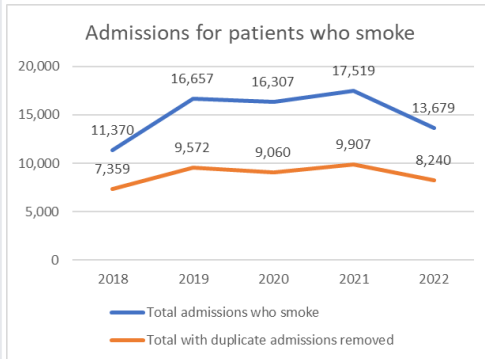


# Introduction



# Current state

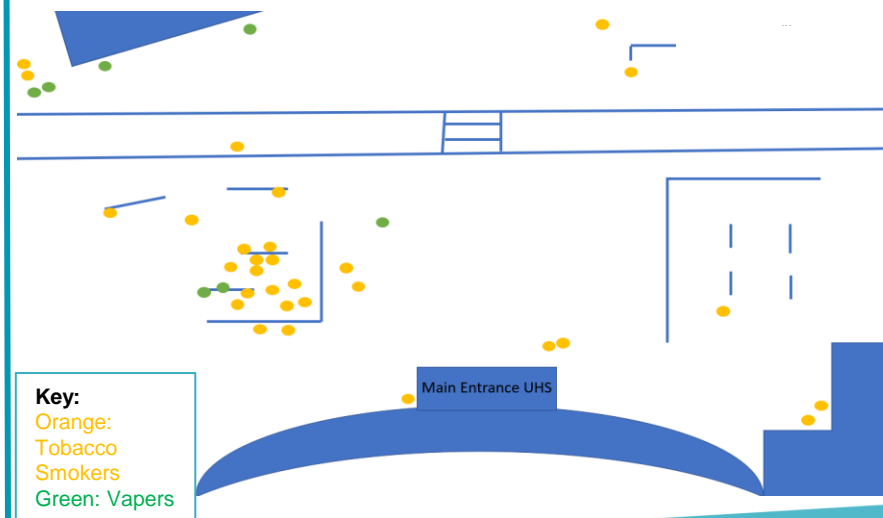
The table below highlights the numbers of smokers admitted at UHS per year:



## Cost of smoking

The price of tobacco relative to retail prices have increased by **48%**, whilst real households' disposable income increased by **8%** over the same 10-year period. As a result, tobacco has become **27%** less affordable since 2009

Observations of the main entrance were completed. At any one time between 12-18 tobacco smokers and 1-4 vapers were observed at the main entrance. Many smokers were seen to congregate around the benches to the left of the front door behind the two partitions. An example of the distribution of smoking at the main entrance is illustrated below.



Approx 10,000 people pass through the main entrance daily.

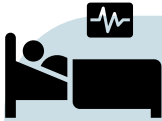


12% of the local population are smokers, therefore we can assume up to 1200 people per day visiting the hospital smoke.



Numerous complaints related to smoking through PALS and on social media platforms.

# Case for change



Our local smoking population costs UHS NHSFT **over £10.8 million per year** with our smoking attributable hospital admissions and COPD related hospital admissions significantly higher than the nationwide average.

Smoking tobacco is linked to over 100 different conditions, including at least 15 different types of cancer, 9 mental health conditions and numerous respiratory, cardiovascular and other disorders (RCP, 2018).



Supporting patients, service users and staff to overcome their tobacco dependence will not only provide improvements in their health but reduce health inequalities and decrease demand on services by reducing the number of smoking related admissions and readmissions.

Smoking accounts for one in six of all deaths in Southampton - 70% of our lung cancer cases, 86% of our COPD patient deaths are directly attributable to smoking. 600,000 non-smokers die each year from second hand smoke, 28% of which are children (WHO, 2022).



Smoking tobacco is linked to just over 500,000 hospital admissions each year, with smokers being 36% more likely to be admitted to hospital than non-smokers. In 2022 there were **13,679 admissions and readmissions to UHS** for 8,240 patients who smoked.

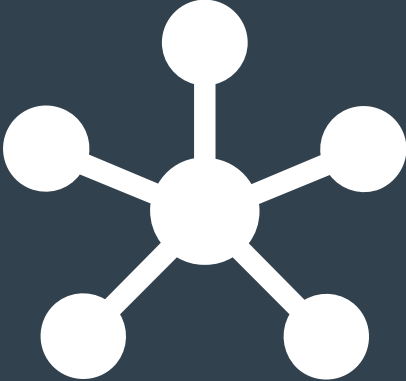
Stopping smoking results in an improved response to cancer treatments, faster recovery after surgery, fewer exacerbations of cardiovascular disease, slower decline in lung function, lower pharmacotherapy costs (for mental health patients) (RCP, 2018)



Supporting patients and staff with tobacco dependence will lead to improved health, reduced admissions, reduced health inequalities, financial benefits to UHS and those who smoke, and reduce pressures on hospital services. We must also focus on providing an environment free from secondhand smoke for non-smokers.

Smoke free site and smoking cessation services go hand in hand to deliver this successfully. Tobacco dependency teams provide support and guidance for individuals to quit. Smoke free site signposts services and creates the environment for interventions to be successful.

# UHS smoke free site model



# Governance

The Tobacco Dependency Steering group, sponsored and chaired by Paul Grundy was established in September 2021 with the following aims:



Recommend options for UHS to go smoke Free

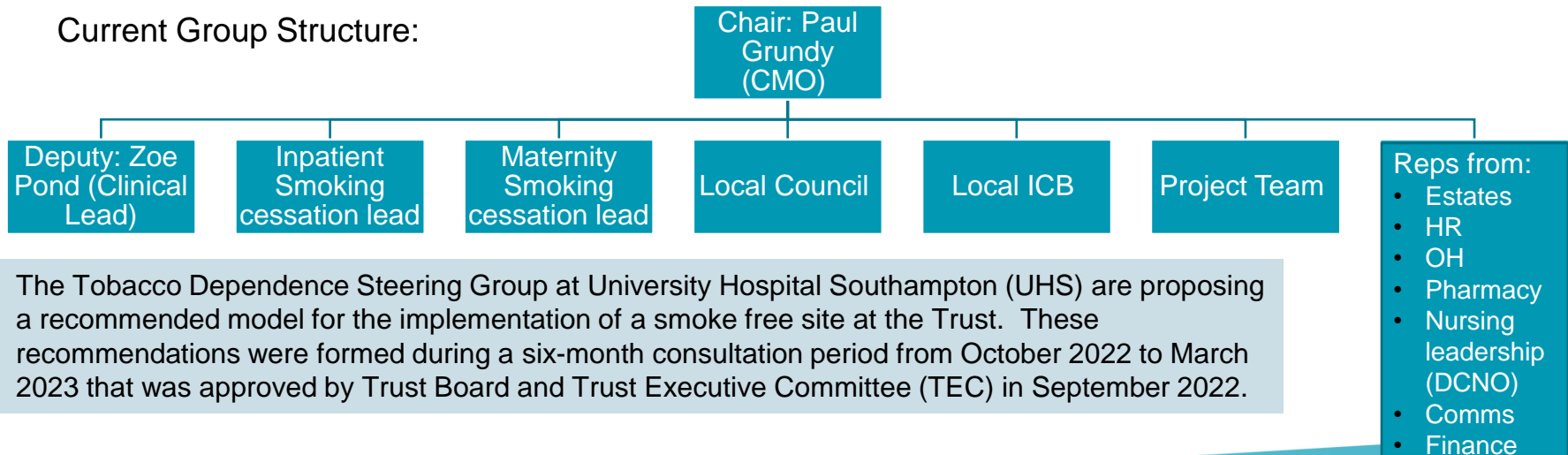


Review and update the current smoking policy



Implement services in inpatients and maternity to achieve the LTP for acute smoking cessation services by 2023/2024

## Current Group Structure:



The Tobacco Dependence Steering Group at University Hospital Southampton (UHS) are proposing a recommended model for the implementation of a smoke free site at the Trust. These recommendations were formed during a six-month consultation period from October 2022 to March 2023 that was approved by Trust Board and Trust Executive Committee (TEC) in September 2022.

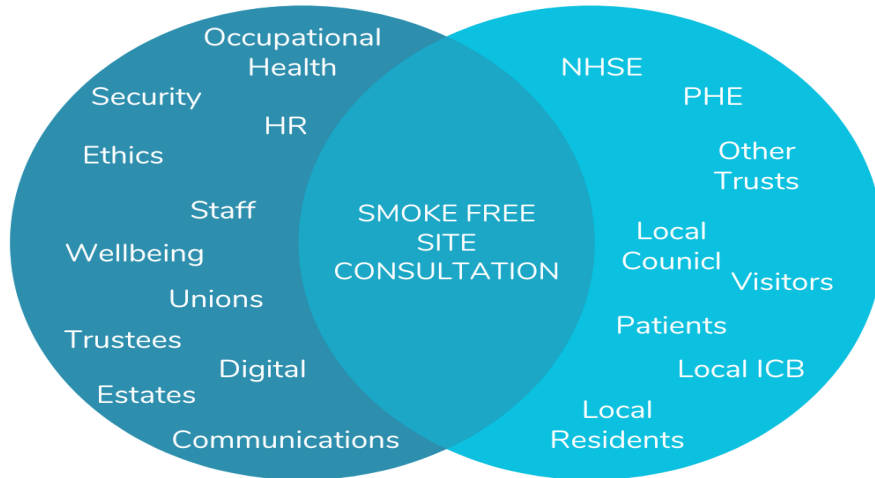
# Consultation Process

Following the approval from Trust board in September the project team have carried out a consultation to identify the concerns around going smoke free whilst reviewing the evidence surrounding going smoke free and working with stakeholders to mitigate risk.

## Stakeholders consulted

Internal Stakeholders

External Stakeholders



## Consultation Activities



8 Staff Focus Groups



Stakeholder Impact Assessments



Patient, Visitor and Resident Survey



Observing number of smokers at Main Entrance



Online Members Meeting

Presented at Talk to David Event



Contacted other trusts nationwide



Attending Health Roadshow Events



Shared learning through PHE and ICB



Review of site maps, signage, shelters and bins

# Consultation Outcomes

During the consultation main themes for concerns were recognised (word cloud below). This gave us a steer on the topics we needed to research and focus on.



Throughout the whole consultation period the majority of stakeholders agreed UHS should be a smoke free site. Findings were fed back to the steering group which informed the discussions and decision outlined within this paper.

## General Comments:



# Workstreams

The UHS smoke free site model has been considered through the following workstreams:



## Environmental enablers

### Smoking presence

- Smoking on site
- Vaping on site

### Estate changes

- Smoking shelters
- Cigarette bins

### Communications

- Signage
- Intranet campaign

### Enforcement

- Smoking policy
- Uniform



## Support and Well-being approach

### Patient services

- Smoking cessation model
- NRT access

### Staff services

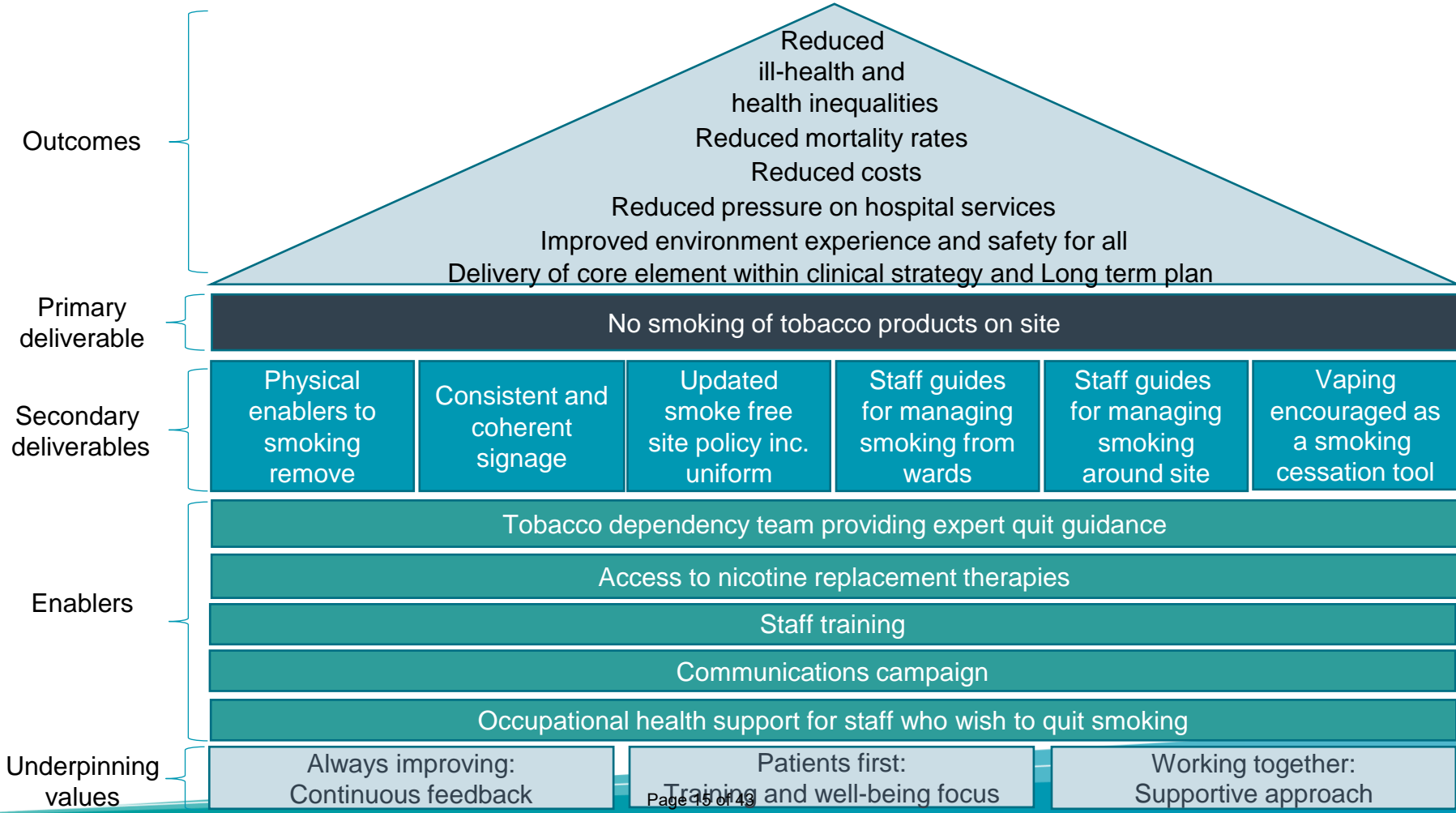
- Smoking cessation support
- Peer support

### Engagement

- Consultation
- Staff training on approach



# UHS Smoke free site model



# Decisions

The UHS tobacco dependence steering group recommends the following decisions related to the UHS smoke free site model. Consultation and research details leading to these decisions can be found in slides 26- 34.

Workstream	Decisions
Smoking presence	<ol style="list-style-type: none"> <li>1. There will be a phased Implementation to the smoke free model</li> <li>2. No smoking of tobacco products on site.</li> <li>3. Vaping will be allowed on site, outside</li> <li>4. Vaping will only be promoted/encouraged as a smoking cessation tool</li> </ol>
Estate changes	<ol style="list-style-type: none"> <li>5. All smoking shelters will be removed</li> <li>6. All prominent bins with ash tray elements will be removed.</li> </ol>
Communications	<ol style="list-style-type: none"> <li>7. Increased and consistent signage around site with smoke free comms campaign</li> </ol>
Enforcement	<ol style="list-style-type: none"> <li>8. UHS smoking policy will be updated to outline enforcement plan for staff and patients, with supportive approach which encourages use of NRT/ smoking cessation services</li> </ol>
Patient services	<ol style="list-style-type: none"> <li>9. NHSE smoking cessation model will be implemented in inpatient wards</li> <li>10. Ward staff will be provided guidance to support management of patients who wish to smoke</li> </ol>
Staff services	<ol style="list-style-type: none"> <li>11. OH will offer 12 weeks NRT and support to those who sign up to stop smoking services</li> </ol>
Engagement	<ol style="list-style-type: none"> <li>12. Staff training will be available on how to approach someone who is smoking</li> <li>13. Maximize engagement through peer support and training tools</li> </ol>

# Ongoing Discussions

The UHS tobacco dependence steering group is yet to form final recommends on the following topics related to the UHS smoke free site model. Further consultation and research is required.

Workstream	Discussion topics
Smoking presence	1. Locations for vaping
Estate changes	2. Use of smoking shelters in non-prominent locations 3. Bins with ashtray elements on periphery of the site
Enforcement	4. Wearing or covering of uniform before smoking on/off site
Patient services	5. Future funding for patient smoking cessation inpatient model 6. Reviewing options for provision of vapes on site with consideration of control (age) and sustainability.
Staff services	7. Options to support staff wellbeing during quit or abstaining from smoking

# Non rec Costs

The table below outlines non recurrent costs required to enable delivery of smoke free site within 2023/24.

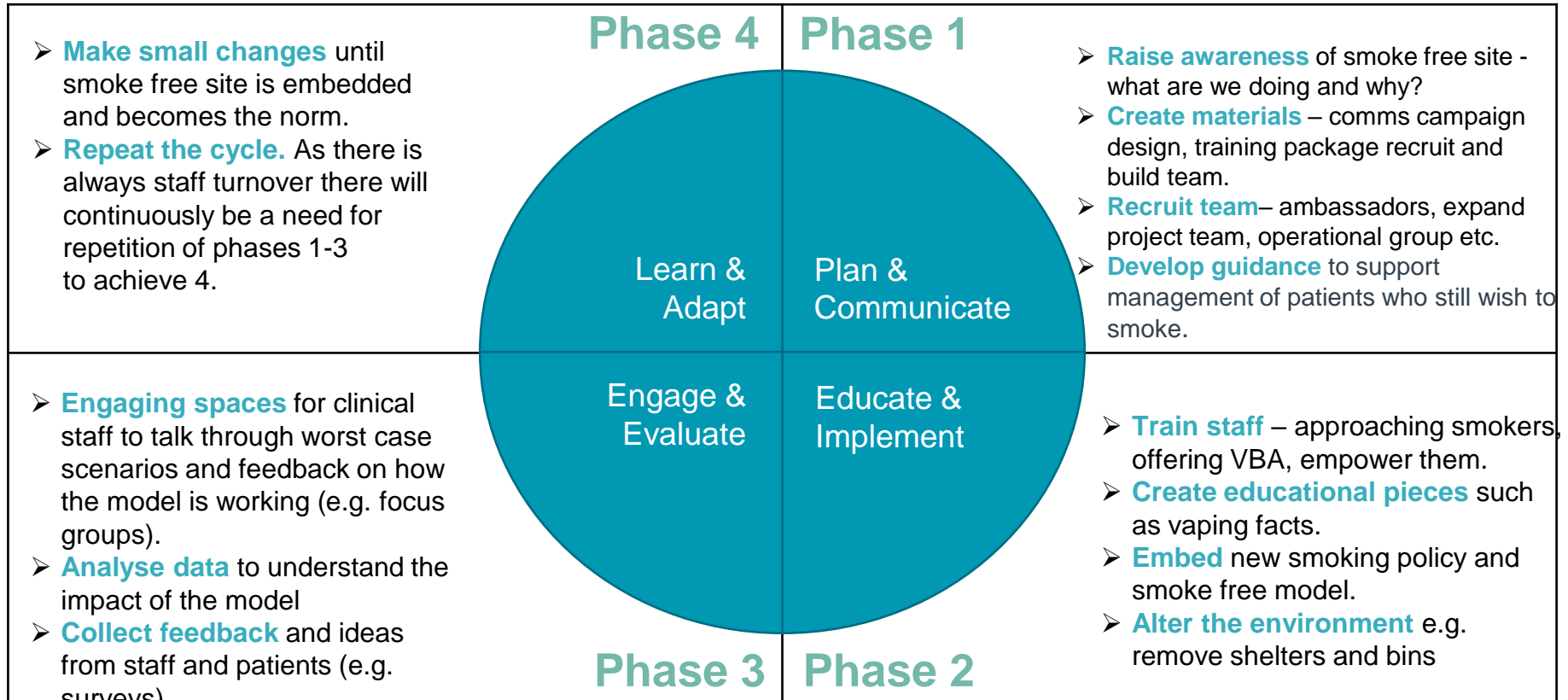
## New costs:

Department	Expenditure type	Rec/ non rec	Expenditure description	Cost (£)
Estates	Non pay	Non rec	Removal of all smoking shelters, bins with ashtray elements, seating and signs.	£7,837
Estates	Non pay	Non rec	Smoke Free Site signage (main entrance and rest of site)	£10,000
Comms	Non pay	Non rec	Design and supply of materials	£6,000
Comms	Pay	Non rec	Communication officer resource (WTE 0.2 B5)	£5,411
<b>Total</b>				<b>£29,248</b>

## Extension of costs within run rate

Department	Expenditure type	Rec/ non rec	Expenditure description	Cost (£)	Current non rec funding in run rate	Net run rate impact
Medical directorate	Pay	Non rec	Project officer to oversee delivery plan (1 WTE B6)	£45,774	£59,506	- £13,732
<b>Total</b>				<b>£45,774</b>	<b>£59,506</b>	<b>- £13,732</b>

# Implementation phases



# Draft implementation plan 2023/24

Workstream	Q1	Q2	Q3	Q4
Smoking presence	Reduction in prevalence of smoking on site			No smoking on site
	Decision: vaping locations			
Estate changes	Prominent shelters removed Prominent bins removed	Decision: use of remaining shelters Decision: peripheral bins	Implement shelter decision Implement bin decision	
Communications	Intranet campaign			
	Signage designed	Signage installed		
Enforcement	Smoking policy published Uniform decisions			
Patient services	Smoking cessation model rolled out across wards			Decision: future funding
Staff services	Staff smoking cessation support offered			
	Peer support planned			
Engagement	Build training package Recruit champions & build teams	Decision: future funding	Staff training and rollout Feedback survey	Feedback survey

# Risks

The table below outlines risks that have been considered and planned mitigations.

Ref	Risk	Likelihood	Impact	Risk score	Mitigation/ impact
R1	If the culture around smoking does not change, people will continue to smoke on site	4	3	12	The smoke free site model will still be seen as a success if numbers of people smoking on site are significantly reduced. In the event the cultural change approach does not have the desired impact, enforcement methods will be documented within the smoking policy for patients, visitors and staff.
R2	If supply of NRT does not improve, we could struggle to offer full range of options to patients.	3	3	9	Brexit and general supply issues have removed the number of products available. We can mitigate with offering patches while we await availability of new products in pipeline. Provision of vapes will also support shortage of traditional NRT methods.
R3	Smoke free site model cannot be funded, then the prevalence of smoking on site will not change		4		Do nothing scenario. Comms will not be developed, signage will not be present and shelters and bins will remain. Efforts to go smoke free will not be coordinated. Smoking at UHS will remain the same without reducing health impact, continued mortality, inequalities, hospital pressures and environmental impact.
R4	If Tobacco dependency team cannot be funded, then patients will not receive support to quit		4		Patients will not have timely access to support and NRT while in hospital. Likely to impact on numbers who are able to quit/ abstain while at UHS and potential risk of increased aggression towards staff if NRT is not prescribed.

# Issues

Becoming smoke free will be challenging and these challenges have been discussed at length with the steering board and through the consultation. Although difficult, agreement has been reached that these should not prevent UHS from taking measures to become smoke free. A small sample of the key issues which have been discussed are outlined below.

Issue/ concern	Discussions/ actions
What about patients or visitors who are facing really challenging times and need to smoke to manage stress/ distress.	NRT will become more readily available to patients via tobacco dependency team and prescription bundles. Decisions ongoing regarding the provision of vapes on site. We expect that smoke free site actions will not immediately eliminate all smoking from the premises. A considerable reduction will be considered a success in improving the environment for our patients and staff. We will take learning from other hospitals, including mental health trusts, who have successfully taken steps to become smoke free.
There is a risk staff will face aggression and violence when asking people to stop smoking	We are taking learning from other organisations who have developed a supportive messaging approach. This will be incorporated into training, along with clarity that staff safety must be taken into account when imposing the smoke free site. Will consider well-being support for staff around difficult conversations. Successful provision of NRT has shown to reduce aggression and violence.
What will staff do if an unwell patient wishes to leave site to smoke	Guidance will be developed support management of patients who wish to smoke.
Preventing smoking on site will push people out on to neighbouring streets, causing conflict with local residents	Local residents have been contacted during the consultation period and will continue to be engaged with.
Will preventing smoking on site encourage smoking in hidden locations, creating a fire risk.	Review of fire risk data from other organisations to be completed to quantify this risk.

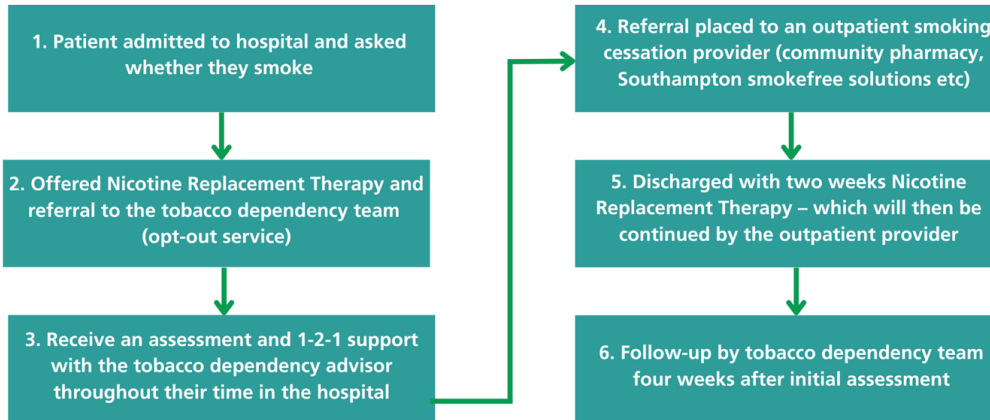


# Smoking cessation services



# Smoking cessation services

## Current Pathway



## Successes

- Currently have 34% successful quit rate.( Other well regarded smoking cessation services are recording quit rates of approx. 26%)
- Invited to present at HSJ Conference
- Recruitment of PT B7 Project manager and FT B4 Tobacco Dependency advisor
- Development and implementation of smoking cessation service in the acute setting with numbers of referral received increasing
- Training and development for all staff- number completed Very Brief Advice training increased from 4 people completing the training to 500!
- Improving methods of prescribing NRT via Jacs prescribing software
- Up to date referral pathway to community services.

## Challenges

- Staffing- current levels of staff does not allow for A/L or sickness and leaves the service extremely vulnerable.
- Difficulties identifying patients that smoke on admission as relevant boxes within Charts often not completed.
- Difficulties accessing enough NRT-due to national shortage
- Funding post non rec ICS investment (March 2024)

## Future Requirements

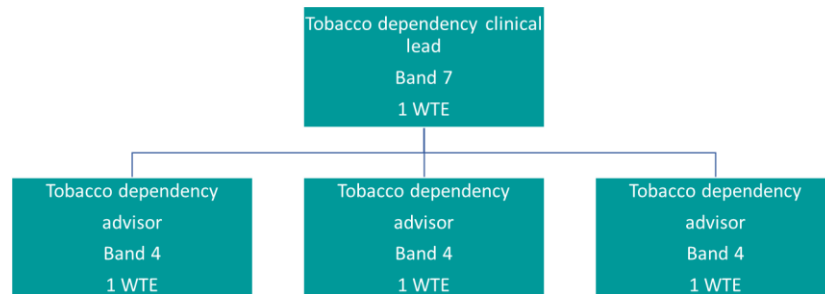
- Sufficient resources to meet demand as service grows- currently at capacity as is
- Substantive roles/ Extension of contracts as currently the whole team are on fixed term contracts.

# Rec Costs

The table below outlines recurrent costs required to enable delivery of smoking cessation services.

Expenditure type	Rec/ non rec	Expenditure description	Cost (£)
Non pay	Rec	CO monitors and consumables	£250
Non pay	Rec	Equipment (laptops, mobiles, printing)	£1,985
Non pay	Rec	Training and conferences	£2,841
Pay	Rec	1 WTE Band 7 Tobacco dependency clinical lead	£56,370
Pay	Rec	3 WTE Band 4 Tobacco dependence advisors	£92,454
<b>Total</b>			<b>£151,137</b>

Ongoing funding model to be discussed with public health and ICS.



# Recommendation



# NHS Smoke free pledge

## The NHS Smokefree Pledge

### As local health leaders we acknowledge that:

- Smoking is the leading cause of premature death, disease, and disability in our communities
- Smoking places a significant additional burden on health and social care services and undermines the future sustainability of the NHS
- Healthcare professionals have a key role to play in motivating smokers to try to quit and offering them further support to quit successfully
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities
- Smoking is an addiction starting in childhood with two thirds of smokers starting before the age of 18
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the tens of thousands of people its products kill in England every year

### We welcome:

- The Government's ambition to make England smokefree by 2030 and tackle health inequalities in smoking prevalence
- The NHS Long Term Plan's commitment for all smokers in hospital, pregnant women, and long-term users of mental health services to be offered NHS funded tobacco dependence treatment by 2023-24
- NICE public health guidance on tobacco

### In support of a smokefree future, \_\_\_\_\_ commits from \_\_\_\_\_ to:

- Treat tobacco dependency among patients and staff who smoke in line with commitments in the NHS Long Term Plan and Tobacco Control Plan for England
- Ensure that smokers within the NHS have access to the medication they need to quit in line with NICE guidance on smoking in secondary care
- Create environments that support quitting through implementing smokefree policies as recommended by NICE
- Deliver consistent messages about harms from smoking and the opportunities and support available to quit in line with NICE guidance
- Actively work with local authorities and other stakeholders to reduce smoking prevalence and health inequalities
- Protect tobacco control work from the commercial and vested interests of the tobacco industry
- Support Government action at national level
- Publicise this commitment to reducing smoking in our communities and join the Smokefree Action Coalition (SFAC), the alliance of organisations working to reduce the harm caused by tobacco

### Signed by:

Chair

Chief Executive

Medical/Clinical Director

The NHS Smokefree Pledge outlines commitment as an organisation to:

- Treat tobacco dependency among patients and staff who smoke in line with commitments in the NHS Long Term Plan and Tobacco Control Plan for England
- Ensure that smokers within the NHS have access to the medication they need to quit in line with NICE guidance on smoking in secondary care
- Create environments that support quitting through implementing smokefree policies as recommended by NICE
- Deliver consistent messages about harms from smoking and the opportunities and support available to quit in line with NICE guidance
- Actively work with local authorities and other stakeholders to reduce smoking prevalence and health inequalities
- Protect tobacco control work from the commercial and vested interests of the tobacco industry
- Support Government action at national level
- Publicise this commitment to reducing smoking in our communities and join the Smokefree Action Coalition (SFAC), the alliance of organisations working to reduce the harm caused by tobacco

In September 2022, the Board agreed a consultation process was required before this pledge could be signed. The UHS tobacco dependency steering group recommend the pledge could be signed from **1<sup>st</sup> April 2023**, if the model, delivery plan and funding proposed in this paper are supported

# Recommendations

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Proposed smoke free site model at UHS is approved for implementation.



UHS sign smoke free pledge.



Recognise benefit and cost implications and support process to identify funding

# Appendices



# Appendices

Number	Detail	Location
Appendix 1.	Detail of Work Stream Area	Slides 29-37
Appendix 2.	Literature Review	Enclosure A



# Detail by workstream area

- Consultation outcomes
- Evidence review
- Decision approach
- Next steps

After discussing all findings and evidence during the consultation, the steering group decided upon the following recommendations:

- No Tobacco smoking on site
- Allow vaping in designated areas
- Phased implementation approach

'Agree Vaping a good method to stop smoking so could have vaping shelters- however feel shelters is enabling smoking'

'Vaping, unnecessary electrically device so we offer to keep it in their medication locker'

'First step to stop smokers smoking cigarette but needs to stop vaping in the future as it still not a healthy habit and behaviour'

## Evidence to allow Vaping

95%

Vaping/ E-cigarettes are 95% less harmful than tobacco smoking



Vapes now available via procurement to support quit attempts

2x

Tobacco smokers are 2x more likely to successfully quit with the use of vapes/ e-cigs



No identified health risks of passive vaping to the health of bystanders

Discussions around allowing or not allowing vaping were extensive, many felt it would give an unclear message. However, after reviewing all the evidence the group found for UHS the recommended option would be to allow vaping as it is widely recognised tool for quitting smoking as well as mitigating concerns around violence and aggression.

## Survey Responses:

Only 29% of respondents in the April 2022 survey agreed UHS should allow Vaping. However, in the focus groups and a recent survey approximately 50% agreed UHS should allow vaping.

## Care Quality

### Commission Recommendations:

"e-cigarettes should not routinely be treated in the same way as smoking. It is not appropriate to prohibit e-cigarette use in health services as part of smokefree policies."

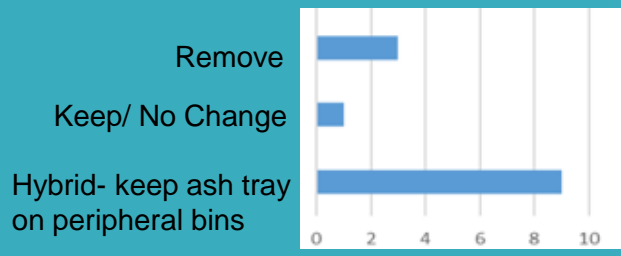
## Southeast Position statement:

*'Allowing e-cigarettes in all or part of the hospital grounds can support compliance with the smokefree policy.'*

Consultation and research that lead to decisions:

- Smoking shelters removed
- Cigarette bins removed
- Thoughts on what to do with those on periphery

## Bins - Ash Tray Element

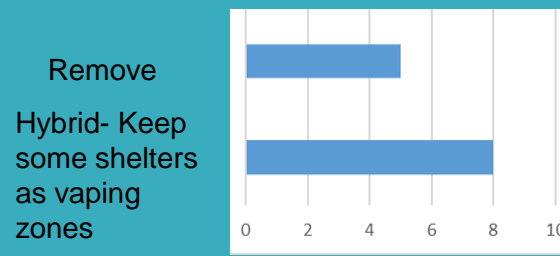


Most of the group felt the bins close to the entrances should have ash trays removed as this facilitates/ promotes tobacco smoking close to the hospital entrances. But peripheral ones to remain to allow safe disposal of cigarette butts.

## UHS Fire Statistics:

- 230 smoking related incidents over the last 7 years with 15 involving vapes/ e-cigs.

## Shelters



The group were all in agreement that the main entrance smoking shelter should be removed. However, ongoing discussions are required to decide what should happen to the remaining shelters.

## Statement from National Fire Chief:

NFCC believes that Trusts should support e-cig/vape smokefree strategies by maximising the opportunities while managing the lower, potential risks.

'Worried people will smoke in places they shouldn't be'

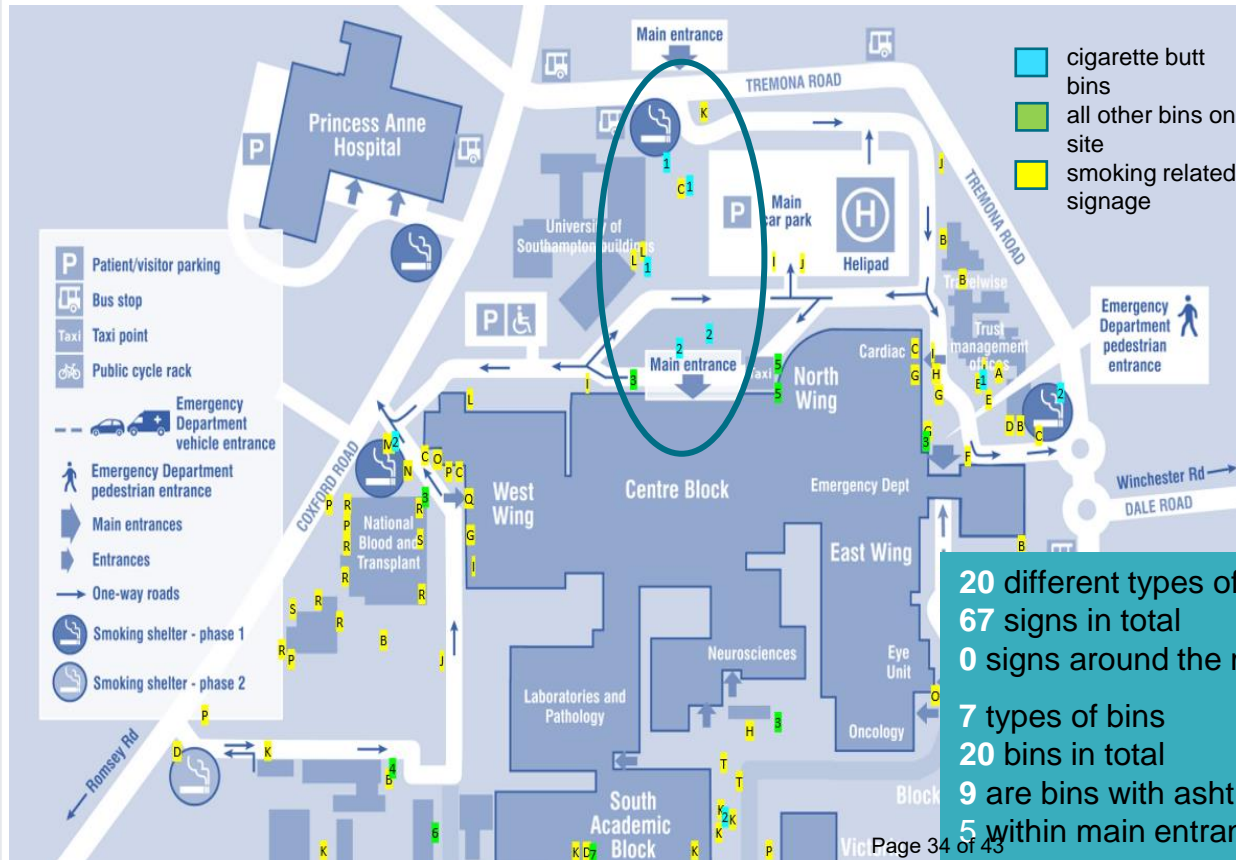
'Need to make it less comfortable for smokers in and around the site-how can we make the environment/buildings and infrastructure unfriendly for smokers'

'My colleagues and I sweep the front entrance of the hospital every day. It is always filthy with dogends everywhere.'

# Environmental enablers- Estate changes

Suggestions from patients at Stoptober stalls that signs are inconsistent prompted a site review of signs and bins. We found that most of the bins with ashtray elements are along the walkway to the main entrance but this area is also where the least amount of smoke free site signage is.

We therefore recommend the first estate changes should be within the main entrance and walkway of the site.



'I find it intimidating walking through a crowd of smokers every time I go in & out of the hospital. The smell makes me feel sick & lingers on my clothes. Not what I want really when feeling ill or on my way to receive treatment'

'Having people smoking outside main entrance is a poor introduction to a healthcare institution'

'Taking patients outside who haven't been out for months to get fresh air but instead being covered in smoke'

'Taking a poorly child through smokers just to enter the hospital. Sometimes with oxygen which is terrifying knowing there are naked flames'

20 different types of signs  
67 signs in total  
0 signs around the main entrance  
7 types of bins  
20 bins in total  
9 are bins with ashtray element,  
5 within main entrance walkway



# Environmental enablers- Communications

Throughout the consultation all stakeholders agreed clear communication is necessary to maximise engagement and thus the success of implementing the change in policy.

A dedicated communication officer would be required to map out and deliver an effective comms plan that would target the main user groups we would need to engage and highlight support:

- Staff
- Patients
- Local and wider community

Visuals designed to match other healthy lifestyle campaigns/ outstanding care strategy.

Methods identified to promote Smoke- Free Site:

- Social Media /Staffnet
- Health roadshow
- Pop up sessions
- Improving current literature supporting smoking cessation

'We are an environment to advocate a healthy lifestyle- a clear narrative is necessary to ensure participation'

'This is our home; this is about what we care about and we as a staff community need to demand the environment we want to work in'

'If trust decides to allow vaping communication needs to be clear of the benefits and risks of vaping'



Central themes throughout the campaign will be our responsibility as a leading healthcare provider to support healthy lifestyle choices in our community, bolstering smoking cessation messaging and support for both staff and patients.

Linking in with 'Wayfinder project' to make sure maps are updated to direct members of the community to where they can or cannot smoke/ vape.



**All stakeholders were clear they wanted the updated policy to reflect a supportive approach rather than strict enforcement to maximise engagement.**

## Learnings for other hospitals:



Trusts expect all staff to ensure this policy is fully implemented.



No evidence of increased violence and aggression



Clear communications essential for successful implementation and sustainability of policy

## Next Steps:

- Working group to progress updated policy
- Submit updated policy to relevant groups for comments e.g. staff partners
- Get policy approved.

Decisions made to be included in the policy:

- Supportive approach that sign posts staff caught smoking on site to OH in the first instance.
- Clarity on uniform policy for smoking and vaping.

Further discussions and decisions required:

- Will there be exceptions to the new policy
- How will staff be supported to manage patients who wish to leave the site for a cigarette.

### Achievements 2022/23:

- Project manager and smoking cessation role in post
- 178 Patients attended by Tobacco Dependency Team since 10/10/202
- 34% successful quit rate
- Phase 1 implementation started in AMU and extended to respiratory wards
- Data is currently demonstrating high quit rates
- Pharma outcomes module developed to enable referral to pharmacy for ongoing support and treatment
- Secured funding for additional investment from public health to enable some onward care to be delivered internally
- Majority of midwives trained in smoking cessation

### Challenges 22/23:

- Informatics system to support delivery will require development to enable integration into UHS systems
- Onward referral post discharge
- NRT supply issues, has prevented giving dual NRT to all

### Opportunity 23/24:

- Training package to be developed to enable embedding into stat and mandatory training across the organisation
- Extension of model to increase wards and staffing
- Review of 23/24 funding from ICB against opportunity to embed pathway into sustainable resourcing, in line with trust prevention strategy

Current Support	Ideas from other Trust's	Forward Support Plan
<ul style="list-style-type: none"> <li>➤ 12-week smoking cessation programme for UHS staff which includes regular behavioural change support, free NRT / medication when available via in-patient pharmacy and Carbon Monoxide (CO) screening</li> <li>➤ Behavioural change support for those staff members who choose to quit smoking using a vaping option</li> <li>➤ Promotion of National Campaigns to enhance awareness of services</li> </ul>	<ul style="list-style-type: none"> <li>➤ 24/7 support and guidance via app</li> <li>➤ Vapes/e-products delivered to staff</li> <li>➤ Free 12 week supply of vapes and NRT</li> <li>➤ Promotion of quitting helping with the cost of living crisis.</li> <li>➤ Approved vaping companies agreed to a 20% staff discount on their products using a code.</li> <li>➤ Free NRT including vapes</li> <li>➤ Vending machine where staff can purchase vapes and recommend the best vapes in practice for staff to use</li> <li>➤ Regional staff tobacco dependency offer – pilot sites for NHSE staff tobacco dependency offer making NRT free and vapes accessible for all NHS foundation trust staff across the region</li> </ul>	<p>The OH department will continue to review and enhance the smoking cessation interventions based on the Trust's policy, national guidelines and scientific evidence and support more UHS staff to quit smoking.</p>





# Support and Well-being approach- Engagement

Throughout the consultation it became evident that all stakeholders felt there should be an emphasis on engaging and supporting members of the UHS community rather than enforcement to successfully implement the cultural change required.

## Ideas from other trusts to improve engagement:

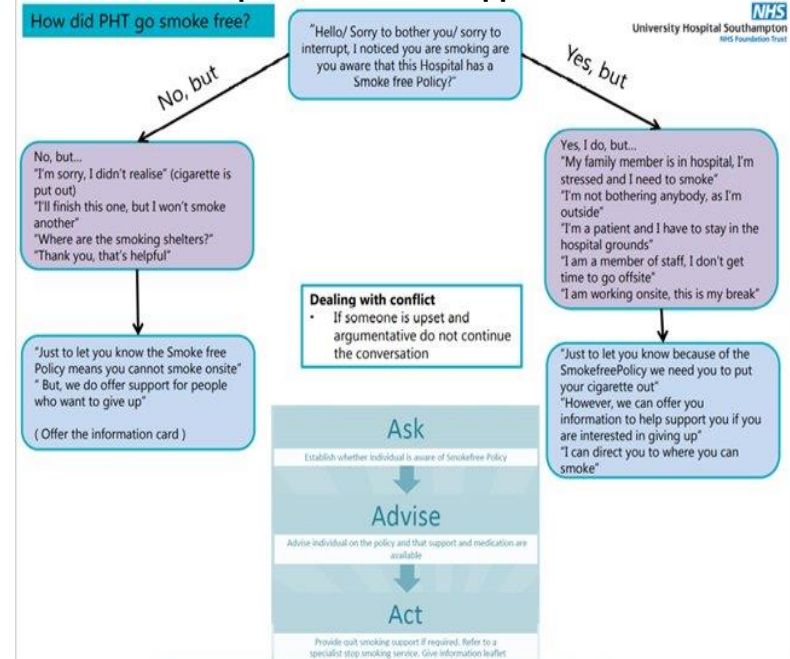
- Training and development.
- Smoke Free Champions
- Wellbeing champions to offer support to peers to quit smoking
- Approaching smokers in a friendly manner informing of the policy and asking for their next cigarette to be off site.

‘Don’t personally feel confident to ask people to move if they are having a cigarette in the wrong place’

‘I’ve been told off for smoking by the south academic block and did not appreciate it as it came across very aggressive’

‘We need to stop being worried about offending smokers and we need a consistent attitude’

The below diagram shows an example of training given to advise staff/ public on how to approach smokers



Continuous feedback would be necessary to build and develop meaningful engagement tools for both smokers and non- smokers.

## Enclosure A

### Smoke free site literature review

Throughout the consultation the project team has provided the steering group literature to evidence the discussions for and against proposed recommendations. The literature review below outlines the information shared and discussed. The focus is on specific areas that were highlighted as areas of concerns during the first stage of our consultation. The group recognises the importance of evidence to support decisions to provide best practice and will continue to use literature in this way during ongoing discussions.

#### E-cigarette/Vaping

A recent Cochrane review (1) including 78 completed studies concluded that there was a high-certainty evidence that electronic cigarettes with nicotine increase quit rates compared to nicotine replacement therapy. The latest review of nicotine vaping in England was published by OHID in September 2022 (2). The evidence review concluded that vaping led to significantly lower exposure to harmful substances compared with smoking. Quit attempts involving vaping were associated with higher success compared to those not involving a vaping product (64.9% compared to 58.6%).

Vaping prevalence in 11 to 18 year olds increased from 4% in 2021 to 8.6% in 2022. Use of disposable vaping products had increased substantially among both young people (7.8% in 2021 and 52.8% in 2022) and adults (2.2% in 2021 and 15.2% in 2022) (2).

The use of vaping as an effective 'quit' tool was also highlighted by the Khan review for OHID (3). The report also cautioned that everything possible should be done to prevent children and young people from vaping, including banning child friendly packaging.

A further concern exists in the environmental impact of vaping products, particularly single use vapes. Vapes are classed as waste electrical and electronic equipment (WEEE) meaning that they should be disposed of at a household recycling centres or at the where the device was purchased (4). An article in The Lancet highlighted concern that incorrect disposal of disposable vapes could release, plastic, electrical and hazardous chemical waste into the environment, calling it "highly concerning on an ecological level." (5)

As part of a study investigating tobacco dependency treatment, participants were asked about vaping on hospital grounds and 65% agreed that vaping should be allowed on site to support them to be smoke-free (6).

#### Hospital sites

Few studies were found evaluating the implementation of measures to create a smoke-free site. One study based in Australia found that multiple interventions, including trained smoke-free site ambassadors, patient messages on signs, cigarette butt bins (incorporating novelty voting) off the main site, and audible messages outside the main entrance resulted in a 73% reduction in smoking on-site (7).

One of the key barriers to implementation that has been highlighted is a lack of knowledge of the harms of smoking and passive smoking. Those with better knowledge were found to be more compliant with smoking bans, supporting the need for education of the public, alongside staff (8). It is also considered to be beneficial to include a range of staff in steering groups so that policies and implementation can address concerns as they arise, rather than a strict top-down approach. Reasonable arguments for smoke free spaces can limit the resistance of smokers to these policies.

Research has shown that protecting children from tobacco smoke exposure is a reasonable and accepted rationale for smokers and non-smokers for setting smoke free outdoor spaces (9).

One paper acknowledged that the evidence base for strategies associated with compliance with smoke-free policies was weak but concluded that enforcement strategies associated with total smoke-free bans resulted in higher levels of compliance than strategies for policies that had only partial smoke-free bans (10). Additionally, partial bans can raise equity concerns as they are often associated with inconsistent application between areas of sites and between staff (11).

### **Staff support**

A survey of 588 staff working across NHS trusts in Greater Manchester concluded that enablers to a smoke-free site included a dedicated tobacco addiction service and appropriate training to support smokers on hospital grounds. Barriers included the lack of awareness and support for the harm reduction benefits of vaping (12).

### **Training**

Clegg et al. (12) highlighted the training needs of staff around the area of smoke-free site implementation. 98% of staff were aware of the severity of harm from smoking tobacco, however, only 35% of respondents strongly agreed or agreed with the statement 'e-cigarettes are less harmful than cigarettes'. This highlighted a gap in knowledge that training could help address. 11% felt confident in providing brief advice and discussing or advising smokers about vaping.

A study on staff behaviour and attitudes towards treatment for smoking (14) shows less than a third of staff thought tobacco addiction should be addressed early in addiction treatment pathways compared to nearly half of patients. This tells us staff assumptions are contributing to successful interventions for smoking cessation and it's important that we provide appropriate training to all staff.

### **Enforcement**

A review of smoke-free hospital policies in Canada concluded that there was limited evidence that fines as a means of enforcement was effective in supporting behaviour change. Instead, policies should be implemented as part of comprehensive smoking cessation programmes (13).

A paper by Robson et al. (15) explains a major barrier to implementing a smoke free policy is the concern that staff trying to enforce the policy could be met with increased levels of physical violence. They compared the number of physical assaults before and after implementation and found that since the policy had been put in place there were 39% less physical assaults per month. They suggest the reason for a decrease in violence was the inclusion of staff training, tobacco dependence treatment and use of e-cigarettes within the policy which aided a change in culture.

### **Southampton Statistics**

One in eight people in Southampton smoke with an associated cost to society of £56 million per year. Our local smoking population costs UHS NHSFT over £10.8 million per year with our smoking attributable hospital admissions and COPD related hospital admissions significantly higher than the nationwide average (ASH, 2019). Smoking tobacco is a well-

known contributor to health inequalities which was highlighted with in the last electoral review which found that in the 20% most deprived areas of Southampton over a fifth of registered patients smoke, compared to less than 10% in the 20% least deprived areas (Southampton Data Observatory 2021).

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Report to the Trust Board of Directors				
<b>Title:</b>	<b>Board Assurance Framework (BAF) Update</b>			
<b>Agenda Item:</b>	<b>5.2</b>			
<b>Sponsor:</b>	<b>Gail Byrne, Chief Nursing Officer</b>			
<b>Author:</b>	<b>Craig Machell, Associate Director of Corporate Affairs Kyle Lacoste, Trust Documents Manager</b>			
<b>Date:</b>	<b>30 March 2023</b>			
<b>Purpose:</b>	<b>Assurance or reassurance</b> ✓	<b>Approval</b>	<b>Ratification</b>	<b>Information</b> ✓
<b>Issue to be addressed:</b>	<p>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.</p> <p>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.</p>			
<b>Response to the issue:</b>	<p>The BAF has been developed with input from responsible executives and relevant stakeholders. It satisfies good governance requirements on information and scoring. This report reflects recent discussion at the Audit &amp; Risk Committee, incorporating challenges around risk titles.</p>			
<b>Risks: (Top 3) of carrying out the change / or not:</b>	<p>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.</p>			
<b>Summary: Conclusion and/or recommendation</b>	<p>The Board Assurance Framework has been refreshed to reflect the updated corporate action plan for 2022/23, as well as increases in risk relating to finance, staffing, and capacity. Scores and dates have been reviewed and updated with pragmatic targets.</p>			

## 1. Purpose

The University Hospital Southampton Board Assurance Framework identifies the strategic ambitions and the key risks facing the organisation in achieving these ambitions. This paper provides the full Board Assurance Framework relating to the 2022/2023 strategic objectives.

This document seeks to provide assurance to the Board that the Trust is appropriately sighted on, and working to mitigate, key strategic risks through an appropriate governance structure.

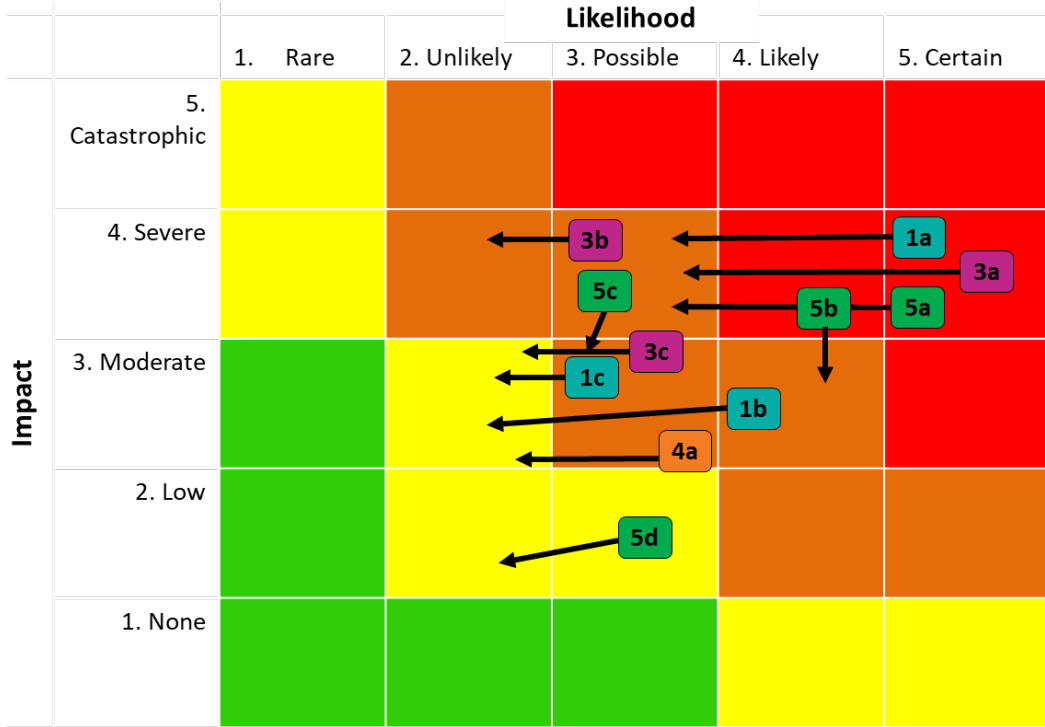
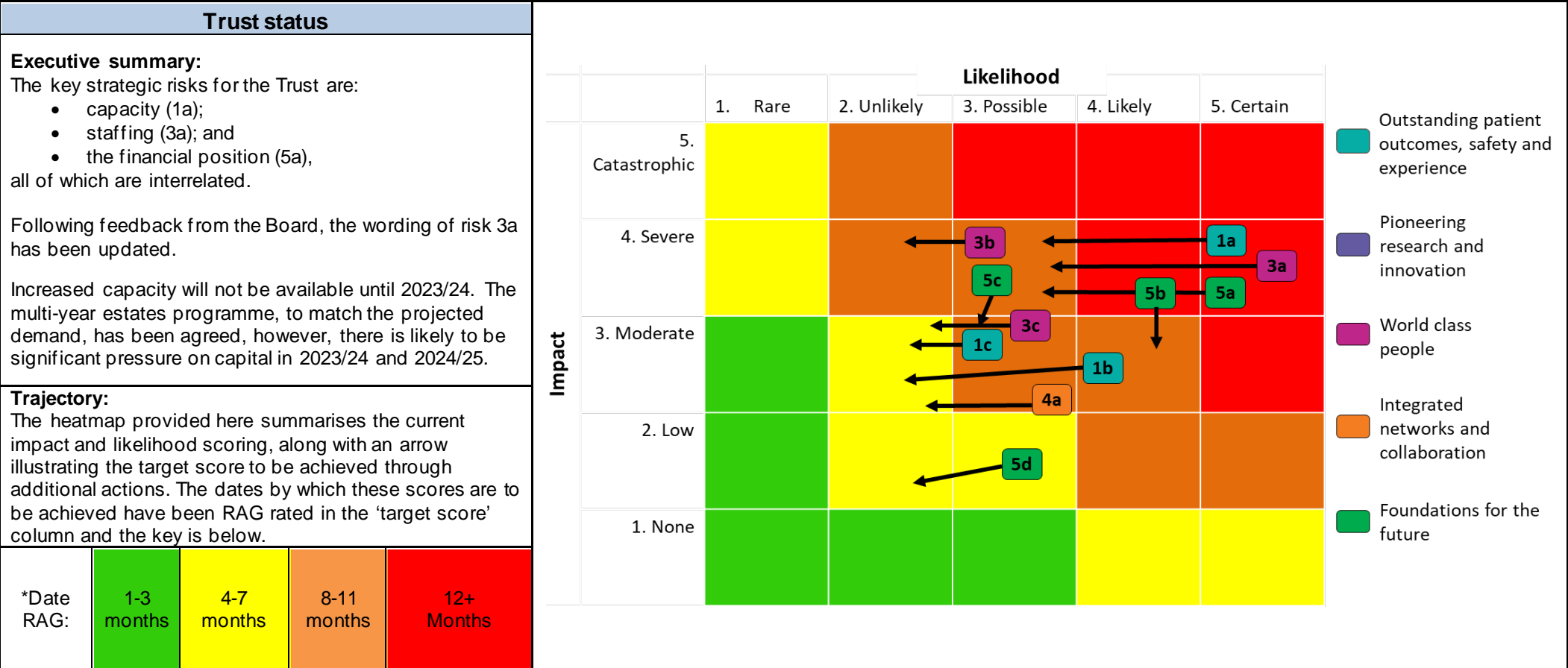
It is acknowledged that several of the critical risks described are not expected to be mitigated for several years. While this might suggest that the organisation will tolerate these critical risks for an extended period, instead it should be understood that mitigations for these risks exist outside of the Trust: National and international drivers are responsible and controls are similarly to be implemented by the wider NHS infrastructure.

Following discussion at Board sub committees the Board Assurance Framework has been updated to reflect key gaps in both controls and assurances, and to reflect the updated corporate action plan. The Trust strategic risk relating to outcomes and patient experience has increased to reflect the negative impact of long waiting times. The full BAF is provided as **appendix 1**.

The Board is asked to consider:

- the level of assurance provided by the Board Assurance Framework and those areas or actions around which further assurance may be required, or conversely where excessive assurance is being sought;
- the appropriateness and timeliness of key actions to develop either the control or assurance framework for these strategic risks, and
- any risks to the delivery of our strategic objectives that are not currently included in the Board Assurance Framework.

## Trust Status



- Outstanding patient outcomes, safety and experience
- Pioneering research and innovation
- World class people
- Integrated networks and collaboration
- Foundations for the future



**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)
<p>Use of independent sector to increase capacity</p> <p>Triage of patient lists based on risk of harm</p> <p>Consultant-led flagging of patients of concern</p> <p>Clinical Prioritisation Framework</p> <p>Capacity and demand planning including trajectories, surge capacity and continuity arrangements</p> <p>Specific operational plans for urgent care and cancer care</p> <p>Business continuity arrangements in place to provide continuity of care</p> <p>Outpatient, theatres and inpatient improvement programmes</p> <p>Successful staff and patient vaccination and testing programmes and dispensing of neutralising monoclonal antibody therapies (nMAD) to eligible patients in the community to reduce COVID-19 related hospitalisations</p>	<p>Excess demand on primary care and social care, employment market for domiciliary/home care and care homes</p> <p>Limited funding, workforce and estate to address capacity mismatch in a timely way</p> <p>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</p> <p>Staff capacity to engage in quality improvement projects due to focus on managing operational pressures</p> <p>Challenges in staffing ED department during periods of extreme pressure</p>	<p>4 x 5 20</p>	<p>Clinical Assurance Framework, reported monthly to executive</p> <p>Live monitoring of bed occupancy and capacity data</p> <p>Monitoring of urgent care and cancer care pathways</p> <p>Monitoring and reporting of waiting times</p> <p>Harm reviews identifying cases where delays have caused harm.</p>	<p>Limited capacity within the Local Authority to support for patients without a criteria to reside</p> <p>Data suggests waiting lists and ED performance are not likely to improve</p>	<p>Outpatient theatres and inpatient flow transformation programmes</p> <p>Review of ED workforce model</p> <p>Development of final plans for urgent care village</p> <p>Review of local delivery system plan for reducing delays throughout the hospital.</p> <p>Deliver target of 106% of 19/20 baseline activity to secure additional funding and address waiting lists.</p> <p>Review plans to deliver no 78 week waiters by end of 22/23.</p> <p>Review the robustness of system winter planning.</p>	<p>4 x 3 12</p>
						<p>Apr-25</p>

1b) Due to the current challenges, we fail to provide patients and their families / carers with a high quality experience of care and positive patient outcomes.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Trust Patient Safety Strategy and Experience of care strategy Organisational learning embedded into incident management, complaints and claims Learning from deaths and mortality reviews Mandatory, high quality training Health and safety framework Robust safety alert, NICE and faculty guidance processes Integrated Governance Framework Trust policies, procedures, pathways and guidance Recruitment processes and regular bank staff cohort Culture of safety, honesty and candour Clear and supportive clinical leadership Always Improving	No agreed funding for the quality of outcomes programme to go forward beyond this year Staff capacity to engage in quality improvement projects due to focus on managing operational pressures	3 x 4 12	Monitoring of patient outcomes CQC inspection reporting: Good overall Feedback from Royal College visits Getting it right first time (GIRFT) reporting to Quality Committee External accreditations: endoscopy, pathology, etc. Kitemarks and agreed information standards Clinical accreditation scheme (with patient involvement) Internal reviews into specialties, based on CQC inspection criteria Current and previous performance against NHS Constitution and other standards Matron walkabouts and executive led back to the floor Quality dashboard, KPIs, quality priorities, clinical audits and involvement in national audits Integrated performance reporting Patient Safety Strategy Oversight Committee	Negative outlier on follow-ups for outpatients.	<b>Introducing a robust and proactive safety culture:</b> Implement plan to enable launch of PSIRF in Q2 2022/23 Embed learning from deaths lead & lead medical examiner roles (primary and secondary care) and develop objectives and strategy Introduce thematic reviews for pressure ulcers and falls. Implement the second round of Ockenden recommendations. <b>Empowering and developing staff to improve services for patients</b> Completion of SDM project, data analysis and formulate plan for ongoing roll-out, predominantly focussed on specialist services. To embed as business as usual from April 2023. Baseline assessments and two quarters' submissions have completed and this will form part of the CQINN this year <b>Always Improving strategy</b> Delivery of year 1 outpatients and theatres agreed quality, operational and financial benefits Increase specialties contributing to	3 x 2 6 Mar-24

Outstanding patient outcomes, safety and experience			Monitoring Committee: Quality Committee		
Executive Leads: COO, CMO, CNO					
Programme					<p>CAMEO There is currently no clinical lead for this project. We expect to recruit within three months, and will develop a new strategy linking outcomes, transformation, and safety.</p> <p>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.</p>

**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 HCAs Risk assessments in place for individual areas for ventilation, bathroom access, etc. to ensure patient safety.	Transmissibility of Omicron Non-compliant patients Refamiliarisation with response to resurgence of other common infections such as norovirus	3 x 3 9	Gold command infection control Hand hygiene and cleanliness audits Patient-Led Assessment of the Care Environment National Patient Surveys Capital funding monitored by executive NHSE/I infection assurance framework compliance reporting to executive, Quality Committee and Board Clinical audit reporting Internal audit annual plan and reports Finance and Investment Committee oversight of estates and digital capital programme delivery Digital programme delivery group meets each month to review progress of MMR Quarterly executive monitoring of Estates KPIs (maintenance, cleanliness, fire safety, medical devices, etc.)	None	Ongoing COVID ZERO and #Don'tGoViral campaign to expand to include all viruses supported by internal and external communications plan Review infection prevention measures in response to changes in guidance and move to 'living with COVID' Look to decentralise COVID pathways, with COVID positive patients to be cared for in the appropriate specialist areas. Review of infection prevention methods for C-diff following missing trajectory.	3 x 2 6 Apr-23

**3a)** We are unable to meet current and planned service requirements due to unavailability of qualified 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)
<p>New 5 year People Strategy and clear objectives for Year 1 monitored through POD.</p> <p>Recruitment and resourcing processes</p> <p>Workforce plan and overseas recruitment plan</p> <p>General HR policies and practices, supported by appropriately resourced HR team</p> <p>Temporary resourcing team to control agency and bank usage</p> <p>Overseas recruitment</p> <p>Recruitment campaign</p> <p>Apprenticeships</p> <p>New recruitment branding and successful targeted campaigns in critical are, ED, Ophthalmology and theatres.</p> <p>Bank and agency cost project – Joint finance and HR controls</p>	<p>Multi-year workforce and education plan to be developed in cooperation with the wider ICS</p> <p>Implementation of talent management and development programme</p> <p>Appropriate resourcing of people directorate commensurate with ongoing recruitment and retention activity</p> <p>Workforce plan is a risk due to current recruitment market challenges, rising pay in private sector, and buoyancy of job market.</p> <p>Inflation of 11% against national pay awarded of 3% is resulting in cost of living outstripping pay</p> <p>Differential pay grading across the ICS leading to retention difficulties</p>	<p>4 x 5 20</p>	<p>Fill rates, vacancies, sickness, turnover and rota compliance</p> <p>NHSI levels of attainment criteria for workforce deployment</p> <p>Annual post-graduate doctors GMC report</p> <p>WRES and WDES annual reports - annual audits on BAME successes</p> <p>Gender pay gap reporting</p> <p>NHS Staff Survey results and pulse surveys</p>	<p>Robust board reporting on wellbeing, belonging and morale</p>	<p>Approval of Year 1 objectives supporting delivery of the Trust’s People Strategy</p> <p>Deliver workforce plan for 22/23 including increasing substantive staff and reducing temporary agency spend. Targeted campaigns in key areas.</p> <p>Refresh talent management and succession planning processes</p> <p>Deliver an increase in apprenticeships starters by 20%</p> <p>To deliver improved workforce deployment through continued expansion of the use of e-rostering, including for medical staff</p> <p>To meet the national requirements of the NHS England and NHS Improvement levels of attainment rostering maturity assessment</p> <p>Review of KPIs via IPR in light of new strategy to address identified gaps in assurance</p> <p>Agree long-term workforce education plan, including building relationships across the ICS and with education providers.</p> <p>Introduce measures to support staff during cost of living increases.</p>	<p>4 x 3 12</p>
						<p>Mar-25</p>

3a) We are unable to meet current and planned service requirements due to unavailability of qualified staff to fulfil key roles.

					<p>Increasing the UHS substantive workforce by 481 by the end of March 2023.</p> <p>Maintaining annual staff turnover below 12%.</p> <p>Developing a longer-term workforce plan linked to the delivery of the Trust's corporate strategy.</p>	
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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)
<p><b>Great place to work including focus on wellbeing</b></p> <p>22/23 Workforce planning completed to support COVID recovery</p> <p>Wellbeing and occupational health support for staff</p> <p>Guardian of Safe Working Hours</p> <p><b>Building an inclusive and compassionate culture</b></p> <p>FTSU guardian and FTSU policies</p> <p>Diversity and Inclusion Strategy/Plans</p> <p>Collaborative working with trade unions</p>	<p>Development of gender equality matrix (GEM) to provide measurements and assurance</p> <p>To recruit to the new network leads for the Trust and re-energise the network capacity and capability</p> <p>EDI strategy</p> <p>Values and behavioural frameworks</p>	4 x 3 12	<p><b>Great place to work including focus on wellbeing</b></p> <p>Annual NHS staff survey and introduction of quarterly pulse engagement surveys</p> <p>Guardian of Safe Working Hours report to Board</p> <p>Regular communications monitoring report Wellbeing guardian</p> <p>Staff Networks</p> <p>Exit interview process</p> <p><b>Building an inclusive and compassionate culture</b></p> <p>Freedom to Speak Up reports to Board</p> <p>Qualitative feedback from staff networks data on diversity</p> <p>Annual NHS staff survey and introduction of quarterly pulse engagement</p> <p>Insight monitoring from social media channels</p> <p>Staff listening sessions – ‘Talk to David’</p> <p>Allyship Programme</p>	<p>Maturity of staff networks</p> <p>Maturity of datasets around EDI, and ease of interpretation</p>	<p><b>Building an inclusive and compassionate culture</b></p> <p>To deliver our inclusion plans to improve the experience of diverse staff, collaboratively with our networks and demonstrating improvement in our WRES and WDES scores</p> <p>Refresh and re-launch of the Trust’s Wellbeing offer post COVID.</p> <p>Approval of Year 1 objectives supporting delivery of the Trust’s People Strategy</p> <p>Improvement of diversity and inclusion insight and intelligence to inform priorities within divisions</p> <p>Creation of divisional steering group for EDI</p> <p>Re-launch a refreshed EDI strategy</p> <p>Deliver a programme on refreshing the underpinning behaviours to the Trusts Values</p> <p>Re-launch appraisal and talent management programme.</p> <p>refresh the underpinning behaviours of our Trust Values and produce a new behaviours framework. This will underpin future leadership development and OD interventions.</p>	<p>4 x 2 8</p> <p>Mar-25</p>

**3c)** We fail to create a sustainable and innovative education and development response to meet the current and future workforce needs identified in the Trust's longer-term workforce plan.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Education Policy Leadership and development opportunities, apprenticeships, secondments In-house, accredited training programmes Provision of high quality clinical supervision and education Access to apprenticeship levy for funding Access to CPD funding from HEE and other sources 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	To have recovered development and education of our people post pandemic (this includes improving appraisals carried out to 92% and appraisal quality as measured through the staff survey) Wellbeing programme Further develop education offer and formal launch of improvement education strategy/ five year education plan Approval of Year 1 objectives supporting delivery of the Trust's People Strategy Relaunch/refresh of the VLE need to be put down as a key action in terms of supporting people to access more self directed learning opportunities? Implement the leadership development and talent plan throughout 2023 and 2024 Strategic leadership programme and positive action programmes Succession planning for executive 1 <sup>st</sup> and 2 <sup>nd</sup> line reports, and hard-to-recruit to senior posts	3 x 2 6
						Mar-25



**Integrated networks and collaboration**

**Monitoring Committee: Quality Committee**

**Executive Leads: CEO, CMO, Director of Networks & Strategy**

**4a)** We do not implement effective models to deliver integrated and networked care, resulting in sub-optimal patient experience and outcomes, increased numbers of admissions and increases in patients’ length of stay.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
<p>Key leadership role within local ICS</p> <p>Key leadership role within local networked care and wider Wessex partnership</p> <p>UHS strategic goals and vision</p> <p>Establishment and development of Hampshire and Isle of Wight Acute Provider Collaborative (HloW APC)</p> <p>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)</p>	<p>Potential for diluted influence at key discussions</p> <p>Arrangements for specialised commissioning – delegated from centre to ICS – historically national and regional, rather than local</p> <p>Form and scope of role for HloW APC in relation to ICS and other acute provider collaboratives</p> <p>Work to develop a shared pharmacy model with Portsmouth has been delayed, and the Trust is looking at alternative options.</p> <p>The costs associated with the Elective Hub in Winchester may have been underestimated. Additional funding sources may need identifying.</p>	<p>3 x 3 9</p>	<p>CQC and NHSE/I assessments of leadership</p> <p>CQC assessment of patient outcomes and experience</p> <p>National patient surveys</p> <p>Friends and Family Test</p> <p>Outcomes and waiting times reporting</p> <p>Integrated networks and collaborations Board set up for regular meetings at executive level</p>	<p>Delay in implementation of new ICS framework and structures until July 2022, and delay in implementation of changes to specialised commissioning to April 2023</p>	<p><b>ICS and PCNs</b></p> <p>Priority networks agreed</p> <p><b>Integrated Networks and Collaboration</b></p> <p>Urology Area Network plan agreed and proceeding at pace</p> <p>Identify appropriate programme management support for networks following appointment for Urology Area Network and approval for HloW Eye Care Alliance</p> <p>Business case for future working of the Southern Counties Pathology Network due for consideration by Trust Board in early 2022/23</p> <p>Business case development for aseptic services and elective hub by HloW APC</p> <p>Further development of HloW APC to drive improvements in outcomes</p> <p>Development of proposals for next phase for Community Diagnostics Centres.</p> <p>Integrated networks and collaboration team set up and recruited to.</p> <p>Elective hub in Winchester – in final business case review. A two year plan to build, recruit, and open.</p>	<p>3 x 2 6</p> <p>April-23</p>

**5a)** We are unable to deliver a financial breakeven position and support prioritised investment as identified in the Trust’s capital plan within locally available limits (CDEL).

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
<p>Financial strategy and Board approved financial plan.</p> <p>Cost improvement programme (CIP, ~£60mil) and transformation programme (Always Improving)</p> <p>Robust business planning and bidding processes</p> <p>Engagement in revised ICS financial architecture</p> <p>Enhanced finance and workforce controls via 2023/24 business rules</p> <p>Robust controls over investment decisions via the Trust Investment Group and associated policies and processes</p> <p>Robust controls over recruitment via the Recruitment Control Panel and associated policies and processes</p> <p>Established counter-fraud specialists and processes.</p> <p>Monthly reporting processes from Care Groups to Trust Board level.</p> <p>Monthly Value for Money meetings with each Care Group</p>	<p>Ability to deliver £60m CIP programme.</p> <p>Elements of activity growth unfunded via block contracts</p> <p>Grip of system wide initiatives and assurance of delivery e.g., Criteria to Reside</p> <p>Ability to control and reduce temporary staffing levels</p>	<p>4 x 5 20</p>	<p>Regular finance reports to Trust Board</p> <p>Divisional performance on cost improvement reviewed by senior leaders on a quarterly basis.</p> <p>Regular review of counter fraud control effectiveness via LCFS, reporting to Audit and Risk Committee</p> <p>Executive oversight of control groups</p> <p>Trust Savings Group oversight of financial recovery plan and CIP programme actions</p> <p>Operating plan based on cash modelling to ensure affordability of capital programme</p>	<p>Current short-term nature of operational planning</p>	<p>Deliver the planned financial deficit.</p> <p>Create a two-year financial recovery programme to deliver a break-even position in 2024/25</p> <p>Finalise and deliver £60m savings programme.</p> <p>Support the organisation to understand the impact and required cultural change relating to the new financial infrastructure</p>	<p>4 x 3 12</p> <p>Mar-23</p>

**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)
<p>Multi-year estates planning, informed by clinical priorities and risk analysis</p> <p>Up-to-date computer aided facility management (CAFM) system</p> <p>Asset register</p> <p>Maintenance schedules</p> <p>Trained, accredited experts and technicians</p> <p>Replacement programme</p> <p>Construction Standards (e.g. BREEM/Dementia Friendly Wards etc.)</p> <p>Six Facet survey of estate informing funding and development priorities</p> <p>Estates masterplan 22-32 approved.</p>	<p>Missing funding solution to address identified gaps in the critical infrastructure</p> <p>Timescales to address risks, after funding approval</p> <p>Operational constraints and difficulty accessing parts of the site affecting pace of investment including refurbishment</p>	<p>4 x 4 16</p>	<p>Compliance with Health Technical Memoranda monitored by estates and reported for executive oversight</p> <p>Patient-Led Assessments of the Care Environment</p> <p>Statutory compliance audit and risk tool for estates assets</p> <p>Monitoring at Finance and Investment Committee, including progress of capital investment and review of critical infrastructure risk and updates to Six Facet survey</p> <p>Quarterly updates on capital plan and prioritisation to the Board of Directors</p>	<p>Funding streams to be identified to fully deliver capacity and infrastructure improvements</p>	<p>Continue work on the estates strategy following the finalisation and agreement of the estates masterplan, including engagement with all clinical and non-clinical divisions</p> <p>Identify future funding options for additional capacity in line with the site development plan</p> <p>Delivery of 2022/23 capital plan</p> <p>Implement the HOIW elective hub.</p> <p>Deliver £9m of critical infrastructure backlog maintenance</p> <p>Agree plan for remainder of Adanac Park site</p> <p>Site development plan for Princess Anne hospital.</p>	<p>3 x 4 12</p>
						<p>Apr-25</p>

<b>Foundations for the future</b>	<b>Monitoring Committee: Finance and Investment Committee</b>
	<b>Executive Lead: COO</b>

**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)
<p>Digital prioritisation programme, informed by clinical priorities and safeguarded by clinical safety officers</p> <p>Global digital exemplar (GDE) recognition</p> <p>Digital strategy incorporating:</p> <ul style="list-style-type: none"> <li>• technology programme</li> <li>• clinical digital systems programme</li> <li>• data insight programme</li> </ul>	<p>Uncertainty around Hampshire and Isle of Wight ICS digital strategy and our direction of travel, including digital convergence, and alignment with wider expectations.</p> <p>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.</p> <p>Lack of workforce plan to retain staff needed to underpin strategy</p> <p>Development of a non-clinical/business systems strategy</p> <p>Greater alignment of Always Improving and digital transformation plans</p>	<p>3 x 4 12</p>	<p>Monthly executive-led digital programme delivery group meeting</p> <p>Finance oversight provided by the Finance and Investment Committee</p> <p>Quarterly Digital Board meeting, chaired by the CEO</p>	<p>Revised timetable to achieve paper switch-off target</p> <p>Difficulties in understanding benefits realisation of digital investment.</p>	<p>Achieve 200,000 My Medical Record (MMR) accounts and 30% paper switch-off</p> <p>Plan in place for generic PROM (patient-reported outcome measure) such as QOL (quality of life)</p> <p>75% migration from outsourced transcription to digital speech recognition completed</p> <p>Digital ophthalmology system project 'open eyes' to be implemented</p> <p>Monitor opportunities for national funding for digital transformation</p> <p>Approve utilisation of funding received from Hampshire and Isle of Wight ICS</p> <p>Identify funding streams to support 2022/23 digital programmes and / or reduce programme in line with available funding.</p> <p>Develop clearer understandings of benefits across whole digital programme</p> <p>Develop digital literacy across trust to support rollout of new products</p> <p>Explore commercial partnership options to mitigate lack of UHS workforce to deliver strategy.</p>	<p>3 x 3 9</p> <p>Mar-24</p>

**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.	

**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	Definition of and reporting against key milestones	Agree funding requirements to commence the delivery of the strategies	2 x 2 4
			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.		Progress decarbonisation study and evaluation of potential for an energy performance contract (EPC) as part of the development of a specification ahead of the end of the Trust's energy contract in March 2023. Business case to be presented for approval in September 2022. Review green energy ambitions following extreme rises in electricity costs.	

Report to the Trust Board of Directors				
Title:	Register of Seals and Chair's Actions			
Agenda item:	6.1			
Sponsor:	Jenni Douglas-Todd, Trust Chair			
Date:	30 March 2023			
Purpose:	Assurance or reassurance	Approval	Ratification Y	Information
Issue to be addressed:	This is a regular report to notify the Board of use of the seal and actions taken by the Chair in accordance with the Standing Financial Instructions and Scheme of Delegation for ratification.			
Response to the issue:	The Board has agreed that the Chair may undertake some actions on its behalf.			
Implications: (Clinical, Organisational, Governance, Legal?)	Compliance with The NHS Foundation Trust Code of Governance (probity, internal control) and UHS Standing Financial Instructions and Scheme of Delegation.			
Risks: (Top 3) of carrying out the change / or not:				
Summary: Conclusion and/or recommendation	The Board is asked to <b>ratify</b> the Chair's actions and application of the seal.			

## 1 Chair's Actions

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

- 1.1 **Single Tender Action** for the payment of overdue invoices relating to the contract for the provision of a tissue and donor searching service to the Trust's bone marrow transplant service from the Anthony Nolan charity, totalling £1,000,000 excluding VAT. This is the only charity that provides this type of service. Donor search services are funded by local commissioners. Approved by the Chair on 27 February 2023.
- 1.2 **Single Tender Action** for the extension of the existing DaVinci Robot contract for Urology Surgery with the Spire Healthcare Ltd Southampton from December 2022 – June 2023 at a total cost of £490,000 (VAT exempt). Approved by the Chair on 22 March 2023.

## 2 Signing and Sealing

- 2.1 **Loan Agreement**,, executed as a Deed, between University Hospital Southampton NHS Foundation Trust (the Lender) and UHS Estates Limited (the Borrower) for the sum of £41,000,000 to support the costs of build projects including Neuro Refurbishment, Theatres 10 and 11, Vertical Extension and Skyways Link (New Wards) and purchase of 2021/22 YE Theatres Equipment and Stock balances. Seal number 242 on 28 February 2023.
- 2.2 **Agreement**, executed as a Deed, between University Hospital Southampton NHS Foundation Trust (the Employer) and Cuffe PLC (the Contractor) relating to the building contract for the Princess Anne Hospital HV Substation Replacement. Seal number 243 on 28 February 2023.
- 2.3 **Reversionary Lease and Deed of Variation** between University Hospital Southampton NHS Trust (the Landlord) and Complete Fertility Limited (the Tenant) relating to an extension of the current Lease of Space on Level G at Princess Anne Hospital for an additional 4 months from 1 April 2023 to 31 July 2023. Seal number 244 on 28 February 2023.
- 2.4 **Deed of Covenant** between University Hospital Southampton NHS Foundation Trust (the Covenantor), Prime Adanac Investment Limited (the Original Covenantee) and McDowell's Development Company Limited (the New Covenantee) relating to Costa coffee shop restriction at Plot 4, Bargain Farm, Frogmore Lane, Nursling, Southampton, Hampshire SO16 0XS. Seal number 245 on 14 March 2023.
- 2.5 **Deed of Rectification** between University Hospital Southampton NHS Foundation Trust and Prime Infrastructure Management Services 4 Limited (Party 1) and Prime Adanac Investment Limited (Party 2), the Deed being supplemental and collateral to the Original Document, relating to the transfer of Plot 4, Bargain Farm, Frogmore Lane, Nursling, Southampton, Hampshire, SO16 0XS, rectified to correctly reflect the intentions of Party 1 and Party 2. Seal number 246 on 14 March 2023.
- 2.6 **Agreement**, executed as a Deed, between University Hospital Southampton NHS Foundation Trust (the Employer) and LST Partnership LLP (Trading as LST Projects) (the Contractor) relating to the building contract for the South Substation D Project. Seal number 247 on 14 March 2023.

## 3 Recommendation

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