University Hospital Southampton NHS Foundation Trust

Agenda Trust Board – Open Session

Date	07/01/2025
Time	9:00 - 13:00
Location	Conference Room, Heartbeat/Microsoft Teams
Chair	Jenni Douglas-Todd
Observing	Fatemeh Jenabi, Specialty Registrar (shadowing Joe Teape)

1 9:00	**Chair's Welcome, Apologies and Declarations of Interest** Note apologies for absence, and to hear any declarations of interest relating to any item on the Agenda.
2	**Patient Story** The patient story provides an opportunity for the Board to reflect on the experiences of patients and staff within the Trust and understand what the Trust could do better.
3 9:15	**Minutes of Previous Meeting held on 5 November 2024** Approve the minutes of the previous meeting held on 5 November 2024
4	**Matters Arising and Summary of Agreed Actions** To discuss any matters arising from the minutes, and to agree on the status of any actions assigned at the previous meeting.
5	**QUALITY, PERFORMANCE and FINANCE** Quality includes: clinical effectiveness, patient safety, and patient experience
5.1 9:20	**Briefing from the Chair of the Finance and Investment Committee** Dave Bennett, Chair
5.2 9:25	**Briefing from the Chair of the People and Organisational Development Committee** Jane Harwood, Chair
5.3 9:30	**Briefing from the Chair of the Quality Committee** Tim Peachey, Chair including Maternity and Neonatal Safety 2024-25 Quarter 2 Report
5.4 9:40	**Chief Executive Officer's Report** Receive and note the report Sponsor: David French, Chief Executive Officer
5.5 10:00	**Performance KPI Report for Month 8** Review and discuss the report Sponsor: David French, Chief Executive Officer

5.6 **Break**

10:35

5.7 **Finance Report for Month 8**

10:45 Review and discuss the report
Sponsor: Ian Howard, Chief Financial Officer

5.8 **ICB Finance Report for Month 8**

10:55 Receive and discuss the report
Sponsor: David French, Chief Executive Officer

5.9 **People Report for Month 8**

11:05 Review and discuss the report
Sponsor: Steve Harris, Chief People Officer

5.10 **Freedom to Speak Up Report**

11:15 Review and discuss the report
Sponsor: Gail Byrne, Chief Nursing Officer
Attendee: Christine Mbabazi, Equality & Inclusion Adviser/Freedom to Speak Up Guardian

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

11:25 Receive and discuss the report
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Diana Hulbert, Guardian of Safe Working Hours and Emergency Department Consultant

5.12 **Learning from Deaths 2024-25 Quarter 2 Report**

11:35 Review and discuss the report
Sponsor: Paul Grundy, Chief Medical Officer
Attendees: Natasha Watts, Deputy Chief Nursing Officer/Jenny Milner, Associate Director of Patient Experience

5.13 **Infection Prevention and Control 2024-25 Quarter 2 Report**

11:45 Review and discuss the report
Sponsor: Gail Byrne, Chief Nursing Officer
Attendees: Julian Sutton, Lead Infection Control Director/Julie Brooks, Deputy Director of Infection Prevention & Control

5.14 **Annual Medicines Management 2023-24 Report**

11:55 Receive and discuss the report
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: James Allen, Chief Pharmacist

5.15 **Annual Ward Staffing Nursing Establishment Review 2024**

12:05 Discuss and approve the review
Sponsor: Gail Byrne, Chief Nursing Officer
Attendee: Rosemary Chable, Head of Nursing for Education, Practice and Staffing

6 STRATEGY and BUSINESS PLANNING

6.1 Board Assurance Framework (BAF) Update

12:15

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

7 CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

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

12:25

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

7.2 Register of Seals and Chair's Actions Report

12:30

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

8 Any other business

12:35

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

9 Note the date of the next meeting: 11 March 2025

10 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.

11 Follow-up discussion with governors

12:45

University Hospital Southampton NHS
NHS Foundation Trust

Agenda links to the Board Assurance Framework (BAF)

7 January 2025 – Open Session

Overview of the BAF

Risk	Appetite (Category)	Current risk rating	Target risk rating	
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.	Minimal (Safety)	4 x 5 20	4 x 2 6	Apr 27
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.	Cautious (Experience)	3 x 3 9	3 x 2 6	Mar 26
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.	Minimal (Safety)	4 x 4 16	2 x 3 6	Apr 27
2a: We do not take full advantage of our position as a leading University teaching hospital with a growing, reputable, and innovative research and development portfolio, attracting the best staff and efficiently delivering the best possible treatments and care for our patients.	Open (Technology & Innovation)	3 x 3 9	3 x 2 6	Mar 25
3a: We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles.	Open (workforce)	4 x 5 20	4 x 3 12	Mar 26
3b: We fail to develop a diverse, compassionate, and inclusive workforce, providing a more positive staff experience for all staff.	Open (workforce)	4 x3 12	4 x 2 8	Mar 27
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.	Open (workforce)	4 x 3 12	3 x 2 6	Mar 25
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.	Cautious (Effectiveness)	3 x 3 9	3 x 2 6	Apr 25
5a: We are unable to deliver a financial breakeven position, resulting in: inability to move out of the NHS England Recovery Support Programme, NHS England imposing additional controls/undertakings, and a reducing cash balance impacting the Trust's ability to invest in line with its capital plan, estates/digital strategies, and in transformation initiatives.	Cautious (Finance)	3 x 5 15	3 x 3 9	Apr 25
5b: We do not adequately maintain, improve and develop our estate to deliver our clinical services and increase capacity.	Cautious (Effectiveness)	4 x 5 20	4 x 2 8	Apr 27
5c: Our digital technology or infrastructure fails to the extent that it impacts our ability to deliver care effectively and safely within the organisation,	Open (Technology & Innovation)	3 x 4 12	3 x 2 6	Apr 27
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.	Open (Technology & Innovation)	2 x 3 6	2 x 2 4	Dec 24

Agenda links to the BAF

No	Item	Linked BAF risk(s)	Does this item facilitate movement towards or away from the intended target risk score and appetite?		
			Towards	Away	Neither
5.5	Performance KPI Report for Month 8	1a, 1b, 1c			x
5.7	Finance Report for Month 8	5a			x
5.8	ICB Finance Report for Month 8	5a			x
5.9	People Report for Month 8	3a, 3b, 3c			x
5.10	Freedom to Speak Up Report	3b			x
5.11	Guardian of Safe Working Hours Quarterly Report	3a, 3b			x
5.12	Learning from Deaths 2024-25 Quarter 2 Report	1b			x
5.13	Infection Prevention Control 2024-25 Quarter 2 Report	1c			x
5.14	Annual Medicines Management 2023-24 Report	All			x
5.15	Annual Ward Staffing Nursing Establishment Review 2024	1b, 3a			x
7.1	Annual Assurance for the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPPR)	1a, 3a, 5b, 5c			x

University Hospital Southampton
NHS Foundation Trust

Minutes Trust Board – Open Session

Date	05/11/2024
Time	9:00 – 11:30
Location	The Ark Conference Centre, HHFT/Microsoft Teams
Chair	Jenni Douglas-Todd (JD-T)
Present	Dave Bennett, NED (DB) Gail Byrne, Chief Nursing Officer (GB) 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) Alison Tattersall, NED (AT)
In attendance	Martin De Sousa, Director of Strategy and Partnerships (MDeS) (item 5.1) Craig Machell, Associate Director of Corporate Affairs and Company Secretary (CM) Ali Keen, Head of Cancer Nursing (AK) (item 4.11) Kelly Kent, Head of Strategy and Partnerships (KK) (item 5.1) 4 governors (observing) 2 members of staff (observing) 2 members of the public (observing)
Apologies	Diana Eccles, NED (DE)

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

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

It was noted that apologies had been received from Diana Eccles.

The Chair provided an overview of her activities since September 2024, including visits to hospital departments, meetings with peers and other key stakeholders.

2. Minutes of the Previous Meeting held on 10 September 2024

The draft minutes tabled to the meeting were agreed to be an accurate record of the meeting held on 10 September 2024.

3. Matters Arising and Summary of Agreed Actions

In respect of action 1175, it was noted that there had been an increase in the number of incidents of delays in giving of medication or pain relief, missed symptoms, and insufficient staffing numbers. However, in part the increase in numbers of incidents was considered to be due to efforts to encourage reporting of such incidents, and the situation had improved more recently. It was agreed to close this action.

It was noted that there were no other matters arising or overdue actions.

4. QUALITY, PERFORMANCE and FINANCE

4.1 Briefing from the Chair of the Audit and Risk Committee

The chair of the Audit and Risk Committee was invited to present the Committee Chair's Report in respect of the meeting held on 14 October 2024, the content of which was noted. It was further noted that:

- The committee reviewed the lessons learned from the 2023/24 annual accounts, and noted that the issues encountered should be resolved in time for the 2024/25 accounts due, largely, to the implementation of a new finance system.
- The committee also received a report in respect of the risk of impersonation fraud for bank/agency staff and the procedures that had been put in place to mitigate this risk.

4.2 Briefing from the Chair of the Finance and Investment Committee

The chair of the Finance and Investment Committee was invited to present the Committee Chair's Report in respect of the meeting held on 21 October 2024, the content of which was noted. It was further noted that:

- The committee had reviewed the Finance Report for Month 6 (item 4.7) and discussed the Trust's re-commitment to its 2024/25 plan in support of its request for deficit support funding from NHS England.
- The position in respect of cash was challenging and the committee discussed what the Trust should do in the final quarter of 2024/25. It was noted that the rules on when and how much cash support could be requested were somewhat unclear.
- The committee discussed a potential expansion of the activities of UHS Pharmacy Limited, although it was subsequently noted that the specific potential opportunity had since failed to materialise.
- The committee also discussed the Trust's financial recovery programme.

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

The chair of the People and Organisational Development Committee was invited to present the Committee Chair's Report in respect of the meeting held on 21 October 2024, the content of which was noted. It was further noted that:

- The Trust had been below its plan in terms of whole-time-equivalent (WTE) numbers, although this position would change from October 2024 onward due to the onboarding of newly qualified nurses and the failure of the Integrated Care System transformation plans to deliver in terms of reduction in patients having no criteria to reside and mental health support.
- The committee noted the cumulative impact on staff of having to balance staff numbers, performance, and patient experience.
- Whilst noting that the annual appraisal rate remained low, it was suspected that more appraisals than recorded had taken place, but that these had not been recorded on the Electronic Staff Record.

4.4 Briefing from the Chair of the Quality Committee

The chair of the Quality Committee was invited to present the Committee Chair's Report in respect of the meeting held on 14 October 2024, the content of which was noted. It was further noted that:

- Patients' access to a rehabilitation and recovery service during and after intensive care unit (ICU) admission was limited due to a lack of service provision. The Trust was non-compliant with national guidance in this area.
- Due to resource constraints the Trust was unable to systematically roll out the National Safety Standards for Invasive Procedures (NatSSIPS) 2. However, it was noted that a solution to this issue was being considered.
- There had been no significant improvement in terms of the Trust's system partners in respect of supporting the Trust with mental health admissions.
- The committee also reviewed the Maternity and Neonatal Safety Report, based on data available at September 2024, and including the NHS Resolution Maternity Incentive Scheme Year 6 progress update, the local response to the Care Quality Commission's National Report Review of Maternity Services in England 2022-2024, and the Antenatal and Newborn Screening Annual Report 2023/24.

4.5 Chief Executive Officer's Report

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

- Whilst the commitment in the Autumn Statement to additional funding for the NHS was welcomed, it was unclear at this stage what this additional funding will mean in practice and how it would be allocated.
- There had been recent media coverage of the Trust's ongoing dispute with its porters following a press release by the UNITE union.
- Arbitration proceedings were expected to commence in respect of a long-running dispute with BAM Construction relating to the construction of the east wing annex building.
- Significant changes in employment legislation were anticipated between now and 2026, although, due to the nature of employment conditions in the NHS, it was not anticipated that these changes would have a significant impact on the Trust.
- The new combined community provider, Hampshire and Isle of Wight Healthcare NHS Foundation Trust was launched on 1 October 2024.
- A meeting had been held with the now independent hospital charity to discuss priorities over the medium term.
- The national NHS staff survey had launched on 20 September 2024 and would run until 28 November 2024. It was noted that the participation rate thus far had been below that seen in previous years.
- The Trust's quality and patient safety partners programme had won the 'Patient Involvement in Safety' award at the Health Service Journal's Patient Safety Awards on 16 September 2024.
- There was a concern that the Government's intended 10-Year Plan for the NHS, which was expected to redirect focus on prevention and community healthcare, could result in an immediate loss of funding for acute providers, i.e. before the longer-term preventative measures had had an opportunity to take effect.

4.6 Performance KPI Report for Month 6

Joe Teape was invited to present the Performance KPI Report for Month 6, the content of which was noted. It was further noted that:

- The Trust's overall performance was good compared to other teaching hospitals. In August 2024, the Trust was first for its 65-week wait performance, and second for the 60-day cancer metric.

- The month of October was proving to be challenging with increased bed occupancy and surge capacity having to be opened. Type 1 Emergency Department attendance was over 400 per day.
- Whilst there had been improvements in the length of stay, the impact of this had largely been negated by the high demand being experienced.
- The 'W-45' initiative was to be implemented at the end of November 2024, whereby ambulances would automatically hand over patients to emergency departments after 45 minutes. It was noted that this policy would potentially put strain the relationship between the Emergency Department and the South Central Ambulance Service (SCAS).
- It was noted that there were potential issues with the data presented in terms of the number of virtual appointments and use of MyMedicalRecord.

The Board discussed the high levels of attendance in the Emergency Department. It was noted that:

- The Trust's winter plans did not assume 400 attendances per day.
- Attendances were typically of higher acuity, and did not appear to be as a result of patients being unable to access GP services.
- The Trust had a number of projects underway in order to direct patients to alternative routes into the hospital, such as through the Same-Day Emergency Care service.
- The importance of ensuring the wellbeing of staff during such a period of sustained demand was also noted.
- In addition, the Trust had requested funding for GPs in the Emergency Department as had occurred in previous years as a means of reducing demand on the Emergency Department.

Action:
Joe Teape agreed to investigate the data in respect of virtual appointment and MyMedicalRecord numbers presented for Month 6.

4.7 Finance Report for Month 6

Ian Howard was invited to present the Finance Report for Month 6, the content of which was noted. It was further noted that:

- The Trust had received additional funding in respect of 2023/24 Elective Recovery Fund (ERF) performance, funding for industrial action costs, and deficit support funding from NHS England. As a result, the Trust had recorded a year-to-date deficit of £8m, a variance of -£4.7m against plan.
- The Trust's underlying deficit continued to be £5-6m per month.
- The Trust had 200-220 patients with no criteria to reside at any one time, and expected reductions in mental health demand had not been realised due to non-delivery of system programmes.
- The Trust had also undertaken £17m of unpaid activity in the first half of 2024/25.
- The Trust had recorded 130% ERF performance in month and 128% year-to-date. It also continued to maintain low bank and agency use, and had delivered £32m of Cost Improvement Programme benefits.
- There was significant financial pressure throughout the NHS in England.

4.8 ICB Finance Report for Month 6

Ian Howard was invited to present the ICB Finance Report for Month 6, the content of which was noted. It was further noted that:

- The report tabled to the meeting had been prepared by the Hampshire and Isle of Wight Integrated Care Board (ICB) for all providers in the system.

- The system's 2024/25 plan targeted a deficit of £70m.
- During the first half of 2024/25, the system had received £55m in deficit support funding from NHS England and a surplus of £20m would be required during the second half of the year in order to be able to meet its 2024/25 target.
- Meeting the 2024/25 target would likely be challenging.
- The system had yet to see any significant benefit from the six transformation programmes.
- It was noted that the ICB report would benefit from additional information in respect of workforce and equality, diversity and inclusion.

4.9 Recovery Support Programme (RSP) Undertakings – Self Assessment

Ian Howard was invited to present the paper 'Recovery Support Programme (RSP) Undertakings – Self-Assessment', the content of which was noted. It was further noted that:

- In June 2024, the Trust, along with all other organisations in the Hampshire and Isle of Wight Integrated Care System (ICS) under the Recovery Support Programme had submitted a self-assessment in respect of the undertakings entered into in 2023. NHS England had provided feedback in respect of these self-assessments in August 2024.
- All providers had been asked to provide a further self-assessment, which would then be incorporated into a system-wide response in January 2025.
- The evidence supplied by the Trust in support of its self-assessment indicated significant engagement by the Trust's Board with the organisation's undertakings under the RSP as well as progress against these undertakings since the previous submission.
- Factors such as the number of patients having no criteria to reside and other matters beyond the Trust's control remained a concern in terms of the Trust's ability to fully meet the undertakings.
- The action plans for the ICS transformation programmes should be included as part of the Trust's response to the request for a self-assessment.

Decision

Having discussed the proposed response by the Trust, the Board agreed the proposed self-assessment, and authorised David French and Ian Howard to submit it to the Hampshire and Isle of Wight Integrated Care Board, subject to there being no material changes prior to submission.

4.10 People Report for Month 6

Steve Harris was invited to present the People Report for Month 6, the content of which was noted. It was further noted that:

- The Trust was currently under its 2024/25 plan by 249 whole-time-equivalents (WTE). However, this situation was expected to change in October 2024 due to the impact of onboarding of newly qualified nurses and midwives, and also due to non-delivery of ICS transformation programmes in non-criteria to reside and mental health, which assumed a reduction of 167 WTE.
- The Trust benchmarked well in terms of its sickness absence rate and turnover.
- The Trust had plans to transfer recording of appraisals from the Electronic Staff Record to the Visual Learning Environment platform, which was considered to be more 'user friendly' and was therefore expected to improve recorded appraisal numbers.

- The Trust was in active negotiations with Unison in respect of the Band 2/3 pay dispute.
- The People and Organisational Development Committee was to examine the overall workforce picture in more detail.

4.11 Cancer Patient Experience Survey Results 2023

Ali Keen was invited to present the Cancer Patient Experience Survey Results 2023, the content of which was noted. It was further noted that:

- The survey involved 132 trusts, and had a 58% response rate at UHS (1,064 patients).
- At the Trust 15 out of 59 questions scored above the expected range, which indicated that the Trust was a positive outlier when compared to trusts of a similar size and demographic.
- Patients with longer-term health conditions and women tended to have worse experiences than other groups.
- The care by and quality of staff at the Trust were rated highly.
- There were opportunities for improvement in some areas such as administration and communication around appointments.

5. STRATEGY and BUSINESS PLANNING

5.1 Corporate Objectives 2024-25 Quarter 2 Review

Martin De Sousa and Kelly Kent were invited to present the Corporate Objectives 2024/25 Quarter 2 review, the content of which was noted. It was further noted that:

- The report now incorporated a forecast for the end of year.
- The overall picture was positive with 12 objectives shown as 'green', two as 'amber', and two as 'red'.
- The main areas of risk in terms of the objectives concerned the deliverability of a stretching financial plan.
- The completion of year two of the Public Sector Decarbonisation Scheme was also at risk due to the state of steam duct tunnels, which required substantial remediation ahead of work commencing on the low temperature hot water system.

5.2 Board Assurance Framework (BAF) Update

Craig Machell was invited to present the Board Assurance Framework Update, the content of which was noted. It was further noted that:

- In September and October 2024, the Board's committees had reviewed the BAF risks assigned to them, and the Audit and Risk Committee had reviewed the entire BAF.
- As a result of these reviews, it had been agreed to increase the risk rating for Risk 1c (Infection Prevention Control) and to extend the target date. In addition, the target dates for all risks were to be reviewed to ensure that they were realistic.
- The Board agenda now included an annex, which indicated where papers were linked to a BAF risk and the impact of any decision by the Board on the Trust's achievement of its target risk rating. Furthermore, Board papers now

had a clear link to any relevant BAF risk included as part of the new cover sheet.

6. CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

6.1 Feedback from the Council of Governors' (CoG) Meeting 23 October 2024

The Chair provided an overview of the meeting of the Council of Governors held on 23 October 2024. It was noted that the meeting had addressed the following matters:

- Attendance at Council of Governors meetings
- Appointment of a member of the Governors' Nomination Committee
- Planning for the Governors' strategy session in December 2024
- Membership engagement
- Feedback from the Working Groups
- The external auditor's report on the Annual Accounts

In addition, on 31 October 2024, the Council of Governors had met with the Hampshire and Isle of Wight ICB to discuss future plans for the system and opportunities for collaboration between providers.

6.2 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. Any other business

There was no other business.

8. Note the date of the next meeting: 7 January 2025

9. Items circulated to the Board for reading

The item circulated to the Board for reading was noted. There being no further business, the meeting concluded.

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 06/06/2024 5.6 Performance KPI Report for Month 1				
1152.	Digital	Teape, Joe	27/02/2025	Pending
	Explanation action item JT agreed to include Digital as an agenda item at a future Trust Board Study Session. Update: Item tentatively scheduled for TBSS on 27/02/2025			
Trust Board – Open Session 25/07/2024 5.4 Briefing from the Chair of the Quality Committee (Oral)				
1163.	Impact of technology	Machell, Craig	27/02/2025	Pending
	Explanation action item Craig Machell agreed to add an item covering the impact of technology over the next 5-10 years to a future Trust Board Study Session agenda. Update: Item tentatively scheduled for 27/02/25 Study Session.			
Trust Board – Open Session 05/11/2024 4.6 Performance KPI Report for Month 6				
1181.	MyMedicalRecord (MMR)	Teape, Joe	07/01/2025	Completed
	Explanation action item Joe Teape agreed to investigate the data in respect of virtual appointment and MyMedicalRecord numbers presented for Month 6. Update: The issue was related to the MMR – drop-in logins in month and the increase in the previous month which was noted in the Month 6 report, as oncology had been added to the system and all patients notified in that month driving a surge in logins.			

Agenda Item 5.1 i)

Committee Chair's Report to the Trust Board of Directors 7 January 2025	
Committee:	**Finance & Investment Committee**
Meeting Date:	**25 November 2024**
Key Messages:	• For month 7, the Trust had reported an in-month deficit of £4.5m and a £12.5m year-to-date deficit. The Trust was £9.2m behind plan. • The non-delivery of system-wide transformation programmes represented approximately half of the overall deficit. The recent pay awards resulted in an additional £2m cost pressure. • Elective Recovery performance was 125%, which was lower than previously due to operational challenges in October 2024, high levels of annual leave, and the performance achieved in October 2019 on which in-month performance was based. • The Trust's workforce numbers were beginning to increase as anticipated as newly qualified staff members were onboarded. • The ongoing discussions with Unison in respect of the Band 2/3 pay dispute would likely lead to additional one-off costs as well as recurring costs if any pay increase were agreed. • It was expected that the Trust would be below the NHS England minimum cash holding during Quarter 4. • It was forecast that the Trust would deliver £67.7m of CIP for 2024/25 against £84.9m of identified schemes. • The Trust's Always Improving programme had succeeded in delivering a 3.6% reduction in length of stay.
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	Not applicable.
Any Other Matters:	• The committee received a quarterly update from Estates, Facilities and Capital Development. • The committee supported the Trust's bid for external funding in support of the Southampton Elective Hub.

Assurance Rating:

Substantial Assurance	There is a robust series of suitably designed internal controls in place upon which the organisation relies to manage the risk of failure of the continuous and effective achievement of the objectives of the process, which at the time of our review were being consistently applied.
Reasonable Assurance	There is a series of controls in place, however there are potential risks that may not be sufficient to ensure that the individual objectives of the process are achieved in a continuous and effective manner. Improvements are required to enhance the adequacy and effectiveness of the controls to mitigate these risks.
Limited Assurance	Controls in place are not sufficient to ensure that the organisation can rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Significant improvements are required to improve the adequacy and effectiveness of the controls.

No Assurance	There is a fundamental breakdown or absence of core internal controls such that the organisation cannot rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Immediate action is required to improve the adequacy and effectiveness of controls.
Not Applicable	Where assurance is not required and/or relevant.

Risk Rating:

Low	Based on the report considered by the committee, there is little or no concern that the Trust will be unable to meet its stated objectives and/or plans.
Medium	There is some concern that the Trust might not be able to fully meet its stated objectives and/or plans based on the information contained in the report considered by the committee.
High	There is a significant risk that the Trust will not be able to meet its stated objectives and/or plans based on the information contained in the report considered by the committee.
Not Applicable	Where risk rating is not relevant.

Agenda Item 5.1 ii)

<table>
<tr><td colspan="4">Committee Chair's Report to the Trust Board of Directors
7 January 2025</td></tr>
<tr><td>Committee:</td><td colspan="3">Finance & Investment Committee</td></tr>
<tr><td>Meeting Date:</td><td colspan="3">16 December 2024</td></tr>
<tr><td>Key Messages:</td><td colspan="3">• The Trust's financial position remains difficult despite significant levels of savings being delivered in areas such as patient flow, theatres, and outpatients.
• The main contributor to the Trust's deficit continues to be non-delivery of system-wide transformation programmes, especially those concerning patients having no criteria to reside.
• The Trust was forecasting to achieve c.£67m of its cost improvement programme target for 2024/25, a shortfall of £17m against the identified opportunities. However, much of the unachieved amount assumed delivery of system transformation programmes.
• The Trust's cash balance was initially expected to fall below the NHS England minimum holding level during Quarter 4. However, the Trust has received £12m of additional cash, which now means that the Trust's cash balance should not fall below minimum required levels until Quarter 1 of 2025/26.</td></tr>
<tr><td rowspan="4">Assurance:
(Reports/Papers reviewed by the Committee also appearing on the Board agenda)</td><td>5.7 Finance Report for Month 8</td><td>Assurance Rating:
Substantial</td><td>Risk Rating:
High</td></tr>
<tr><td colspan="3">• The Trust's in-month deficit was £5.7m and a year-to-date deficit of £18.2m, £14.8m behind plan year-to-date.
• The Trust has carried out £21m of unfunded activity during the year.
• The Trust continues to benchmark well in terms of value for money, and continues to apply measures to ensure financial grip and governance with strong controls in place.</td></tr>
<tr><td>6.1 Board Assurance Framework (BAF) Update</td><td>Assurance Rating:
Substantial</td><td>Risk Rating:
N/A</td></tr>
<tr><td colspan="3">• Risks 5a, 5b and 5c have been updated, following discussions with the respective Executive Director(s).
• The risk rating for Risk 5a has been increased from 15 to 20 due to the deteriorating cash balance and the ongoing financial pressures.</td></tr>
<tr><td>Any Other Matters:</td><td colspan="3">• The committee reviewed the outputs of the review of non-pay expenditure carried out by Deloitte.
• The committee supported the outline strategy for a possible private patient unit.
• The committee gave its support in principle for the Trust to bid for £1.75m of funding in support of the Trust's Same-Day Emergency Care service.</td></tr>
</table>

Assurance Rating:

Substantial Assurance	There is a robust series of suitably designed internal controls in place upon which the organisation relies to manage the risk of failure of the continuous and effective achievement of the objectives of the process, which at the time of our review were being consistently applied.
Reasonable Assurance	There is a series of controls in place, however there are potential risks that may not be sufficient to ensure that the individual objectives of the process are achieved in a continuous and effective manner. Improvements are required to enhance the adequacy and effectiveness of the controls to mitigate these risks.

Limited Assurance	Controls in place are not sufficient to ensure that the organisation can rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Significant improvements are required to improve the adequacy and effectiveness of the controls.
No Assurance	There is a fundamental breakdown or absence of core internal controls such that the organisation cannot rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Immediate action is required to improve the adequacy and effectiveness of controls.
Not Applicable	Where assurance is not required and/or relevant.

Risk Rating:

Low	Based on the report considered by the committee, there is little or no concern that the Trust will be unable to meet its stated objectives and/or plans.
Medium	There is some concern that the Trust might not be able to fully meet its stated objectives and/or plans based on the information contained in the report considered by the committee.
High	There is a significant risk that the Trust will not be able to meet its stated objectives and/or plans based on the information contained in the report considered by the committee.
Not Applicable	Where risk rating is not relevant.

Agenda item 5.2

<table>
<tr><td colspan="4">Committee Chair's Report to the Trust Board of Directors
7 January 2025</td></tr>
<tr><td>Committee:</td><td colspan="3">People & Organisational Development Committee</td></tr>
<tr><td>Meeting Date:</td><td colspan="3">13 December 2024</td></tr>
<tr><td>Key Messages:</td><td colspan="3">• The Trust's substantive workforce grew by 7 whole-time-equivalents (WTE) during November 2024 in line with forecast. However, an adjustment has also been made to the substantive numbers being reported due to the status of a hosted network (the CRN), which expanded following a TUPE transfer of staff.
• The rate of bank staff usage had increased in November 2024 due to the need to open surge capacity. This was expected to continue during the remainder of the year. Reduction in bank benefit has been assumed though, commencing in January linked to NQNs exiting supernumerary periods.
• The non-delivery of system-wide transformation programmes continues to pose a significant risk to the Trust's delivery of its 2024/25 workforce plan.
• A Mutually Agreed Resignation Scheme (MARS) has been approved by NHS England, which was expected to deliver a reduction in workforce of c.20 WTE by March 2025.
• The Trust was forecasting a total workforce of 13,464 WTE at the end of the year – broadly flat compared with the end of 2023/24. Increases in substantive workforce has been forecasted during December and January. Due to the volatility of predicting start dates during the Christmas period, a reforecast may take place in January.</td></tr>
<tr><td rowspan="4">Assurance:
(Reports/Papers reviewed by the Committee also appearing on the Board agenda)</td><td>5.9 People Report for Month 8</td><td>Assurance Rating:
Substantial</td><td>Risk Rating:
High</td></tr>
<tr><td colspan="3">• The Trust is above its 2024/25 workforce plan by 77 WTE due to a combination of the planned increases in substantive staff as newly qualified employees are onboarded, and the assumed reduction in workforce requirements due to delivery of system-wide transformation programmes.
• The system-wide transformation programmes assumed a reduction in workforce of 218 WTE. Non-delivery of these programmes therefore poses a significant risk to the Trust's achievement of its overall 2024/25 workforce plan.
• The Trust's sickness absence rate was 3.3% against the target of 3.9%, and turnover was lower than expected.
• The response rate to the Staff Survey was low compared to the national average.</td></tr>
<tr><td>6.1 Board Assurance Framework (BAF) Update</td><td>Assurance Rating:
Substantial</td><td>Risk Rating:
N/A</td></tr>
<tr><td colspan="3">• Risks 3a, 3b and 3c have been updated, following discussions with the respective Executive Director(s).
• The financial situation and uncertainty in respect of the NHS long-term workforce plan poses a significant underlying risk, and it was suggested that increasing the rating of risk 3c should be considered to reflect this.</td></tr>
<tr><td>Any Other Matters:</td><td colspan="3">• A detailed update was provided in respect of the ongoing industrial dispute with the porters and in respect of the Band 2/3 pay dispute.</td></tr>
</table>

	• The need to manage ongoing industrial disputes was impacting the Trust's People team's capacity to make progress on other areas, such as those relating to transformation.

Assurance Rating:

Substantial Assurance	There is a robust series of suitably designed internal controls in place upon which the organisation relies to manage the risk of failure of the continuous and effective achievement of the objectives of the process, which at the time of our review were being consistently applied.
Reasonable Assurance	There is a series of controls in place, however there are potential risks that may not be sufficient to ensure that the individual objectives of the process are achieved in a continuous and effective manner. Improvements are required to enhance the adequacy and effectiveness of the controls to mitigate these risks.
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Not Applicable	Where assurance is not required and/or relevant.

Risk Rating:

Low	Based on the report considered by the committee, there is little or no concern that the Trust will be unable to meet its stated objectives and/or plans.
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Not Applicable	Where risk rating is not relevant.

Agenda item 5.3

<table>
<tr><td colspan="4">Committee Chair's Report to the Trust Board of Directors
7 January 2025</td></tr>
<tr><td>Committee:</td><td colspan="3">Quality Committee</td></tr>
<tr><td>Meeting Date:</td><td colspan="3">25 November 2024</td></tr>
<tr><td>Key Messages:</td><td colspan="3">• There had been seven never events reported during 2024/25.
• There had been a decrease in the number of category 2 pressure ulcers, which was possibly due to increased training rates.
• Three prostate patients had been lost to follow up, and there were concerns in respect of capacity within the prostate service.
• Overall, the Quality Indicators show a system under pressure.
• There were also concerns in respect of cardiac surgery services due to staffing levels and culture within the team, which had led to cancellations and increased waiting lists.
• The PALS/complaints service had had 2,135 interactions during Quarter 2. The top themes related to clinical treatment, patient care, and communication.
• The number of Inquests was increasing, which was putting pressure on services.</td></tr>
<tr><td rowspan="4">Assurance:
(Reports/Papers reviewed by the Committee also appearing on the Board agenda)</td><td>5.12 Learning from Deaths 2024-25 Quarter 2 Report</td><td>Assurance Rating:
Substantial</td><td>Risk Rating:
Medium</td></tr>
<tr><td colspan="3">• Whilst the overall death rate had increased, this was in line with national trends. The Trust was performing well, and was one of 13 trusts scoring below the expected figure.
• A mobile application to share the outputs of mortality and morbidity meetings was being reviewed.
• The lack of available side rooms was leading to an increasing number of patients dying on wards rather than in a private environment.</td></tr>
<tr><td>5.13 Infection Prevention and Control 2024-25 Quarter 2 Report</td><td>Assurance Rating:
Substantial</td><td>Risk Rating:
High</td></tr>
<tr><td colspan="3">• The Trust was expected to miss most bacteraemia targets for 2024/25.
• The Trust was mid-table compared with other teaching hospitals.
• The rate of MRSA had increased to 4-5 cases per annum from 2020 onwards, compared with 0-2 per annum between 2015 and 2020.
• An audit of hand washing had raised concerns about the compliance rate.
• The loss of experienced staff since the COVID-19 pandemic was considered to be a significant contributor to the decline in performance.</td></tr>
<tr><td>Any Other Matters:</td><td colspan="3">The committee reviewed the Maternity and Neonatal Safety 2024-25 Quarter 2 Report and noted the following:
• Caesarean section rates remained high.
• The Trust's post-partum haemorrhage rate remained above the national expectations, but no key themes had been identified following review of this matter.
• In a review of third- and fourth-degree tears, no key themes had been identified.
• One maternal death was under investigation.</td></tr>
</table>

Assurance Rating:

Substantial Assurance	There is a robust series of suitably designed internal controls in place upon which the organisation relies to manage the risk of failure of the continuous and effective achievement of the objectives of the process, which at the time of our review were being consistently applied.
Reasonable Assurance	There is a series of controls in place, however there are potential risks that may not be sufficient to ensure that the individual objectives of the process are achieved in a continuous and effective manner. Improvements are required to enhance the adequacy and effectiveness of the controls to mitigate these risks.
Limited Assurance	Controls in place are not sufficient to ensure that the organisation can rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Significant improvements are required to improve the adequacy and effectiveness of the controls.
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Not Applicable	Where assurance is not required and/or relevant.

Risk Rating:

Low	Based on the report considered by the committee, there is little or no concern that the Trust will be unable to meet its stated objectives and/or plans.
Medium	There is some concern that the Trust might not be able to fully meet its stated objectives and/or plans based on the information contained in the report considered by the committee.
High	There is a significant risk that the Trust will not be able to meet its stated objectives and/or plans based on the information contained in the report considered by the committee.
Not Applicable	Where risk rating is not relevant.

University Hospital Southampton NHS Foundation Trust

Agenda Item 4.6 Report to the Quality Committee, 25 November 2024	
Title:	Maternity and Neonatal Safety 2024-25 Quarter 2 Report
Sponsor:	Gail Byrne, Chief Nursing Officer
Author:	Alison Millman, Quality Assurance and Safety Midwifery Matron Jessica Bown, Quality Assurance and Safety Midwifery Matron Hannah Mallon, Quality Assurance and Safety Neonatal Matron Marie Cann, Maternity and Neonatal Safety Lead Emma Northover, Director of Midwifery

Purpose

(Re)Assurance	Approval	Ratification	Information
x	x		x

Strategic Theme

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

Executive Summary:

NHS Resolution (NHSR) requires that the Maternity & Neonatal (MatNeo) service reports to our Trust Quality Committee each time it meets. This Quarter 2 (Q2) 24-25 MatNeo services safety report will continue to be adapted and responsive to safety concerns or issues within our service providing assurance around safety improvements impacting our families, services, and staff. The information provided is for assurance and reassurance, whilst meeting the requirements of NHSR Maternity Incentive Scheme (MIS)Year 6 and highlights the safety improvement work and learning from all aspects of the services. We ask members to continue to support the MatNeo Services and provide monitoring and scrutiny as required.

Contents:

This report provides an update in relation to the following areas for Quarter 2 2024/25:

Risk(s):	
The risk implications for the UHS Trust and MatNeo Services sit within several frameworks including: • **Reputational** – Safety concerns can be raised by the public to both NHS Resolution and the CQC. • **Financial** – Compliance with NHS Resolution Maternity Safety Actions to meet all ten safety actions remains to be an expectation for maternity safety requirements. • **Governance** – Safety concerns can be escalated to the Care Quality Commission for their consideration and to NHS England, the NHS Improvement Regional Director, the Deputy Chief Midwifery Officer, the Regional Chief Midwife. • **Safety** - Non-compliance with requirements or recommendations would have a detrimental impact on the women and their families leading to increased poor outcomes and staff wellbeing. MNSI can raise concerns regarding the safety of MatNeo services and instigate reviews.	
Equality Impact Consideration:	N/A

1. Perinatal Quality Surveillance – Maternity & Neonatal full Dashboard (Appendix 1)

The red flag exceptions can be found in **Appendix 1**, most of these remain known to the Quality Committee with no 'new exceptions', to note these are:

1.1 Scheduled Caesarean Section Capacity

Current number ↑ Q2 207. Elective caesarean section capacity continues to be well monitored, and oversight provided by the senior team. This surveillance indicator is set at no more than 157 within the quarter and 627 in the calendar year, which continues to be exceed causing wider service pressures, this has been above target since 2022. This issue has been widely discussed and is on our Risk Register (**Risk 788 High Red**).

1.2 Post Partum Haemorrhage (PPHs)

Current compliance:

- >500ms (43.58%) NMPA target is <34%, the Trust position has been consistently above target since 2022.
- >1500mls (5.8%) NMPA target is <2.8%, the Trust position has been consistently above target since 2022.

This surveillance indicator has received a full thematic review, this was shared in a recent report to the Committee. Audit monitoring remains in place to understand any safety concerns. We are participating in the Obstetric Bleeding Study (OBS) UK research project, which aims to implement a 'PPH bundle', seeking to improve the identification and management of postpartum haemorrhage (PPH).

1.3 Episiotomy

Current compliance 26.47%, consistently above target of <24.6%, the reported figure relates to all births at UHS. This indicator continues to be monitored with **1.4 (3rd and 4th degree tears)** with senior midwifery and obstetric oversight.

1.4 3rd and 4th degree tears

Current compliance 4.9%, consistently above the National target of 3%

The rate of 3rd and 4th degree tears has a natural variation but has been consistently above target since 2023. A thematic review was undertaken earlier this year, this did not identify any significant concern with clinical care. Our current improvement plan includes ongoing reviews and senior oversight of 3rd / 4th degree tear rates with a focus on Pelvic Health Education for all staff.

1.5 ITU transfers

The current total is 5 women/birthing people for Q2, performance indicator is set as 1. 3 were planned due to pre-existing cardiac history and 2 unplanned. There is a thematic review planned to look at all women and birthing people admitted to ITU to identify any potential learning. All ITU admissions are reviewed with an MDT through the local clinical events meeting seeking to identify any safety concerns or omissions in care. To date, there have been no clinical care concerns identified.

1.6 Apgars <7 at 5mins

A thematic review was undertaken earlier in the year and shared in a previous report to the Committee. There are ongoing improvement actions to contact comparable services to gain insight into any quality improvements that can be made.

1.7 Stillbirths per 1000 births

The rate for Q2 was 4.95 per 1000 births, the National target is 4.1 or less per 1000 births. Stillbirths (as rate per 1000) is closely monitored, as a Trust there has been some variation month on month, yet locally we have consistently been <4.1 per 1000 births in the calendar year for 2022 and 2023. Learning from stillbirths is included in **Appendices 4 and 5**.

1.8 Booked Continuity of Carer (CoC)

Current compliance: Total booked CoC Model - Q2 compliance 13.8%, National target is >35%
Global majority booked CoC Model – Q2 compliance 19.5%, National target is >35%

The most vulnerable families are still supported by our Needing Extra Support Teams (NEST) and as we progress workstreams around future workforce plans, the service aspires to develop new and more sustainable CoC models of care. To give assurance we monitor and audit outcomes to ensure that groups most likely to be offered a CoC model are not showing as exceptions in our data or when clinically reviewing adverse outcomes.

1.9 FFT recommenders as % of responders

Current compliance: 83.9% of responders would recommend our service. This has fallen slightly from Q1 (87.4%).

As mentioned in the previous Committee report, the % of responders who would recommend our postnatal ward dropped to 67% in September 2024. This was escalated to the inpatient matrons and an improvement plan focusing on two areas has been developed (**Appendix 2**). These areas are:

- Partner or someone else involved in service users care being allowed to stay with them as much as the service user wanted during their stay in hospital.
- After the birth, ensure that women and birthing people are given the opportunity to ask any questions they may have about their labour and birth.

1.10 Maternity Opel 4 Diverts

There has been an increase in the number of occasions when the Maternity Service has moved through escalation and ultimately declared OPEL 4. There are escalation processes and policies in place that aim to ensure appropriate decision making and the safety of our families and workforce. This issue has been widely monitored through Birthrate Plus reporting and reviewed within safety incident investigations and is on our Risk Register (Risk 259 High Red). As per the Trust's PSIRF plan, harm tools are completed for each Opel 4 exceeding 24 hours to review the wider impact and harm associated with the service being on divert. **Appendix 3** provides assurance to the Board that the Trust seeks to identify any thematic learning ensuring safety remains paramount.

1.11 Number of major complaints received for Maternity Services

There was 1 major complaint received in Q2. This related to bladder care postnatally and was not upheld. However, the service has identified that there have been several incidents reported related to bladder care and a thematic review of these cases is occurring in November. The findings from this will be shared in the next Committee report.

1.12 Concerns to Maternity Safety Champions

Concerns were raised to the Maternity Safety Champions in Q2 regarding:

- Increasing number of OPEL 3 and 4 alerts.
- Staffing in Maternity Services.
- Increasing caesarean section rates.

These concerns have been discussed through the Safety Champion meetings and through the Trust governance and safety processes.

2. Maternity and Newborn Safety Investigations (MNSI), Patient Safety Incident Investigations (PSII) and PMRT cases

Appendix 4 provides assurance to the members that the appropriate reporting has taken place for Q2. The report includes all new MNSI cases, of which there was 1, and any PSII cases. Also providing an update on all cases closed within the same timeframe, together with any thematic learning identified.

Information will also be included which relates to new and closed perinatal mortality cases even where there are no patient safety care concerns for the service to continue to be transparent. **Appendix 4** also includes a summary of the moderate incidents reported in Q2.

There were 3 MNSI and 2 PSIIs cases closed in Q2 and the learning slides are featured within the appendix:

- Incident 9970378 – Trust shared learning slide included within a previous report.
- MNSI 036677 case.
- MNSI 036718 case.
- Patient Safety / PMRT case 91230.
- Patient Safety / PMST case 9969932 / 92263.

3. Perinatal Mortality Review Tool learning and themes

A summary of PMRT Reviews of Q2 PMRT cases and learning are noted within **Appendices 4** and **5**. **Appendix 5** also includes the ethnicity and IMD decile of the women and birthing people. The MatNeo Service can confirm that there is high level oversight of reported and processed cases to ensure reviews and feedback from and to families are captured within appropriate timeframes. Case information is reviewed at a level where the service can look to identify any themes or vulnerable groups. Learning has been identified within the information and is shared with our LMNS.

An overall update of compliance with MBRRACE reporting as per NHSR MIS Safety Action 1 is included within **Appendix 6**. This demonstrates that the MatNeo Service is meeting the relevant standards.

4. ATAIN update (NHSR Safety Action 3)

NHSR MIS Safety action 3 asks for Trusts to complete at least one quality improvement (QI) initiative to decrease admissions and/or length of stay.

On reviewing Trust data, the most common reason for unexpected admission is due to respiratory symptoms. Previous QI projects have been undertaken, including introducing nasogastric tube feeding on Transitional Care (TC) (in 2023), as well as widening the weight and gestation criteria for TC. The Trust also implemented “Think 30” as an aim to support postnatal transition after birth to reduce respiratory distress. This was then amended to “Think 45”. However, there continue to be unexpected admissions to the Neonatal Unit due to respiratory symptoms. Therefore, a QI project was launched called “Think 60”.

In Q1 2024/25 it was noted that there were a few admissions where babies were admitted for less than 24 hours, had delayed discharges, or were started on 6L high flow rather than 4L. Therefore, there was also a project launched called “What to do post Think 60”.

“Think 60” and “What to do post Think 60” were launched in July 2024. The “Think 60” posters were printed, laminated, and attached to all resuscitaires across Maternity and Neonatal Services.

From April 2024 to the launch of Think 60, there were 21 babies admitted to the Neonatal Unit with the reason for admission being poor perinatal adaption / transition / transient tachypnoea of the newborn (TTN) and 1 baby admitted with meconium aspiration.

From the launch of Think 60 to 24 September 2024, there have been 18 babies admitted to the Neonatal Unit for the same reason for admission and 1 further baby admitted with meconium aspiration.

Preliminary results have shown an improvement in the admission respiratory support with a reduction of babies starting on High Flow 6L and an increase of babies starting on High Flow 4L. There has also been a reduction in the mean and median length of stay.

Preliminary results have been reported to the LMNS and Safety Champions. There is a plan to share a further update to the LMNS in a few months' time.

Unexpected term admissions continue to be reviewed with quarterly updates provided to the Women and Newborn Governance Steering Group as well as Quality Committee. **Appendix 7** provides an overview of the unexpected admissions in Quarter 2 2024/25 as well as any identified learning. It should be noted that there has been an increase in the number of babies admitted for hypoglycaemia management. An updated guideline on the management of hypoglycaemia in term infants is planned to be ratified through local governance processes in November 2024 which follows the national BAPM guidance and introduces a change in practice. Therefore, there should be a reduction in babies being admitted to Neonatal Services following this.

5. Midwifery and Obstetric workforce (NHSR Safety Action 5)

5.1 Midwifery workforce

With ongoing scrutiny, continuing focus and steer at National, regional as well as local level, operational pressures and maternity workforce continue to be a driving agenda for our Mat/Neo Service. Whilst the influencing factors are complex, maternity workforce related issues will have a direct impact upon patient safety. An overall update of compliance in respect of safe staffing standards across the Maternity workforce at UHS can be found in **Appendix 8.**

5.2 Obstetric workforce

NHS Resolutions MIS Year 6 does not require a formal obstetric workforce report but does require evidence of an audit demonstrating adherence with the RCOG standards relating to short and long-term locums, approaches to compensatory rest and attendance of obstetric consultants in line with RCOG guidance for attendance in mandatory scenarios/situations. Whilst the service is mindful of these requirements the service has not required the appointment of long or short-term locums of any grade during the audit period (6 months from February 2024). Additionally, the service continues to discuss compensatory rest in principle with feedback and monitoring. Finally, there have been no episodes of reported non-attendance by consultant obstetricians to review. **Appendix 9** gives information to the Committee as to when consultant obstetricians have been called in to attend key issues out of hours.

6. Neonatal workforce (NHSR Safety Action 4)

6.1 Neonatal Medical Workforce

In 2023, Southampton Neonatal Unit delivered 3211 ITU care days. Medical staffing meets the BAPM recommendations for units delivering >2500 ITU care days as follows:

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

Current risks:

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

However, following an increase in consultant numbers and subsequent successful recruitment, from 1 January 2025 we will provide on-site 12 hour a day cover at weekends (0830-2100) in addition to an on-site consultant presence from 0830 until 2300 at night during the weekdays.

Risk mitigation:

- Due to minimum staffing of both two tier 1 and two tier 2 doctors on all shifts, even if the tier 2 doctor/ANNP covering the transport service is called out overnight, there will still be 3 medical staff on the unit. In addition, as well as the on-call consultant (who will be on site until 2300) there is a second consultant available on-call at home, if needed. Furthermore, the number of transport referrals requiring medical cover at night are minimal.
- As described above, consultant cover will extend to a minimum of 12 hours a day, 7 days a week, as recommended by BAPM from 1 January 2025.

6.2 Neonatal Nursing Workforce Action Plan

The lack of suitably trained neonatal nursing staff to safely care for intensive care babies remains on the Trust Risk Register. There is an ongoing plan to increase the number of qualified in speciality (QIS) nurses with inhouse training. The vacancy for band 5 QIS increases to 30 WTE with the neonatal expansion. Please see **Appendix 10** for evidence progress against the previously agreed action plan from NHSR MIS Year 5. **Appendix 11** is the action plan for Year 6.

7. Trust Claims scorecard

The Quality Assurance Matron Team have met with NHS Resolution to review the Trust claims scorecard for obstetrics and neonatology. It was discussed how best to triangulate this information for greatest impact on service safety and improvement. **Appendix 12** provides a breakdown of the claims. To note, this scorecard does not include claims registered under the NHS Resolution Early Notification Scheme and there were 0 claims in the last 2 years.

8. Saving Babies' Lives Care Bundle V3 – NHSR update

8.1 Assure

The Trust is on track for full implementation of the Saving Babies Lives Care bundle (version 3) as per NHSR MIS year 6, which is required by March 2025. The Trust compliance with all interventions is assessed externally by the LMNS using the national implementation tool on the NHS futures platform, current evidence position can be found below.

8.2 Advise

UHS continues to hold 3 variances for Element 2 of the care bundle: Fetal Growth Restriction (FGR) that have been approved by the LMNS/ICB and quarterly audits continue to support these local variations to the care bundle. An additional variance is being requested against intervention 2.14 – NICE guidance on the use of PlGF testing, this variance is being written by the maternal medicine team, to include the rationale and risks and will be shared with the LMNS/ICB for approval.

The Trust has met all bar 1 of the 27 interventions for Element 5 of the care bundle: Reducing Preterm Birth. This remaining intervention 5.15 is in progress, pending the Preterm Birth local guideline to be completed, this is expected by the Q3 update.

8.3 Alert

Element 2: FGR Intervention reference: 2.6 recommends that as part of the FGR risk assessment blood pressure should be recorded using a digital monitor that has been validated for use in pregnancy for all pregnant women. The Trust holds a local action plan, this is awaiting funding to be approved for sufficient digital monitors for the community hubs and the Maternity Service would appreciate the Committee's support to enable full implementation of the Saving Babies Lives care bundle.

Implementation progress update

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Fully implemented	100%	Fully implemented	100%
Element 2	Fetal growth restriction	Partially implemented	90%	Partially implemented	90%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Partially implemented	93%	Partially implemented	96%
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%
All Elements	TOTAL	Partially implemented	94%	Partially implemented	96%

9. Extremely low birth weight referrals to UHS

In Q2 it was identified that there had been a significant reduction of babies born at UHS who were either under 27 weeks gestation or 28 weeks gestation for multiple pregnancies or were under 800g at birth. Babies who fit these criteria should be born in a service with a Level 3 Neonatal Intensive Care Unit (NICU) on-site and would often be in utero transfers from within the region. To note, in Q2 there was 1 baby who was born at 25 weeks gestation and 2 babies born at home at 27 weeks gestation who were from a concealed pregnancy.

This data is being benchmarked regionally and nationally and UHS is much lower than the other NICUs within the Operational Delivery Network (ODN). The benchmarking focuses on those babies who have their first episode of care with us – i.e. they were born at UHS. Within January – September 2024, there were 14 babies born compared to 31 born in 2023 and compared to 28 born at Portsmouth for January – September 2024. Data has also been ascertained looking at these babies and where their nearest NICU was (QAH or UHS) – there were 9 babies born at QAH who's nearest NICU was UHS. Incident forms are being completed when in utero transfers for this cohort of babies are being refused within the MatNeo Service to monitor and review.

The process for receiving referrals for in utero transfers within the Maternity Service has been reviewed and amended. These referrals will go directly to Gold command for acceptance or refusal. This will continue to be monitored and reported monthly through the Maternity and Neonatal performance meeting.

Appendix 1

UHS Maternity Dashboard													
Antenatal Booking	**Q3 23/24**	**Q4 23/24**	**Q1 total**	**July**	**August**	**September**	**Q2 total**	**2022 (calendar year)**	**2023 (calendar year)**	**2024 (calendar year)**	**Green**	**Red**	**Comments**
Total number of women/clients booked	1307	1321	1598	501	455	403	**1359**	**5475**	**5336**	**4278**	No performance threshold		
% Bookings ≤ 9+6 weeks (NICE recommendation)	6.63%	5.67%	31.30%	73.70%	73.00%	74.20%	73.63%	**6.30%**	**9.90%**	**36.87%**	Acceptable level >50% Achievable level >75%		
% Bookings ≤ 10+6 weeks	25.52%	18.61%	42.50%	82.24%	81.10%	83.62%	82.32%	**13.10%**	**28.94%**	**47.81%**			
Timeliness of testing KPI for Sickle cell and Thalassemia screening	10.9%	10.0%	36.0%	69.0%	77.5%	76.0%	74.17%	**5.8%**	**17.5%**	**40.03%**	Performance threshold of testing Acceptable level >50% Achievable level >75%		The proportion of pregnant women/clients having antenatal sickle cell and thalassemia screening for whom a screening result is available ≤10 weeks + 0 days gestation.
Birth Outcomes - mothers	**Q3 23/24**	**Q4 23/4**	**Q1 total**	**July**	**August**	**September**	**Q2 total**	**2022 (calendar year)**	**2023**	**2024**	**Green**	**Red**	**Comments**
Total number of Births (women/people)	1304	1235	1205	390	400	410	1200	**5094**	**4963**	**3640**	1375 or fewer a quarter	More than 1375 a quarter	
Predicted birth rate	1230	1237	1159	402	408	424	1234	**4897**	**4808**	**3630**	1375 or fewer a quarter	More than 1375 a quarter	Predictions as of 01/10/2024 - Q3 - 1183 Q4 - 1208
Sets of Multiples	14	18	23	7	3	11	21	**74**	**79**	**62**	20 a quarter	21+ a quarter	
Home birth rate	0.61%	1.00%	0.33%	0.50%	0.00%	1.00%	0.50%	**0.56%**	**0.63%**	**0.61%**	No performance threshold		
IOL rate	32.67%	32.40%	35.17%	30.50%	35.80%	28.80%	31.70%	**30.23%**	**32.46%**	**33.09%**	Less than 33%	More than 33%	
Scheduled Caesarean Section capacity	225	189	195	72	62	73	207	**689**	**814**	**591**	157 or Less a QTR. 52 or less a month	Greater than 157 a QTR. Or 52 a month	The Maternity services have calculated the number of elective caesarean sections capacity as 157 slots per quarter, equalling 627 a year.
Number of scheduled CS slots blocked due to complexity of cases on the list	18	22	29	11	8	6	25	**New measure 2023**	**77**	**76**	No performance threshold		
PPH 500ml or more - NMPA	36.69%	40.34%	42.16%	42.04%	41.78%	46.93%	43.58%	**35.63%**	**35.74%**	**42.03%**	34.0% or less	Over 34.1%	% of term, singleton births with an obstetric haemorrhage more than or equal to 500ml. Source NMPA 2016/17 - UHS 34.5%(unadjusted) & 34.3% (adjusted) - National Mean 34.1%
PPH 1500ml or more - NMPA	4.10%	4.49%	5.26%	5.74%	5.01%	4.80%	5.18%	**3.45%**	**3.80%**	**4.98%**	2.8% or Less	Over 2.9	% of term, singleton births with an obstetric haemorrhage more than or equal to 1500ml. Source NMPA 2016/17 - UHS 3.4%(unadjusted) & 3.3% (adjusted) - National Mean 2.9%.
Episiotomy rate	25.6%	25.07%	26.9%	21.7%	27.6%	30.1%	26.47%	**25.5%**	**26.8%**	**26.14%**	24.6% or less	Over 24.6%	Reported figure related to all births UHS
3rd/4th degree tears - NMPA	4.98%	5.88%	3.88%	5.76%	5.16%	3.79%	4.90%	**3.05%**	**3.94%**	**4.89%**	3.0% or Less	Over 3.0%	% of term, singleton, cephalic, vaginal births with a 3rd or 4th degree perineal tear. Source NMPA published report 2018/19 - UHS 3.5%(adjusted) - National Mean 3.1%. NMPA Rapid report 2022 - National mean 3.0 - Local indicators updated Q1 2024/25 - 3.0%
ITU Transfers	2	3	1	1	1	3	5	**8**	**9**	9	1	2 or more	
Hysterectomy	0	0	0	0	0	0	0	**2**	**0**	**0**	0	1+	
Birth Outcomes - Babies	**Q3 23/24**	**Q4 23/4**	**Q1 total**	**July**	**August**	**September**	**Q2 total**	**2022**	**2023**	**2024**	**Green**	**Red**	**Comments**
Total babies born	1318	1253	1228	397	403	421	1221	**5169**	**5043**	**3702**	1375 or fewer	More than 1375	
Total liveborn babies		1247	1218	392	397	418	1207	**5132**	**4997**	**3672**	No performance threshold		
Total number of registerable babies	1313	1247	1220	395	398	420	1213	**5149**	**5012**	**3680**	No performance threshold		All liveborn babies plus stillborn babies born from 24 weeks gestation
Normal Birth Rate (babies)	45.50%	47.67%	47.18%	44.80%	43.30%	42.80%	43.63%	**48.79%**	**45.91%**	**46.16%**	No performance threshold		All babies born via normal vaginal delivery
Apgar's <7 at 5 minutes - NMPA	2.6%	2.6%	2.37%	3.0%	3.1%	1.9%	2.67%	**2.1%**	**2.6%**	**2.53%**	1.1% or Less	Over 1.1%	% of liveborn, singleton, term babies with an Apgar score of less than 7 at 5 minutes (BBAs excluded). Source NMPA 2018/19 - UHS 2.3%(adjusted)) - National Mean 1.1% - Local indicators updated Q1 2022/23 - 1.1%
Pre-term birth rate (registerable babies)	8.7%	8.8%	10.30%	11.7%	9.8%	6.9%	9.5%	**8.7%**	**9.7%**	**9.51%**	No performance threshold		
% <3rd centile >37+6 weeks - SBLs	51.20%	46.04%	28.66%	55.55%	60.00%	33.33%	49.6%	New measure 2023	57.7%	41.4%	To be defined		Numerator - number of babies born greater than 37+6. Denominator - total babies born less than the 3rd centile
Low Birth Weight at Term (<2500g)	2.3%	2.0%	3.3%	2.9%	2.5%	2.1%	2.5%	**2.5%**	**2.2%**	**2.6%**	Less than 2.8%	More than 2.8%	Source Public Health England 2017 National average 2.82% of live term births.
Number of late fetal losses (16+0 - 23+6)		6	8	2	5	1	8	20	31	22	No performance threshold		
Total Number of Stillbirths (greater than 24+0)	5	4	7	**3**	**1**	**2**	6	**17**	**15**	**17**	5 or less	6 or above	Actual number of Stillbirths each quarter
Number of intrapartum stillbirths		1	0	0	0	0	0	2	0	1	No performance threshold		
Stillbirth rate per 1000 births	3.81	3.21	5.74	7.59	2.51	4.76	4.95	**3.30**	**2.99**	**4.62**	4.1 or less	4.2 or above	National rate 2021 4.2 per 1000 births
Neonatal outcomes	**Q3 23/24**	**Q4 23/4**	**Q1 total**	**July**	**August**	**September**	**Q2 total**	**2022**	**2023**	**2024**	**Green**	**Red**	**Comments**
Encephalopathy >34 weeks (inborn babies, graded moderate and above)	0	2 Moderate (3 mild)	1	0	0	0	0	**4**	**7**	**2**	No performance threshold		
Term Admission to NNU -All babies	5.7%	7.1%	5.4%	6.1%	5.8%	4.8%	5.6%	**4.8%**	**5.7%**	**6.0%**	Less than 5%	More than 5%	Data source - Neonatal Network. Term admissions as a percentage of total birth rate as per reporting requirement to TV&W ODN.

Unexpected Term Admission to NNU - Excluding surgical/cardiac/congenital babies	4.9%	4.6%	3.3%	4.0%	3.9%	2.6%	3.5%	3.3%	3.9%	3.8%	Less than 5%	More than 5%	Data source - Neonatal Network and excludes babies coded under the surgical and cardiac categories
Avoidable term admissions to NNU			0.2%	0.5%	0.3%	0.0%	0.3%						
Appropriate place of birth	100%	100%	100%	99%	100%	100%	99.8%	100%	100%	100%	100%		
Number of neonatal deaths (Inborn)	3	6	4	1	0	0	1	23	19	11	No performance threshold		Safer Maternity Care Progress Report published in 2021 removes the performance threshold for Neonatal Deaths occurring at any gestation. Moving forward the measure have changed to reflect liveborn from 24+0 weeks gestation who sadly die. This includes deaths that occur within the Children's Hospital that received neonatal care. Only deaths that fit the MBRRACE/PMRT criteria are included. From January 2024 deaths are reported in the month they occure to align with other reporting streams
Neonatal deaths per 1000 live births	2.29	4.81	3.28	2.55	0.00	0.00	0.83	4.50	3.80	3.00	No performance threshold		
Number of neonatal deaths - outborn		3	1	1	0	0	1	New measure			No performance threshold		New measure 2024 - Data souce NNU. Neonatal deaths of babies <28 days of age. This includes deaths that occur within the Children's Hospital that received neonatal care.
Public Health Outcomes	**Q3 23/24**	**Q4 23/4**	**Q1 total**	**July**	**August**	**September**	**Q2 total**	**2022**	**2023**	**2024**	**Green**	**Red**	**Comments**
Infant feeding - Breast Feeding Initiation (mothers)	79.4%	78.2%	79.6%	80.3%	80.3%	81.8%	80.8%	75.3%	77.1%	79.5%	More than 75.0%	Less than 75.0%	
Infant feeding - Breast Feeding at Discharge to community (babies)	71.6%	71.3%	75.4%	74.6%	74.9%	74.8%	74.8%	67.7%	64.7%	73.8%	More than 70.6%	Less than 70.6%	
Smokers at booking	7.6%	6.3%	6.4%	7.2%	7.0%	5.0%	6.4%	11.1%	11.3%	6.3%	No performance threshold		
Smoking at Delivery	8.5%	6.8%	7.2%	5.1%	5.3%	4.4%	4.9%	9.8%	8.2%	6.3%	Less than 6.0%	More than 6.0%	
% of delivered women who quit during pregnancy	30.9%	32.8%	31.8%	31.0%	28.0%	25.0%	28.0%	26.8%	29.1%	30.9%	No performance threshold		
Southampton City Smoke Free Pregnancy Monitoring	35.6%	62.5%	8.7%	Reportable next quarter				24.0%	43.6%	35.6%	Greater than 35%	Less than 35%	
Booked Continuity of Carer - Southampton NEST only	**Q3 23/24**	**Q4 23/4**	**Q1 total**	**July**	**August**	**September**	**Q2 total**	**2022**	**2023**	**2024**	**Green**	**Red**	**Comments**
Booked - total women/pregnancy people booked onto a CoC pathway	10.9%	11.4%	13.0%	13.3%	15.6%	12.4%	13.8%	12.4%	13.1%	12.7%	Greater than 35%	Less than 35%	
Booked - total Global Majority women / pregnant people booked onto a CoC pathway	14.2%	14.7%	22.9%	19.2%	19.3%	20.0%	19.5%	71.8%	18.6%	19.1%	Greater than 51%	Less than 51%	
Booked - total women living within an IMD-1 area booked onto a CoC pathway	42.0%	27.1%	64.9%	92.6%	87.2%	91.7%	90.5%	75.1%	31.7%	60.8%	Greater than 51%	Less than 51%	
Ockenden review	**Q3 23/24**	**Q4 23/4**	**Q1 total**	**July**	**August**	**September**	**Q2 total**	**2022**	**2023**	**2024**	**Green**	**Red**	**Comments**
% Risk assessments undertaken at each AN contact (reviewed and authorised)	55.2%	55.3%	62.8%	94.7%	95.1%	96.3%	95.4%	46.9%	59.7%	71.2%	Acceptable level ≥ 80% Achievable ≥ 90%		
% Place of birth risk assessments undertaken at each AN contact	58.7%	75.5%	76.3%	85.1%	83.9%	87.2%	85.4%	68.9%	75.3%	79.1%			
% High Risk women allocated a named consultant at any point during pregnancy	99.7%	100.0%	99.8%	100.0%	99.7%	99.7%	99.8%	94.0%	97.3%	99.9%			
Risk and Patient Safety cases	**Q3 23/24**	**Q4 23/4**	**Q1 total**	**July**	**August**	**September**	**Q2 total**	**2022**	**2023**	**2024**	**Green**	**Red**	**Comments**
Total number of cases UHS have reported to MNSI	0	5	2	0	1	0	1	6	5	8	n/a	n/a	
Total number of UHS cases accepted for review by MNSI	0	5	2	0	1	0	1	6	5	8	n/a	n/a	
Term Intrapartum Stillbirths	0	1	0	0	0	0	0	0	0	1	n/a	n/a	
Early neonatal death	0	0	0	0	0	0	0	1	1	0	n/a	n/a	
Severe brain injury	0	4	2	0	0	0	0	4	5	6	n/a	n/a	
Maternal death	0	0	0	0	1	0	1	3	0	1	n/a	n/a	
The number of incidents logged graded as moderate or above and what actions are being taken	7	13	11	0	2	2	4	48	30	28	n/a	n/a	
Number of PSIIs reported and under investigation	0	5	5	0	0	0	0	11	6	10	n/a	n/a	
Number of major complaints received for Maternity Services	0	0	1	1	0	0	1	10	3	2	n/a	n/a	
Education and training	**Q3 23/24**	**Q4 23/4**	**Q1 total**	**July**	**August**	**September**	**Q2 total**	**2022**	**2023**	**2024**	**Green**	**Red**	**Comments**
Fetal Monitoring Training (SBL3 & NHSR)													
Midwives	89.5%			87.00%	86.1%	87.8%					90% compliance target		
Consultant Obstetricians	91.2%			90.00%	90.0%	94.7%							
Obstetric trainees	93.4%			83.30%	83.3%	83.3%							
PROMPT (inc newborn live support update)													
Obstetric trainees				90.00%	68.8%	78.1%					90% compliance target		
Consultant Obstetricians				79.00%	75.0%	90.0%							
Consultant Anaesthetists				78.00%	72.2%	72.2%							
Anaesthetic Trainees				75.00%	76.7%	52.0%							

UHS Midwives				90.00%	89.4%	87.5%							
MSWs and Nursery Nurses				87.00%	93.6%	78.7%							
Theatre													
Neonatal Life Support													
Neonatal Consultants			85.0%	92.0%	92.0%	100.0%							
Neonatal junior doctors (who attend any births)			62.0%	96.0%	96.0%	90.0%					90% compliance target		Measure added from Q1 2024/25. To note that compliance is for the reporting period of 1st Dec 23 to 30th Nov 24.
Neonatal nurses (Band 5 and above)			36.0%	59.0%	59.0%	73.0%							
Advanced Neonatal Nurse Practitioners (ANNP)			60.0%	60.0%	60.0%	100.0%							
Friends and Family Test	**Q3 23/24**	**Q4 23/4**	**Q1 total**	**July**	**August**	**September**	**Q2 total**	**2022**	**2023**	**2024**	**Green**	**Red**	**Comments**
Responders as % of eligible populations	26.9%	33.0%	31.7%	35.3%	26.9%	33.5%	31.9%	**24.2%**	**28.2%**	**32.2%**	20% or more	Less than 20%	
Recommenders as % of responders	82.7%	84.3%	87.4%	84.0%	85.0%	82.7%	83.9%	**86.4%**	**85.7%**	**85.2%**	90% or more	Less than 90%	
NOT recommending as % of responders	4.5%	4.8%	3.9%	5.0%	3.4%	5.0%	4.5%	**3.9%**	**3.9%**	**4.4%**	Less than 5%	5% or more	
Service monitoring	**Q3 23/24**	**Q4 23/4**	**Q1 total**	**July**	**August**	**September**	**Q2 total**	**2022**	**2023**	**2024**	**Green**	**Red**	**Comments**
Black Alerts / OPEL 4	8	10	11	8	2	12	22	**31**	**27**	**43**	0	1 or more a month	
Concerns raised - Maternity Safety Champions	0	1	4	1	2	3	6	**New reporting measure June 2023**	**4**	**11**	0	1 or more a month	September 2024 - Increasing number of Opel 3 and 4 alerts. Staffing in Maternity Services, Increaseing LSCS rates. All of these will be discussed at the Safety Champion meeting and through the Trust safety and governance structures.
Maternity Day Assessment Unit - DRAFT new measure		2036	2115	754	658	719	2131			4151			Measure only includes BSOTs opened in MDAU, and logic applied to dates
Number of attendances triaged within 15 minutes		1898	1990	690	619	659	1968			3888			
% of women triaged within 15 minutes - DRAFT new measure		93.22%	94.09%	91.51%	94.07%	91.66%	92.35%			93.66%	Acceptable level >90% Achievable level >95%		

Maternity Improvement Plan Postnatal care in Hospitals

Partner or someone else involved in service users care being allowed to stay with them as much as the service user wanted during their stay in hospital

- F Level Matron has been to one other SHIP Trust, with further visits planned to explore what they do and what works well.
- Extended visiting for one visitor to be introduced on a trial basis
- Continue to explore/consider whether current facilities/estates support partners staying over night

After the birth, ensure that women are given the opportunity to ask any questions they may have about their labour and birth

- F Level Matrons engage in intentional rounding, cross covering ward areas as required.
- Care concerns escalated where necessary to the appropriate speciality, both positive and constructive negative feedback given to staff where required
- F Level Matrons exploring new ways of working including the introduction of 'call for concern' within Maternity services

Appendix 3

MatNeo Opel 4 Escalations

Quarter 2 2024/25 summary

University Hospital Southampton NHS Foundation Trust

Date	Total number of escalations to Opel 4	Total number of reported AERs	Total number of critical incidents - Mother	Total number of critical incidents - Baby	Number of women birth	Spontaneous birth		Scheduled CS		Emergency CS		Total CS		Instrumental (inc breech)		Stillbirths	Neonatal Deaths	PPH <1500mls rate	
						No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate			No.	Rate
Jul-24	8	97	35	55	390	176	45.1%	72	18.5%	101	25.9%	173	44.4%	42	10.8%	3	1	23	5.9%
Aug-24	2	101	26	46	400	177	44.3%	62	15.5%	110	27.5%	172	43.0%	53	13.3%	1	0	21	5.3%
Sep-24	12	74	29	41	403	178	44.2%	73	18.1%	101	25.1%	174	43.2%	58	14.4%	2	0	19	4.7%
Quarter 2 2024/25 Total	22	272	90	142	1193	531	44.5%	207	17.4%	312	26.2%	519	43.5%	153	12.8%	6	1	63	5.3%

AER Themes

- Opel 4 – staffing/capacity/acuity
- Term admissions (? ATAIN)/Baby readmission
- Ex-utero transfer out (baby)
- Delays in elective work (IOL/EL LSCS)
- HDU patient admitted to GICU due to staffing/skill mix
- Unable to accept IUT (Level 3 NICU)
- Documentation/communication error

Top 3 Critical Incidents

Mum

- PPH
- BBA (Birth before arrival)
- HDU Admission

Baby

- Term admission
- Apgar <7
- 1 x cord Ph <7.05 arterial or < 7.10 venous

Appendix 4
Maternity and Newbon Safety Investigations (MNSI), Patient Safety Incident Investigations (PSII) and PMRT cases – Quarter 2 2024/25

New Patient Safety Cases

Case type MNSI / PMRT etc	Incident form	Log Date	Incident Trigger	Summary of incident	Outcome of incident
Patient safety	9978989	13 – 14/07/2024	Maternity Services on Opel 4 alert >24 hours	Maternity Services was on Opel 4 alert from 13 – 14/07/2024.	Harm tool to be completed.
Patient safety	9979945	29 – 31/07/24	Maternity Services on Opel 4 alert >24 hours	Maternity Services was on Opel 4 alert from 29 – 31/07/2024.	Harm tool to be completed.
MNSI	9981888 / MI-038270	29/08/24	Maternal death	Maternal death and antenatal stillbirth following suspected brain aneurism. 999 call to home in Gosport, air lifted to UHS due to suspected neuro involvement but under the care of Portsmouth.	Reviewed through Patient Safety Case Review. Incidental learning identified relating to equipment available in the neonatal resuscitation grab bag taken to the delivery in the Emergency Department. Case referred to MNSI and accepted for investigation.
Patient safety	9983770	27/09/24	Maternity Services on Opel 4 alert >24 hours	Maternity Services was on Opel 4 alert from 27 – 28/09/2024.	Harm tool to be completed.

New PMRT cases

PMRT number	Log Date	Incident Trigger	Summary of incident	Outcome of incident
94119	02/07/2024	Neonatal Death	Baby born at 27+5 weeks gestation. Known fetal hydrops. Born in reasonable condition, required high pressures to support with chest movement. NLS management including CPR continued for 67 mins.	Reported to PMRT. PMRT ongoing within timeframe. Heard at CDRM, learning identified re. maternal thyrotoxicosis and a delay in treatment, there was also

			Agreed with parents for CPR to cease and baby given to mum to cuddle.	no evidence of offer or parallel care ACP plan on counselling antenatally. There was also a lack of coordinated bereavement care and she felt overwhelmed by contact / correspondence after baby died.
94233	09/07/2024	Antepartum stillbirth	Attended MDAU at 26+6 with PV bleed and abdominal pain. Suspected placental abruption. IUD confirmed and baby boy delivered stillborn.	Reported to PMRT and closed. Graded A/B. Heard at Clinical Events Review. Learning re. mental health care / support for bereaved families.
94478	26/07/2024	Antepartum stillbirth	Attended at 24+3 with history of reduced fetal movements for 24 hours. IUD confirmed in MDAU. Baby boy delivered stillborn at 24+6.	Reported to PMRT and closed. Graded B/A. Heard at Clinical Events Review. Learning re. advice given regarding following local guidance for women reporting absent fetal movements to the maternity triage line.
94518 (led by the Children's Hospital)	29/07/2024	Late Neonatal death	Born at 29+4 weeks on IOW. Transferred via SONeT to QAH. Transfer to PAH due to postnatal diagnosis of TAPVD, ASD and VSD. Discharged to PICU at 39+2 weeks. Under care of E1 / PICU. Died on PICU.	Reported to PMRT. PMRT ongoing within timeframe. To be reviewed at PICU Child Death Review Meeting in October 24.
94525	30/07/2024	Antepartum stillbirth	Attended MDAU at 39+3 with reduced fetal movements (first episode in 3 weeks). IUD confirmed in MDAU. Baby girl delivered stillborn at 39+5 weeks.	Reported to PMRT. PMRT ongoing within timeframe. Heard at Clinical Events Review. No learning identified.
94951	29/08/2024	Stillbirth	Perimortem CS in ED at 36+4 due to suspected maternal brain aneurism. Booked under QAH. Born with no signs of life.	Reported to PMRT. Maternal death under investigation via MNSI (see section above). Patient Safety Case Review held. Incidental learning identified relating to equipment available in the neonatal resuscitation grab bag taken to the delivery in the Emergency Department.
95320	24/09/2024	Stillbirth	Known to fetal medicine with likely diagnosis of T13. Attended MDAU at 30+5 weeks with RFM for 24 hours. IUD confirmed and baby delivered stillborn.	Reported to PMRT. PMRT ongoing within timeframe. To be reviewed through Clinical Events.

95321	25/09/2024	Stillbirth	Attended MDAU at 39+3 with absent fetal movements. IUD confirmed and baby delivered stillborn.	Reported to PMRT. PMRT ongoing within timeframe. To be reviewed through Clinical Events.

Closed Cases

Case type MNSI / PMRT etc	Incident form	Log Date	Incident Trigger	Summary of incident	Outcome of incident
MNSI	9970378	12/03/2024	Therapeutic cooling	Term vaginal delivery. Neonatal collapse around 1 hr 40 mins of age whilst having skin-to-skin with mum.	Reported to MNSI but rejected for investigation due to no care concerns from the family or the Trust and no evidence of moderate or severe HIE. Case discussed at local Morbidity and Mortality Meeting in July and learning shared re. skin to skin. Learning slide shared in the August report to Quality Committee.
MNSI	9965682 / MI-036677	03/01/2024	Therapeutic cooling	Admitted for induction of labour post spontaneous rupture of membranes. Normal labour, pathological CTG therefore ventouse extraction performed. Baby born in very poor condition. NNU team present, baby intubated and ventilated prior to being taken to NNU for cooling.	Reported to MNSI, investigation completed, and local action plan written – plan to be closed at PSIIOG in October 24. See lessons learned slide.
MNSI	9966021 / MI-036718	10/01/2024	Therapeutic cooling	Patient underwent a category 3 CS for a failed induction of labour. There had not been any CTG monitoring since earlier that day (0914) which was documented as normal. The baby was born in unexpected poor condition and required resuscitation and transfer to the neonatal unit. Baby underwent therapeutic cooling as met criteria A, B and C.	Reported to MNSI, investigation completed, and local action plan written – plan to be closed at PSIIOG in October 24. See lessons learned slide.
Patient safety	9971294	23/03/2024	Maternity Services on Opel 4 alert >24 hours	Maternity Services was on Opel 4 alert from 22 – 23/03/2024.	Harm tool completed. No new learning identified. Closed at Patient Safety Steering Group in July 2024.

Patient Safety / PMRT	91230	06/01/2024	Neonatal death	Baby born at 34+5 weeks. Under care of NNU and home team. Discharged 7 days of age. Found unresponsive at home 12 days of age. Brought into the Emergency Department and confirmed he had died.	Patient Safety Incident Investigation (PSII) completed and closed at PSIIOG in September 2024. Lessons learned slide to be shared in the next report.
Patient Safety / PMRT	9969932 / 92263	05/03/2024	Neonatal death	Baby born following very difficult delivery - trial of vaginal delivery in theatre but converted to C section. Born in poor condition with neurology concerns and limited movements. MRI suggestive of brainstem injury. No change in clinical condition over 3 days. Decision made for comfort care with parents. Baby died at 3 days of age.	Patient Safety Incident Investigation (PSII) completed and closed at PSIIOG in September 2024. PMRT to be closed with grading confirmed as C/A/C. Lessons learned slide to be shared in the next report.
PMRT	89598	27/09/2023	Neonatal death	Baby born at 26+5 weeks at PAH. Out of area mother due to no cots in Bristol. Severe IUGR. He developed a pneumothorax following elective endotracheal tube change at a few hours of age. He deteriorated at 56 hours of age with abdominal distension and a worsening mixed acidosis. Referred for Coroner's PM which confirmed cause of death as complications of extreme prematurity.	Reported to PMRT and closed. Graded B/B/A. Local learning identified relating to endotracheal tube sizing at initial intubation.
PMRT	90457	18/11/2023	Neonatal death	Twin pregnancy. Baby born at 34+5 weeks at Derriford Hospital. Postnatal diagnosis of cardiac condition. Transferred to PAH for surgical care as he developed NEC.	Reported to PMRT and closed. Graded C/C/B. No learning identified for UHS.

PMRT	90798	09/12/2023	Stillbirth	Presented with reduced fetal movements at 25+3 weeks. IUD confirmed and baby boy delivered stillborn at 25+5 weeks.	Reported to PMRT and closed. Graded A/A. No learning identified.
PMRT	90809	09/12/2023	Neonatal death	Baby born at 33+6 weeks. Late booker, but under care of UHD. Baby had antenatal diagnosis of T18. Brought to UHS ED by HEMS due to major trauma (RTA).	Reported to PMRT and closed. Graded A/A/C. Action identified relating to no computer available at SGH which had access to BadgerNet or MetaVision. There were also multiple transfers for mum between sites within UHS.
PMRT (led by the Children's Hospital)	90961	19/12/2023	Neonatal death	Baby born at 39+2 weeks. Cardiac diagnosis antenatally (HLHS). Lesion determined to be inoperable and palliative pulmonary artery bands placed. Baby died on PICU.	Reported to PMRT and closed. Graded A/B/B due the family being unable to go to the hospice on the day she died.
PMRT	92745/2	07/04/2024	Neonatal death	MCDA twins with TTTS. Born prematurely at 29+4 weeks. He was the larger/recipient twin (Twin 2). Deteriorated with extensive grade IV intraventricular haemorrhage that caused him to have ongoing seizures which were difficult to control. Discussions were had with his parents, and it was agreed that care should be redirected. Baby died at 9 days of life.	Reported to PMRT and closed. Graded A/A/A. No learning identified.
PMRT	92952	20/04/2024	Antepartum Stillbirth	Presented at 27+1 weeks with a history of reduced fetal movements. Baby boy delivered stillborn 27+3 weeks.	Reported to PMRT and closed. Graded A/B due to a delay in cabergoline administration.
PMRT	93529	27/05/2024	Neonatal Death	Baby born at 27+0 weeks. IUT from Poole. Sudden deterioration on D12. Suspected intestinal perforation with e-Coli sepsis. For coroners PM.	Reported to PMRT and closed. Graded A/B/A. Action identified for development of a major haemorrhage protocol for neonates.

PMRT	93852	16/06/2024	Antepartum Stillbirth	Presented at 31+4 weeks with history of reduced FM since previous evening. IUD confirmed. Born at 32+0 weeks.	Reported to PMRT and closed. Graded B/B due to a short delay in MDAU admission and some incorrect information on her notes.
PMRT	93873	18/06/2024	Antepartum Stillbirth	Admitted to Lyndhurst ward with hypertension and fetal tachycardia at 23+5 weeks. Known IUGR and echogenic bowel. Plan for daily fetal auscultation. No fetal heart heard on 24+1 weeks, confirmed IUD. IOL commenced 24+2.	Reported to PMRT. Closed C/A due to TFT's at booking not being acted upon. There was also a delay in commencing misoprostol due to the service being on Opel 4.

Moderate incidents

Incident Date/Number	Type of Incident	Summary of incident	Outcome of incident
21/08/2024 9981445	Moderate incident	Late preterm newborn was admitted to the neonatal ICU from the community for jaundice on day 3 which was 12 boxes above the exchange transfusion line. Incident report put in because of the significant level of the jaundice.	Incident to be reviewed through Clinical Events.
29/08/2024 9981888	Maternal Death	Maternal death and antenatal stillbirth following suspected brain aneurism. 999 call to home in Gosport, air lifted to UHS due to suspected neuro involvement but under the care of Portsmouth.	As per MNSI section above.
03/09/2024 9982637	Moderate incident	Patient who developed urinary incontinence following vaginal delivery in July 24.	Incident to be reviewed through Clinical Events.
07/09/2024 9982437	Moderate incident	Patient admitted overnight with severe hypertension 33/40. Patient has significant obstetric history of previous pre-eclampsia - was not prescribed aspirin, not seen in antenatal clinic and not offered growth USS as per hypertension guideline.	Reviewed and closed as moderate incident. Learning shared with those involved and a reflective discussion held. Reminder sent to all community midwives to check the guidance re. aspirin and fetal growth.

Lessons Learned Slide – MI–036677

The Patient Safety Incident Response Framework (PSIRF) Learning Slide

A 22-year-old White British mother, in her first pregnancy, was booked for maternity care at 8 weeks. The Mother followed a midwifery-led care pathway. No concerns were noted during the antenatal period. At 39+6 labour was induced following SROM. Almost 24 hours post IOL, when the Mother was in , concerns were noted with 2nd stage the Baby's heart rate, Birth was expedited using a ventouse cup. At birth, following an initial attempt to cry, the Baby did not spontaneously breathe on its own and care was handed over to the neonatal team who were present for the birth. The Baby was resuscitated before being transferred to the local neonatal unit for ongoing management. This included 72 hours of therapeutic cooling. On re-warming, the Baby had a significant seizure and was cooled for an additional 24 hours. An MRI scan of the Baby's head was performed at 8 days of age and showed abnormalities, which are in keeping with an acute, severe hypoxic-ischaemic malperfusion

Questions from family

Parental questions re placental histology

Organisation Learning

When the Mother presented with a history of SROM, the options of expectant or active management were not discussed. This meant the Mother was not given all options available to her to aide informed choice.

External Learning

Equipment issues –as below

Tools & Technology Learning

- Equipment issues –O2 cylinders /Video laryngoscopes/Pedi caps

Local Learning

Ensure appropriate equipment available in the use of a video Laryngoscope/Pedi -Caps(EMMA'S)

Ensure that there are adequate Neonatal resuscitation areas on Labour ward.

Oxygen cylinders –Ensure that they are kept at a working level

Additional cylinders are kept on LW

Porters to be called to all NN emergencies to help if there needs to be a cylinder change

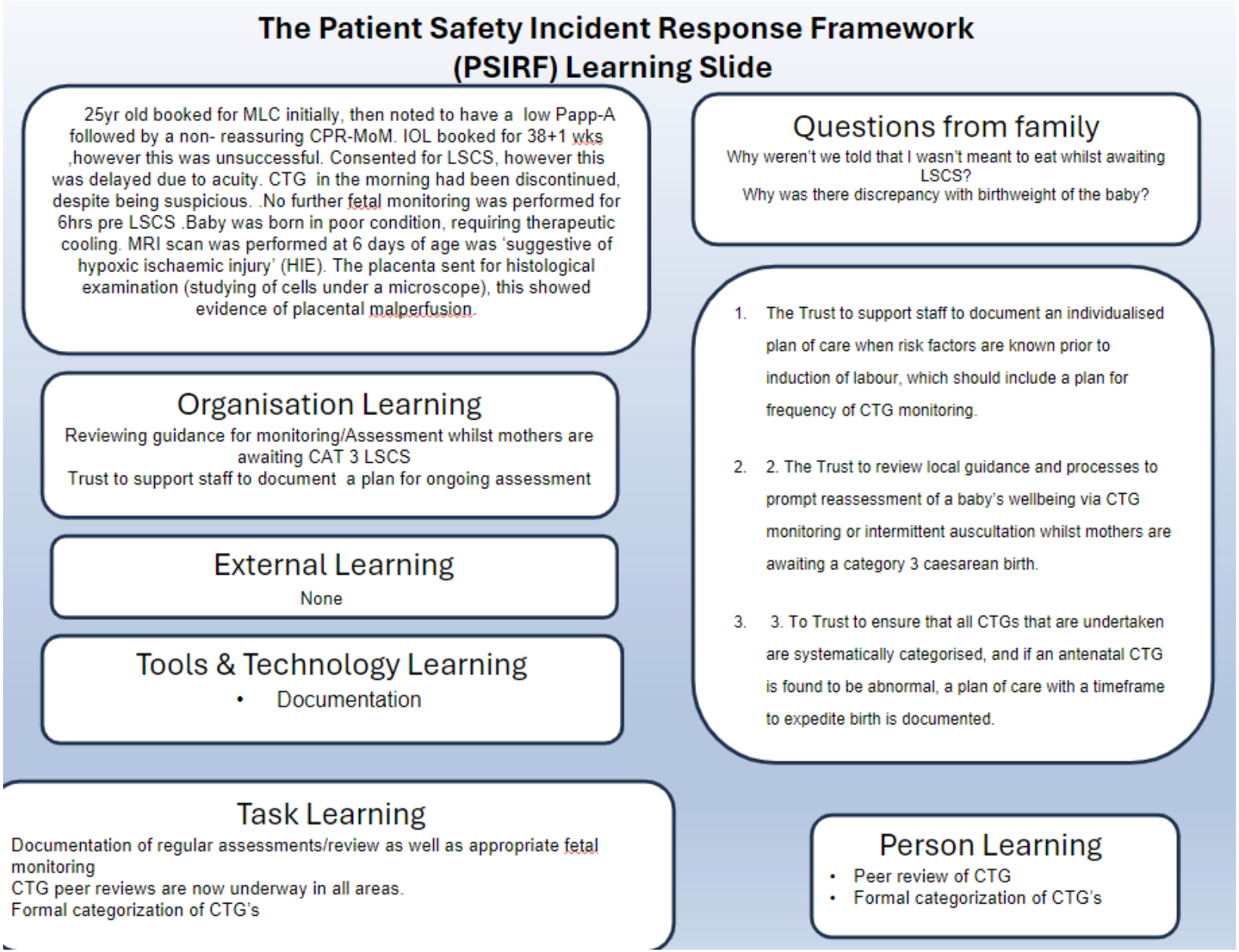
Task Learning

Ensuring O2 cylinders are kept at a working level
Awareness of additional cylinders on LW for use
Ensuring that the porters are called for NN emergencies to facilitate changing O2 cylinders

Person Learning

- Ensuring that the porters are called for NN emergencies to facilitate changing O2 cylinders

Lessons Learned Slide – MI–036718



Lessons Learned Slide – Patient Safety / PMRT case 91230

The Patient Safety Incident Response Framework (PSIRF) Learning Slide

Second pregnancy which was complicated by severe hyperemesis gravidarum. This was prolonged and required multiple hospital admissions/reviews and treatment including steroids for much of the pregnancy. Monitoring and management, including appropriate steroid dose reduction was difficult due to variable attendance for antenatal care appointments. Mother was noted to have a complex social and mental health history. Although several concerns were raised during the pregnancy, including a positive toxicology screen, these did not meet the threshold for a MASH referral. Premature labour at 34+5 weeks. Baby boy born via ventouse delivery and transferred to the NNU followed by TCU. Mother and baby discharged on New years eve with follow up planned by the NHT and HV. On 06/01/2024, Baby was found unresponsive in his crib. He was in cardiac arrest and taken to Children's Emergency Department (CED) by ambulance. Unfortunately, he did not respond to resuscitation and passed away. As this was an unexpected death, the police were informed. There is an ongoing police investigation.

Tasks

Variable attendance for antenatal care appointments throughout the pregnancy.

Confusion regarding postnatal appointments- which team is making contact?

Person

Multiple teams involved in the care

Allocation of a bereavement key worker when multiple teams involved

Questions from family

UHS has not received any communication from the family.

Organisation

Communication between teams

Safeguarding supervision

External Environment

Police involvement and removal of parent's phones made communication difficult.

Tools & Technology

Badgernet safeguarding referral

Use of Badgernet alerts when patients are on steroids

Local learning

Formal (written) safeguarding referrals to be made to safeguarding team when concerns raised.
Staff education re how to activate Badgernet alerts.
Clear escalation plan to ensure team leaders are alerted to missed appointments.
Communication plan for patients under shared care.
Difficult case. Need to ensure staff are supported

Lessons Learned Slide – Patient Safety / PMRT case 9969932 / 92263

The Patient Safety Incident Response Framework (PSIRF) Learning Slide

G6P3 Previous history of PTL. At 24+weeks was seem in FMU at DCH and baby was found to be SGA and have anyhdramnious .There was a miscommunication re her follow up ,however she returned the following day for follow up and was then admitted to UHS for a few days of observation and it was felt that she had SROM'd. She then presented at DCH ?in PTL and was transferred to UHS for further care. On admission baby was cephalic, however this changed during the labour and despite some internal manoeuvres the baby was unable to be born vaginally She was then transferred to Theatre for an emergency LSCS. Baby was born in poor condition and sadly care was redirected a few days after birth as his condition was not survivable .

Questions from family

The care for myself and my baby was very poor, no communication the whole system from Dorchester hospital all the way to Southampton labour ward was disgusting disgraceful my baby boy would be here if I was listened to if something was done when my water first broke, now I've lost my son something nobody should ever have go through.

Was told at Southampton at 24weeks if I was to go into labour this early, they would have to do an emergency c section onto which that would be a cut up and not a normal c section as that could be dangerous or cause harm to myself or the baby where he was so little and already low down so why wasn't I given this straight away on arrival at Southampton and why have I got a normal c section?

Organisation Learning

Fetal Monitoring concerns

Difficulty in providing adequate analgesia

Use of internal manoeuvres

External Learning

Delay in PPROM diagnosis

Delay in transfer to Level 3 Unit

Tools & Technology Learning

CTG monitoring

Local Learning

Anaesthetic team not being able to provide analgesia due to concerns of sepsis. Consideration of raised WCC being related to steroid use and not specifically sepsis reason.

If there had been an epidural in situ this would have helped the Obstetric team to perform an episiotomy more easily.

There was a lack of debriefing following this incident which impacted upon staff.

Task Learning

Use of closed loop communication

All in-utero transfers are now to be discussed with Silver/Gold command

Ensuring that all specimens are sent appropriately

Person Learning

Adherence to the guidelines about accepting in-utero transfers

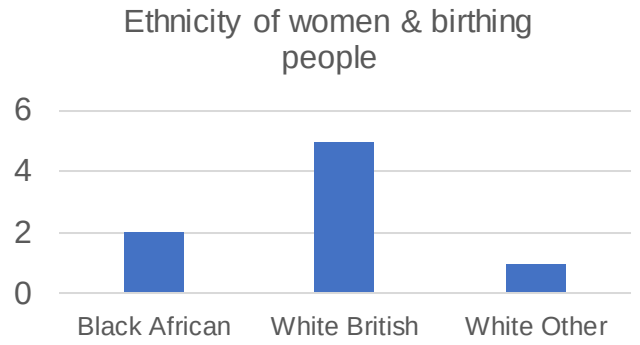
Appendix 5

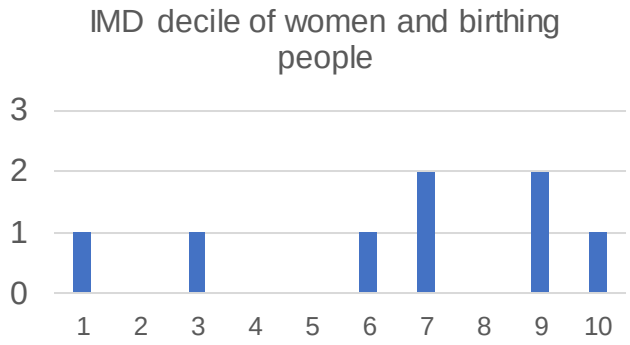
University Hospital Southampton NHS Foundation Trust

PMRT cases for Q2 2024/25

Eligible cases for PMRT = 8

- Stillbirth = 6
- Neonatal death = 2





Learning points / Actions:

- No clear evidence of offer of parallel care ACP plan on counselling.
- Lack of coordinated bereavement care and family had felt overwhelmed by contact / correspondence after the baby had died.
- Mental health care / support for bereaved families.
- Missed opportunity for a growth scan.
- Communication regarding seeing the baby (asking staff on multiple occasions for their baby to be brought up from the holding room and explain the reason each time).
- Discrepancy in availability of equipment within the neonatal emergency bag.

Appendix 6

PMRT update

8th Dec 2023 – 30th September 2024

University Hospital Southampton NHS Foundation Trust

Standard a): Notify all eligible deaths (reportable to MBRRACE – incl TOP) within **7** working days.

38 deaths notified in reporting period within the timescale, with 32 eligible for PMRT.

Standard b): Seek parents views for at least **95%** of the deaths of babies eligible for PMRT review.

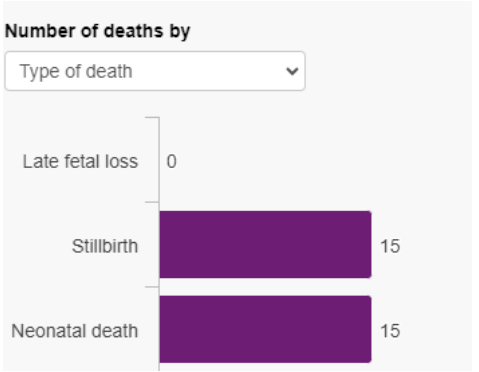
Parents views have been sought for 97% of the deaths of babies eligible for PMRT review in this reporting period.

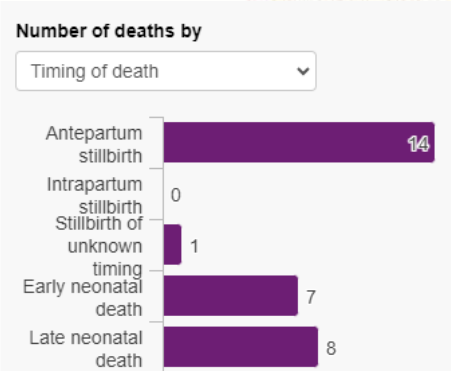
Standard ci): Start the reviews for **95%** of the deaths of babies who were born and died in our Trust within **2 months.**

Reviews were started for 96% of cases within 2 months.

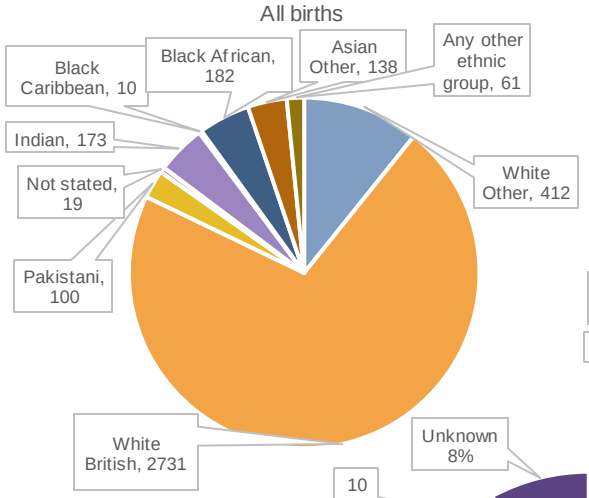
Standard cii): Complete and publish the reviews for **60%** of the deaths of babies who were born and died in our Trust within **6 months.**

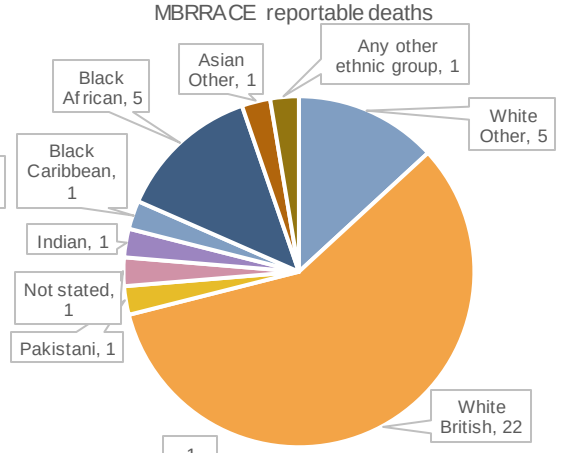
Reviews have been published for 80% of cases within 6 months.



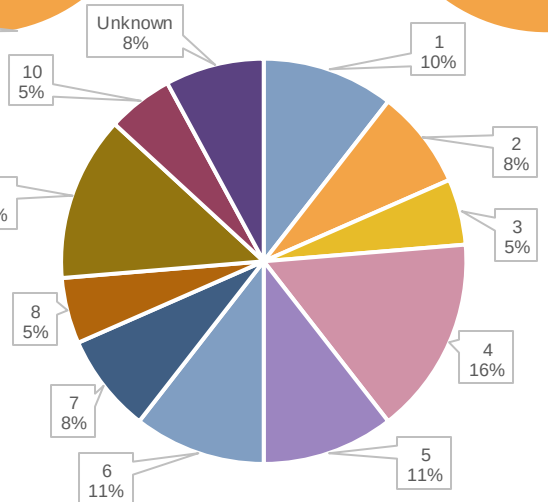


Ethnicity of women / birthing people





IMD deciles of women / birthing people of the MBRRACE reportable deaths



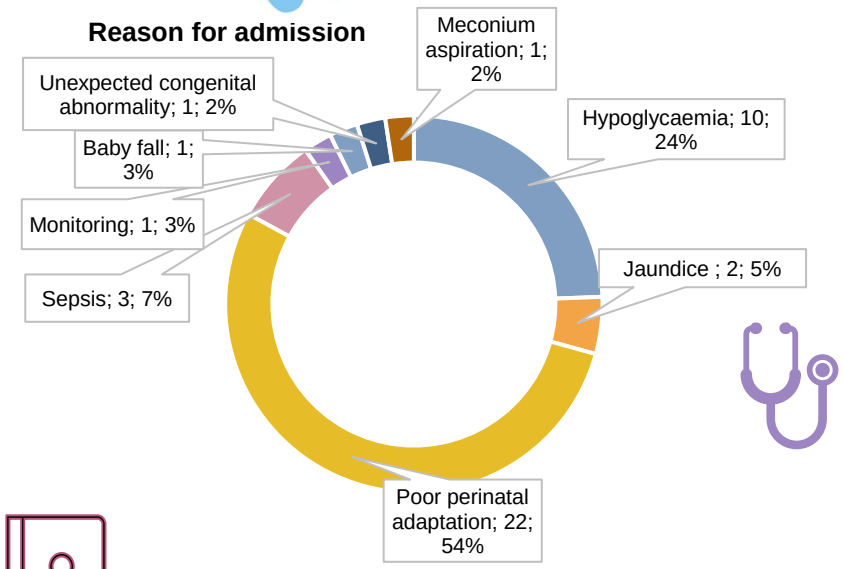
ATAIN

Appendix 7

Qtr. 2 2024/25 – 41 unexpected term admissions

University Hospital Southampton NHS Foundation Trust

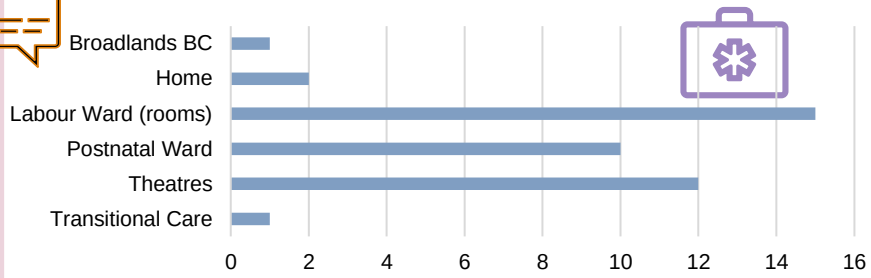
Reason for admission



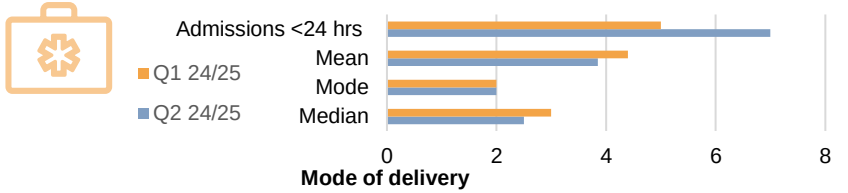
Learning identified

- 31 cases identified for review
- 19 reviews completed
- 3 cases deemed avoidable admissions
- Themes/issues highlighted:
  - Temperature management
  - CTG interpretation
  - Use of in reach nurse could have benefitted
  - NLS management
  - No cord gases taken at delivery
  - Safety netting re. baby falls

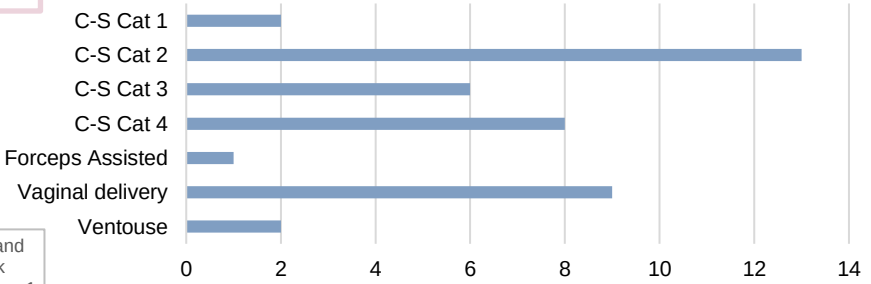
Admission from



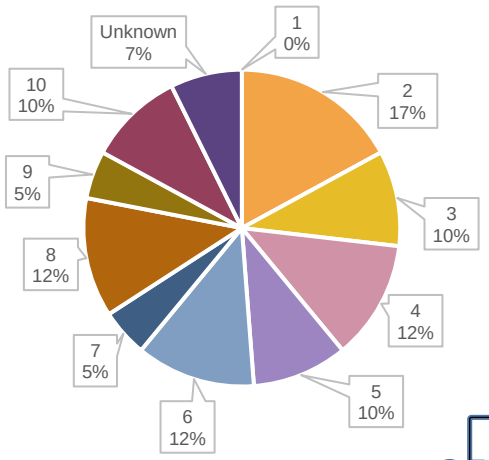
Average length of stay



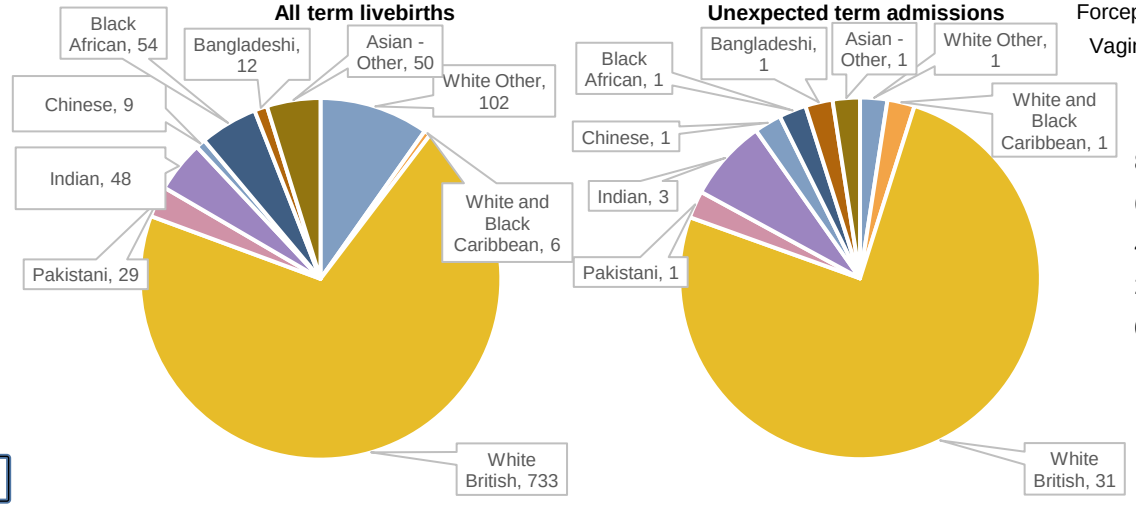
Mode of delivery

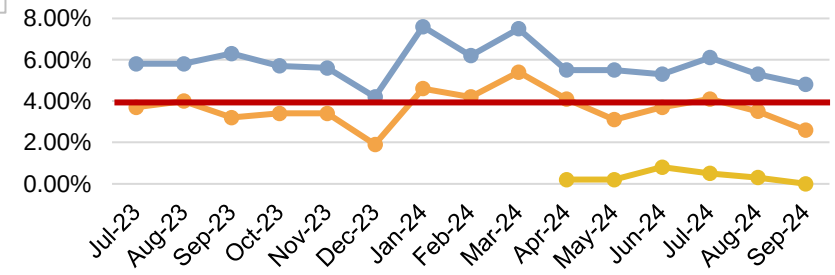


IMD deciles of women / birthing people



Ethnicity of women / birthing people





Term admissions to NNU (percentage of total birth rate)

Unexpected term admissions (percentage of total birth rate)

Avoidable term admissions (percentage of total birth rate)

Target

Appendix 8

Report to the Quality Committee				
Title:	**Midwifery Workforce Report**			
Agenda item:				
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Carly Springate, Head of Midwifery** **Emma Northover, Director of Midwifery and Professional Lead for Neonatal Services**			
Date:				
Purpose:	**Assurance or reassurance** **x**	**Approval**	**Ratification**	**Information** **x**
Issue to be addressed:	This report is being presented to the members of the Quality Committee in order to provide information relating to the Midwifery workforce. This report is a requirement to demonstrate compliance with NHS Resolutions (NHSR) Safety Actions 5 - Midwifery Workforce. The report provides an overview of future workforce planning and actions to mitigate our current challenges.			
Response to the issue:	**1. An Effective System of Midwifery Workforce Planning** **1.1 A clear breakdown of BirthRate Plus (BR+) or equivalent calculations to demonstrate how the required establishment has been calculated** In line with national drivers for assurance in relation to safe staffing levels within maternity services, UHS Maternity Services utilise BirthRate Plus (BR+) as a system and framework for workforce planning and strategic decision making. UHS Maternity Services previously had a BR+ review in 2018 where it was recommended that to ensure safe staffing levels, the funded establishment, inclusive of support staff was 226.55 WTE. At the time this was based on 5500 births. In March 2024 an updated BR+ review was commissioned and upon receipt of the final report in June, an uplift in total establishment from **226.55 WTE** to **235.01 WTE** has been recommended. This is inclusive of support staff contribution to ensure that safe staffing levels are maintained. Of note, this is despite the birth rate falling to 4993 across 2023/2024. Maternity is growing in complexity nationally and this calls for more input not just from midwifery staff but the whole MDT. Our case mix at UHS reflects this growing trend and is further enhanced by being a specialist, regional fetal and maternal medicine centre. The Neonatal Intensive Care Unit at UHS is also a regional referral centre for babies requiring surgery or specialist cardiac care. These reasons, in addition to our overall CQC rating of 'Good' sees UHS as a place that many women and birthing people are choosing for their maternity care.			

1.2 In line with Midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations

In contrast to 2018 when UHS Maternity Services were working to a Midwife v Birth ratio of 1:24, over the last 3 years we have seen this increase steadily to 1:27. However, across the last quarter this number has significantly increased to 1:34. This indeed has felt very uncomfortable and has seen clinical and operational input from across the Midwifery leadership teams, including the Director of Midwifery in and out of hours. This has posed multiple challenges in terms of wellbeing and delays in progressing our midwifery agenda but with these contingency frameworks in place, the service has remained safe.

On the 1 October 2024, Maternity Services recorded a vacancy rate of 34 WTE midwives. This has led to days where we have operated on 50% staffing resulting in an unprecedented amount of pressure on the workforce. This has led to delays in care particularly around our elective and scheduled care pathways such as inductions as we look to prioritise and respond to the high volume of unscheduled activity, particularly across our high-risk areas. This situation is further compounded by high levels of short-term and long-term sickness with stress/anxiety being the highest reportable cause.

Despite the challenges however, UHS Maternity Services has retained all of the newly qualified midwives who have joined over the last 12 months and we continue to be a provider that people wish to join and come to work at. The pastoral and close line management support that we provide to our staff is testament to this and the team ethos across all levels is evident throughout.

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

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

By utilising the dashboard it allows the Director of Midwifery to report to the Board, accurate workforce projections and forecasted changes in our vacancy rate. This ensures and supports an ongoing process for rolling recruitment, involving both qualified and unqualified staff groups.

With national evidence directly linking reduced midwifery staffing levels and poor maternity and neonatal outcomes for families, recruitment to clinical maternity roles, both registered and unregistered has been supported by the Trust Board and prioritised at recruitment panels.

With this support, Maternity Services has continued to recruit to vacant posts and following a successful recruitment drive, we will be welcoming 38 newly qualified B5 Midwives into our service and 12 additional B6 midwives over the next 3 months.

In response to feedback from previous cohorts, we have adapted the way in which the preceptorship programme in Maternity will be run this year. Our new starters will remain in a protected supernumerary capacity in the clinical areas for a concentrated period of 4 months. Recognising the vulnerabilities in this staffing group and with staff support, wellbeing and retention in mind, we are looking for ways to increase band 7 senior midwifery practitioner presence across our high-risk areas in the coming weeks.

1.4 Midwifery red flag reporting – Evidencing compliance that all women / birthing people receive 1:1 midwifery care in active labour and the protected supernumerary status of the labour ward coordinator.

UHS Maternity Services record our staffing V acuity data every 4 hours across the intrapartum areas using the BR+ tool. Within our staffing template the labour ward coordinator is rostered and protected to maintain a supernumerary status at all times. This standard is achieved and maintained across the entirety of every shift, not just the start which is the reportable required standard. The skillset of this staff group is pertinent to the safe running of the labour ward, our most acute and high-risk clinical area. The table below offers assurance to the Trust Board that UHS Maternity Services consistently meet this safety standard with no red flag events recorded for the whole of 2023 and to date in 2024.

The labour ward coordinator team recognise the specialist nature of their role and reliably respond to cover unexpected vacant shifts. Across our operational and leadership teams, we have staff who also hold the labour ward coordinator skillset as a dual or previous role which offers extra flexibility and redeployment options at times where a substitute coordinator may be required.

At UHS, the labour ward coordinator does not take responsibility for any patients, nor do they cover breaks for other members of staff enabling them to have continuous oversight of their clinical environment.

Red Flag Report - Labour Ward (scheduled assessments only)							
Red Flag	**Red Flag Description**	**2023 total**	**June**	**July**	**Aug**	**Sept**	**Oct**
RF9	**Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour**	0	0	0	0	0	0
RF10	**Labour ward coordinator not supernumerary status**	**0**	0	0	0	0	0

Red Flag Report - Broadlands (scheduled assessments only)							
Red Flag	**Red Flag Description**	**2023 total**	**June**	**July**	**Aug**	**Sept**	**Oct**
RF9	**Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour**	0	0	0	0	0	0

Another red flag that is closely monitored and reportable to Trust Board as a measure of good practice is the assurance that all women / birthing people receive 1:1 care in active labour across all birth environments. At UHS Maternity Services we respond quickly and effectively to the fast paced, unpredictable nature of intrapartum care and evoke our maternity escalation plan to source additional midwives for intrapartum care. Currently midwives are redeployed often to meet the needs of the service which can cause uncertainty and frustration for them at times. Morale and job satisfaction levels are low amongst midwives who are continuously called upon for support, however all would agree that safe care is the priority. It is only through this escalation that we continue to provide safe care to the women / birthing people accessing our service in the right place, at the right time and by the right people. If we cannot provide 1:1 care in active labour, UHS Maternity Services will declare the highest level of escalation, OPEL 4, and look to divert incoming people in labour to neighbouring Trusts across the region.

Since the start of 2024, UHS Maternity Services have escalated to OPEL 4 on **52 occasions.** This is a significant and stark increase in service pressure that our Maternity Service is experiencing with staffing and acuity accounting for the majority of escalations. Whilst we report that we are compliant with providing 1:1 care in active labour and we are safe, we are seeing an increase in other reportable red flags such as delays in induction and being unable to facilitate birthplace choices. We look to see a noticeable and significant reduction in OPEL 4 escalations as we move towards being fully recruited for Midwives in February 2025.

1.5 Maternity Workforce Development – Next Steps/Way Forward

Ensuring that an appropriately skilled practitioner is available to meet service demands in the most responsive and efficient way remains pivotal in the planning for our future workforce. This will be pertinent to models and pathways of care provision, operating both in and out of the hospital setting, including homebirth and intrapartum services within our low-risk birth centres. Drivers around flexible working, retention and restorative practice will all underpin the direction and future of the way in which we work.

In terms of strategic workforce planning, there is currently a significant focus around the issue of supply and demand for maternity staff, particularly registered midwives. Some options for workforce development see alternative training pathways for health care workers who previously may not have benefitted from such openings and include shortened midwifery conversion courses for registered nurses, return to practice midwifery courses, midwifery apprenticeship models and foundation programmes for aspiring maternity support workers.

	UHS Maternity Services are committed to investing in their people and as such have dedicated programmes for career development starting at band 2 and progressing to band 9. Our prime focus is to consider new ways in which we can future proof our maternity services going forward, whilst investing wholly in the health and wellbeing of our existing workforce.
Risks: (Top 4) of carrying out the change / or not:	The risk implications for UHS Maternity include: • **Reputational** – Safety concerns can be raised by the public to both NHS Resolution and the CQC. The CQC can undertake reviews of services who they believe have safety concerns. • **Financial** – Compliance with NHS Resolution Maternity Safety Actions to meet all ten standards is an expectation for many maternity safety requirements. • **Governance** – Safety concerns can be escalated to the Care Quality Commission for their consideration and to NHS England, the NHS Improvement Regional Director, the Deputy Chief Midwifery Officer, the Regional Chief Midwife and DHSC for information. • **Safety** - Non-compliance with requirements or recommendations would have a detrimental impact on the women and their families leading to increased poor outcomes and staff wellbeing.

Appendix 9

NHSR MIS Year 6 Requirements

Royal College of Obstetricians & Gynaecologists

NHS
University Hospital Southampton
NHS Foundation Trust

Situations in which the consultant MUST ATTEND
GENERAL
In the event of high levels of activity e.g a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input
Any return to theatre for obstetrics or gynaecology
Team debrief requested
If requested to do so
OBSTETRICS
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary
Caesarean birth for major placenta praevia / abnormally invasive placenta
Caesarean birth for women with a BMI >50
Caesarean birth <28/40
Premature twins (<30/40)
4th degree perineal tear repair
Unexpected intrapartum stillbirth
Eclampsia
Maternal collapse e.g septic shock, massive abruption
PPH >2L where the haemorrhage is continuing and Massive Obstetric Haemorrhage protocol has been instigated
GYNAECOLOGY
Any laparotomy

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

Reporting period: 2 April 2024 until 30 November 2024

Consulant Attendance	
4.7	Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service when a consultant is required to attend in person?
4.8	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance?
4.9	Do you have evidence that the Trust position with the above has been shared with Trust Board?
4.10	Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?
4.11	Do you have evidence that the Trust position with the above has been shared with the LMNS?

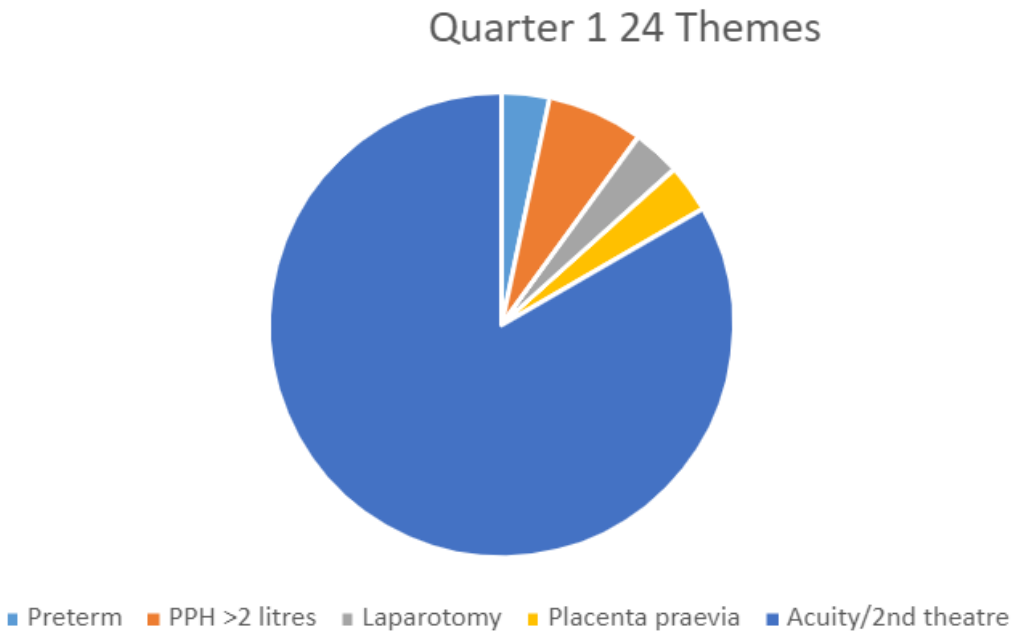
Quarter 4 23/24 (FEB 2024 Re-launch) 3x Called.

Times Consultant called in Quarter 1 24/25

April: 15
May: 10
June: 8

Maternity Opel 4s in Q1 24/25

April x0
May x3
June x7



Comments

"Stayed following evening ward round as unit busy, multiple deliveries"

"On site due to high acuity"

"Stayed on site due to high acuity+++"

"3x Emergency buzzers and MOH, stayed until settled"

"Asked to stay for theatre case"

"Stayed for complex case – 32 weeks PET"

"Busy covering LW acuity & MDAU"

Situations in which the consultant MUST ATTEND

Royal College of Obstetricians & Gynaecologists

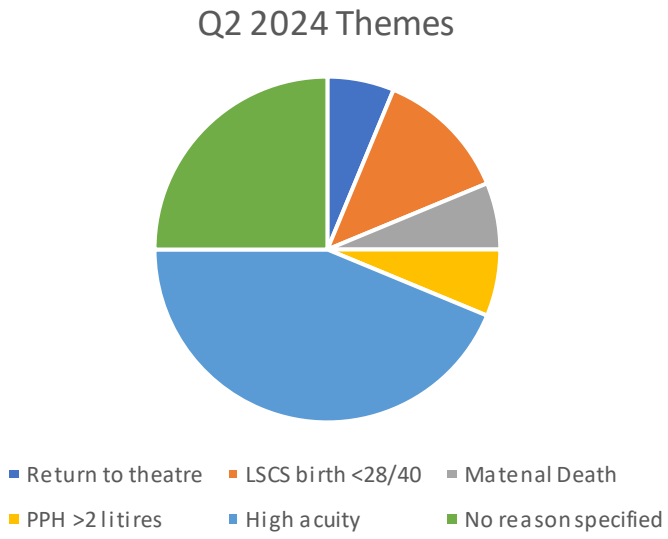
NHS University Hospital Southampton NHS Foundation Trust

Times Consultant called in Quarter 2 24/25

July: 7
August: 3
September: 6

Maternity Opel 4s in Q2 24/25

July x
August x
September x12



Comments

Busy due to acuity and complexity. Remained on site until 0400.
Need for 2nd theatre, background fof high labour ward acuity.
Gynae consultant present due to ruptured ectopic & torsion.
On site 08:30-17:00 due to high activity. Returned at 21.30 and stayed until 01.30.
Remained on site due to acuity.

Times Consultant called in Quarter 3 24/25

October:
November:
December:

Appendix 10

Progress against action plan for NHS Resolution 2023 MIS Year 5

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

Recommendation complete	
Recommendation within timescale for completion	

Recommendation	Action Plan	Action Owner	Target for Completion	Status
1 – Increase further the numbers for inhouse QIS training	• We have a strategy with approved funding for increasing QIS training rates in house and talent management in recruiting the right people for the training positions. • Full recruitment to non-QIS vacancies to support their development prior to starting.	Victor Taylor Neonatal Services Matron	Review March 2024 but expectation is that this is a 2-3 year plan. Cohort from Sept 23 expected to complete in May 24.	This is an ongoing plan. 7 QIS have been trained from the cohort from Sept 23. There are 8 identified for a new cohort to start Nov 24. Sept 24 vacancy for B5 QIS is 16 WTE. This equates to 2 training cohorts.
2 – Development of neonatal nurse education team	• Appointment of B7 education lead and Consultant Neonatal Nurse. • Investment completed into education team to support theory and practical learning. • Provision of shared SIM space with Maternity Services for learning experiences.	Victor Taylor Neonatal Services Matron	Completed Sept 23.	Completed.
3 – Continue rolling advert for B5 and B6 QIS nurses	• Rolling advert continues. • Engagement with recruitment team to promote this hard to recruit cohort.	Victor Taylor Neonatal Services Matron	Ongoing recruitment into B5 and B6 QIS posts. Review March 24.	This is an ongoing action. Sept 24 vacancy for B5 QIS is 16 WTE. Sept 24 vacancy for B6 QIS is 9 WTE. There is a national shortage therefore there needs to be continued training as per recommendation 1.

4 – Incentivise NHSP for QIS nurses	• Continue NHSP incentive (B7 for this vacancy level). • Flexibility in hours offered additional to contract, for example the evening shift to complete specific clinical tasks.	Victor Taylor Neonatal Services Matron	Review March 24.	Completed.
5 – Continue to recruit at B4	• Rolling adverts. • Internal development for promotion. • Link to Trust international recruitment team to identify those with appropriate experience for neonatal services.	Victor Taylor Neonatal Services Matron	Ongoing. Review March 24.	Ongoing. Sept 24 vacancy for B4 is 4.7 WTE.
6 – Strong focus on wellbeing and culture	• Improve staff facilities for rest and breaks. • Ensure leaders at all levels are appropriately developed to improve unit culture. • Education and Training opportunities to improve unit culture and retention. • Engagement with staff survey and “you said, we did” feedback to teams on outcomes with specific action plan linked to feedback results. • Increase variation in contracts for staff with flexible working requirements.	Victor Taylor Neonatal Services Matron	Ongoing. Review March 24.	This is an ongoing action. The staff room was refurbished in Dec 23. A B7 Wellbeing lead has been identified and a wellbeing team has been established. Neonatal specific TRiM was also launched in July 24. There has been a continued focus on celebrating diversity including celebrating pride month and days focusing on international nurses' cultural awareness.

Appendix 11

Action plan for NHS Resolution 2023 MIS Year 6

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

Recommendation complete	
Recommendation within timescale for completion	

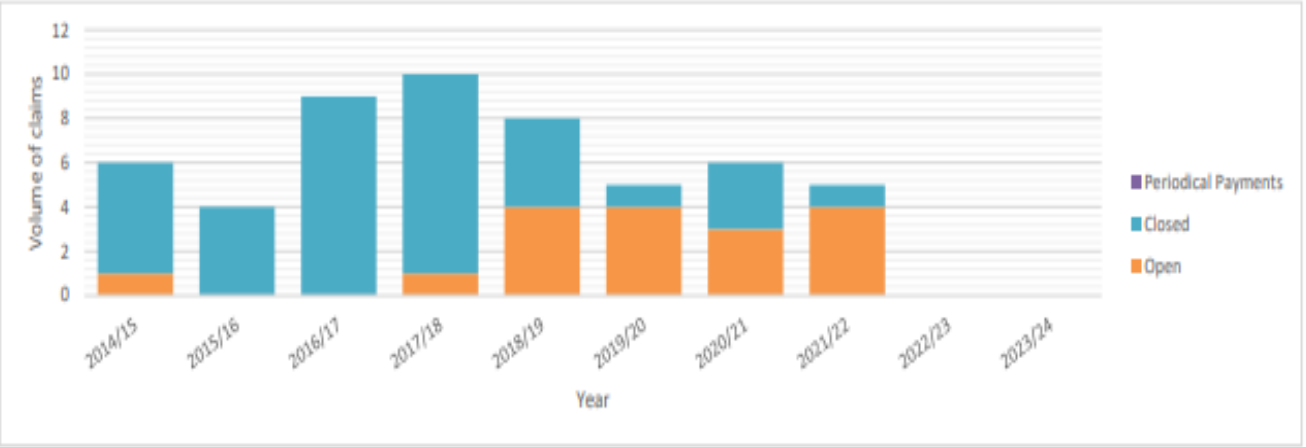
Recommendation	Action Plan	Action Owner	Target for Completion
1 – Increase further the numbers for inhouse QIS training	• We have a strategy with approved funding for increasing QIS training rates in house and talent management in recruiting the right people for the training positions. • Full recruitment to non-QIS vacancies to support their development prior to starting.	Victor Taylor Neonatal Services Matron	This is a long-term goal. Sept 24 vacancy for B5 QIS is 16 WTE, which equates to approximately 2 training cohorts. However, with the neonatal expansion, the vacancy will increase to 30 WTE. This equates to approximately 4 training cohorts in total. At present, there is 1 cohort a year.
2 – Continued education and training needs of the workforce	• Consultant Nurse now in post to support the B7 education lead and to take a lead on nurse education.	Victor Taylor Neonatal Services Matron	Completed Sept 23.
3 – Continue rolling advert for B5 and B6 QIS nurses	• Rolling advert continues. • Engagement with recruitment team to promote this hard to recruit cohort.	Victor Taylor Neonatal Services Matron	Ongoing recruitment into B5 and B6 QIS posts. Review March 25.
4 – Continue to recruit at B4	• Rolling adverts. • Internal development for promotion. • Link to Trust international recruitment team to identify those with appropriate experience for neonatal services.	Victor Taylor Neonatal Services Matron	Ongoing. Review March 25.
5 – Continued focus on wellbeing and culture	• Engagement with staff survey and “you said, we did” feedback to teams on outcomes with specific action plan linked to feedback results.	Victor Taylor Neonatal Services Matron	Ongoing. Review March 25.

	• Formulate an action plan following results of the 2023 staff survey and SCORE survey, focusing on burnout and continuing personal professional development. • Improve response rate to the staff survey 2024. • Continue to celebrate diversity.		

Appendix 12 - University Hospital Southampton NHS Foundation Trust Selection Criteria: CNST claims received with an Incident Date between 01/04/2014 and 31/03/2024

Volume of claims by Incident Year (Incidents Excluded)

Year	Open	Closed	Periodical Payments
2014/15	1	5	0
2015/16	0	4	0
2016/17	0	9	0
2017/18	1	9	0
2018/19	4	4	0
2019/20	4	1	0
2020/21	3	3	0
2021/22	4	1	0
2022/23	0	0	0
2023/24	0	0	0
Total	**17**	**36**	**0**



Top 5 injuries by volume for Obstetrics

	Injury	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Brain Damage	9	33,913,498	3,768,166	16%	27%
2	Fatality	7	2,146,905	306,701	12%	2%
3	Psychiatric/Psychological Dmge	5	519,488	103,898	9%	0%
4	Unnecessary Pain	5	398,590	79,718	9%	0%
5	Cerebral Palsy	4	43,431,270	10,857,818	7%	35%
Total Top 5 injuries by Volume for Obstetrics		**30**	**80,409,751**	**2,680,325**	**53%**	**64%**

Top 5 injuries by value for Obstetrics

	Injury	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Cerebral Palsy	4	43,431,270	10,857,818	7%	35%
2	Brain Damage	9	33,913,498	3,768,166	16%	27%
3	Hypoxia	3	28,379,351	9,459,784	5%	23%
4	Developmental Delay	1	14,470,000	14,470,000	2%	11%
5	Fatality	7	2,146,905	306,701	12%	2%
Total Top 5 injuries by Volume for Obstetrics		**24**	**122,341,025**	**5,097,543**	**42%**	**97%**

Top 5 causes by volume for Obstetrics

	Causes	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Fail / Delay Treatment	12	17,064,427	1,422,036	21%	14%
2	Fail To Monitor 2nd Stg Labour	8	29,393,680	3,674,210	14%	23%
3	Failure/Delay Diagnosis	8	19,557,754	2,444,719	14%	16%
4	Inappropriate Treatment	6	433,712	72,285	11%	0%
5	Fail To Make Resp To Abnrm FHR	5	42,915,834	8,583,167	9%	34%
Total Top 5 causes by Volume for Obstetrics		**39**	**109,365,408**	**2,804,241**	**68%**	**87%**

Top 5 causes by value for Obstetrics

	Causes	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Fail To Make Resp To Abnrm FHR	5	42,915,834	8,583,167	9%	34%
2	Fail To Monitor 2nd Stg Labour	8	29,393,680	3,674,210	14%	23%
3	Failure/Delay Diagnosis	8	19,557,754	2,444,719	14%	16%
4	Fail / Delay Treatment	12	17,064,427	1,422,036	21%	14%
5	Birth Defects	2	14,491,270	7,245,635	4%	12%
Total Top 5 causes by Volume for Obstetrics		**35**	**123,422,966**	**3,526,370**	**61%**	**98%**

University Hospital Southampton NHS Foundation Trust

Agenda item 5.4	**Report to the Trust Board of Directors, 7 January 2024**
Title:	Chief Executive Officer's Report
Sponsor:	David French, Chief Executive Officer
Author:	Craig Machell, Associate Director of Corporate Affairs

Purpose

(Re)Assurance	Approval	Ratification	Information
			x

Strategic Theme

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

Executive Summary:

The CEO's Report this month covers the following matters:

- Water supply failure
- NHS Reforms
- Proposals to regulate NHS Managers
- Insightful Board
- Annual Members' Meeting
- NHS Providers: State of the Provider Sector
- Woodlands Ward – Special Care Baby Unit

Contents:

Risk(s):

N/A

Equality Impact Consideration:	N/A

Chief Executive Officer's Report

Water Supply Failure

Due to a technical problem at a nearby water treatment works operated by Southern Water, UHS and a significant number of homes / businesses in the area lost supply of water on 18 December 2024. At the time of writing (20 December), the fault has been fixed and we are reconnecting to the water supply. Multi-agency liaison was established in place through formal incident procedures. Southern Water prioritised the hospital's supply and arranged for regular tanker deliveries of fresh water and this ensured that soft (non-drinking) water was available throughout. Sufficient water pressure requirements on G level were intermittently not achieved and this caused disruption throughout the incident. Initially using on-site supplies, buying from local retailers and mutual aid from Hampshire Hospitals, then subsequently through pallet deliveries by Southern Water, bottled water was distributed so that drinking water was available for patients and staff. I would like to thank the many estates and operations staff who worked exceptionally well to coordinate our response, often going above and beyond, to minimise disruption to the hospital; only a few theatre cases were (unavoidably) lost during the three-day outage.

NHS Reforms

On 13 November 2024, the Secretary of State announced a package of reforms and a proposal for a new league table of NHS providers.

Key points from the announcement include:

- A review by NHS England of NHS performance across the country with providers being placed into a league table.
- Persistently failing managers will be replaced and turnaround teams deployed to help providers which are running big deficits or poor services.
- High-performing providers will be given greater freedom over funding and flexibility.
- The NHS Oversight Framework will be updated by the next financial year to ensure that performance is properly scrutinised.
- A new pay framework for Very Senior Managers will be published before April 2025, with rewards for successful managers being introduced as well as making poor performing managers ineligible for pay rises.
- The launch of a consultation on a proposal to ban use of agency staff to fill band 2 and 3 posts.

In addition, on 5 December 2024, the Prime Minister announced that the Government was committed to ensuring that 92% of patients should wait no longer than 18 weeks from referral to start consultant-led treatment of non-urgent health conditions.

Proposals to regulate NHS Managers

The Department of Health and Social Care launched a consultation on proposals to regulate NHS managers on 26 November 2024. The consultation will run until 18 February 2025.

The consultation seeks views on the type of regulation that may be most appropriate for leaders and managers, including:

- Which managers should be in scope – as a minimum, all board level directors in NHS organisations in England, arm's length body board level directors, and integrated care board members.
- What kind of body should exercise such a regulatory function.
- Consideration of the types of standards that managers should be required to demonstrate.

The consultation sets out two possible frameworks:

- A statutory barring system: a list of people who have committed offences or have otherwise been found to be unfit to practise a particular profession similar to the system used in teaching or by Companies House for directors.
- A professional register: based on either a mandatory (statute-based) or voluntary accreditation route.

The consultation seeks views on whether to extend the duty of candour to managers as a professional duty of candour in a similar way to that already applicable to those registered with bodies such as the General Medical Council or Nursing and Midwifery Council.

In addition, the consultation asks about whether individuals in leadership positions should have a legal duty to record, consider and respond to any concerns about healthcare being provided.

The consultation can be read at: https://www.gov.uk/government/consultations/leading-the-nhs-proposals-to-regulate-nhs-managers/leading-the-nhs-proposals-to-regulate-nhs-managers

Insightful Board

On 12 November 2024, NHS England published two guidance documents: the *Insightful Provider Board* and the *Insightful ICB Board*. This non-mandatory guidance aims to support provider boards and ICB boards to turn data into a useful insight. The documents also consider effective governance practice around board reporting and assurance seeking.

The *Insightful Provider Board* is in three sections:

- The board's role in governance and organisational culture.
- Suggestions for ensuring that information boards receive and review is meaningful.
- Domains for consideration by boards, with related key questions they might wish to consider.

The guidance highlights the board's responsibility for ensuring quality and safety, and for promoting the long-term sustainability of the trust. It also states the need for effective governance arrangements, open, curious and transparent cultures, and insightful information needed for boards to undertake these complex functions and to assure themselves of progress.

Governance and culture are recognised as significantly impacting on the board's ability to obtain and use information effectively. NHS England sets out that an effective provider board:

- is curious,
- takes necessary actions,
- requires continuous assurance, and
- supports staff and system.

The guidance highlights the importance of committees effectively escalating to the board after reviewing more granular data, and also the importance of triangulation, considerations around aggregating data, making good use of analytical tools, and pitfalls to avoid.

The guidance can be read at: https://www.england.nhs.uk/long-read/the-insightful-provider-board/

Annual Members' Meeting

The Trust held its annual members' meeting on 21 November 2024. The event was held in-person for the first time since the pandemic. The event provided an opportunity for the Chair and Executive Directors to share highlights from the past financial year with members, as well as an opportunity for a 'question and answer' session, which covered a range of topics.

In addition, teams from across the Trust were invited to showcase their patient services and projects.

NHS Providers: State of the Provider Sector

On 12 November 2024, NHS Providers published its latest state of the provider sector survey, sharing trust leaders' responses to current pressures across the healthcare sector. 171 trust leaders from 118 trusts responded to the survey, which was carried out during September 2024.

The key findings were:

- 96% said they were extremely or moderately concerned about the impact of seasonal pressures over winter.
- The top three risks to the provision of high-quality patient care over winter were delayed discharge, social care capacity, and acute bed capacity.
- 79% said they were very worried or worried about whether their trusts have capacity to meet demand for services over the next 12 months. In 2019, this figure was 61%.
- 85% said that it was very likely or likely that their trust would have to reconfigure services in order to manage or improve the financial position of their trust.
- 71% of trust leaders, and all respondents (100%) from acute specialist and ambulance trusts, said it is very unlikely or unlikely that the NHS can meet the constitutional standards over the next five years. Only 14% of trust leaders think it is very likely or likely.
- 98% were in support of the national policy agenda to shift more care from acute services to community and move care closer to home for patients. However, 72% were very worried or worried about whether sufficient investment is being made in public health and prevention in their local area.

Further details can be found at: https://nhsproviders.org/state-of-the-provider-sector-2024

Woodlands Ward – Special Care Baby Unit

The Trust has unveiled a new state-of-the-art special care baby unit (SCBU), designed to increase capacity and offer enhanced specialist care for some of the region's sickest babies. Located at Princess Anne Hospital, the expansion increases the total neonatal service capacity by five. The new SCBU, known as Woodlands Ward, allows parents to stay overnight in comfortable surroundings.

The unit is designed to care for babies born at greater than 32 weeks gestation and weighing at least 1.5kg, serving as a step-down from the neonatal intensive care unit (NICU). It will also accommodate babies born extremely prematurely (from 22 weeks) and those admitted directly from maternity services.

The new build, funded by the Trust, has created space to expand the current NICU, which is the next phase of the project and is due to be operational by May 2025.

University Hospital Southampton NHS Foundation Trust

Agenda item 5.5 Report to the Trust Board of Directors, 7 January 2025	
Title:	Performance KPI Report 2024/25 Month 8
Sponsor:	David French, Chief Executive
Author:	Sam Dale, Associate Director of Data and Analytics

Purpose

(Re)Assurance	Approval	Ratification	Information
x			

Strategic Theme

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

Executive Summary:

This report covers a broad range of trust performance metrics. It is intended to assist the Board in assuring that the Trust meets regulatory requirements and corporate objectives, whilst providing assurance regarding the successful implementation of our strategy and that the care we provide is safe, caring, effective, responsive, and well led.

Contents:

The content of the report includes the following:

- An 'Appendix,' which presents monthly indicators aligned with the five themes within our strategy
- An overarching summary highlighting any key changes to the monthly indicators presented and trust performance indicators which should be noted.
- An 'NHS Constitution Standards' section, summarising the standards and performance in relation to service waiting times

Risk(s):

Any material failures to achieve Trust performance standards present significant risks to the Trust's long-term strategy, patient safety and staff wellbeing.

Equality Impact Consideration:	NO

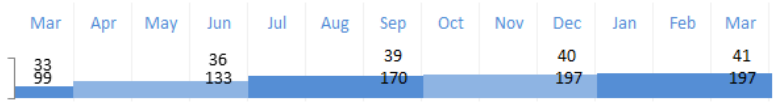
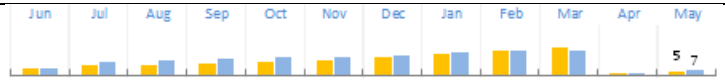
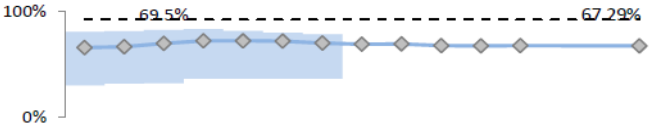
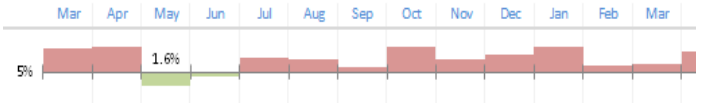
University Hospital Southampton NHS
NHS Foundation Trust

Performance KPI Board Report

Covering up to
November 2024

Sponsor – David French, Chief Executive Officer
Author – Sam Dale, Associate Director of Data and Analytics

Report guide

Chart type	Example	Explanation
Cumulative Column		A cumulative column chart is used to represent a total count of the variable and shows how the total count increases over time. This example shows quarterly updates.
Cumulative Column Year on Year		A cumulative year on year column chart is used to represent a total count of the variable throughout the year. The variable value is reset to zero at the start of the year because the target for the metric is yearly.
Line Benchmarked		The line benchmarked chart shows our performance compared to the average performance of a peer group. The number at the bottom of the chart shows where we are ranked in the group (1 would mean ranked 1st that month).
Line & bar Benchmarked		The line shows our performance, and the bar underneath represents the range of performance of benchmarked trusts (bottom = lowest performance, top = highest performance)
Control Chart		A control chart shows movement of a variable in relation to its control limits (the 3 lines = Upper control limit, Mean and Lower control limit). When the value shows special variation (not expected) then it is highlighted green (leading to a good outcome) or red (leading to a bad outcome). Values are considered to show special variation if they -Go outside control limits -Have 6 points in a row above or below the mean, -Trend for 6 points, -Have 2 out of 3 points past 2/3 of the control limit, -Show a significant movement (greater than the average moving range).
Variance from Target		Variance from target charts is used to show how far away a variable is from its target each month. Green bars represent the value the metric is achieving better than target and the red bars represent the distance a metric is away from achieving its target.

Introduction

The Performance KPI Report is prepared for the Trust Board members each month 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.

Summary

This month's spotlight report explores UHS recent performance on diagnostic waiting times. The report highlights that:-

- Diagnostic performance is measured by the percentage of patients on the waiting list who have been waiting longer than six weeks for one of fifteen nationally recognised diagnostic tests or procedures. The national ambition is to reach 95% by March 2025.
- The organisation has delivered more diagnostic activity every year since the pandemic including through the 2024/25 financial year. However demand and capacity pressures in certain services have driven a recent reduction to the overall position which has now remained at 87% for the last three months.
- The services experiencing waiting time pressures are within cardiology, urology, gastroenterology and respiratory medicine. These pressures include referral volumes, staff vacancies and theatre time availability. They are being addressed through recruitment, insourcing, upskilling staff and improved utilisation and booking processes.
- The trust benchmarks strongly for diagnostics when compared to national waiting times and peer teaching hospitals. It has a robust governance process for monitoring performance and discussing service actions plans to ensure all patients are appropriately monitored and prioritised.

Areas of note in the appendix of performance metrics include: -

1. The trust reported 12,321 attendances to the Main ED department in November 24 with a four hour performance position of 56.1%. This is the second month in a row that the Trust has seen on average 450 patients per day arriving across the main and eye emergency departments. A combined performance position incorporating the Lymington and Royal South Hants Urgent Treatment Centres is 73% for November for all attendance types.
2. The overall RTT waiting list marginally reduced compared to the previous month, reporting 60,338 in November 2024 compared to 60,879 in October 2024. 62.4% of patients on the waiting list are below 18 weeks and the latest comparator data (October 2024) ranks the trust in the top quartile when compared to twenty peer teaching hospitals for this metric
3. The trust reported four patients waiting over 78 weeks for November 2024. All patients were within Ophthalmology and awaiting national release of corneal transplant tissue by the NHS Blood and Transfusion service which is expected to be available in December.
4. The trust reported 24 patients waiting over 65 weeks for November 2024. Twenty of these patients were also awaiting corneal tissue release - the remaining four patients were in Oral Surgery, ENT, Paediatric Cardiac Surgery and Neurosurgery. The latest comparator information available for this metric (October 2024) showed that UHS ranked in first place when compared to twenty equivalent teaching hospitals across the UK.
5. The organisation reported improvements in cancer waiting times for 28 day faster diagnosis (84.8%) and for 31 day standard (94.2%). The Trust ranks in the top quartile for two metrics and second quartile for the third metric when compared to peer teaching hospitals for all key cancer metrics for the latest available month (October 2024).
6. Despite the ongoing commitment and actions to improve flow through the hospital, the average number of patients per day not meeting the Criteria to Reside in hospital remains high, reporting 225 for October 2024 which aligns to the same period last year.

7. The volume of virtual appointments being reported remains artificially low. November data was unavailable at the time of publication and there remains a backlog of data entry required for prior months in this financial year - additional resource has been put in place to resolve this reporting lag.
8. The trust reported zero cases of MRSA, one Never Event and one Patient Safety Incident Investigations for November 2024.

Ambulance response time performance

The latest unvalidated weekly data is provided by the South Central Ambulance Service (SCAS). In the week commencing 9th December 2024, our average handover time was 15 minutes 13 seconds across 830 emergency handovers and 17 minutes 19 seconds across 39 urgent handovers. There were 38 handovers over 30 minutes and 5 handovers taking over 60 minutes within the unvalidated data. Across November the average handover time was 16 minutes 59 seconds.

Spotlight: Diagnostic Performance

The following report is based on the validated October 2024 position.

Introduction

NHS diagnostic services play a critical role in early disease detection, timely treatment planning and overall patient outcomes and experience. These services encompass a wide range of tests and procedures including imaging, physiological assessments and pathology-based diagnostics all aimed at supporting effective clinical decision-making.

At the start of the 2024/25 financial year, one of the key NHS priorities was to improve performance against the core diagnostic standards, more specifically to increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%.

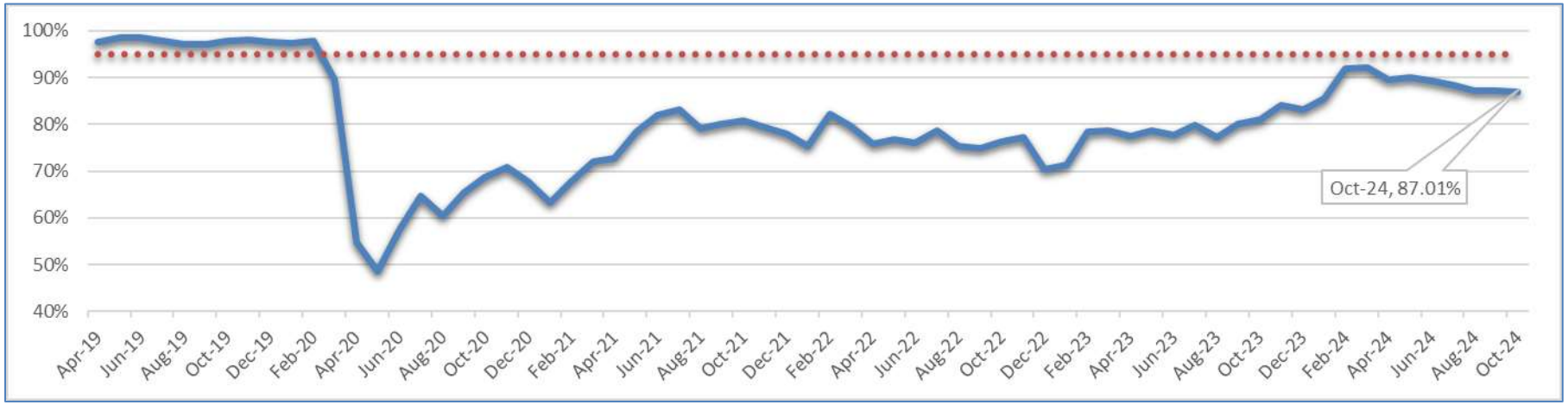
These national diagnostic waiting times measure the duration between a referral for a diagnostic test and the completion of that test specifically for fifteen different modalities. These tests are divided into three categories:

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

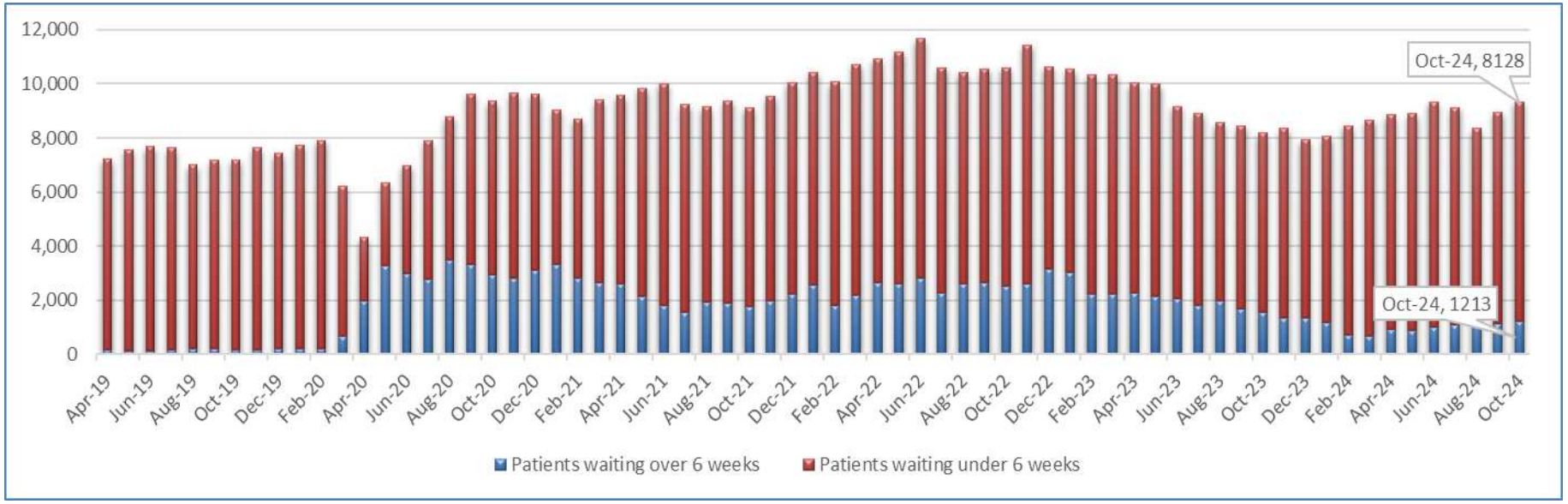
This report lists the current UHS performance position against the national target for all fifteen diagnostic tests, exploring the activity volumes being delivered and the size of the associated waiting lists. It compares Trust performance to peer sites and national statistics. It also highlights any reporting changes, successes and actions being taken to address low performance within specific services. The hospital is constantly exploring initiatives aimed at reducing waiting times, enhancing efficiency, and ensuring equitable access to high-quality diagnostic services.

Performance Overview

In the pandemic, the performance position (for patients waiting under 6 weeks for diagnostics) reduced below 50% (May 2022). Since then UHS performance has been on an upward trajectory as we strive to recover our waiting times to pre-pandemic levels. In March 2024, the organisation achieved 92% however an increase in overall demand alongside capacity, equipment and staffing challenges has seen the performance position marginally reduce this financial year, remaining at 87% in the latest three reported months (August to October 2024). The total number of patients waiting six weeks or more at the end of October 2024 was 1213. This is a 22% improvement on October 2023 and a 52% improvement on October 2022.

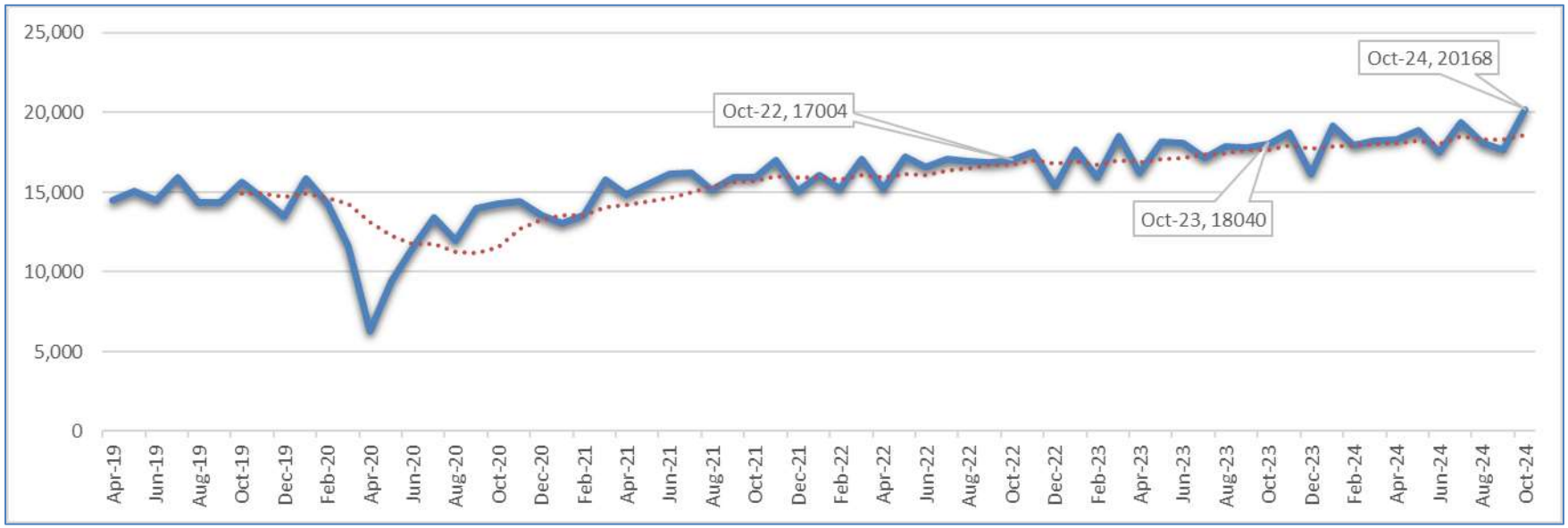


Graph 1. UHS Diagnostic Performance Trend (% patients waiting over 6 weeks)



Graph 2. Diagnostic Waiting List with breakdown (% patients waiting over 6 weeks)

The interventions and actions that have been embedded as part of the Trust's activity recovery plans have proved successful in delivering more activity. This is clearly illustrated in Graph 3 with over 20,000 monthly tests being delivered for the first time in October 2024. This consistent increase is also reflected in the national picture as over 2.5m tests were delivered by the NHS in October 2024 for the first time.



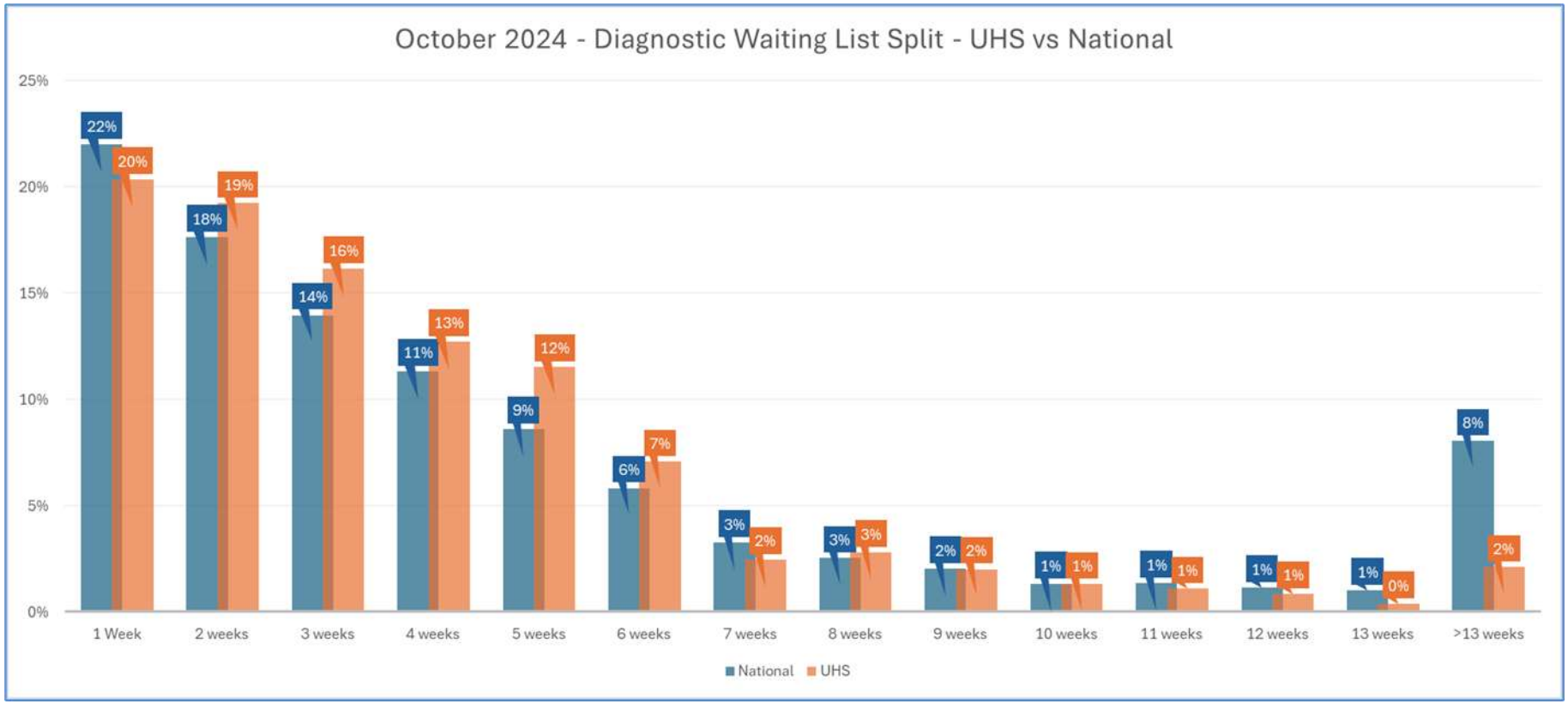
Graph 3. UHS Diagnostic activity delivered

The volume of diagnostic tests and procedures reported include those delivered for emergency admissions/attendances, patients on an RTT waiting list and also patients on a planned pathway i.e. those who are on an existing pathway and require a future diagnostic to monitor their ongoing condition. Whilst there can be some volatility within different radiology services due to demand and clinical prioritisation, the split is consistently 60% of diagnostics being delivered for the waiting list, 25% for emergency services and 15% for planned or surveillance pathways.

NHS England recently reiterated the need for consistency across the NHS for the reporting of planned patients. This has resulted in a small change to UHS diagnostic reporting to ensure that when a patient reaches their planned diagnostic date, they are transferred onto a waiting list and therefore within our performance reporting. This reporting change was prioritised for endoscopy patients in line with the national request – no patients in this cohort are waiting over six weeks from their planned date. We are now reviewing the smaller cohort of patients in other modalities who book patients onto a planned or surveillance pathway.

Despite the recent slowdown of diagnostic performance, the hospital continues to benchmark well both nationally and across the region. The trust has placed in the top quartile for each of the last eight months (Feb-24 to Sep-24) when compared to twenty peer teaching hospitals across the country.

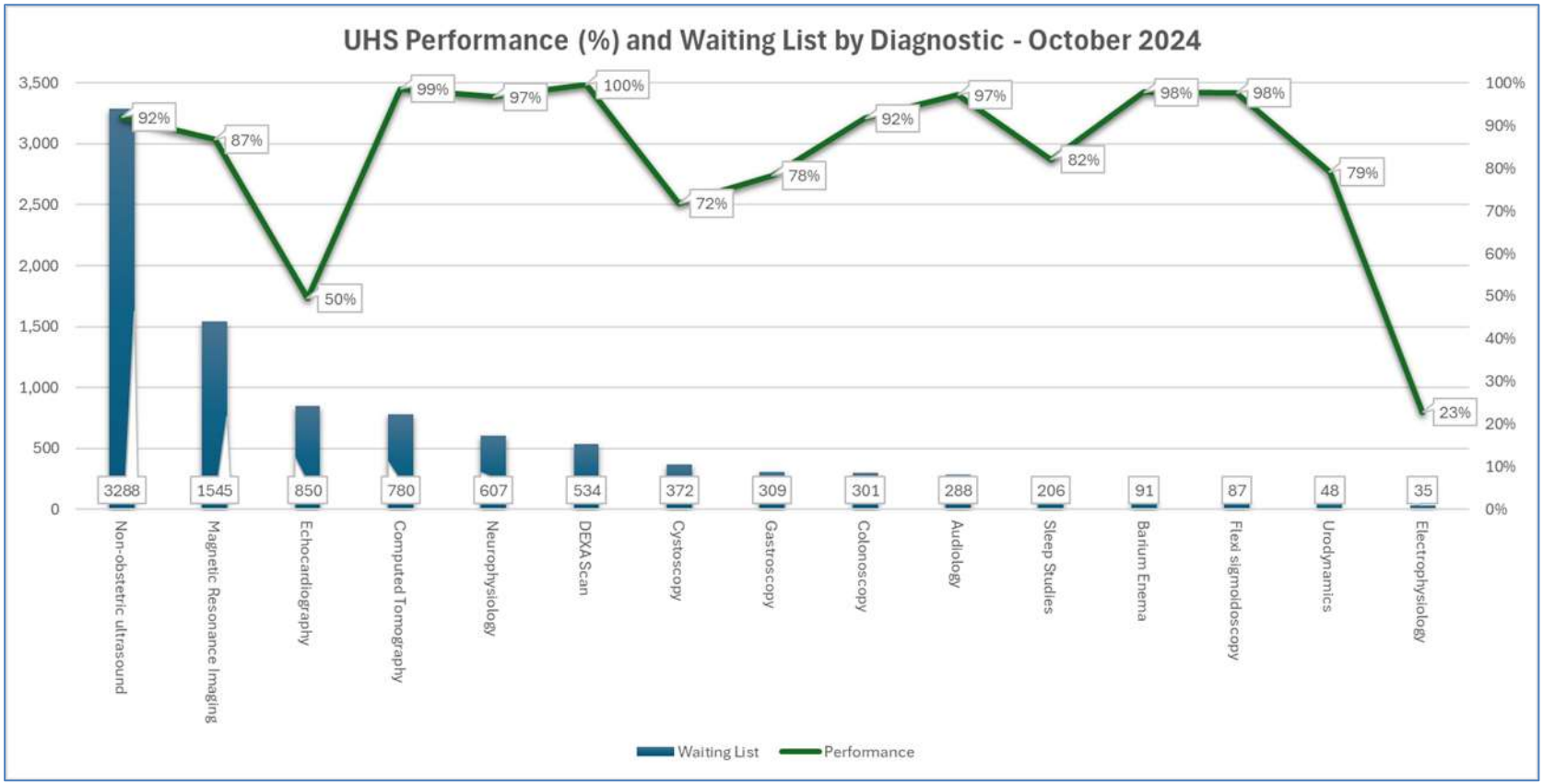
Graph 4 illustrates the split of the current UHS diagnostic waiting list by waiting times and compares it to entire national NHS position. In October 2024 the total number of patients waiting less than six weeks was 79.3% across the country compared to 87% at UHS. The equivalent statistics for patients waiting less than 13 weeks for October 2024 are 97.9% (UHS) and 92.0% (National). The trust had 197 patients waiting over 13 weeks at the end of October 2024 predominantly within Non-Obstetric Ultrasound, Cardiology Services and Endoscopic Services.



Graph 4: Proportion of the waiting list (October 2024) by waiting time – UHS vs National position

Modality Focus

Whilst the organisation is measured at consolidated Trust level for the fifteen diagnostic tests, the hospital performance is monitored internally at service and test level to ensure all patients are being prioritised appropriately irrespective of the size of the service. Whilst large services (particularly within radiology) have the staffing and capacity resources to flex to suit demand, they can also be impacted by the volatility of emergency services. Conversely services such as electrophysiology and urodynamics can be challenged due to reliance on smaller staffing cohorts.



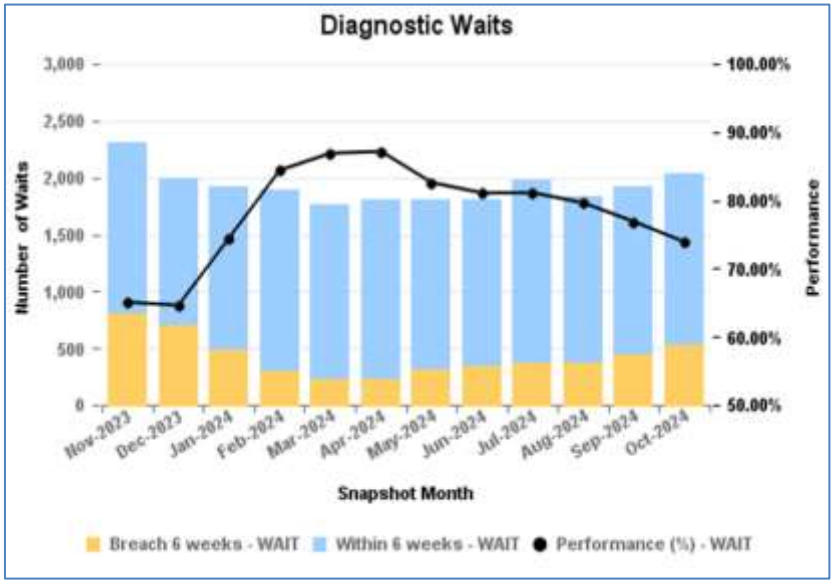
Graph 5: Performance (%) and Waiting List Size by Diagnostic Area

The **Physiological Modality** includes Audiology, Echocardiography, Electrophysiology, Neurophysiology and Sleep Studies. Whilst this cohort only represents 20% of the entire diagnostic waiting list, the significant waiting list improvements seen at the start of the 2024/25 calendar year have declined with performance transitioning from 87% in April 2024 to 74% in October 2024.

The **Neurophysiology** department has maintained high performance levels consistently above the national ambition of 95% with just 20 patients waiting over 6 weeks in October and one patient over 13 weeks. The service is currently supporting activity delivery through insourcing and expect this arrangement to remain for the rest of the financial year.

The **Audiology** service delivers on average 350 diagnostic tests per month and consistently achieves the national target. Whilst the performance is at 97% in October 2024, the service is experiencing staffing restrictions. The small team has been impacted by maternity leave and staff reduction in hours, but are focussing on DNA reductions and maximising clinical productivity to ensure all patients are monitored appropriately and high performance maintained.

There is a well-recognised national increase in **Sleep Study** referrals and the service have faced recruitment challenges to replace departing physiologists or add additional clinical resource to maintain the waiting list. Nevertheless performance has increased through the year reaching 82% in October 2024 with known success in DNA reductions through texting reminder services.



Graph 8: Performance and waits for all physiological metrics

Cardiology diagnostics remain the most challenged area of the physiological modality due to multifactorial reasons; high inpatient demand, increased referrals, equipment downtime for repairs and team vacancies (as this is a hard to recruit to profession). The team maximised their clinical capacity through the cessation of training time, the use of a locum and WLIs as well as adding additional clinics whenever staffing and space enables this; this resulted in ~200 breaching patients being seen in November and additional 138 appointment slots have been created for January 2025 and a further 70 through weekend WLIs.

The service is forecasting an improvement from February 2025; originally this was anticipated to be January 2025 but one of the team's new starters has been delayed (due to visa delays) and the new CDC posts have been filled by existing team members, creating new vacancies in the UHS team.
In terms of managing patient harm, all patients are triaged and seen in an appropriate timeframe; urgent patients are seen within two weeks and routine patients are scheduled prior to their outpatient appointment to avoid delays in their onward pathway.

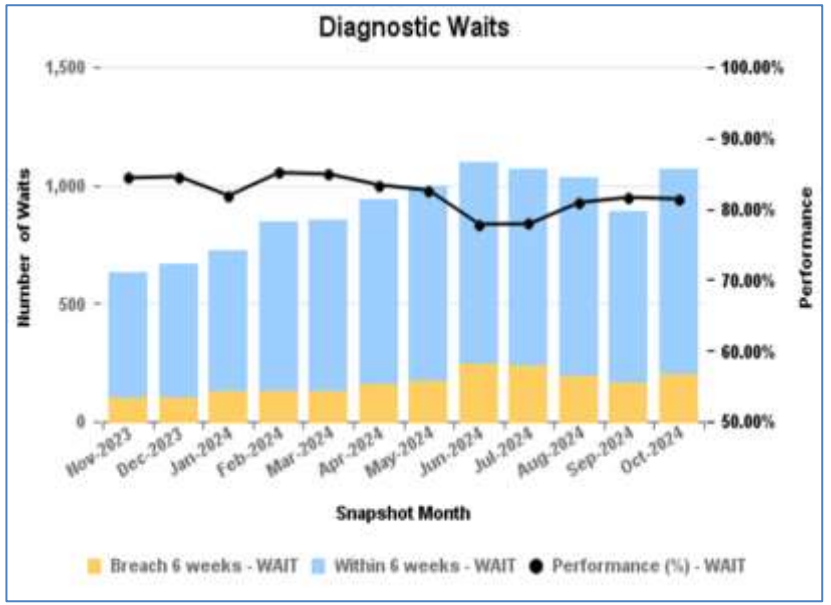
The **Endoscopy Modality** includes colonoscopy, cystoscopy, flexi-sigmoidoscopy and gastroscopy for both adult and paediatric services. The October 2024 performance position combined across all these services is 81% with 199 patients breaching the six week waiting time target. The waiting list currently stands at 1069 patients.

Within the adult services, three of the four endoscopic procedures consistently deliver performance at or close to the 95% national target. However, the cystoscopy service is the main area of challenge representing 37% of the waiting list with a growing referral demand increasing the waiting list from 107 in October 2023 to 368 in October 2024.

October Cystoscopy performance was 72%. The service delivered more activity through super weekends and hopes to maintain this throughput with a locum joining the team. This will be supplemented by a new nurse cystoscopist available from mid-January and increasing the footprint of the Urology centre. The team are also looking for efficiency opportunities in the booking process as part of an action plan to align demand with capacity.

The paediatric endoscopy service has a small impact on the overall trust position but continues to report below the national target due to the reliance on theatre availability as the procedure takes place under general anaesthetic. Performance in October 2024 was 29% with 60 patients waiting over 6 weeks. Outsourcing and regional mutual aid are being explored but options are limited given the scope of paediatric services available in the region.

Additional theatre lists at WLI rates are used when other children's specialty teams cannot operate. Further investigation is underway to scope opportunities for improved theatre utilisation including the review of any late starts and early finishes to accommodate an additional patient and benchmarking theatre throughput with peer Children's hospitals. A business case for an additional Gastro consultant



Graph 9: Performance and waits for all endoscopy metrics

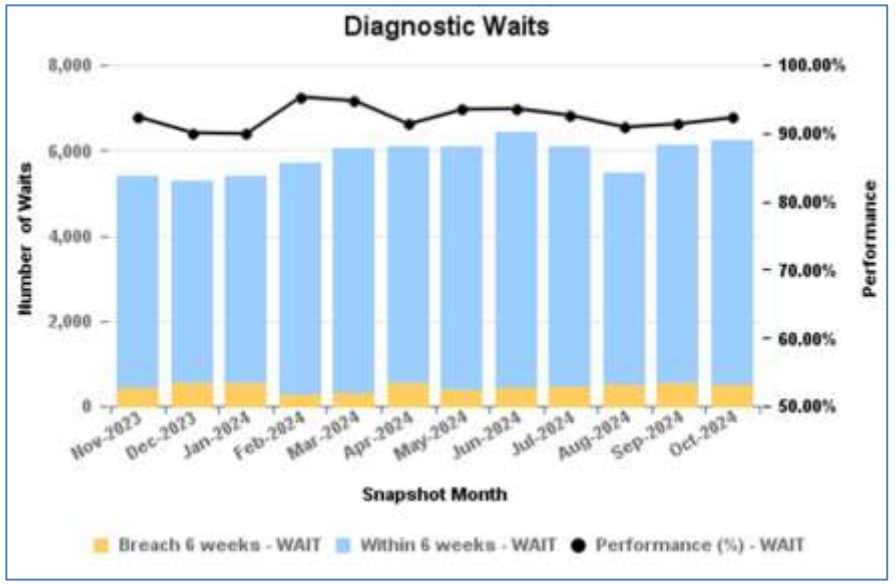
Graph 10: Cystoscopy – waiting list vs activity delivered

and theatre time is being prepared as this would enable current demand and capacity to be more aligned.

The **Imaging Modality** includes MRI, CT, Non-Obstetric Ultrasounds, Dexa Scans and Barium Enemas. The October 2024 performance position is 92% with 483 patients breaching the six week waiting time target. The waiting list currently stands at 6238 patients.

The challenged diagnostic continues to be cardiac MRIs which remain at 60% performance with 180 patients waiting over 6 weeks in October 2024. Service of equipment has now been completed which should prevent any further downtime and alongside an upskilling training programme within the team to support additional activity.

A business case for seven day working has been internally approved but the service can only be fully implemented once full recruitment has taken place. Extra lists are being delivered on our C level scanner to provide some mitigation.



Graph 11: Performance and waits for all imaging metrics

Ultrasound performance (97% in March 2024) is expected to continue throughout 2024/25 with the only risk being the high level of vacancy within the sonographer team and the shortage of head and neck specialist radiologists. This is being addressed by upskilling the competency levels of the existing sonographers.

Summary

Whilst the organisation benchmarks strongly against the national position and peer teaching hospitals, it recognises that staffing and capacity restraints have restricted our performance trajectory over the last three months in certain diagnostic modalities. The performance function within the Trust constantly scrutinises the activity delivered, the waiting list and most importantly the waiting times of our patients as part of weekly meetings with each service. The prioritisation process in place ensures capacity is flexed to meet the most urgent patients and this is supported by analysis to ensure any long waits are minimised. We will continue to explore options to increase capacity, recruit to appropriate staffing levels and add efficiency into pathways as we maintain our ambition to reach the national target by March 2025.

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 eleven 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

		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD
31	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	75%	62.7%													62.4%	≥92%	63.5%
		50%	4 4 4 4 4 4 4 4 4 4 4 4 4 4 4															
			6 5 4 4 4 4 4 4 4 4 3 4 4 3															
39	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	100%	69.7%													77.5%	≥70%	75.4%
		40%	6 9 7 6 4 3 7 4 9 7 6 4 5 5															
			1 2 3 2 2 1 3 3 5 5 6 2 2 2															
39 - As of April 2024, YTD and Monthly targets changed from 85% to 70% in line with latest operational guidance																		
28	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 16) South East average (& rank of 16)	95%	55.8%													56.1%	≥95%	65.7%
		30%	12 10 11 8 4 4 4 9 6 8 6 10 6 6 12															
			7 7 7 5 2 3 2 5 2 4 5 6 4 4 9															
37	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching Hospital average (& rank of 20) South East Average (& rank of 18)	40%	15.8%													13.4%	≤5%	11.83%
		0%	8 7 7 7 7 5 5 5 4 5 5 5 5 6															
			7 7 6 7 5 5 4 5 5 5 6 6 6 8															
37 - As of April 2024, YTD and **Monthly Target changed from 1% to 5%** to reflect latest guidance																		

Outcomes		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD	YTD target
1	HSMR (Rolling 12 Month Figure) - **UHS** HSMR (Rolling 12 Month Figure) - **SGH**	95.0 85.5												89.5		75.0 84.3	≤100	87.5	≤100
2	HSMR - Crude Mortality Rate	3.0% 2.7%												2.5%		2.2%	<3%	2.1%	<3%
3	Percentage non-elective readmissions within 28 days of discharge from hospital	15% 11.9%												12.3%		10%	-	11.8%	-
		Q4 2023/2024			Q1 2023/2024			Q2 2023/2024			Q3 2024/2025			Q4 2024/2025			Quarterly target		
4	**Cumulative Specialties** with Outcome Measures Developed (Quarterly)	80 72			73			75			76			76		70	+1 Specialty per quarter		
5	Developed Outcomes RAG ratings (Quarterly) Red Amber Green	100% 37 75 75% 333 50%			41 67 335			41 62 334			36 77 342			39 79 319			-		

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		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD	YTD target
6	Cumulative Clostridium difficile **Most recent 12 Months** vs. **Previous 12 Months**	65	69	73	79	77	85	84	93	9	12	14	19	22	29	27	38	37	51	47	61	55	71	60	81	≤8	81	≤64
7	MRSA bacteraemia	0	1	2	1	2	0	1	1	0	0	0	0	1	0	0	0	2	0
8	Gram negative bacteraemia	15	28	20	18	22	19	16	31	25	25	29	22	35	23	29	≤19	219	≤144
9	Pressure ulcers category 2 per 1000 bed days	0.29														0.40	<0.3	0.39	<0.3
10	Pressure ulcers category 3 and above per 1000 bed days	0.36														0.33	<0.3	0.31	<0.3
11	Medication Errors (severe/moderate)	0														2	≤3	16	24
12	Watch & Reserve antibiotics, usage per 1,000 adms **Most recent months** vs. **2023/24**	2,702														2,613	<2625	2,513	<2580

12 - Beginning June 2024, target and comparison changed in accordance with National Action Plan.

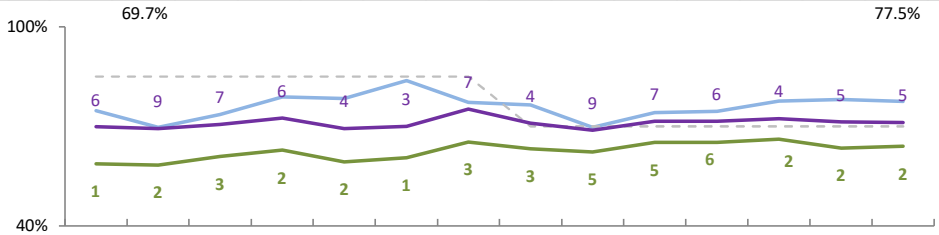
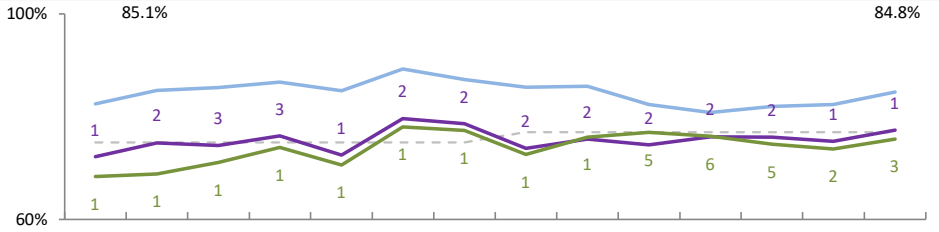
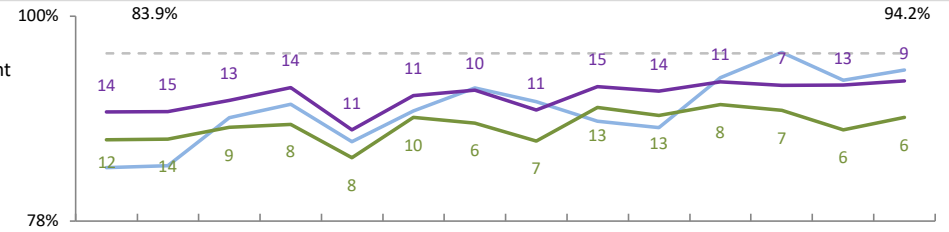
Safety		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD	YTD target
13	Patient Safety Incident Investigations (PSIIs) (based upon month reported, excluding Maternity)			0												1	-	7	-
13a	Never Events			3												1	0	5	0
14	Patient Safety Incident Investigations (PSIIs)- Maternity			0												0	-	0	-
15	Number of falls investigated per 1000 bed days			0.00												0.05	-	0.12	-
16	% patients with a nutrition plan in place (total checks conducted included at chart base)			95.7%												96.7%	≥90%	94%	≥90%
				772	770	932	935	962	961	1,012	930	973	977	930	869	826	964	961	
17	Red Flag staffing incidents			22												20	-	143	-
Maternity		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD	YTD target
18	Birth rate and Bookings Birth Rate - total number of women birthed Bookings - Total number of women booked	400	467	409	428	406	401	428	411	415	379	390	400	410	438	392	-	-	-
		442	446	469	392	483	429	409	448	633	517	501	480	403	523	451			
19	Staffing: Birth rate plus reporting / opel status - number of days (or shifts) at Opel 4.	3	3	1	4	4	0	6	0	3	8	8	2	12	6	1	-	-	-
20	Mode of delivery % number of normal birthed (women) % number of caesarean sections (women)	43.50%	44.33%	45.23%	49.30%	47.29%	50.62%	46.73%	45.99%	46.51%	53.03%	44.80%	44.25%	43.90%	41.10%	46.68%	-	-	-
		43.00%	43.47%	43.52%	38.55%	39.16%	38.90%	40.89%	43.80%	39.04%	35.88%	44.40%	43.00%	42.44%	48.40%	41.07%			

Patient Experience		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD	YTD target
21	FFT Negative Score - Inpatients	3%		0.2%												0.4%	≤5%	0.7%	≤5%
		0%																	
22	FFT Negative Score - Maternity (postnatal ward)	10%		2.3%												3.2%	≤5%	2.3%	≤5%
		0%																	
23	Total UHS women booked onto a continuity of carer pathway	30%		8.9%												16.0%	≥35%	14.0%	≥35%
		0%																	
24	Total BAME women booked onto a continuity of carer pathway	100%		11.8%												15.6%	≥51%	20.3%	≥51%
		0%																	
25	% Patients reporting being involved in decisions about care and treatment	100%		89.6%												87.3%	≥90%	88.0%	≥90%
		80%																	
26	% Patients with a disability/reporting additional needs/adjustments met (total questioned at chart base)	100%		87.5%												88.5%	≥90%	88.3%	≥90%
		80%	214	234	336	208	272	304	268	339	340	280	258	317	221	353	247			
26 - Performance is a scored metric with a "Yes" response scoring 1, "Yes, to some extent" receiving 0.5 score and other responses scoring 0.																			
27	Overnight ward moves with a reason marked as non-clinical (excludes moves from admitting wards with LOS<12hrs)	100		90												61	-	484	-
		0																	

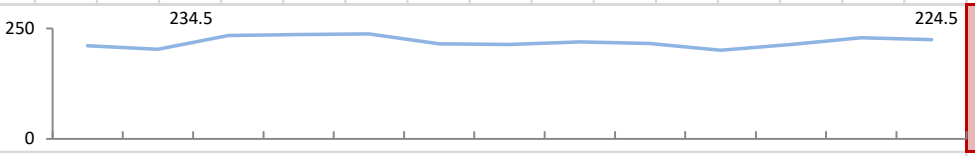
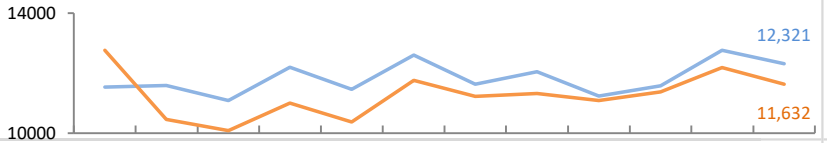
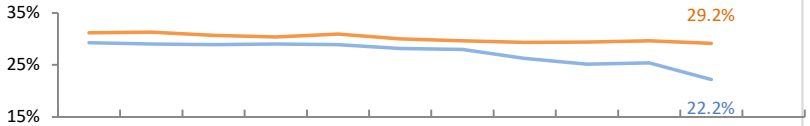
Access Standards		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD	YTD target
28	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 16)	95% 55.8% 12 7	10 7	11 7	8 5	4 2	4 3	4 2	9 5	6 2	8 4	6 5	10 6	6 4	6 4	12 9 30%	≥95%	65.7%	≥95%
29	Average (Mean) time in Dept - non-admitted patients	05:00 03:47														03:33 02:00	≤04:00	03:19	≤04:00
30	Average (Mean) time in Dept - admitted patients	07:00 06:25														05:40 03:00	≤04:00	05:32	≤04:00
31	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	75% 62.7% 4 6	4 5	4 4	4 4	4 4	4 4	4 4	4 4	4 4	4 4	4 3	4 4	4 4	4 3	62.4% 50%	≥92%	63.5%	≥92%
32	Total number of patients on a waiting list (18 week referral to treatment pathway)	65,000 59075														60338 55,000	-	60,338	-
33	Patients on an open 18 week pathway (waiting 52 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	8,000 1835 3 8	2 8	2 8	2 9	2 10	3 9	3 10	4 10	3 10	2 9	2 9	2 8	2 9	2 8	1340 0	≤1393	1340	≤1393

		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD	YTD target
34	Patients on an open 18 week pathway (waiting 65 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	278														24	0	24	0
35	Patients on an open 18 week pathway (waiting 78 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	22														4	0	4	0
35a	Patients on an open 18 week pathway (waiting 104 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	1														0	0	0	0
36	Patients waiting for diagnostics	8341														9428	-	9,428	-
37	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	15.8%														13.4%	≤5%	11.8%	≤5%

37 - As of **April 2024**, **YTD and Monthly Target** changed from **1% to 5%** to reflect latest guidance

			Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD	YTD target
39	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)																	≥70%	75.4%	≥70%
39 - From October 2023 data onwards, the 62 day standard metric published in NHS england data combines Urgent Suspected Cancer and Breast Symptomatic with previously excluded Screening and Upgrade routes. As of April 2024, YTD and Monthly targets changed to 70% in line with latest operational guidance																				
40	Cancer 28 day faster diagnosis Percentage of patients treated within standard UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)																	≥77%	83.3%	≥77%
40 - As of April 2024, YTD and monthly targets changed from 75% to 77% in line with latest operational guidance																				
41	31 day cancer wait performance - decision to treat to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)																	≥96%	83.3%	≥96%
41	From October 2023 data onwards, the 31 day standard metric published in NHS england data combines First Treatment and Subsequent Treatment routes.																			

R&D Performance		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD	YTD target
43	Comparative CRN Recruitment Performance - non-weighted	17	17	16	15	15	15	15	9	7	6	9	9	8	10	8	Top 10	-	-
44	Comparative CRN Recruitment Performance - weighted	12	11	12	9	11	11	11	6	8	9	10	10	10	10	10	Top 5	-	-
45	Study set up times - 80% target for issuing Capacity & Capability within 40 Days of Site Selection	60%	67%	46%	88%	55%	50%	64%	50%	55%	47%	100%	44%	38%	78%	36%	-	-	-
46	Achievement compared to R+D Income Baseline Monthly income increase % YTD income increase %	16.7%	133.3%	133.3%	84.7%	65.2%	157.6%	75.0%	26.8%	119.5%	70.7%	51.2%	90.2%	80.5%	26.8%	80.5% / 10.1%	≥5%	-	-

Local Integration		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD	YTD target
47	Number of inpatients that were medically optimised for discharge (monthly average)																≤80	225	-
48	Emergency Department activity - type 1 This year vs. last year																-	95,660	-
49	Percentage of virtual appointments as a proportion of all outpatient consultations This year vs. last year																≥25%	0.0%	≥25%

Digital		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD	YTD target
50	My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month)			181762												223745	-	223,745	-
51	My Medical Record - UHS patient logins (number of logins made within each month)			33304												38230	-	292,698	-
51 - The YTD Figure shown represents a rolling average of MMR logins per month within the current financial year																			
52	Average age of IT estate Distribution of computers per age in years			0	0	21	19	33	59	172	476	684	979	2270	2850	1810	1890	-	-	-
				14	13	12	11	10	9	8	7	6	5	4	3	2	1			
53	CHARTS system average load times - % pages loaded <= 5s - % pages loaded <= 3s			99.8%	99.7%	99.8%	99.8%	99.8%	99.8%	99.8%	99.3%	99.2%	99.3%	99.3%	99.4%	99.4%	99.3%			
53 - From **April 2024** , metric was changed from % loading time**s under 5s** to % loading times **under 3s**																			

University Hospital Southampton NHS Foundation Trust

Agenda item 5.7 Report to the Trust Board of Directors, 7 January 2025	
Title:	Finance Report 2024-25 Month 8
Sponsor:	Ian Howard, Chief Financial Officer
Author:	Philip Bunting, DoOF and Anna Schoenwerth, ADOF

Purpose

(Re)Assurance	Approval	Ratification	Information
			x

Strategic Theme

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

Executive Summary:

The Trust monthly finance report provides insight and awareness of the financial position and the key drivers for any variance to plan. It also provides commentary around future risks and opportunities. This covers the three key domains of income and expenditure, capital and cash.

The headlines for the November report are as follows:

- The Trust has reported a £5.7m deficit in month and a £18.2m deficit YTD. The Trust is now £14.8m behind plan YTD.
- UHS continues to deliver significant levels of financial savings (£42.6m YTD), particularly from UHS transformation programmes on patient flow, theatres and outpatients.
- UHS benchmarks as providing good value for money across a range of metrics.
- One of the main drivers of the deficit continues to be the non-delivery of system transformation initiatives. In particular, Non-Criteria to Reside (NCTR) numbers have increased rather than reduced.
- The Trust continues to overtrade – undertaking activities beyond funding levels being received.
- The Trust financial position remains off-plan, with monthly improvements required to deliver our Financial Recovery Plan.
- There are further risks to the Trusts financial position regarding ERF income levels, staffing costs and winter pressures.
- Additional rigour continues to be applied around financial grip and governance ensuring strong controls are in place. The Trust also continues to work with Deloitte around non pay savings opportunities.
- Cash has decreased to £34.7m in month. There is a significant risk in Q4 that cash will reduce close to zero and cash support will be required.
- The Trust's capital programme is £7m behind plan YTD, with £33.6m to be spent in the remainder of the financial year. Slippage risks on schemes are currently being reviewed with the capital planning process for 2025/26 and 2026/27 having now commenced.

Contents:

Finance Report

Risk(s):

5a - We are unable to deliver a financial breakeven position, resulting in: inability to move out of the NHS England Recovery Support Programme, NHS England imposing additional controls/undertakings, and a reducing cash balance impacting the Trust's ability to invest in line with its capital plan, estates/digital strategies, and in transformation initiatives.

Equality Impact Consideration:	N/A

University Hospital Southampton NHS Foundation Trust

UHS Finance Report – M8

Headlines

As reported in previous months, following the receipt of £11.2m of deficit support funding in October, UHS is now being measured against an annual plan of £3.3m deficit. This deficit is fully phased into the first half of the year with the prevailing plan for the second half of the year a monthly breakeven target.

The below table illustrates both the in-month and YTD reported I&E position both before and after the deficit support funding:

Financial Position – Pre-Deficit Support	M7	YTD	Annual
Plan	0.0	(14.5)	(14.5)
Actual Surplus / (Deficit)	(5.7)	(29.3)	
Variance	(5.7)	(14.8)	

Financial Position - After Deficit Support	M7	YTD	Annual
Re-set Plan	0.0	(3.3)	(3.3)
Actual Surplus / (Deficit)	(5.7)	(18.2)	
Variance	(5.7)	(14.8)	

Financial Improvements

The Trust is continuing to substantively deliver on financial improvements from its savings and transformation programmes. For example:

- The Trust has delivered length of stay improvements for P0 patients of 5%.
- We have delivered a significant improvement to our outpatient ratio, undertaking more first appointments, procedures and advice & guidance.
- The Trust has implemented new workforce controls embedded within Divisions, which have been widely supported. We are below our pay expenditure plan YTD with all divisions operating within workforce control totals.
- We are currently utilising agency for 0.8% of our total workforce, significantly below the national target of 3.2%. Our temporary staffing remains below plan.
- UHS is performing well on ERF activity through transformation programmes and other initiatives, with YTD performance at 128% of baselines, above the overall national target of 107% (although below our internal plan target of 133%).
- UHS has delivered £42.6m (>6% of addressable spend) of CIP by M8, which is above the trajectory from 23/24.
- Since March 24, our ERF performance has increased by 12%, and at the same time our staffing levels have reduced by 2%.
- The Trust has recently received benchmarking information which highlights its relative efficiency, notably:
    - National Cost Collection score of 89 – 11% more efficient than national average.
    - Model Hospital data for 22/23 – further improvement to 15th national performance, above peer organisations.
    - Back-office benchmarking highlighting efficient use of resources.

Key Drivers

The key drivers for the £14.8m variance to plan YTD are as follows:

- System Transformation programmes targeted delivery of reductions to Non-Criteria to Reside (NCTR) and Mental Health numbers attending the hospital. Despite best endeavours of UHS and system partners, patient numbers remain above planned levels, meaning the Trust continues to incur additional temporary staffing costs and is maintaining additional bed capacity above funded levels. Savings of £8.8m have not been delivered across all system transformation schemes YTD.
- Final elements of the pay award have been made to resident doctors and Band 8+ staff on the November payroll. The combined impact of pay awards is confirmed to have an in-year funding shortfall of c£2m with c£1.3m impacting YTD. This poses a significant risk to the delivery of the financial recovery plan.
- The UHS ERF target with Specialised Commissioning was increased by £1.2m after the plan was submitted (£0.8m YTD). This was related to movement in the target of another Trust. This was challenged but upheld by NHS England.
- Non pay cost pressures including the impact of inflation above planned levels continues to cause pressure.
- The Combined Heat and Power (CHP) units have broken down on several occasions, meaning electrical power is imported from the national grid at a higher cost. This has had an in-year impact of £1.1m YTD. One of the units has recently been serviced with the aim of reducing the number of breakdowns.
- Non-Elective growth and staffing challenges have resulted in under-performance against our elective income plan in Cardiac Surgery.
- An underspend on pay in the early part of the year has helped supress the above cost pressures with pay £4.8m favourable to plan YTD after removing the impact of the pay award and non-delivery of system transformation savings. This position is not expected to continue, with staffing numbers and normalised pay spend increasing over the last two months. This was particularly noticeable in midwifery where there had recruitment challenges.

Other Headlines

Income performance was strong in month with Elective Recovery Fund (ERF) performance 135% of 19/20 levels which is the highest % reported so far this year. The trust is now 128% YTD. This has generated income of £20m in overperformance YTD.

Pay expenditure normalised for the pay award increased by c£0.5m consistent with staffing number increases seen in M7 for which we have now had a full month of costs. It is expected some of this should be offset by future bank and agency reductions especially within nursing once staff have completed their supernumerary periods of working.

Non pay expenses (excluding pass through) are reporting a £22.5m adverse variance YTD with the majority of this relating to unidentified CIP that was planned for within this category (£13.5m YTD / £20m FY). Savings have however been achieved in other areas partially offsetting this variance. We are also currently working with Deloitte to review and implement non pay savings opportunities.

The underlying position, removing all further one-off items of income and expenditure, shows consistency at c£6m per month deficit. This is because increased ERF income performance has been offset by increased costs on pay and non pay. The underlying trend continues to be refreshed for any backdated costs and benefits.

An assessment of YTD performance highlights that the trust delivered over £20.8m of valued activity above block contracts in months 1 - 7. There is currently no funding solution within HIOW to resolve this problem.

Financial Recovery

UHS Trust Board considered a Financial Recovery Plan for H2 following a request from NHS England. The Trust I&E position in M8 was consistent with the trajectory set with the exception of the YTD pay award pressure of £1.3m. Month on month improvements are required for the remainder of the year.

Risks

- ERF data has now been received by NHS England for months 1-5. Following data validation there has been a £1.8m reduction applied to prior months reporting. We continue to review prior months data to ensure levels of data quality are robust and will keep the committee.
- There are seasonality risks that may mean surge capacity costs increase and elective income cannot be maintained at prior month levels. Notably NCTR levels have increased in month. This has risks for both increased expenditure and reduced ERF income.
- There are early indications that for 2025/26, ERF will be capped for systems, although the exact level and mechanisms are unknown. Formal planning guidance has yet to be published.

Cash

A cash update report has been provided separately this month for review by the committee.

Capital

Capital expenditure of £25.7m YTD is £7.1m (22%) behind plan, leaving over £33.6m to be spent across the remainder of 24/25 (excluding IFRS 16 capital additions/remeasurements). Changes to the Building Safety Act have created delays and overspends in several key projects notably the Neonatal expansion. The Community Diagnostic Centre (CDC) development is the other project facing slippage risks with costs £3.9m behind plan YTD.

A briefing paper has been provided to Trust Board seeking sign off of the Trusts capital forecast in line with NHS England requirements. This confirms the expectation that we will deliver our plan in full and manage slippage risks accordingly. The capital prioritisation for 25/26 and 26/27 has now commenced with services and will be shared early in 2025.

ICBXX/0XX

NHS
Hampshire and Isle of Wight

Integrated Care Board

Board Meeting in Public

Title of paper	ICS Public Board Finance Report		
Agenda item	(number)	**Date of meeting**	Click or tap to enter a date.
Lead	Martin Sheldon	**Clinical Sponsor**	(if applicable)
Author	Lindsay Jones		
Purpose	For Information		

Executive Summary	
The purpose of the Month 8 (M8) Finance Report for Hampshire & Isle of Wight Integrated Care System (ICS) is to provide details of the financial position and system recovery plan for the ICS as at the end of November 2024. At M8, the Hampshire and Isle of Wight system in-month position is a deficit of £7.72m compared to a planned surplus of £2.28m, an adverse variance to plan of £10.0m. The ICS is reporting a year-to-date deficit of £39.71m at the end of November 2024, compared to a planned year-to-date deficit of £10.23m, so an adverse variance to plan of £29.48m. The ICS, following receipt of the £70m cash support, now has a combined £0 (breakeven) planned, and it forecasts achievement of this by financial year end 2024/25. All providers are currently developing recovery action plans to reduce and mitigate risks to delivering our breakeven forecast. The report also summarises key quality indicators relating to safety, effectiveness and patient experience.	
Recommendations	1 Each Board needs assurance that their organisation is going to deliver on their operating plan, and that appropriate mitigations and recovery plans are in place where required. 2 Each Board needs assurance from their executives on their organisation's contribution to each system transformation programme.

Strategic objectives
1. To make best use of our resources, living within our means

Risks to the strategic objectives
☒ 4B) There is a risk that the Integrated Care System's NHS financial plans are insufficient or do not deliver as planned to achieve the individual organisation and/or system financial plans.
Regulatory and legal implications (e.g., NHS England/Improvement ratings, Care Quality Commission essential standards, competition law etc)
The system remains in System Oversight Framework (SOF) 4 as a result of our financial and operational performance
Financial implications / impact (e.g., cost improvement programmes, revenue/capital, year-end forecast)
As described in the executive summary and paper
Specific communications and stakeholder/staff engagement implications
Patient / staff implications (e.g., linked to NHS Constitution, equality and diversity)
All decisions arising from our financial recovery process will be subject to assessment of their impact on quality across the system and appropriate organisational and system governance.
Equality and quality impact assessment
As above
Data protection impact assessment
None
Previous considerations by the Board
Background papers / supporting information

1. Purpose

1.1 The purpose of the Month 8 (M8) Finance Report for Hampshire & Isle of Wight Integrated Care System (ICS) is to provide an overview of the financial position and system recovery plan for NHS organisations within the Hampshire and Isle of Wight ICS as at the end of November 2024.

1.2 This report has been shared with all NHS organisations in the system, to ensure Boards are able to gain assurance and hold their organisation(s) to account for delivery of their operating plan as well as their contribution to recovery of the whole system.

1.2.1 At the close of Month 6, Southern Health NHS Foundation Trust and Solent NHS Trust merged into a new organisation called NHS Hampshire and Isle of Wight Healthcare Foundation Trust.

2. Background

2.1 The final agreed system plan for 2024/25 is a £70m deficit, consisting of a £9.6m surplus plan for NHS Hampshire and Isle of Wight (the Integrated Care Board), and a combined provider deficit plan of £79.60m. This plan was agreed on the basis that NHS England would provide £70m of non-recurrent deficit support funding, enabling our plan to reduce to £0 (breakeven).

2.2 In month 6, NHS England confirmed the anticipated £70m in non-recurrent deficit support. This support requires a matching improvement in our plan, taking the Hampshire and Isle of Wight system plan to a combined £0 breakeven plan for the financial year. The £70m cash support is repayable as part of national business rules on repayment of deficits and will not reduce the Hampshire and Isle of Wight system historic deficit.

2.3 The whole system continues to be in the NHS England (NHS E) Financial Recovery programme. This requires additional assurance and reporting requirements to NHSE as well as controls around decision making.

3. Discussion

3.1 Integrated Care System Financial Overview

3.1.1 The £70m deficit cash support funding resulted in the ICS being required to improve its combined annual plan from £70m deficit to breakeven, and our M8 reporting is against this revised breakeven plan. Whilst the Hampshire and Isle of Wight system combined plan is a breakeven position for this financial year, there are some organisations that are planning a surplus and some a deficit. Table below shows how the deficit cash support funding has been phased into the financial position:

Organisation	M6	M7	M8	M9	M10	M11	M12	Full Year
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Hampshire and Isle of Wight ICS	55,282	2,435	2,265	5,339	2,198	1,795	684	69,998

3.1.2 The table below summarises the ICS financial position reported at month 8 (November 2024). In November itself, the ICS reported a deficit of £7.72m against a planned surplus of £2.28m, so an adverse variance to plan of £10.01m.

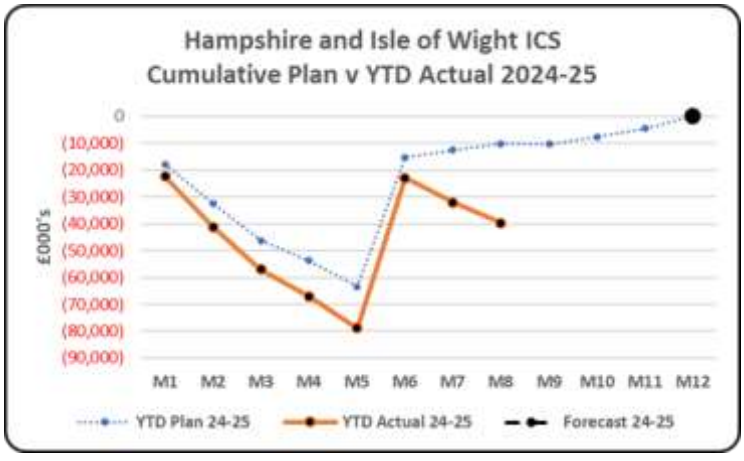
Organisation	In Month			Year to date			Forecast Outturn		
	In Month Plan £'000	In Month Actual £'000	Variance £'000	YTD Plan £'000	YTD Actual £'000	Variance £'000	Annual Plan £'000	Forecast Outturn £'000	Variance £'000
Hampshire and Isle of Wight ICS Total	£2,288	(£7,723)	(£10,011)	(£10,227)	(£39,707)	(£29,480)	£0	£0	£0

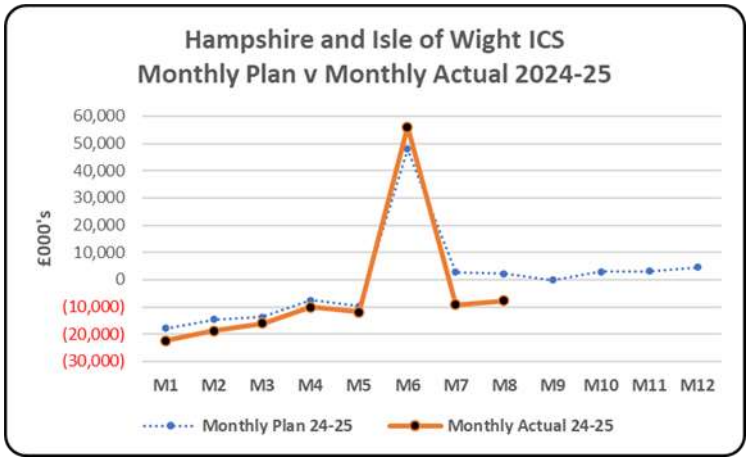
3.1.3 The system is currently reporting a year-to-date deficit of £39.71m at month 8 compared to a planned £10.23m deficit, therefore a £29.48m adverse variance to plan.

3.1.4 The ICS is forecasting to achieve its current plan of a combined breakeven position.

3.1.5 The ICS will continue to prioritise the implementation of the agreed system plan and transformation programmes to support achievement of our financial plan in financial year 2024/25.

3.1.5 The graphs below summarise the ICS position reported at month 8:





3.1.6 The ICS and all its constituent NHS organisations must continue to prioritise the implementation of the agreed system plan and transformation programmes to support achievement of each organisation's financial plan in financial year 2024/25. All system transformation savings are embedded within the financial plans of Hampshire and Isle of Wight organisations, so system success is reliant upon every organisation delivering on their commitments.

3.2 System Actions to Support Financial Recovery

3.2.1 In 2023/24, additional controls were required by NHS England as a consequence of our deficit plan. Individual providers may also have had enhanced conditions as described in undertakings letters and where revenue or capital cash support was required, additional conditions will apply, including assessment of affordability of capital plans. All our existing system business rules, conditions and controls remain extant in 2024/25.

3.2.2 System financial recovery and delivery of our system transformation programmes is overseen by a monthly System Recovery and Transformation Board, which is attended by all Provider Chief Executives and chaired by the ICB Chief Finance Officer and Deputy CEO.

3.2.3 System leaders have agreed additional steps in 2024/25 to strengthen our delivery of plans, including:

- A system vacancy control panel, to review any proposed external recruitment and identify opportunities to resource from within the existing NHS workforce
- Chief executive-level leadership for each system transformation programme
- Organisation and system-level delivery units focused on our system transformation programmes, coordinated by a system Programme Management Office (PMO).

3.2.4 Additional external support has been commissioned for some system organisations, either to support continued delivery of their 2024/25 plan, or to support recovery where organisations are already materially off-plan.

3.3 System Transformation Programmes

3.3.1 Our system plan for 2024/25 is intended to address the challenges impacting our financial position which required a system response. Together we identified six key programmes for corrective action to reduce our system deficit in 2024/25 and enable delivery of each organisation's operating plan. Our system transformation programmes are:

Programme	Lead Chief Executive	Lead ICB Executive

Discharge	Penny Emerit	Caroline Morison
Local Care	Alex Whitfield	Lara Alloway
Urgent and Emergency Care	David Eltringham	Nicky Lucey
Mental Health	Ron Shields	Nicky Lucey
Planned Care	David French	Lara Alloway
Workforce (including Corporate Right-Sizing)	David French	Danny Hariram

3.3.2 Each transformation programme reports on progress and key metrics into the monthly System Transformation and Recovery Board, which is attended by all Provider Chief Executives. Reporting is supported by a system Programme Management Office.

3.4 Elective Recovery Fund

3.4.1 The Elective Recovery Fund (ERF) aims to increase elective activity in the NHS by providing additional funding to Integrated Care Boards (ICBs). The funding is uncapped meaning that additional funding can be given to ICBs and NHS Providers that exceed their individual targets.

3.4.2 Each organisation has a specific target level of activity growth (compared to 2019/20) above which additional income is earned. For Hampshire and Isle of Wight as a whole, our target level is 108.7% of 2019/20 activity, but our operating plans for 2024/25 were based on achieving 120.5%. At Month 8, initial data estimates show achievement of 121.0%.

4. Quality

4.1 Regulatory

Care Quality Commission: there continues to be a delay in the publication of Care Quality Commission (CQC) inspection reports, including an unannounced Emergency Department to one of our providers during February 2024.

Quality Assurance and Improvement Levels: all providers, apart from one Trust, remain in the routine quality assurance and improvement level.

4.2 Patient Experience

Friends and Family Test Performance: the latest data relates to September 2024, in general, for our key NHS providers, performance in relation to positive feedback is equal to or greater than the national rate, apart from:

- **Inpatient (national positive 94%):**
  - **One Trust achieved (93% positive)** – the Trust are focusing on improving patient communication and aim to achieve a 95% positive patient response. In October, NHS reviews and ratings showed the

Trust received six patient feedbacks, of which 3 included inpatient feedback: two receiving 5* and one 1*. Positive feedback highlighted patient, compassionate, respectful and person-centred staff. The negative feedback related to a gynaecology/early pregnancy ward and highlighted no water in the waiting room, poor communication, rude and unhelpful staff. The Trust has not yet responded to the feedback - the NHS Hampshire and Isle of Wight team will check that steps have been taken to ensure drinks are available for patients.

- **Maternity Postnatal (national positive 92%):**
  - **One Trust received 73% positive feedback** – the Trust remain below the national performance for positive feedback for postnatal care. The Trust will be requested to share the key themes from negative feedback to see where improvements could be made.

- **Maternity Postnatal Community (national positive 93%):**
  - **One Trust received 88% positive feedback** – the Trust remain below the national performance for positive feedback for postnatal community care but continue to show an improving position.

- **Mental Health (national positive 88%):**

One Trust achieved 85% positive feedback – the Trust's acute services had seen improved levels of satisfaction in recent months (May to June 2024) following focussed work to identity key themes. However, the figures for August and September 2024, 83% and 61% respectively, show lower levels of satisfaction. Work undertaken to date identified a number of themes for improvement. The Trust also collects feedback in several other ways. The Friends and Family Test data is triangulated with an expanding range and depth of feedback received from patients, families and carers including Service User Led Audits, Care Opinion kiosks where patients give feedback directly to staff who can provide an immediate response. A thematic review is then completed quarterly to identify overall themes. This report is shared with service leads to develop improvement plans.

Mixed-Sex Accommodation Breaches (September 2024): the threshold for mixed sex accommodation breaches is >0. All providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient. In August 2024, three of our Trusts reported mixed sex accommodation breaches (Statistics » Mixed-Sex Accommodation Data):

- One Trust reported three breaches reported, of note, the Trust's latest Board report advises that there were no breaches reported in October 2024.
- One Trust reported 17 mixed sex accommodation breaches.
- One Trust reported 127 breaches which was the same as the previous month; the Trust has consistently breached the mixed-sex accommodation threshold this financial year.

It is anticipated that the work being undertaken in relation to improving hospital and system flow should have an impact on some of the mixed-sex accommodation breaches. However, as a System, this metric continues to be breached, and a review of the data indicates it is not showing any signs of improvement.

4.3 Safety

Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infections: 2023/24 saw an increase in Methicillin-resistant Staphylococcus aureus (MRSA) Blood Stream Infection, in particular healthcare associated cases. There is an improving trend in cases with a reduction from 29 cases in the rolling 12 months June 2023 to July 2024 to 27* cases in the 12 months between December 2023 to November 2024.

Table: Methicillin-resistant Staphylococcus aureus (MRSA) Blood Stream Infection infections - current position					
Total number of cases - financial year to date*	**No learning/ lapses in care**	**Lapse in care**	**Incidental Learning post Methicillin-resistant Staphylococcus aureus Blood Stream Infections**	**Cases under review**	**Quartile position against latest OF metrics**
19	3	5	2	9	Latest information not available.
*** The June case has been successfully appealed but it has not yet been reallocated.**					

Three cases in November 2024 were all Community Onset Community Associated - they are under review, so far, there has not been any learning identified apart from incidental learning around the undertaking of a full set of observations and calculation of a National Early Warning Score 2 (NEWS2).

The overall trend is encouraging, however, there is concern that some Trusts are not impacting their numbers as much as others. NHS Hampshire and Isle of Wight Infection Prevention and Control team continue to link with the Trust for oversight and to support improvements through the sharing of learning from themes.

Clostridium difficile infection rate: the monthly trajectory for Clostridium difficile is 44 – the November 2024 data currently shows that we have not exceeded this yet, however, it is likely that the laboratories may report more November cases.

Table: Clostridium difficile infections - current position			
Number of cases reported* in month (November 2024)	**Total number of cases financial year to date***	**Performance against 2024/25 trajectory***	**Quartile position against latest OF metrics**
36	407 (+50)*	407/535	Latest information not available.
Narrative:			

November 2024* case number is likely to end the month 40 cases above the same November 2023 out-turn. The Integrated Care Board has now used 76% of its annual trajectory in month eight against a target of 66%. **A review of the trend in cases since April 2017 evidence an increase in the proportion of Hospital Onset, Healthcare Associated cases when compared to Community onset cases, this trend is replicated when the cases are split into Healthcare associated cases versus Community Associated cases.**
*November 2024 data will not be confirmed until the 16 December, the information is based on data submitted the Health Care Associated Infection Data Capture System but may not be a true reflection of November 2024 cases.

Overall, Hampshire and the Isle of Wight is following the same trend as other areas in the South East Region – learning seems to imply increased complexity, frailty and acuity of patients post pandemic and decreased conditioning of the population. There is concern in relation to the number of Clostridium difficile cases reported by one Trust and further assurances will be sought. It is assuring to note the impact of the actions being taken by one Trust in particular and this will be shared across the System.

SO42a Escherichia coli (E. coli) bloodstream infections (BSI): the trajectory for Escherichia coli (E. coli) bloodstream infections has been exceeded.

Table: Escherichia coli (E. coli) bloodstream infections - current position			
Number of cases reported* in month (November 2024)	**Total number of cases financial year to date***	**Performance against 2024/25 trajectory**	**Quartile position against latest OF metrics**
90	906 (+93)*	906/1219	Latest information not available.
Narrative: The Integrated Care Board has now used 73% of its annual trajectory in month eight against a target of 66%. However there are likely to be a further 10+ cases added to the November cases before the reporting system closes on the 16th November.			
**November 2024 data will not be confirmed until the 16 November, the information is based on data submitted the Health Care Associated Infection Data Capture System but may not be a true reflection of November 2024 cases.*			

It is of concern that the trajectory for Escherichia coli (E. coli) bloodstream infections is not being met. Support is being provided to those Trusts that have exceeded their 5% trajectory for the month and learning from the cases is shared across the System. The main change seems to be associated with Community Onset, Healthcare Associated cases, however the reason for this is unknown. NHS Hampshire and Isle of Wight is assured that very few cases are associated with initial treatment failures in primary care. The majority are spontaneous events.

Never Events: the national threshold for Never Events is zero. During 2024/25 to end of November 2024, there have been 11 Never Events reported, all of which relate to surgical procedures.

Referral to Treatment harm reviews: one completed harm review (from August 204) was submitted by a Trust in November 2024, although it was for a 'no harm' event which highlighted ongoing challenges in relation to lost to follow-up patients across one particular pathway.

Regulation 28 - Ref: 2024-0649 – Dean Bray: there was one Regulation 28 report published on 28 November 2024, relating to the former Southern Health NHS

Foundation Trust, now part of NHS Hampshire and Isle of Wight Healthcare NHS Foundation.

The report under Regulation 28 was raised following a patient death at the end of 2021: https://www.judiciary.uk/prevention-of-future-death-reports/dean-bray-prevention-of-future-deaths-report/. An article relating to the case was also available on the BBC news – link here: Southampton nurses' neglect led to death of psychiatric patient - BBC News.

The Trust has until 16 January 2025 to respond to the Coroner outlining actions undertaken/planned in response. NHS Hampshire and Isle of Wight is gaining assurances from the Trust about current ward processes for ensuring patients' risks are routinely assessed and monitored to prevent a deterioration in patients' physical health.

4.4 Clinical Effectiveness

Standardised Hospital-level Mortality Indicator (SHMI) – July 2023 - June 2024: all providers are reporting 'as expected' (band 2) or 'lower than expected' (band 3) mortality rates.

National Hip Fracture database – 30-day mortality (October 2024): the latest data from the national hip fracture database shows that all Hampshire and Isle of Wight acute providers continue to be below the national mortality 30-day rate.

National Hip Fracture database – hours to operation (October 2024): early surgery for hip fractures has been shown to reduce mortality rates and surgical complications. The national target is for patients to have surgery within 36 hours, this is because delays beyond this are shown to have increased mortality. Within Hampshire and Isle of Wight only one of our four acute providers met this target.

In October, three Trusts did not meet the hours to operation target; however, one Trust is showing an improving position whilst the other two Trusts are showing a declining variation. This is currently not affecting 30-day mortality performance.

4.5 Quality Impact Assessments

NHS Hampshire and Isle of Wight have a weekly panel in place which reviews all Quality Impact Assessments that are linked to our financial recovery (i.e., not linked to a usual business case) and financial recovery savings that exceed £50,000 requiring higher level Integrated Care Board or potential Integrated Care System scrutiny. The panel reviews all Quality Impact Assessments that meet the above criteria and makes recommendations based on the information presented.

During November 2024, four Quality Impact Assessments were formally submitted to the Hampshire and Isle of Wight panel for review, one of these was submitted by a provider.

5. Recommendations

5.1 Each Board needs assurance that their organisation is going to deliver on their operating plan, and that appropriate mitigations and recovery plans are in place where required.

5.2 Each Board needs assurance from their executives on their organisation's contribution to each system transformation programme.

University Hospital Southampton NHS Foundation Trust

Agenda item 5.9 Report to the Trust Board of Directors, 7 January 2025	
Title:	People Report 2024-25 Month 8
Sponsor:	Steve Harris, Chief People Officer
Author:	Matthew Kelly, Interim Head of Workforce

Purpose

(Re)Assurance	Approval	Ratification	Information
x			

Strategic Theme

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

Executive Summary:

As forecast the Trust has now moved above its NHSE workforce plan by 77 WTE. This is through a combination of planned increases of substantive staff during September and October for newly qualified employees and the NHSE plan reducing during Q3 and Q4. The reductions in the NHSE plan were based primarily on 218 WTE in both temporary and permanent staff linked to significant improvements in mental health and NCTR. Performance in these areas, linked to large-scale system transformation, has not improved and thus closure of capacity has not been possible.

Divisions are all still operating within their AWL limits as part of UHS controls and are forecast to remain so for the remainder of the 24/25. Actual workforce growth in substantive was 7 WTE. However, our position has been adjusted and corrected to fully exclude the clinical research network (CRN a network fully funded and hosted) which has expanded following a TUPE transfer. This was previously only partially excluded in our workforce numbers.

A spike in mental health patients has driven an increase in agency, although it remains well below plan overall. Bank is broadly stable, although now above plan. At present the forecast for the end of year 24/25 is for UHS to finish at a total workforce (Substantive, bank and agency) of 13464 WTE which would be 186 over plan.

Based on predicted starters, the forecast assumes further growth of 85 WTE using information at this stage. It is planned to re-forecast again prior to January Board once more certainty is available on known starters following Christmas. This forecast assumes no impact of NCTR and mental health reductions but, does assume gains made in bank through the benefit of NQNS becoming part of the established workforce. It also assumes some level of benefit from the MARS programme (20 WTE).

Turnover has reduced again in November, taking the UHS rate to 10.6% and well below target of 13.6%. Overall sickness reduced in month to 3.3%.

The Trust has been in negotiations with UNITE, with support from ACAS regarding the porters' dispute. A deal has been reached and focus now turns to implementation.

Negotiations with UNISON regarding the band 2/band 3 dispute are ongoing. UNISON will be putting a deal to its members for consideration. There has been intense work to support the Cardiac team, including a workshop to try to drive improvements and reverse lost patient activity linked to additional contractual work.

Contents:	
The report contains workforce data and reporting set out against our People Strategy, Thrive, Excel and Belong pillars.	
Risk(s):	
3a: We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles. 3b: We fail to develop a diverse, compassionate, and inclusive workforce, providing a more positive staff experience for all staff. 3c**:** We fail to create a sustainable and innovative education and development response to meet the current and future workforce needs identified in the Trust's longer-term workforce plan.	
Equality Impact Consideration:	EQIA assessments undertaken as required for specific streams within the People Strategy.

UHS People Report

WORLD CLASS PEOPLE

November 2024

THRIVE EXCEL BELONG

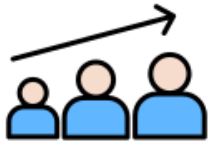
Summary

PEOPLE REPORT OVERVIEW: 2024/25 M8 (NOV-24)

In-month sickness (3.3%) below target (3.9%)

Appraisal completion rates increased in November (75%)

R12m turnover rate (10.6%), which is below target (13.6%)



Substantive workforce currently above NHSE 24/25 workforce plan as forecasted

Bank usage decreased from prior month and is now 91 WTE above plan

Increase (7 WTE) in agency; staffing. Agency remains under plan

Decrease in patient safety incidents from 98 to 67 in November

Pulse Survey for Q2 shows a stable engagement score

Executive Summary

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A spike in mental health patients has driven an increase in agency, although it remains well below plan overall. Bank is broadly stable, although now above plan. At present the forecast for the end of year 24/25 is for UHS to finish at a total workforce (Substantive, bank and agency) of 13464 WTE which would be 186 over plan. Based on predicted starters, the forecast assumes further growth of 85 WTE using information at this stage. It is planned to re-forecast again prior to January Board once more certainty is available on known starters following Christmas. This forecast assumes no impact of NCTR and mental health reductions but, does assume gains made in bank through the benefit of NQNS becoming part of the established workforce. It also assumes some level of benefit from the MARS programme (20 WTE). Turnover has reduced again in November, taking the UHS rate to 10.6% and well below target of 13.6%. Overall sickness reduced in month to 3.3%.

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Overall Position

WTE Movement (M7 to M8)

Total Workforce

The total workforce **decreased by 38 WTE** to 13,442 WTE from M7 to M8.

During this period, the substantive workforce decreased by **33 WTE**, while the overall temporary staffing decreased by **5 WTE.**

As of M8, the Trust is now **over the total plan** (by 77 WTE).

Substantive WTE

Substantive WTE decreased by **33 WTE** between October and November.

Admin and Clerical staff group and the Nursing and Midwifery Registered staff group both decreased by 21 WTE and 17 WTE respectively, while Healthcare Scientists increased by 6 WTE .

Position has been adjusted and corrected to fully exclude the clinical research network (CRN - a network fully funded and hosted) which has expanded following a TUPE transfer. This was previously only partially excluded in our workforce numbers.

Bank & Agency WTE

Total Bank and Agency usage decreased by 5 WTE in November 2024.

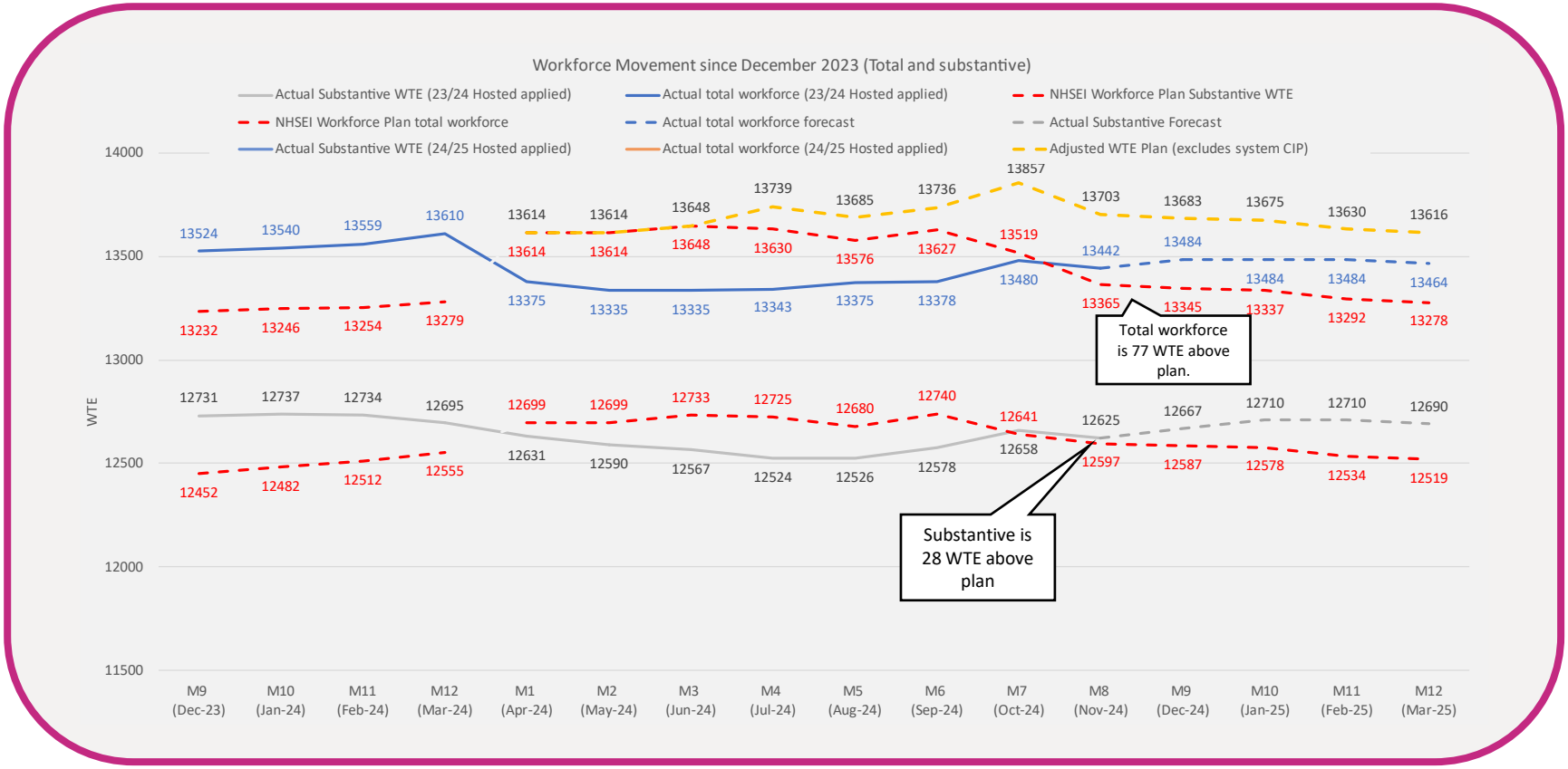
Bank usage **decreased** from October to November by 2% (766 to 754 WTE; a 12 WTE decrease).

Agency usage **increased** in November by 11% compared to October 2024 (56 to 63 WTE; an increase of 7 WTE).

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

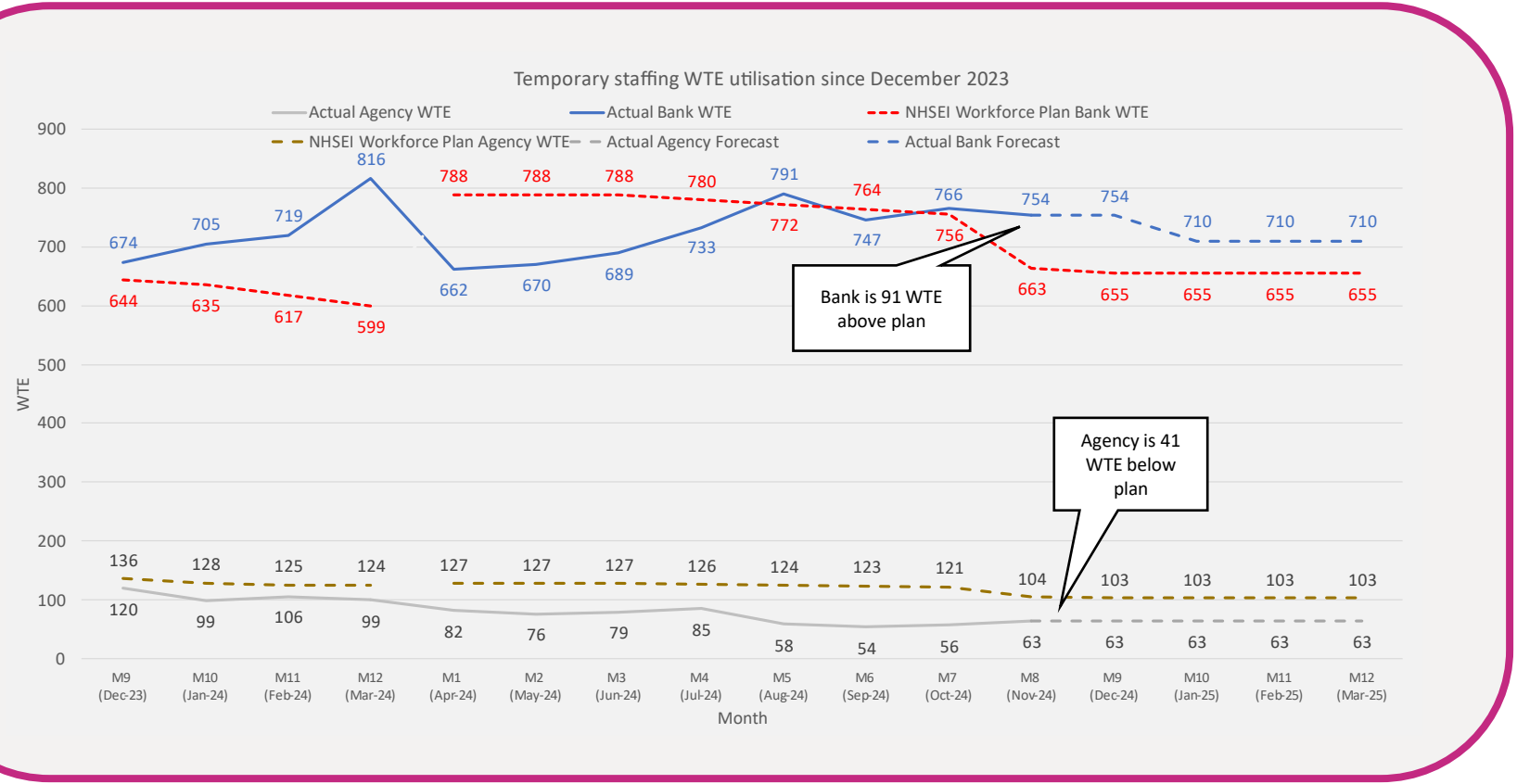
Mental Health training is being provided by the trust to ensure that NHSP workers have the appropriate training to support UHS patients.

Workforce Trends: Total & Substantive



Source: ESR as of November 2024. Please note that the total workforce forecast is based on expected substantive starters and November B&A actuals
NB: Please note that the hosted service criteria in 2024/25 is the same as in 2023/24. We have adjusted our substantive position to account for the full exclusion of the CRN (Clinical Research network – A hosted and external funded network) now this transfer has completed. This has reduced A&C by 34 WTE in December.

Workforce Trends: Bank & Agency



Source: NHSP Bank + THQ Medical Bank & Agency (NHSP Agency & 247 Agency) as of November 2024

Workforce Trends: Assumptions

Forecast Assumptions

Substantive:

- The forecast cautiously anticipates growth from December to February based on predicted starters. However, there is potential volatility with starters booked for December and January due to the Christmas period, as start dates are expected to change.
- All divisions are projected to remain within the established AWL limits.
- A re-forecast will be conducted before submitting to the January Board, once the December position is confirmed and there is more clarity on January starters.

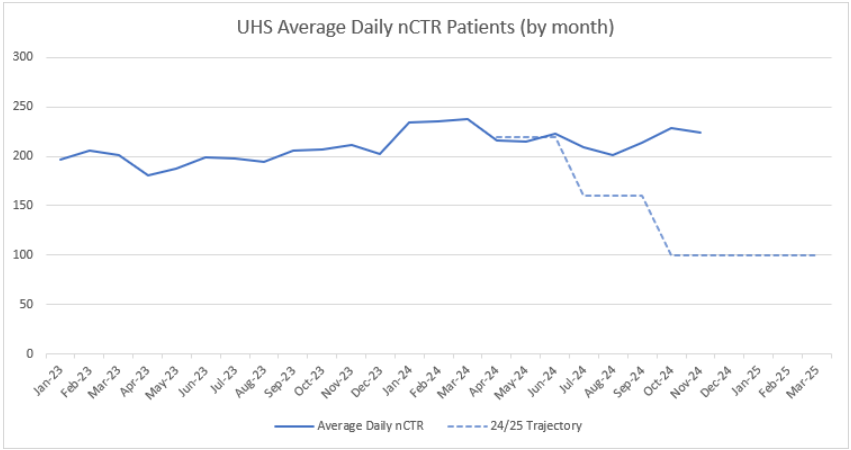
Bank:

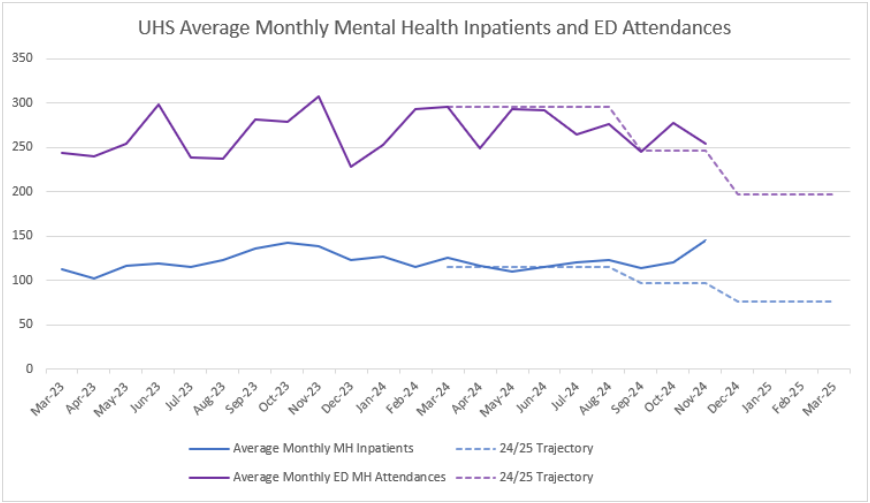
- Bank assumes a level of benefit achieved from the conversation of substantive starters. This assumes a prudent reduction of 43 WTE in bank once super nummary periods, and other substantive staff come on stream in January.
- However, it assumes no significant increases in sickness, no significant increases in surge capacity.

Agency:

- Agency remains low and below target and we have assumed this will remain stable until the end of the year.

Delivery against Schemes (nCTR & MH)

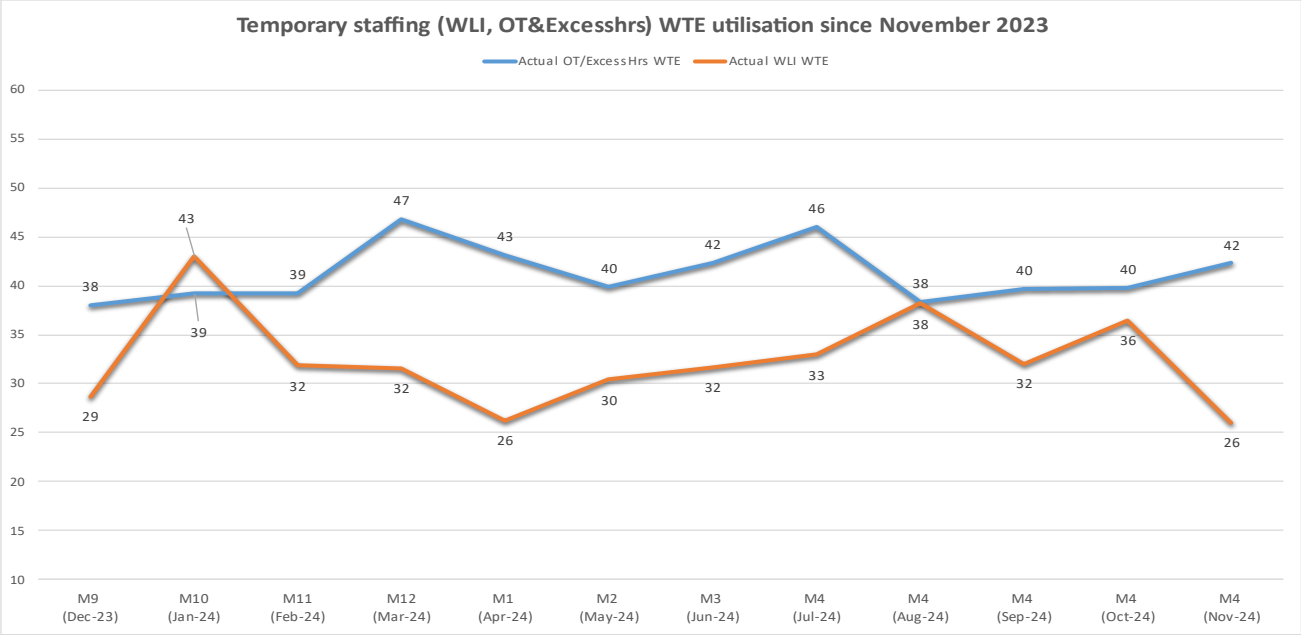




November 2024

Workforce Trends: WLI and Overtime

WLI Movement	M9 – M10	M10 – M11	M11 – M12	M12 – M1	M1 – M2	M2 - M3	M3 - M4	M4 - M5	M5 - M6	M6 - M7	M6 - M8	M12 - M7
	14	-11	0	-6	5	3	0	5	-7	5	-11	**-6**



Source: Healthroster as of November 2024; retrospective WLI figures have been updated M7 to M8 movement.

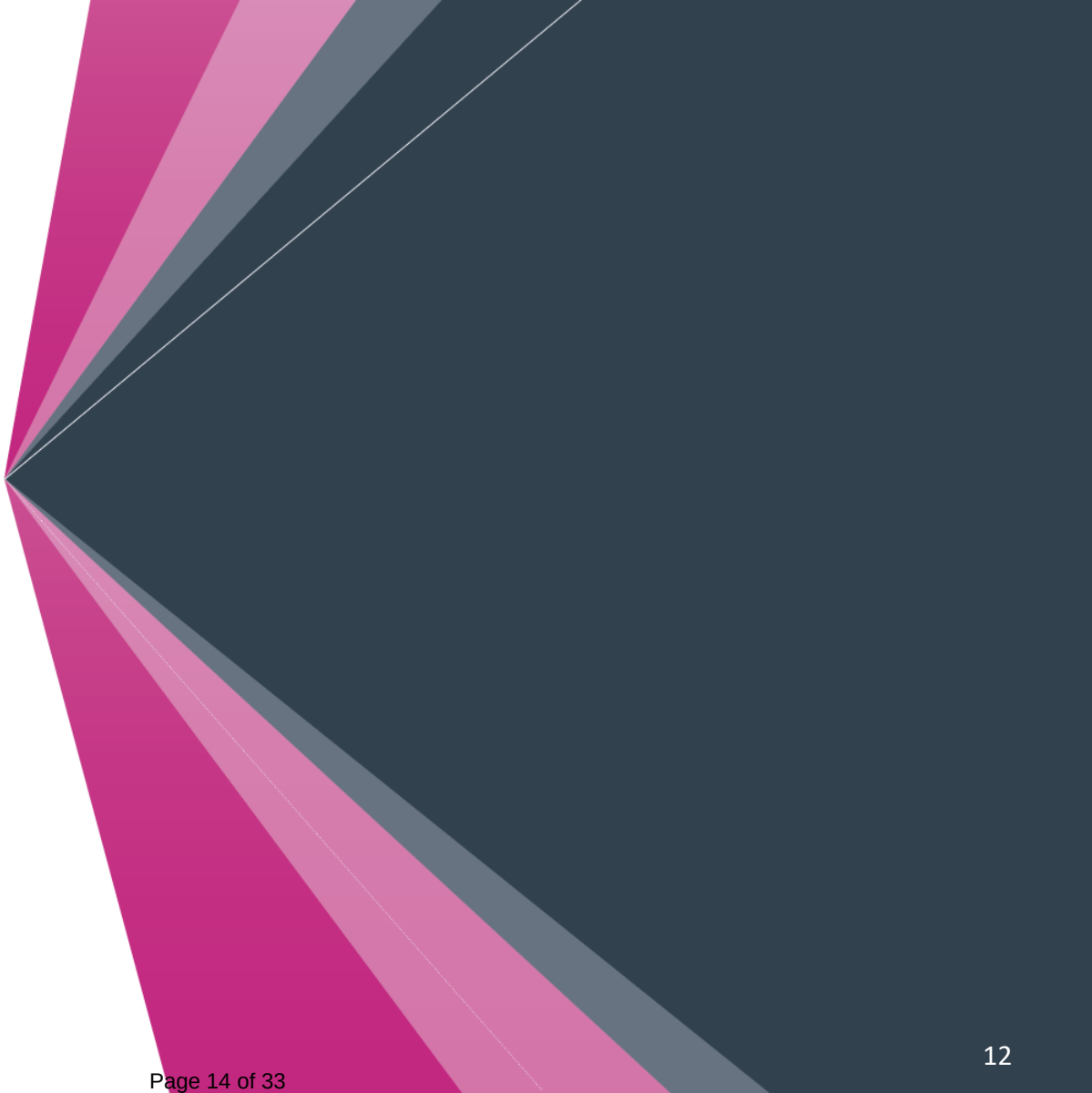
Quarterly People Heatmap – 2024/25 Q2 (NOTE: Pulse Survey outcomes updated to July 2024)

	THRIVE				EXCEL			BELONG				
	AWL as of M5 (August 24)	% Turnover	Vacancy Rate (AWL - WTE Worked)	Apprentice numbers (WTE)	Appraisals completed	Sickness absence	% Flexible working requests approved	Pulse Survey - Recommendation as a place to work	Pulse Survey - Staff Engagement	Pulse survey - sense of belonging	% of staff at Band 7 and above (BAME)	% of staff band 7 and above LID
UHS Overall	**13332**	**11.06%**	**434**	**619.4**	**72.90%**	**3.90%**	**68.90%**	**64.1%**	**6.84**	**65.2%**	**12.0%**	**13.1%**
Division A Overall	2514	9.3%	33	82.8	68.2%	3.9%	51.9%	57.3%	6.56	61.8%	14.7%	12.5%
Critical Care	659	10.0%	-13	19.7	71.6%	3.8%	0.0%	72.6%	6.75	65.9%	7.8%	9.1%
Ophthalmology	324	12.0%	16	10.2	43.9%	4.4%	75.0%	54.8%	6.72	67.1%	14.3%	7.1%
Surgery	596	10.9%	0	18.5	67.5%	3.2%	36.4%	51.6%	6.34	56.4%	7.7%	15.4%
Theatres & Anaesthetics	921	6.8%	27	33.5	75.1%	4.2%	56.7%	53.2%	6.51	58.8%	33.9%	16.1%
Division B - Overall	3546	11.0%	40	131.0	71.2%	4.2%	78.0%	61.9%	6.73	60.9%	13.4%	14.2%
Cancer Care	783	9.4%	-20	24.1	63.5%	4.3%	82.4%	53.2%	6.31	51.6%	18.3%	17.5%
Emergency Care	726	12.5%	-2	17.9	70.9%	4.2%	88.6%	57.9%	6.30	56.4%	10.1%	21.5%
Medicine	824	10.8%	2	37.5	85.5%	4.3%	8.3%	73.6%	7.22	71.9%	25.6%	7.0%
H&IOWAA	0	9.8%	0	1.0	90.0%	1.5%	100.0%	-	-	-	0.0%	10.7%
Pathology	624	12.7%	9	40.5	57.3%	4.4%	91.3%	60.2%	6.71	61.0%	12.2%	9.9%
Specialist Medicine	641	9.8%	-1	4.7	78.5%	4.0%	85.7%	64.1%	7.03	64.7%	9.7%	12.5%
Division C - Overall	2830	11.7%	82	148.6	69.7%	3.8%	70.5%	63.6%	6.79	63.5%	9.8%	12.4%
Child Health	923	9.7%	25	35.4	64.7%	3.9%	71.4%	60.4%	6.72	61.7%	4.3%	13.6%
Clinical Support	905	13.9%	34	85.6	76.6%	2.7%	76.5%	68.6%	6.86	65.3%	13.2%	10.3%
Women & Newborn	875	9.6%	22	22.2	68.9%	4.9%	70.8%	60.2%	6.75	63.0%	5.5%	17.8%
Division D - Overall	2519	11.1%	97	105.6	81.4%	3.8%	70.3%	66.6%	6.90	70.1%	15.5%	13.7%
CV&T	943	10.4%	34	47.6	78.8%	3.9%	75.0%	73.6%	7.12	72.0%	18.7%	15.8%
Neuro	486	12.2%	7	19.6	83.2%	4.4%	75.0%	57.6%	6.69	65.2%	19.4%	13.9%
Radiology	538	9.9%	34	17.7	86.8%	3.0%	75.0%	68.6%	6.84	75.4%	7.3%	9.8%
T&O	469	12.6%	14	15.4	79.6%	4.2%	40.0%	64.4%	6.89	67.0%	20.0%	10.0%
THQ - Overall	1753	12.0%	182	148.0	76.6%	3.8%	62.2%	67.3%	7.07	69.2%	10.2%	13.3%
Chief Finance Officer	125	8.3%	0	16.0	61.2%	2.7%	-	64.3%	7.17	73.3%	9.5%	14.3%
Chief Operating Officer	87	9.6%	4	3.0	56.4%	4.9%	-	66.7%	7.02	66.7%	11.1%	7.4%
Clinical Development	81	18.2%	-4	1.0	61.6%	2.8%	0.0%	66.7%	7.15	71.1%	10.9%	26.1%
Estates	347	13.8%	79	47.0	83.1%	6.0%	87.5%	56.6%	6.63	61.0%	2.2%	10.9%
Informatics	269	6.2%	19	22.9	71.8%	1.8%	66.7%	66.2%	6.99	68.5%	16.0%	7.4%
People / HR	172	16.5%	19	19.0	79.3%	3.4%	25.0%	74.3%	7.31	71.1%	2.7%	18.9%
R&D	397	14.7%	25	10.0	87.7%	3.9%	71.4%	75.3%	7.21	72.7%	14.8%	11.1%
Training & Education	226	6.8%	18	16.4	92.1%	2.9%	100.0%	79.4%	7.61	70.6%	10.5%	10.5%

NB: Care groups and THQ departments of < 50 WTE have been excluded from the above

* Pulse Survey participation rate was 21% (3,037 of 14,401 eligible staff headcount)

THRIVE

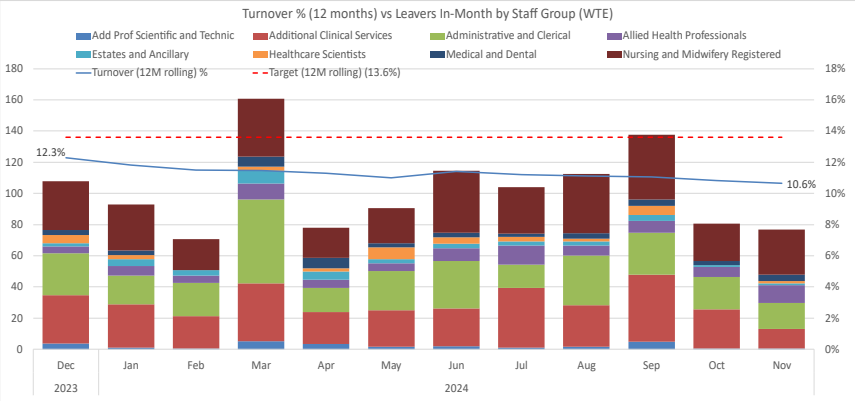


Substantive SIP by Staffing Group

Substantive Monthly Staff in Post (WTE) for last 12 months													
	2023/24 M9 (Dec)	2023/24 M10 (Jan)	2023/24 M11 (Feb)	2023/24 M12 (Mar)	2024/25 M1 (Apr)	2024/25 M2 (May)	2024/25 M3 (Jun)	2024/25 M4 (Jul)	2024/25 M5 (Aug)	2024/25 M6 (Sep)	2024/25 M7 (Oct)	2024/25 M8 (Nov)	M7 to M8 movement
Add Prof Scientific and Technic	403	402	401	402	397	400	396	396	401	301	301	300	-1
Additional Clinical Services	2146	2158	2152	2136	2135	2134	2130	2117	2099	2098	2088	2091	3
Administrative and Clerical	2328	2317	2304	2288	2248	2230	2223	2214	2199	2210	2222	2201	-21
Allied Health Professionals	698	698	700	696	703	700	699	688	686	808	815	813	-2
Estates and Ancillary	385	382	380	380	374	372	373	376	373	370	373	375	3
Healthcare Scientists	493	497	497	498	499	495	498	496	497	495	504	510	6
Medical and Dental	2137	2161	2183	2184	2165	2163	2161	2155	2217	2240	2244	2241	-3
Nursing and Midwifery Registered	4086	4069	4060	4053	4052	4039	4030	4025	3998	3998	4055	4038	-17
Students	53	53	58	58	58	58	58	58	58	58	58	56	-1
Grand Total	**12731**	**12737**	**12734**	**12695**	**12631**	**12590**	**12567**	**12524**	**12526**	**12578**	**12658**	**12625**	-33

Source: ESR substantive staff as of November 2024; includes consultant APAs and junior doctors' extra rostered hours, excludes CLRN, Wessex AHSN, UEL and WPL (same criteria as 23/24). Numbers relate to WTE, not headcount.

Turnover



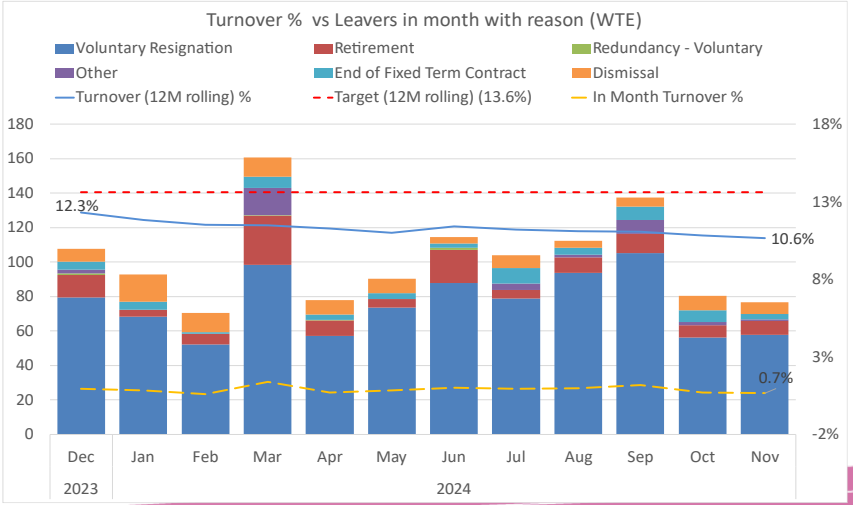
In November 2024, there was a total of 77 WTE leavers, 3 WTE less than October 2024 (80 WTE). The lowest since May 2024.
Division C recorded the highest number of leavers (19 WTE). Within Division C, Allied Health Professionals staff group had the highest number of leavers (7 WTE), followed by the Nursing and Midwifery Registered staff group at 5 WTE.

Divisions A and B had the second and third highest number of leavers (17 and 16 WTE respectively); with the largest numbers being Nursing and Midwifery Registered staff group for Div A (6 WTE), and Nursing and Midwifery Registered staff group for Div B (10 WTE).

Total leavers by division is as follows:

- **Division A: 17 leavers**
- **Division B: 16 leavers**
- **Division C: 19 leavers**
- **Division D: 14 leavers**
- **THQ: 12 leavers**

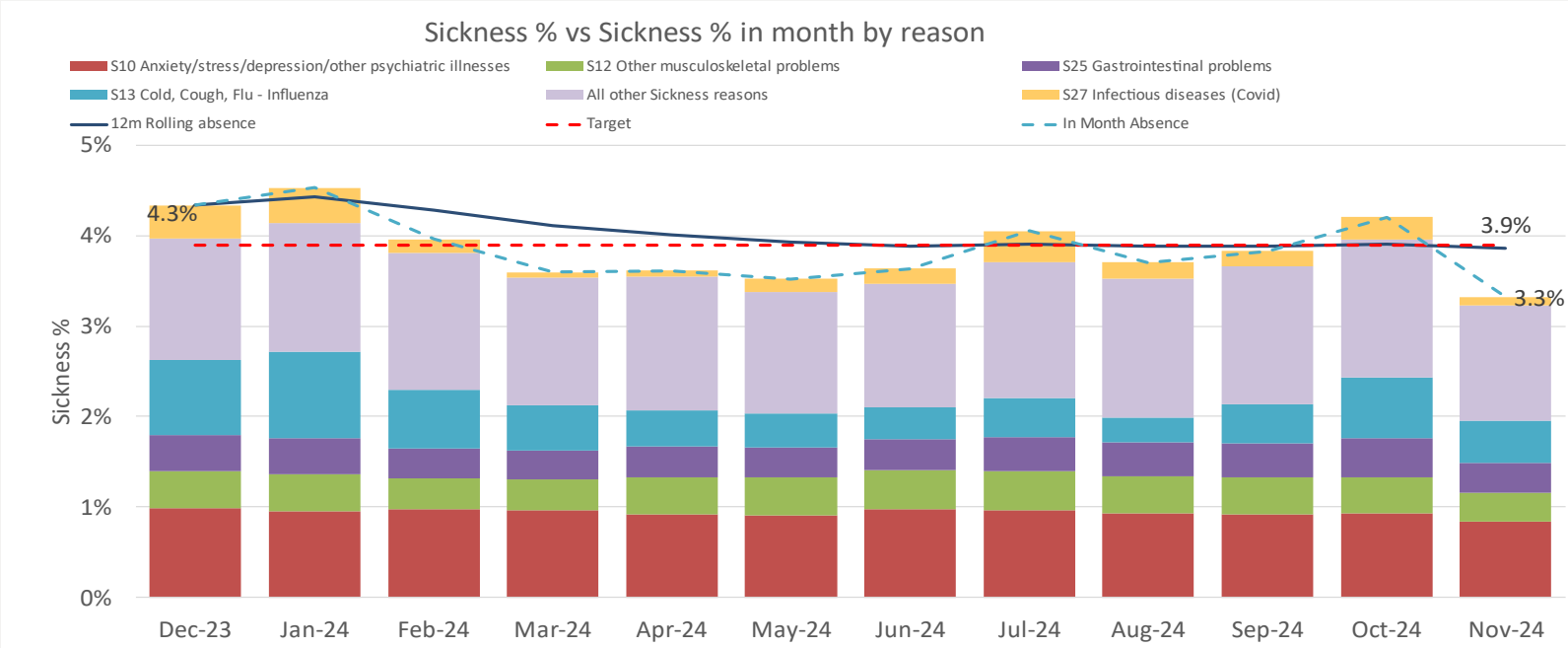
Staffing group	Leavers (WTE) in month	Turnover In-Month	Turnover 12m rolling %
Add Prof Scientific and Technic	0.5	0.2%	6.9%
Additional Clinical Services	12.7	0.6%	15.7%
Administrative and Clerical	16.6	0.7%	12.1%
Allied Health Professionals	11.4	1.4%	11.4%
Estates and Ancillary	1.0	0.2%	11.2%
Healthcare Scientists	1.6	0.3%	6.5%
Medical and Dental	4.2	0.5%	4.7%
Nursing and Midwifery Registered	28.7	0.7%	9.3%
UHS total	**76.7**	**0.7%**	**10.6%**



Source: ESR – Leavers Turnover WTE, ESR Staff Movement November 2024 (excludes junior doctors & hosted services)

Sickness

Current in-month sickness: 3% | Rolling 12-month sickness: 3.9%



Source: ESR – November 2024

Temporary Staffing

TEMPORARY RESOURCING

Qualified nursing demand/fill (WTE) status:

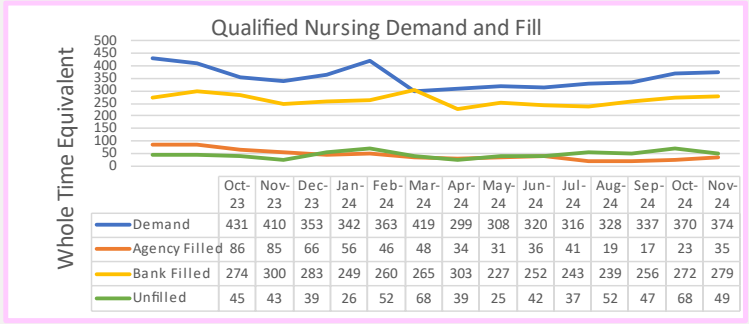
- Demand increased from 370 WTE in October to 374 in November (increase of 4), of which, bank filled 280, agency filled 35 (up 12 on prior month) and 49 remained unfilled.
- Bank fill for qualified nursing increased 1% on prior month (74%)
- Demand for qualified nursing is 36 WTE lower than in November 2023.

HCA demand/fill (WTE):

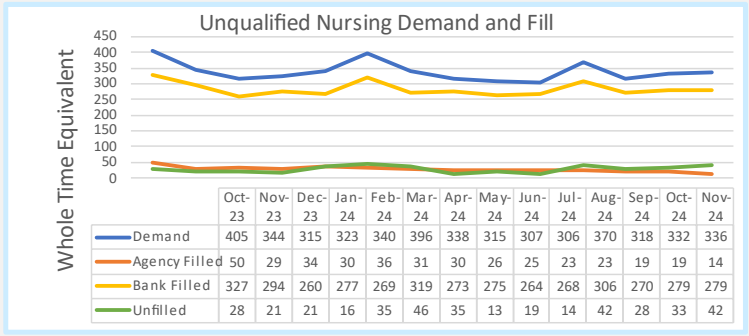
- Demand increased from 332 in October to 336, of which, bank filled 279, agency filled 14 WTE (all MH HCA's) and 42 remained unfilled.
- Bank fill for HCA decreased from 84.14% in October to 83.23% in November.
- Demand for HCA's is 8 WTE lower than November 2023.

Actions:

- Agency rate reduction plan – NHSi cap compliance for majority of shifts.
- SE Collaborative Bank rate project – reviewing UHS current Nursing rates.
- Migration of Mental health agency workers to NHSP on going for both Registered and Unregistered – agency switch off for band 2 January 2025.
- Re-launch Medical Students working as HCA at UHS to increase HCA pool.



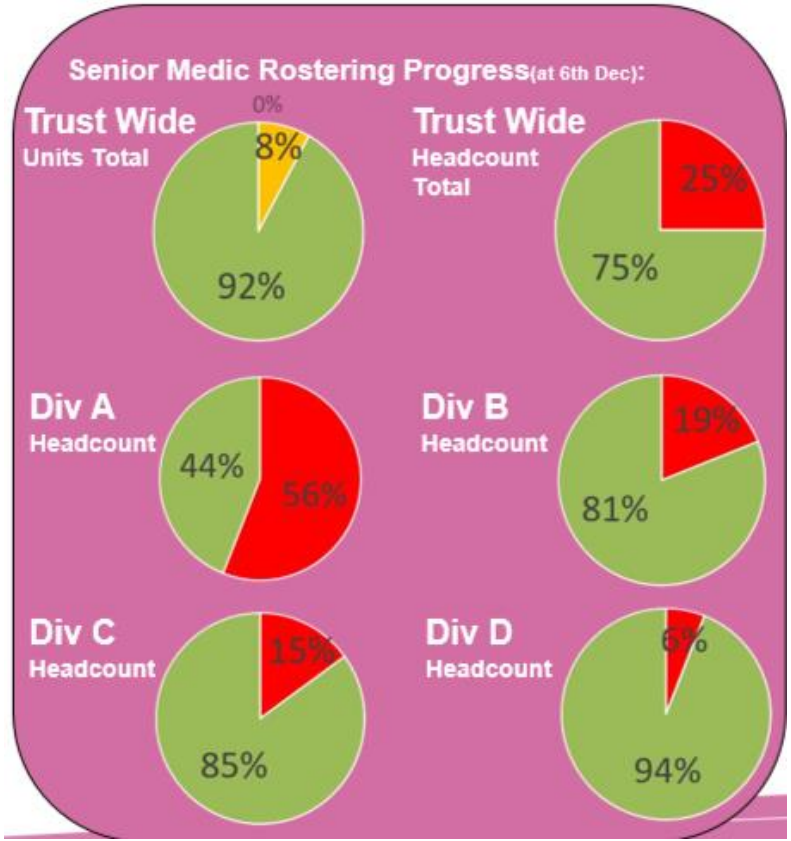
	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Demand	431	410	353	342	363	419	299	308	320	316	328	337	370	374
Agency Filled	86	85	66	56	46	48	34	31	36	41	19	17	23	35
Bank Filled	274	300	283	249	260	265	303	227	252	243	239	256	272	279
Unfilled	45	43	39	26	52	68	39	25	42	37	52	47	68	49

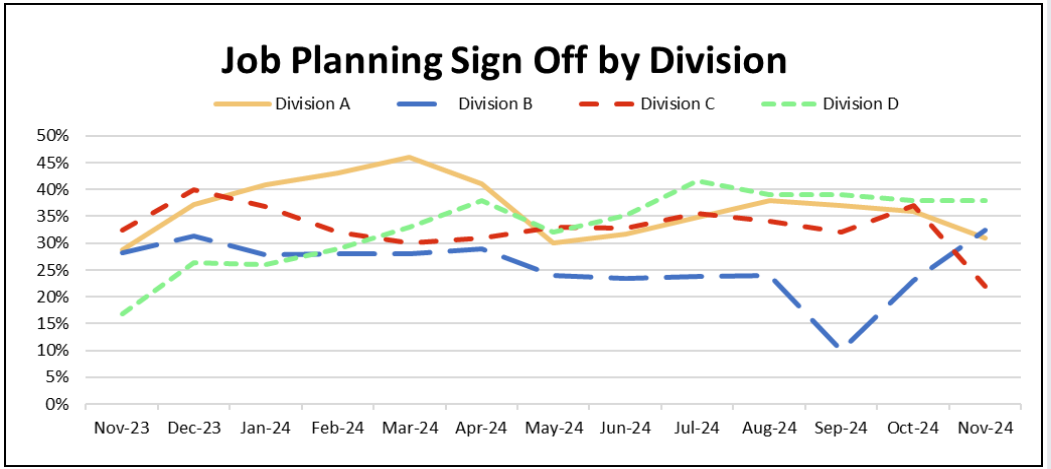


	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Demand	405	344	315	323	340	396	338	315	307	306	370	318	332	336
Agency Filled	50	29	34	30	36	31	30	26	25	23	23	19	19	14
Bank Filled	327	294	260	277	269	319	273	275	264	268	306	270	279	279
Unfilled	28	21	21	16	35	46	35	13	19	14	42	28	33	42

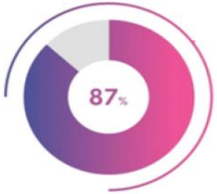
Source: NHSP November 2024

Workforce Deployment and Medic Online Utilisation





Signed off Job Plans



Active Job Plans

Job planning sign off levels at 32%
Active Job Plans up 1% to 87%.
We are now reporting monthly on Sign Off progress at Care Group Level to encourage improvement
Div C have extended the Sign Off of 22% of Job Plans into their second year, showing they didn't need changes. Reducing the admin burned on Senior Clinicians.

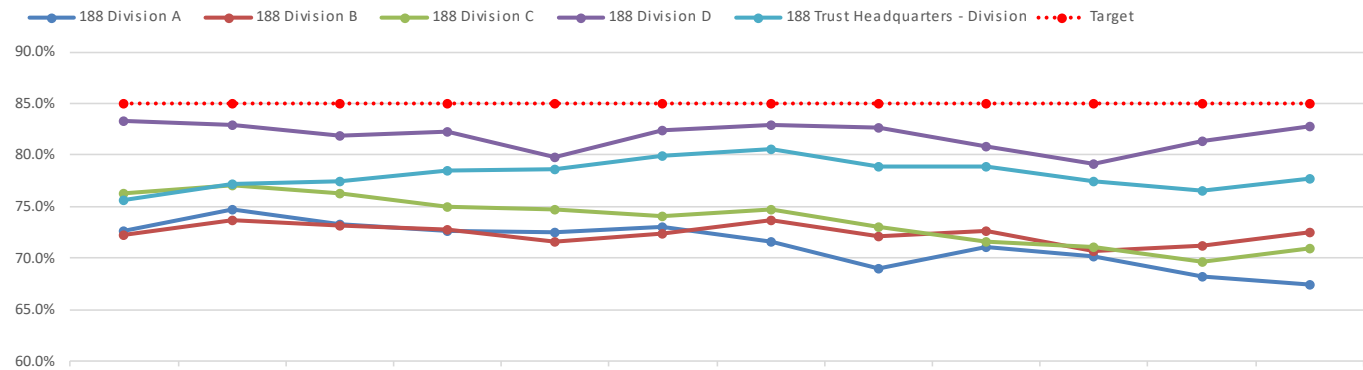
- VLE Job Planning Training launched.

EXCEL

Appraisals

Summary

The Trust's appraisal completion rate is 75% (700 appraisals completed) as of November 2024 (up from 74% in October 2024).

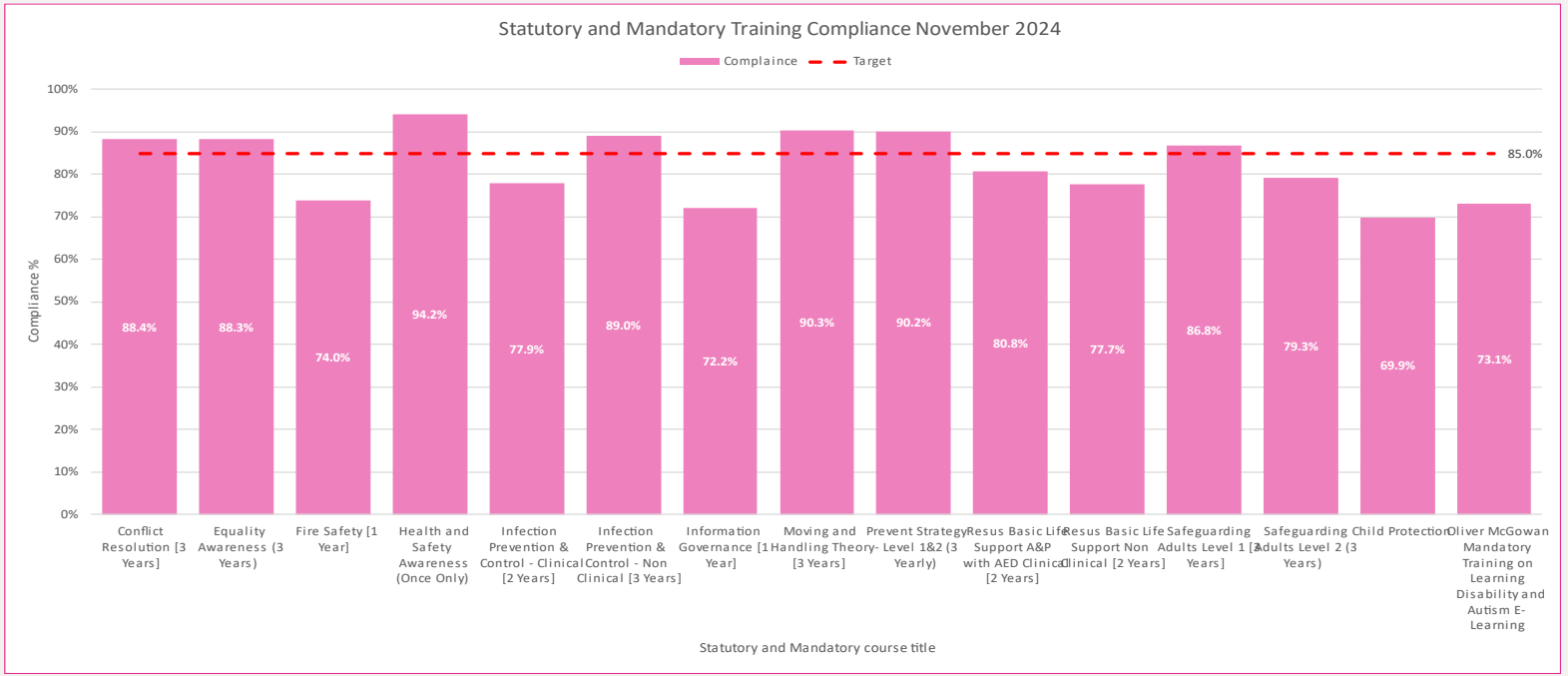


	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
188 Division A	72.6%	74.7%	73.3%	72.6%	72.6%	73.0%	71.6%	69.1%	71.0%	70.1%	68.2%	67.4%
188 Division B	72.2%	73.7%	73.2%	72.8%	71.6%	72.3%	73.6%	72.1%	72.7%	70.6%	71.2%	72.5%
188 Division C	76.3%	77.0%	76.3%	75.0%	74.7%	74.0%	74.7%	73.0%	71.5%	71.1%	69.7%	70.9%
188 Division D	83.3%	82.9%	81.9%	82.3%	79.8%	82.4%	83.0%	82.7%	80.8%	79.2%	81.4%	82.8%
188 Trust Headquarters - Division	75.7%	77.2%	77.4%	78.5%	78.6%	80.0%	80.6%	78.9%	78.8%	77.4%	76.6%	77.7%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Source: ESR – Appraisal data for Divisions A, B, C, D and THQ only (excluding Medical and Dental staff group) November 2024

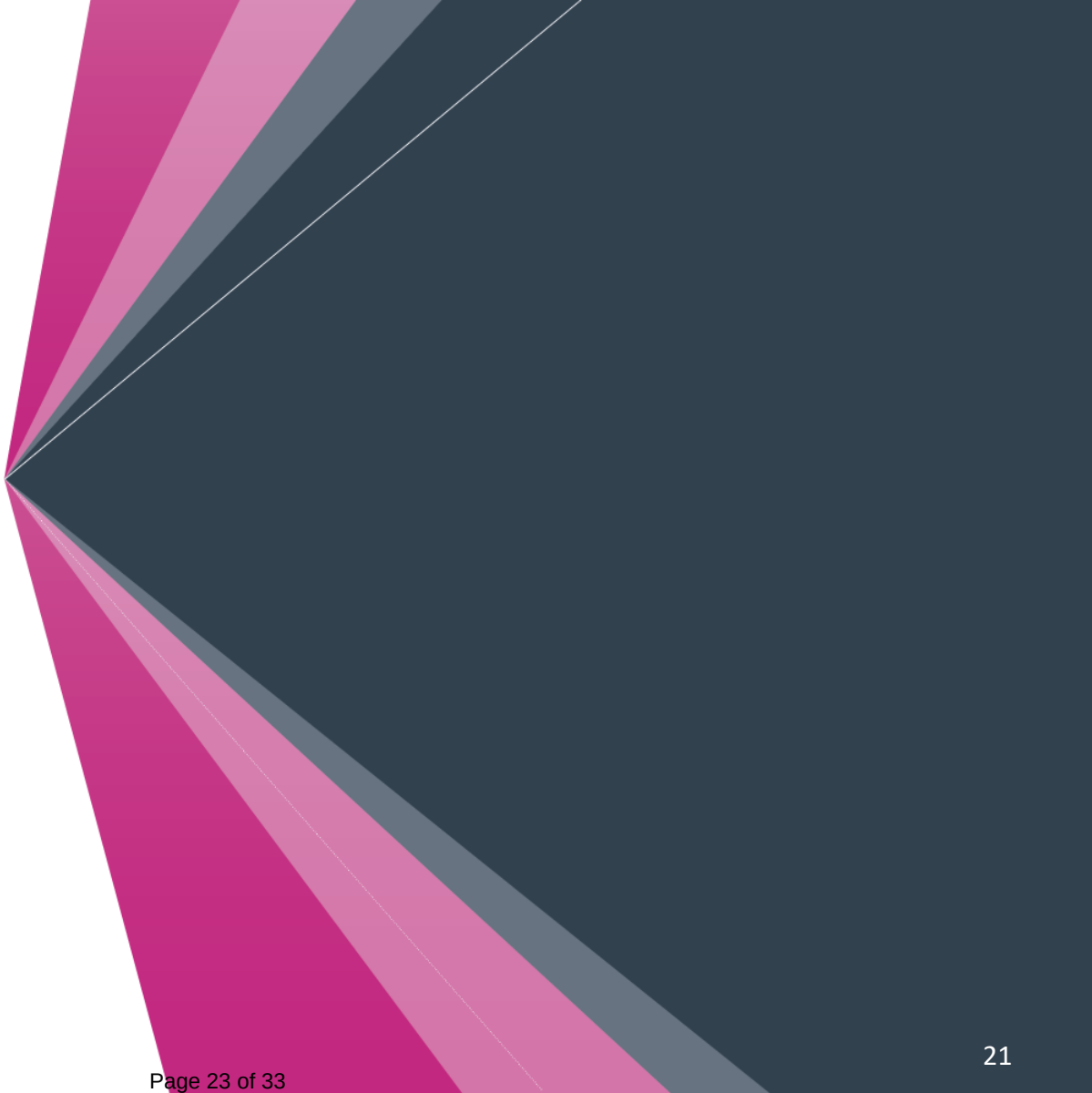
Statutory & Mandatory Training

The Trust's average completion rate for November 2024 is 80%, lower than October 2024 at 81% with 7 of 15 measures above the 85% target. Please note that the audiences for both Safeguarding Adults and Children is currently under review.

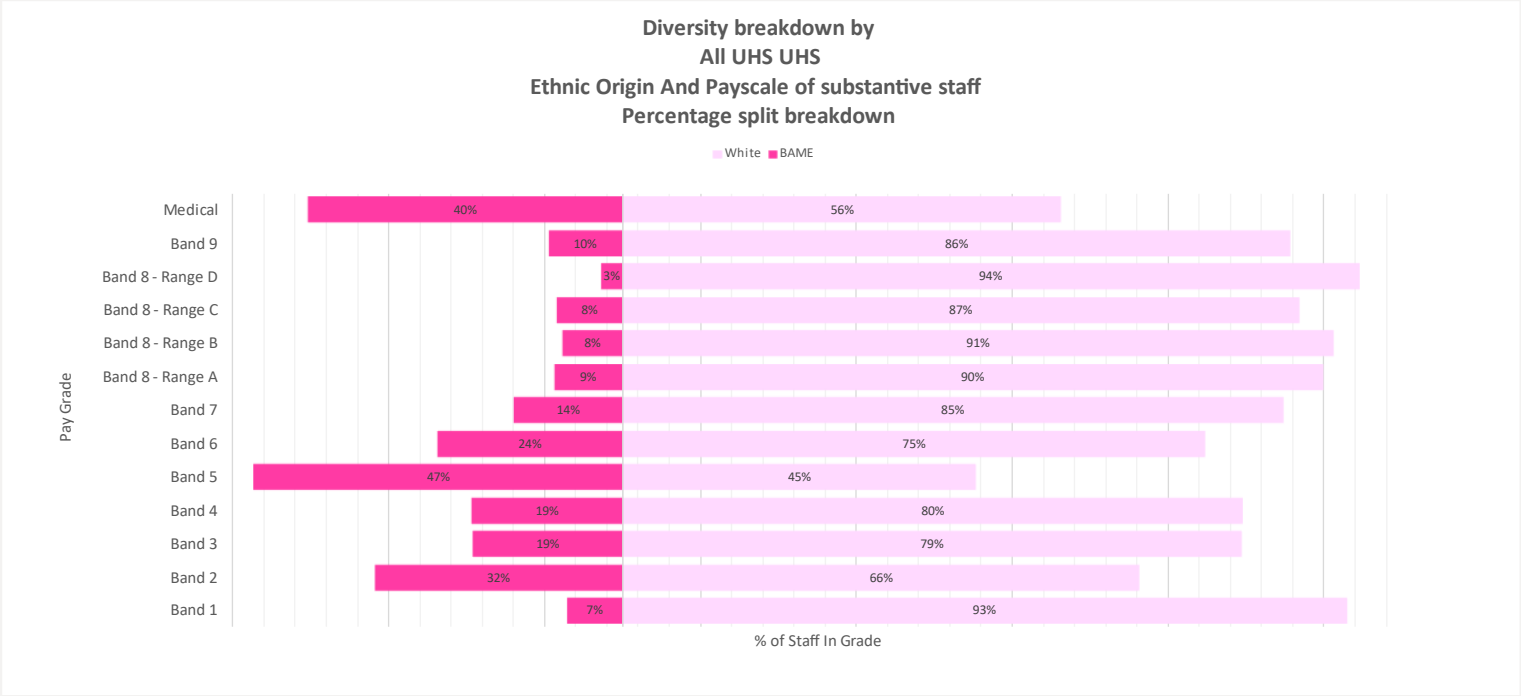


Source: Virtual Learning Environment (VLE) November 2024

BELONG

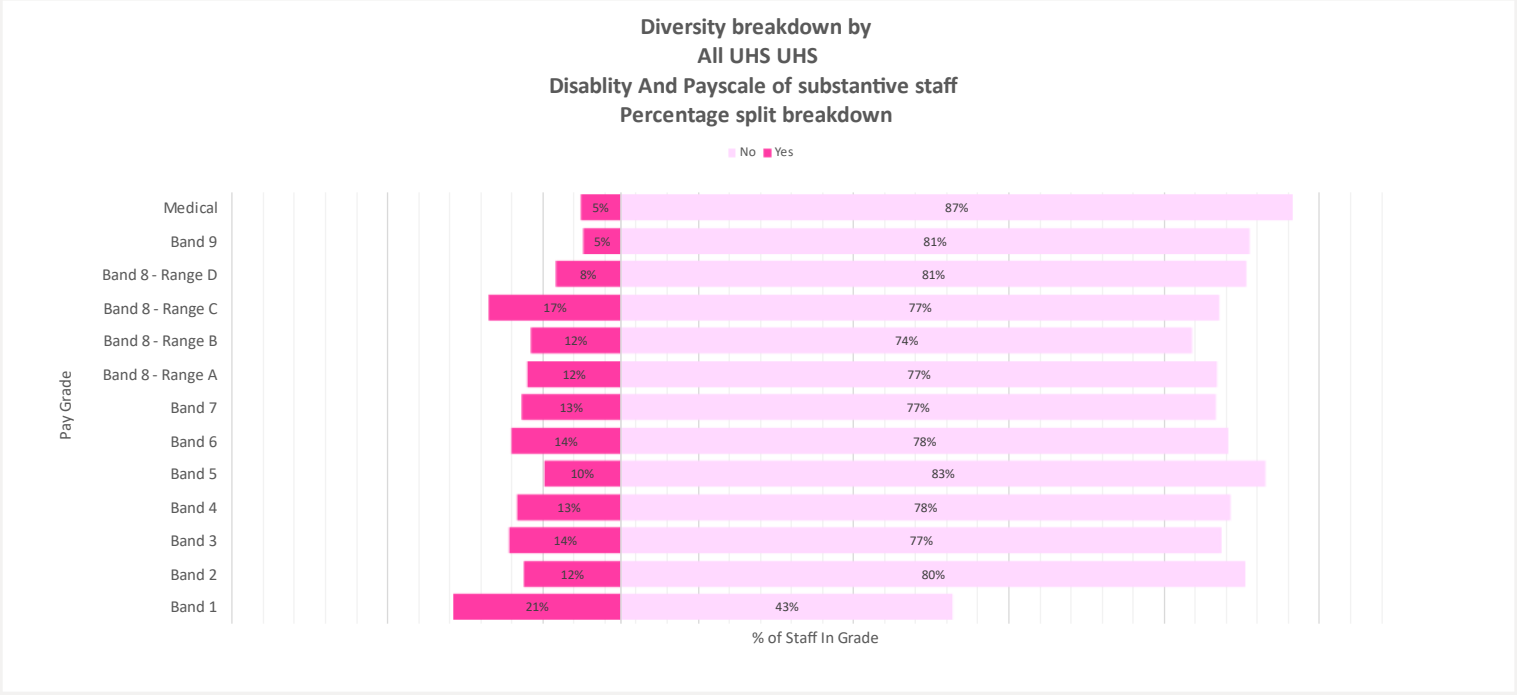


Staff in Post - Ethnicity



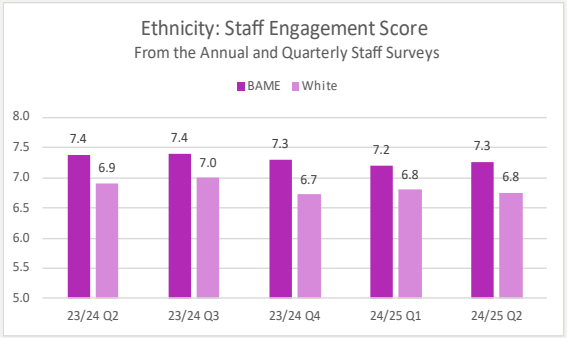
Source: ESR – November 2024

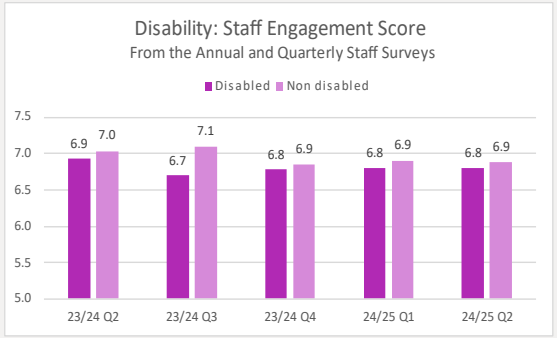
Staff in Post – Disability Status

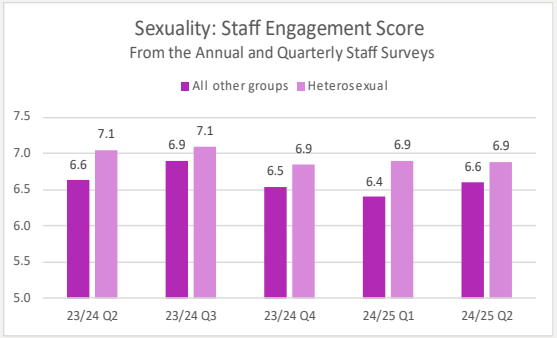


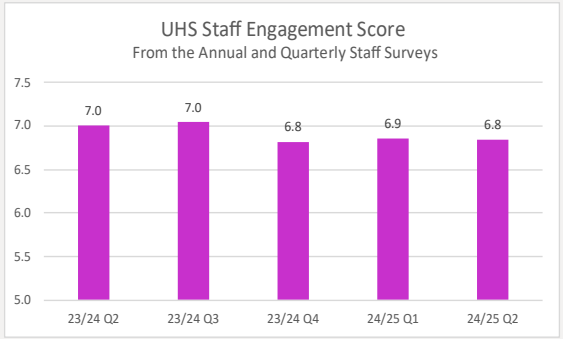
Source: ESR – November 2024

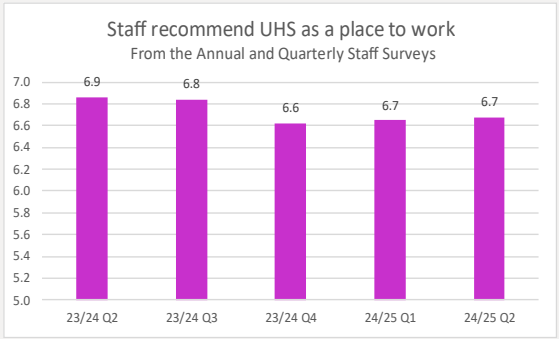
Pulse Survey – 2024/25 (July 2024)







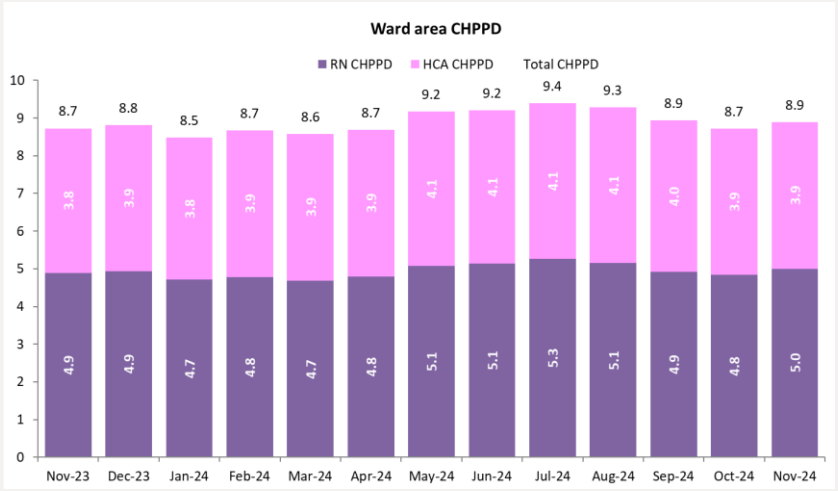




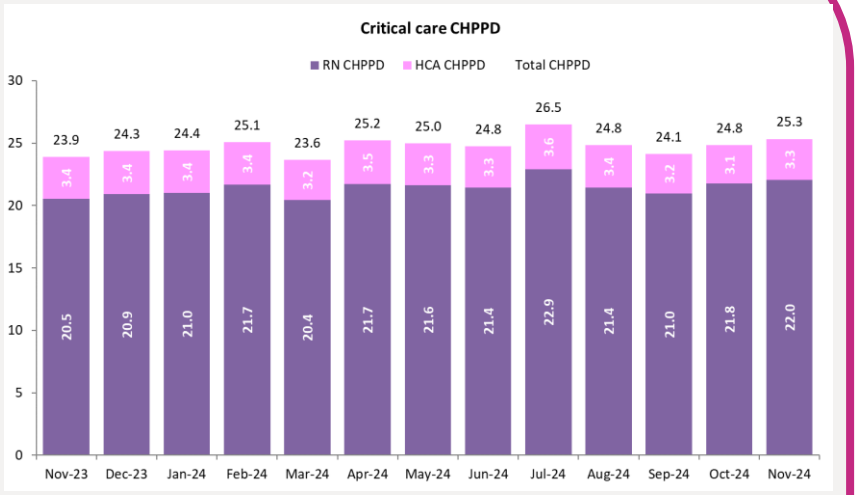
Source: Picker (Qualtrics)

The Ward areas CHPPD rate in the Trust has increased from last month to RN 5.00 (previously 4.84), HCA 3.89 (previously 3.88) overall 8.89 (previo

CHPPD



The Ward areas CHPPD rate in the Trust has increased from last month to RN 5.0 (previously 4.8), HCA 3.9 (previously 3.89) overall 8.9 (previously 8.7).

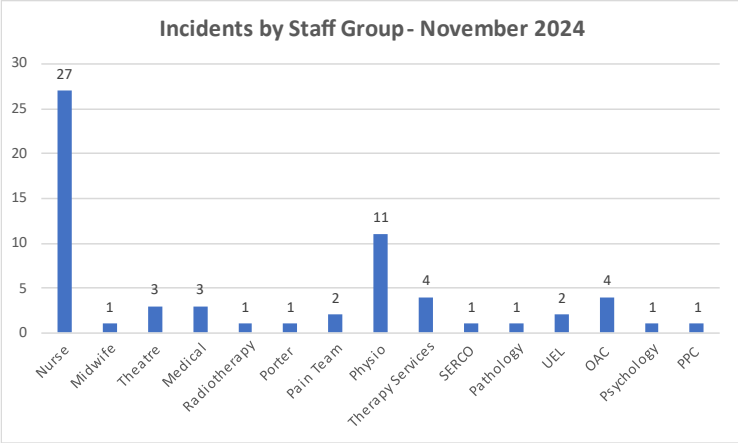


The CHPPD rate in Critical care has increased overall from last month. RN 22 (previously 21.8), HCA 3.3 (previously 3.1) overall 25.3 (previously 24.8).

Source: HealthRoster, NHSP & eCamis – November 2024

Patient Safety – Staffing Incidents & Red Flags

67 incident reports were received in November 2024 which cited staffing. This is a significant decrease on the 98 reported in October and represents a continued fall on the elevated level of 109 reported in March.



Incidents by Division November 2024 vs October 2024

Month Incident occurred	Division A	Division B	Division C	Division D	THQ	Trust total
Nov 2024	27	12	17	6	5	67
Total	27 ↑ (18)	12 ↓ (27)	17 ↓ (36)	6 ↓ (11)	5 ↓ (6)	67 ↓ (98)

Month Incident occurred	Division A	Division B	Division C	Division D	THQ	Trust total
Oct 2024	18	27	36	11	6	98
Total	18 ↑ (12)	27 ↑ (15)	36 ↑ (26)	11 ↑ (10)	6 ↓ (10)	98 ↑ (73)

Source: Safeguard System November 2024

Patient Safety – Staffing Incidents & Red Flags cont.

DIVISIONAL BREAKDOWN:

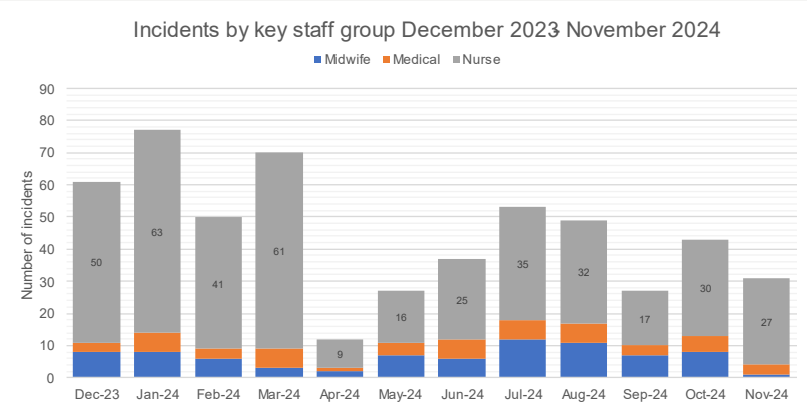
Div A:
Twenty-Seven incidents reported in November 2024, up on the 18 in the previous month. Red Flags were up from 1 to 7.

Div B:
Twelve incidents were reported in November (down from 27 in the previous month). Red flags were down from 21 to 9 and were spread evenly across all 4 reported categories.

Div C:
Seventeen incidents reported in November (down from 36 in the previous month). There were no red flags reported.

Div D:
Six incidents reported in November 2024 (down from 11 in the previous month). Red flags increased, with 7 reported (up from 5).

THQ:
Five incidents reported in November 2024 (down from 6 in the previous month). The incidents were reported across a range of services.



	Red flag category	Number of reports	Div A	Div B	Div C	Div D
November 2024	Delay in medication	5	1	1	0	3
	Delay in pain relief	6	2	2	0	2
	Delay in observations	6	2	3	0	1
	Less than 2 registered	6	2	3	0	1
	Total	**23**	**7**	**9**	**0**	**7**

	Red flag category	Number of reports	Div A	Div B	Div C	Div D
October 2024	Delay in medication	4	0	3	0	1
	Delay in pain relief	10	1	6	1	2
	Delay in observations	7	0	6	0	1
	Less than 2 registered	7	0	6	0	1
	Total	**28**	**1**	**21**	**1**	**5**

Source: Safeguard System November 2024

Appendices

UHS Workforce Plan 2024/25

WTE Movement Summary
Total reduction of -333 WTE
Substantive reduction of 176 WTE
Bank reduction of 133 WTE
Agency reduction of 24 WTE

KPIs
Sickness – **3.9%**
Turnover – **13.6%**

Governance
Via the People Board, Trust Savings Group, FIC, PODC, TEC

Substantive

Substantive WTE baseline is M12's closing position (12,695 WTE) and is projected to be 12,519 WTE (a **reduction of 176 WTE**).
NQNs (100 WTE), **IENs** (108 WTE), and **business case growth** (135 WTE) are included in growth

Bank

Bank WTE baseline is 788 WTE and is projected to be 655 WTE by March 2025 (a **reduction of 133 WTE** or 17%). Bank WTE has grown from December 2023 to March 2024 by 20% from 674 to 816 WTE

Agency

Agency WTE baseline is 127 WTE and is projected to be 103 WTE by March 2025 (a **reduction of 24 WTE** or 19%). Agency WTE throughout 2023/24 has been steadily reducing by over 40% and we closed agency under plan last year

Total WTE

By March 2025, there will be a total WTE **reduction of 333 WTE** from the baseline of 13,610 WTE (M12) to 13,277 WTE. Each of substantive, bank and agency are expected to reduce, with a bigger focus on temporary resourcing

Risks

Ensuring safe staffing
Affordability of workforce versus demand
System delivery of NCTR and Mental health reductions

Assumptions

National assumption of low/no Covid impact and low/negligible industrial action impact. There will be 50% reduction in **ncTR** and **mental health** (and WTE associated with both) and a stretch ambition of -120 WTE

Data Sources

Metric	Data Source	Scope
Industrial Action	HealthRoster	All staff rostered for strike action during IA periods
Substantive Staff in Post (WTE)	ESR (Month-end contracted staff in post; consultant APAs; junior doctors' extra rostered hours)	For 24/25 Exclusions: Honorary contracts; Career breaks; Secondments; WPL, CLRN, Wessex AHSN and list of Hosted networks within Divisions.
Additional Hours (WTE)	Overtime & Excess Hours; WLIs; Extra Duty Claims; non-contracted APAs	For 24/25 Exclusions: WPL, CLRN, Wessex AHSN and list of Hosted networks within Divisions.
Temporary Staffing (WTE)	Bank: NHSP; MedicOnline Agency: Allocate Staff Direct (Medical & Non-medical); all other framework and non-framework agencies	Exclusions: Vaccination activity
Turnover	ESR (Leavers in-month and last 12 months)	Trainee/junior doctors excluded
Sickness	ESR (Sickness absence in-month and last 12 months)	No exclusions
Appraisals	ESR (Appraisals completed in-month and last 12 months)	AfC staff only
Statutory & Mandatory Training	VLE	No exclusions
Staff in Post (Ethnicity & Disability)	ESR	No exclusions
Pulse Survey	Picker (Qualtrics)	No exclusions
Care Hours PER Patient Day (CHPPD)	HealthRoster (In-month shifts) eCamis (In-month daily patient numbers)	Clinical inpatient wards, Critical Wards, and ED only


WORLD CLASS PEOPLE

University Hospital Southampton NHS Foundation Trust

Agenda item 5.10 Report to the Trust Board of Directors, 7 January 2025	
Title:	Freedom to Speak Up Report
Sponsor:	Gail Byrne, Chief Nursing Officer
Author:	Christine Mbabazi, Freedom to Speak Up Guardian

Purpose:

(Re)Assurance	Approval	Ratification	Information
			x

Strategic Theme:

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

Executive Summary:

To provide an update on the Freedom to Speak Up (FTSU) agenda, cases, themes and actions taken and lessons learnt from the concerns raised.

1. Mechanism to support a culture where staff feel safe and can speak up about concerns.
2. Compliance with the raising concerns policy for the NHS following the recommendations made by Sir Robert Francis after the enquiry into Mid Staffordshire NHS Foundation Trust.
3. Compliance with the Public Interest Disclosure Act 1998.

Trust Board is asked to:

- Note the number of FTSU cases received to date.
- Note the lessons learnt from concerns raised.

Contents:

Paper
Appendix A

Risk(s):

1. Failure to keep improving services for patients and the working environment for staff.
2. Failure to support a culture based on safety, openness, honesty and learning.
3. Failure to comply with NHS requirements and best practice and commissioning contracts

Equality Impact Consideration:	N/A

1. Executive Summary / Purpose

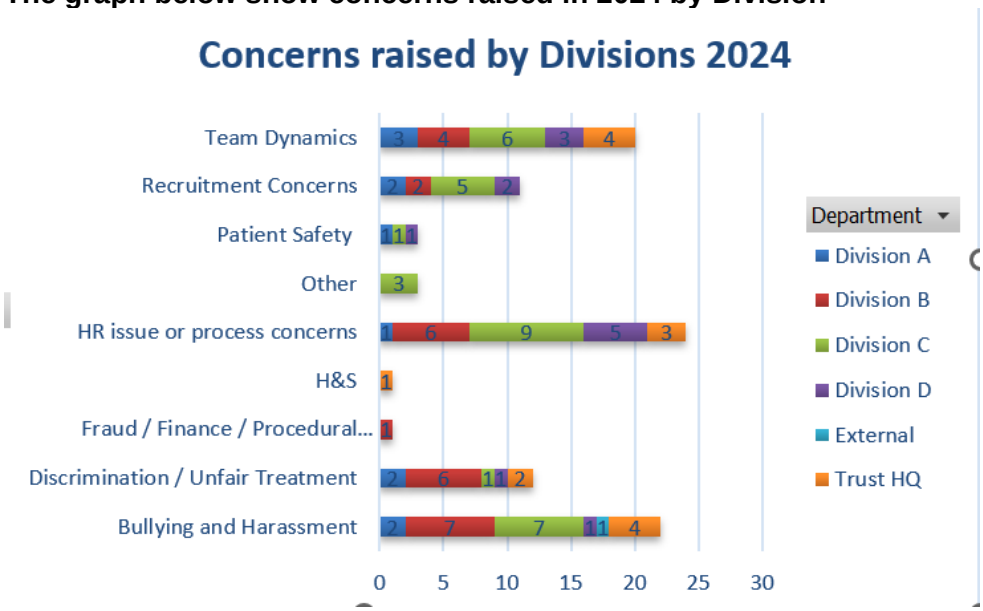
To provide an update following the last report written in June 2024. This report provides an update on the Freedom to Speak Up (FTSU) agenda. In addition, it also makes note of the lessons learnt from concerns raised to the FTSU guardian.

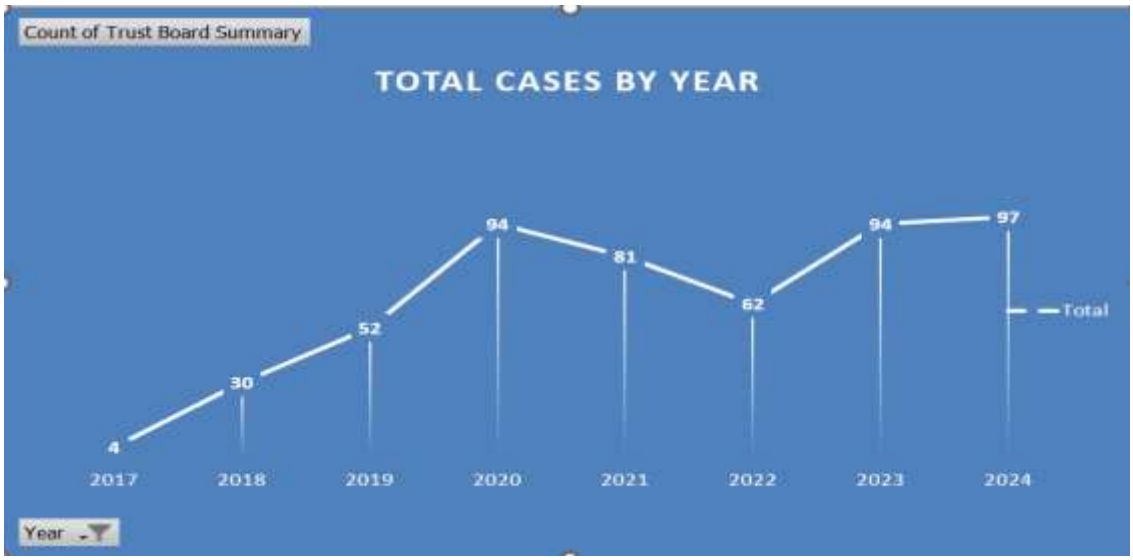
2. Key Issues

2.1 Case Update

From 13th May 2024 – 11th December 2024 the Trust has received 47 FTSU cases totalling to 97 cases in the year 2024. This is close to the same number of cases raised in 2023.

The graph below show concerns raised in 2024 by Division





The key themes this year have been HR issues or process concerns, bullying and harassment, and Team dynamics. Depending on different departmental needs and concerns HR has sought the help of the Trust's Organisational Development Team as well as the clinical psychologists to get involved resolving some of these issues.

2.2. Lesson Learnt from concerns raised

Listening to different concerns has led to a discovery of several things one of them being that the different management styles can foster the themes above or have the capacity to change the outcomes.

- Results oriented versus Relationship oriented managers

The social exchange theory suggests that relationships are formed and maintained based on cost benefit analysis which may explain why results oriented people tend to prioritise the direct contribution of relationships to their personal or professional goals. Relationship oriented people on the other hand place high value on the emotional and psychological aspects of a relationship. These differences can lead to conflict but both sides can adjust their approach to meet each other's needs.

- Compassionate leaders or managers

Compassionate leadership involves a focus on relationships through careful listening to, understanding, empathising with, and supporting other people, enabling those we lead to feel valued, respected, and cared for, so they can reach their potential and do their best work. A lack of this creates an environment of not being valued listened to or even supported, leading to conflict.

- Process-driven versus Outcome driven approach.

There are two ways to get things done. The outcome-driven and the process-driven approach. The outcome driven is all about results. If you want to get something done, focus on what you want to achieve and find the quickest and most efficient way to make it happen. Process-driven means prioritising processes and procedures to achieve objectives. The process-driven approach is about following steps to achieve the desired outcome. Both methods have advantages and disadvantages it is essential to know the difference and to choose the right one for the job otherwise sometimes this leads to conflict.

- The gap between intent and impact

In a conflict, one might be tempted to weigh intent over impact. If we focus on impact, we put perception ahead of intention. It is expected that everyone knows how their actions will be seen. Yet by assuming good intern, we make others unaccountable for negative impacts. Doing so minimises feelings, polices reactions and possibly marginalises minorities.

Bridging or widening the gap between our good intention and bad impact is all in how we respond. We may not be able to control the person's feelings, but that doesn't make them invalid. We cannot correct unintended results by minimizing feelings with words like; He did not mean to, I am sorry but, you are too sensitive.

3. UNITE industrial action for Porters

On 21st October UNITE initiate a strike ballot of it's members within the portering department at University Hospital Southampton. Porters are an invaluable part of the successful running of UHS and all we do for patients.

Prior to the ballot and having been made aware of the staff concerns, the Trust commissioned an independent external review seeking views of all the portering department.

The external review led to the following recommendations relevant to FTSU:

	Raising Concerns	
17	Behavioural Expectations	We suggest the Trust's Organisational Development Team work with the Department to develop and design a behavioural expectation framework with staff and leaders, to draw a clear line in the sand to what can be expected of each other in the workplace.
18	Raising Concerns	Increasing confidence and safety for raising concerns is vital for the development of culture and a safe working environment in portering. We would suggest the Trust Freedom to Speak up Guardian clarifies their role and the support available from them to staff. Additionally, the Department may benefit from HR training sessions on policy, procedures and support for raising concerns within the Trust.
19	Raising Concerns	Training should also be provided to the Department on the Ulysses incident reporting system, increasing confidence and competence using the system to raise concerns.
20	Raising Concerns	The leadership and management team should take steps to actively encourage staff in putting forward ideas and suggestions for improving the staff experience and patient care. When staff put forward ideas and suggestions, the team will need to consider how they can demonstrate to staff that they will be listened to, acknowledged and actively considered and how feedback will be provided to staff who have contributed.

The FTSU guardian will work with the department on the recommendations made in the report.

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

The FTSU Guardian and Champion network will continue to work with different teams to achieve the recommended actions from the external report above. The importance of doing this is to ensure that we create a culture where patients and staff safety are at the centre of what we do.

- **Recommendation**

Trust Board is asked to:

- Note the number of FTSU cases received to date.
- Note the lessons learnt from concerns raised.

Appendix A – FTSU CASES 14/05/2024 – 04/12/2024

Yea	Qt	Date Concern Raised	Month Rais	Departm	Contact Method (Internal / External)	Trust Board Summary
2024	Q1	23/05/2024	May	Division C	Internal	HR issue or process concerns
2024	Q1	31/05/2024	May	Division C	Internal	Team Dynamics
2024	Q1	01/06/2024	June	Trust HQ	Internal	HR issue or process concerns
2024	Q1	10/06/2024	June	Division D	Internal	HR issue or process concerns
2024	Q1	11/06/2024	June	Division C	Internal	HR issue or process concerns
2024	Q1	13/06/2024	June	Division C	Internal	HR issue or process concerns
2024	Q1	13/06/2024	June	Division D	Internal	HR issue or process concerns
2024	Q1	14/06/2016	June	Division C	Internal	HR issue or process concerns
2024	Q1	14/06/2024	June	Trust HQ	internal	H&S
2024	Q1	25/06/2024	June	Division B	internal	Bullying and Harassment
2024	Q1	26/06/2024	June	Division D	Internal	Team Dynamics
2024	Q1	26/06/2024	June	Division D	Internal	Team Dynamics
2024	Q2	05/07/2024	July	Division B	Internal	Team Dynamics
2024	Q2	08/07/2024	July	Division D	Internal	Team Dynamics
2024	Q2	09/07/2024	July	Division C	Internal	Team Dynamics
2024	Q2	09/07/2024	July	Division B	Internal	Team Dynamics
2024	Q2	17/07/2024	July	Division B	Internal	HR issue or process concerns
2024	Q2	22/07/2024	July	Trust HQ	Internal	Team Dynamics
2024	Q2	26/07/2024	July	Division B	Internal	Bullying and Harassment
2024	Q2	31/07/2024	July	Division D	Internal	HR issue or process concerns
2024	Q2	06/08/2024	August	Division A	Internal	Bullying and Harassment
2024	Q2	12/08/2024	August	Division D	Internal	Patient Safety
2024	Q2	29/08/2024	August	Trust HQ	internal	Team Dynamics
2024	Q2	03/09/2024	September	Division D	Internal	Recruitment Concerns
2024	Q2	13/09/2024	September	Division A	Internal	Team Dynamics
2024	Q2	11/09/2024	September	Division C	Internal	Team Dynamics

Yea	Qt	Date Concern Raised	Month Rais	Departm	Contact Method (Internal / External)	Trust Board Summary
2024	Q2	28/09/2024	September	Division B	Internal	Fraud / Finance / Procedural Fairness / Data Manipulation
2024	Q2	30/09/2024	September	Division D	Internal	HR issue or process concerns
2024	Q2	30/09/2024	September	Division B	Internal	Bullying and Harassment
2024	Q3	11/10/2024	October	Division C	Internal	Bullying and Harassment
2024	Q3	16/10/2024	October	Division A	Internal	Team Dynamics
2024	Q3	01/11/2024	November	Division C	Internal	Team Dynamics
2024	Q3	05/11/2024	November	Division B	internal	Team Dynamics
2024	Q3	08/11/2024	November	Division C	Internal	Bullying and Harassment
2024	Q3	06/11/2024	November	Division C	Internal	Discrimination / Unfair Treatment
2024	Q3	06/11/2024	November	Division C	Internal	other
2024	Q3	06/11/2024	November	Division C	Internal	HR issue or process concerns
2024	Q3	06/11/2024	November	Division D	Internal	Discrimination / Unfair Treatment
2024	Q3	20/11/2024	November	Division C	Internal	HR issue or process concerns
2024	Q3	21/11/2024	November	Division D	External	HR issue or process concerns
2024	Q3	21/11/2024	November	Division B	Internal	HR issue or process concerns
2024	Q3	28/11/2024	November	Division C	Internal	HR issue or process concerns
2024	Q3	28/11/2024	November	Trust HQ	Internal	Bullying and Harassment
2024	Q3	29/11/2024	November	Division B	Internal	Discrimination / Unfair Treatment
2024	Q3	02/12/2024	December	Division B	Internal	Recruitment Concerns
2024	Q3	02/12/2024	December	Division C	Internal	Bullying and Harassment
2024	Q3	04/12/2024	December	Division B	Internal	Discrimination / Unfair Treatment

University Hospital Southampton NHS Foundation Trust

Agenda item 5.11 Report to the Trust Board of Directors, 7 January 2025	
Title:	Guardian of Safe Working Hours Quarterly Report
Sponsor:	Paul Grundy, Chief Medical Officer
Author:	Dr Diana Hulbert, Emergency Medicine Consultant & Guardian of Safe Working Hours

Purpose

(Re)Assurance	Approval	Ratification	Information
			x

Strategic Theme

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

Executive Summary:

In March 2024 NHS England issued the Priorities and National planning Guidance for 2024/25. This included the changes expected to be made to improve the working live of our staff, including the resident doctors.

A letter was sent to all NHS People Leaders in April 2024 regarding a number of actions expected for all Trusts to take in relation to Residents. At UHS we established a group to deliver these actions.

The vacancy rate for resident doctors is currently 9.16 %, in keeping with previous years.

The amount spent on locums covers both short-term vacancies and longer-term gaps in the rotas. The controls on the locum request process reflect a need for clear financial governance around staffing spending and is seen in all NHS trusts. In the last four months there have been 4,668 locum requests, 85.14 % of which were filled by the Medical Locum Bank.

The Exception Reporting system reveals the self-reported hours worked above those contracted and also highlights missed educational opportunities.
In the last four months there have been 252 reports received.

Contents:

Quarterly Report – Guardian of Safe Working
Appendix 1 - Improving the Lives of Residents at UHS
Appendix 2 – Vacancy data
Appendix 3 – Medical Locum Bank data

Risk(s):

3a: We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles.
3b: We fail to develop a diverse, compassionate, and inclusive workforce, providing a more positive staff experience for all staff.

Equality Impact Consideration:	N/A

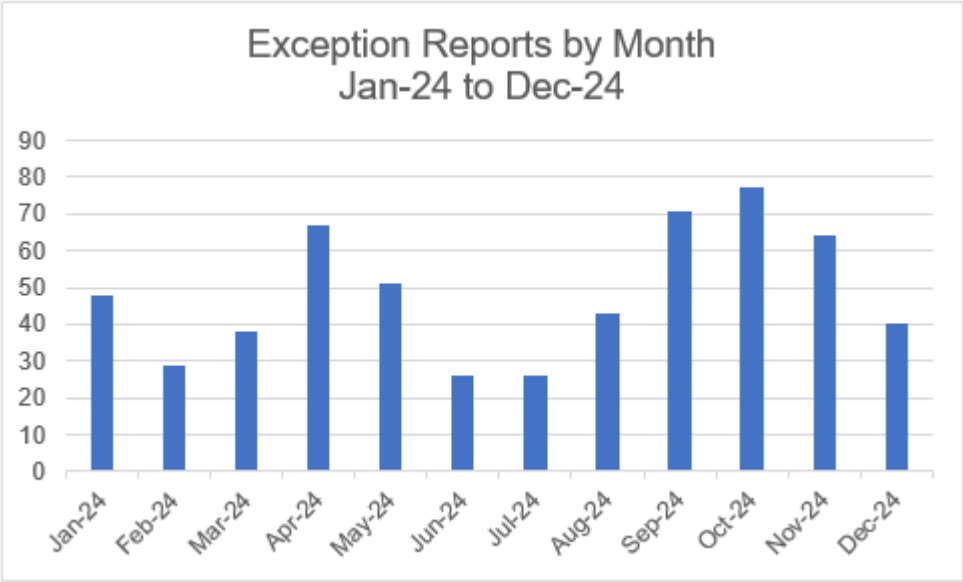
Quarterly Report - Guardian of Safe Working Hours

Employment

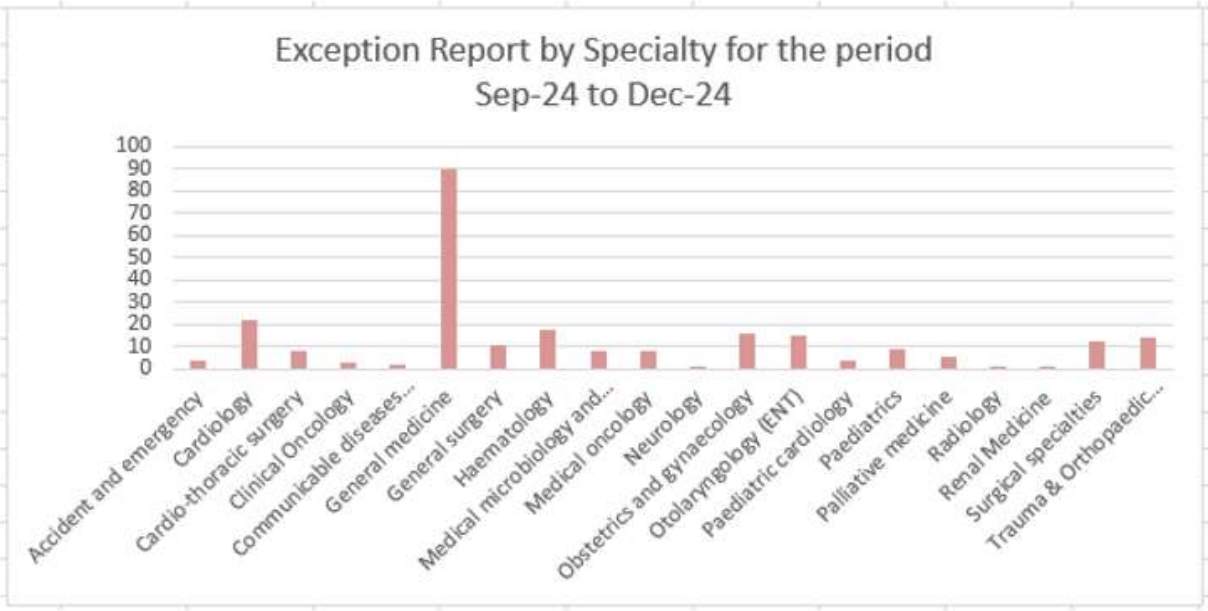
In December 2024 the vacancy rate for resident and local employed doctor posts across the Trust was 9.16%.
Recruitment continues for current approved vacancies and Medical HR are working with departments to plan for future gaps. (Appendix 2)

Exception reporting

There were 580 exception reports received over last 12 months, which is an average of 48 per month:



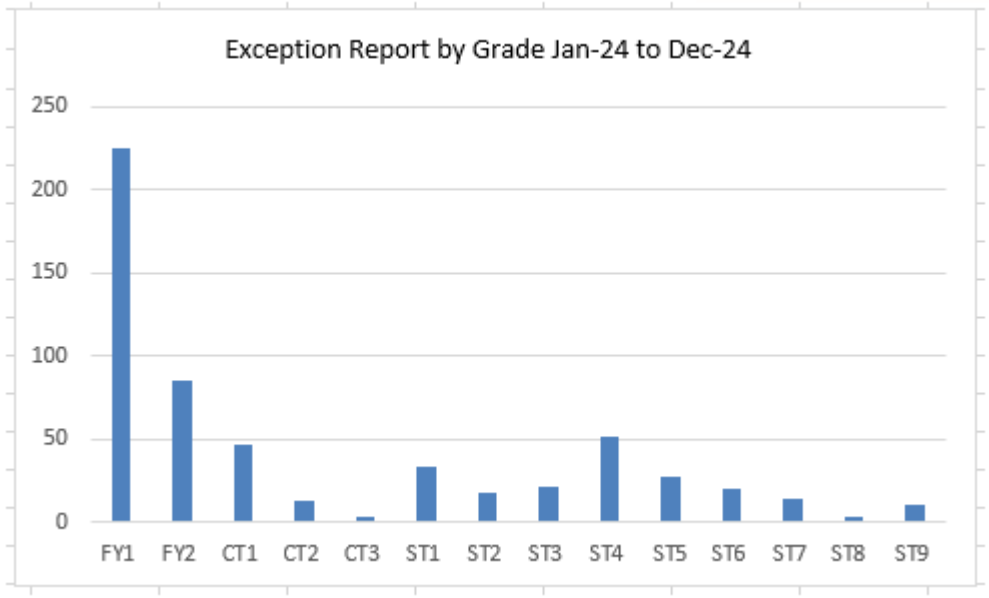
Exception reporting over the four months has been highest in General Medicine

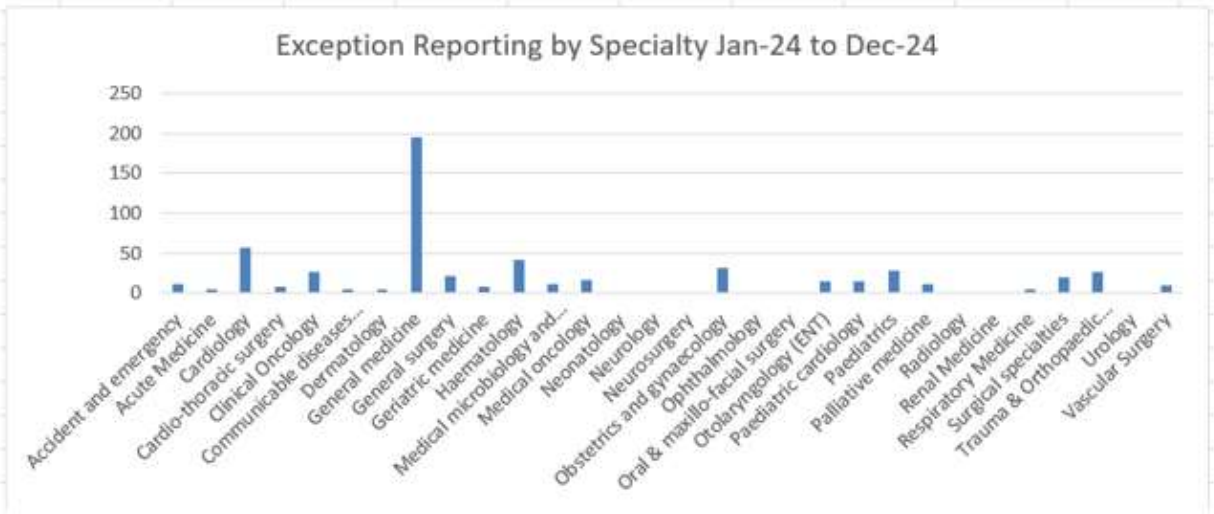


The most common reason for the submission of an exception report is additional working hours and the most common resolution is additional payment for the additional hours worked.

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

As has always been the case the majority of the exception reports received are from FY1 Doctors.





Self-Development Time (SDT)

All doctors are given two hours of dedicated SDT each week to be used in addition to their formal training hours; this is recorded in the doctors' work schedules.

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 accordingly.

In the last 12 months we have received one exception report stating missed SDT.

Activity

The Resident Doctor Executive Committee, led by the Chief Registrar, meets quarterly to bring together representatives of the Residents from all the care groups, the Guardian, the DME and members of the UHS Executive. These meetings facilitate discussion between the Residents (via their reps) with senior figures in the Trust who can help effect change.

The Resident Doctor Forum, also led by the Chief Registrar, meets monthly and acts as an open and informal meeting to allow easy communication between the Residents, the Chief Registrar, the Guardian, the DME, and the Medical Workforce Team. We are encouraging in-person meetings for this forum to generate more open discussions.

The Guardian and Medical Workforce Team attend monthly Trust induction to ensure that all the Residents who join UHS feel connected to the team and can ask for help and advice.

The new Chief Registrar, Dr Guendalina Bonnifacio (a senior doctor in training in neurology), has set out an ambitious programme of projects for her year in post. These include a project to provide a management teaching programme for the Registrars at UHS.
I am delighted that UHS continues to support this role which is invaluable for Resident engagement and representation.

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.

Work intensity remains high and the impact of the covid pandemic on the health-seeking behaviour and health anxiety of patients and on the rather stuttering recovery of the NHS generally remains difficult to quantify but still feels significant.

The impact of staff sickness continues to be huge, particularly with recent flu cases, and rotas can be over-stretched. It is not only medical staff sickness that impacts medical rotas; shortages in other professional groups have a significant effect on Residents' work patterns as the hospital becomes inefficient and doctors take on tasks usually carried out by other members of the MDT. This tends to particularly impact the out of hours work burden for some Residents.

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 use of the Medical Locum Bank system has led to more efficient and timely coverage of short-term rota gaps. In addition, specialties with significant challenges are becoming easier to identify earlier, allowing more effective intervention. In the last 4 months 85.41% of the unfilled required duties that have been sent to the locum bank duties have been filled.

The significant expenditure on locums suggests that regular reviews of medical and non-medical staffing is required to ensure appropriate staffing levels are maintained.
Any uplift in the workforce will need innovative solutions for staffing patterns and recruitment but would undoubtedly help retention. (Appendix 3)

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

There is greater transparency, more consistency, and a better understanding around rotas and rota gaps. It is important to recognise that there are some particularly hard-pressed specialties including Emergency Medicine and Paediatrics and this is reflected in the locum pay rates.
I am hopeful that these pay agreements will continue to be successful and acceptable to all. There will be regular review of the agreements. It will be particularly important to review the needs of the most hard-pressed specialties by assessing the regularity with which exceptional payments are requested, the number of unfilled locums and the number of exception reports.

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 teams in various departments rather more than through the exception reporting system.
The most fruitful discussions which generate the best understanding of the challenges and offer some solutions come from informal meetings with the Residents themselves.
This workforce is bright, engaged and innovative and able to ask to solve problems in a practical and informed way. I suspect it is an untapped source of solutions.

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 resident doctor workforce.

These issues/ challenges are the subject of the work that I do with the Residents, the DME, the Chief Registrar, the Medical Workforce Team led by Becci Mannion, the Executive and other colleagues.

The main concerns include local induction, provision of non-clinical space, IT provision and the presence of sleep rooms after night shifts.

I am delighted that Dr Kate Nash, the DME, has taken on the challenge of local induction for the Trust as this is regularly highlighted as an area of concern by the Residents.

Members of the Executive are helping Kate and I review the provision of non-clinical spaces alongside our Chief Registrar. The scoping exercise has revealed a number of challenges in many areas of the hospital. In most areas of the Trust the lack of space impacts all sectors of the workforce.

We are re-examining the provision of sleep rooms to ensure we make the system simple and effective.

A significant aim for UHS is the understanding of the different expectations of different generations of doctors.
In a big teaching hospital trust with more than 1000 doctors in training and more than 1000 consultants and SAS doctors it can be difficult to fully understand how people feel. It is only by walking in peoples' shoes that we can understand how to create a happy workforce who can give their best to UHS.
Many doctors at UHS embark on a new career in an unfamiliar city (sometimes in an unfamiliar country) in a big Trust where they know no one, have no support system and may be working an antisocial shift system. Some residents in this situation may only have four months to understand, assimilate and succeed before moving on to another team. It is the provision of support in all its forms that determines the ability to thrive.

If I were to offer an ambitious suggestion it would be to view doctors in short-term posts as having unique challenges and treat them accordingly.
Historically different professional groups were viewed and treated differently; over the last 20 years we have endeavored to ensure that the highest standards of care are given to all. However, there is a unique challenge in being in a short-term post dictated by career necessity, not by choice.

Some of our residents will not only be at UHS for only six months, they will only be in Hampshire for six months. In some cases this may be their first job in the UK.
We expect them to manage their job and their life with relatively little practical support at a time when they are isolated socially and new to everything in their professional and private life.

I believe that, in the short-term at least, UHS should try to be their family and offer robust support which is more granular than the induction package we can offer at present.

I was delighted to be part of a Study Day for members of the Executive and Non-Executives which focused on the lives of Residents in 2024. The lived experience of the six Residents who were part of the presentation were particularly valuable and gave a real insight into the highs and lows of the working lives of Residents.

I would like to conclude by offering huge thanks to the Becci Mannion, Lynne Stassen and their team who work so hard to provide rotas which work so effectively for the doctors, the teams and the patients at UHS.

Great thanks also to Ellie Starkey (outgoing Chief Registrar) Guendalina Bonnifacio (Chief Resident) and Angharad Chilton (deputy) who have been superb in their additional roles.

Final thanks to the Executive team (particularly Joe, Paul and Steve) who continue to engage with the challenges facing these doctors so positively.

I would like to include my particular thanks to Joe Teape who has always been a passionate supporter of the Resident doctor workforce showing real understanding of their specific needs and a commitment to ensuring that UHS is dedicated to improving their lot.
Joe - we shall miss you.

Appendix 1 - Improving the Lives of Residents at UHS

1. On 27 March 2024, NHS England published the Priorities and Operational Planning Guidance for 2024/25. Amongst other priorities, the publication set out the expected changes to be made locally and nationally to improve the working lives of our staff, including junior doctors, by addressing some of the most widely felt frustrations that adversely impact their experience working in the NHS.

2. On 25 April 2024, a letter from NHS England was sent to NHS People Leaders regarding a number of actions for trusts relating to junior doctors, including issues requiring board visibility.

3. Representatives for medical workforce and medical HR from UHS reviewed the letter and its required actions on 14 May 2024 with a view to conducting a gap analysis; please see appendix for reference.

4. The summary of that gap analysis is as follows:

Objective	**UHS progress to date**
Increase choice and flexibility	We have made good progress on this; it can be hard to determine how many work schedules have been provided eight weeks in advance as the picture is changing regularly. The deanery issues the details of the Deanery training rotations to UHS so this information is not within our control.
Reduce duplicative inductions and pay errors	Payroll queries are dealt with rapidly; any issues are rectified as soon as possible and all interactions are documented in appropriate detail.
Create a sense of value and belonging for our doctors	This is quite mixed – there are challenges around the provision of lockers, facilities and desk space and further work is ongoing. The onboarding is well received by the majority of respondents.

5. On 15 May 2024, a discussion on NETS (the National Education & Training Survey) took place at People Board, encouraging a wider discussion on the reported responses of resident doctors.

6. The Medical Workforce & Education Group regularly discusses the priorities and next steps for improving the working lives of resident doctors at UHS.

7. On 15 July 2024, the first Improving Doctors' Working Lives Task and Finish Group was established, to be run monthly, chaired by the Trust's Director of Medical Education and the Guardian of Safe Working Hours.

I am pleased to report good progress with the piece of good work.

I attach the current draft of the Document which I expect to be finalised in early 2025.

Appendix 2 - Vacancy data

			Previous Months Data					
Division	**Care Group**	**Cost centre**	No of posts	Number of Vacancies	Fill rate as of 6/11/24	No of posts	Number of Vacancies	Fill rate as of 4/12/24
A	Critical Care	Anaesthetics	73	11	84.93%	73	11	84.93%
A	Critical Care	CICU	11	0	100.00%	11	1	90.91%
A	Critical Care	GICU	48	11	77.08%	48	10	79.17%
A	Critical Care	NICU	12	0	100.00%	12	0	100.00%
A	Critical Care	SHDU	10	0	100.00%	10	1	90.00%
A	Ophthalmology	Ophthalmology	28	1	96.43%	28	2	92.86%
A	Surgery	ENT	16	0	100.00%	16	0	100.00%
A	Surgery	General Surgery	50	4	92.00%	50	2	96.00%
A	Surgery	OMFS	10	2	80.00%	10	3	70.00%
A	Surgery	Urology	13	1	92.31%	13	1	92.31%
B	Cancer Care	Clinical Oncology	18	4	77.78%	18	2	88.89%
B	Cancer Care	Haematology	23	0	100.00%	23	0	100.00%
B	Cancer Care	Medical Oncology	19	1	94.74%	19	2	89.47%
B	Cancer Care	Palliative Care	9	2	77.78%	9	2	77.78%
B	Cancer Care	Acute Oncology	3	1	66.67%	3	1	66.67%
B	Emergency	Acute Med	23	3	86.96%	23	4	82.61%
B	Emergency	Acute Med OOH	6	0	100.00%	6	0	100.00%
B	Emergency	ED	70	0	100.00%	70	1	98.57%
B	Emergency	PHEM	2	0	100.00%	2	0	100.00%
B	MOP	MOP	44	0	100.00%	44	1	97.73%
B	Pathology	Chemical Pathology	2	1	50.00%	2	1	50.00%
B	Pathology	Microbiology	13	4	69.23%	13	5	61.54%
B	Pathology	Histopathology	24	9	62.50%	24	10	58.33%
B	Specialist Med	Allergy/Respiratory	28	0	100.00%	28	0	100.00%
B	Specialist Med	Clinical Genetics	4	0	100.00%	4	0	100.00%
B	Specialist Med	Dermatology	11	1	90.91%	11	0	100.00%
B	Specialist Med	Endo/Diabetes	4	0	100.00%	4	0	100.00%
B	Specialist Med	General Medicine	14	0	100.00%	14	0	100.00%
B	Specialist Med	GI Renal	33	0	100.00%	33	1	96.97%
B	Specialist Med	Rheumatology	4	1	75.00%	4	1	75.00%
C	Child Health	Paediatric Cardiology	14	1	92.86%	14	2	85.71%
C	Child Health	Paediatrics	57	9	84.21%	57	7	87.72%
C	Child Health	Paeds ED	13	0	100.00%	13	0	100.00%

C	Child Health	PICU	18	1	94.44%	18	0	100.00%
C	W&N	Neonates	27	1	96.30%	27	4	85.19%
C	W&N	O&G	36	0	100.00%	36	0	100.00%
D	CV&T	Cardiology	38	2	94.74%	38	2	94.74%
D	CV&T	Cardiothoracic Surgery	35	2	94.29%	35	2	94.29%
D	CV&T	Vascular Surgery	12	1	91.67%	12	1	91.67%
D	Neurosciences	Neurology	22	1	95.45%	22	1	95.45%
D	Neurosciences	Neurophysiology	2	0	100.00%	2	1	50.00%
D	Neurosciences	Neurosurgery	25	4	84.00%	25	3	88.00%
D	Neurosciences	Stroke	8	0	100.00%	8	0	100.00%
D	T&O	Spinal Surgery	3	0	100.00%	3	0	100.00%
D	T&O	T&O	58	6	89.66%	58	6	89.66%
		Total	**993**	**85**	91.44%	**993**	**91**	90.84%

Appendix 3 Medical Locum Bank data

Count of Status				Status		
Unit	Months (Date)	Days (Date)	Date	Filled Bank	UnFilled Bank	Grand Total
CAN Clin Onc Med Staff	Jul			25	1	26
	Aug			20	1	21
	Sep			23		23
	Nov			2		2
CAN Clin Onc Med Staff Total				70	2	72
CAN Haem Onc Medical Staff	Sep			15	8	23
	Oct			61	15	76
	Nov			51	18	69
CAN Haem Onc Medical Staff Total				127	41	168
CAN Haematology Medical Staff	Jul			41	4	45
	Aug			23		23
	Sep			3		3
	Oct			3		3
	Nov			3	1	4
CAN Haematology Medical Staff Total				73	5	78
CAN Medical Oncology Medical Staff	Jul			17	2	19
	Aug			9		9
	Sep			4		4
	Oct			5		5
	Nov			5		5
CAN Medical Oncology Medical Staff Total				40	2	42
CAN Palliative Care Medical Staff	Jul			5		5
	Aug			1	1	2
	Sep			1		1
CAN Palliative Care Medical Staff Total				7	1	8
CAR Med Staff Vascular	Jul			1		1
	Aug			5	5	10
	Sep			7		7
	Oct			7	1	8
	Nov			7	1	8
CAR Med Staff Vascular Total				27	7	34
CAR Medical Staff Cardiac Surgery	Jul			18	5	23
	Aug			20	2	22
	Sep			10		10
	Oct			22	1	23
	Nov			26	2	28
CAR Medical Staff Cardiac Surgery Total				96	10	106
CAR Medical Staff Cardiology	Jul			36	15	51
	Aug			33	11	44
	Sep			26	6	32
	Oct			27	10	37
	Nov			21	5	26
CAR Medical Staff Cardiology Total				143	47	190
CC CICU Medical Staff	Jul			14		14
	Aug			5		5
	Sep			14		14
	Oct			13		13
	Nov			10		10
CC CICU Medical Staff Total				56		56

CC GICU Medical Staff	Jul	10	24	34
	Aug	10	4	14
	Sep	6	5	11
	Oct	6	8	14
	Nov	10	9	19
CC GICU Medical Staff Total		42	50	92
CC NICU Medical Staff	Jul	22		22
	Aug	3	3	6
	Nov	1		1
CC NICU Medical Staff Total		26	3	29
CC SHDU Medical Staff	Jul	13	8	21
	Aug	14	6	20
	Sep	10	1	11
	Oct	17	1	18
	Nov	9	7	16
CC SHDU Medical Staff Total		63	23	86
CHI Medical Staff Junior	Jul	21		21
	Aug	51	5	56
	Sep	20	2	22
	Oct	16	1	17
	Nov	23		23
CHI Medical Staff Junior Total		131	8	139
CHI Medical Staff Paediatric Cardiology	Jul	22	5	27
	Aug	21	3	24
	Sep	13		13
	Oct	5		5
	Nov	12		12
CHI Medical Staff Paediatric Cardiology Total		73	8	81
CHI Medical Staff PICU	Jul	14	7	21
	Aug	3	1	4
	Sep	2	1	3
	Oct	5	2	7
	Nov	4	2	6
CHI Medical Staff PICU Total		28	13	41
CHI Paed ED Junior Doctors	Jul	20	9	29
	Aug	38	2	40
	Sep	28	1	29
	Oct	25	1	26
	Nov	21	2	23
CHI Paed ED Junior Doctors Total		132	15	147
ECM AMU Medical Staff	Jul	69	15	84
	Aug	60	8	68
	Sep	55	6	61
	Oct	73	13	86
	Nov	80	14	94
ECM AMU Medical Staff Total		337	56	393
ECM Emergency Dept Medical - Junior Doctors	Jul	54	18	72
	Aug	38	7	45
	Sep	26	8	34
	Oct	21	7	28
	Nov	37	16	53
ECM Emergency Dept Medical - Junior Doctors Total		176	56	232

ECM Out of Hours Medical Team	Jul	6		6
	Aug	16		16
	Sep	12		12
	Oct	4		4
	Nov	4		4
ECM Out of Hours Medical Team Total		42		42
MED Medical Staff MOP	Jul	36	4	40
	Aug	28		28
	Sep	12		12
	Oct	19	3	22
	Nov	15		15
MED Medical Staff MOP Total		110	7	117
MED Medical Ward Based	Jul	12	4	16
	Aug	21	3	24
	Sep	27	14	41
	Oct	21	1	22
	Nov	18	9	27
MED Medical Ward Based Total		99	31	130
NEU Med Staff Neurology	Jul	11	3	14
	Aug	7		7
	Sep	2	1	3
	Nov	1		1
NEU Med Staff Neurology Total		21	4	25
NEU MedStaff Neurosurgery	Jul	39	2	41
	Aug	23	4	27
	Sep	19		19
	Oct	12		12
	Nov	14		14
NEU MedStaff Neurosurgery Total		107	6	113
OPH Medical Staff	Jul	11		11
	Aug	8		8
	Sep	6		6
	Oct	4	1	5
	Nov	7	1	8
OPH Medical Staff Total		36	2	38
RAD Wessex Registrars	Jul	10	1	11
	Aug	3		3
	Sep	9		9
	Oct	4		4
	Nov	2		2
RAD Wessex Registrars Total		28	1	29
RD NIHR WTCRF	Aug	1		1
RD NIHR WTCRF Total		1		1
SME General Medicine Med Staff	Jul	75	8	83
	Aug	60	5	65
	Sep	69	6	75
	Oct	79	6	85
	Nov	79	3	82
SME General Medicine Med Staff Total		362	28	390
SME MedStaff Dermatology	Jul	3		3
	Aug	4	1	5
	Sep	4		4
	Oct	9		9
SME MedStaff Dermatology Total		20	1	21

SME MedStaff GI/Renal	Aug	1		1
	Sep	3		3
	Nov	1		1
SME MedStaff GI/Renal Total		5		5
SUR Med Staff ENT	Jul	8		8
	Aug	16	4	20
	Sep	8	1	9
	Oct	2	7	9
	Nov	4	1	5
SUR Med Staff ENT Total		38	13	51
SUR Med Staff GI	Jul	94	15	109
	Aug	121	15	136
	Sep	81	15	96
	Oct	82	7	89
	Nov	52	13	65
SUR Med Staff GI Total		430	65	495
SUR Med Staff Urology	Jul	12		12
	Aug	2		2
	Sep	6	1	7
	Oct	8		8
	Nov	2		2
SUR Med Staff Urology Total		30	1	31
SUR OMF Medics	Jul	24		24
	Aug	17		17
	Sep	33	1	34
	Oct	23		23
	Nov	20		20
SUR OMF Medics Total		117	1	118
T&O Medical Staff	Jul	117	16	133
	Aug	138	22	160
	Sep	97	16	113
	Oct	142	59	201
	Nov	131	44	175
T&O Medical Staff Total		625	157	782
THR Anaesthetics Medical Staff	Jul	20	1	21
	Aug	7		7
	Sep	5		5
	Oct	7		7
	Nov	3		3
THR Anaesthetics Medical Staff Total		42	1	43
W&N Med Staff Breast/Endo	Jul	5		5
	Aug	2		2
	Sep	1		1
	Oct	2		2
	Nov	3		3
W&N Med Staff Breast/Endo Total		13		13
W&N Med Staff Junior	Jul	16	1	17
	Aug	30	2	32
	Sep	29	4	33
	Oct	17	1	18
	Nov	45	8	53
W&N Med Staff Junior Total		137	16	153
W&N Neonatal Med Staff	Jul	24		24
	Aug	16		16
	Sep	21		21

	Oct	5		5
	Nov	11		11
W&N Neonatal Med Staff Total		77		77
Grand Total		3987	681	4668

Improving the working lives of Resident Doctors at UHS

November 2024

1. On 27 March 2024, NHS England published the Priorities and Operational Planning Guidance for 2024/25. Amongst other priorities, the publication set out the expected changes to be made locally and nationally to improve the working lives of our staff, including junior doctors, by addressing some of the most widely felt frustrations that adversely impact their experience working in the NHS.

2. On 25 April 2024, a letter from NHS England was sent to NHS People Leaders regarding a number of actions for trusts relating to doctors, including issues requiring board visibility.

3. Representatives for medical workforce and medical HR from UHS reviewed the letter and its required actions on 14 May 2024 with a view to conducting a gap analysis; please see appendix for reference.

4. The summary of that gap analysis is as follows:

Objective	UHS progress to date
Increase choice and flexibility	We have made good progress on this; it can be hard to determine how many work schedules have been provided eight weeks in advance as the picture is changing regularly. The deanery issues the details of the Deanery training rotations to UHS so this information is not within our control.
Reduce duplicative inductions and pay errors	Payroll queries are dealt with rapidly; any issues are rectified as soon as possible, and all interactions are documented in appropriate detail.
Create a sense of value and belonging for our doctors	This is quite mixed – there are challenges around the provision of lockers, facilities and desk space and further work is ongoing. The onboarding is well received by the majority of respondents.

5. On 15 May 2024, a discussion on NETS (the National Education & Training Survey) took place at People Board, encouraging a wider discussion on the reported responses of resident doctors.

6. The Medical Workforce & Education Group regularly discusses the priorities and next steps for improving the working lives of resident doctors at UHS.

7. On 15 July 2024, the first Improving Doctors' Working Lives Task and Finish Group was established, to be run monthly, chaired by the Trust's Director of Medical Education and the Guardian of Safe Working Hours. The below gap analysis has been updated in light of that discussion (with actions noted in **bold**)

APPENDIX 1: GAP ANALYSIS

How we are delivering against the NHS England set of standards as per 2024/25 planning guidance and letter of 25 April 2024

Objective	Standard	UHS progress to date	RAG	Future actions based on discussion 09/12/2024
Increase choice and flexibility	(1) Provide work schedules at least eight weeks in advance. (2) Finalised duty rosters provided six weeks in advance	There is an internal target of 80% of work schedules to be issued to Medical HR at the 10-week deadline. Late information from the doctors themselves and from the Deanery impacts our ability to meet this target. KN has raised our concerns with the Deanery, but there is limited scope for UHS to influence their timescales. XXX of doctors issued with their work schedule XXX weeks before they began their posts Bespoke work schedules are received for people working LTFT		**DH is meeting with all clinical rota leaders to understand the issues they face; this will inform further discussions with DCDs and Medical Workforce.** **LS (updated on behalf of DH) that engagement by rota leads and uptake with meetings was patchy to date. Await further updates,** **For escalation/discussion with DCDs?** **LS to provide average figures on issuing of work schedules – reported that for major intakes it was good, but less in some other months, therefore average figure would be most representative**
	Improve rota management and move to self-rostering. Where rota changes are required with less than six weeks' notice, the resident doctors impacted should be involved in creating the new rota. In such situations all pre-existing leave arrangements must be accommodated	Preferential rostering rather than self-rostering allows for service and training demands to be met. This is in place, with bespoke rotas for service and training provided for many. LTFT have bespoke schedules and rotas from the start		**LS – interfacing of rotas is a work in progress. Onboarding, access aiming to be available 6 weeks in advance. This will allow access to systems on Loop when switching organisations**

		ED and CED are already self-rostering The named medical administrator and clinical rota lead for each doctor is shared at local inductions and they should be contacted by the residents in the first instance regarding leave requests. Names are added to work schedule templates.		**DH will coordinate the writing and publication of a brief practical guide for resident doctors (February - August 2025)**
Reduce duplicative inductions and pay errors	Pay specific attention to payroll accuracy for all staff, particularly junior doctors who rotate	There is an average of 9 errors per month (1.2% of total trainees). Peak rotational months see higher errors due to volume of entry changes and late work schedules or changes. Pay errors are often related to departmental recording for maternity leave and sick leave. A Teams group has been established for updates, communications, and reminders for medical administrators. The underpayment / overpayment process is reviewed monthly. Individuals must be responsible for checking their own pay slips and raising any concerns and or inaccuracies.		

		An example of both substantive and bank contract payslips and their components will be shared at Trust induction and on Staffnet. BM gave a presentation on understanding payslips at the resident doctor forum.		
	Develop local SLAs to include timescales for dealing with individual payroll errors so payroll queries are handled swiftly by the end of July 2024 and implement a board governance framework for monitoring and reporting payroll errors for all staff by the end of July 2024	We rectify the problems immediately (as soon as feasible) Payroll queries are dealt with rapidly and there are none outstanding currently. Payroll maintin a list of all errors and corrections for all staffing groups Overarching policies are already in place that outline procedures for all staff in the Trust.		
Create a sense of value and belonging for our doctors	Protect training time for both learners and educators. For example, no member of staff should have to do mandatory training in their own time	Self-development and MAST training is carried out in work time SDT is added to contract and included in roster summary with the work schedule This is 2 hours a week or approximately one day a month Recording of lost SDT is positive at UHS and encouraged by the exception reporting system		

		Clarity of definitions of study leave and SDT are included in trust induction slides		
	Address the unique issues caused by rotations, such as reviewing on-boarding processes, and other practical steps to help foster a sense of wellbeing and belonging such as reviewing the application processes for lockers or car parking spaces, the availability of facilities and inclusion in team photos etc	There is good feedback from residents for the on-boarding processes. The processes and timelines and regularly reviewed. On-call rooms are constantly used by all staff groups There is a lack of office space and desks. There are IT limitations KN and DH have joined a UHS Estates group.	Green Red for estates	**DH, GB & BM to review the too tired to drive home policy** **Small group to include JT DH and GB to meet the Junior doctors' mess team.** **Walkabouts ongoing – T&O, oncology, neurosciences completed.** **Still red for lockers – need to take up with estates team KN/DH. Can funds be directed towards addressing this? Need to agree priorities for spending of the allocated funding.** **Feeling that any spending needs to be seen to have equity e.g. by division?** **KN to link with Martin regarding timescale to spend money to inform decision on further walkabouts. Ongoing work required outside of this main meeting (KN/DH/GB)** **An estates representative will be invited to this group to discuss estate-related projects.** **PAH doctors' room might be improved with c £15k funding**

		IT rollout project commenced August 2023		**We need to invite an IT colleague to join this group.** **The location and utility of spare laptops and raising tickets with IT need to be added to the resident doctors' guide.** **If a doctor is peripatetic and not able to access hardware or software, what is the course of action they need to undertake to resolve this? How can we make it easier for doctors in this situation? For example, is there a pool of spare laptops for doctors to access readily?**
	Align to the latest Core Skills Training Framework (CSTF) by the end of June 2024, confirming with NHS England when your organisation has done so	National programme of work on Statutory & Mandatory training ongoing with more changes expected in January 2025. Local team is reviewing S&M. UHS are partially aligned (and not a statistical outlier). Ongoing dialogue about what training is mandatory KN is a member of SMOG		**https://www.e-lfh.org.uk/programmes/statutory-and-mandatory-training/** The UK Core Skills Training Framework (CSTF) sets out 11 statutory and mandatory training topics for all staff working in health and social care settings Ongoing review required as further information provided on National programmes
	Use the free eLearning for Healthcare packages and shorter e-assessments by the end of October 2024	TBC		**Resus is the only e-assessment outstanding for eLfH due to the number of courses within resuscitation e-learning**

	Adopt the NHS Digital Staff Passport at the earliest opportunity	HR digital passport – been involved in multiple versions. Will roll out when released nationally.		Tracking this but nothing issued or confirmed nationally Piloted in the north of England; awaiting a national update on this programme LB confirmed that UHS are involved in shaping this programme of work
	Take action to improve the experience of trainees by ensuring the National Training and Education Survey and GMC Survey are treated in the same way as the National Staff Survey results, with reviews by trust boards supported by clear action plans	As a trust we present at a variety of forums NETS went to People Board on 15 May for wide discussion GMC NTS is subject to extensive analysis and presented to TEC. DME team review concerns with local areas and work with them to create action plans towards resolving issues. Targeted intervention is undertaken where there are free text concerns or other areas requiring extra scrutiny, with close liaison with the NHS-E quality teams		
	Identify a senior, named individual to oversee the implementation of these actions and be accountable to the trust board	Paul Grundy is the executive lead		
	Consider BMA wellbeing guidance recently published and implementation at local level	Karen M wellbeing induction and support networks DH has joined the UHS Wellbeing Group		**All to read /review for future discussion**

		Five priorities for improving wellbeing in the workplace (BMA) 1. On-call designated parking spaces* 2. Self-directed learning time to commensurate the training needs of each individual (in place for Deanery and LEDs) 3. The right to work from home to undertake portfolio and self-directed learning (in place) 4. Mess, rest facilities and lockers included in all hospitals including any new hospital builds* 5. Access to an out-of-hours menu 24/7 that includes a hot meal and cold snacks for staff (vending machines and microwaves are available on General and PAH sites)		**We need to have resident doctor participation in this group DH to coordinate** **Could there be funding allocated to rest facilities?** **KN to clarify with Travelwise. This only relates to a few doctors who are on call** **Progress outlined above. DH/KN now on Estates group, hopefully will assist with ensuring space is included in new builds**

Reviewed on 14 May 2024; updated with further actions on 15 July 2024 and 16 August 2024, 16 September 2024 and 9 December 2024

University Hospital Southampton NHS Foundation Trust

Agenda item 5.12 Report to the Trust Board of Directors, 7 January 2025	
Title:	Learning from Deaths 2024-25 Quarter 2 Report
Sponsor:	Paul Grundy, Chief Medical Officer
Author:	Jenny Milner, Associate Director of Patient Experience Lauren Kennedy, Lead Medical Examiner Officer

Purpose

(Re)Assurance	Approval	Ratification	Information
x			

Strategic Theme

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

Executive Summary:

This report ensures that mortality reporting in relation to deaths, reviews, investigations, and learning is regularly provided to the board.

The report also provides an update on the development and effectiveness of the medical examiner service.

The National Guidance on Learning from Deaths sets out expectations that:

Boards must ensure robust systems are in place for recognising, reporting, reviewing, or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care. Providers should ensure such activities are adequately resourced.

This paper sets out a plan to meet these requirements more fully.

1. The Trust reduces avoidable deaths in our hospitals.
2. The Trust promotes learning from deaths, including relating to avoidable deaths and reviews quality of end-of-life care.
3. The Trust promotes an open and honest culture and support for the duty of candour.

Contents:

Report

Risk(s):

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.
Risk 828 – Bereavement Services (latest review in Q2 reduced risk rating to 9 due to successful recruitment.

Equality Impact Consideration:	N/A

1. Introduction

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

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

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

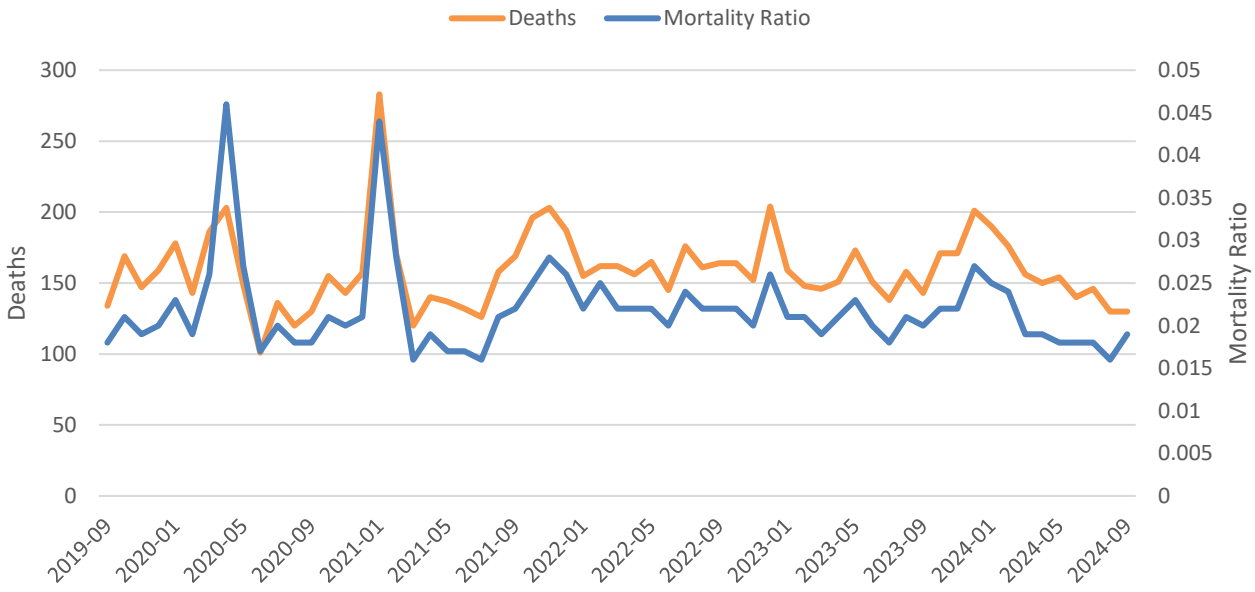
2. Analysis and discussion

2.1 Deaths at UHS

Quarter	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Q1	485	540	483	504	512	466
Q2	416	516	591	526	471	446
Q3	474	599	651	565	578	
Q4	506	644	537	489	558	
Total	1881	2299	2262	2084	2119	

The second quarter of 2024-25 saw 446 deaths at UHS sites, compared to 471 in Q2 2023-24.

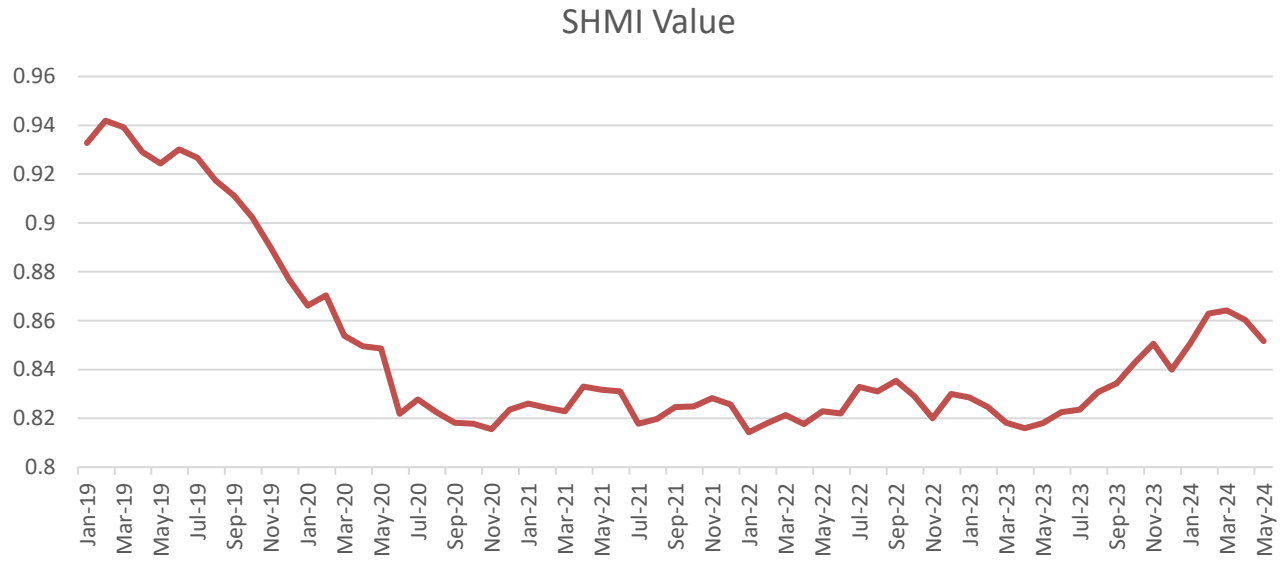
45 of Q2 deaths at UHS are recorded as happening in the Emergency Department and the remainder were inpatients.



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

2.2 SHMI (replacing HSMR) (This is calculated by NHSE)

SHMI (Summary of Hospital Level Mortality Indicator) is the ratio between the number of patients who die following hospitalisation at the Trust and, the number that would be expected to die based on average England figures, given the characteristics of the patients treated here.



SHMI remains in the 'lower than expected' range at 0.85 for the 12 months to May 2024. However, over the latest 10 SHMI reports there has been an upward trend in the data that should be noted.

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

Diagnosis Group Description	SHMI Value	SHMI Banding
Septicaemia (except in labour), Shock	1.0072	As expected
Cancer of bronchus; lung	0.7532	Lower than expected
Secondary malignancies	0.5839	Lower than expected
Fluid and electrolyte disorders	0.5808	Lower than expected
Acute myocardial infarction	0.7131	Lower than expected
Pneumonia (excluding TB/STD)	0.999	As expected
Acute bronchitis	0.5503	Lower than expected
Gastrointestinal haemorrhage	0.7956	As expected
Urinary tract infections	0.6818	Lower Than expected
Fracture of neck of femur (hip)	0.89	As expected

For the 12 months to May 2024, 4 diagnosis level values are in the 'as expected' range, 6 are in the 'lower than expected' range.

2.3 Medical Examiner reviews

In Q2 the MES reviewed 791 deaths, of which 419 occurred at UHS acute sites and 372 occurred in the community. This compares to 781 deaths reviewed in Q1.

74 acute deaths were referred to the coroner, 58% of these were taken for further investigation through a coroner postmortem or inquest.

2.3.1 Referrals to M&M

8 cases were referred to speciality M&Ms by MES, 7 of which were discussed at their respective review meetings, one of these cases had a postmortem following a coroner referral. Referrals were made to the following specialities: ENT, Gastroenterology, CV&T, Oncology, Cardiac surgery, and Elderly Care.

In all cases that were discussed, it was felt that patients were managed appropriately, and outcomes were unavoidable. However, referrals stimulated discussion among clinical teams with regards to discharges from ICU to ward environments out of hours, and imaging for patients who are unlikely to survive irrespective of imaging findings. In one case, actions for refresher training for CHADS-VASC and HAS-BLED scoring and the importance of clear of documentation of risks considered when planning to withhold anti-coagulant medications was noted. In another, the documentation of upper GI bleeds was highlighted to nursing and medical staff as an area for improvement and to not let the 'status of a patient as palliative' impact this. Overall, there was a theme of documentation among referrals, and this was fed back to appropriate teams.

2.3.2 Referrals to Patient Safety

1 case was referred to the Patient Safety Team by MES. This case was referred to ask if the hand-over for this patient was robust enough, and if hypoglycaemia could have been prevented. The main learning point identified for AMU was regarding handover process, in this case SBAR form was not completed and sent with the patient. However, there was a phone handover to the receiving ward, although this was not documented in the patient's medical notes. Upon discussion with the team, this is thought to be due to capacity issues and a process to be improved by the department. However, they have advised that they monitored/managed the glucose levels reasonably.

2.4 UHS 'End of Life' incident reports

For Q2, there were a total of 41 incidents reported relating to end-of-life care. In July there were 22, in August there were 11 and, in September there were 8.

Overall, the main themes of the incidents were related to:

- Communication and documentation among clinical staff and support staff (for example, the signing of EOLCP or documentation of implants).
- A shortage of side or private rooms resulting in patients dying in bays and in one instance, a chair which was distressing to the families.
- The incorrect transfer of deceased patients including the improper use of body coverings which were reported by the mortuary.

Clinical teams continue to raise Adverse Incident Reports for events where side rooms are unavailable.

In all instances where possible, staff were given feedback on incidents and advised of correct processes and procedures, and where necessary families of the deceased were updated, reassured, or apologised to. Some incidents were discussed further at meetings, such as the PICU risk and PQR meeting for learning and development of policies.

2.5 UHS complaints relating to End of Life care

There were 3 complaints featuring end of life care raised by family members of deceased patients and 2 additional cases were raised through PALS. The main themes were around:

- Recognising needs of the family.
- Providing a suitable environment (i.e. a side room for dying patients and families).
- Communication between staff, the patient and family.
- Pain relief for dying patients.

Most of the cases were resolved through conversations with the clinical treating team either through organised meetings, telephone conversations or formal responses by letter.

3. Morbidity and Mortality data capture & standardisation

The M&M app is still currently in use by the trial group and feedback has been positive. It was presented at the Digital Oversight Prioritisation Group at the beginning of October, to request that the Trust builds a similar programme that can communicate with Trust systems and patient records. It was approved and marked as a medium priority. As a result of the meeting, several external programmes are being explored as an option. The main aim of this is to ensure M&M recording is consistent across the Trust and outcomes can be shared more widely for learning.

4. Medical Examiner Service update

The MES service became statutory on 9th September. The introduction of these legislative changes means that MES must review all acute and community non-coronial deaths in Southampton. MES worked to onboard 40 GP practices to this new process prior to the statutory go-live date of the 9th September 2024 to ensure a smooth transition.

In Q2, for acute deaths that occurred at UHS, 93% of families were contacted by the service to ask if they had concerns about care, compared to 88% in Q1. Reasons for non-contact are there was no informant, or the informant declined to be involved. 5% of bereaved contacts had raised concerns about care and 20% of these were significant concerns.

49% of Medical Certificate of Cause of Death (MCCDS) were sent to the registry office by day 3 from date of death, compared to 57% in Q1. This decrease could be attributed to the introduction of additional steps in the process since becoming statutory.

5. Palliative Care update

Palliative Care has developed material to provide families with written information to supplement conversations with clinical staff to give them better insight into the dying process and support available to them. This was instigated in response to family feedback about the gap in available resources. Palliative care has highlighted that these were not written to replace interaction with clinical staff but to give relatives something to refer to and share with other family members. One booklet has been written for patients dying in UHS and another with an expectation of the patient being discharged at the end of life.

University Hospital Southampton NHS Foundation Trust

Agenda item 5.13 Report to the Board of Directors, 7 January 2025	
Title:	Infection Prevention and Control 2024-25 Quarter 2 Report
Sponsor:	Gail Byrne, Chief Nursing Officer/Director of Infection Prevention & Control
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Purpose

(Re)Assurance	Approval	Ratification	Information
x			x

Strategic Theme

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

Executive Summary:

This report provides an overview of performance and progress in relation to reducing the risk of healthcare associated infection in UHS including:

- Performance against key infection indicators.
- Assurance of infection prevention standards, practices and processes.
- Identification of learning and actions to further reduce risks of HCAI to patients, staff, the organisation and the public.

Performance in Q2 2024/25 in relation to HCAIs has continued to be challenging with target thresholds in a number of HCAI indicators exceeded for the quarter. Focus on ensuring that the fundamental standards of infection prevention and control practice are consistently applied by all staff to reduce risk of transmission of infection and risk of antimicrobial resistance remains in place, along with other targeted improvement initiatives, as outlined in this report.

Members of Trust Board are asked to review the report and actions identified to support improvements in performance and note the following actions requested of Divisions/care Groups:

1. Divisions and Care Groups to ensure that the detailed actions in each section are addressed via the Divisional Governance processes, with relevant teams and staff group.
2. Divisions and Care Groups to ensure that processes and plans remain in place and are subject to ongoing review to improve IP&C practice standards, including hand hygiene, cleanliness of equipment, glove use, management and care of invasive devices, measures to reduce the risk of MRSA colonisation and infection.

Contents:

Risk(s):

Strategic: Board Assurance Framework Risk number 1c

Operational: Risk No. 489 inadequate ventilation in in-patient facilities. High risk (risk score:15)

Equality Impact Consideration:	N/A

1.Introduction

Category		Q2	Annual Limit	Action /Comment
National Thresholds (as set by NHSE)	MRSA bacteraemia (Threshold = 0)	R	R	1 MRSA BSI attributable to UHS in Q2 2024/25 (2 cases YTD)
	Clostridioides difficile infection (Threshold = 99)	R	G	32 cases in Q2 2024/25 against an internal limit of 24 (61 cases YTD)
	E coli Bacteraemia (Threshold = 141)	R	G	50 cases in Q2 2024/25 against an internal limit of 36 (101 cases YTD)
	Klebsiella Bacteraemia (Threshold = 56)	R	G	24 cases in Q2 2024/25 against an internal limit of 14 (43 cases YTD)
	Pseudomonas Bacteraemia (Threshold = 23)	R	G	11 cases in Q2 2024/25 against an internal limit of 6 (21 cases YTD)
Other	MSSA			9 cases in Q2 2024/25 (26 cases YTD)
	VRE			1 case in Q2 2024/25 (7 cases YTD)
Antimicrobial Stewardship	Prudent antibiotic prescribing	G	G	National AMR 5-year plan target: reduction of 5% overall human antibiotic use (compared to a baseline of calendar year 2019) = 1% reduction per year.
Provide assurance of basic infection prevention practice:	Assurance of Infection Prevention Practice Standards	A	G	Analysis of Q1&2 IP&C audits show 41% of areas are currently not meeting requirements needed to achieve full accreditation at year end in March 2025.

2. Analysis

2.1 Healthcare Associated Infection

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

MRSA Bloodstream infection (MRSA BSI)

1 case of Community Onset Healthcare Associated (COHA) MRSA BSI attributed to UHS in Q2 2024/25.

The case underwent a detailed concise review led by the Infection Prevention Team and an after-action review (AAR) with the relevant clinical teams to identify learning and areas for improvement.

Summary of case:

September 2024 (Trauma and Orthopaedics)	60-year-old female with advanced liver disease, known to be colonised with MRSA. Initially admitted in August 2024 to Trauma and Orthopaedics with a head injury and fractured skull following a fall. During this admission the patient developed a fever and cellulitis on the dorsum of the right hand at an intravenous cannula insertion site. The patient was prescribed a short course of antibiotics but did not complete the course following discharge (no antibiotics prescribed on discharge). The patient was re-admitted 10 days after discharge with pneumonia and sepsis and a blood culture grew MRSA. The source of the MRSA BSI was considered as chest source, suggestive of disseminated MRSA disease secondary to bacteraemia. It is possible that the patient originally developed bacteraemia on the previous admission likely related to the cannula site infection which was not fully treated. Review of the case identified a lack of assurance related to the management of the IV cannula during the patients previous admission. There was no insertion/ongoing care record on the patients electronic in-patient noting record and thus no documented record of observation of the cannula site The cannula was inserted in the emergency department with documentation on a paper form but an insertion/care record was not created on inpatient noting when the patient was transferred to the ward. The challenges and potential risk of having different electronic systems and a combination of electronic and paper records has been highlighted as part of this review. In addition the review raised questions related to the medical management of cellulitis in the right hand in respect to the short course of antibiotics which were discontinued on discharge.

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

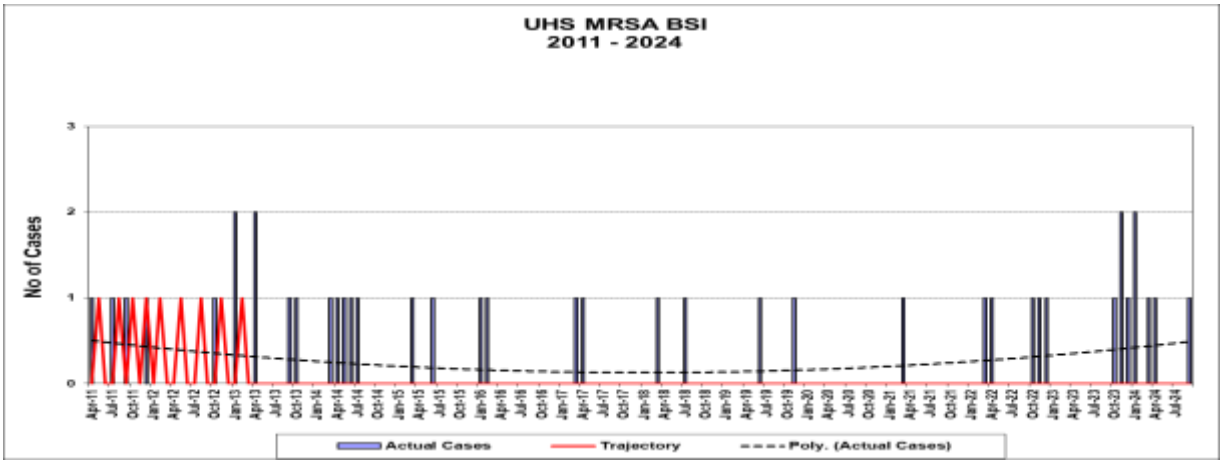
**Hospital-onset, healthcare associated (HOHA) - Specimen date is ≥3 days after the current admission date (where day of admission is day 1)*

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

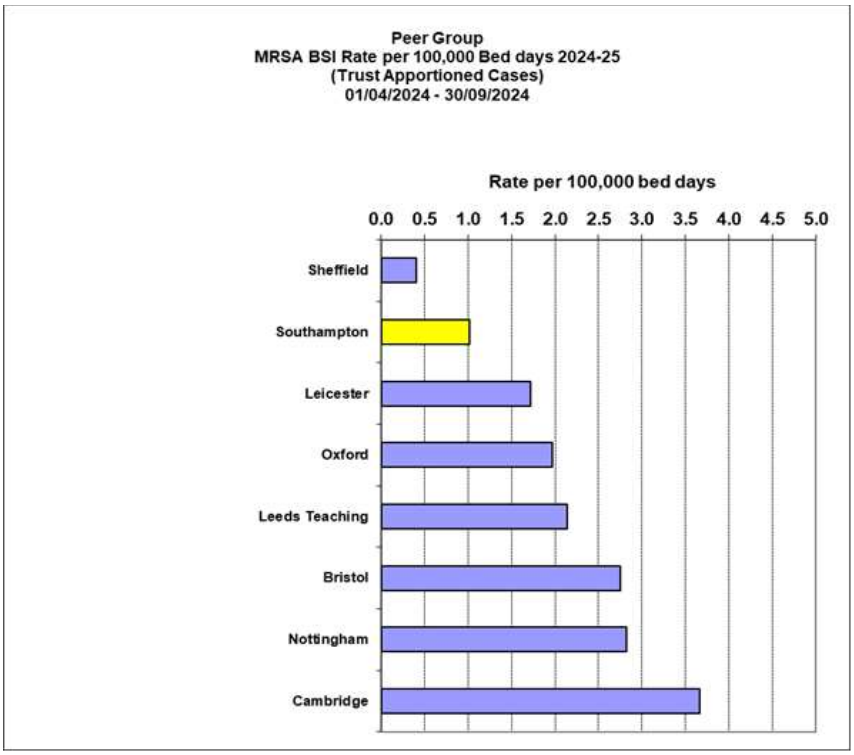
**Community-onset, community associated (COCA) - Is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 28 days prior to the specimen date (where day 1 is the specimen date)*

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

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



UHS has an attributable MRSA BSI rate of 1.02 cases/100,000 bed days and ranks second of 8 self-selected peer hospitals.



Acquisition of MRSA colonisation in UHS

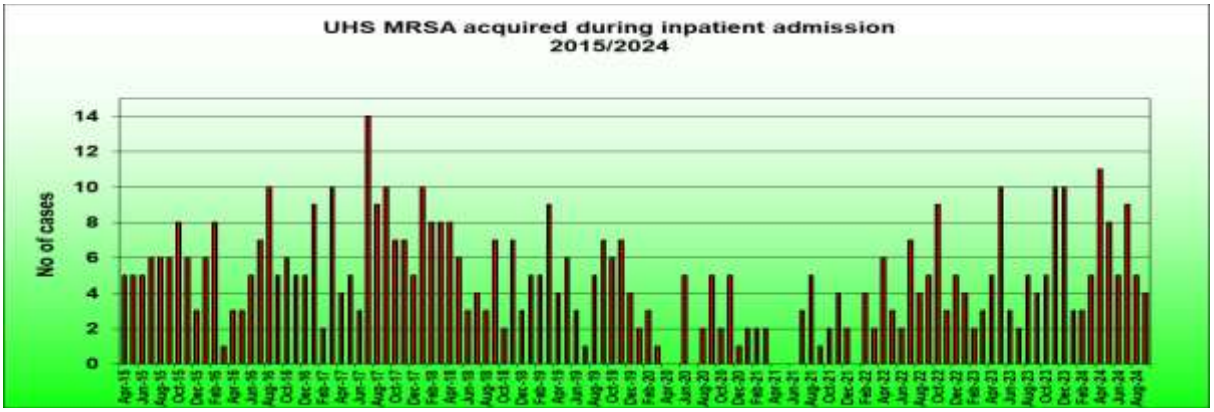
18 patients acquired MRSA (colonisation or infection) in UHS in Q2 2024/25.

MRSA infection prevention & control (IP&C) practice reviews by the Infection Prevention Team (IPT) were undertaken for patients who were newly colonised with MRSA to ensure that all expected measures were undertaken as per UHS policy. Key themes from the reviews undertaken in Q2 remained similar to Q1, but with some evidence that improvements have been made in a number of areas of practice:

- 9 (50%) of the 18 patients did not have documented evidence of MRSA risk reduction washes on or prior to admission, compared to 64% in Q1, an improvement of 14%.
- 6 (33%) of the 18 patients did not have their MRSA status documented in their patient notes, compared to 44% in Q1, an improvement of 11%.
- 4 (22%) of the 18 patients did not have MRSA topical decolonisation therapy prescribed following confirmation of positive MRSA result, compared to 36% in Q1, an improvement of 14%.
- 4 (22%) of the 18 patients did not have a UHS isolation risk assessment completed, compared to 44% in Q1, an improvement of 22%.

Actions and interventions taken and ongoing to support improvements in practice in Q2 have included:

- Continued MRSA IP&C practice reviews by the Infection Prevention Team (IPT).
- Provision of targeted education/training to support improvements in practice in response to findings from the focused MRSA ward rounds/reviews that were undertaken by the IPT in Q1, particularly in relation to MRSA risk reduction washes and MRSA topical decolonisation.
- Focus on measures to reduce risk of MRSA colonisation and infection included in weekly combined antimicrobial stewardship (AMS)/IP&C ward rounds (by IPT and pharmacy-micro team).
- Review of the MRSA policy for adults and paediatrics underway.



Clostridioides difficile (C.difficile)

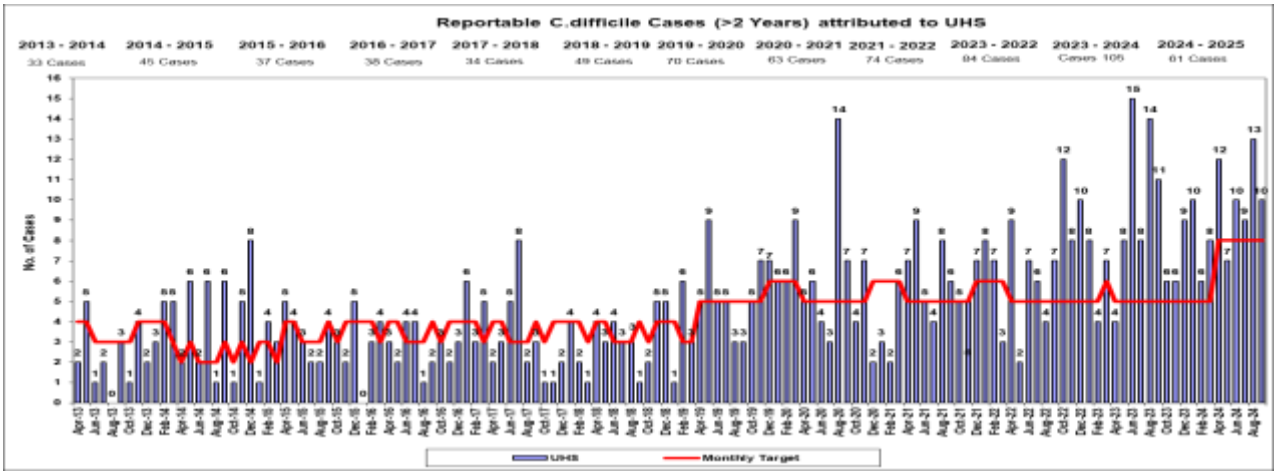
Trusts are required under the NHS Standard Contract 2024/25 to minimise rates of C. difficile so that they are no higher than the threshold levels set by NHS England and Improvement. Trust-level thresholds comprise total healthcare-associated cases i.e. Hospital-onset healthcare associated (HOHA) and Community-onset healthcare associated (COHA).

2024/25 progress:
32 cases in Q2 2024/25. 61 cases year to date (Q1 & Q2) against a nationally set annual threshold of 99.

Q2 cases:

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

2023/24	July	Aug	Sept	Total
HOHA	5	10	10	**25**
COHA	4	3	0	**7**



The number of cases in Q2 2024/25 was similar to the same period last year with 32 cases compared to 33 cases in 2023/24.

IP&C practice reviews have continued to be undertaken in Q2 on wards where patients with a newly confirmed positive result are isolated (toxin positive and toxin negative cases irrespective of whether hospital/ community onset or healthcare/community associated) for assurance that all expected standards are in place to reduce the risk of onward transmission. 68 *C. difficile* IP&C practice reviews were undertaken and key themes remain similar to Q1 with evidence that further focus is required to improve practice in a number of standards:

- 37% of commodes that were found to be clean were missing an "I am clean" sticker, compared to 26% in Q1 , a decrease of 11%.
- 32% of commodes were found to be visibly soiled with body fluids including faeces, compared to 25% in Q1, a decrease of 7%.
- 32% of cases did not have an isolation risk assessment completed, compared to 45% in Q1, an improvement of 13%.
- 18% of patients were not isolated as per UHS isolation of patients with infectious conditions policy, compared to 14% in Q1, a decrease of 4%.
- 16% of cases had incorrect cleaning products being used for the cleaning of equipment for patients in isolation, compared to 6% in Q1, an improvement of 6%.

During Q2 2024/25, 2 periods of increased incidence (PII) were declared (two or more new cases of *C. difficile* on a ward in a 28-day period). Actions were implemented in response which included enhanced cleaning of the whole ward with Sochlor/Actichlor plus; increased activity on the ward by the IPT (including a formal weekly review of the ward/observations of practice); review of isolation procedures; review of antibiotic usage; enhanced communications with staff; *C. difficile* isolates sent to the national reference laboratory for strain typing (ribotyping). The weekly ward reviews undertaken by the IPT identified concerns related disposal of PPE in overflowing bins, missed hand hygiene opportunities and commode cleaning. Improvement plans were requested from all wards with ongoing monitoring to ensure actions/learning becomes embedded into practice.

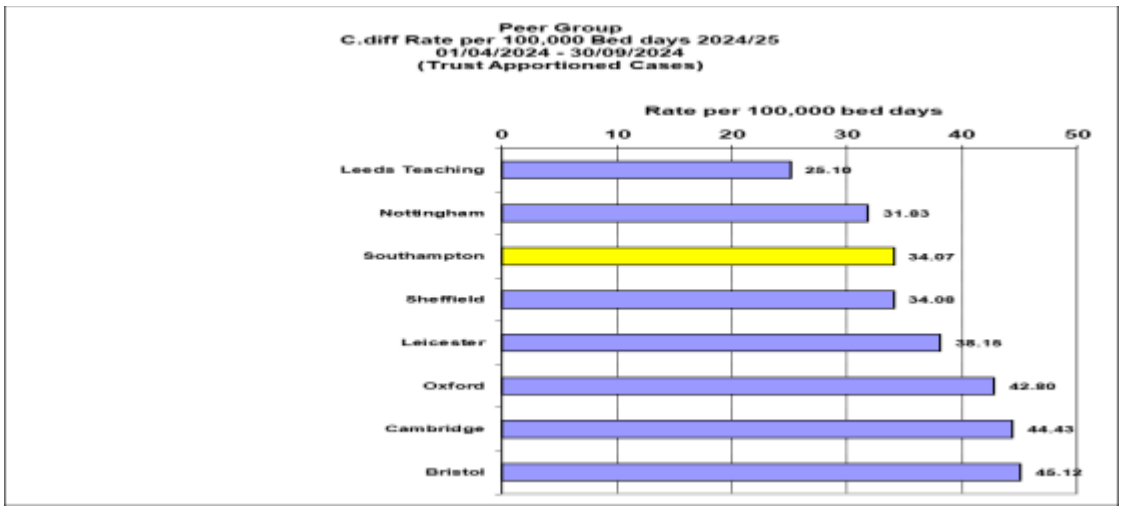
Actions and interventions to support improvements in practice in Q2 have included: .

1. Approval and launch of an updated isolation of patients with infectious conditions policy.
2. Focused isolation care ward rounds/reviews undertaken by the Infection Prevention Team, supported by education/awareness activities to improve knowledge of the expected standards of practice.
3. Ongoing focus on improving IP&C practice standards including equipment cleanliness, hand hygiene practices, appropriate glove use.
4. Ongoing focus on antimicrobial stewardship (AMS) and application of the principles of prudent antimicrobial prescribing – antimicrobial stewardship ward rounds (microbiologists & pharmacists), combined IP&C and AMS wards rounds (by IPT and pharmacy-micro team), ongoing programme of review and update of antimicrobial prescribing guidelines.
5. Launch of the clinical cleaning escalation framework.
6. Development of an IP&C improvement plan with specific focus on hand hygiene and equipment cleaning.

Further enhanced focus will be taken in Q3 specifically relating to:

1. Delivery of actions within the IP&C improvement plan, focusing on hand hygiene and equipment cleaning.
2. Delivery of an IP&C awareness campaign throughout the month of October.
3. Ongoing focus on antimicrobial stewardship and application of the principles of prudent antimicrobial prescribing including education/awareness during World Antimicrobial Awareness week.
4. Launch of revised cleaning roles and responsibilities framework.

In Q2 UHS ranked third out of 8 self-selected peer acute trusts, with a rate of 34.07 cases/ 100,000 bed days. Comparative data needs careful interpretation because of differences in test selection, methodology and reporting criteria between trusts.



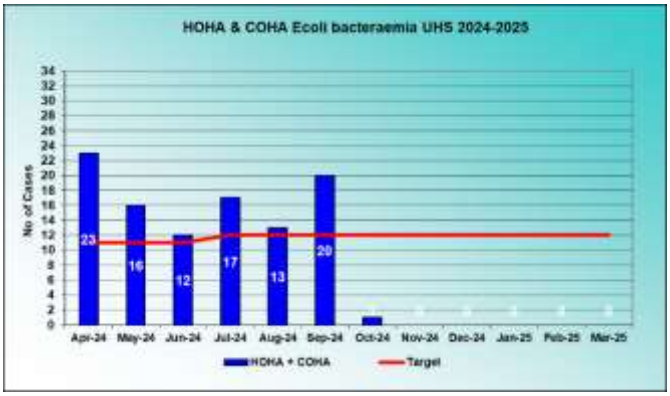
Healthcare Associated Bloodstream (excluding MRSA)

Trusts are required under the NHS Standard Contract 2024/25 to minimise rates of Gram-negative bloodstream infections (BSI) so that they are no higher than the threshold levels set by NHS England and Improvement. Trust-level thresholds comprise total healthcare-associated cases i.e., Hospital-onset healthcare associated (HOHA) and Community-onset healthcare associated (COHA).

Post-48h BSI	Q1 & Q2 2024-25	2023-24	2022-23	2021-22	2020-21
E coli	101 (141)	147 (120)	154 (127)	138 (151)	67
Klebsiella	43 (56)	58 (56)	51 (73)	64 (64)	40
Pseudomonas	21 (23)	24 (33)	35 (36)	30 (34)	13
MSSA	26	59	45	43	36
VRE	7	12	4	9	7

(Annual National thresholds in brackets)

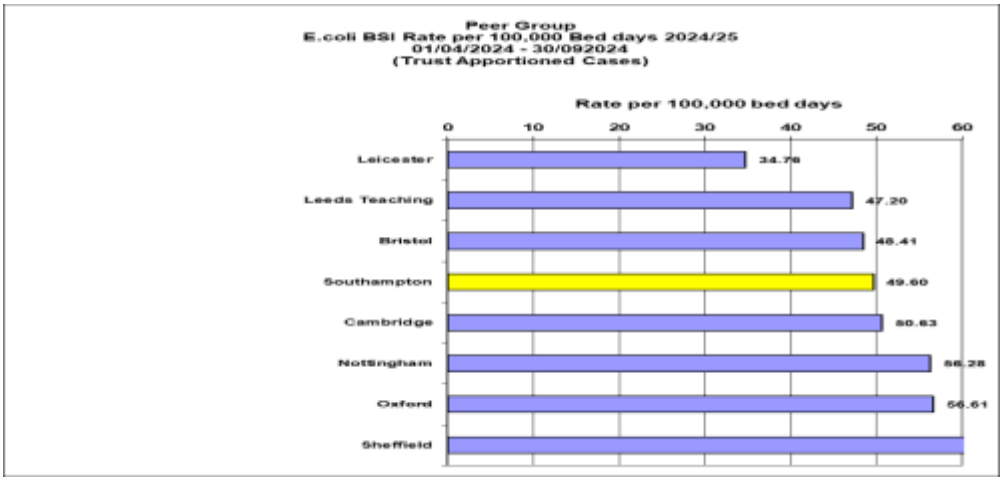
E coli BSI: 101 cases year to date (Q1 & Q2) against a nationally set annual threshold of 141 cases for the year



Q2 Progress:
50 cases

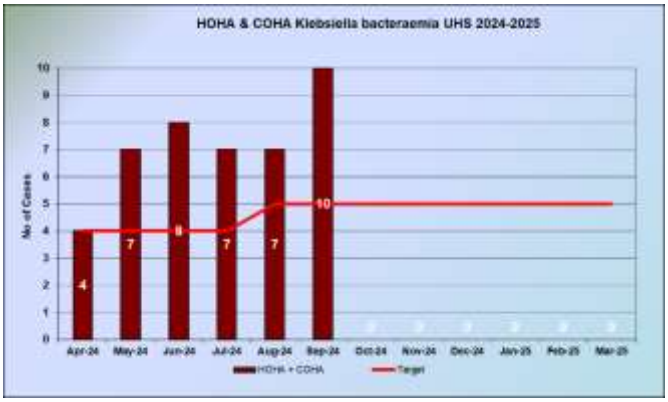
- 27 Community Onset – Healthcare Associated (COHA)
- 23 Hospital Onset – Healthcare Associated (HOHA)

7 concise case reviews undertaken.



UHS ranks fourth out of 8 self-selected peer acute trusts for *E. coli* bloodstream infection (BSI) per 100,000 bed days.

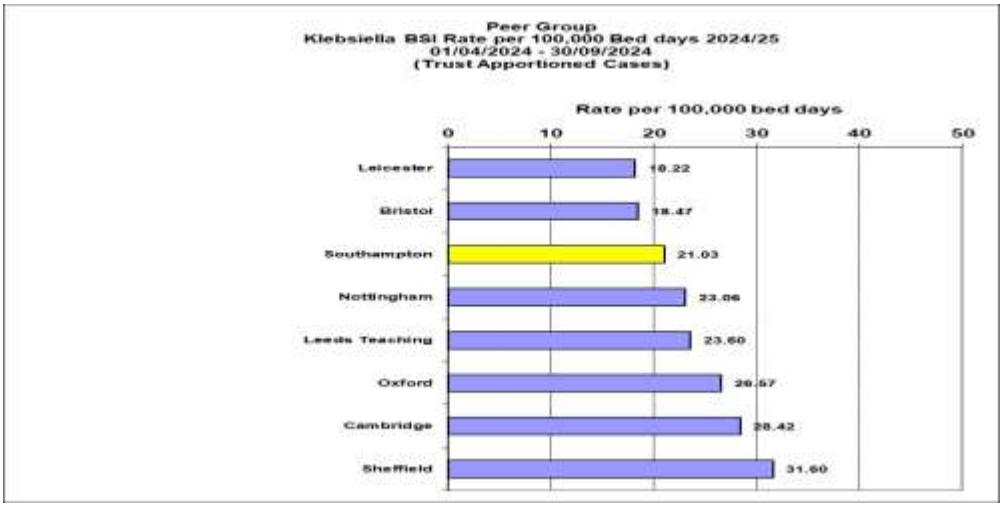
Klebsiella BSI: 43 cases year to date (Q1 & Q2) against a nationally set annual threshold of 56 cases for the year.



Q2 Progress
24 cases:

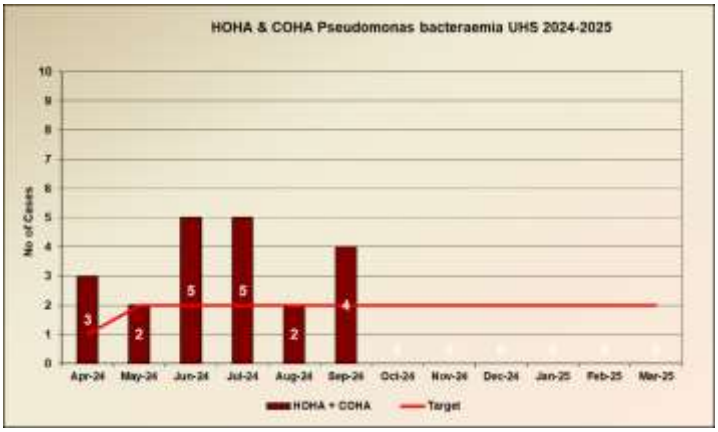
- 7 Community Onset – Healthcare Associated (COHA)
- 17 Hospital Onset – Healthcare Associated (HOHA)

7 concise case reviews undertaken.



UHS ranks third out of 8 self-selected peer acute trusts for Klebsiella bloodstream infection (BSI) per 100,000 bed days.

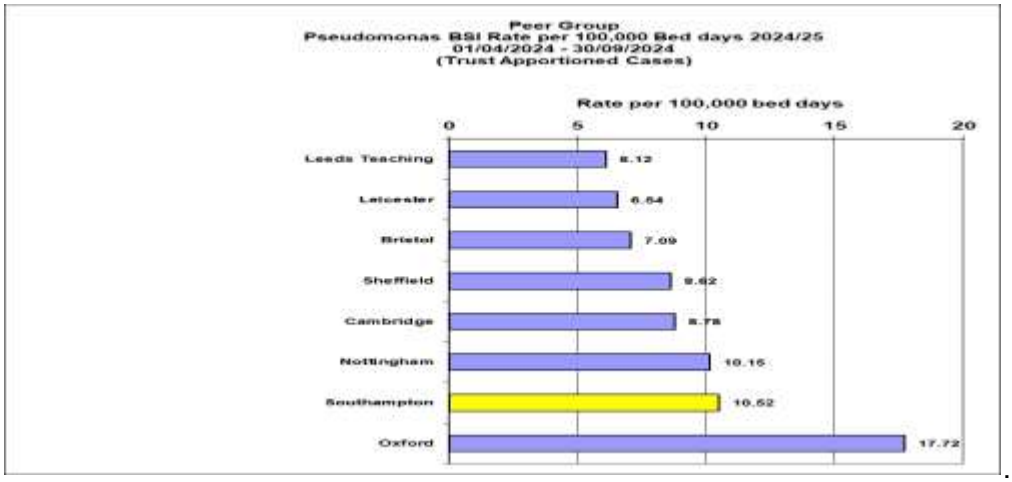
Pseudomonas BSI: 21 cases year to date (Q1 & Q2) against a nationally set annual threshold of 23 cases for the year.



Q2 Progress:
11 cases:

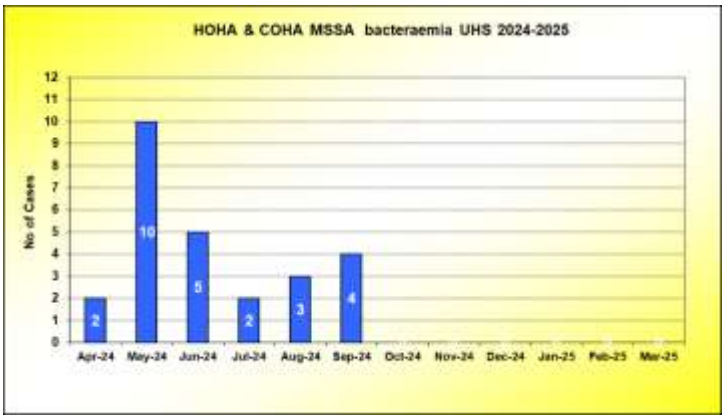
- 3 Community Onset – Healthcare Associated (COHA)
- 8 Hospital Onset – Healthcare Associated (HOHA)

1 concise case review undertaken.



UHS ranks seventh out of 8 self-selected peer acute trusts for Pseudomonas bloodstream infection (BSI) per 100,000 bed days.

MSSA BSI: 26 cases year to date. No nationally set threshold level but ongoing focus to minimise MSSA bloodstream infections.

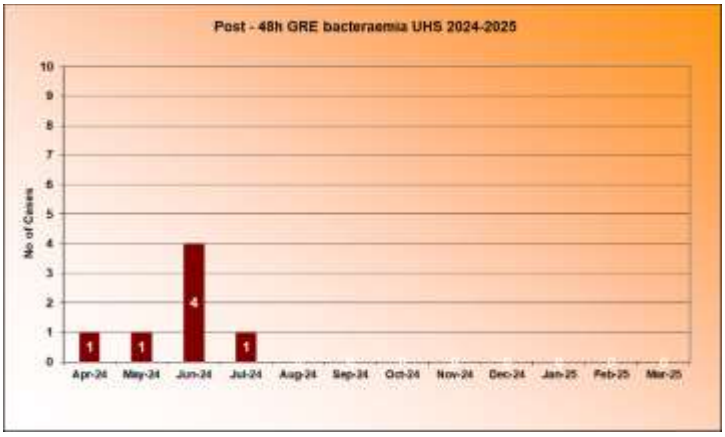


Q2 Progress:
9 cases:

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

3 concise case reviews undertaken.

VRE BSI: 7 cases year to date. No nationally set threshold level but ongoing focus to minimise VRE bloodstream infections.



Q2 Progress:
1 case:

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

1 concise case review undertaken.

Summary of Blood stream infection case reviews

A total of 95 cases of healthcare associated BSI (gram negative, MSSA & VRE) were reviewed in Q2. The likely source of infection was determined as:

Hepatobiliary	19% (n=18)
Intravascular Device (including Pacemaker/ ICD or CVC)	18% (n=17)
Lower Urinary Tract	16% (n=15)
Source Unclear	12% (n=11)
Lower Urinary Tract (Catheter Associated)	11% (n=10)
Lower Respiratory Tract (Pneumonia, VAP, Bronchiectasis, exacerbation COPD etc)	5% (n=5)
Neutropenic Sepsis	4% (n=4)
Gastrointestinal or Intraabdominal collection (excluding Hepatobiliary)	4% (n=4)
Upper Urinary Tract (Pyelonephritis/Abscess)	3% (n=3)
Skin or Soft Tissue (including Ulcers, Cellulitis, Diabetic Foot Infections without OM)	2% (n=2)
Bone and Joint (no Prosthetic Material)	2% (n=2)
Gut Translocation	1% (n=1)
Bone and Joint (with Prosthetic Material)	1% (n=1)
Cardiovascular or Vascular (without Prosthetic Material, including Fistula Infection)	1% (n=1)
Upper Respiratory Tract	1% (n=1)

For *E. coli* , Klebsiella, Pseudomonas, MSSA, and VRE BSI (HOHA/COHA) a concise review/IP&C practice review was completed by the Infection Prevention Team for cases that were deemed likely related to IV access devices, urinary catheters, surgical site infection or ventilator associated pneumonia where an initial review (by infection control doctor/senior infection prevention practitioner) identified potential concerns with IP&C practices or patient management that may have contributed to developing the BSI and/or cases where new learning was likely. Where deemed necessary, subsequent after-action review meetings were held with the relevant clinical team to review the case and focus on lessons learned, good practice, recommendations for improvement, agree actions & how learning will be shared.

19 concise case reviews were undertaken in Q2 with key themes/learning remaining similar to those in Q1:

- Gaps in documentation and assurance related to insertion and daily review and care of urinary catheters, including ongoing reason for catheter and plan for TWOC.
- Gaps in documentation and assurance related to daily review and care of IV devices including CADI form completion and reason for retention of cannula.

Focus on reducing healthcare associated BSI has remained ongoing in Q2 including:

1. Focus on reducing risk of catheter associated UTI (CAUTI) through management of urinary catheters, avoiding unnecessary catheterisation and appropriate early removal of catheters:
    - Review of patients with indwelling urinary catheters, as part of the weekly combined IP&C and AMS wards rounds (by IPT and pharmacy-micro team) to support discussions regarding ongoing need for catheter and plans for removal.
    - Ongoing project work in T&O to reduce the duration of catheterisation & development of a flowchart for the early removal of catheters with pilot of a nurse led TWOC protocol.
    - Ongoing delivery of a project (UCast project) with 3 other sites to develop and test a surveillance tool for urinary catheters and catheter-associated urinary tract infection (following a successful funding application to the Infection Prevention Society).
2. Improving IV device care and management
    - Review of patients with IV cannulas as part of the weekly combined IP&C and AMS wards rounds (by IPT and pharmacy-micro team) to support discussions regarding device care and management.
3. Improving hand hygiene practices and reducing glove use
    - Ongoing observation, education and awareness activities related to hand hygiene, including IPT covert hand hygiene audits.
    - Ongoing implementation of the 'give up the gloves' campaign to support reduction of unnecessary use of gloves.
4. Ongoing delivery of the UHS Fundamental Care Project led by the Deputy Chief Nurse.
5. Review of documentation of invasive device care and management, including options to improve the current forms on the electronic Inpatient Noting system.

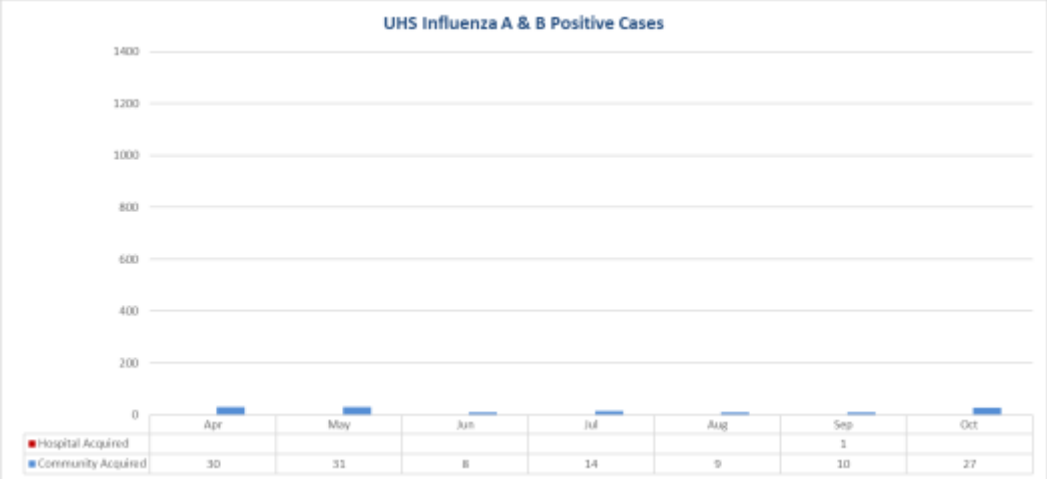
Further focus is planned in Q3 specifically relating to:

- Delivery of actions within the IP&C improvement plan focusing on hand hygiene, including an IP&C awareness campaign throughout the month of October.
- Quality improvement initiatives/projects in defined areas to improve the management of urinary catheters, avoiding unnecessary catheterisation and ensure appropriate early removal of catheters

2.2 Respiratory Viruses

Influenza

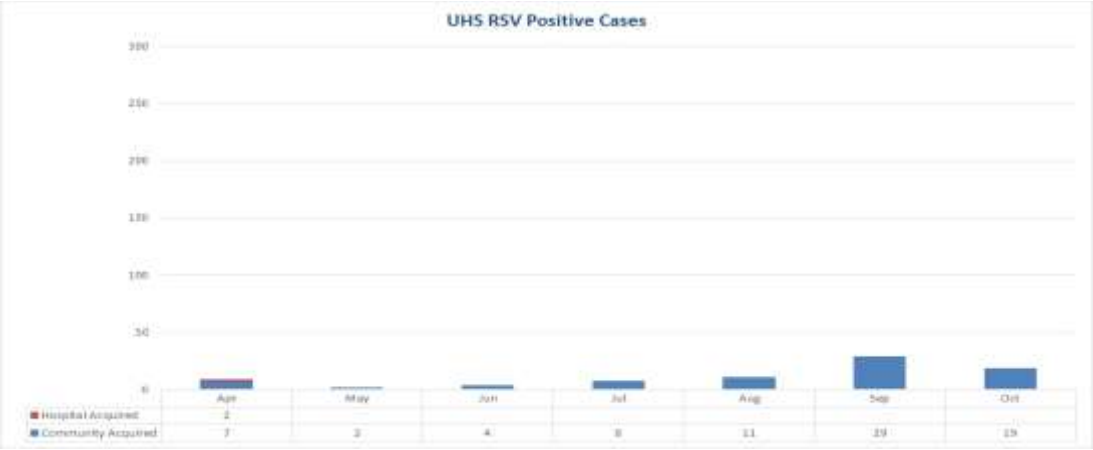
Prevalence of influenza remained low in Q2 as expected for the time of year. Of the cases seen within UHS, 33 were community acquired/community onset and 1 case was categorised as healthcare associated (samples taken from inpatients after 5 days of admission to UHS).



Source	Number of Cases	Number Admitted
ED	22	12
Admission Areas (AMU, MAOS,TAU)	5	
Inpatients	4	
Outpatients / Clinics	3	
Total	34	

RSV

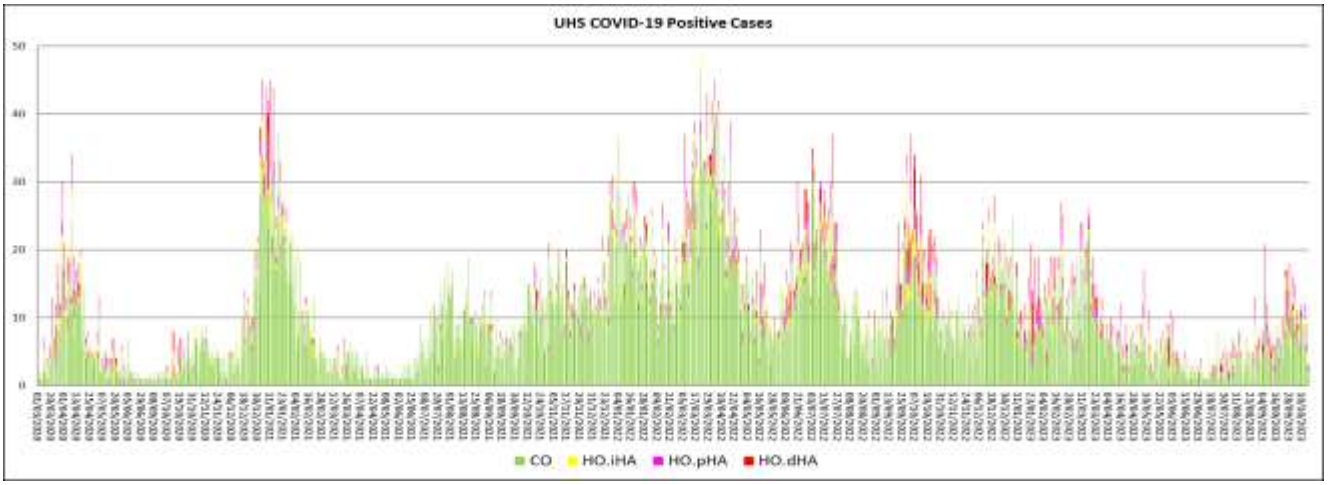
Prevalence of RSV remained low in Q2. Of the cases seen within UHS, 48 were community acquired/ community onset (40 children and 8 adults) and 0 cases were categorised as healthcare associated.



Source	Number of Cases	Number Admitted
ED	44	24
Admission Areas	2	
Inpatients	2	
Outpatients / Clinics	0	
Total	48	

COVID-19

Prevalence of COVID-19 increased in Q2 compared to both Q1 2024/25 and the same period last year (Q2 2023/24). This coincided with an increase in community prevalence.



Cases identified in UHS: July 2024 to September 2024

	Community Onset (CO)	Indeterminate (HO.iHA)	Probable (HO.pHA)	Definite (HO.dHA)
Q2	447	31	41	50

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

Respiratory Virus Outbreaks

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

	Number of Outbreaks	Total Number of Positive Patients	Total Number of Positive Staff
COVID-19	11	49	3
Influenza	0	0	0
RSV	0	0	0

Outbreaks continue to be managed by the Infection Prevention Team, with targeted control measures implemented as required and ongoing monitoring until 14 days following the last confirmed case. A number of small outbreaks of COVID-19 were seen in Q2 resulting in 5 bay closures and 13 lost bed days.

As a result of changes to testing and other IP&C measures it is now often difficult to determine specific factors that have resulted in acquisition of or outbreaks of COVID-19. The virus itself remains highly transmissible

and key themes contributing to this remain largely unchanged from 2023/24 including the physical environment (lack of ventilation & toilet/bathroom facilities on some wards) and patient factors.

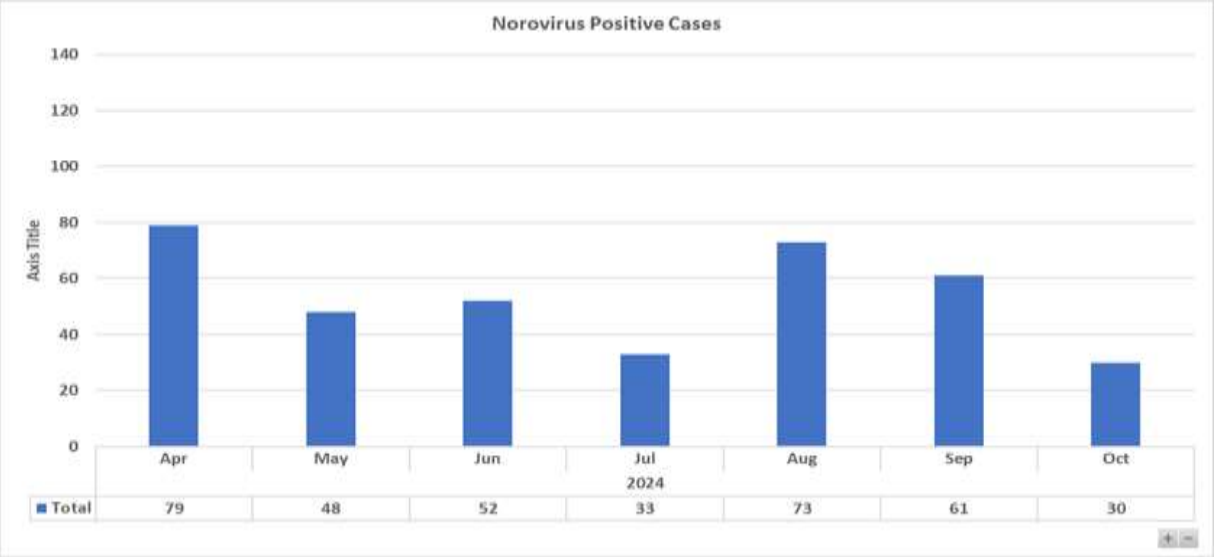
2.3 Viral Gastroenteritis including Norovirus.

167 patients tested positive for Norovirus in Q2.

- 20 bays closed due positive cases of Norovirus and the requirement to quarantine Norovirus contacts, with 25 lost bed days.

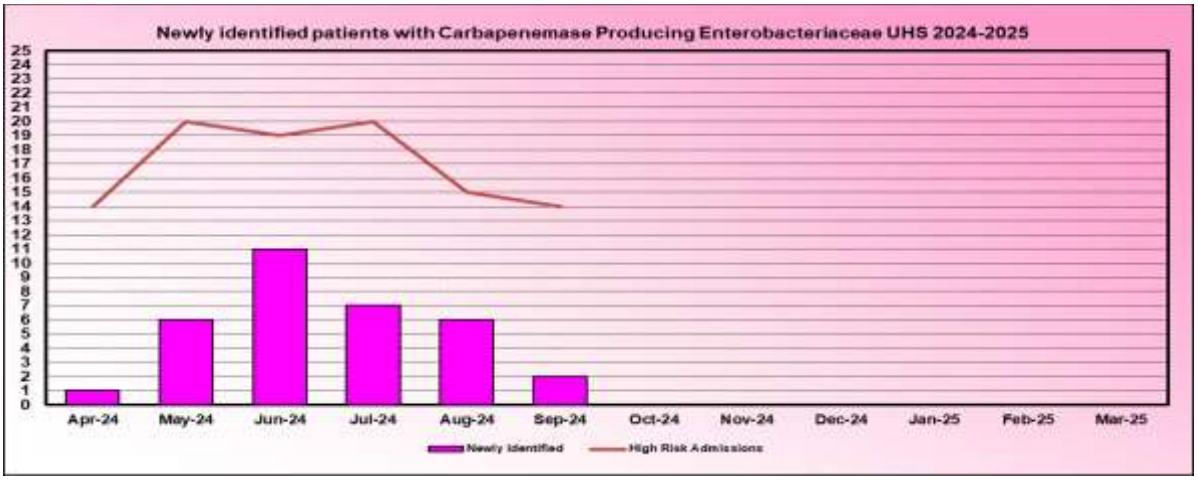
Source	Number of Cases
ED	60
Admission Areas (AMU, MAOS,TAU)	58
Inpatients	47
Outpatients / Clinics	2
Total	167

The majority of the Norovirus positive cases (132) were identified through use of rapid in-lab diagnostic testing for gastrointestinal (GI) pathogens for symptomatic patients (those with potentially infective diarrhoea) either on admission (in agreed admission pathways) or led by the IPT within ward bays throughout the hospital. The use of rapid GI testing continues to facilitate faster diagnosis (or exclusion of an infectious GI pathogen) within 2-3 hours of a rectal swab sample being taken rather than 24-48hrs if waiting for a standard laboratory test result on a stool sample. This results in earlier implementation of targeted control measures, such as isolation of patients with a confirmed positive result and quarantine of contacts (for Norovirus), reducing the risk of transmission to other patients and outbreaks occurring.



Year	Bed days lost due to bay/ward closures
2019-20	1039
2020-21	0
2021-22	361
2022-2023	503
Q1&Q2 2024-2025	240

2.4 Carbapenemase-producing Gram-negative bacteria.



- 15 newly identified CPE cases (from any sample site, including rectal screens and clinical samples) in Q2 compared to 18 in Q1.
- 49 high risk patients admitted to UHS in Q2 compared to 53 in Q1.

Carbapenemase-producing Enterobacterales (CPE) continues to be an increasing risk for UHS and early identification of patients at risk and appropriate management is the key to reducing risk of transmission.

Antimicrobial resistance including CPE, continues to be a major public health risk as identified by the World Health Organisation and as outlined in the UK's updated five-year national action plan, (published in May 2024) for tackling antimicrobial resistance (Confronting antimicrobial resistance 2024-2029).

Key actions to reduce risk and transmission from CPE:

- Focus on antimicrobial stewardship to reduce use of broad-spectrum antibiotics especially carbapenem group of antibiotics (e.g. Meropenem).
- To continue to undertake extensive screening for CPE including patients admitted that meet the high-risk criteria for CPE carriage and patients on carbapenems (e.g. patients who have recently been an inpatient in a hospital overseas).
- Ensuring consistent application of high standards of infection prevention practices, including regular review of inpatient cases of CPE by the IPT for assurance that correct IP&C precautions are in place to reduce minimise risk of transmission to other patients.

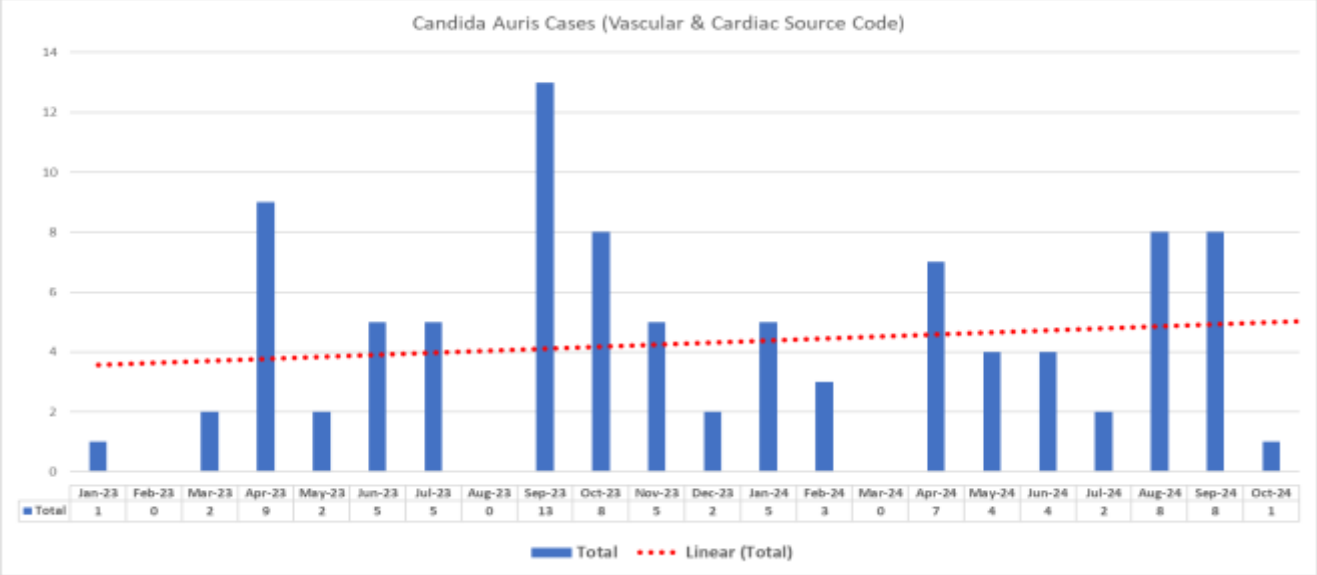
2.5 *Candida auris* outbreak

The outbreak of *Candida auris* centred on D4 Vascular ward at UHS, but also impacting on Trusts within the region whose patients access the UHS Vascular service, has continued with further cases identified in Q2. A wide range of control measures, remain in place and under ongoing review, with guidance and support from regional and national colleagues from UKHSA and other expert colleagues with experience of managing *C. auris* outbreaks.

To date (March 2023 - end of September 2024) 93 cases of *Candida auris* have been confirmed with the large majority of positive cases having spent some time as an inpatient on D4 ward or linked to cases who have spent time on D4. Whilst nearly all patients have been identified via surveillance screening within UHS.

The ward environment on D4 has been highlighted as a factor which is likely to have impacted on the ability to effectively and control transmission of *C. auris* and thus potentially contributing to the ongoing outbreak. This includes high ambient temperature, poor ventilation (no mechanical ventilation and limited natural ventilation), aging and deteriorating ward infrastructure (e.g. floor and ceiling tiles), limited space, cluttered and crowded ward environment which overall compromises the ability to effectively clean the ward. In response to the further escalation of the above concerns in the 2023/24 IP&C annual report remedial estates work was undertaken to improve the ward environment involving a full decant of the ward, followed by full high level decontamination of the ward using hydrogen peroxide vapour (HPV). The ward was closed for a period of 3 weeks to facilitate this with the vascular service relocated to ward F6 during this time.

Following re-opening of D4 on 09/09/2024, 2 new C. auris positive patients were identified through surveillance testing taken on 22/09/2024, having had a negative screen for C. auris on admission. Investigations suggest that these patients evidently acquired C. auris either on F6 or D4, either from an item of medical equipment or surface in the ward F6 or D4 ward environment or acquired it directly from a staff member(s), which would normally occur by direct patient contact by the staff member(s) with their hands (whether wearing gloves or not). A further review of control measures was undertaken in response to this including introduction of additional surveillance screening, further review of IP&C practices, cleanliness standards and equipment.



2.6 Other Infections

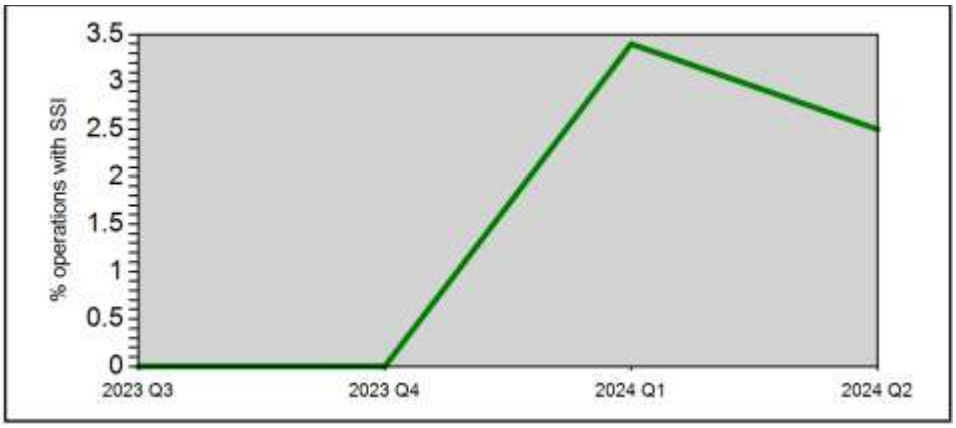
Within UHS, we continue to see a wide range of infections (single cases, clusters and outbreaks), outside of those already detailed in the report. These have been identified through laboratory reporting, UHS surveillance systems, national notifications, notifications from clinical teams. All have required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

Preparedness to safely respond to patients presenting with a potential High Consequence Infectious Disease (HCID) has been a key area of focus in Q1 and Q2 with plans and pathways being reviewed and updated, This has been led by one of the UHS Infectious Disease Consultants and Infection Prevention Matron, working in collaboration with clinical teams.

2.7 Surgical Site Infections (SSI)

Trends in Rates SSI

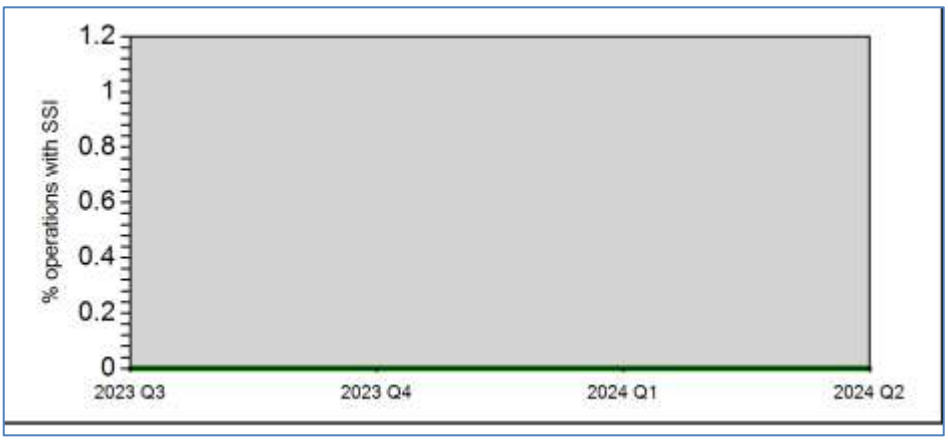
Percentage Operations Infected (Inpatient and Readmission SSIs) - Elective Hip replacement Category:



The trend data is based on a small number of operations. In Q1 2(58) infected cases (1 superficial and 1 deep infection) were reported to UKHSA. In Q2, 3(80) infected cases were reported. 1 of the cases was a patient reported infection, 1 superficial and 1 deep infection.

A meeting is scheduled to review the infections for governance purposes and learning from the discussions will be shared in the Q3 report.

Percentage Operations infected (Inpatient and Readmission SSIs) – Elective Knee Replacement category:



No infections have been reported in the knee category.

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

Infection Prevention Practice standards

The Trust annual infection prevention audit programme remains in place for 2024/25 to monitor infection prevention and control practice standards in clinical and non-clinical areas.

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

	Month	Element	% Standards met
Preventing Surgical Site Infection	August 2024	Pre-Operative	98%
		Peri-Operative	93%
		Post-Operative	99%
Care of Ventilated Patients	August 2024		91%

Hand Hygiene

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

Monitoring and assurance of hand hygiene practice for inpatient areas in 2024/25 will consist of:

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

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

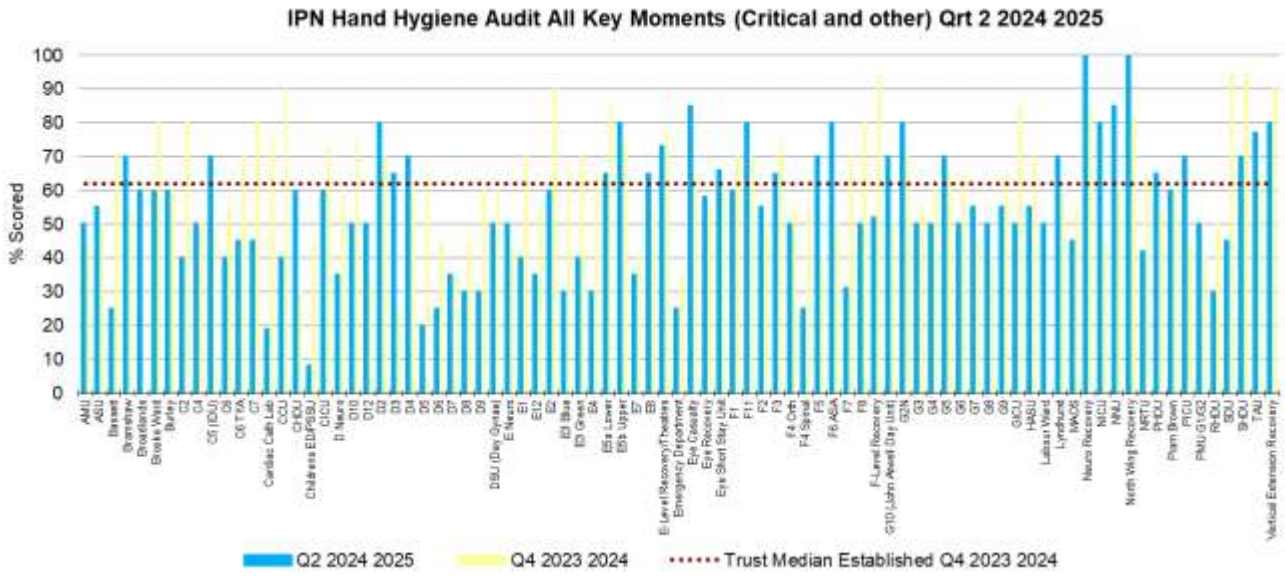
- peer audits only

Audit type	Month	% Standards met	
Inpatient areas (covert audit undertaken by Infection Prevention Nurses)	Q2 -All inpatient areas	Q2 overall trust median score = 54%.	Against a performance improvement target of 62%.

Within the hand hygiene performance improvement framework (non-self-assessed audits) for 2024/25 inpatient areas are now measured against a performance improvement target of 62% (increased from the previous score of 60% that was originally established in 2019). All areas are expected to improve performance to score above the trust median score.

Of the 85 areas audited within UHS Trust:

- 28 areas (33%) achieved on or above the Trust median score of 62%, a decrease of 22 areas compared to 50 areas (60%) in Q4 2023/24
- 57 areas (67%) achieved below the Trust median score of 62%.
- 12 areas achieved equal to or below 30%.



Actions and interventions to support improvements in hand hygiene practice in Q2 have included:

- Feedback of audit results to clinical areas, Care group & Divisional management teams with requirement to identify and implement measures for improvement.
- Areas not achieving expected standards have been required to implement local actions to improve practice.
- Areas achieving 30% or below have met with the Chief Nursing Officer and IPT to discuss and review improvement actions.
- Development of a trust wide IP&C improvement plan with specific focus on hand hygiene.
- The Infection Prevention Team have continued to work with ward leaders and matrons to improve hand hygiene practice, though education and awareness activities.
- Focus on improving standards of hand hygiene practice amongst medical staff and other staff groups.

Improving standards of hand hygiene practice will remain an ongoing area of focus in Q3 and beyond with delivery of actions within the IP&C improvement plan, including a focused IP&C awareness campaign throughout the month of October.

Miscellaneous Audits (all self-assessed)

Audit	Month	% Standards met	
Sharps Safety Audit	July 2024	97%	
Isolation Audit	July 2024	98%	
Personal Protective Equipment Audit	September 2024	98%	
Cleaning and Decontamination Audit	September 2024	Infected	98%
		Non-Infected	94%

Infection Prevention Accreditation – Mid Year Review April 2024 – Sept 2024

Target**:** All areas to achieve full accreditation at year end 2024/25.

Accreditation status for each clinical area is calculated based on self-reported performance in audits undertaken as part of the Infection Prevention Audit Programme (high impact intervention audits hand hygiene, miscellaneous audits), IPN Hand Hygiene Audits and clinical cleaning scores as detailed below:

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

Progress: Trust overall performance (146 areas):

April to September 2024 midyear review (based on self-assessed audit scores only) a total of 56 areas were fully accredited (38%) and 31 areas partially accredited (21%).

59 areas did not achieve full or partial accreditation (41%).

- 13 areas rated in Division A
- 17 areas rated in Division B
- 17 areas rated in Division C
- 12 areas rated in Division D

Non-submission of audits continues to be the main reason as to why areas are not achieving full accreditation.

Summary of actions to improve accreditation status:

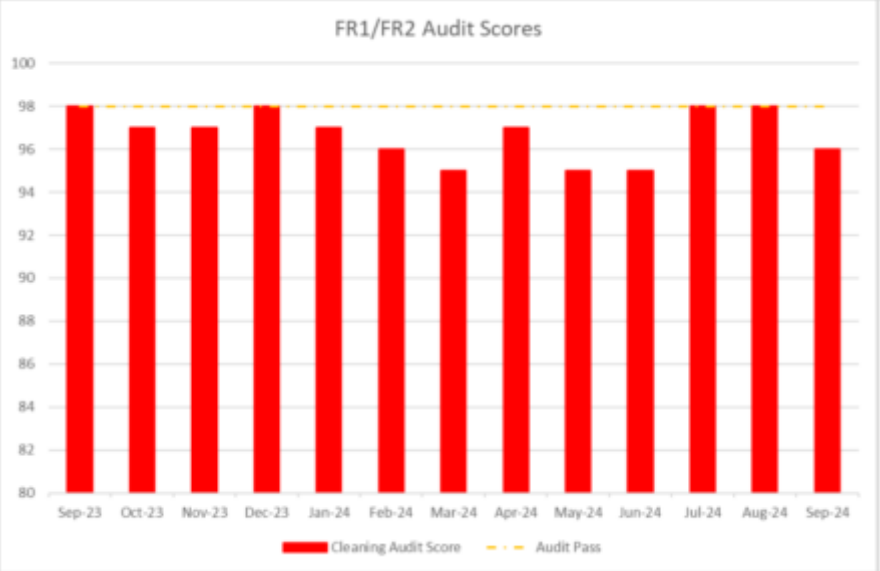
1. Divisions and Care Groups to review and review and take action in order to address those areas not meeting required standards, including ensuring that required audits are submitted as per the annual infection prevention audit programme.
2. The Infection Prevention Team to continue to work with areas to support achievement of full accreditation by the end of 2024/25.
3. Performance for individual clinical areas is subject to monthly review by the IPT as part of a continual improvement process.

Environmental Cleaning

Monitoring of environmental cleaning standards (domestic and clinical) continues to be undertaken by the environmental monitoring team and Serco in Q2.

During this period, the EMT have been operational at full capacity with work being completed to support the fundamentals of care and providing support with engagement with clinical teams and education for the Serco team. Levels of audits has remained consistent, ensuring all areas of the hospital are being assured for cleanliness, with star ratings being updated and sitting at 5* across the entire trust.

The average score of Serco domestic audits per month is 99%, however we are still seeing inconsistency with audit outcomes in the last quarter, not meeting the national target of 98% in September.

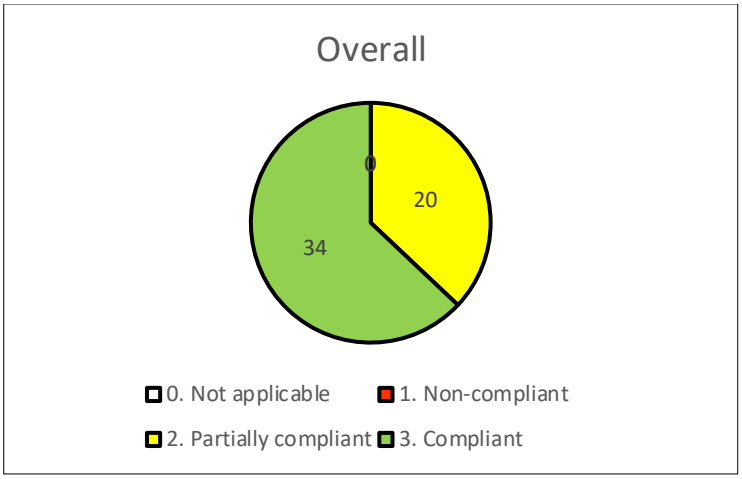


Over the last 12 months a total of 20,972 terminal cleans have been completed at an average of 1,747 per month, this is a slight increase on last year.

Clinical cleaning has seen an improvement with the average score sitting at 99% and clinical pass rates of 99% in July, 100% in August and 98% in September. This is a significant improvement from 12 months ago. The introduction of the clinical education lead has continued to see relationships between EMT, and the

clinical teams improve with much better engagement around clinical cleaning. A new escalation process for clinical cleaning has been approved and is now in use.

Infection Prevention and Control Board Assurance Framework.
The IP&C Board Assurance framework was updated by NHSE/I in September 2022 to enable a self-assessment of compliance with the new National Infection Prevention and Control Manual (NIPCM) and other related infection prevention and control guidance to identify risks associated with infectious agents, gaps in assurance and actions to mitigate/control risks. The UHS self-assessment against the 10 key lines of enquiry within the framework was reviewed and updated in Q2 2024/25 and presented to the Infection Prevention Committee. Gaps in assurance have resulted in a number of elements being assessed as partially compliant, with either mitigating actions in place or actions identified to meet assurance.



2.9 Antimicrobial Stewardship.

Antimicrobial stewardship, along with the focus on infection prevention and control, is a key component in reducing antimicrobial resistance and is a key requirement within the Health and Social Care Act 2008 : Code of Practice for health and adult social care on the prevention and control of infections and related guidance (updated 2022), with a requirement for registered healthcare providers to demonstrate appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance
Appendix 1 provides a full report on antibiotic usage/consumption within UHS (Note – full data for Q2 not yet available).

2.10 Estates & the Built Environment

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

The UHS EFCD team continue overall to have effective processes in place to ensure that consideration of IPC practices occurs throughout the planning, design, construction and refurbishment phases of a project, including regular consultation with the IPT.

Concerns continue to be highlighted in relation to the existing environment in many areas of our hospital sites (e.g. lack of mechanical ventilation, limited toilet/bathroom facilities, limited of isolation facilities, general

repair of ward/outpatient environments) and the impact on preventing & controlling infection. Reviews undertaken by the IPT in response to specific incidents/clusters/outbreaks of infection or identified via walkabouts continue to highlight a wide range of issues associated with the general fabric/repair of the environment which can have an impact on the ability to effectively prevent and control infection e.g. damage to the fabric of the environment which can provide a reservoir for micro-organisms and cannot be cleaned effectively. Whilst some progress continues to be made in addressing some of these issues e.g improvements to the ward environment on ward D4 (as outlined in section 2.6), rectification measures to address mould in labour ward rooms, funding remains a limiting factor.

Water Quality

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

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

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

In additional a sub-group has also been established with the remit to focus on key operational topic at each meeting e.g. use of point of use filters.

The annual Water Safety Audit was undertaken by the Trust Appointed Authorising Engineer in August 2024. Findings from this audit will be reviewed and an action plan developed that will be overseen and monitored by the Trust Water Safety group.

Progress continues to be made in addressing Pseudomonas in our water systems (as demonstrated by a continued reduction in positive water samples) and in completing remedial works required to improve water hygiene. Where sample failures do occur, investigations are undertaken to identify potential cause, measures implemented to mitigate risk to patients and actions identified to address issues.

In September 2024, multiple sample failures were identified in wards C2 and D12 (oncology) with Pseudomonas aeruginosa detected in 8 water outlets. Investigations were undertaken and point of use filters deployed to reduce the risk to patients. Measures have been identified to address the issue, including review of IP&C practices such as sink cleaning and engineering solutions related to the outlets.

Air Quality/Ventilation

Providing a clean environment, including fresh air, is considered essential to the healthcare environment. Good ventilation is an important line of defence for controlling transmission of infection which was highlighted further during the COVID-19 pandemic, where the association between transmission and outbreaks of respiratory virus infection, and poor ventilation in a range of settings (healthcare and non-healthcare) was clearly established. Focus on ventilation in the built environment may also further reduce the risk from many other healthcare associated infections such Norovirus, MRSA and multi-drug resistance organisms.

General ventilation across UHS wards, outpatient areas and offices is variable, with only a small number of areas having good ventilation. Many of the general inpatient wards within the SGH & PAH sites have no mechanical ventilation or do not meet the current standard for inpatient areas of 6 air changes per hour.

Many areas where ventilation is poor also experience high temperatures which affects both patient and staff wellbeing.

Long term solutions to improve/install mechanical ventilation in existing inpatient wards will require a large scale of work with potential disruption and significant investment. Long term solutions to install ductwork will be scheduled in line with future ward refurbishment programmes and newly built inpatient wards will be designed with mechanical ventilation e.g. D12 and E12.

Ventilation remains on the estates risk register (Risk 489) and is identified as one of estates highest priorities for addressing. It continues to be included in the backlog maintenance replacement programme but requires funding. Replacement of the existing air handling units (AHU's) which serve general west wing wards is scheduled for this year with the intention to deliver 4 AHUs compliant in design to HTM03-01 capable of delivering compliant airflows to areas served.

The use of portable air purification units to wards/bays deemed to be at high risk of respiratory virus transmission/outbreaks and in high-risk areas such as admission units continue to be used to address the risk relating to poor/lack of ventilation. However, use of these units is only a temporary short-term solution.

3.0 Operational and financial impact of Healthcare Associated Infection

Outbreaks of infection e.g. Norovirus, Influenza, COVID-19 can result in significant impact on operational capability/capacity of the Trust resulting in cancellation of elective procedures and staff absence. The increased length of stay and treatment costs associated with healthcare associated infection e.g. C. difficile, bloodstream infections, contributes further to decreased operational productivity. A recent study has estimated the total annual cost of healthcare associated infection in the UK to be 774 million pounds.

4.0 Appendices

Appendix 1: Pharmacy Anti-infectives Team Report (Q2 2024/25)
Appendix 2: Q2 Division A Matron and CGCL Report
Appendix 3: Q2 Division B Matron and CGCL Report
Appendix 4: Q2 Division C Matron and CGCL Report
Appendix 5: Q2 Division D Matron and CGCL Report

Appendix 1

Pharmacy Anti-infectives Team Report to Infection Prevention Committee ,TEC, Quality Committee and Trust Board.
November 2024 (covering Q1 and Q2 2024/25)

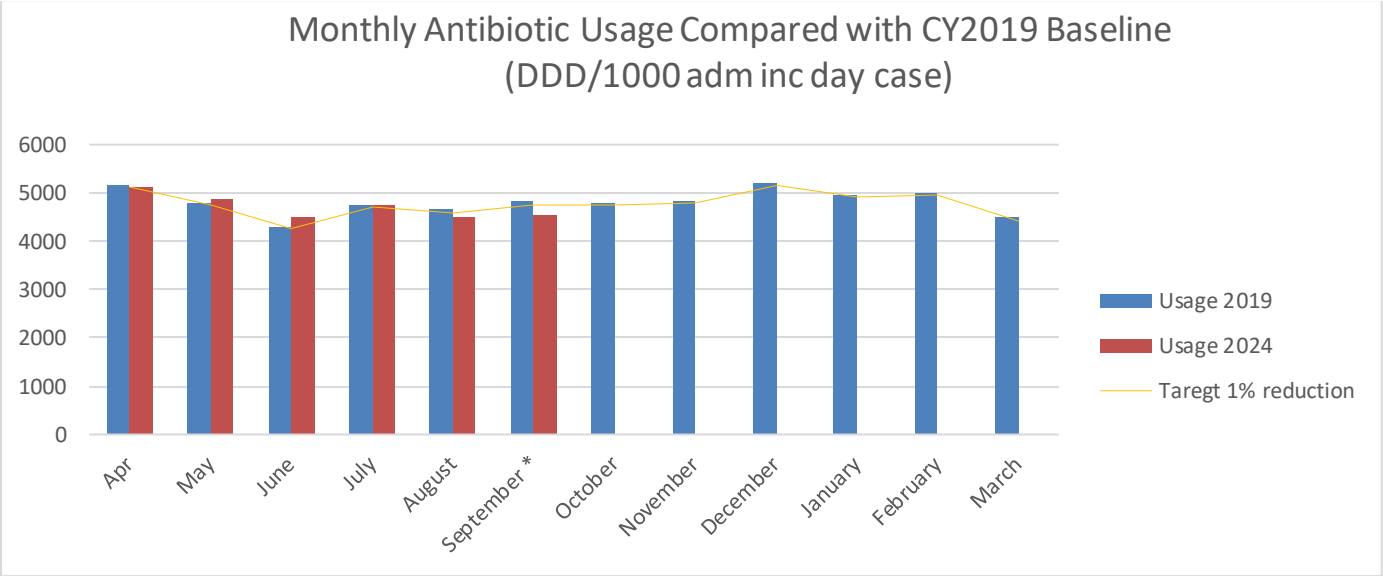
Introduction

Antimicrobial resistance is an emergent crisis threatening health outcomes across all healthcare settings. The Health and Social Care Act 2008 outlines responsibilities for antimicrobial stewardship (AMS) activity to ensure appropriate antimicrobial use to optimise patient outcomes whilst reducing the risk of adverse events and antimicrobial resistance. AMS functions well when there is strong leadership across clinical specialities and when adequate resources are deployed to allow effective change to occur. At UHS oversight is provided by the antimicrobial stewardship committee reporting via this medium to TEC and Trust Board.

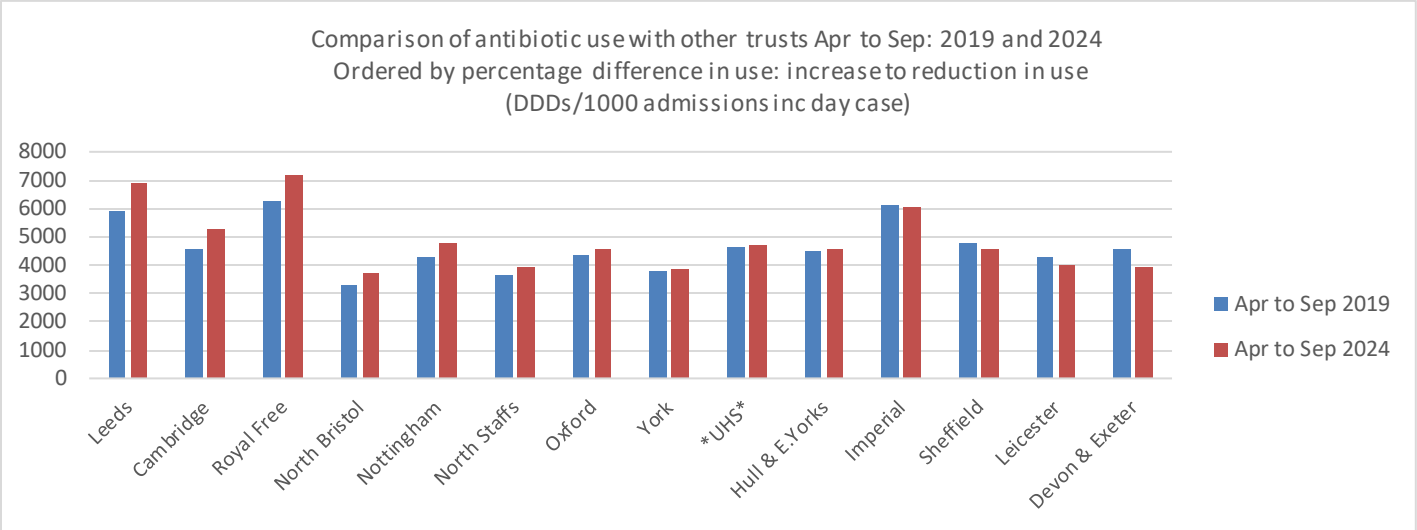
1. Reduction in Antibiotic Usage

a. Total Antibiotic Consumption Reduction

The second UK 5-year national action plan (NAP) for antimicrobial resistance was published in May 24 (Confronting Antimicrobial Resistance: policy paper) and provides targets related to antibiotic use. Over the next 5 years overall human antibiotic use should reduce by 5% compared to a baseline of calendar year 2019. The chart below compares Q1 usage 2024/5 to CY 2019. The required 1% requirement is indicated by the amber yellow line. Antibiotic usage (adjusted for activity) was 1.2% higher from April to July 2024 compared with 2019 baseline. This trend appears to have shifted to reduction in use of 3.4% for August 2024, *the September data is yet to be confirmed. There is an overall increase in antimicrobial usage of 0.3% over the first five months of 2024/25 compared with 2019 CY baseline.



The following chart shows how UHS compares to other teaching trusts in overall antibiotic use and change since 2019 baseline.

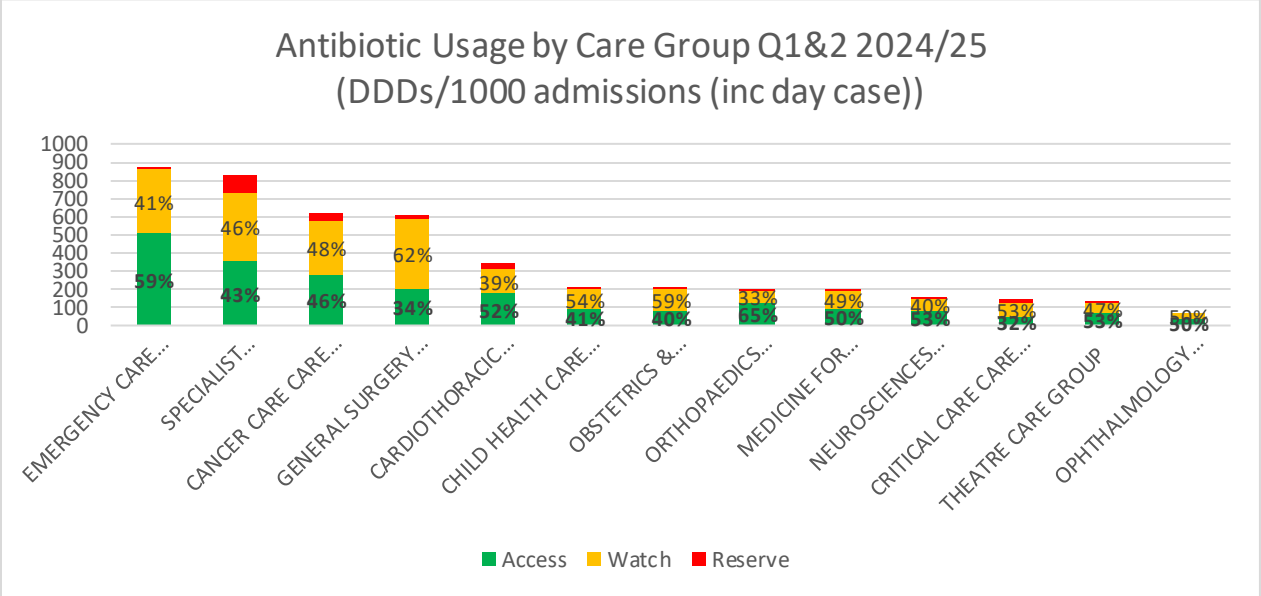


Ref: Internal reporting; source data from https://www.rx-info.co.uk/ (Define)

b. Type of Antibiotic Prescribed

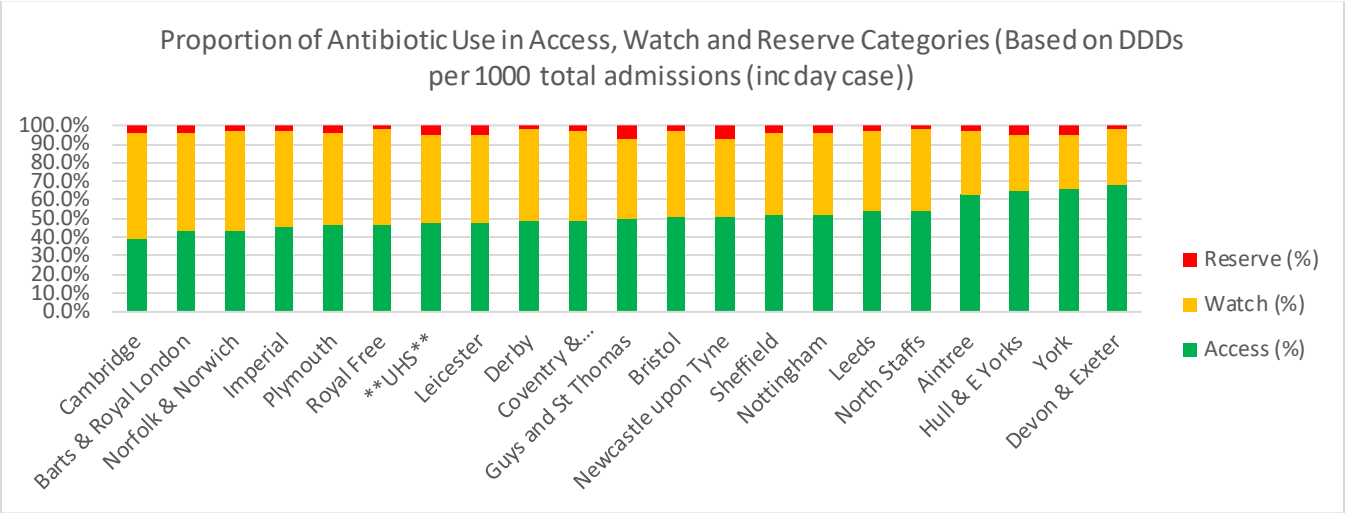
The NAP requires that the proportion of antibiotics from the access category of the UK adapted WHO AWaRe antibiotic classification should increase to 70% of total human usage by 2029. In the AWaRe antibiotic classification system, antibiotics are classified into three groups: access, watch and reserve. Access antibiotics tend to be narrower spectrum and should be used first line, whereas watch and reserve antibiotics are generally broader spectrum with activity against more resistant organisms, their use should be limited.

Overall antibiotic usage and the type of antibiotic used per care group can be seen in the next chart. The green category is the preferred access category with the watch category in amber and reserve is red. The emergency medicine care group has highest overall antibiotic use but includes medical outpatients and ED as well as medical wards. Specialist medicine's 11% use of reserve antibiotics are largely accounted for by antibiotic use in cystic fibrosis patients.



Ref: Internal reporting; source data from rxinfo report(Define)

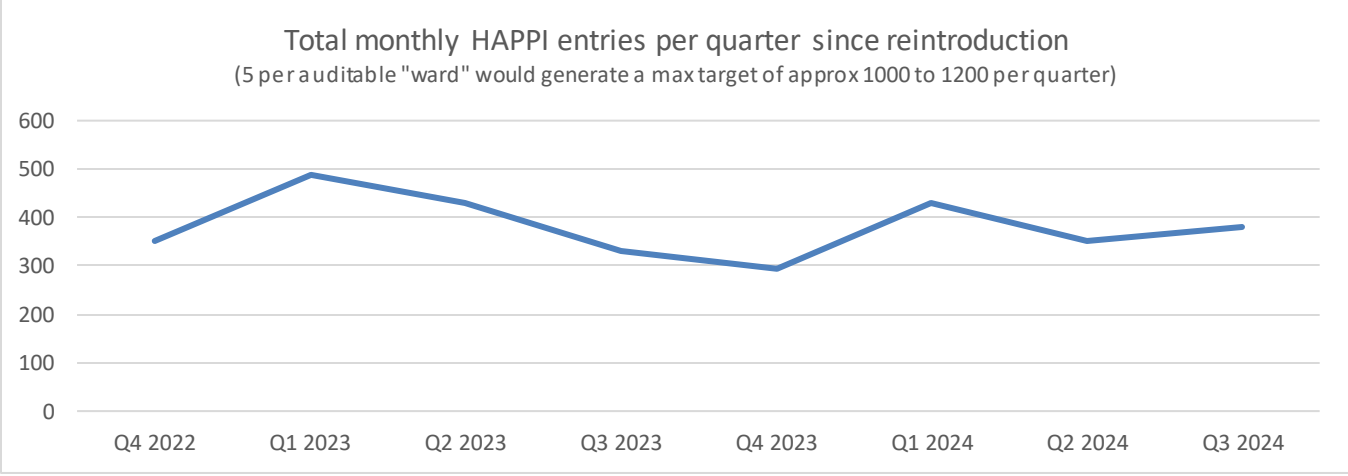
The following chart compares UHS to other teaching hospitals (April- September 24). In Q1 and 2 UHS averaged 47% access proportion of antibiotic usage. To compare, the highest trust use of access was at 68% and the lowest 39%.



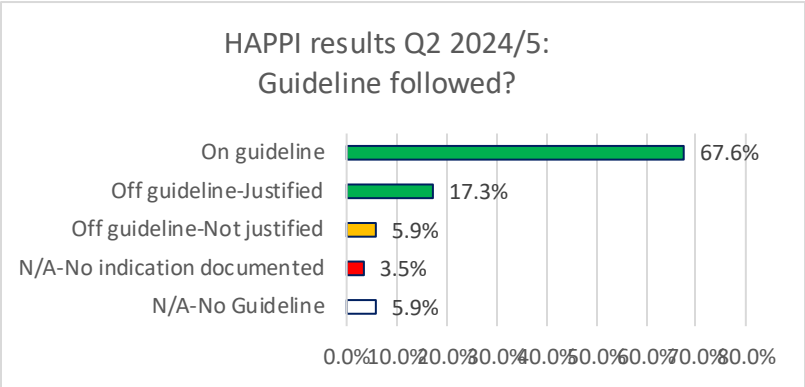
Ref: Internal reporting; source data from rxinfo report (Define)

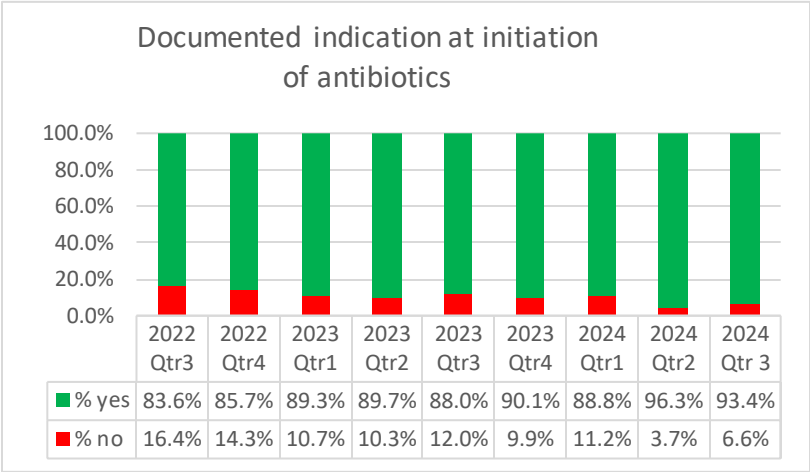
d. HAPPI Audits

Hospital Antibiotic Prudent Prescribing Indicators (HAPPI) audits have been re-introduced (September '22) to gain information on appropriateness of antimicrobial prescribing. They allow UHS to fulfil its obligation as per the H&SC Act 2008 to monitor the use of antimicrobials to ensure inappropriate and harmful use is minimised. **Note that patients are NOT selected randomly, making selection bias a possibility.** The aim is for 5 audits to be completed each month for each ward by the ward pharmacists.



HAPPI audit training for pharmacists resulted in an increase in completion rates in Q1 2024 from the steady decline in 2023. However the focus on discharge appears to be distracting pharmacists from inpatient care and has impacted on the number of audits completed, the recent drop has stabilised in the last quarter. However some clinical areas are not represented and this will be a focus for improvement should resources allow.





	2022 Qtr3	2022 Qtr4	2023 Qtr1	2023 Qtr2	2023 Qtr3	2023 Qtr4	2024 Qtr1	2024 Qtr2	2024 Qtr 3
% yes	83.6%	85.7%	89.3%	89.7%	88.0%	90.1%	88.8%	96.3%	93.4%
% no	16.4%	14.3%	10.7%	10.3%	12.0%	9.9%	11.2%	3.7%	6.6%

Of auditable cases 6.6% did NOT have a documented indication at the time of prescribing, this is an increase from 3.7% in Q1 2024/5 but an improvement on 16% in Q3 2022. Documenting the indication for an antibiotic is part of the national Start Smart then Focus antimicrobial stewardship toolkit.

A further element of the start smart then focus toolkit is audited: documented review of antimicrobial prescriptions at 48 to 72 hours. In Q2 2024/25 of 379 completed audits 153 were audited beyond this time. Of these prescriptions 87% had a documented review, a small decline on the result of previous quarter of 90.9%.

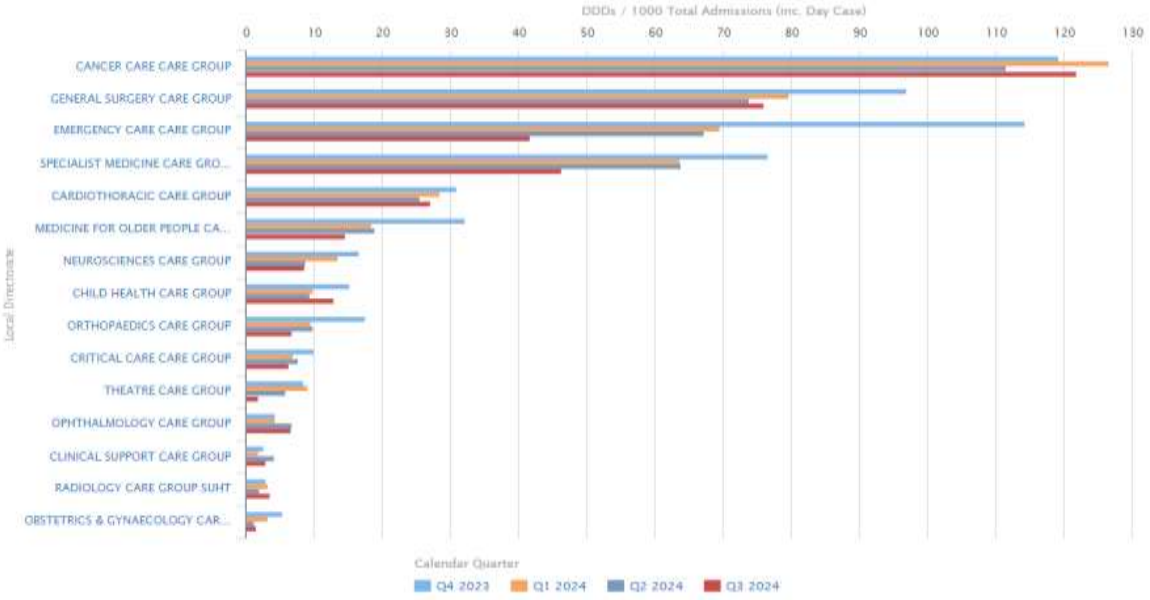
The number of times guidelines were followed (or justifiably deviated from) remains around 85% of cases.

2. Stewardship Targets

2a. Reduction in Fluoroquinolone use

Following the updated MHRA alert in January 2024 mandating that this class of antibiotics (including ciprofloxacin, levofloxacin, moxifloxacin and delafloxacin) should only be prescribed when other commonly recommended antibiotics are inappropriate work has been done to update guidelines and inform prescribers. Guideline updates to further minimise fluoroquinolone use were published in August. Overall use has reduced over the last 12 months.

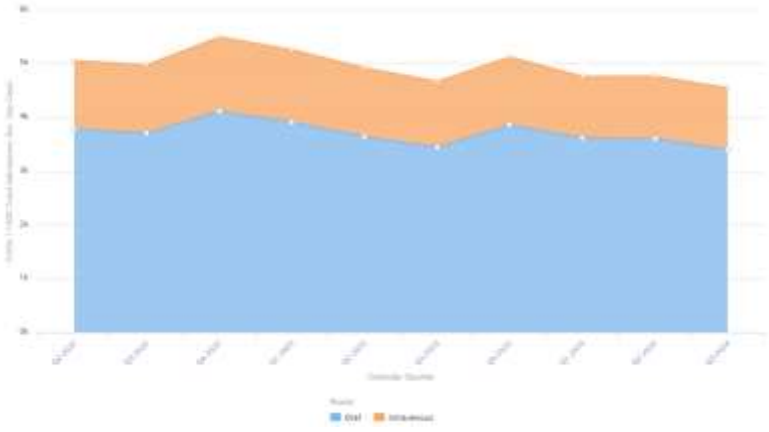
Fluoroquinolone use for each directorate from Oct 2023 to Sep 2024 Ref: Internal reporting; source data from Rx info(Refine)


DDDs / 1000 Total Admissions (inc. Day Case)
0
10
20
30
40
50
60
70
80
90
100
110
120
130
CANCER CARE CARE GROUP
GENERAL SURGERY CARE GROUP
EMERGENCY CARE CARE GROUP
SPECIALIST MEDICINE CARE GRO...
CARDIOTHORACIC CARE GROUP
MEDICINE FOR OLDER PEOPLE CA...
NEUROSCIENCES CARE GROUP
CHILD HEALTH CARE GROUP
ORTHOPAEDICS CARE GROUP
CRITICAL CARE CARE GROUP
THEATRE CARE GROUP
OPHTHALMOLOGY CARE GROUP
CLINICAL SUPPORT CARE GROUP
RADIOLOGY CARE GROUP SUHT
OBSTETRICS & GYNAECOLOGY CAR...
Local Directorate
Calendar Quarter
Q4 2023
Q1 2024
Q2 2024
Q3 2024

2b. Timely IV to Oral switch

Switching antibiotics to oral from IV has numerous associated benefits including saving nursing time and reduction in length of stay as well as reducing healthcare associated infection and reducing plastic waste. This was a quality improvement CQUIN for 2023-24 with value in continuing working on for the next year. Estimates are that 20% of patients on IV antibiotics at UHS could be on oral. This offers a potential £250-300k saving in drug costs per annum and nursing time saved equating to 15 WTE. Unfortunately, there has been no change to practice over the last 2 years. Despite executive leadership, an extensive communications campaign and attendance at care group and leadership meetings it is disappointing that there was no difference in practice noted. One area did improve following weekly microbiologist led ward rounds with some focus on IV to oral switch which shows that with more resource there could be an impact to realise these potential benefits. The plan for Q4 2024/25 is to trial a project in the medicines for older persons directorate with engagement of medical, nursing and pharmacy staff to see if localised engagement improves outcomes.

IVOS: Quarterly UHS proportion of intravenous to oral antibiotic use predating CQUIN to current time (Q2 2022 to Q3 2024)



Ref Rx info (Define)

3. Miscellaneous

This quarter the pharmacy infection team managed the transition of our antimicrobial guidelines from the Microguide platform to the Eolas platform due to the purchase of the former by the latter. This involved validation of the information transfer, ensuring communications for all staff and managing the transition of the non-infection guides as well as meeting the trust required governance arrangements for an IT system of this nature. This was a significant piece of work that was vital to ensure guidelines, as the cornerstone of antimicrobial stewardship, are readily available to all.

Appendix 2

Division A Q2 Matron and CGCL Report

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

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

Clinical Lead: John Knight, Aris Konstantopoulos and Aby Jacob

Date of Report: October 2024

Author: Colette Perdrisat

Performance Quarter 2 – 1st July to 30th September 2024

Key Indicator	Division A	Limit	Trust Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 1** (HOHA +COHA)
***Clostridium difficile* diarrhoea**	**2**	**Trust Limit 24**	**Trust Total 32** (HOHA + COHA)
E. coli (HOHA)	**10**	**Trust Limit of 36**	**Trust Total 50** (HOHA + COHA)
Pseudomonas (HOHA)	**3**	**Trust Limit of 6**	**Trust Total 11** (HOHA + COHA)
Klebsiella (HOHA)	**5**	**Trust Limit of 14**	**Trust Total 24** (HOHA + COHA)
MSSA Bacteraemia	**1**	**No Limit**	**Trust Total 9**
GRE	**0**	**No Limit**	**Trust Total 0**

Incidents / Outbreaks of Infection and PIIs	
MDRO in Bay on E8	Bay closed with MDRO contacts due to patient being placed in the bay, resulting in 4 patient contacts. Staff not checking CPI alerts on admission and once isolated, isolation door left open.
Pseudomonas PII on NICU	4 Cases healthcare associated of Pseudomonas within 28 days on NICU. Apron fell on the floor still used by staff. Staff found not bare below the elbows. Dusty Equipment (trolley frame, physio trolley and bio bin trolley) Missed hand hygiene opportunities.

Performance Year to Date: 1st April 2024 – 30th September 2024

Key Indicator	Division A	Limit	Trust Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 2** (HOHA +COHA)
***Clostridium difficile* diarrhoea**	**4**	**Trust Limit 99**	**Trust Total 61** (HOHA + COHA)
E. coli (HOHA)	**16**	**Trust Limit of 141**	**Trust Total 101** (HOHA + COHA)
Pseudomonas (HOHA)	**5**	**Trust Limit of 23**	**Trust Total 21**

			(HOHA + COHA)
Klebsiella (HOHA)	**10**	**Trust Limit of 56**	**Trust Total 43** (HOHA + COHA)
MSSA Bacteraemia	**2**	**No Limit**	**Trust Total 26**
GRE	**0**	**No Limit**	**Trust Total 6**

Key Learning from Investigation of Infections and Deaths:

Critical Care

Neuro ICU (Sept) **Pseudomonas Aeruginosa PII**. There was no correlation between 7 cases. Some IP learning identified: Encouraging BBE in the clinical area and hand hygiene in accordance with policy, all teams (nursing, medical and AHP) are receiving daily reminders including on-ward rounds and Hawkeye, with particular focus on visiting and external staff.

- Encouraging the correct use of PPE as part of general surveillance and 'use of PPE' audit in September (in particular use of visors, changing PPE between tasks and not using PPE that falls on the floor). Reminders and education on unit and as part of MSD continues. As part of an ongoing Neuro ICU project, bed space layouts are being reviewed to ensure IPT and PPE accessibility is considered.
- Ensuring equipment is cleaned daily and is compliance is monitored by IP links during cleaning and decontamination audit. Liaising with physios and other members of neuro ICU to ensure equipment and BioBin trolleys are included in the daily clean. Cleaning records are available for completion attached to physio trolley, and other trolleys in the unit. concerns expressed regarding 'dust' is from fibres from the cloths being used. This information has been relayed to IPT via email. Awaiting reply from IPT. Monitoring continues.
- Report from the water safety team*: The water has been a source of contamination but on testing all the outlets in the clinical area are free from pseudomonas as we have modern systems in place. However, the water in the 2 staff toilets (filters in place) and the shower in rest room 1 are positive.* Staff are now using alcohol gel after hand washing in toilets which is available either in the room or dispenser just outside.

The flow of water through the filters can reduce to a dribble and this indicates they are doing the job and should be changed. They are currently on a 12-week replacement cycle which is too long so will be reduced to 8 weeks. Please report to estates if the flow is reduced so they can be replaced earlier. Matron to address requirement to remodel staff toilet facilities, to incorporate a larger sink, to avoid splash back, and possible replacement of old water pipes, to prevent need for filters.

There is a follow up water meeting 12/11/24 to be attended by a Neuro ICU representative to get latest water results for Neuro ICU. The Neuro ICU senior team will be vigilant if water filters require changing and action it. IP links on Neuro ICU will follow up with water team at regular intervals.

- Respiratory precautions – practice continues to be observed and remind given regarding cleaning/disposal of ventilator circuits and consumables e.g. nebuliser pods. Nothing incorrectly witnessed during PII. Cough Assist machine used by physiotherapists - IPT have provided cough assist tubing care recommendations. This information has been disseminated to all staff and Critical Care physios. The rep. for new Cough Assist machine, attended the unit. Neuro ICU education, and physio team attended training where questions were asked about cleaning, multiple patient use and storage of patient specific tubing between use. Teams fed back to wider neuro ICU team.

CICU – (August) **Candida Auris** across CV&T and CICU. Additional screening at initial outbreak, now admission screening for CICU (combined groin and axilla swab, and all accessible wounds) continues. No further cases identified on CICU. CDiff (August) x1 all elements of care bundle adhered to.

GICU (August) **Pseudomonas BSI** – related to wound infection but no learning was identified after in-depth patient notes review.

All key learning is shared in local IP newsletters and MSD across critical care.

Progress and Success:

Critical Care

GICU – no further cases of Achromobacter xylosoxidans since the last quarter.

Environmental audits in SHDU, Neuro ICU and CICU 98-100%.

Isolation audits 100% for all of critical care, Sharps audit 100% for GICU, CICU and SHDU.

VAP audit and surgical site infection audit 100%, PPE and cleaning/decontamination audits 100% GICU, CICU and SHDU

Lead IP Sister and Matron walkabouts commenced within Critical Care.

No further complaints regarding powder paint deteriorating off Hamilton Ventilators. Ongoing surveillance continues.

Ophthalmology

- Performance of the 4 areas

Ward	2024 2025 Ongoing %	Comment
ESSU	99	**Fully compliant to September 2024**
Eye Casualty	89	**Audit Non-Compliance** Sharps Safety Audit July 2024 – 92% PPE Audit September 2024 – 84% IPN Covert Hand Hygiene Audit Q2 2024 25 – 85%
Eye Outpatient Department	97	**Fully compliant to September 2024**
Eye Unit Theatres	82	**Audit Non-Submission** Isolation Audit July 2024 **Audit Non-Compliance** IPN Covert Hand Hygiene Audit Q2 2024 25 – 58% **Clinical Cleaning Scores – Target 98%**

- Environmental audits from EMT – predominantly 98-100% in all areas except MR (See Ongoing challenges)

Theatres

Continue seeing excellent clinical clean results.

Focus on hand hygiene across all clinical areas with a specific focus on F level recovery. Marked improvement but work still continues with regular re audit.

Waste management improvement continues to be implemented with upcoming audit of clinical waste due soon.

Reviewing recovery capacity and demand and looking at the option of keeping VE recovery (the one area with side rooms) open until 22:00.

Large number of cardiac sternal wounds noted 10-14. Reviewed by infection prevention and not issue raised with cardiac theatres practice.

Ongoing Challenges:

Critical Care

Neuro ICU (June 2024) CPE positive spinal patient cared for in main unit of NICU (rather than managed in isolation side room). This was risk assessed with consultant microbiologist and IPT nurse and appropriate enhanced precautions were carried out on the main unit. There is a requirement for support for Neuro ICU to consider any future expansion with increased isolation facilities. The side room capacity has already been raised as an alert is on the Risk Register due to the difficulty/ inability to isolate all necessary patients for certain infections due to their complex spinal management (e.g. 5-6 staff 3 hrly turns).

GICU - Environmental monitoring audits – failures now on Black alert (although no failures since June until week 4 of September: 97%). Action plans written to remind staff to clean all blood splashes from around blood gas machine and BioBins and associated labels and ensure all beds particularly those arriving from other areas are inspected and cleaned if found to be dirty. Bed cleaning (from other areas) can take up to ½ hour per bed. Advocating AERS to be completed for all unclean beds arriving to CC areas.

93% sharps audit in NICU – wrong items in BioBins. PPE 94% and cleaning/decontamination audit 90% – further education required with ongoing surveillance and repeat audit.

Waste audit - Staff across the critical care group are confused about waste segregation due to the number of waste streams. Ongoing education and posters displayed, working with waste management and encouraging more staff to become waste advocates.

Covert hand hygiene audits by IPT GICU 50%, CICU 60%, SHDU 70%, NICU 80% - ongoing education, surveillance and repeat audits by local IP links. What are our specific actions that have been agreed to improve.

Fit Testing compliance within care group is improving, but there are still a large number of nursing and medical staff who have only 1 or no mask fitted in accordance with the Trust's 2 FFP3 masks fitted 2 yearly. Very few staff able to fit test. There is still a requirement for PeRSo hoods, ongoing education, servicing and storage continues. Fit Testing room capacity in CC soon to be limited with GICU refurbishments taking out existing room.

30.10.24 fit testing compliance in Critical Care	2 masks	1 mask + PeRSo = 2 mask	1 mask	No data/ no mask
CICU (96)	47%	50%	21%	22%
GICU (220)	73%	80%	20%	7%
NICU (93)	4%	-	29%	67%
SHDU (43)	58%	61%	21%	
CCOT (14)	5%	-	43%	36%
CC techs (24)	25%	33%	25%	50%
Consultants CICU (16)	6%	-	0%	94%
Consultants GICU (25)	12%	24%	24%	64%
Consultants NICU (12)	-	-	-	100%
CC ACCP (11)	(2)	-	(2)	(7)
554	55%		21%	33%

Surgery

E5 lower had 2 cases of c-diff and samples have been sent for ribotyping. Action plan has been submitted by ward

Ophthalmology

- Failure of environmental audits predominantly in Medical Retina Suite although improvements seen.
- Low submissions, compliance with audit results in Eye Unit Theatres and Eye Casualty.

Actions Taken:

- Regular Walkabouts: Senior nursing staff, alongside the matron, are conducting frequent walkabouts to ensure improved compliance and to identify ongoing issues.
- Identify IPC Link Staff assigned to each area.
- Quarterly IPC Meetings: A structured plan to hold quarterly IPC meetings has been set up. These meetings will include IPC Division A staff and focus on; reviewing audit compliance and discussing results action plans.
- IPC Boards: Results and updates from audits will be clearly displayed on IPC boards in all relevant areas to keep staff informed and engaged in ongoing infection prevention efforts.

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

Critical Care

Current focus HCID planning in GICU – PPE ordering, donning/doffing education, posters and information folder.

Continuing to focus on correct waste segregation, hand hygiene and environmental cleanliness across all areas and improvements in other IP audits, whilst highlighting actions/ lessons learnt following post infection reviews and based on audit results. Continuing to encourage AERs to be written for any dirty beds arriving from other ward areas.

Critical Care IP link sister support the care group, completing observations of practice, surveillance to ensure staff are following policy and providing assurance that infection prevention practices are adhered to. Information is cascaded via newsletter, emails and one to one education whilst in the clinical areas.

Ophthalmology

Continue to closely monitor endophthalmitis cases.

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

None

Date this report will be an agenda item at Care Group Governance Meeting	Date this report will be an agenda item at Divisional Governance Meeting
October 2024	October 2024

Appendix 3

Division B Q2 Matron and CGCL Report

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

Matrons: Steph Churchill, Julia Tonks, Susie Clake, Matthew Payne, Claire Smith, Emma Chalmers, Sandra Souto, Carole Spratt, George Kirk, Steve Hicks, Gillian Lambert, Nat Kinnaird, Samantha Brownsea and Kat Black

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

Date of Report: October 2024

Author: Suzy Pike

Performance Quarter 2 – 1st July to 30th September 2024

Key Indicator	Division B	Limit	Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 1** (HOHA +COHA)
***Clostridium difficile* diarrhoea**	**8**	**Trust Limit 24**	**Trust Total 32** (HOHA + COHA)
E. coli (HOHA)	**11**	**Trust Limit of 36**	**Trust Total 50** (HOHA + COHA)
Pseudomonas (HOHA)	**3**	**Trust Limit of 6**	**Trust Total 11** (HOHA + COHA)
Klebsiella (HOHA)	**5**	**Trust Limit of 14**	**Trust Total 24** (HOHA + COHA)
MSSA Bacteraemia	**1**	**No Limit**	**Trust Total 9**
GRE	**0**	**No Limit**	**Trust Total 0**

Incidents / Outbreaks of Infection and PIIs	
Candida Auris Positive patient in Bay on AMU	Patient with Candida auris alert on the system admitted to bay 3 on AMU, resulting in 4 patient contacts. Staff not checking CPI for alerts.
CPE positive patient admitted to bay on D12	Patient admitted in bay 3 on D12 from AOS with a CPE positive alert, resulting in 3 patient contacts. Staff not checking CPI for alerts. Staff not communicating within their team, Nurse looking after the bay did not communicate with NIC.
HCID patient in bay on AMU	Patient admitted via ED treated as HCID due to travel to Guinea isolated in ED but move to a bay on AMU. Delay in testing at Porton down meant full VHF PPE had to be worn for a further 24 hours.
Patient with MDRO admitted to Bay on C4	Patient alerted for MDRO was admitted to C4 Room 1 from MAOS, resulting in 5 patient contacts. Staff not checking CPI alerts and communicating on transfer.
Patient with pulmonary TB admitted to Bay on G6.	Patient with suspected pulmonary TB admitted to Bay on G6 (Pending TB result), resulting in staff and patient contacts.

Performance Year to Date: 1st April 2024 – 30th September 2024

Key Indicator	Division B	Limit	Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 2** (HOHA +COHA)
***Clostridium difficile* diarrhoea**	**20**	**Trust Limit 99**	**Trust Total 61** (HOHA + COHA)
E. coli (HOHA)	**20**	**Trust Limit of 141**	**Trust Total 101** (HOHA + COHA)
Pseudomonas (HOHA)	**4**	**Trust Limit of 23**	**Trust Total 21** (HOHA + COHA)
Klebsiella (HOHA)	**7**	**Trust Limit of 56**	**Trust Total 43** (HOHA + COHA)
MSSA Bacteraemia	**4**	**No Limit**	**Trust Total 26**
GRE	**3**	**No Limit**	**Trust Total 6**

Key Learning from Investigation of Infections and Deaths:

- Checking alerts on CHARTS as part of admission process.
- Review of check list for HCID and guidelines with IPT.
- Asking travel questions in all admission areas.
- ED Specific - Code orange trolley updated and now stored in sisters' office, which can be accessed 24/7. Tag attached to ensure kit is not easily removed.
- Use of isolation risk assessment tool

Specialist Medicine- Nil linked to the above.

Progress and Success:

Cancer care:
Hand hygiene focus ongoing.
Emergency Medicine:
Ongoing hand hygiene audits within the Emergency department. Hand hygiene focus week in October.
Linking with clinicians for hand hygiene education at handovers and as part of focus week.
Staff encouraged to nudge visiting teams if poor practice is observed.

AMU- Letter to all staff (Nursing and Medical) sent with expectations and standards of IP.
Monthly meeting ongoing with IPC team to discuss issues arising and next steps
Hand hygiene spot checks and 'light box' focus week (w/c 21st Oct)

Acute Medicine/Mop-
-Letter to all ward areas regarding standards and expectations of IP. Action plans created by those areas scoring 40% or below.
-IPT Walkabout template produced and plan for matrons/B7s and teams to walk other areas within care group.
Monthly IP meetings with IP Team to update areas of concern and good practice.
Reviewing SNAP audits and action plans are taken through the governance process.

Specialist Medicine-
For PPE audit in September 2024, all submitted areas scored 97- 100%. Some areas on non-submission in PFTs and Sleep (Lymington). PFTs is often included in the D level/TRC submission, will aim to check with audit lead.
For sharps safety audit in August 2024, all submitted areas scored 96-100% with no areas of non-submission.

Ongoing Challenges:

Cancer care
Increase in AER's submitted related to lack of SR's, which supports in highlighting SR pressures.

Pseudomonas discovered from water testing on C2 and D12. Filters installed and replaced by estates. Highlighted difference in expected frequency of Serco cleans on the late shift vs cleans getting done. Followed up by ward leaders with IPT.
Continued focus on hand hygiene and improving compliance in all staff groups.

Emergency Medicine
Hand hygiene in majors is particularly challenging when busy and over capacity as many of the gel dispensers are along the walls where trolleys are queued with patients, making them less accessible. Linking with other emergency departments to hear how they tackle these challenges.

Lack of SR availability within the emergency department makes isolating infections very challenging and at times this is not possible. IPT reviewing which infections are higher risk and should be prioritised due to new infections such as candida.

AMU- Visiting clinicians and teams not always adhering to IPC standards. Staff are encouraged to challenge lack of compliance.
Alcohol gel dispensers not always working. Maintenance book in place to report and monitor this.

Acute Medicine/Mop
Gel dispensers not filled on entrance to a lot of clinical areas this has been escalated to Manjeev Pathak and George Clark. This is being monitored.

Specialist Medicine-
Some ongoing work in Dermatology RSH with regards to use of sterile gloves vs non-sterile gloves for minor procedures. Discussion between surgical lead and IPT/Micro to explore evidence and criteria. To update in next report.

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

Cancer care:
Current focus on hand hygiene and updating cancer care respiratory virus policy ready for Winter.
Capacity including SR's now on risk register.

Emergency Medicine:
Continued hand hygiene focus.
SR challenges remain on issue log.
Continued reminders regarding travel and M-pox as updates available.

Acute Medicine/Mop Continue focus on hand hygiene Specialist Medicine- as above. Ongoing review of areas on non-submission as some services are often audited within one shared area (eg TRC with PFTs)

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

Nil

Date this report will be an agenda item at Care Group Governance Meeting	**Date this report will be an agenda item at Divisional Governance Meeting**
October 2024	October 2024

Appendix 4

Division C Q2 Matron and CGCL Report

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

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

Clinical Lead: Balamurugan Thyagarajan and Charlie Keys

Date of Report: April 2024

Author: Louisa Green, Emma Northover

Performance Quarter 2 – 1st July to 30th September 2024

Key Indicator	Division C	Limit	Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 1** (HOHA +COHA)
***Clostridium difficile* diarrhoea**	**3**	**Trust Limit 24**	**Trust Total 32** (HOHA + COHA)
E. coli (HOHA)	**0**	**Trust Limit of 36**	**Trust Total 50** (HOHA + COHA)
Pseudomonas (HOHA)	**2**	**Trust Limit of 6**	**Trust Total 11** (HOHA + COHA)
Klebsiella (HOHA)	**4**	**Trust Limit of 14**	**Trust Total 24** (HOHA + COHA)
MSSA Bacteraemia	**1**	**No Limit**	**Trust Total 9**
GRE	**0**	**No Limit**	**Trust Total 0**

Incidents / Outbreaks of Infection and PIIs	
Enterobacter PII on NNU	3 neonates with Enterobacter. Serco domestic not changing gloves and not doing hand hygiene. IPT/ Neonatal unit to facilitate isolation and management of patients with MDRO's

Performance Year to Date: 1st April 2024 – 30th September 2024

Key Indicator	Division C	Limit	Status
MRSA Bacteraemia	**1**	**Trust Limit 0**	**Trust Total 2** (HOHA +COHA)
***Clostridium difficile* diarrhoea**	**7**	**Trust Limit 99**	**Trust Total 61** (HOHA + COHA)
E. coli (HOHA)	**3**	**Trust Limit of 141**	**Trust Total 101** (HOHA + COHA)
Pseudomonas (HOHA)	**3**	**Trust Limit of 23**	**Trust Total 21** (HOHA + COHA)
Klebsiella (HOHA)	**8**	**Trust Limit of 56**	**Trust Total 43** (HOHA + COHA)
MSSA Bacteraemia	**2**	**No Limit**	**Trust Total 26**
GRE	**0**	**No Limit**	**Trust Total 6**

Key Learning from Investigation of Infections and Deaths:

Neonates
An investigation was conducted regarding the Enterobacter outbreak in the Neonatal Unit. Staffing limitations have impacted the availability of isolation rooms; however, this is mitigated by Infection Prevention measures, with all infected infants being cared for in incubators to reduce the risk of spread.

PICU
Investigations into Salmonella cases in the PICU are ongoing, with identifying the source remaining a challenge. The PICU team continues to emphasise hand hygiene and cleaning practices, supported by weekly screenings highlighted during bi-monthly statutory and mandatory training sessions.
Awareness has also been raised around the daily completion of the isolation risk assessment form, communicated through training and regular email updates to the PICU team. This form has been updated to align with the new Isolation Policy and Transmission-Based PPE precautions.

Progress and Success:

Maternity

Hand Hygiene and equipment cleaning audits are a focus this month.

Work is being undertaken to try to improve cleaning records by introducing a QR code system.

A maternity patient with a chronic bed bug issue was appropriately managed during their hospital stay. With community input, the infestation was contained, with no spread within the maternity unit. The patient's belongings were securely bagged to prevent contamination.

PICU
Cleaning audit scores above 98% consistently maintained, reflecting a strong focus on high standards, including bedside cleaning. Efforts to improve mask fit testing compliance have been supported by the Mask Fit Testing Hub and Health Safety, who provided equipment and guidance. A substantial number of PICU staff have been tested, significantly raising compliance levels.

Waste segregation on PICU has improved, with staff now trained on various waste streams in line with trust policy. Support from the Stericycle team has ensured proper information and a steady supply of bio bins. Bi-monthly training sessions continue to be effective, covering critical topics like light box training, handwashing, and waste management, as well as infection prevention practices like Ventilated Acquired Pneumonia (VAP) prevention and oral hygiene.

New VAP education posters are displayed on PICU, and adjustments to Metavision forms and access points have been made to streamline documentation, with updates shared during training and through regular communications.

Child Health

Significant progress has been made in fit mask testing, with many staff members now booked through the Virtual Learning Environment (VLE) or tested by trained ward staff. However, many staff still require updated fit mask tests, and efforts continue to address this.

The “Good Practice Guide” is increasingly adopted across the children’s hospital, although additional work remains to fully integrate these standards. Support for timely audit submissions is ongoing, ensuring that all necessary data is consistently provided.

In preparation for RSV season, an RSV-positive bay has been opened twice since September 1 but was closed within 24 hours in both instances. A dedicated MPOX response trolley has also been set up and is stored for easy access when needed on Ward C5.

Ward accreditation scores currently reflect the need for targeted improvements: 25% of wards are Green, 19% Amber, and 56% Red. These results will be addressed with ward leaders to develop action plans for improvement.

Neonates

The Neonatal Unit has been making several impactful changes to improve sustainability, efficiency, and compliance. One recent adjustment is extending the frequency of bagging circuit changes to every three months, rather than after each patient, as the circuits are rarely used. This shift supports sustainability efforts without compromising safety.

To ensure high standards in infection prevention, the medical team receives practical training in Aseptic Non-Touch Technique (ANTT) during their induction. The education team is dedicated to completing assessments to uphold these standards across the team.

Audit results reflect the positive impact of these changes, with compliance scores consistently reaching an impressive 96-100%. The team is committed to maintaining this high standard as they continue to improve.

Ongoing Challenges:

Maternity

Fit mask testing remains challenging due to staffing vacancies. However, with the recent onboarding of 40 midwives and by raising these issues with Health and Safety, there is optimism that fit mask testers will soon be available, improving testing across the team.

Challenges with long-term sickness in housekeeping team on Labour ward and Broadlands resulted in a failed cleaning audit with the redistribution of staff (Using a Band 2 in the interim) the reaudit was passed.

Operational challenges have meant Infection Prevention Lead has been required clinically and therefore unable to carry out Infection prevention link duties. There is hope this will improve with the onboarding of the 40 midwives.

As highlighted in previous reports, The Princess Anne Hospital began a window replacement scheme but due to funding restrictions, was unable to complete windows in the Broadlands Birth Centre and most of the Labour Ward. The older windows that remain had recurring mould, dampness, and insulation issues, posing risks to patients and staff. Remedial mould removal is now complete on the Labour Ward, with a documented plan to complete Broadlands by May, though issues are expected to recur until full window replacements occurs. Reports of mould staining now evident – Joint walkarounds with clinical staff, infection prevention team and estates to carry out regular walkabouts to increase support in escalations.

The maternity wards show wear, with damaged paintwork and cracked flooring joints identified during recent Spotlight reviews. White rock walls and new flooring would better withstand the heavy use of these spaces.

PICU

Ceiling leaks have been problematic for several months. Estates have been working to remedy the leaks, a leak diverter remains in place whilst awaiting roof repair/replacement. Repairs are now underway with a completion due by end of November. Infection Prevention and Estates will inform PICU if any beds need to be closed for repair, although this looks unlikely. Recent adverse weather saw water running down the outside of the tube diverter as well as down the inside of the tube on the unit.

Increased Ventilated Acquired Pneumonia rates on PICU. Continuing to improve education surrounding tipping the child to a certain degree, oral hygiene, particularly teeth cleaning and documenting this on Metavision. Statutory and mandatory training emphasises oral hygiene and VAP Prevention training.

Eye protection has poor compliance, consultants are saying eye protection makes line insertion challenging. Infection Prevention aware. An idea has been suggested to purchase protective eye covering that belongs to the individual to increase compliance, some already doing this on PICU.

Child Health

The limited number of cubicles remains a challenge, especially as winter approaches. This requires daily risk assessments to appropriately cohort patients with respiratory viruses and gastroenteritis (D&V), while considering the isolation needs of older children with mental health requirements. Increased demand for cubicles complicates the challenge of managing diverse patient needs effectively.

Clarification around admission protocols from the Emergency Department (ED), particularly for respiratory symptoms and swabbing processes, is under review to streamline patient flow. Respiratory swabbing demand for children has increased, and bed availability remains tight. To optimise bed allocation, swabs are recommended for children on the Paediatric Short Stay Unit (PSSU) who may require admission, helping to minimise waiting times and ensure a child is admitted to the correct area within the Children's hospital (isolation or main bay), this aims to minimise the risk of further transmission of respiratory infections.

Neonates

Following a failed Medical Waste Inspection a dedicated ambassador has been trained to oversee waste compliance, providing clear guidance to staff on proper disposal practices.

The Sluice remains out of action therefore a designated toilet is being used as sluice.

1 x denomination room on E level to be used on the new woodlands – cot decontamination room.

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

Continue to promote hand hygiene using in huddles. Ensuring equipment is thoroughly cleaned. Concentrated focus on hand gel before and after patient contact. Focus on what is preventing audits being undertaken and introducing mitigations.

All areas can borrow Fit Mask testing equipment to carry out training on wards facilitated by train the trainers. As well as this VLE have increased appointments.

Introducing gloves off campaign across Division C over the month of November.

Neonates and Child Health are opening discussions about implementing a Total Parental Nutrition Standard Operating Procedure to standardised practice enabling a smooth transition between the 2 areas.

The removal and replacement of Soap dispensers has caused significant damaged to walls. This appears to be a trust wide issue with estates.

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

Ongoing relocation of the Special Care Baby Unit (SCBU) and renovations to the neonatal unit promise to enhance efficiency and provide more space for both staff and families. Works are due to be completed 11th November with a Grand opening on 25th November 2024.

Date this report will be an agenda item at Care Group Governance Meeting	**Date this report will be an agenda item at Divisional Governance Meeting**
October 2024	October 2024

Appendix 5

Division D Q2 Matron and CGCL Report

Care Groups: Cardiovascular and Thoracic, Neurosciences, Trauma and Orthopaedics and Radiology
Matrons: Jenny Dove, Sonia Webb, Jean-Paul Evangelista, Beverley Ann Harris, Rebecca Tagg, Claire Liddell, Tracy Mahon, and Rebecca Tagg.
Clinical Lead: Edwin Woo, Boyd Ghosh, Jonathan Hempenstall, Nick Hancock, and Charles Peebles
Date of Report: October 2024
Author: Sarah Halcrow

Performance Quarter 2 – 1st July to 30th September 2024

Key Indicator	Division D	Limit	Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 1** (HOHA +COHA)
***Clostridium difficile* diarrhoea**	**12**	**Trust Limit 24**	**Trust Total 32** (HOHA + COHA)
E. coli (HOHA)	**2**	**Trust Limit of 36**	**Trust Total 50** (HOHA + COHA)
Pseudomonas (HOHA)	**0**	**Trust Limit of 6**	**Trust Total 11** (HOHA + COHA)
Klebsiella (HOHA)	**3**	**Trust Limit of 14**	**Trust Total 24** (HOHA + COHA)
MSSA Bacteraemia	**4**	**No Limit**	**Trust Total 9**
GRE	**0**	**No Limit**	**Trust Total 0**

Incidents / Outbreaks of Infection and PIIs	
C.difficile PII on F2	4 Cases healthcare associated of C.difficile within 28 days on F2. 2 of the 4 cases 078 Ribotype, send for sub typing. Dirty commodes in the sluice Staff are not cleaning patient shared equipment in the bay. Multiple missed hand hygiene opportunities Not using actichlor across the ward during the PII Sluice door persistently left open - door is broken however so has been again reported to estates and we are waiting for this work to be undertaken.
C.difficile PII on F3	5 Cases healthcare associated of C.difficile within 28 days on F3. 1 of the 5 cases 078 Ribotype (same as F2 cases), send for sub typing. Lack of bed end gels, hand hygiene missed opportunities. Cardboard boxes on the floor in sluice (a lot of stock) Staff not aware of PII and requirement to clean of equipment with actichlor, Dirty commodes.

TB Patient on E4	Patient with suspected TB admitted into a bay on E4. Potential TB not noted by thoracic team on transfer of patient from RBH, despite information on the transfer letter, resulting in patient not being isolated and correct precautions not being taken. Identified as potential TB in theatres, although procedure already commenced, resulting in staff contacts. This information does not appear to have been communicated to the ward as patient was not isolated on return from theatre. Patient did not have a productive cough therefore patient contacts avoided on this occasion.

Performance Year to Date: 1st April 2024 – 30th September 2024

Key Indicator	Division D	Limit	Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 2** (HOHA +COHA)
***Clostridium difficile* diarrhoea**	**16**	**Trust Limit 99**	**Trust Total 61** (HOHA + COHA)
E. coli (HOHA)	**6**	**Trust Limit of 141**	**Trust Total 101** (HOHA + COHA)
Pseudomonas (HOHA)	**3**	**Trust Limit of 23**	**Trust Total 21** (HOHA + COHA)
Klebsiella (HOHA)	**6**	**Trust Limit of 56**	**Trust Total 43** (HOHA + COHA)
MSSA Bacteraemia	**6**	**No Limit**	**Trust Total 26**
GRE	**0**	**No Limit**	**Trust Total 6**

Key Learning from Investigation of Infections and Deaths:

T&O:

MRSA bacteraemia – Ward F3

A patient was admitted to UHS on 12/03/24 and tested positive for MRSA on an admission sample taken on the same day and she was discharged on 13/03/24 and no reduction measures were given.

The patient was re-admitted under orthopaedics on 16/08/24. A peripheral canula was inserted in ED before the patient was transferred to Ward F3. The patient was given platelet transfusion and developed cellulitis on the dorsum of the right hand. 21/22nd August the patient was febrile with a temperature of 38.4c. A course of clindamycin was started but not continued on discharge 02/09/24.

The patient was re-admitted on 12/09/24 with shortness of breath and slurred speech. Investigations done showed MRSA bacteraemia, multifocal consolidation on CXR and grew MRSA from ascitic tap. RIP on 26/09/24.

Learning

1. Cannula inserted in ED pitstop had insertion paperwork but VIP scores of the cannula were not recorded in inpatient noting. To ensure cannulas are not missed out on admission, admitting nurses on Ward F3 are now recording cannulas on the hand over sheet for everybody to know. According to the ward manager, this was school holiday, and the staffing skill mix was not the best and some nurses had left to courses.
2. Blood culture was not taken when the patient spiked a temperature.
3. Antibiotics were prescribed but not continued post discharge.

Further discussion of this particular learning of paper to E noting reviewed at band 7 meeting.

CV&T:

Clostridium Diff:

Case 1:

Judged as an unavoidable cause of C. diff.

Case 2&3:

- Inappropriate PPE use, staff were found retrieving items from the store with their PPE while attending to patient's personal hygiene.
- Hand Hygiene found to be inadequate.
- Dirty commode & Commodes without clean sticker label found in the sluice room.

Klebsiella: Practice review identified lapses in Urinary catheter management:

Learnings:

- Genitalia care for patients with urinary catheter: External urethral meatus should be cleaned adequately.
- Daily assessment of urinary catheter and skin area
- Above the floor and below the bladder positioning of urinary catheter bags:
- Surgical ANTT during catheterisation and appropriate supervision if task is delegated to a practising member of staff.

MSSA Bacteraemia: Not for concise review or practice review

Progress and Success:

Neurosciences:

Have passed all clinical/domestic cleaning audits.

CV&T:

Increase in IP audit submission.

Ongoing Challenges:

Neurosciences:

Poor hand hygiene compliance on recent audits. Raised with ward management teams to better understand these results and action plans made to impact this. Plan to discuss at divisional level to understand how some care groups are able to achieve and benchmark ourselves against them to replicate their successes.

Clusters of Noro outbreak impacting neuro wards. Well managed but added to operational pressures.

T&O:

Estates work and ability to be able to react to the wards needs in reference to IP- ie sluice door on F2 which has had temporary work and needs further review.

CV&T:

Candida Auris Infection on D4- There is regular update, meetings, and review by IPT.

Low performance on Hand Hygiene – A lot of the areas in the care-group are currently undertaking hand hygiene improvement plan.

Dirty beds are being reported by CICU from across CVT areas, improvements noted, and barriers identified are:

- Time: It takes an average time of 20min for 2 people to properly take bed panels apart for cleaning.
- Staffing Level and workload: There are no adequate staff a lot of times to focus on standard bed clean and turnover happens very quickly.
- Beds move across the Trust, and it is inevitable to receive beds that have not been properly cleaned from other areas.
- Environment/Space: for standard bed cleaning, mattresses must be put away on the floor to take out bed frames: this sort of space for mattress to sit during cleaning isn't available and not ideal on our ward areas.

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

None

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

Neurosciences:

Although norovirus outbreak managed well in neuro challenges around our estate make this harder to achieve, limited doors separating the bays increase the risk of transmission from bay to bay.

Date this report will be an agenda item at Care Group Governance Meeting	**Date this report will be an agenda item at Divisional Governance Meeting**
October 2024	October 2024

Agenda item 5.14	Report to the Trust Board of Directors, 7 January 2025
Title:	Annual Medicines Management 2023-24 Report
Sponsor:	Paul Grundy, Chief Medical Officer
Author:	James Allen, Chief Pharmacist

Purpose

(Re)Assurance	Approval	Ratification	Information
x			x

Strategic Theme

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

Executive Summary:

This paper informs the Trust Board about progress, strengths and weaknesses within UHS medicines management systems. It includes updates on progress with the UHS Medicines Management Strategy and recommends strategy and improvements where appropriate. The report primarily focuses on 2023/24 with reference to key strategic updates and recommendations through the first half of 2024/25.

Key points:

- UHS expenditure on medicines was £219m. This is a 4% increase on the £210m in 2022/23, reflecting lower growth than in previous years.
- A combination of procurement savings and new generic and biosimilar opportunities were used to deliver £2.1m in medicines savings.
- The pharmacy department observed high training success and ongoing increases in non-medical prescribers.
- Recovery in clinical trial numbers and growth in department research has begun to be realised following a significant focus in 22/23.
- UHS aseptic units continue to meet regulator requirements, and the performance of the oncology pharmacy department has remained consistent since the previous report.

Improvement focusses:

- Update policies and utilise intelligence gathered during focussed medicine ward visits to support improvements in medicine security, particularly concerning mental health patients.
- Work to upgrade digital systems and increase electronic prescribing in outpatients.
- Improve technician training and recruitment to reduce the vacancy rate in our ward-based technician teams.
- Continue to explore sustainability projects and funding opportunities linked to sustainability interventions.

The committee is requested to note the report's contents and raise any questions or concerns to support the Medicines Management Strategy and Action Plan.

Contents:

Risk(s):

1. Outstanding patient outcomes, safety, and experience – 1a, 1b, 1c
2. Pioneering research and innovation – 2a
3. World class people – 3a
4. Integrated networks and collaboration – 4a
5. Foundations for the future – 5a, 5b, 5c, 5d

Equality Impact Consideration:	N/A

1. Summary introduction

1.1.1 Medicines are the most commonly used healthcare intervention. Virtually all UHS patients will receive medicines while in hospital, on discharge from hospital, as outpatients, and/or via homecare. Organisational use of medicines is associated with significant risks related to patient safety, compliance with statutory regulations, and financial risk. This report seeks to appraise executive and board members of the key areas of progress and risk in relation to medicines management in UHS.

1.1.2 At UHS, approximately 2.7 million prescriptions are written, and 8 million doses are administered annually. In total, medicines cost UHS £219m in 2023/24, an increase of 4% from the previous year.

1.1.3 In 2023/24, 2,827 safety incidents involving medicines were reported, of which 32% resulted in some level of harm. The rate of moderate to severe harm has remained constant.

1.1.4 This paper informs the Trust Executive Committee about progress, strengths and weaknesses within UHS medicines management systems. It includes updates on progress with the UHS Medicines Management Strategy and recommends strategy and improvements where appropriate. The report primarily focuses on 2023/24 with reference to key strategic updates and recommendations through the first half of 2024/25.

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

Analysis and Discussion

2. Key areas of good practice, progress and improvement

2.1 Leadership

2.1.1 UHS continues to be a national leader in transferring medicines-related information to patient's community pharmacies. The ward-based pharmacy team referred around 1800 patients in 23/24 to their community pharmacist for follow-up and support regarding their medicines after discharge. The NHS Discharge Medicines Service is an essential service within the community pharmacy contract. This has given further incentive to continue these referrals with greater reassurance that patients will be followed up in the community. Work continues with community colleagues to ensure that community pharmacies submit claims for undertaking this service. The next steps include a review of the referral process to align with other acute Trusts across the ICS, training pharmacy support workers to send referrals so we can prevent more readmissions, and extending this referral system to local care homes to support the transfer of care and the national medicines optimisation in care homes programme.

2.1.2 Regular antimicrobial stewardship ward rounds continue within the key specialities. In addition, the ward-based pharmacy teams continue to monitor and audit antimicrobial prescriptions monthly in line with our legal obligations as per the Health and Social Care Act 2008. The team has focused on antimicrobial stewardship and antimicrobial guideline update with increasing focus on increasing the prescribing of Aware access category antibiotics. A significant work-stream was leading the rollout of the timely intravenous to oral switch of antibiotics project, which has numerous benefits, including a reduction in length of stay, saving of nursing time, reductions in healthcare-associated infection and line-related adverse reactions. We continue supporting educational activities for all staff groups on antimicrobial stewardship within the trust and via links with the University of Southampton on their prescribing and public health postgraduate courses. We also continue to provide input to infections of interest including Mpox, C.auris and C.difficille – where we partake in reviews of antimicrobial prescribing for areas of increased incidence in conjunction with infection prevention and control.

2.1.3 Public health promotion in relation to smoking and alcohol advice continues to be provided on admission by the Medicines Management Team. The intervention continues as part of the NHS Long-Term Plan for health promotion. The pharmacy team have supported the development of a system to enable electronic referrals from specialist nurses to community pharmacies for nicotine replacement therapy (NRT) and/or smoking cessation support (dependent on whether the pharmacy is registered for this service). The development of UHS towards becoming a Smoke-Free Site has included members of the pharmacy team and pharmacists supporting the Tobacco Dependency Advisors (TDAs) on a daily basis by adding nicotine replacement therapy (NRT) to the electronic prescribing system so that use can be documented and included on discharge paperwork. Work continues to empower TDAs to document NRT themselves, both on the electronic prescribing system for use in the hospital and for supply on discharge prior to review by a nominated community pharmacist.

2.1.4 The Chief Pharmacist is the designated Controlled Drugs Accountable Officer (CDAO). The Trust's CDAO is responsible for the safe and effective use and management of controlled drugs and has a statutory responsibility to provide quarterly occurrence reports to the NHS England (South) CDAO. These reports detail any concerns regarding the management or use of controlled drugs across the Trust or other organisations/agencies involved. All occurrence reports have been completed and submitted for 23/24 as required. The CDAO is also a member of the NHS England (South) Local Intelligence Network (LIN).

2.2 Medicines Finance

2.2.1 In 2023/24, UHS expenditure on medicines was £219m. This is a 4% increase on the £210m in 2022/23, reflecting lower growth than observed in previous years. The key drivers for this increase remained similar to previous years and were:

- A £4.3 million increase in NHS England commissioned medicines driven primarily by CAR-T and other newly commissioned cancer therapies or the widening of eligible patient cohorts in these areas.
- A £2.3 million increase in Cancer Drug Fund and Innovative Medicines Fund medicines.
- A £0.7m increase in NHSE-funded block medicines and a £1.7million increase in tariff medicines driven by increased patient volumes and inflationary pressure.

2.2.2 Data from the national medicines data repository (Rx-Info) continues to place UHS just outside the top 25% of similar-sized trusts for total medicines spent. Given the range and depth of specialist services, this is to be expected and aligned with peer organisations as described in the table below.

	Spend (£ millions)		
Trust	2022/23	2023/24	2024/25 (projected)
UHS	210	218	225
Cambridge	167	190	205
Nottingham	184	195	211
Bristol	158	171	179
Sheffield	215	236	263
Guys & St Thomas's	315	327	383

2.2.3 Throughout 23/24, UHS clinicians and pharmacy continued to deliver essential savings in a range of schemes that released UHS capacity and promoted best value medicines usage. For this period, these savings equated to £2.1m of which £1.7m was realised. These were achieved through homecare schemes and our focus on switching to new generic or biosimilar medicines. UHS Pharmacy continues to develop comprehensive models for identifying and reporting savings incorporating volume analysis and the new commissioning landscape. Over £3.6m of in-tariff and block medicine savings have been identified in 24/25.

2.2.4 Work is underway to develop a digital process to collate and control the billing of medicines data to commissioners. This process, which represents approximately £184 million per annum, is currently manual and no longer meets the contractual data quality requirements outlined by commissioners. This project is expected to be completed in the second half of 24/25, realising significant efficiency and data quality improvements.

2.3 Workforce and Training

2.3.1 High-quality training and development remain a mainstay of the pharmacy department with a 100% success rate for trainees in 23/24. The pharmacy team continue to be commissioned by NHSE WTE South to provide foundation trainee pharmacist training for Hampshire and Isle of Wight local learning sets and by the University of Southampton to deliver teaching for medical, nursing and AHP students. We continued to build our trainee pharmacy technician numbers through the new apprenticeship, with two intakes per year now in September and February, both funded by NHSE WTE.

2.3.2 In 25-26, it will become mandatory that pharmacist training posts be multi-sector, ensuring that pharmacy, as a profession, develops a flexible and adaptable workforce. UHS has offered cross-sector training since 2021, recognising it is one of the most popular national schemes consistently attracting high-calibre candidates. Cross-sector partnerships are being increased for 25-26 and 26-27 with trainees in community pharmacy, primary care, and South Central Ambulance Service placements.

2.3.3 Consultant pharmacists serve as senior clinical experts, delivering advanced patient care and leading systemic improvements across multiple trusts within the healthcare network. Since the previous report, two additional consultant pharmacist positions have been developed in critical specialist areas: Adult Intestinal Failure and Paediatric Oncology. Upon credentialing of these postholders, UHS will have a total of six consultant pharmacists who will actively contribute to both local and national healthcare strategies, as well as advancing the research agenda of the trust.

2.3.4 The number of non-medical prescribers (NMPs) within UHS continues to rise. Currently, 353 active NMPs are recorded on the live register, an increase of 40 since last year (313). Of these, 67 are pharmacists, 24 are AHPs, and the remaining 264 are nurses. The new advanced practice pathways for nurses and AHPs can include prescribing. There are 32 NMPs in training, 19 nurses, 10 pharmacists and 3 AHPs in training.

2.3.5 The new undergraduate pharmacy course includes prescribing; students graduating in 2026 will be qualified as independent prescribers when they register in 2027. A working group within UHS and across HIOW ICB is developing the training programme for Trainee Pharmacists. Work has begun on developing the programme to include prescribing-related activity, a prescribing framework for newly qualified prescribers, and establishing a plan for the required Designated Prescribing Practitioner training and development.

2.4 Research & Development

2.4.1 The pharmacy team's clinical trial activity has begun to recover after implementing the key elements of the R&D action plan. Several elements have supported this improvement, in particular the ring-fenced dedicated CRN-funded resource aligned to cancer activity, which has realised significant improvements in both adult and paediatric cancer studies. The next step is replicating this strategy within the broader aseptic trial context using the 3-year NIHR/DHSC funding we were awarded on June 24.

	2022/23	2023/24	2024/25 (M7)
Cancer	33	10	22
Non-Cancer	51	43	37
Advanced Therapy	1	6	2
Total	85	59	54

2.4.2 Advanced Therapeutic Medicinal Products (ATMP) outputs increased in 23/24, with 6 additional studies opened. A significant vacancy has constrained progress in 24/25 but additional investment in the pharmacy AT(I)MP team has now increased the resilience in this highly specialist area of pharmacy. All areas of medicine will likely see the emergence of AT(I)MP therapies in the next few years, with pharmacy working closely with Research and Development to deliver the objectives outlined in the emerging therapies unit strategy.

2.4.3 Three pharmacy team members have successfully applied for research awards with BRC and ARC internships and are being supported to apply for further awards. The number of research active staff increased from 16 to 28 in 23/24 and is already at 21 staff members in 2024/5. Peer-reviewed publications increased from 13 to 26.

2.4.4 The UHS Consultant Pharmacist for Pharmacogenomics will support an approved NIHR research bid assessing pharmacogenetic-guided prescribing using routinely collected healthcare data. It is expected that the learning generated from this study will be able to directly support the work within UHS to develop pharmacogenomic testing capacity for Wessex.

2.5 Medication Incidents

2.5.1 The number of medication incidents reported in 23/24 increased from 2470 to 2827 primarily because of more no-harm incident reports, indicating a good reporting culture. The proportion of incidents resulting in harm has decreased but not significantly from 33% to 32%. The medicines safety team reviews all incidents and provides learning on a weekly basis via Workplace. Further details can be found in the annual Medicines Safety Officer report.

2.5.2 A medication-related never event was reported in 23/24 relating to an incorrect dose of insulin being measured in a standard syringe. The patient was located in Critical Care when the incident occurred and did not come to any major harm. The incident was investigated thoroughly using the PSIRF with the support of the medicines safety team. Incidents relating to insulin have increased throughout 23/24. One significant driver for this increase has been the combined unfamiliarity of clinicians with diabetes therapies alongside significant far-reaching shortages of insulins and diabetes medicines. A dedicated task group has been developed to focus on this key risk across UHS.

2.5.3 Demand for the patient Medicines Helpline remains high at around 150 calls per month during 2023/24. Often, calls are for clinical advice or follow an error or oversight relating to the discharge process. The helpline team can intervene to prevent patient harm and avert potential complaints or the need to see another HCP. The lead pharmacist for the Helpline works with the Medication Safety Group to identify and address the causes of the most common types of error and has provided data to inform the trustwide Discharge Checklist and improvements to the Trust discharge paperwork. The Helpline is advertised widely via different media, including My Medical Record, enabling rapid access to medication-related advice via this patient portal.

2.5.4 The Southampton Medicines Advice Services (SMAS) continues to develop its national training website, the Medicines Learning Portal, and has secured NHSE funding to write a chapter on Pharmacogenomics. It teaches clinical problem-solving skills to hospital pharmacists, is being used across the whole NHS and has exceeded 1 million visits.

2.6 Operational & Infrastructure

2.6.1 Medication shortages remain an enormous and growing national primary and secondary care issue. National data indicates that formal notifications of impending shortages have doubled in three years, rising from 648 in 2020 to 1,634 in 2023. The UHS pharmacy team work closely with clinical teams across all specialities to mitigate the risks of medication shortages, and systematic processes to improve the early identification and communication of shortages remain in place. An increased proportion of medication shortages are being circulated to trusts as national patient safety alerts. The co-ordination and oversight of these alerts is led by the trust Medication Safety Officer with the support of the Deputy Chief Nursing Officer and Head of Clinical Engineering.

2.6.2 A new national assessment framework for unlicensed aseptic units came into force in March 2023 (iQAPPs). This system focuses on monthly unit-submitted quality assurance reports alongside the established inspection schedule. The framework emphasises continued timely evidence of safety rather than the historical intermittent inspection schedule. A similarly timed update to the legal and governance framework associated with unlicensed aseptic units provides commissioners and Regional Quality Assurance (QA) with greater powers to enforce the closure of units felt to be operating outside safe limits, including those working above their established operating capacity. All units within UHS continue to submit the required information with no concerns highlighted by the regional QA team.

2.6.3 Annual aseptic unit inspections still continue with a focus on facilities, equipment, and process validation. The pharmacy aseptic unit (TSU) received its final inspection before the planned relocation to Adanac Park in March 2025. Despite the ageing design and estate, the unit has been assessed and rated as in the lowest risk category on the new national iQAPPs inspection framework.

2.6.4 Significant improvements in the operational performance of the oncology pharmacy unit were observed throughout 23/24. However, more recently, there have been challenges in maintaining the consistency of this performance with the volume of work. The focus remains on optimising capacity and improving communications with cancer care to improve the patient experience; however, the unit has a finite capacity, which is now likely being reached until capacity from Adanac Park can be utilised. The team has been working on digital methods to support treatment schedulers and ensure capacity is available before patient booking. It is hoped this will improve patient experience while maximising capacity. A revised capacity plan and service level agreement are being developed with cancer care to aid KPI monitoring and support the opportunities for future service developments.

Category	Oct-21	Mar-22	Sep-23	Mar-24	Aug-24
Prepared in advance	21.5%	34.2%	40.6%	32.7%	41.0%
Not delayed	12.1%	28.4%	45.7%	42.1%	34.9%
0 - 1 hr delay	40.4%	29.7%	11.7%	22.2%	20.0%
1 - 2 hrs delay	18.5%	6.1%	1.0%	2.0%	2.8%
2 - 3 hrs delay	5.6%	0.9%	0.6%	0.4%	0.8%
3 - 4 hrs delay	1.3%	0.3%	0.1%	0.2%	0.3%
Over 4hrs delay	0.6%	0.4%	0.2%	0.3%	0.3%
Item Total	2107	2184	2197	2468	2788

2.6.5 The homecare service for medicines has continued to increase, releasing critical UHS capacity and moving care closer to home for our patients. Patient numbers have increased to 7800 in 2023/24. The pharmacy homecare and clinical pharmacy teams received additional critical investment at the start of 2023/24 to ensure we can meet the organisation's demands and quality requirements. This investment has been critical to supporting the appropriate oversight of homecare services, many of which have faced significant operational challenges over the last 12 months.

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

2.6.7 The introduction of an electronic system for wards to request discharge medicines on their eWhiteboards has been well received. The transformation, pharmacy and digital teams have continued to promote this system and make regular improvements, with a view to improving communication about discharge between the wards and pharmacy. The expectation is that this will reduce the time of discharge and shorten the length of stay, supporting Trust operational targets.

2.7 Medicines Policy & Governance

2.7.1 The UHS pharmacy team has continued developing shared medicines policy documents for use across Hampshire and the Isle of Wright. These documents include

- Standardised shared care documents and notification templates to enable patients to continue their specialist medicines in primary care with appropriate specialist clinical oversight.
- A single free of charge (FOC) and compassionate use medicines policy to ensure the relevant operational, clinical, ethical and financial risks are considered within a systemwide forum. In addition, this policy aims to address any inequality of access and duplication of effort across the acute trusts in our system.

2.7.2 The UHS Drugs Committee met monthly throughout 23/24, undertaking the following activities:

- approved the addition of 33 items to the formulary, of which 15 were because of published NICE guidelines.
- removed 9 items from the formulary
- reviewed and approved 71 policies and procedures/clinical guidelines

2.7.3 Patient Group Directions (PGDs) allow specific healthcare professionals to supply and/or administer a medicine directly to a patient with an identified clinical condition without needing a prescription or instruction from a prescriber. The pharmacy team have worked hard to get all the Trusts PGDs in date, and have put a rolling process in place to help ensure this remains so. Future developments include implementing a national PGD audit tool to improve local governance. The PGD committee has:

- reviewed and approved 36 PGDs
- reviewed and approved 2 occupational health work instructions for staff vaccination
- removed a further 12 unnecessary PGDs from use

2.7.4 Free of Charge (FOC) and compassionate use schemes provide early access to or compassionate use of medicines that would otherwise be unavailable to patients. They must be considered carefully for clinical, operational, ethical, and financial risks. The Drugs Committee continues to provide governance and oversight to these schemes using newly updated policy guidance based on national guidance released in Aug 2023. These schemes remain essential to patient care as a major teaching hospital with regional and national specialities, with the Drugs Committee reviewing 11 schemes for their suitability for use in UHS in 23/24.

2.7.5 Individual Funding Requests (IFRs) are requests for medicines in patients that are not commissioned. In 2023/24, the frequency of applications has returned to pre-pandemic levels. However, a proportion of this relates to NHSE policies that need updating, particularly regarding paediatrics. A summary of the applications throughout 2023/24 and the first half of 24/25 is below:

	Total			ICB		NHSE	
	2022-23	2023/24	M6 24/25	2023/24	24/25 M6	2023/24	24/25 M6
Submitted	17	32	18	21	10	11	8
Approved	12	29	12	19	10	0	2

2.7.6 During 23/24, the UHS IFR panel, comprising the requesting clinician, the Chief Pharmacist, the Medical Director and the Director of Finance, considered 7 unique rejected cases for non-commissioned medicines indications. These cases were all approved on the basis of clinical need at a total risk of £108k which resulted in a £54k in year spend. Work is underway to retrospectively appraise all approved IFRs in order to inform future decision-making by the panel.

2.8 Digital

2.8.1 The pharmacy digital team continues to support the organisation in deploying and improving its digital architecture concerning medicines. Throughout 23/24 the team have:

- Supported the deployment of Openeyes, particularly the prescribing functionality, theatre pathways, outpatient recommendation letters, and medical retina prescribing pathways.
- Begun testing as the first pilot site for an upgrade to the ward-based prescribing system (Care Flow Medicines Management). Testing is being completed in collaboration with PUH with the aim of going live in early 2025.
- Established an ICS EPMA group to support collaboration and consistencies between system configuration and training.
- Developed and led on the HIOW EPR procurement specification.
- Miya ED patient registration integration with Omnicell cabinets in AMU & JAC/CMM - in development to be delivered with Phase 1 of the project in conjunction with UHS digital.
- Air Ambulance and PAH ward direct digital ordering of stock medicines. This new service development reduces paper, ordering errors, and time for staff by allowing staff a secure digital mechanism to order stock medicines.

2.8.2 The Varian Aria chemotherapy prescribing and scheduling system urgently needed an upgrade to the latest cloud-based software, as its current version had become unstable and would reach end-of-support in 2023-2024. The plan is to establish the new BT fibre-optic connection by mid-December, allowing data migration from PUH and integration with UHS to begin system validation. If everything proceeds on schedule, the system is expected to go live by April 2025. The UHS pharmacy oncology team is managing the upgrade programme across the relevant sites in the network.

2.9 Integrated Care Board and Regional Medicines Optimisation

2.9.1 The UHS Chief Pharmacist continues to co-chair the HIOW ICS system leadership group for Pharmacy. This group's primary strategic objective is developing and delivering the Integrating NHS Pharmacy and Medicines Optimisation (IPMO) programme for the HIOW Integrated Care Board (ICB). The plan covers key workstreams for medication safety, digital, workforce, medicines savings, and sustainability.

2.9.2 Systemwide medication shortages remain a significant challenge. The UHS Pharmacy leadership team led on several systemwide shortages, engaging experts in all sectors to ensure that systems were in place for patients to access critical medicines. The most recent example includes the response to national shortages of pancreatic enzyme replacement therapies, where representatives for GP practices, community pharmacies, dietetics, and procurement devised plans to enable appropriate unlicensed stock to be accessible in a timely manner as directed by the national patient safety alert. The planning and solutions developed were led by UHS and have now been adopted by several neighbouring systems.

2.9.3 The planned development of an offsite aseptic unit at Adanac Park remains on track for commissioning in 2025-26. The design of the unit and equipment schedules have been finalised, and the outline shell of the unit looks likely to be completed on March 25. Work is still ongoing at a regional level with the four local trusts (UHS, PUH, IOW and HHFT) to take a collaborative approach across the ICS. At this stage, Adanac remains on track to deliver sufficient capacity to become the supra-regional unit and provide much-needed aseptic resilience to the local and neighbouring systems.

2.9.4 The ongoing work to prevent harm to unborn babies from the use of sodium valproate continues and is led by the UHS Medication Safety Officer via an ICB working group. The group reviews action across each provider, ensuring this remains within the medicines safety priorities for 24/25.

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

3. Key areas requiring action/improvement

3.1 Medicines Policy & Governance

3.1.1 While progress has been made, several overarching medicines policies for UHS (medication storage, prescribing) need updating and refreshing to implement new legislation and developments. Work began in 23/24 to engage with key stakeholders, including training and education teams, in these policies. This work has culminated in a recent pharmacy and nursing leadership walkaround programme across almost all ward areas to discuss areas of deviation from practice and better inform any policy updates. A key objective of this policy is to make the policies accessible and, where appropriate, practical to support staff across the organisation.

3.1.2 The increased volume and acuity of mental health inpatients have presented challenges regarding medicine security. The security of patients' own medicines in transit between ward areas has been identified as a particular weakness, and our risk assessments for medication self-administration pay minimal attention to the risks of neighbouring or ward patient misappropriate access. The pharmacy team is actively reviewing near-patient and transport security containers and is working with nursing leadership to assess the appropriateness of these options for ward-based deployment.

3.1.3 The pharmacy team continue to audit and report incidences of unlocked cupboards and medicines that are not stored securely for each ward that receives a pharmacy-led stock top-up. Ward leaders use this information as part of the accreditation process. The data will soon be available across UHS on our digital platform, Triscribe.

3.1.4 In March 2023, NHSE published guidance on minimising time-weighted exposure to nitrous oxide in healthcare settings. Initial mitigations are in place, and environmental monitoring has commenced. Further funding will enable additional assurance via personal monitoring, which is planned for February 25. Additionally, the medical gases committee is reviewing and developing proposals for the use of scavengers across the acute trusts in the ICS and will develop a case for their use in UHS over the coming months.

3.2 Digital

3.2.1 A new contract for the ward-based ePrescribing system has been signed with the intention to bridge until the Hampshire and Isle of Wright EPR procurement is complete.

3.2.2 The planning phase for an upgrade to the pharmacy stock control and ward-based e-prescribing system (JAC/System C — CareFlow Medicine Management) has started. Validation of an updated version will start in November, with implementation planned for late January or early February 2025. It is hoped that this update will resolve the challenges in progressing other strategic projects, including:

- Closed loop supply (Omnicell cabinets on AMU) ePrescribing interface
- Additional electronic Outpatient Deployment
- Digital prescribing of fluids and complex infusions.

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

3.2.4 Prescription transfer between IT systems remains a risk when patients move between clinical areas that have JAC/CareFlow Medicine Management and MetaVision ePrescribing systems. Several process-driven mitigations are currently adequately managing the risk. However, there remains a concern that as operational pressure increases, these processes may fail.

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

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

3.2.7 The electronic prescribing systems used in UHS cannot prevent the inadvertent prescribing of oral methotrexate at the wrong frequency. Under the current framework, such an event would be registered as a never event in the presence of an EPMA system. The systems have been set up to mitigate this as far as possible and we expect to be able to re-review this area of concern when the new HIOW EPR prescribing system is deployed.

3.2.8 The current fridge monitoring at ward level is retrospective and does not record how long a fridge has been out of range. There is currently no escalation of a fridge alarm at ward level. A digital fridge monitoring system for wards would provide cost savings from wasted stock, added assurance for CQC, and the hospital's quality/storage of our medicines. The trust-wide asset tracking project has developed some processes that have been successfully deployed in the PAH, and so we plan to collaborate further to deliver a solution for UHS.

3.2.9 The use of physical controlled drug record books is limiting the opportunities to deliver improved oversight and monitoring of controlled drugs across UHS. In trusts with digital systems, there is a closed loop between the prescribing, recording and ordering process. Additionally, these systems maintain stock balances and enable usage triangulation to better identify cases of diversion. In addition, there are opportunities to save significant nursing time in relation to record-keeping and stock control of controlled drugs. Several complete digital systems are now available, and demonstrations have been provided to the ICS Chief Pharmacist groups. A key target within 25/26 is to develop a case to deploy a digital solution across the acute trusts in ICS.

3.3 Operational and Infrastructure

3.3.1 Progress in implementing the regional medicines procurement hub has ceased, with the regional stock system vendor removing the required digital architecture from their roadmap. This resulted in the requirement to replace the pharmacy logistics robot which occurred in Nov 24. Work is underway with system partners to ensure capacity within this regional procurement hub is now redirected to alternative strategic projects (e.g. aseptics).

3.3.2 Despite the use of remote working, there is insufficient space within the pharmacy footprint to accommodate the team. Furthermore, expanding clinical trials and storing increased numbers of investigational medicinal products present a challenge. The pharmacy team continues working closely with the estates team to shape the 10-year master plan and provide a vision for re-using the space released when the TSU relocates to Adanac Park.

3.4 Workforce and Development

3.4.1 The recruitment status for pharmacy technicians provides the most significant recruitment challenge. Over 23/24, the combination of new primary care roles and reduced training numbers in 22/23 led to a significant shortfall in this critical workforce. In particular, the most impacted team is the ward-based pharmacy technicians, which results in significant reductions in key medicines management metrics such as medicines reconciliation. Pharmacist vacancies have significantly reduced throughout 23/24 and are somewhat mitigating the risks of this shortfall. However, this remains an inefficient use of skill mix and a key target throughout the remainder of 24/25 is to improve the job satisfaction and flexibility of our pharmacy technician roles to reduce the appeal of roles in primary care.

3.4.2 The Pharmacy workforce strategy needs to be updated and aligned to the trust workforce strategy while addressing the aforementioned areas of fragility in service provision. This plan has been deferred to ensure that it can be approached from an integrated system perspective and to cover critical changes in pharmacy training and education. The UHS pharmacy team expects to play a significant role as a training centre over the coming years, both for prescribing practitioners and for the regional aseptic workforce.

3.5 Sustainability and UHS Green Plan

3.5.1 Several important areas linked to sustainability have seen improvements in 23/24. Work to reduce the usage of the anaesthetic gas desflurane continues to be successful, and there are active projects underway linked to the reduction of Entonox and Nitrous Oxide manifolds. The pharmacy team continues to support the trust sustainability clinical lead in identifying and targeting additional areas of intervention such as intravenous to oral switches and inhaler recycling schemes.

4. Conclusion

4.1.1 The actions required to address the concerns raised in section 3 above are listed in the action plan (Appendix A). The action plan also includes areas of innovative development in support of the Trust's values.

4.1.2 The senior pharmacy managers will periodically review progress against the action plan, escalating through Division C management as required. This progress will be reported formally in the 2024/25 Medicines Management Report.

5. Recommendation

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

6. Appendices

7. Appendix A – UHS Medicine Management Strategy and Action Plan

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

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

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

Medicine Management Theme	Component	Alignment to Trust Values		
		Patients First	Working Together	Always Improving
Best practice in the use of medicines	Excellence in all drug use processes, procurement, storage, prescribing dispensing, administration, monitoring, disposal	✓	✓	✓
	Evidence-based formulary and guidelines	✓		
	Medication error monitoring and learning	✓		✓
	Education and training		✓	✓
	Implementation of national guidance	✓		✓
	Research and quality improvement	✓	✓	✓
	Clinical audit	✓		✓
	Regulatory compliance and strong governance	✓	✓	✓
Improving patient experience	Medicines optimisation – maximising patient benefit from medicines	✓	✓	✓
	Patients as partners in selection of treatment	✓		
	Optimising transfer between care settings		✓	
	Implementing alternative care pathways	✓	✓	✓
	Provision of information, advice and support	✓	✓	
	Timely intervention – access to medicines when and where they are needed seven days a week	✓		
	Promoting self-care and healthy living	✓		

Best value from resources	Develop and support the medical, nursing and pharmacy workforce and explore new ways of working		✓	✓
	Integrate technology and innovation and use data effectively			✓
	Medicine procurement for value and safety	✓	✓	
	Evaluate and measure to improve effectiveness and productivity	✓		✓
	Partnership working with other organisations		✓	

Summary of medicines management actions

Actions completed, closed or paused due to dependencies in 2023/24

	Action	Outcome	Additional information
1	Implement e-prescribing to ED.	Paused	A scoping exercise undertaken in early 2020 identified that e-prescribing was only part of a much larger digitisation project within the ED. As such, the implementation of e-prescribing has been delayed until a full digitisation project can be fully explored.
2	Implement digital homecare management system to reduce administrative burden and improve contingency arrangements	Paused	Initial scoping suggests no suitable systems available although there are pilot sites testing electronic prescription transfer using EPS. Further exploration including scope to build bespoke solution expected when Alcidion partnership is finalised
	Submit Medcura for national consideration as part of the newly formed National Aseptic Review panel	Paused	The five pathfinder sites are not at a stage to consider their aseptic preparative management systems. The UHS Pharmacy team plan to concentrate on the build and the MHRA validation of the Adanac Hub with a view to developing Medcura once the unit is operational.
3	Transition the UHS medicines procurement and distribution service to the Solent Acute Alliance hub	Closed	Confirmation from IT system vendor that digital infrastructure to link procurement hub and UHS is no longer on the system roadmap. Work now underway to redefine how the capacity within the PUH procurement hub will be best utilised across the system.

Ongoing Action Plan

RAG Status:

	No progress or significantly delayed (>6 months)
	Progress is underway but delayed or slower than plan (< 6 month delay)
	On track, no significant concern

	Identified	Actions	Progress / Update	RAG Status	Timeline	Lead
1	21/22	Ensure the new aseptic unit based at Adanac Park delivers on the organisation's investment and strategic requirements	Discussions regarding the commercial and capacity plan are ongoing at the ICS and South East/South West regional levels. An oversight and delivery group has been created and will begin with regular reporting to NHSE and UHS Executive Committees in Q4 24/25.		Q4 24/25	Chief Pharmacist – James Allen & Deputy Chief Pharmacist – Mark Pepperrell
2	21/22	Embed the discharge checklist in adult discharge pathways. Develop the nurse discharge checklist for paediatric areas & work with nurse leaders to improve utilisation in adult ward areas.	A new version has been created for adults and is being tested and approved. It is intended to be incorporated into eNoting. A paediatric version is still to be developed and lessons from pharmacy helpline reports are being assessed to support the development of this procedure.		Q4 24/25	Nicola Howarth - Deputy Chief Pharmacist

	Identified	Actions	Progress / Update	RAG Status	Timeline	Lead
3	21/22	Update the pharmacy workforce strategy in light of the new NHS Long-Term Workforce Plan and regional workforce programmes	A regional workforce plan is under development, with the expectation that a UHS plan can be devised once it is complete. Elements of this work were completed following the workforce oversight deployed in UHS. Key areas such as aseptics are already complete in preparation for Adanac aseptics		Q3 2023/24	Chief Pharmacist – James Allen
4	21/22	Formalise a programme of work to consider and implement evidence-based interventions to reduce the organisation's carbon footprint concerning medicines.	Carbon footprint is now routinely considered in relation to new medicines reviewed as part of the regional formulary process. Formal plans to reduce desflurane from UHS have been completed. The pharmacy team are actively supporting the development of new plans and national bids to support the sustainable use of medicines.		Q3 2023/24	Chief Pharmacist – James Allen
5	22/23	Upgrade the regional electronic chemotherapy prescribing (Aria) to ensure to ensure ongoing stability for chemotherapy provision and cancer scheduling	Upgrade planned underway with expected system availability from April 2025		Q1 25-26	Chief Pharmacist – James Allen
6	23/24	Develop and deliver an action plan to reduce Nitrous Oxide exposure to staff	Initial mitigation is in place. Environmental monitoring has commenced. Funding being sought for personal monitoring in Feb 25. Exploring the use of scavengers in the ICB.		Q4 2023/24	Deputy Chief Pharmacist - Andy Fox

	Identified	Actions	Progress / Update	RAG Status	Timeline	Lead
			Work to assess the risks across the wider trust footprint is also underway			
7	23/24	Refresh Medicines Management policies and safe storage audit programme. Ensure these are aligned with the relevant CQC and regulatory frameworks and include formal reporting arrangements within the organisation	Extensive assessment of areas that require update has been undertaken in conjunction with stakeholders.		Q2 2024/25	Chief Pharmacist – James Allen
8	Restarted 24/25	Electronic outpatient prescribing – objectively increase the proportion of outpatients prescribed digitally from baseline (~10%).	Planning is underway with the UHS digital and outpatient clinical lead.		Q1 25/26	Chief Pharmacist – James Allen
9	Restarted 24/25	Upgrade JAC system to - Achieve the complete safety and operational benefits from Omnicell Implementation - Respond to concerns raised in the Klas survey undertaken in 2021 regarding the system usability.	Validation of system underway with early review suggestive that deployment in early 2025 will realise several delayed strategic objectives.		Q4 24/25	Chief Pharmacist – James Allen
10	New 24/25	Work with pharmacy and nursing leaders across HIOW to assess and procure a digital system for the stock control and ordering of controlled drugs.	New for 24/25 – System demonstrations are underway with nursing and systemwide pharmacy leadership.		Q3 25/26	Chief Pharmacist – James Allen

University Hospital Southampton NHS Foundation Trust

Agenda item 5.15 Report to the Trust Board of Directors, 7 January 2025	
Title:	Ward Staffing Nursing Establishment Review July 2024 – October 2024
Sponsor:	Gail Byrne, Chief Nursing Officer
Author:	Rosemary Chable, Head of Nursing for Education, Practice and Staffing

Purpose

(Re)Assurance	Approval	Ratification	Information
x			

Strategic Theme

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

Executive Summary:

a) The report details the methodology, findings, risk assessment and recommendations arising from the ward staffing review undertaken from July 2024 – October 2024.

Recommendations in this report link to the statutory responsibilities arising from the National Quality Board (2016) expectations on ensuring safe, sustainable, and productive staffing, the NHS Improvement Developing Workforce Safeguards guidance (2018) and the Nursing Workforce Standards (RCN May 2021) assessed as part of CQC 'safe' and 'well-led' domain.

The report outlines UHS progress in meeting the 38 recommendations included in the NICE guideline (2014) on safe staffing for in-patient wards and provides an update on the action – plan to achieve the recommendations in the national staffing levels guidance published by the National Quality Board in July 2016 (a key requirement of the NHSI 'Developing workforce safeguards' guidance (October 2018).

b) To note findings of this annual ward establishment review and the Trust position in relation to adherence to the monitored metrics on nurse staffing levels, specifically:

Overall, the staffing establishments remain appropriate and within recommended guidelines. There are some key exceptions where acuity and dependency levels and growing demand continue to outstrip the nursing ratios, coupled with the impact of ward reconfigurations – recommendations for uplifts in these areas will be put forward by the Divisions as part of the annual budget setting process.

- UHS nursing establishments are set to achieve a range of 1:1 to 1:9 registered nurse to patient ratio in most areas during the day with the majority (43) set between 1:4 to 1:8. Differences relate to specialty and overall staffing model.
- The majority of wards (32) are staffed at between 50:50 and 80:20 registered/unregistered ratio or above. Those wards with lower ratios (21 wards) are linked to the systematic and evaluated implementation of trained band 4 staff where appropriate and those with higher ratios (2) are both higher intensity care areas requiring a higher registered skill. 33 wards (down from 35 last year but remaining up significantly from 25 in 2019) are below the 60:40 ratio.
- Planned total Care Hours Per Patient Day (CHPPD) range from 4.2 – 19.2 and average at 7.7
- High levels of enhanced care demand, a reduced skill-mix and impact of financial controls have been highlighted as ongoing challenges for mitigation to ensure safe staffing.

The paper is presented for DISCUSSION.

c) The report is presented in full to Trust Board as an expectation of the National Quality Board guidance on staffing which requires presentation and discussion at open board on all aspects of the staffing reviews.	
Contents:	
Paper; Appendix 1: National Quality Board (NQB Expectations for safe staffing Safe, Sustainable, and productive staffing; Appendix 2: NQB Safe Staffing Recommendations – UHS action plan; Appendix 3: NICE Guideline 1: Safe Staffing for nursing in adult inpatient wards in acute hospital - UHS action plan; Appendix 4: Ward by Ward staffing review metrics spreadsheet; Appendix 5: Specific Divisional issues emerging; Appendix 6: RCN Workforce Standards	
Risk(s):	
1b – Due to the current challenges we fail to provide patients and families/carers with a high-quality experience of care and positive patient outcomes. 3a – We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles.	
Equality Impact Consideration:	NO

1.0 Introduction or Background

1.1 The purpose of this paper is to report on the outcomes of the review of ward staffing nursing establishments undertaken from July 2024 – October 2024. This 6-monthly review forms part of the Trust approach to the systematic review of staffing resources to ensure safe staffing levels effectively meet patient care needs.

1.2 This paper focuses specifically on a review of nursing levels for in-patient ward areas. Areas such as maternity, critical care, theatres and the emergency department are reviewed separately.

1.3 Divisional 'light touch' 6 monthly staffing reviews took place in March/April 2024 for all 4 clinical divisions and were reported to their relevant divisional boards and Nursing and Midwifery Staffing Review Group. Emergent themes have been incorporated into this review.

1.4 The ward staffing review this year has taken place against the backdrop of financial recovery measures, some of which came into effect in Q4 of 2023/24 after the last annual staffing review with increasing measures being introduced in 2024/25. Discussions at the staffing review meetings focussed on any impact arising from the close monitoring and management of establishment levels and any mitigations/adjustments needed to continue to assure the delivery of safe care.

1.5 It should also be noted that there were some key ward reconfigurations and refurbishments, some ward moves and a new ward opening since the last annual review and these areas have now been fully included in the annual cycle.

1.6 The report also includes an update on the NICE clinical guideline 1 – Safe Staffing for nursing in adult inpatient wards in acute hospitals, issued in July 2014 and details progress with the action plan for adopting this guideline within UHS.

1.7 This report fulfils expectation 1 and 2 of the National Quality Board requirements for Trusts in relation to safe nurse staffing and fulfils a number of the requirements outlined in the NHS Improvement 'Developing Workforce Safeguards' guidance (October 2018) which sets out to support providers to deliver high quality care through safe and effective staffing. This review also meets standards outlined in the RCN Nursing Workforce Standards (May 2021). Organisations are expected to be compliant with the recommendations in these reports and are subject to review on this as part of the CQC inspection programme under both the 'safe' and 'well led' domains.

2.0 Analysis and Discussion

2.1 Ward staffing review methodology

2.1.1 In 2006 UHS established a systematic, evidence based and triangulated methodological approach to reviewing ward staffing levels on an annual basis linked to budget setting and to staffing requirements arising from any developments planned in-year. This was aimed to provide safe, competent and fit for purpose staffing to deliver efficient, effective and high-quality care and has resulted in consistent year-on-year review of the nursing workforce matched by increased investment where required.

2.1.2 Following the National Quality Board expectations in 2014 and the refresh in 2016, a full review is now undertaken annually (with a light touch review at 6 months reporting to Divisional boards to ensure ongoing quality) with annual reporting to Trust Board in October/November.

2.1.3 The approach utilises the following methodologies:

- Shelford Safer Nursing Care Tool Acuity/Dependency staffing multiplier (A nationally validated tool reviewed in 2013 - previously AUKUH acuity tool). Now incorporated into the Healthroster Safecare system
- Care Hours Per Patient Day (CHPPD)

- Professional Judgement
- Peer group validation
- Benchmarking and review of national guidance including Model Health System data
- Review of eRostering data
- Review of ward quality metrics

2.2 National guidance

2.2.1 In 2013 as part of the national response to the Francis enquiry, the National Quality Board published a guide to nursing, midwifery and care staffing capacity and capability (2013) *'How to ensure the right people, with the right skills, are in the right place at the right time.'* This guidance was refreshed, broadened to all staff, and re-issued in July 2016 to include the need to focus on safe, *sustainable and productive* staffing. The NQB further reviewed this document and issued an updated recommendations brief in July 2017. The expectations outlined in this guide are presented in Appendix 1.

These expectations are fulfilled in part by this review and the detailed action plan (Appendix 2) has been updated with progress towards achieving compliance with the 37 recommendations that make up the 3 over-arching expectations.

2.2.2 The latest 4 monthly review of the action plan (November 2024) shows maintenance of compliance levels despite the ongoing activity and financial challenges. UHS remaining compliant with 35 of the 37 recommendations. The following 2 outstanding areas are progressing but require further action before being signed off:

Allocated time for the supervision of students and learners: *Staffing establishments take account of the need to allow clinical staff the time to undertake mandatory training and continuous professional development, meet revalidation requirements, and fulfil teaching, mentorship and supervision roles, including the support of preregistration and undergraduate students.* Whilst there is some allowance within the 23% headroom, requirements for supervision are growing with revised initiatives around preceptorship, staff wellbeing and student supervision. Learner numbers (students, international and apprentices, preceptees) are increasing with limited additional supervisory support available. It is also important to note that the Ward Leader Supervisory allowance was put on hold in Q4 2023/24 and reinstated slowly from Q1 2024/25 as part of the trust recovery plan. This impacted short term on some of the supervision and support available to students and learners.

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

2.2.3 In July 2014 NICE published *Clinical Guideline 1: Safe Staffing for nursing in adult inpatient wards in acute hospitals.* This guideline is made up of 38 recommendations. A detailed action plan was developed within UHS and is reviewed 4 monthly by the Nursing and Midwifery Staffing review group. The current assessment (November 2024) shows UHS has maintained compliance in 37 of the 38 recommendations.

The 1 remaining recommendation is:

Escalation actions taken to address deficits on one ward should not compromise another. Management of trustwide staffing deficits and thrice daily reviews of staffing via the staffing hub, as well as an improved recruitment situation, have minimised the risk of this. The close management and maintenance of minimal staffing levels,

however, does not enable assurance that wards are not compromised by staff movements in extremis.

The ongoing action plan is included at Appendix 3 detailing the recommendations and the UHS compliance position and actions in progress.

2.2.4 In October 2018 NHS Improvement published 'Developing Workforce Safeguards' guidance which sets out to support providers to deliver high quality care through safe and effective staffing. It includes many of the actions identified in both the NICE guidance and the National Quality Board recommendations broadened to all staff groups.

2.2.5 In May 2021 the Royal College of Nursing published their Nursing Workforce Standards (Appendix 6), developed as part of their safe staffing campaigns. The standards summarise the expectations in other national guidance and reiterates the importance of the Chief Nurse being responsible for setting nurse staffing levels based on service demand and user needs and the requirement to report directly to the Trustboard. Self-assessment undertaken by the Nursing and Midwifery Staffing Review Group (NMSRG) show UHS remains compliant with these standards. In October 2024 the RCN launched a review of these standards which are expected to be published at the end of the year. In light of this imminent review NMSRG have refreshed the self-assessment and confirmed that UHS remains compliant with the standards.

2.2.6 In September 2022 a key research study was published (Zaranko B, Sanford NJ, Kelly E et al. BMJ Quality and Safety Epub) which highlights the link between higher registered nurse numbers and seniority and improved patient outcomes. Additionally in August 2024 an additional follow-up article (Griffiths, P; Saville C; Ball, J JAMA Network open) identified that substitution of registered gaps with temporary staff does not necessarily significantly lower the risks for patients.

2.2.7 In late 2023 NIHR published an evidence based Professional Judgement Framework to support the application of professional judgement in nurse staffing reviews. Rosemary Chable and Natasha Watts from UHSFT were contributors to this guidance and are acknowledged in the authorship. This framework has been used as the basis for professional judgement throughout the staffing reviews.

2.3 6 monthly Ward Staffing review July 2024 – October 2024 – Outcomes

2.3.1 The 6 monthly review was carried out from August 2024 – October 2024 with initial review meetings taking place with each Division (attended by DHN, Matrons, Ward Leaders, Finance representatives, workforce representatives and facilitated by the Head of Nursing for Education, Practice and Staffing). The same triangulated methodology was used as in previous reviews. An update on the latest guidance and reporting requirements in relation to staffing were also included in the divisional review meetings.

2.3.2 The detailed spreadsheet with ward-by-ward findings is included at Appendix 4. This provides information on the current establishment data broken down by shift and assessing against registered/unregistered ratios; CHPPD; nurse to patient ratios by registered and total nurse staffing and acuity information from Safecare where appropriate.

2.3.3 It should be noted that a number of wards continue to be regularly reconfigured in response to the changing capacity and service situation, including new ward build and ward moves. A number of rostering template reviews were therefore instigated as a result of the review discussions so some figures may have changed for individual wards since the review.

2.3.4 The ***staffing hub*** which was established in April 2020 to co-ordinate and oversee the real-time nurse staffing levels across the hospital in support of the clinical site function has continued to operate and adapt. It now maintains a stronger role in the daily deployment of staff and the ongoing management of bank/agency bookings and is

having a measurable impact on the reduction in high-cost agency bookings. This is particularly evident in reviewing the deployment of bank and agency support for enhanced care.

The hub activity is led by a daily designated staffing matron who takes responsibility for leading the continuous review and reassignment of the nurse staffing resource throughout the day.

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

2.3.5.1 The ward establishments across UHS allow for registered nurse to patient ratios **during the day** to range from 1:1 (Piam Brown – Children) to 1:9 (Bassett, D6, D7 G6, G8, G9, E7 and E12) depending on specialty and overall staffing model. This is a further slight increase in the number of wards with lower RN: patient ratios (up from 4 wards to 8 wards with all areas in medicine) and this will require ongoing monitoring to ensure there is not further drift.

2.3.5.2 The average level is set to achieve 1:4 to 1:8 registered nurse to patient ratio in most areas during the day (43 wards, previously 47) with 42 wards set between 1:4 to 1:7 (up from 38). Exceptions are where there has previously been a planned model of trained band 4 staff to mitigate recruitment challenges and is particularly evident in Medicine and Medicine for older people.

2.3.5.3 The areas on or above 1:7 (22 wards) include the medicine wards, Medicine for Older People wards, some Trauma and Orthopaedic wards, including Brooke and the Acute Stroke Unit. These areas include a higher ratio of band 2 to 4 staff creating a total nurse to patient ratio of 1:3 – 1:4. It should be noted that the ratio of patients to registered nurse can regularly increase when wards are not fully established and these wards with lower RN to patient ratios are working on their minimum safe levels.

2.3.5.4 Planned staffing ratios at **night** require constant oversight to ensure the model is sufficient to provide the required support for patients out of hours.

- In areas that are working on lower staffing ratios, managing the workload at night has again emerged as an area that still requires action in a number of ward areas.
- Wards are piloting different twilight shift patterns (within existing budget) to continue to support the demands at night.
- Rising acuity of patients, more therapeutic activity taking place overnight and the impact of more geographically spread clinical areas has increased the pressure on the staffing resource at night. This also highlights the importance of supernumerary bleep-holders in supporting the ward areas

2.3.5.5 There are now 3 in-patient ward areas with ratios of 1:11 (RN to patient) at night (the same level as the previous year). These are E3(G), Acute Surgical Assessment and F7 this is offset by a total nurse to patient ratio of 1:5 and 1:6 with the utilisation of support staff.

2.3.6 ***Registered to unregistered ratios***

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

2.3.6.2 15 wards are now rostered at between 60:40 and 70:30. This is an increase of 1 ward on last year when there had been a reduction of 5 wards.

2.3.6.3 32 wards (an improvement on the 35 in the previous year but still remaining up significantly from 25 in 2019) are below the 60:40 ratio. These wards are utilising band 4 staff as a key contribution to the model of care and are areas where there is a wider multidisciplinary team contributing to care (e.g., MOP, T & O, Medicine, Acute Stroke). It should be noted however that this reducing trend needs to be kept under close review against other metrics to ensure safe, quality care can be provided within the

establishments. As highlighted previously, recent research highlights the impact on patient outcomes in areas with reduced registered nurse cover.

2.3.6.4 8 wards (1 more than 2023) are above the 70:30 ratio reflecting the increased specialism of our regional specialties where the intensity of the patient needs requires a higher ratio of registered staff (Child Health, CV&T, Neurosciences, and Cancer Care areas).

2.3.6.5 The support of band 4 roles continues to be designed in as part of a model of care in a number of areas linked to the further development of apprenticeship opportunities. This has also provided a role in which to appoint the emerging cohorts of nursing associates who have qualified and registered with the NMC from January 2019 onwards. In many areas where the acuity and intensity of patients has increased, and treatment and medication regimes are complex, further reduction in the overall skill-mix of registered to unregistered staff is not appropriate to maintain safe staffing levels and ensure adequate supervision. Additionally, in some cases a band 4 model was used to mitigate ongoing gaps in registered roles – this was particularly notable in Medicine for Older People. As recruitment for registered nurses improves these areas will be reviewing the overall required skill mix model.

2.3.6.6 Focus will continue on reviewing the overall registered to unregistered ratios to ensure reductions are linked to planned model of care changes and are accompanied by appropriate quality impact assessment and evaluation.

2.3.6.7 The current review of band 2/3 banding linked to national job assimilation will not have an impact on the overall registered to unregistered ratios but will have a financial impact on the establishments where uplift results. It is important to note that this will need to be managed without reducing the overall availability of unregistered nursing hours in order to maintain staffing levels.

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

- The Safer Nursing Care Tool (acuity/dependency model) has been used to model required staffing based on the national recommended nurse to patient ratios for each category of patient in all the areas. This is integrated into the health roster system as part of the safe-care tool and provides information on acuity/dependency levels and corresponding staffing levels on a real-time basis converted into recommended care hours per patient day. Where the predicted levels differ from established numbers, professional judgement has been used to assure that the levels set are appropriate for the speciality and number of beds. During the review period, a Trust-wide rollout of a new version of the software took place which has seen a total refresh of the use and application of the safer nursing care tool to ensure this is being used consistently across the organisation. There is also ongoing education and support work taking place to ensure all areas are using the tool in line with the recommendations to ensure consistency.

2.3.8 *Care Hours Per Patient Day*

2.3.8.1 Planned total Care Hours Per Patient Day (CHPPD) range from 4.2 (G5) rising to 19.2 (Piam Brown) and average at 7.7. The average is slightly lower than the previous year and there are a higher number of wards in the lower range. This will be linked to small bed increases in ward areas that have not been accompanied by staffing increases.

2.3.8.2 Planned Registered care hours per patient day range from 1.9 (G5) rising to 14.5 (Piam Brown) and average at 4.5. This average is slightly lower this year.

2.3.8.3 Planned Unregistered care hours per patient day range from 1.3 (C6 TYA) – 8.7 (G2 Neuro) and average at 3.2. This average is slightly lower than last year.

2.3.8.4 Actual CHPPD fluctuate significantly across the year and are strongly linked to patient numbers and changes in patient acuity. For example, increased staffing for patients who require enhanced care will increase the overall CHPPD numbers attributed to a ward. An aggregated Trust-wide average, whilst useful to review month by month and

annually for a trend, are less meaningful than the granular review of each ward CHPPD.

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

2.3.9.1 All areas have 23% funding allocated to allow for additional headroom requirements arising from non-direct care time. It is recognised that in a number of areas this percentage is too low to cover all of the indirect requirements in an area, particularly related to speciality and supervisory and training needs. There remains significant pressure on maintaining staffing within the allowed headroom. This is due to high training levels (resulting from the more junior workforce) and maternity/paternity levels that consistently exceed the allowance.

2.3.9.2 New national initiatives and requirements of the NHS contract such as the implementation of Professional Nurse Advocacy for all staff and Preceptorship support for all new registrants has further increased the pressure on this set level of headroom.

2.3.9.3 A discussion around management of headroom was included in each of the ward staffing reviews which took place with clear actions for the ward leaders to implement.

2.3.9.4 UHS has an established Ward Leader Supervisory model which means the Ward Leader is not included in the established numbers required to deliver safe care per shift. This enables them to focus more time on supervising and leading the ward team whilst supporting clinical care. This proved particularly important during recent years with developing the junior workforce.

2.3.9.5 In Q4 2023/24 and Q1 24/25 this model was paused as part of the financial recovery plan and Ward Leaders were rostered directly to support shifts. This impacted a range of indicators including appraisal completion, sickness reviews, roster management and learner development. In Q2 this was reinstated as part of the workforce plan for nursing and key metrics have again improved. The model is used flexibly whilst the priority is always to ensure safe staffing levels on the wards. Ward Leaders clearly articulated the personal and professional impact of this pause during the discussions at the review meetings.

2.3.10 ***Specific Divisional issues emerging***

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

2.4 <u>Trust wide risks and issues considered in the review</u>

2.4.1 ***Establishment monitoring and controls in line with financial recovery***

The staffing reviews took place against the backdrop of ongoing financial recovery. During the review period inpatient areas have been working to 97% of establishments (with identified exceptions) as a control measure and this is being monitored weekly to ensure any impact on quality indicators and staff wellbeing are flagged and responded to in a timely way to ensure safe staffing in line with NQB standards. Issues arising from these measures were openly discussed at the staffing reviews.

2.4.2 ***Increasing patient acuity/dependency***

The ongoing development of our defining services continues to result in an evidenced increase in the complexity, acuity and dependency of the patients cared for in our general ward beds, also linked to reducing length of stay.

COVID-19 has had a significant impact as our patients are definitely presenting with a higher level of both acuity and dependency.

Information on the acuity and dependency of our patients is available via the ‘Safe Care’ functionality in health roster and is used in real time as part of our daily staffing

meetings. The information is also used at the 6 monthly reviews as part of the professional judgment assessment.

2.4.3 ***Increasing enhanced care needs***

Trust wide we have continued to see an increase in the complexity of patients particularly in relation to mental health needs including dementia and patients remaining in the acute settings for prolonged lengths of time whilst awaiting appropriate placements.

We have also seen a significant rise in the episodes of violence and aggression experienced in our clinical areas which creates additional needs for staffing support.

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

Division B retain the Trustwide overview for enhanced care, specifically mental health support, and provide an advice service, supporting clinical areas in their decision making around the need for additional support.

Divisions have then developed enhanced care bays on wards and/or a local pool of staff to deploy to support enhanced care needs. Ward leaders report that this has made a major difference to the management of patients with these enhanced needs and has reduced the reliance on last minute agency to support.

The numbers however remain unpredictable and are therefore managed in real-time as part of overall considerations around safe staffing.

The management of additional enhanced care needs extends beyond the definition of patients requiring formal mental health support. Increased numbers of patients with challenging behaviour or needing 1:1 presence brings additional pressures to ward establishments but are necessary to keep the environment safe for all patients.

Through the work completed in agreeing and setting an affordable workforce level for 24/25 there was recognition and agreement to fund enhanced care based on 2023/24 M10 position, as an addition to establishments. This has had a positive impact and has resulted in a reduction in usage due to the controls in place and leadership/oversight from the matrons.

During 24/25 the staffing hub has been co-ordinating the requests for additional staff with additional mental health needs specifically linked to the mental health support team. This has shown key reductions in the use of registered mental health staff and tangible financial savings but despite these efforts, demand has continued to outstrip supply.

2.4.3 ***Supervising and supporting the junior workforce***

The professional judgement discussions with all the Ward Leaders again highlighted the additional challenges posed to the staffing models of appropriately supervising and supporting the increasing range of learners having placements on the ward areas. This includes the ability to meet the supervisory standards with an increasingly junior workforce.

New national guidance was issued in October 2022 and implemented within UHS during 2023 with additional requirements in relation to the provision of preceptorship for all staff new to registration. Protected time for both preceptors and preceptees is now an expectation for organisations.

The robust retention and recruitment strategies across the Trust and the strong vision to ‘grow our own’ nurses for the future means that wards continue to support a range of learners including undergraduate students, trainee nursing associates, nurse degree apprentices, Return to Practice students, newly registered staff undergoing preceptorship and internationally educated nurses awaiting registration.

Education teams across the trust have proved key to supporting the development and learning into the wards and particularly in continuing to train and support learners to full registration and into preceptorship.

The capacity and capability within the education and support teams needs to be further reviewed for 25/26 and beyond to ensure they can continue to support the further increase in numbers which will be required for UHS to meet the challenging workforce targets set in the national plan - with nursing student placements alone set to increase by up to 230% in the southeast over the coming years.

2.4.4 *Benchmarking using the Model Health System*

UHSFT provides data monthly to the national Model Hospital System (MHS) detailing the actual CHPPD provided (based on patient numbers) for all clinical areas including critical care. During 2024 the uploads to this system from UHS have been resubmitted following some data anomalies over the summer. It is unclear whether all of the corresponding graphs and information have been amended following this change.

Direct comparison of ward areas or specialty is no longer available via the benchmarking system however an overall average of total CHPPD is available to review via peer group and this is used as part of the staffing review.

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

Table 1

Organisation/Group	Total CHPPD	Registered CHPPD	Unregistered CHPPD
UHS excl. Critical Care	8.7	4.8	3.9
UHS with Critical Care	10.5	6.7	3.8
Shelford Group	9.8	6.7	3.2
MHS Peer Group	9.56	5.7	3.4
Region	8.9	5.6	3.3
National	8.7	5.1	3.5

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

Data is from the MHS August 2024 (latest figure) and includes nursing and midwifery and ward AHP staffing. and the UHS excluding critical care is UHS reporting Sept 2024 figure from People Report just for nursing.

2.4.5 *Review of quality metrics and staffing incidents*

The NICE guidance outlines some key quality metrics that should be considered as part of the staffing reviews. The safety metrics defined are patient falls, pressure ulcers and medicine administration errors. These metrics, along with a range of other UHS defined quality indicators are already monitored through our internal clinical quality dashboard and are discussed ward by ward as part of the professional judgement methodology in the reviews.

In addition, there is ongoing review of red flags raised as part of the adverse event reporting system and on ‘safecare’.

3.0 Conclusion

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

3.2 Overall the staffing establishments remain appropriate and within recommended guidelines. There are some key exceptions where acuity and dependency levels and

growing demand continue to outstrip the nursing ratios, coupled with the impact of ward reconfigurations – recommendations for uplifts in these areas will be put forward by the Divisions as part of the annual budget setting process.

4.0 Recommendations

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

4.2 To note findings of this annual ward establishment review and the Trust position in relation to adherence to the monitored metrics on nurse staffing levels.

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

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

4.5 To note and acknowledge the ongoing risks and challenges of matching actual staffing to established staffing levels and to agree the continuous monitoring of this with the introduction of any additional financial recovery measures.

4.6 To support the continued Trust wide commitment and momentum on actions to fill clinical nursing vacancies and further reduce the reliance on high-cost agency against the backdrop of rising acuity and emergency and elective recovery.

4.7 Systematic ward staffing reviews to be reported to board annually, with 6 monthly light touch reviews reported through Divisional Boards. Next full staffing review to be presented to Trust Board in November 2025.

5.0 Appendices

Appendix 1: National Quality Board (NQB Expectations for safe staffing Safe, Sustainable, and productive staffing

Appendix 2: NQB Safe Staffing Recommendations – UHS action plan

Appendix 3: NICE Guideline 1: Safe Staffing for nursing in adult inpatient wards in acute hospital - UHS action plan

Appendix 4: Ward by Ward staffing review metrics spreadsheet

Appendix 5: Specific Divisional issues emerging

Appendix 6: RCN Workforce Standards

Appendix 1

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

Expectation 1: Right staff	• Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations. • Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (i.e., the use of evidence-based tools, professional judgement, and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. • This should be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. • There should also be a review following any service change or where quality or workforce concerns are identified. • Safe staffing is a fundamental part of good quality care, and CQC will therefore always include a focus on staffing in the inspection frameworks for NHS provider organisations. • Commissioners should actively seek to assure themselves that providers have sufficient care staffing capacity and capability, and to monitor outcomes and quality standards, using information that providers supply under the NHS Standard Contract.
Expectation 2: Right skills	• Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services, and there is a staffing resource that reflects a multi professional team approach. • Decisions about staffing should be based on delivering safe, sustainable, and productive services. • Clinical leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and expertise, where there is an identified need or skills gap.
Expectation 3: Right place and time	• Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board, if concerns arise. • Directors of nursing, medical directors, directors of finance and directors of workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.

NATIONAL QUALITY BOARD - JULY 2016

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

	Descriptor	No.	Recommendation	Current measures in place	Assessed UHS rating (November 2024) C = compliant A = Actions required	Identified actions required and notes on compliance	Timescale	Lead
Expectation 1: Right staff	Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations. Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (i.e. the use of evidence-based tools, professional judgement and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. This should be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified. Safe staffing is a fundamental part of good quality care, and CQC will therefore always include a focus on staffing in the inspection frameworks for NHS provider organisations. Commissioners should actively seek to assure themselves that providers have sufficient care staffing capacity and capability, and to monitor outcomes and quality standards, using information that providers supply under the NHS Standard Contract.	**1.1 Evidence-based workforce planning**						
		1.1.1	The organisation uses evidence-based guidance such as that produced by NICE, Royal Colleges and other national bodies to inform workforce planning, within the wider triangulated approach in this NQB resource (see Appendix 4 for list of evidence-based guidance for nursing and midwifery care staffing).	Triangulated approach to staffing establishments well embedded. Shelford SNCT used and embedded in 'safecare' as part of eRostering. NICE guidance systematically reviewed 3 x per year.	C	Continue with current approach and strengthen with the use of CHPPD and safecare	complete	Head of Nursing - staffing/DMT
		1.1.2	The organisation uses workforce tools in accordance with their guidance and does not permit local modifications, to maintain the reliability and validity of the tool and allow benchmarking with peers.	All tools used as recommended.	C	Need to ensure there is corporate rigour on adapting SNCT while rolling out 'safecare'. Monitor the impact on the inclusion of 'enhanced care' scoring. Participate in the national NIHR research	complete	Head of Nursing - staffing/DMT
		1.1.3	Workforce plans contain sufficient provision for planned and unplanned leave, e.g. sickness, parental leave, annual leave, training and supervision requirements.	23% included in all direct care in-patient areas. Compliance monitored as part of healthroster reporting suite	C	Ongoing compliance monitored as part of healthroster reporting suite. Increased headroom requirement due to COVID-19	complete	DoF/Chief Nurse
		1.2 Professional judgement						
		1.2.1	Clinical and managerial professional judgement and scrutiny are a crucial element of workforce planning and are used to interpret the results from evidence-based tools, taking account of the local context and patient needs. This element of a triangulated approach is key to bringing together the outcomes from evidence-based tools alongside comparisons with peers in a meaningful way.	6 monthly staffing reviews include face to face meetings with Corporate Nursing Team/DHN/Matron/ward leaders as well as workforce systems and finance. Professional judgement key part of the reviews.	C	Continue with current approach and strengthen with the use of CHPPD and safecare	complete	Head of Nursing - staffing/DMT
		1.2.2	Professional judgement and knowledge are used to inform the skill mix of staff. They are also used at all levels to inform real-time decisions about staffing taken to reflect changes in case mix, acuity/dependency and activity.	As above. Professional judgement also used as part of the daily staffing review meetings through site control.	C	Continue with current approach. Professional judgement remains the ultimate measure of safe staffing. Key part of the staffing hub set-up during COVID-19	complete	Head of Nursing - staffing/DMT/site team
		1.3 Compare staffing with peers						
		1.3.1	The organisation compares local staffing with staffing provided by peers, where appropriate peer groups exist, taking account of any underlying differences.	Previous ad hoc benchmarking included through AUKUH network and targeted at specific services under development. Need to strengthen and formalise	C	Build on the current benchmarking capabilities included in the Model Hospital and N&M Dashboard. Continue to utlise the 'civil eyes' data for child health. Work with eRoster provider to introduce reporting that includes benchmarking data	complete	Head of Nursing - staffing/workforce systems team
		1.3.2	The organisation reviews comparative data on actual staffing alongside data that provides context for differences in staffing requirements, such as case mix (e.g. length of stay, occupancy rates, caseload), patient movement (admissions, discharges and transfers), ward design, and patient acuity and dependency.	All considered as part of the systematic staffing reviews	C	Model hospital benchmarking now being used routinely. All services benchmark with other areas where appropriate	complete	Head of Nursing - staffing/DMT
		1.3.3	The organisation has an agreed local quality dashboard that triangulates comparative data on staffing and skill mix with other efficiency and quality metrics: e.g. for acute inpatients, the model hospital dashboard will include CHPPD.	Clinical Quality Dashboard (CQD) includes all staffing and quality metrics. Used as part of the systematic clinical accreditation scheme reviews	C	Build the model hospital work into the CQD	complete	Head of Quality and Clinical Assurance

Expectation 2: Right skills	Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services, and there is a staffing resource that reflects a multiprofessional team approach. Decisions about staffing should be based on delivering safe, sustainable and productive services. Clinical leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and expertise, where there is an identified need or skills gap.	**2.1 Mandatory training, development and education**						
		2.1.1	Frontline clinical leaders and managers are empowered and have the necessary skills to make judgements about staffing and assess their impact, using the triangulated approach outlined in this document.	All frontline leaders skilled to manage staffing agenda. Included in competencies for ward leaders	C	Continue to maintain competence, skills and knowledge through master classes and staffing review meetings	complete	Head of Nursing - staffing/DMT
		2.1.2	Staffing establishments take account of the need to allow clinical staff the time to undertake mandatory training and continuous professional development, meet revalidation requirements, and fulfil teaching, mentorship and supervision roles, including the support of preregistration and undergraduate students.	23% headroom allowance and provision of supervisory ward leader role covers most aspects of time identified but not fully assured around adequate time for supervision of all learners. Backfill provided for some roles in development - degree apprenticeships but does not cover release for all staff	A	23% headroom is included in all nursing establishments as well as an allowance in all areas for the Ward Leader to be supervisory. A number of additional requirements e.g. increased student numbers and supervision, increased numbers of junior staff needing more supernumerary training time and professional nurse advocacy have led to the 23% allocation falling short of the needs in a number of areas. This is particarly notable in critical care and ED where the training needs outstrip the provision in the 23% headroom. Important to note that the Ward Leader Supervisory allowance was put on hold in Q4 2023/24 and reinstated slowly from Q1 2024/25 as part of the trust recovery plan. This impacted short term on some of the non-direct activities and KPI's eg appraisal rates/progression/HR actions	Unable to identify an expected date for compliance. Mitigations in place	Head of Nursing - staffing/DHN's/Divisional Education Leads/Education Quality Lead
		2.1.3	Those with line management responsibilities ensure that staff are managed effectively, with clear objectives, constructive appraisals, and support to revalidate and maintain professional registration.	All expectations clearly included in JD and annual objectives for line managers	C	Monitored as part of ongoing HR key performance metrics	complete	Associate Director of People/DMT
		2.1.4	The organisation analyses training needs and uses this analysis to help identify, build and maximise the skills of staff. This forms part of the organisation's training and development strategy, which also aligns with Health Education England's quality framework.	Annual training needs analysis process well embedded within the annual cycle for the trust	C	Continue with current approach with review in 2020 to further streamline priorities to staffing needs and match to changed CPD arrangements .	complete	Divisional Education Leads/Education Quality Lead/DMT
		2.1.5	The organisation develops its staff's skills, underpinned by knowledge and understanding of public health and prevention, and supports behavioural change work with patients, including self-care, wellbeing and an ethos of patients as partners in their care.	Comprehensive training programmes in place to equip staff with required skills	C	Monitored through ongoing evaluation	complete	Director of TD&W/Divisional Education Leads//DMT
		2.1.6	The workforce has the right competencies to support new models of care. Staff receive appropriate education and training to enable them to work more effectively in different care settings and in different ways. The organisation makes realistic assessments of the time commitment required to undertake the necessary education and training to support changes in models of care.	Comprehensive training programmes in place to equip staff with required skills	C	Monitored through ongoing evaluation	complete	Director of TD&W/Divisional Education Leads//DMT
		2.1.7	The organisation recognises that delivery of high quality care depends upon strong and clear clinical leadership and well-led and motivated staff. The organisation allocates significant time for team leaders, professional leads and lead sisters/charge nurses/ward managers to discharge their supervisory responsibilities and have sufficient time to coordinate activity in the care environment, manage and support staff, and ensure standards are maintained.	100% Supervisory ward leader time provided in all inpatient direct care areas. Clinical leaders programme in place	C	Continue to review % of time achieved as supervisory linked to ongoing vacancy position	complete	Head of Nursing - staffing/DMT/workforce systems
		2.2 Working as a multiprofessional team						
		2.2.1	The organisation demonstrates a commitment to investing in new roles and skill mix that will enable nursing and midwifery staff to spend more time using their specialist training to focus on clinical duties and decisions about patient care.	Range of new roles developed and evaluated within the organisation. Extended scope policies in place to support.	C	Further strengthen the trustwide approach to service by service workforce development	complete	Director of TD&W/Divisional Education Leads//DMT
		2.2.2	The organisation recognises the unique contribution of nurses, midwives and all care professionals in the wider workforce. Professional judgement is used to ensure that the team has the skills and knowledge required to provide high-quality care to patients. This stronger multiprofessional approach avoids placing demands solely on any one profession and supports improvements in quality and productivity, as shown in the literature.	Multiprofessional approach to all aspects of workforce development and training delivered within an integrated Training, Development and Workforce department	C	Continue with current approach and strengthen integration	complete	Director of TD&W/Divisional Education Leads//DMT
		2.2.3	The organisation works collaboratively with others in the local health and care system. It supports the development of future care models by developing an adaptable and flexible workforce (including AHPs and others), which is responsive to changing demand and able to work across care settings, care teams and care boundaries.	Strong record of working with other providers both in provider and HEI/FE sector.	C	Continue with current approach and strengthen partnership working through STP projects	complete	Director of TD&W/Divisional Education Leads//DMT

		2.3 Recruitment and retention						
		2.3.1	The organisation has clear plans to promote equality and diversity and has leadership that closely resembles the communities it serves. The research outlined in the NHS provider roadmap42 demonstrates the scale and persistence of discrimination at a time when the evidence demonstrates the links between staff satisfaction and patient outcomes.	Full action plan in place to address equality and diversity within trust linked to WRES data	A	Detailed in separate ED&I action plan. Ensuring any N&M specific actions are also incorporated into the retention toolkit and action plan	ongoing through E & D	Chief Nurse/People Director
		2.3.2	The organisation has effective strategies to recruit, retain and develop their staff, as well as managing and planning for predicted loss of staff to avoid over-reliance on temporary staff.	Full retention and recruitment programme of work ongoing and a workforce project management office established to maintain the focus	C	Confident that there are effective strategies in place and remains an area for ongoing action. Continued focus and evaluation of the wide ranging streams of work in place to support retention and recruitment	ongoing through R & R steering group	People Director /DMT
		2.3.3	In planning the future workforce, the organisation is mindful of the differing generational needs of the workforce. Clinical leaders ensure workforce plans address how to support staff from a range of generations, through developing flexible approaches to recruitment, retention and career development	Generational work starting to be incorporated into projects for retention and recruitment and specifically around preceptorship.	C	Research partnership with Burdett and Birmingham to review self rostering. Flexibility sub group established as part of R & R actions to review different approaches to flexibility for generational needs. Joined RePAIR work on flexibility and NHSI retention collaborative	ongoing through R & R steering group	Associate Director of People/Director of TD&W/DMT
	Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board, if concerns arise. Directors of nursing, medical directors, directors of finance and directors of workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.	**3.1 Productive working and eliminating waste**						
		3.1.1	The organisation uses 'lean' working principles, such as the productive ward, as a way of eliminating waste.	Transformation work incorporates lean techniques and productive ward techniques applied as appropriate including reviews of care hours, safety crosses, knowing how we're doing boards and patient status at a glance	C	Lean techniques used systematically as part of transformation	complete	Head of transformation/DMT
		3.1.2	The organisation designs pathways to optimise patient flow and improve outcomes and efficiency e.g. by reducing queuing.	Incorporated into all service redesign	C	Clear focus on flow and avoiding bottle-necks in service design.	complete	Head of transformation/DMT
		3.1.3	Systems are in place for managing and deploying staff across a range of care settings, ensuring flexible working to meet patient needs and making best use of available resources.	Staff are employed to be fully flexible (skills and competence allowing).	C	Continued review as part of daily staffing meetings to maximise flexibility of staff	complete	Chief Nurse/DMT
		3.1.4	The organisation focuses on improving productivity, providing the appropriate care to patients, safely, effectively and with compassion, using the most appropriate staff.	Staff are employed to be fully flexible (skills and competence allowing).	C	Continued review as part of daily staffing meetings to maximise flexibility of staff	complete	Chief Nurse/DMT
		3.1.5	The organisation supports staff to use their time to care in a meaningful way, providing direct or relevant care or care support. Reducing time wasted is a key priority.	Included as part of methodology of reviews of staffing. Direct care time monitored. Other roles utilised to maximise direct care	C	Continue with current approach	complete	Chief Nurse/DMT
		3.1.6	Systems for managing staff use responsive risk management processes, from frontline services through to board level, which clearly demonstrate how staffing risks are identified and managed.	Clear escalation processes in place and risk register and AER system used to record, review and learn from any staffing issues	C	Continue with current approach and monitor ongoing trends with staffing risks	complete	Chief Nurse/DMT

Expectation 3: Right place and time		**3.2 Efficient deployment and flexibility**						
		3.2.1	Organisational processes ensure that local clinical leaders have a clear role in determining flexible approaches to staffing with a line of professional oversight, that staffing decisions are supported and understood by the wider organisation, and that they are implemented with fairness and equity for staff.	Involvement of clinical leaders at all levels in setting establishment levels and rostering workforce. This is systemetically reviewed through 6 monthly staffing reviews reported to board	C	Continue with current approach	complete	Chief Nurse/DMT
		3.2.2	Clinical capacity and skill mix are aligned to the needs of patients as they progress on individual pathways and to patterns of demand, thus making the best use of staffing resource and facilitating effective patient flow.	Clinical speciality, acuity, dependency and pathways inlcuded as part of the systematic review of staffing levels	C	Continue with current approach	complete	Chief Nurse/DMT
		3.2.3	Throughout the day, clinical and managerial leaders compare the actual staff available with planned and required staffing levels, and take appropriate action to ensure staff are available to meet patients' needs.	Regular reviews of staffing levels planned and actual undertaken at care group, Division and trust wide level through daily stafifng meetings linked to site.	C	Continue to strenghten the daily staffing meetings and utilise safecare information	complete	Head of Nursing - staffing/DHN/Matrons/Site
		3.2.4	Escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed for safe, effective and compassionate care, and staff are aware of the steps to take where capacity problems cannot be resolved.	Escalation policies in place into site for unresolved staffing issues. Temporary staffing escalation in place and resource shared trustwide when required	C	Continue ot strengthen the information into site around staffing resource	complete	Head of Nursing - staffing/DHN/Matrons/work force systems team
		3.2.5	Meaningful application of effective e-rostering policies is evident, and the organisation uses available best practice from NHS Employers and the Carter Review Rostering Good Practice Guidance (2016).	Best practice guidance included in UHS poilicies around application of eRostering. Use of eRoster systematically reviewed and managed through the management team structure	C	Continue to strenthen the use of eRoster by utilising report function and reviewing compliance levels - specifically for: Approvals, unused hours, safecare	complete	Head of Nursing - staffing/DHN/Matrons
		3.3 Efficient employment, minimising agency use						
		3.3.1	The annual strategic staffing assessment gives boards a clear medium-term view of the likely temporary staffing requirements. It also ensures discussions take place with service leaders and temporary workforce suppliers to give best value for money in deploying this option. This includes an assessment to maximise flexibility of the existing workforce and use of bank staff (rather than agency), as reflected by NHS Improvement guidance.	Currently undertake 6 monthly staffing reviews that take account of all of the recommendations. Staffing reviews closely aligned to the Retention & Recruitment and temporary staffing strategies and clear actions in place to maximise bank use (NHSP) and reduce agency	C	Continue with all of the actions to reduce temporary staffing use and increase use of bank staff.	complete	Chief Nurse/Associate Director of People/DMT
		3.3.2	The organisation is actively working to reduce significantly and, in time, eradicate the use of agency staff in line with NHS Improvement's nursing agency rules, supplementary guidance and timescales.	Plan in place to reduce agency usage in line with NHSI guidance	C	Continue with all of the actions to reduce temporary staffing use and increase use of bank staff.	complete	Chief Nurse/Associate Director of People/DMT
		3.3.3	The organisation's workforce plan is based on the local Sustainability and Transformation Plan (STP), the place-based, multi-year plan built around the needs of the local population.	UHS fully engaged in development of STP workfroce aspects and workforce plan based on actions	C	Continue with engagement in STP development	complete	CEO/Chief Nurse/DoE
		3.3.4	The organisation works closely with commissioners and with Health Education England, and submits the workforce plans they develop as part of the STP, using the defined process, to inform supply and demand modelling.	UHS fully engaged in development of STP workfroce aspects and workforce plan based on actions	C	Continue with engagement in STP development	complete	CEO/Chief Nurse/DoE
		3.3.5	The organisation supports Health Education England by ensuring that high quality clinical placements are available within the organisation and across patient pathways, and actively seeks and acts on feedback from trainees/students, involving them wherever possible in developing safe, sustainable and productive services.	Strong systems in place to idetnfiying palcement capacity and monitor student allocation and quality across all staff groups	C	Continue with current model. Work with universities to constantly review the placement models for students in line of developing undergraduate programmes and apprenticeships	complete	DoE/Education leads

37 recommendations: 35 compliant 2 require further action

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

UHS FT self-assessment and action plan

	No.	Recommendation	NICE category Must (M) Should (S) Consider (C)	Current measures in place	Initial Assessed UHS rating (July 2014) C = compliant A = Actions required	Identified actions required (24 compliant, 14 action)	Timescale	Lead	October 2024 compliance	October 2024 (37 compliant, 1 requiring action)
	Organisational strategy - Recommendations for hospital boards, senior management and commissioners in line with NQB expectations									
Organisational strategy - Recommendations for hospital boards, senior management and commissioners in line with NQB expectations	1.1.1	Ensure patients receive nursing care they need regardless of ward, time, day.	M	Specialty and sub-specialty ward system in place Outlying/inlying patients monitored through site	C	Continued monitoring of compliance	Maintain	Clinical teams/DMT	C	Continued monitoring of compliance. Reconfiguration of ward specialties and skills occurring due to COVID-19 and ongoing review of skills taking place as part of staffing allocations.
	1.1.2	Develop procedures to ensure ward staff establishments are sufficient to provide safe nursing care for each patient	M	6 monthly establishments reviews in place led by DoN team with DHN/Matron/ward leaders as appropriate.	C	Continued development of staffing review methodology linked to NICE guidance	Maintain	Chief Nurse/Head of Nursing - staffing/ DHN	C	6 monthly light touch review not completed in all divisions in March due to COVID-19 but all establishments reviewed regularly during crisis and as part of restart. Full reviews scheduled for July/Aug 2020
	1.1.3	Ensure final ward establishments developed with registered nurses responsible and approved through chief nurse and trust board	M	6 monthly establishments reviews in place led by DoN team with DHN/Matron/ward leaders as appropriate. Reported and discussed through board	C	Strengthen involvement of ward sisters through supervisory competencies	Maintain	Chief Nurse/Head of Nursing - staffing/ DHN	C	6 monthly reviews now involving ward leaders
	1.1.4	Ensure senior nursing managers are accountable for nursing rosters produced	M	Reflected in job descriptions for DHN/Matrons/Ward Leader and included in ward leader competencies Hierarchy in eRoster reinforces requirements	C	Strengthen the monitoring and follow up of roster KPI's	Maintain	Chief Nurse/Head of Nursing - staffing/DHN/ HR	C	Roster audits now reinstated and accountability for rosters clearly within ward leader and matron job roles. Workforce systems centrally supporting some roster approvals during the COVID-19 period
	1.1.5	Ensure inclusion of adequate 'uplift' to support staffing establishment	M	23% uplift included in all inpatient nursing establishments	C	Continued monitoring of achievement of allocated 'uplift' through eRostering KPI's		DHN/Matron/Ward Leaders	C	Continued monitoring of achievement of allocated 'uplift' through eRostering KPI's. Focussed project taking place on headroom and headroom increases formally acknowledged due to COVID-19
	1.1.6	Include seasonal variation/fluctuating patient need when setting establishments	M	Included as a consideration when setting establishments	C	Continued consideration at establishment reviews	Maintain	Head of Nursing - staffing/DHN	C	Continued consideration at establishment reviews
	1.1.7	Establishments should be set appropriate to patient need taking account of registered/unregistered mix and knowledge and skills required	S	Included as a consideration when setting establishments	C	Continued consideration at establishment reviews		Head of Nursing - staffing/DHN	C	Continued consideration at establishment reviews
	1.1.8	Ensure procedures in place to identify differences between on the day requirements and staff available	M	Escalation processes in place through bleep-holders through to site. Matrons responsible for reviewing staffing daily	C	Further strengthen the daily review processes through site. Strengthen the matron out of hours model to provide further oversight for staffing through to site	Maintain	Head of Nursing - staffing/DHN/Matrons/Site	C	Safe staffing meetings extended to cover 7 days per week. Winter on-call matron arrangements now discontinued but staffing review meetings maintained. Safecare used actively at meetings
	1.1.9	Hospital to have a system in place for nursing red flag events to be reported by nursing teams, patients, relatives to registered nurse in charge (see separate tab)	M	eReporting of incidents becoming embedded. Staff informally include red flag information	A	Formalise 'red flag' inclusions on e incident reporting. Educate staff on 'red flag' events through safe staffing master classes and local care group/divisional updates. Review 'red flags' on all quality review visits to ward areas.	Maintain	Head of Nursing - staffing/DHN/safety team	C	Red flag information now routinely captured through safecare (real-time) and reviewed through staffing hub. AER's also capture red flag information and this is reviewed systematically monthly and reported to board for trends. Included in staffing establishment reviews.
	1.1.10	Ensure procedures in place for effective response to unplanned variations in patient need - including ability to increase/decrease staffing	M	Clear escalation processes and review of staffing actioned through bleep holding arrangements in Divisions	A	Continued monitoring of effectiveness of escalation and staffing status	Maintain	Head of Nursing - staffing/DHN	C	Escalation clear and embedded throughout all of the staffing review meeting. Enhanced care requirements specifically flagged and linked to the revisited policy re-issued May 2019. Agreed now compliant. Staffing hub set up during COVID-19 to take real-time view and manage staffing requirements across the trust
	1.1.11	Actions to respond to nursing staff deficits on a ward should not compromise staff nursing on other wards	S	Escalation processes include the need to review other wards/departments. All ward normal staffing included on trust wide spreadsheet daily	A	Continued monitoring of effectiveness of escalation and staffing status	Unable to identify a time when the organisation will be able to assure this. Mitigations in place.	Head of Nursing - staffing/DHN	A	Management of trustwide staffing deficits via the staffing hub have minimised the risk of this however the recruitment position, the dilute skillmix, the additional workforce controls in place and the capacity situation does not enable assurance that wards are not compromised by staff movements. Important to note that due to improved staffing levels, episodes of staffing in extremis to balance deficits have reduced however still unable to assure fully.
	1.1.12	Ensure there is a separate contingency and response for patients requiring continuous presence 'specialling'	M	Specialling processes in place and agreed escalation process within divisions.	C	Review the process for requesting specialling support.	Maintain	Head of Nursing - staffing/DHN	C	Escalation processes clear. Policy updated in 2020
	1.1.13	Consider implementing approaches to support flexibility such as adapting nursing shifts, skill mix, location and employment contracts	C	Variety of shift patterns worked within the trust and flexibility within rostering policy allows for variation	C	Continue to review as part of professional judgement element of staffing reviews	Maintain	Head of Nursing - staffing/DHN	C	Continue to review as part of professional judgement element of staffing reviews
	1.1.14	Ensure procedures in place for systematic ongoing monitoring of safe nursing indicators and formal review of nursing establishments twice a year	M	Nursing indicators monitored through incident reporting, ongoing monitoring and through CQD. Twice yearly formal staffing reviews embedded and managed through DON team	C	Continue to strengthen the process	Maintain	Head of Nursing - staffing/DHN	C	Included at establishment reviews

	1.1.15	Make appropriate changes to ward establishments as a response to reviews	M	Establishments amended as result of staffing reviews. Staffing review linked to budget setting process. Evidenced increases noted through trust board reporting	C	Continue to strengthen and evidence the process	Maintain	Head of Nursing - staffing/DHN	C	Continue to strengthen and evidence the process
	1.1.16	Enable nursing staff to have appropriate training for the care they are required to provide	M	Strong track record of training within Trust. Individual care group education teams support ongoing development needs	C	Continue to strengthen and evidence the process	Maintain	Head of Nursing - staffing/DHN/ Education leads	C	Continue to strengthen and evidence the process
	1.1.17	Ensure there are sufficient registered nurses who are experienced and trained to determine day-to-day staffing needs in 24 hour period	M	Bleep-holder role includes requirement to assess and review staffing and risk assess	A	Review to ensure all bleep-holders are competent and capable in staffing assessment and risk management	Maintain	DHN/Matron	C	Additional education put into bleep holding as part of winter pressure oversight arrangements. Now in place with bleep holding and band 7 weekend review
	1.1.18	Organisation should encourage staff to take part in programmes to assure quality of nursing care and care standards	S	Nursing staff involved in range of quality improvement programmes e.g. essence of care, nursing practice, turnaround, clinical accreditation scheme	C	Continue to involve staff at all levels in nursing quality standard development	Maintain	DHN/Head of Quality and Clinical Assurance	C	Continue to involve staff at all levels in nursing quality standard development
	1.1.19	Involve nursing staff in developing nursing policies which govern nursing staff requirements such as escalation policies	S	Nursing staff involved in developing policy through groups and consultation	C	Continue to involve staff at all levels in nursing policy development	Maintain	DHN/Head of Quality and Clinical Assurance	C	Continue to involve staff at all levels in nursing policy development
Principles for determining nursing staffing requirements - Recommendations for registered nurses in charge of individual wards or shifts	**Principles for determining nursing staffing requirements -** Recommendations for registered nurses in charge of individual wards or shifts who should be responsible for assessing the various factors used to determine nursing staff requirements									
	1.2.1	Use systematic approach to determining nursing staff requirements when setting nursing establishments and on day to day	M	Professional judgement and SNCT embedded for use within the Trust. Clear 'established levels' identified on eRoster	C	Continue to support staff at local ward level to understand establishments and staffing models	Maintain	DHN/Matrons/Ward Leaders	C	Continue to support staff at local ward level to understand establishments and staffing models. Staffing hub has strengthened the understanding of staff at different levels
	1.2.2	Use a decision support toolkit endorsed by NICE to determine nursing staff requirements		Not yet available through NICE but UHS already uses nationally validated Safer Nursing Care Tool (SNCT) as part of methodology for reviewing staffing levels	C	Review NICE endorsed tools as they emerge	Continuous review of emerging national guidance	Head of Nursing - staffing	C	Review NICE endorsed tools as they emerge. Continue to use endorsed SNCT and incorporate into safe care module.
	1.2.3	Use informed professional judgement to make a final assessment of nursing staff requirements	M	Professional judgement used as mainstay of methodology for reviewing establishments and day to day staffing	C	Continue to support staff at local ward level to understand establishments and staffing models	Maintain	DHN/Matrons/Ward Leaders	C	Continue to support staff at local ward level to understand establishments and staffing models. Stregnthened through the staffing hub
	1.2.4	Consider using nursing care activities included in guidance as a prompt to help inform professional judgement (see separate tab)	C	Already considered routinely as part of professional judgement and methodology	C	Continue to support staff at local ward level to understand establishments and staffing models	Maintain	DHN/Matrons/Ward Leaders	C	Continue to support staff at local ward level to understand establishments and staffing models
Setting the ward nursing staff establishment - Recommendations for senior registered nurses responsible for determining nursing staff requirements or those involved in setting the nursing staff establishment	**Setting the ward nursing staff establishment -** Recommendations for senior registered nurses responsible for determining nursing staff requirements or those involved in setting the nursing staff establishment of a particular ward									
	1.3.1	Setting ward establishments should involve designated senior registered nurses at ward level experienced and trained in determining nursing staff requirements using recommended tools	S	Ward sisters already involved in ward establishment reviews but approach needs strengthening. Competency for establishment review included in ward leader competencies	A	Strengthen involvement and training of ward leaders and other nurses through staffing master classes	Maintain	Head of Nursing - staffing/DHN/Workforce Systems	C	Current staffing review has full representation from ward leaders
	1.3.2	Routinely measure the average amount of nursing time required throughout a 24 hour period for each patient expressed as nursing hours per patient.	S	Methodologies not previously based on nursing hours per patient but safe nursing care tool and professional judgement	A	Include nursing hours per patient as a methodology in the staffing reviews from November 2014 Introduce next version of eRostering which has functionality to convert data into hours per patient	Maintain Maintain	Head of Nursing - staffing/Workforce Systems Head of Nursing - staffing/Workforce Systems	C C	Care hours per patient day now embedded as part of monthly reporting and included in safecare module of eRoster. Used as part of 6 monthly review from July 2016. reviewed as a metric in the staffing hub Safe care rollout complete
	1.3.3	Formally analyse the average nursing hours required per patient at least twice a year when reviewing the ward nursing staff establishments	S	Methodologies not previously based on nursing hours per patient but safe nursing care tool and professional judgement	A	Include nursing hours per patient as a methodology in the staffing reviews from November 2014	Maintain	Head of Nursing - staffing/Workforce Systems	C	Care hours per patient day now embedded as part of monthly reporting and included in safecare module of eRoster. Used as part of 6 monthly review from July 2016
	1.3.4	Multiply the average number of nursing hours per patient by the average daily bed utilisation	S	Methodologies currently based on using 100% bed occupancy - bed utilisation considered as part of the professional judgement	A	Introduce bed utilisation into the staffing review methodology for November 2014	Maintain	Head of Nursing - staffing/Workforce Systems	C	Bed utilisation discussed as part of the staffing review sonce July - Sept 2015 particularly in admission areas. Continue to calculate on 100% bed occupancy
	1.3.5	Add an allowance for additional nursing workload based on the relevant ward factors such as turnover, layout and size and staff factors	S	Already included in professional judgment considerations	C	Continued consideration at establishment reviews	Maintain	Head of Nursing - staffing/DHN	C	Continued consideration at establishment reviews
	1.3.6	Identify appropriate knowledge and nursing skill mix required - registered to unregistered - reviewing appropriate delegation	S	Trust baseline registered: unregistered 60:40 - no inpatient ward establishment drop below this. Assessed as part of professional judgement	C	Continued consideration at establishment reviews	Maintain	Head of Nursing - staffing/DHN	C	Continued consideration at establishment reviews
	1.3.7 and 1.3.8	Ensure planned uplift included in the calculation on average patients nursing needs	S	Trust baseline to include 23% on all ward establishments to cover uplift. Additional 0.8 wte uplift being rolled out for supervisory ward leader model	C	Continued consideration at establishment reviews. Continued monitoring of 23% headroom through eRostering	Maintain	Head of Nursing - staffing/DHN	C	Continued consideration at establishment reviews. Continued monitoring of 23% headroom through eRostering
n the day meet ons for registered	**Assessing if nursing staff available on the day meet patients' nursing needs -** Recommendations for registered nurses on wards who are in charge of shifts									
	1.4.1	Systematically assess that the available nursing staff for each shift or at least each 24 hour period is adequate to meet the actual nursing needs of patients on the ward	S	Daily spreadsheet used in site to review safe staffing - Matrons expected to link with all wards to determine staffing levels	C	Continued review of staffing levels included as a key responsibility in the ward leader and matron role	Maintain	Ward Leaders/ Matrons/ DHN	C	Continued review of staffing levels included as a key responsibility in the ward leader and matron role. Oversight from the staffing hub now enhancing the 24 hr view

Assessing if nursing staff available or patients' nursing needs - Recommendation nurses on wards	1.4.2	Monitor the occurrence of the nursing red flag events throughout a 24hour period	M	Escalation processes in place through bleep-holders through to site. Matrons responsible for reviewing staffing daily and this should include red flags	A	Care groups/Divisions to develop processes for review, reporting and capture of red flags through escalation processes	Maintain	Ward Leaders/ Matrons/ DHN	C	Monitoring of red flags on ongoing basis and key metric considered at staffing hub huddles. Reflected in AER reporting
	1.4.3	If a nursing red flag occurs it should prompt an immediate escalation response by the registered nurse in charge - with potential to allocate additional nursing staff	M	Escalation processes in place through bleep-holders through to site. Matrons responsible for reviewing staffing daily and this should include red flags	A	Care groups/Divisions to develop processes for review, reporting and capture of red flags through escalation processes	Maintain	Ward Leaders/ Matrons/ DHN	C	Monitoring of red flags on ongoing basis. Reflected in AER reporting and noted in bleep-holder logs
	1.4.4	Keep records of the on-the-day assessments of actual nursing staff requirements and reported red flag events so that they can be used to inform future planning or establishments	M	Escalation processes in place through bleep-holders through to site. Matrons responsible for reviewing staffing daily and this should include red flags	A	Care groups/Divisions to develop processes for review, reporting and capture of red flags through escalation processes	Maintain	Ward Leaders/ Matrons/ DHN	C	On the day records maintained and all red flag events captured through AER. Information used as part of the annual staffing reviews for each area to inform establishment changes. Examples at budget setting of changes as a result.
Monitor & evaluate ward nursing establishments - Recommendations for senior management and matrons	**Monitor and evaluate ward nursing staff establishments -** Recommendations for senior management and nursing managers or matrons to support safe staffing for nursing at ward level									
	1.5.1	Monitor whether the ward nursing staff establishment adequately meets patients nursing needs using safe nursing indicators. Consider continuous data collection of these nursing indicators	S	Majority of safe nursing indicators already included as part of the clinical quality dashboard	A	Expand the clinical quality dashboard to include the identified safe nursing indicators	Maintain	DHN/Head of Nursing - staffing/Head of Quality and Clinical Assurance	C	Clinical Quality Dashboard reviewed and relaunched September 2015. Review of indicators included as part of clinical accreditation scheme completed
	1.5.2	Compare results of safe nursing indicators with previous results over 6 month period	S	Review as part of monitoring of clinical quality dashboard	A	Include review of safe nursing indicators as part of staffing reviews from 2015 onwards	Maintain	Matrons	C	Review of indicators included as part of clinical accreditation scheme and annual matron reviews completed
	1.5.3	Monitor all of the nursing red flags and safe nursing indicators linked to wards exceeding 1 RN to 8 patients during the day	S	1:8 indicator included in daily staffing spreadsheet as a trigger to review staffing	A	Matrons to review all safe nursing indicators routinely for all ward areas	Maintain	Matrons	C	Matrons review all safe nursing indicators routinely for all ward areas. Retrospective review of red flag/AER incidents included as part of staffing discussions.

Appendix 4

															Planned CHPPD is calculated based on the type and number of the shifts set up in the Template and number of the beds in the ward			Actual demand CHPPD is calculated based on the Type and number of patients in the ward	Actual CHPPD is calculated based on the nursing hours ward staff worked and the number of patients on the ward at midnight
						Finance budgeted			Staffing Numbers						Planned on Template (long day factor applied)			Actual demand average(In Safe Care)	Actual average (Calculated on actual hours provided and average patient numbers at midnight)
	Division	Care Group	Unit Name	Shift	Total Beds	Budgeted Total Nursing Establishment (WTE)	Budgeted Registered Staff (WTE)	Budgeted Unregistered Staff (WTE)	Demand Registered (Count)	Demand Unregistered (Count)	Total nurse per shift	Skill Mix (RN:URN)	Patients RN Ratio (RN: Patient)	Patients Nursing Ratio (Total Nurse: Patient)	Planned Registered (CHPPD)	Planned Unregistered (CHPPD)	Total Planned CHPPD	Total Actual Demand CHPPD	Total Actual CHPPD
	Division A	Surgery	SUR E5 Lower GI	Early	18	30.3	18.7	11.7	4	3	7	58 : 42	1 : 5	1 : 3	4.1	3.3	7.5	8.1	7.1
			SUR E5 Lower GI	Late	18				3	1	4	76 : 24	1 : 6	1 : 5					
			SUR E5 Lower GI	Night	18				2	2	4	52 : 48	1 : 9	1 : 5					
			SUR E5 Upper GI	Early	18	31.1	17.4	13.7	4	3	7	55 : 45	1 : 5	1 : 3	3.8	3.1	6.9	8.5	7.5
			SUR E5 Upper GI	Late	18				4	3	7	59 : 41	1 : 5	1 : 3					
			SUR E5 Upper GI	Night	18				2	2	4	52 : 48	1 : 9	1 : 5					
			SUR E8 Ward	Early	26	53.0	33.9	19.1	7	4	11	64 : 36	1 : 4	1 : 3	4.8	2.7	7.6	7.8	8.5
			SUR E8 Ward	Late	26				7	4	11	64 : 36	1 : 4	1 : 3					
			SUR E8 Ward	Night	26				5	3	8	63 : 37	1 : 6	1 : 4					
			SUR F11 IF	Early	17	30.7	20.7	10.0	4	2	6	67 : 33	1 : 5	1 : 3	5.0	2.7	7.7	10.8	7.5
			SUR F11 IF	Late	17				4	2	6	67 : 33	1 : 5	1 : 3					
			SUR F11 IF	Night	17				3	2	5	61 : 39	1 : 6	1 : 4					
			SUR Acute Surgical Unit	Early	12	24.9	16.3	8.6	3	2	5	60 : 40	1 : 5	1 : 3	4.7	4.1	8.8	8.3	10.6
			SUR Acute Surgical Unit	Late	12				3	2	5	60 : 40	1 : 5	1 : 3					
			SUR Acute Surgical Unit	Night	12				2	2	4	50 : 50	1 : 7	1 : 4					
			SUR Acute Surgical Admissions	Early	30	40.0	23.8	16.2	6	3	9	67 : 33	1 : 6	1 : 4	3.1	2.0	5.1	7.6	13.3
			SUR Acute Surgical Admissions	Late	30				6	3	9	67 : 33	1 : 6	1 : 4					
			SUR Acute Surgical Admissions	Night	30				3	3	6	50 : 50	1 : 11	1 : 6					
			SUR F5 Ward	Early	28	36.7	22.7	14.0	5	3	8	64 : 36	1 : 6	1 : 4	3.6	2.0	5.5	7.3	6.3
			SUR F5 Ward	Late	28				5	2	7	71 : 29	1 : 6	1 : 5					
			SUR F5 Ward	Night	28				3	2	5	60 : 40	1 : 10	1 : 6					
		Cancer Care	CAN Acute Onc Services	Early	12	36.2	22.0	14.2	4	3	6	60 : 40	1 : 4	1 : 2	6.3	3.2	9.5	1.9	14.9
			CAN Acute Onc Services	Late	12				4	0	4	100 : 0	1 : 3	1 : 3					
			CAN Acute Onc Services	Night	12				2	2	4	50 : 50	1 : 7	1 : 4					
			CAN C4 Solent Ward Clinical Oncology	Early	23	40.1	23.6	16.4	5	3	8	63 : 38	1 : 5	1 : 3	4.0	2.5	6.4	7.8	8.1
			CAN C4 Solent Ward Clinical Oncology	Late	23				5	3	8	63 : 38	1 : 5	1 : 3					
			CAN C4 Solent Ward Clinical Oncology	Night	23				3	2	5	60 : 40	1 : 8	1 : 5					
			CAN C6 Leukaemia/BMT Unit	Early	21	47.6	38.5	9.1	8	2	10	80 : 20	1 : 3	1 : 3	7.6	1.6	9.2	7.2	9.7
			CAN C6 Leukaemia/BMT Unit	Late	21				8	2	10	80 : 20	1 : 3	1 : 3					
			CAN C6 Leukaemia/BMT Unit	Night	21				6	1	7	86 : 14	1 : 4	1 : 4					
			CAN C6 TYA Unit	Early	10	16.2	14.7	1.5	3	1	4	76 : 24	1 : 4	1 : 3	5.7	1.3	7.0	6.4	10.8
			CAN C6 TYA Unit	Late	10				3	1	4	73 : 27	1 : 4	1 : 3					
			CAN C6 TYA Unit	Night	10				2	0	2	100 : 0	1 : 6	1 : 6					
			CAN C2 Haematology	Early	27	54.7	39.3	15.4	8	3	11	73 : 27	1 : 4	1 : 3	5.8	2.6	8.4	9.6	9.4
			CAN C2 Haematology	Late	27				8	3	11	73 : 27	1 : 4	1 : 3					
			CAN C2 Haematology	Night	27				6	3	9	67 : 33	1 : 5	1 : 4					
			CAN D12	Early	24	39.0	24.2	14.8	5	3	8	63 : 38	1 : 5	1 : 4	4.3	2.3	6.6	7.2	7.7
			CAN D12	Late	24				5	3	8	63 : 38	1 : 5	1 : 4					
			CAN D12	Night	24				4	2	6	67 : 33	1 : 7	1 : 5					
	Division B	Medicine	MED D5 Ward	Early	28	41.6	19.9	21.7	4	5	9	44 : 56	1 : 7	1 : 4	2.8	2.6	5.4	8.1	7.1
			MED D5 Ward	Late	28				4	4	8	50 : 50	1 : 7	1 : 4					
			MED D5 Ward	Night	28				3	3	6	50 : 50	1 : 10	1 : 5					
			MED D6 Ward	Early	24	38.3	17.3	21.1	3	5	8	38 : 62	1 : 9	1 : 4	2.9	3.4	6.3	7.5	7.5
			MED D6 Ward	Late	24				3	5	8	38 : 62	1 : 9	1 : 4					
			MED D6 Ward	Night	24				3	2	5	60 : 40	1 : 9	1 : 6					
			MED D7 Ward	Early	16	26.4	12.0	14.4	2	3	5	42 : 58	1 : 9	1 : 4	2.9	3.4	6.3	7.7	9.3
			MED D7 Ward	Late	16				2	3	5	42 : 58	1 : 9	1 : 4					
			MED D7 Ward	Night	16				2	2	4	50 : 50	1 : 9	1 : 5					
			MED D8 Ward	Early	24	37.7	17.3	20.5	3	5	8	38 : 63	1 : 8	1 : 3	2.8	2.9	5.7	7.4	7.7
			MED D8 Ward	Late	24				3	4	7	43 : 57	1 : 8	1 : 4					
			MED D8 Ward	Night	24				3	3	6	50 : 50	1 : 8	1 : 4					
			MED D9 Ward	Early	28	40.4	19.9	20.5	4	5	9	45 : 55	1 : 8	1 : 4	2.9	2.6	5.5	7.9	6.8
			MED D9 Ward	Late	28				4	4	8	51 : 49	1 : 8	1 : 4					
			MED D9 Ward	Night	28				3	3	6	50 : 50	1 : 10	1 : 5					
			MED E7 Ward	Early	26	37.7	17.3	20.5	3	5	8	38 : 63	1 : 9	1 : 4	2.2	2.0	4.2	9.5	5.5
			MED E7 Ward	Late	26				3	5	8	38 : 63	1 : 9	1 : 4					
			MED E7 Ward	Night	26				3	2	5	60 : 40	1 : 9	1 : 6					
			MED F7 Ward	Early	20	32.3	14.6	17.6	3	3	6	52 : 48	1 : 7	1 : 4	3.2	3.0	6.3	7.1	8.1
			MED F7 Ward	Late	20				3	3	6	52 : 48	1 : 7	1 : 4					
			MED F7 Ward	Night	20				2	2	4	50 : 50	1 : 11	1 : 6					
			MED C5 Isolation Ward	Early	14	29.6	12.0	17.6	2	4	6	34 : 66	1 : 8	1 : 3	3.4	4.9	8.3	6.7	10.9
			MED C5 Isolation Ward	Late	14				2	4	6	34 : 66	1 : 8	1 : 3					
			MED C5 Isolation Ward	Night	14				2	2	4	50 : 50	1 : 8	1 : 4					
			MED D10 Isolation Unit	Early	18	33.7	14.6	19.0	3	4	7	43 : 57	1 : 7	1 : 3	3.2	3.9	7.1	5.3	7.6
			MED D10 Isolation Unit	Late	18				3	4	7	43 : 57	1 : 7	1 : 3					
			MED D10 Isolation Unit	Night	18				2	2	4	50 : 50	1 : 10	1 : 5					
			MED G5 Ward	Early	28	40.2	19.9	20.2	4	5	9	44 : 56	1 : 7	1 : 4	1.9	2.3	4.2	7.7	5.4
			MED G5 Ward	Late	28				4	5	9	44 : 56	1 : 7	1 : 4					
			MED G5 Ward	Night	28				3	2	5	60 : 40	1 : 10	1 : 6					
			MED G6 Ward	Early	26	39.9	17.3	22.6	3	5	8	38 : 62	1 : 9	1 : 4	2.7	3.1	5.8	7.9	6.5
			MED G6 Ward	Late	26				3	5	8	38 : 62	1 : 9	1 : 4					
			MED G6 Ward	Night	26				3	2	5	60 : 40	1 : 9	1 : 6					
			MED G7 Ward	Early	14	26.4	12.0	14.4	2	3	5	40 : 60	1 : 7	1 : 3	3.3	3.1	6.4	8.7	7.7
			MED G7 Ward	Late	14				2	3	5	40 : 60	1 : 7	1 : 3					
			MED G7 Ward	Night	14				2	2	4	50 : 50	1 : 7	1 : 4					
			MED G8 Ward	Early	26	38.1	17.3	20.8	3	5	8	38 : 63	1 : 9	1 : 4	2.4	2.8	5.3	#N/A	5.8
			MED G8 Ward	Late	26				3	5	8	38 : 62	1 : 9	1 : 4					
			MED G8 Ward	Night	26				3	2	5	59 : 41	1 : 10	1 : 6					
			MED G9 Ward	Early	26	36.9	17.3	19.6	3	5	8	38 : 63	1 : 9	1 : 4	2.6	3.1	5.7	7.6	6.0
			MED G9 Ward	Late	26				3	5	8	38 : 63	1 : 9	1 : 4					
			MED G9 Ward	Night	26				3	2	5	60 : 40	1 : 9	1 : 6					
			MED Bassett Ward	Early	26	44.2	17.3	26.9	3	6	9	33 : 67	1 : 9	1 : 3	2.9	4.4	7.4	12.0	6.7
			MED Bassett Ward	Late	26				3	5	8	38 : 63	1 : 9	1 : 4					
			MED Bassett Ward	Night	26				3	4	7	43 : 57	1 : 9	1 : 4					
			MED E12	Early	24	37.7	17.3	20.5	3	5	8	38 : 62	1 : 9	1 : 4	2.8	3.3	6.1	7.3	3.3
			MED E12	Late	24				3	5	8	38 : 62	1 : 9	1 : 4					
			MED E12	Night	24				3	2	5	60 : 40	1 : 9	1 : 5					

Appendix 4

						Finance budgeted			Staffing Numbers						Planned CHPPD is calculated based on the type and number of the shifts set up in the Template and number of the beds in the ward			Actual demand CHPPD is calculated based on the Type and number of patients in the ward	Actual CHPPD is calculated based on the nursing hours ward staff worked and the number of patients on the ward at midnight
															Planned on Template (long day factor applied)			Actual demand average(In Safe Care)	Actual average (Calculated on actual hours provided and average patient numbers at midnight)
	Division	Care Group	Unit Name	Shift	Total Beds	Budgeted Total Nursing Establishment (WTE)	Budgeted Registered Staff (WTE)	Budgeted Unregistered Staff (WTE)	Demand Registered (Count)	Demand Unregistered (Count)	Total nurse per shift	Skill Mix (RN:URN)	Patients RN Ratio (RN: Patient)	Patients Nursing Ratio (Total Nurse: Patient)	Planned Registered (CHPPD)	Planned Unregistered (CHPPD)	Total Planned CHPPD	Total Actual Demand CHPPD	Total Actual CHPPD
	Division C	Child Health	CHI Paed Medical Unit	Early	18	50.6	34.5	16.2	6	2	8	75 : 25	1 : 4	1 : 3	7.9	2.5	10.4	8.2	11.9
			CHI Paed Medical Unit	Late	18				6	2	8	75 : 25	1 : 4	1 : 3					
			CHI Paed Medical Unit	Night	18				6	2	8	75 : 25	1 : 4	1 : 3					
			CHI Piam Brown Unit	Early	12	49.4	40.2	9.2	13	3	15	83 : 17	1 : 1	1 : 1	14.5	4.7	19.2	10.3	17.9
			CHI Piam Brown Unit	Late	12				5	2	7	71 : 29	1 : 3	1 : 2					
			CHI Piam Brown Unit	Night	12				4	2	6	67 : 33	1 : 5	1 : 3					
			CHI Ward E1 Paed Cardiac	Early	16	43.1	33.6	9.5	6	2	8	77 : 23	1 : 3	1 : 2	8.8	2.2	11.0	9.0	10.8
			CHI Ward E1 Paed Cardiac	Late	16				6	2	8	75 : 25	1 : 3	1 : 3					
			CHI Ward E1 Paed Cardiac	Night	16				5	1	6	83 : 17	1 : 4	1 : 3					
			CHI Ward G2 Neuro	Early	6	14.9	13.2	1.7	2	2	4	50 : 50	1 : 4	1 : 2	8.1	8.7	16.7	8.3	9.7
			CHI Ward G2 Neuro	Late	6				2	2	4	50 : 50	1 : 4	1 : 2					
			CHI Ward G2 Neuro	Night	6				2	2	4	50 : 50	1 : 4	1 : 2					
			CHI Ward G3	Early	20	47.4	32.2	15.2	6	4	10	60 : 40	1 : 4	1 : 3	6.7	4.4	11.2	8.2	11.9
			CHI Ward G3	Late	20				6	4	10	60 : 40	1 : 4	1 : 3					
			CHI Ward G3	Night	20				5	3	8	63 : 38	1 : 5	1 : 3					
			CHI Ward G4 Surgery	Early	18	53.1	38.6	14.5	6	3	9	68 : 32	1 : 3	1 : 2	7.5	3.4	10.9	8.2	11.3
			CHI Ward G4 Surgery	Late	18				6	3	9	68 : 32	1 : 3	1 : 2					
			CHI Ward G4 Surgery	Night	18				5	2	7	71 : 29	1 : 4	1 : 3					
		Women & Newborn	W&N Bramshaw Womens Unit	Early	18	27.1	17.5	9.6	3	2	5	62 : 38	1 : 7	1 : 4	3.5	2.2	5.7	#N/A	9.4
			W&N Bramshaw Womens Unit	Late	18				3	2	5	62 : 38	1 : 7	1 : 4					
			W&N Bramshaw Womens Unit	Night	18				2	2	4	57 : 43	1 : 8	1 : 5					
		Cardiovascular & Thoracic	CAR Ward D3 Cardiac	Early	22	48.8	28.6	20.2	7	2	9	75 : 25	1 : 4	1 : 3	5.7	2.3	8.0	8.3	8.6
			CAR Ward D3 Cardiac	Late	22				6	2	8	73 : 27	1 : 4	1 : 3					
			CAR Ward D3 Cardiac	Night	22				4	2	6	67 : 33	1 : 6	1 : 4					
			CAR Ward D4 Vascular	Early	22	43.7	23.4	20.4	6	3	9	66 : 34	1 : 4	1 : 3	4.6	3.1	7.8	7.0	12.4
			CAR Ward D4 Vascular	Late	22				5	3	8	61 : 39	1 : 5	1 : 3					
			CAR Ward D4 Vascular	Night	22				3	3	6	51 : 49	1 : 8	1 : 4					
			CAR Ward E2 YACU	Early	17	34.6	20.6	14.0	5	3	7	64 : 36	1 : 4	1 : 3	4.7	3.0	7.6	9.0	8.3
			CAR Ward E2 YACU	Late	17				4	2	6	67 : 33	1 : 5	1 : 3					
			CAR Ward E2 YACU	Night	17				2	2	4	52 : 48	1 : 9	1 : 5					
			CAR Ward E3 Green	Early	24	43.0	26.0	17.0	4	4	8	51 : 49	1 : 6	1 : 4	3.2	3.0	6.2	6.8	6.5
			CAR Ward E3 Green	Late	24				4	3	7	62 : 38	1 : 6	1 : 4					
			CAR Ward E3 Green	Night	24				2	3	5	46 : 54	1 : 11	1 : 5					
			CAR Ward E3 Blue	Early	18	35.2	20.2	15.0	4	2	7	68 : 32	1 : 5	1 : 3	4.3	2.5	6.8	7.2	6.9
			CAR Ward E3 Blue	Late	18				4	2	6	67 : 33	1 : 5	1 : 4					
			CAR Ward E3 Blue	Night	18				2	2	4	51 : 49	1 : 9	1 : 5					
			CAR Ward E4 Thoracics	Early	20	44.9	24.7	20.2	3	2	5	60 : 40	1 : 7	1 : 5	4.4	3.5	7.8	9.5	10.3
			CAR Ward E4 Thoracics	Late	20				3	2	5	60 : 40	1 : 7	1 : 5					
			CAR Ward E4 Thoracics	Night	20				3	2	5	60 : 40	1 : 7	1 : 5					
			CAR Ward D2 Cardiology	Early	15	30.4	16.9	13.5	4	2	6	66 : 34	1 : 5	1 : 3	4.5	2.9	7.3	9.7	8.4
			CAR Ward D2 Cardiology	Late	15				3	2	5	60 : 40	1 : 6	1 : 4					
			CAR Ward D2 Cardiology	Night	15				2	2	4	51 : 49	1 : 8	1 : 4					
	Division D	Neurosciences	NEU Acute Stroke Unit	Early	28	55.3	22.7	32.7	4	7	10	37 : 63	1 : 8	1 : 3	3.1	4.5	7.6	11.3	7.3
			NEU Acute Stroke Unit	Late	28				4	7	10	37 : 63	1 : 8	1 : 3					
			NEU Acute Stroke Unit	Night	28				4	4	7	48 : 52	1 : 8	1 : 4					
			NEU Regional Transfer Unit	Early	10	26.6	17.9	8.7	3	1	4	74 : 26	1 : 4	1 : 3	6.0	3.4	9.4	9.0	11.8
			NEU Regional Transfer Unit	Late	10				3	1	4	74 : 26	1 : 4	1 : 3					
			NEU Regional Transfer Unit	Night	10				2	2	4	50 : 50	1 : 6	1 : 3					
			NEU ward E Neuro	Early	26	52.4	26.5	25.9	5	4	8	57 : 43	1 : 6	1 : 4	4.1	3.2	7.3	8.8	7.9
			NEU ward E Neuro	Late	26				5	4	8	58 : 42	1 : 6	1 : 4					
			NEU ward E Neuro	Night	26				4	4	8	52 : 48	1 : 7	1 : 4					
			NEU HASU	Early	13	35.0	25.3	9.7	4	1	5	80 : 20	1 : 4	1 : 3	7.1	1.7	8.8	16.4	11.8
			NEU HASU	Late	13				4	1	5	80 : 20	1 : 4	1 : 3					
			NEU HASU	Night	13				4	1	5	80 : 20	1 : 4	1 : 3					
			NEU Ward D Neuro	Early	27	60.4	28.8	31.6	5	5	10	50 : 50	1 : 6	1 : 3	3.9	4.2	8.1	9.4	8.6
			NEU Ward D Neuro	Late	27				5	5	10	50 : 50	1 : 6	1 : 3					
			NEU Ward D Neuro	Night	27				4	5	9	44 : 56	1 : 7	1 : 4					
		Spinal Service	SPI Ward F4 Spinal	Early	22	42.8	22.7	20.1	4	3	7	57 : 43	1 : 6	1 : 4	3.8	3.0	6.8	#N/A	9.4
			SPI Ward F4 Spinal	Late	22				4	3	7	57 : 43	1 : 6	1 : 4					
			SPI Ward F4 Spinal	Night	22				3	3	6	50 : 50	1 : 8	1 : 4					
		Trauma & Orthopaedics	T&O Ward Brooke	Early	18	33.9	16.6	17.3	3	3	6	50 : 50	1 : 7	1 : 4	3.2	3.7	6.9	12.2	6.8
			T&O Ward Brooke	Late	18				3	3	6	50 : 50	1 : 7	1 : 4					
			T&O Ward Brooke	Night	18				2	3	5	40 : 60	1 : 10	1 : 4					
			T&O Trauma Admissions Unit	Early	8	26.1	13.2	13.0	3	2	5	57 : 43	1 : 4	1 : 2	6.5	5.6	12.1	11.7	15.6
			T&O Trauma Admissions Unit	Late	8				2	2	4	50 : 50	1 : 5	1 : 3					
			T&O Trauma Admissions Unit	Night	8				2	2	4	50 : 50	1 : 5	1 : 3					
			T&O Ward F1 Major Trauma Unit	Early	32	66.1	34.9	31.2	6	5	11	55 : 45	1 : 6	1 : 4	4.1	3.6	7.7	11.5	9.1
			T&O Ward F1 Major Trauma Unit	Late	32				6	5	11	55 : 45	1 : 6	1 : 4					
			T&O Ward F1 Major Trauma Unit	Night	32				5	5	10	50 : 50	1 : 7	1 : 4					
			T&O Ward F2 Trauma	Early	26	51.7	22.7	29.0	4	5	9	44 : 56	1 : 7	1 : 3	3.3	3.9	7.1	10.7	8.7
			T&O Ward F2 Trauma	Late	26				4	5	9	44 : 56	1 : 7	1 : 3					
			T&O Ward F2 Trauma	Night	26				3	4	7	43 : 57	1 : 9	1 : 4					
			T&O Ward F3 Trauma	Early	24	52.2	22.7	29.6	4	6	10	40 : 60	1 : 7	1 : 3	3.4	5.1	8.6	10.5	10.3
			T&O Ward F3 Trauma	Late	24				4	5	9	45 : 55	1 : 7	1 : 3					
			T&O Ward F3 Trauma	Night	24				3	5	8	38 : 63	1 : 9	1 : 4					
			T&O Ward F4 Elective	Early	18	35.4	17.8	17.5	4	2	6	66 : 34	1 : 5	1 : 4	3.5	3.6	7.1	7.5	7.1
			T&O Ward F4 Elective	Late	18				3	3	6	50 : 50	1 : 7	1 : 4					
			T&O Ward F4 Elective	Night	18				2	3	5	40 : 60	1 : 10	1 : 4					

Appendix 5

Specific Divisional issues emerging - Ward Staffing Review 2024

Division A

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

The ask for inpatient areas to work to 97% of establishments as a control measure in response to the current financial position is being monitored weekly to ensure any impact on quality indicators and staff wellbeing are flagged and responded to in a timely way to ensure safe staffing in line with NQB standards.

Although SDU is not part of this review process, it still receives funding for six inpatient beds. Despite this funding allocation, the unit has consistently been over capacity, handling significantly more patients – up to 24 at times – throughout the year. This has been staffed by bank staff with a temporary uplift to accommodate 12 beds. It has been suggested that a review of service requirement would be useful. Currently in progress.

Uplifts have been agreed, and budgets have been adjusted for F5 and F11, recruitment is under way.

A trial for the Same Day Emergency Care unit (SDEC) on ASU. To enable this, four beds were reallocated from F6. This reflects efforts to optimize patient flow and provide more immediate emergency care services.
There is currently adequate allocated budget within the surgery care group due to the Enhanced recovery programme not running and the movement of four beds from F6. The exact source needs to be identified, and further discussions are necessary to decide if additional funding needs to be secured.

Areas to be put forward at budget setting post 2024 review – Division A:

- SDEC funding post discussion.
- Supernumerary bleep-holders budget was not allocated to all care groups. To support flow, and staffing this is essential to support.

Division B

The established staffing levels are appropriate in most wards and registered nurse vacancy levels are low, however healthcare assistant vacancies remain challenging.

The ask for inpatient areas to work to 97% of establishments as a control measure in response to the current financial position is being monitored weekly to ensure any impact on quality indicators and staff wellbeing are flagged and responded to in a timely way to ensure safe staffing in line with NQB standards.

Ward leader supervisory time was paused for a period, and we saw an impact on workload and wellbeing amongst this group. Particularly in their ability to effectively manage a team, such as absence and appraisals. Whilst the pause is now lifted, supervisory time is inconsistent and often cancelled to support achieving safe staffing levels across the division, which is something we are monitoring to ensure balance.

Through the work completed in agreeing and setting an affordable workforce level for the division for 2024/25 G5, G7 and C6 wards were aligned with other inpatient wards improving their CHPPD position slightly and reduced reliance on bank to mitigate the risks posed by the original deficit.

Enhanced care including mental health remains a significant challenge for medicine inpatient wards and AMU. Cancer care, similar but less impacted by mental health. Recognition of this and agreement to fund this in addition to our establishments as part of the affordable workforce limit has been a positive step forward, and whilst based on 2023/24 M10 position and the unpredictability of demand, thus far the division has seen a reduction in usage due to the controls in place and leadership/oversight from the matrons.

Violence and aggression incidences remain a concern across the division and particularly within AMU and medicine inpatient ward areas. Many nursing hours are lost in managing and de-escalating these incidences and time needed for debriefing and sign posting staff to support wellbeing. We are engaged in the work the wider trust is doing around violence and aggression and monitoring closely.

Medicine/MOP

Medicine opened E12, a 24 bedded ward on 11th December 2023.

Through budget setting the discharge lounge staffing request was approved and now funded, no longer requiring pull from ward establishments.

Specialist medicine day unit (4 beds) run as part of D7 Ward has been successful and looking to pilot expanding. Currently being staffed from ward establishment so impacting on the CHPPD data being collated. This is being monitored and will be reviewed going into 2025/26.

Cancer Care

Cancer care have seen a rise in the number of patients outside the cancer care footprint who require administration of chemotherapy, and this is currently being supported by releasing registered nurses from ward-based establishments impacting at times on achieving safe staffing levels.
This is currently under review and may lead to an ask through budget setting 2025/26.

Areas to be put forward at budget setting post 2024 review – Division B:

- D12 ward has seen a significant rise in their acuity on the ward and this has been further impacted by changes to pathways and the geography of the ward resulting in a requirement for an additional registered nurse on the early and late shift to ensure safe staffing levels. This is currently being achieved through use of bank when required. This will be highlighted through budget setting.

- Enhanced care, including mental health, remains challenging, likely ask through budget setting to maintain funding for this separate to establishments.

- Medicine care group still have a proportion of Band 4 nurses as part of a mitigation when band 5 vacancies were high, likely ask through budget setting to convert back to band 5 model.

Division C (excluding Midwifery)

The established staffing levels across most areas within the Southampton Children's Hospital (SCH) and Bramshaw at Princess Anne Hospital (PAH) are deemed appropriate to support the acuity of patients. Certain areas have specific challenges that require attention.

SCH – Vacancy levels

Vacancy rates within Children's Hospital have been a concern. Active measures have been taken to recruit newly qualified nurses and they started in October and November 2024. This intake is expected

to address existing gaps significantly. However, it is recognised there will continue to be a skill mix gap.

Enhanced Care for CAMHS patients and children with behavioural needs

Staffing for patients requiring enhanced care due to mental health or behavioural challenges remains a consistent pressure. However, the demand for additional staffing has seen an overall reduction due to improved management strategies and skill adjustments.

Critical Care included in SCH ward areas

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

NHS England are reviewing the need for more paediatric critical care capacity, currently they are supporting PICU/PHDU with some additional funding for nursing for additional beds in winter. Paediatric oncology services are also being reviewed and may result in an increase in patient numbers and have a direct impact on staffing requirements for nurses and other multi professional staffing groups.

Skill mix adjustments

The need for skill mix changes has been recognised to address the growing acuity of patients (an example is within Piam Brown). These adjustments have been effectively managed within the allocated financial footprint.

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

- No areas identified as part of this review; however, it has been recognised there is a national shortage of paediatric critical care capacity and therefore if we are requested to expand our current services an investment in additional staff would be required.

<u>Division D</u>

Overall established staffing levels are appropriate in most ward areas, for the level and acuity of patients with no ward areas emerged as requiring any changes.

There has been an increase of violence, aggressive and mental health/enhanced care patients. The pressure on staffing continues for enhanced care and mental health provision for this patient group,

F4 spinal continues to go over staffing establishment when they have increased amount of tetraplegic patient's requiring increased dependency. NHSE had previously funded a support worker role to aid with nursing care for the increased dependency, but funding has been withdrawn.

Funding has been identified for supernumerary bleep holders in CVT to enable support to flow within the trust. Whilst this is a good move forward this needs to be equitable in all care groups.

Whilst staffing at a trained nurse level on most wards, and some wards being fully recruited, skill mix at times is poor. With high numbers of junior nurses in places, presenting a challenge to support these nurses and maintain a safe productive environment.

Cath lab and neurology day case are opened as surge capacity at night but staffed by ward areas, there is no sustainable budget for this activity.

Recruitment and retention of health care assistance remains a challenge with some ward areas at 40% vacancy. This remains a focus of recruitment. Welcome ward funding ceased in April 2024, which has reduced the support to new health care support workers in a clinical area.

Transformation project works continue with opening a stroke SDEC for two months in the emergency department. HASU will be staffing this with using Bank to back fill the shifts.

Areas to be put forward at budget setting post 2024 review – Division D:

- No budget was allocated this year for enhanced care funding, this continues to be a challenge even with new staffing hub controls.

- Supernumerary bleep-holders budget was not allocated to all care groups. To support flow, and staffing this is essential to support

- Discharge lounge in CVT and Neuro is not funded but is currently open for a twelve-hour day, staffed from existing establishments – this is essential for supporting flow throughout the division.

Appendix 6

RCN Nursing Workforce Standards – May 2021

Overview

University Hospital Southampton NHS Foundation Trust

Agenda item 6.1 Report to the Trust Board of Directors, 7 January 2025	
Title:	Board Assurance Framework (BAF)
Sponsor:	Gail Byrne, Chief Nursing Officer
Author:	Lauren Anderson, Corporate Governance & Risk Manager Craig Machell, Associate Director of Corporate Affairs

Purpose

(Re)Assurance	Approval	Ratification	Information
x			x

Strategic Theme

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

Executive Summary:

The Board Assurance Framework (BAF) provides assurance against the achievement of our strategic objectives; highlighting those that are at risk of not being delivered. The BAF provides evidence to support the annual governance statement and is a focus of CQC and audit scrutiny. This report sets out the strategic risks, control framework, sources of assurance and action plans. The BAF is a dynamic document that will reflect the Trust's changing strategic position.

The BAF has been developed with input from responsible executives and relevant stakeholders. It satisfies good governance requirements on information and scoring. The report has been updated following discussions with the relevant executives and their teams.

The Board is asked to note the updated Board Assurance Framework and information contained within this report.

Contents:

Paper
Appendix A – The full Board Assurance Framework

Risk(s):

All BAF risks are contained within this report as well as the linked operational risks where applicable.

Equality Impact Consideration:	N/A

1. Purpose

1.1. The University Hospital Southampton Board Assurance Framework (BAF) identifies the strategic ambitions and the key risks facing the organisation in achieving these ambitions. The full BAF is provided as appendix A.

1.2. 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. Each risk detailed within the BAF is overseen by a subcommittee of board.

1.3. When reviewing the BAF the Board are asked to consider:

- the level of assurance provided by the BAF and those areas or actions around which further assurance may be required;
- 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, or key operational risks not identified.

2. Key updates

2.1. The board last received the BAF in November 2024. Since then, all risks have been reviewed by the responsible executive(s) and/or committees, and updated where appropriate.

2.2. Key changes to individual strategic risks are shown within the current assurances and updates on each risk within the BAF.

2.3. The risk rating for one risk has increased since the committee last received this report. This is risk 5a relating to finance, which has been reassessed as 20 (severe x certain) in recognition of the continued fiscal pressures and decreasing cash balance. Previously this risk was assessed to be 15 (moderate x certain).

2.4. At present there are 5 risks which sit outside of the Trust's stated risk appetite, however all of them have target ratings which do sit within either the tolerable or optimal appetite, along with actions identified to achieve this.

University Hospital Southampton NHS
NHS Foundation Trust

UHS Board Assurance Framework (BAF)

Updated December 2024

The Board Assurance Framework (BAF) is a dynamic document which provides assurance against the achievement of our strategic objectives, highlighting those risks that may threaten delivery.

The risks are grouped according to the Trust's key strategic themes:

1. Outstanding patient outcomes, safety, and experience

- 1a: Lack of capacity to appropriately respond to emergency demand, manage the increasing waiting lists for elective demand, and provide timely diagnostics, that results in avoidable harm to patients.
- 1b: Due to the current challenges, we fail to provide patients and their families / carers with a high-quality experience of care and positive patient outcomes.
- 1c: We do not effectively plan for and implement infection prevention and control measures that reduce the number of hospital-acquired infections and limit the number of nosocomial outbreaks of infection.

2. Pioneering research and innovation

- 2a: We do not take full advantage of our position as a leading University teaching hospital with a growing, reputable, and innovative research and development portfolio, attracting the best staff and efficiently delivering the best possible treatments and care for our patients.

3. World class people

- 3a: We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles.
- 3b: We fail to develop a diverse, compassionate, and inclusive workforce, providing a more positive staff experience for all staff.
- 3c: We fail to create a sustainable and innovative education and development response to meet the current and future workforce needs identified in the Trust's longer-term workforce plan.

4. Integrated networks and collaboration

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

5. Foundations for the future

- 5a: We are unable to deliver a financial breakeven position, resulting in: inability to move out of the NHS England Recovery Support Programme, NHS England imposing additional controls/undertakings, and a reducing cash balance impacting the Trust's ability to invest in line with its capital plan, estates/digital strategies, and in transformation initiatives.
- 5b: We do not adequately maintain, improve, and develop our estate to deliver our clinical services and increase capacity.
- 5c: Our digital technology or infrastructure fails to the extent that it impacts our ability to deliver care effectively and safely within the organisation
- 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.

Executive Summary

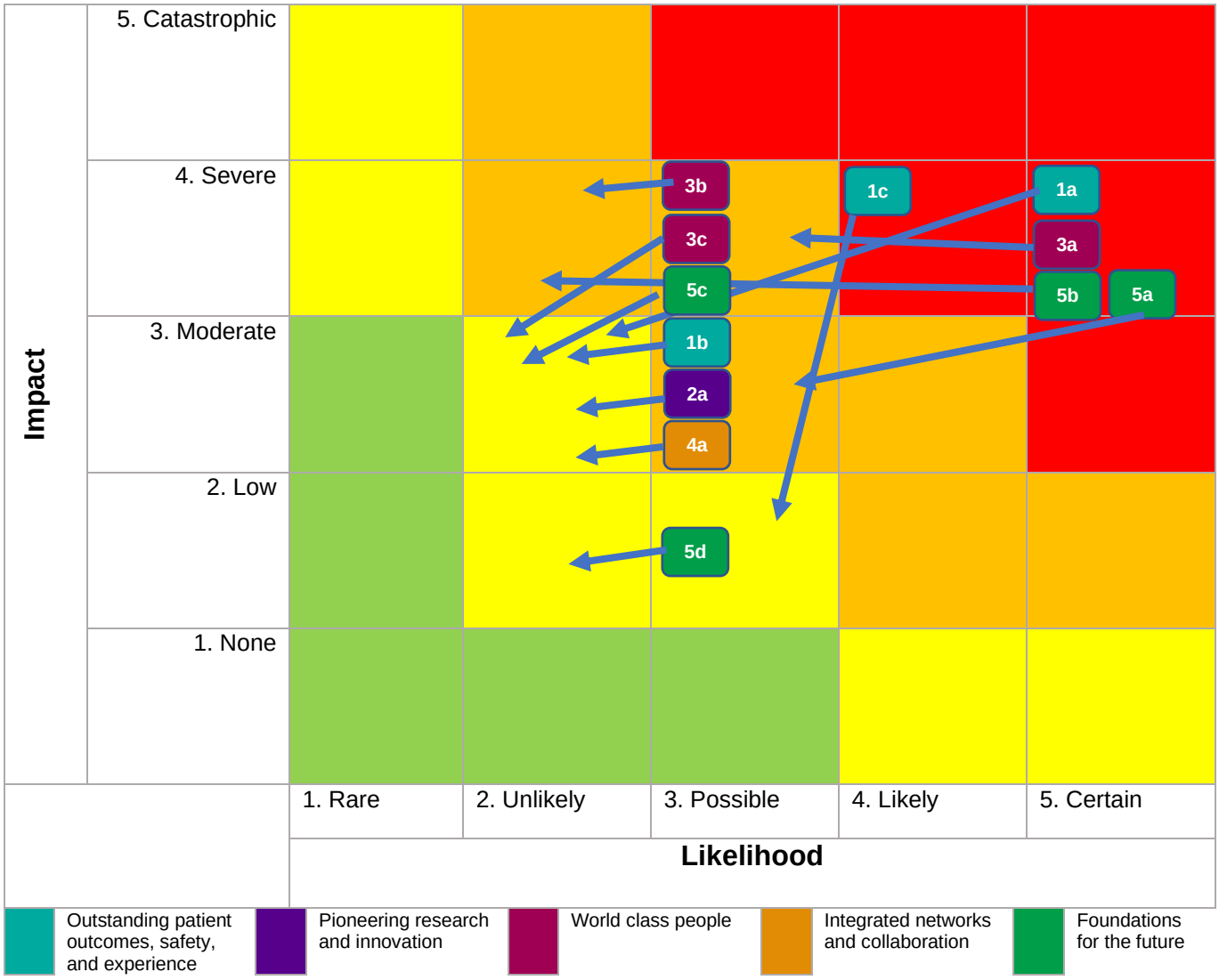
There are 5 critical strategic risks with a red risk rating above 15. These are:

- 1a) Capacity (4 x 5 = 20)
- 1c) Infection Prevention (4 x 4 = 16)
- 3a) Staffing (4 x 5 = 20)
- 5a) Finances (4 x 5 = 20)
- 5b) Estates (4 x 5 = 20)

At present there are 5 risks with a current risk rating outside of the optimal or tolerable appetite. These are: 1a, 1c, 3a, 5a, and 5b. All of these risks are being actively treated with the aim of reducing the risk score and all risks set out within the BAF have a target risk rating which sits within the optimal or tolerable risk appetite.

Trajectory

The heatmap provided below demonstrates the current risk rating based on the impact and likelihood, along with an arrow illustrating the target score to be achieved through implementation of planned actions and mitigations.



Outstanding patient outcomes, safety, and experience

1a) Lack of capacity to meet current demand resulting in avoidable patient harm

Monitoring committee: Quality Committee	**Executive leads:** COO, CMO, CNO

Cause	Risk	Effect
If there is inadequate capacity due to increasing demand, suboptimal flow, and limited resources (including funding, workforce, estate, and equipment);	This could lead to an inability to respond to emergency demand in a safe, timely and appropriate manner, delays in elective admissions and treatment, and delays in timely diagnostics;	Resulting in avoidable harm to patients and increased incidents, complaints, and litigation.

Category	Appetite	Status
Safety	Minimal *The current risk rating is outside of the stated risk appetite. The target risk rating is within the tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 5 20	April 2022	4 x 5 20	December 2024	3 x 2 6	April 2027

Risk progression: (previous 12 months)	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24
	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20

Current assurances and updates

This risk has been reviewed by the responsible executives in December 2024 with minor updates included within the controls, assurances, and actions as appropriate to ensure the risk is current. No revisions to the risk rating or target are required.

Current updates include:

- There has been a significant increase in type 1 attendances (self-presentations) to ED since September 2024 which contributes to long waits for patients. This is reflective of capacity restraints in the wider system as some patients may have been suitable for care through other avenues (e.g. GP, Urgent Treatment Centre, etc..) and work is underway to look at alternative avenues for patient care throughout winter. This includes exploring whether we can recommission GPs in ED to provide support.
- Following a successful trial in Portsmouth, a single point of access within the ambulance service will commence with support from our ED clinicians. The intent is to divert suitable patients away from ED to the most appropriate place of care which may be in the community, or may be a direct speciality admission.
- A pilot for a stroke SDEC has been undertaken at UHS with the intent of reducing admissions and providing patients with quicker access to the care they need, which in turn improves outcomes and lowers the risk of patients' experiencing further TIAs. This has been very successful with 69 patients seen in SDEC, a third of whom would normally have been seen in ED or HASU. 25% of patients were able to avoid a HASU admission.
- The Trust continues to receive ongoing requests to support other providers with mutual aid in respect of elective recovery, and non-elective transfers, which is increasing demand further.
- UHS has also sought mutual aid from other providers to address the significant backlog within cardiac surgery caused by increased emergency referrals and insufficient capacity in theatres. Mutual aid has been formally requested through the specialised commissioning unit, and received, in respect to P1b patients (urgent patients requiring treatment within 72 hours). Additionally, harm review tools are underway to assess the impact to patients on waiting lists, for example P2 patients. There are also plans to write to patients on the waiting lists to ensure that we are candid about the anticipated waiting times and that we involve patients in decisions about their place of care.
- Following the joint NHSE and NHS HIOW ICS supportive quality visit to ED in September 2024, formal feedback has now been received in writing. This acknowledged the immense pressure the department is

facing and recognised that whilst corridor care is not accepted as normal, where this is necessary staff work to mitigate the risk and ensure that patient safety is always prioritised.	
Key controls	**Gaps in controls**
Clinical Prioritisation Framework. Triage of patient lists based on risk of harm with consultant led flagging of patients of concern. Capacity and demand planning, including plans for surge beds and specific seasonal planning. Patient flow programme to reduce length of stay and improve discharge. This is governed through the Inpatient Steering Group (IPSG) with senior clinical and non-clinical leadership including the CNO, deputy CMO, and deputy COO. Targeted workstreams underpinning the objectives include criteria led discharge and discharge lounge use. Outpatients and operating services transformation programme focused on improving utilisation of existing capacity and reducing follow up demand. Use of independent sector to increase capacity. Urgent and Emergency Care Board established to drive improvements across UEC pathways. UEC recovery plan to support improvements across UEC pathways. UEC standards have been developed and implemented with guidance for site management to ensure that we admit the right patient to the right place. Monitored through patient flow programme board. Rapid Improvement Plans to support improvements across cancer pathways.	Excess demand in community and social care combined with cuts to Hospital Discharge Funding may further increase the number of patients in hospital not meeting the criteria to reside. Limited funding, workforce, and estate to address capacity mismatch in a timely way. Lack of local delivery system response and local strategy to manage demand in our emergency department as well as to address delays in discharge from the acute sector. However emerging NHS HIOW transformation programmes are focussed on discharge, planned care, local mental health care, and urgent and emergency care. Challenges in staffing ED department during periods of extreme pressure. Ongoing industrial action through 23-24 and into 24-25 presents significant risk to the Trust's ability to meet ongoing demand on our services. Staff capacity to engage in quality improvement projects due to focus on managing operational pressures. Workforce and recruitment controls result in ward leaders working within the safe staffing numbers as opposed to in a solely supervisory capacity reducing their ability to plan discharges and oversee flow. Lack of a clear capacity and demand plan to resolve cardiac capacity issues. Lack of sustainable capacity in some specialities resulting in long wait breaches, e.g. gynae, ENT, some cancer specialities.
Key assurances	**Gaps in assurances**
Clinical Assurance Framework, reported quarterly to the executive. Reported bi-weekly via CPRP. Harm reviews identifying cases where delays have caused harm. Weekly divisional performance meetings with a particular focus on cancer and long waiting patients. Live monitoring of bed occupancy and capacity data. Monitoring and reporting of waiting times. Implementation of PSIRF with oversight of red incidents at TEC. Transformation programme work plans. An assurance paper was taken to Trust Board in September 2024 in response to a recent BBC Dispatches documentary secretly filmed at Royal Shrewsbury Hospital showing significant delays in urgent and emergency care, and subsequent letter from NHSE outlining steps acute organisations must take to mitigate against potential similar concerns. NHSE and NHS HIOW ICS supportive quality visit to ED (September 2024).	Local system plans to reduce patients without a criteria to reside are emerging but currently lack detail to provide assurance.

Key actions
Establish local delivery system plan for reducing delays throughout the hospital.
Deliver ERF targets for 2024/25 to secure additional funding and address waiting lists.
Deliver plans to hit the trajectory of no patients waiting over 65 weeks by September 2024 - complete. Update October 2024: excluding corneal patients, this was achieved except for 2 patients (cardiac and gynae) remaining. Update November 2024: 16 corneal and 8 surgical patients outstanding.
Pursue significant improvement in cardiac wait times through development of a demand and capacity plan and mutual aid.
Community Diagnostic Hub opening in Q4 2024/5 to provide additional diagnostic capacity. Previously scheduled for 2023/4 however this has been delayed following redesign.
New theatres and MRI suite scheduled to open in September 2024 - complete. 5 new all day theatre lists opened.
Engagement in the NHSE Further Faster programme for elective care.
Delivery of improvement work in 2024/25 on patient flow and optimising operating services and outpatients.
An external visit from the Emergency Care Intensive Support Team took place in February 2024 and we have now received their report with findings and recommendations to review and implement. The Emergency Department Team have clear actions to take forward as well as some Trust wide schemes. Revised pathways have been trialled in ambulatory majors and pitstop both demonstrating improved safety and more timely access. Pilot is being reviewed with a view to implement.
The Trust has been awarded capital funding to build a multi-speciality SDEC unit to support the emergency department through provision of alternate presentation options for patients requiring urgent care. Plans to be developed with a work commencing February 2025.

Linked operational risks				
No.	**Title**	**Current risk rating**	**Target risk rating**	**Target Date**
74	If there is a continued demand for SDU bed Capacity for inpatients there will be an impact on elective admission flow, patient experience, financial cost and staff well-being	3 x 3 = 9	3 x 2 = 6	31/08/2024
95	Delays in discharge of children and young people with acute mental illness or behavioural disturbance may impact on capacity within the Children's hospital.	3 x 5 = 15	2 x 3 = 6	31/12/2024
187	Inability to deliver critical services within the emergency department due to increased demand, overcrowding and inadequate flow out of the department, which is resulting in harm to patients.	5 x 5 = 25	4 x 3 = 12	20/12/2024
259	Capacity and Demand in Maternity Services	5 x 5 = 25	2 x 2 = 4	30/03/2025
266	There is a risk that Maternity and Obstetric Theatre Capacity and availability is not able to meet demand at PAH this includes elective and emergency C-section capacity	4 x 4 = 16	2 x 2 = 4	06/01/2025
395	The risk is to cardiac surgical patients who are on the waiting list and are clinically deteriorating as demonstrated by harm reviews. They are categorised as P2 requiring treatment within 4 weeks and we have over 160 patients breaching the 4 week target.	4 x 5 = 20	2 x 3 = 6	31/12/2024
443	Lack of capacity within the sleep service resulting in long waits for respiratory and neurological sleep studies, and long waits for outpatient appointments within the neurological sleep service.	3 x 4 = 12	3 x 2 = 6	29/11/2024
470	Risk to reputation and patient safety due to insufficient theatre capacity across Child Health, resulting in long waiting times for surgery.	4 x 4 = 16	3 x 2 = 6	16/12/2024
473	Insufficient capacity within the Paediatric Neurology to cope with current demand.	3 x 3 = 9	2 x 2 = 4	29/11/2024
610	Insufficient capacity to provide a safe and effective Out of Hours medical and ANP service across Div B	4 x 3 = 12	3 x 2 = 6	28/02/2025
652	Prostate cancer capacity	4 x 4 = 16	3 x 2 = 6	31/03/2025
671	Capacity within the melanoma and soft tissue cancer pathways.	3 x 4 = 12	3 x 2 = 6	31/01/2025
681	Adult inpatient pain service is struggling to deliver a robust service - demand is exceeding the current capacity in the pain service.	3 x 4 = 12	3 x 1 = 3	31/12/2024
687	Impact on patient care due to delayed recovery discharges, because of lack of patient flow throughout the hospital.	3 x 5 = 15	3 x 1 = 3	31/12/2024
697	Delays in surgery for paediatric congenital cardiac patients due to lack of capacity and a growing waiting list	5 x 4 = 20	3 x 2 = 6	30/06/2025
758	Urology stone service - including stent change delays & capacity challenges	4 x 4 = 16	3 x 2 = 6	31/03/2025
766	Inability to deliver a critical service to those with a life threating illness/injury due to our resuscitation bays being overcrowded. Compromised ability to function as the Regional Major Trauma Centre.	5 x 5 = 25	4 x 2 = 8	31/12/2024
767	HoLEP capacity issues	3 x 3 = 9	3 x 1 = 3	31/03/2025
775	Kidney cancer capacity	4 x 3 = 12	4 x 1 = 4	31/07/2025
788	Elective caesarean section list capacity	3 x 5 = 15	2 x 2 = 4	21/09/2024
804	Congenital cardiac (adult & paeds) surgery demand	4 x 4 = 16	4 x 2 = 8	30/09/2025
814	Inability to provide a safe pleural service	4 x 2 = 8	2 x 2 = 4	01/01/2025
816	Inability to discharge patients due to non-criteria to reside status and/or ineffective processes will compromise effective flow and result in patient harm, a suboptimal patient experience, and insufficient admitting capacity	5 x 4 = 20	3 x 2 = 6	31/03/2025
822	Ophthalmology Glaucoma Capacity	4 x 4 = 16	4 x 4 = 16	30/06/2025
823	Ophthalmology Medical Retina Service Capacity	4 x 4 = 16	4 x 2 = 8	30/09/2025
840	Paediatric haemodialysis capacity	4 x 3 = 12	2 x 2 = 4	28/02/2025

845	There is a risk that the obstetrics service will be compromised due to excess levels of demand and unmatched capacity within the consultant team	3 x 4 = 12	4 x 1 = 4	01/04/2025
850	Inability to effectively run the pelvic floor service due to staffing and capacity	3 x 5 = 15	2 x 2 = 4	31/08/2025

Outstanding patient outcomes, safety and experience

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

Monitoring committee: Quality Committee	**Executive leads:** COO, CMO, CNO

Cause	Risk	Effect
If demand outstrips capacity, and/or we have insufficient workforce to meet the demand,	This could result in an inability to provide a fully comprehensive, and exceptional, experience of care,	Resulting in not fully meeting the needs of our patients and their families and carers, which may lead to an increase in complaints and poor feedback. Additionally, patents may suffer delays, complications, poorer outcomes, and longer lengths of stay if their needs are not addressed at the earliest opportunities.
Category	**Appetite**	**Status**
Experience	Cautious *The current risk rating is within the tolerable risk appetite and the target risk rating is within the optimal risk rating.*	Treat

Inherent risk rating (I x L)		**Current risk rating (I x L)**		**Target risk rating (I x L)**	
3 x 3 9	April 2022	3 x 3 9	December 2024	3 x 2 6	March 2026

Risk progression: (previous 12 months)	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24
	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9

Current assurances and updates

- This risk has been reviewed by the responsible executive leads in December 2024. No revisions to the risk rating or targets are required.
- Full deployment and implementation of NATSIPPS2 is a priority for the organisation and one medical PA per week has now been allocated to this, with further consideration being given to operational and clerical support, and divisional resource to deliver training. Additionally, an executive led oversight meeting has been initiated which includes oversight and scrutiny of never event incidents, to seek assurance that lessons are learnt and embedded.

Key controls	**Gaps in controls**
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.	Patient experience strategy is out of date and now not in keeping with national and local objectives. New strategy to be co-designed with involved patients. There are no involved patients embedded on estates works and projects. The implementation of QPSPs (quality safety partners) will support the transition for the Trust. Currently there are no SOPs/Frameworks for involved patients. The Head of Patient Involvement role was not replaced in Sept 2023 and therefore there is limited capability to engage the local community. Staff capacity to engage in quality improvement projects due to focus on managing operational pressures .

Delivery of 23/24 Always Improving Programme aims. Involvement of patients and families through our Quality Patient Safety Partners (QPSPs) in PSSG, SISG and Quality Improvement projects. Implementation of PSIRF. Patient Involvement and engagement in capital build projects Working with communities to establish health inequalities and how to ensure our care is accessible and equitable. Health inequalities board established with sponsors for priorities, health inequalities liaison role sitting within patient experience, and allocation of dedicated time across multiple roles in the clinical strategy and BI teams. Maternity safety champions.	Reduction in head count (decreased bank utilisation) due to the measures taken because of financial challenges. There is no longer any dedicated resource for SDM due to recruitment restraints and prioritisation of work. The clinical strategy team can only respond to small, adhoc, requests for support.
Key assurances	**Gaps in assurances**
Monitoring of patient outcomes with QPSP input. 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. Performance reporting. Governance and oversight of outcomes through CAMEO and M+Ms Patient Safety Strategy Oversight Committee Transformation Oversight Group (TOG) including TOG dashboard to oversee impact. Health Inequalities Board Established governance oversight and escalation from ward to board through care group and divisional governance groups, as well as the Quality Governance Steering Group and the Quality Committee (sub committee of the board). Providing other avenues of FFT feedback that suits the needs of our demographic, or example SMS surveys, ensuring our care is informed by ours patients voice. Patient experience week (May 2024) evidencing and celebrating FFT and sharing learning from complaints.	Ongoing industrial action through 22-23 and 23-24, and into 24-25 presents risk to the Trust's ability to meet ongoing demand on our services. There is no additional resource to support patient feedback with community engagement. The average reading age of Southampton is 7-10 yr. age, so therefore there needs to be officers reaching out personally to get feedback on care.
Key actions	
Introducing a robust and proactive safety culture: Implement plan to enable launch of PSIRF in Q3 2023/24 and continued implementation and embedding into 2024/25.	

Embed learning from deaths lead & lead medical examiner roles (primary and secondary care) and develop objectives and strategy.

Introduce thematic reviews for VTE.

Implement the second round of Ockenden recommendations – completed.

Always Improving programme

Delivery of 23/24 aims of patient flow, outpatient and optimising operating services programmes and associated quality, operational and financial benefits (incl. Outpatient follow-up reduction).

Embedding 'voice of the patient' into all improvement activities through aligning each Division with a QPSP who will champion patient insight and involvement.

Further development of our continuous improvement culture to ensure a sustained focus on quality and outcomes.

Introducing exec and senior leadership team walkabouts focussed on improvement.

Increase specialties contributing to CAMEO. We are developing a new strategy linking outcomes, transformation, and safety.

Actively managing waiting list through points of contact, escalating patients where changes are identified. Ongoing harm reviews for p2s and recurring contact for p3 and p4 patients.

Always Improving self-assessment against NHSE guidance to be taken to Trust Board in December 2023.

Fundamentals of care programme roll out across all wards.

Patient experience initiatives

Roll out of SMS and other feedback mechanisms, offering clinical teams targeted response surveys to ensure specific care needs are not only identified they are also addressed. This in part has started, the ED SMS survey has proven to be a success and yielded a 700% improved response rate for ED. The learning from this has now been shared trust wide and Eye Casualty and Ophthalmology are now next to move to FFT SMS, which captures a wider demographic of patients.

Experience of Care team to provide meaningful patient feedback to individual services through Div Gov and local level groups to disseminate and support service improvement through codesign and patient experience. This is ongoing work, there have been several vacancies in the Experience of Care, but with the recruitment of a new Head of Patient Experience there is now a renewed focus to provide divisional tailored reports at care group and divisional level.

We are Listening events to be held in local community areas to capture protected characteristic patients that may not explore traditional complaint routes into the Trust. This is an aspiration however currently there is no resource to do this with loss of Head of Patient Involvement.

Measures in place to identify and share thematic learning. There has been a refresh on the 'Learning from Death' and 'Experience of Care', with both board reports now reporting on patients lived experiences and including cross sections of patient experience related AERS which previously did not feature. For example, there is a now a review of AERs relating to End of Life care and a current theme on deaths outside of a side room/private area.

Health inequalities Programme

The UHS health inequalities programme and board have been initiated with key priorities crossing how we enable change within our organisation, how we have impact on nationally recognised drivers of health inequalities with high prevalence in Southampton, data and measurement and engagement and communications.

A health inequalities liaison post has been recruited within patient experience. They will be working with the clinical strategy team and transformation to support the organisation to understand health inequalities, to recognise inequalities within their service provision, to make changes to reduce the impact of health inequalities and to escalate challenges and risks as required. These actions will support to improve the experience and outcomes of our patients.

Linked operational risks				
No.	**Title**	**Current risk rating**	**Target risk rating**	**Target Date**
440	Children and young people with acute mental illness or behavioural disturbance will be at increased risk of harm if there are no dedicated CAMHS facilities and insufficient CAMHS staffing at Southampton Children's Hospital; this risk will be exacerbated if there are also delays in their discharge.	4 x 5 = 20	2 x 3 = 6	31/12/2024
645	Increase in mental health patients and ligature risk in ED and AMU	3 x 5 = 15	2 x 2 = 4	31/12/2024
765	Risk to patient safety and patient experience due to a lack of plasma exchange provision for children at UHS	4 x 4 = 16	4 x 2 = 8	31/12/2024
805	Clinical harm and never events may occur if NATSIPPS2 cannot be embedded due to insufficient resource	4 x 4 = 16	3 x 1 = 3	31/12/2024

Outstanding patient outcomes, safety and experience

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

Monitoring committee: Quality Committee	**Executive leads:** CNO, COO

Cause	Risk	Effect
If there are gaps in compliance with IPC measures and policy, either due to increased working pressures, or a lack of awareness or understanding,	Patients may acquire a new infection whilst in hospital and there may be nosocomial outbreaks of infection,	Resulting in patient harm, longer lengths of stay, a detrimental impact to patient experience if visiting restrictions are necessitated, and an operational impact as bays and wards are closed.

Category	Appetite	Status
Safety	Minimal *The current risk rating is outside of the stated risk appetite. The target risk rating is within the tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
3 x 3 9	April 2022	4 x 4 16	December 2024	2 x 3 6	April 2027

Risk progression: (previous 12 months)	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24
	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	4 x 4 16	4 x 4 16

Current assurances and updates

- The risk has been reviewed by the responsible executive with no alterations to the risk rating or target required.
- Infection rates of winter viruses, including RSV, are increasing which may pose a risk to PICU capacity given the national PICU bed shortage. Updated respiratory pathways have been developed and published on Staffnet and the full respiratory virus policy is being updated ahead of ratification and publishing early Q4 2024/25.

Key controls	Gaps in controls
Annual estates planning, informed by clinical priorities. Digital prioritisation programme, informed by clinical priorities. Infection prevention & control agenda, annual work plan, audit programme. Local infection prevention support provided to clinical teams. Compliance with NHSIE Infection Prevention & Control Assurance Framework. Focused IP&C educational/awareness campaigns e.g. hand hygiene, 'Give up the gloves' winter virus. campaigns. PPE requirements, specifically the requirement for use of gloves, updated in the Trust Isolation policy (published June 2024) to support the 'give up the gloves' campaign. Digital clinical observation system. Implementation of My Medical Record (MMR).	Transmissibility of respiratory virus infections (e.g. COVID-19, Influenza, RSV), Norovirus and other infections. Resurgence of infections such as measles and pertussis plus emergence of newer infections e.g. Candida Auris and increased national prevalence of multi-drug resistant organisms such as CPE. Familiarisation with response to resurgence of infections such as norovirus, measles, pertussis plus new infections. Challenges in the ability to isolate patients presenting with suspected infection due to limited infrastructure in some areas e.g. limited single rooms/demand on single rooms.

Screening of patients to identify potential transmissible infection and HCAIs. Programme of monitoring/auditing of IP&C practice and cleanliness standards. Review of incidents/outbreaks of infection and sharing learning and actions. Risk assessments in place for individual areas for ventilation, bathroom access, etc. to ensure patient safety. Guidance disseminated around identifying potential cases of measles and pertussis and monitoring symptoms following a national and local increase in presentations. Supported by national messaging and encouragement of vaccinations. Education and support provided to clinical areas not meeting expected cleanliness standards, providing by EMT and external providers. The fundamentals of care continue to be rolled out which includes embedding expected IPC measures This also addresses learning from the recent MRSA BSIs and other infections e.g. risk reduction measures for MRSA, focus on hand hygiene practice and correct PPE. Focussed activity/support to wards by the Infection Prevention Team in response to need, including ward reviews/feedback and education and training. Monthly infection prevention and control newsletter continues to be issued in response to current trends, themes, and need. Point of Care testing in AMU. Expedited laboratory testing facilities for respiratory and GI infections.	IPC measures are reliant on people and their actions will be influenced by human factors, therefore 100% compliance cannot be enforced. Lack of established administrative support with appropriate capacity to facilitate timely contact tracing. Requirement and mitigations to be scoped.
Key assurances	**Gaps in assurances**
Infection Prevention Committee and IP&C Senior Oversight Group. Hand hygiene, IP&C and cleanliness audits. Patient-Led Assessment of the Care Environment. National Patient Surveys. Capital funding monitored by executive. NHSE/I infection prevention & control 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.). Ongoing focus on hand hygiene by the IPT and Divisions/Care groups – improvements starting to be seen in hand hygiene practice (as demonstrated in	Ward and bay closures due to norovirus outbreaks. Increase in cases of C.Diff , MRSA BSIs (blood stream infections) and other gram negative BSI above national set thresholds. Not all areas consistently submitting IP&C audits to demonstrate assurance of expected IP&C practices.

audits) and evidence of ongoing focus within clinical areas to drive improvements in practice.	

Key actions

Ongoing programme of IP&C policy review to ensure alignment with national infection prevention & control manual for England and other national guidance. e.g.standard infection control precautions policy, high consequences infectious disease policy, policy for the management of patients with unexplained/unexpected diarrhoea and/or vomiting.

Ongoing focused IP&C education and awareness campaigns supported by internal and external communications plan.

Re-enforce processes to ensure all areas submit required audits to demonstrate assurance of IP&C practice standards and follow up/support provided by the IPT.

Delivery of IPT work plan to support improvements in practice (MRSA focus in Q1, Isolation care focus in Q2).

Follow-up/review of all new cases of Cdifficile & MRSA for assurance that expected standards are in place to reduce risk of onward transmission.

Ongoing review of new cases of healthcare associated bloodstream infections (E-Coli, klebsiella, pseudomonas, MRSA, MSSA, VRE) to identify potential gaps in practice, learning and actions for improvement.

Monthly Infection Prevention Newsletter to provide updates/education and share learning.

Pioneering research and innovation

2a) We do not take full advantage of our position as a leading university teaching hospital with a growing, reputable, and innovative research and development portfolio, attracting the best staff and efficiently delivering the best possible treatments and care for our patients

Monitoring committee: Trust Board	**Executive leads:** CMO

Cause	Risk	Effect
If there is: • insufficient research workforce and limited capacity in clinical support services; • an organisational culture which does not encourage and support staff to engage with research and innovation.	This could lead to: • an inability to set-up and deliver research studies in a safe and timely manner; • a lack of development opportunities for staff which impacts the next generation of researchers and innovators.	Resulting in: • failure to deliver against existing infrastructure awards; • impact our national ranking; • reduced access for patients to innovative new treatments; • reputational damage to our university teaching hospital status and ability to secure funding awards in the future.

Category	Appetite	Status
Technology & Innovation	Open *Both the current and target risk ratings are within the optimal risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 2 8	April 2022	3 x 3 9	December 2024	3 x 2 6	March 2025

Risk progression: (previous 12 months)	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24
	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9

Current assurances and updates

This risk has been reviewed by the responsible executive in December 2024 with no revisions required to the risk rating or targets. The assurances have been updated to reflect the improvement in performance in Trust Board KPIs ranked nationally.

Key controls	Gaps in controls
Research strategy, approved by Board and fully funded. Always improving strategy, approved by the board and detailing the UHS improvement methodology. Partnership working with the University and other partners. Clinical academic posts and training posts supporting strategies. Secured grant money. Host for new regional research delivery network, supporting regional working. Local ownership of development priorities, supported by the transformation team.	Operational pressures, limiting time for staff to engage in research & innovation. Limited capacity to support new studies and research areas, relating to hard to recruit areas, turnover, and existing clinical priorities. Research priorities with partners not necessarily led by clinical or operational need. No overarching strategy to support innovation. Impact of recruitment processes on vacancy rates in research workforce and clinical support services is impacting performance, with vacancy rates having a particular impact in R&D office and clinical trials pharmacy. Vacancies being filled, but R&D turnover still higher than Trust average or target.
Key assurances	**Gaps in assurances**
Governance structure surrounding University partnership.	Limited corporate approach to supporting innovation across the Trust.

Board to Council meetings. Joint Senior operational group. Joint Research Strategy Board. Joint executive group for research. Joint executive group for innovation. Joint Innovations and Commercialisation Group – UHS/UoS. Monitoring research activity funding and impact at R&D steering group. MHRA inspection and accreditation. Strategy and transformation process. CQC review of well-led criteria, including research and innovation. R&D Trust Board KPI's being monitored closely to benchmark our performance nationally. In 24/25 we are seeing the impact of the focus on our recruitment with improvement in our national performance: recruitment ranking has improved from 16th in 23/24 to 8th in September 2024, and weighted recruitment has improved from 13th in 23/24 to 10th in September 2024.	National benchmarking: previously ranking was below optimal although improvements are being seen since September 2023. Action plan underway. Now meeting Trust Board KPI for recruitment ranking (improvement from 16th in 23/24 to 8th September 2024) and weighted recruitment has improved (from 13th in 23/24 to 10th September 2024).

Key actions

Staff survey to test staff engagement and understanding of innovation at UHS.

Deliver R&I Investment Case. Annual Plan approved by TB which includes investment RoI evaluation.

Established mechanisms to capture RoI on investment are now built into annual planning process. International Development Centre, attracting external funding to support staff in pursuing innovation.

Execute an agreed joint programme of work with partners through establishing executive group for education.

Maximise the benefits of the newly established Wessex Health Partnership as a founding member. WHP Annual Review starting to identify RoI, UHS ongoing commitment being sought for next 3 year term.

Supporting departments in increasing recruitment and retention through work with R&D to create innovative roles. Staff engagement initiatives to be present to TBSS in February 2025.

Review the Trust's approach to corporate-wide innovation.

Processes being streamlined and new digital tools being adopted to increase clinical research delivery efficiency. On-going improvement programme, but impact being felt as seeing improved recruitment ranking.

Joint Research Vision, developed with University of Southampton, went to Senior Operational Group in June 2024, and will be finalised by Joint Research Strategy Board in January 2025.

UHS led on a regional bid for an NIHR Commercial Clinical Research Delivery Centre (submitted 02/07/2024) for £4.7m supported by all Wessex NHS Partners, Dorset and HIOW ICBS, Wessex Health Partners and Heath Innovation Wessex. Outcome expected Autumn 2024.

Seeking funding from Wessex Health Partners to take forward outputs from Innovation workshop - to develop processes for UHS/UoS partnership and in the longer term a UHS innovation strategy. Links to review of corporate wide innovation approach above.

World class people

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

Monitoring committee: People & Organisational Development Committee | **Executive leads:** CPO

Cause	Risk	Effect
Nationally directed financial restraints limiting workforce size and growth pose a risk, and this is compounded in some hard to fill professions and specialities by national and international shortages;	This could result in an inability to recruit the number and skill mix of staff required to meet current demand;	This may result in a suboptimal patient care and experience and may be damaging to staff engagement and morale.

Category	Appetite	Status
Workforce	Open *The current risk rating is outside of the stated risk appetite. The target rating is within the tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 4 16	April 2022	4 x 5 20	December 2024	4 x 3 12	March 2026

Risk progression: (previous 12 months)

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24
4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20

Current assurances and updates

- This risk has been reviewed in December 2024 with no revisions to the ratings or target dates required.
- There are extensive recruitment controls in place presently which have been necessary to slow overall headcount growth in light of nationally directed financial pressures. However, this results in a tension between current clinical and operational demand and the workforce available. As anticipated, despite the controls, workforce growth was seen throughout Q2 and Q3 2024/25 due to recruitment of NQNs and NQMs, however this is now expected to stabilise again and assessment is underway to reduce bank and agency usage in light of the recruitment as set out above.
- In November Unite union issued notice of a series of strike days throughout December and January, however ongoing discussions between UHS, Unite and ACAS have been productive and all scheduled strikes have been stood down to date. Furthermore, following the independent external review of the portering service, commissioned by the Chief People Officer in August, the report and recommendations have now been received. This includes wide ranging findings relating to staff feedback, culture, configuration of the department, rostering, and opportunities to foster a sense of community and engagement within the department and across the organisation. Implementation of all mutually agreed actions with the portering service and Unite are a priority and associated work is underway.
- Discussions and negotiations also continue with Unison regarding the national dispute around banding, duties and pay for band 2 and 3 HCA staff.
- As an additional mitigation to the financial pressures, UHS is planning to initiate MARS (Mutually Agreed Resignation Scheme) in line with national terms. This is likely to be communicated in December 2024 with voluntary applications from staff electing to participate open until January 2025.
- A system wide rostering audit has taken place across Hampshire and Isle of Wight, and UHS have now received the findings which provides strong, positive, assurance of our practice with continued opportunities around medical rostering and job planning.

Key controls	Gaps in controls
New 5-year People Strategy and clear objectives for Year 2 monitored through POD. Recruitment and resourcing processes.	Completion of objectives for South-East temporary collaborative for 2024/25.

Workforce plan and overseas recruitment plan. General HR policies and practices, supported by appropriately resourced HR team. Temporary resourcing team to control agency and bank usage. Overseas recruitment including a reduced level of nurse vacancies. Recruitment campaign. Apprenticeships. Recruitment control process to ensure robust vacancy management against budget. Workforce reviews to respond to specific recruitment and retention issues (e.g. the ACP review). Improved data reporting. ICB wide transformation programme established with leadership including the UHS CEO. The focus is on grip and control of temporary staffing use, including supply issues, and corporate services. ICB recruitment panel established to limit recruitment within HIOW for specific roles. Affordable workforce limits have now been agreed with all divisions and THQ. Workforce plan for 2024/25 submitted to ICB. Plan for nursing recruitment agreed for 2024/25 including overseas recruitment, newly qualified recruitment, and domestic recruitment to ensure the overall nurse vacancy position is sustained. Planning for 2025/26 underway.	People report for Board to be refreshed. Phase 1 completed – phase 2 underway to be launched in 2025/26.
Key assurances	**Gaps in assurances**
Fill rates, vacancies, sickness, turnover and rota compliance . NHSI levels of attainment criteria for workforce deployment. Annual post-graduate doctors GMC report. WRES and WDES annual reports - annual audits on BAME successes. Gender pay gap reporting. NHS Staff Survey results and pulse surveys. Joint finance and Workforce working group on data assurance. Temporary staffing collaborative diagnostic analysis on effectiveness.	Universal rostering roll out including all medical staff. Review of implications for education and training infrastructure from national workforce plan.
Key actions	
Approval of Year 3 objectives supporting delivery of the Trust's People Strategy. Deliver workforce plan for 2024/25 including increasing substantive staff in targeted areas offset by reducing temporary agency spend. To develop and implement Divisional Workforce Plans. Completion of objectives for South-East temporary collaborative for 2024/25. To implement a range of programmes to ensure turnover remains below 13.6%. To implement a range of measures to ensure our staff absence remains below 3.9%.	

To implement a range of measures to improve medical deployment. Ensure accuracy of leave allocation and recording for medical staff via Health roster for all care groups. Increase use of Health roster across medical staff groups.

Review and refresh of the People report to Board (Q2 2024/25 Phase 1 completed. Phase 2 underway.)

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
20	Potential for mis-diagnosis from non-optimised imaging or unnecessary radiation exposure due to staffing levels in Radiation Protection	3 x 4 = 12	1 x 5 = 5	01/10/2025
67	There is a risk that Consultant demand v capacity shortfall will be the cause of non covered sessions. This includes all areas that require anaesthetic support, such as theatres; POAC - gen and PAH; Critical care; POM etc.	2 x 4 = 8	3 x 2 = 6	31/12/2024
86	Reduced skill mix, education and experienced critical care nursing staff	4 x 3 = 12	3 x 2 = 6	31/03/2025
167	MRI physics staffing risk	4 x 2 = 8	2 x 1 = 2	20/12/2024
180	Lack of pathology staff and inappropriate skill mix	3 x 4 = 12	3 x 2 = 6	31/07/2025
286	Inadequate staffing in Nuclear Medicine Physics for the size and complexity of the expanded service	3 x 4 = 12	3 x 3 = 9	31/12/2024
458	Demand for therapy input exceeding available workforce capacity putting patients at risk of ELOS and suboptimal input.	3 x 4 = 12	2 x 2 = 4	31/12/2024
578	Impact of reduced critical care outreach team service due to vacancy rate and skill mix on patient safety for adult deteriorating patients and ward based teams across UHS and personal health and wellbeing impact on CCOT ACPs.	4 x 4 = 16	2 x 2 = 4	31/01/2025
604	Risk in epilepsy nursing service	3 x 3 = 9	2 x 2 = 4	18/06/2025
623	Insufficient reporting capacity (Specialist radiologist reporters)	4 x 3 = 12	2 x 1= 2	24/06/2025
646	Reduced ACP Cover across Neurosciences care group	3 x 3 = 9	4 x 1 = 4	28/02/2025
661	Insufficient Medical staff to safely manage patient activity within cancer care	4 x 3 = 12	2 x 3 = 6	31/10/2025
662	Cellular Pathology Staffing and Capacity	4 x 5 = 20	4 x 2 = 8	31/03/2025
684	Difficulty recruiting B4 mechanical and electrical trade staff	4 x 3 = 12	4 x 1 = 4	30/09/2024
711	Insufficient staff resource in Robotic SFA to meet the Robotic service demand	2 x 4 = 8	3 x 1 = 3	31/03/2025
712	Risk to patient safety due to no designated junior doctors on the major trauma unit	4 x 3 = 12	4 x 2 = 8	29/02/2024
726	Ophthalmology clinical/AHP workforce	4 x 3 = 12	4 x 1 = 4	31/01/2025
729	Neuro critical care technologists (NCCT) providing 24 hour care and cover seven days a week service to NICU currently not possible	3 x 2 = 6	3 x 1 = 3	31/10/2024
748	There is a risk that patients may be cancelled, have peri-op complications, or longer hospital stays due to staffing concerns within the perioperative care and perioperative assessment clinic service	3 x 4 = 12	2 x 1 = 2	28/02/2025
776	Insufficient clinical pharmacy workforce	3 x 5 = 15	3 x 3 = 9	31/03/2025
782	Paediatric dietetics staffing risk	3 x 3 = 9	2 x 3 = 6	31/01/2025
783	Adult dietetics staffing risk	3 x 4 = 12	2 x 3 = 6	01/09/2024
785	The provision of the congenital cardiac service in theatres may be affected due to high vacancy and slow throughput of learners	3 x 2 = 6	3 x 1 = 3	30/11/2024
791	Patient services centre staffing risk	3 x 3 = 9	2 x 3 = 6	01/11/2024
797	Paediatric Speech and Language Therapy Staffing Risk	3 x 3 = 9	2 x 3 = 6	31/12/2024
798	SACT CNS team	3 x 4 = 12	3 x 3 = 9	31/01/2025
820	CED consultant under staffing due to vacancies and also increased capacity	4 x 3 = 12	3 x 1 = 3	31/01/2025

825	Risk to patient safety due to inconsistent SHDU medical cover and deanery trainees expected to cover core medical working patterns	3 x 3 = 9	2 x 2 = 4	31/12/2024
837	Quality of patient care and the wellbeing of staff may be compromised if recruitment controls on the nursing workforce are not implemented safely with appropriate oversight and flexibility to meet individual services needs	3 x 4 = 12	3 x 2 = 6	31/03/2025
844	Patients may not receive lifesaving emergency cardiac surgery due to a lack of cardiac trained staff.	4 x 4 = 16	4 x 1 = 4	31/03/2025
859	Reduced Portering workforce (volume and skill/knowledge) due to industrial action may affect the operational ability of UHS to provide safe and efficient patient care	3 x 5 = 15	3 x 1 = 3	31/03/2025

World class people

3b) We fail to develop a diverse, compassionate and inclusive workforce, providing a more positive staff experience for all staff

Monitoring committee: People & Organisational Development Committee	**Executive leads:** CPO

Cause	Risk	Effect
If longstanding societal and NHS wide challenges surrounding inclusion and diversity, and current operational pressures on the NHS post covid, are not mitigated;	There is a risk that we will not recruit a diverse workforce with a range of skills and experience, and that we will not develop and embrace a positive and compassionate working culture where all staff feel valued;	Resulting in a detrimental impact to staff morale, staff burnout, higher absence and turnover, and the potential for reputational risk and possible litigation. This in turn has an impact on our patients when staff capacity cannot match clinical requirements, as we need to look after our staff to enable them to look after our patients.
Category	**Appetite**	**Status**
Workforce	Open *The current risk rating is within the tolerable risk appetite and the target risk rating is within the optimal risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 3 12	April 2022	4 x 3 12	December 2024	4 x 2 8	March 2027

Risk progression: (previous 12 months)	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24
	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12

Current assurances and updates

- This risk has been reviewed in December 2024 with no revisions to the ratings or target dates required.
- Charitable funding has been allocated to complete the refurbishment of the Muslim prayer facilities at UHS for both staff and patients, to ensure the facilities are fit for purpose. The intention is to complete this ahead of Ramadan (commencing end of February/early March 2025).
- A working group has been set up focussing on improving the working facilities for resident doctors to ensure a sense of belonging.
- Proud2BAdmin and Proud2Bops campaigns and networks were launched in November to support development and recognition of this non clinical workforce, with a follow up event planned in January 2025.

Key controls	Gaps in controls
Great place to work including focus on wellbeing UHS wellbeing plan developed. Guardian of Safe Working Hours. Re-launched appraisal and talent management programme. Comprehensive employee recognition programme embedded including monthly staff spotlight and annual awards. **Building an inclusive and compassionate culture** Inclusion and Belonging Strategy signed off at Trust Board.	Ensure each network has dedicated leadership to continue to support well-functioning and thriving networks. Coverage of allyship training to increase to 80% compliance by 31/03/2025. Launch of digital appraisal process. Improving implementation of national improving working lives actions for junior doctors following national letter May 2024.

Creation of a divisional steering group for EDI. FTSU guardian, local champions and FTSU policies. Diversity and Inclusion Strategy/Plans. Collaborative working with trade unions. Launch of the strategic leaders programme with a cohort of 24 across UHS. Senior leader programme launched. Positive action programme completed. Nurse specific positive action programme also launched. All leadership courses now include management of EDI issues and allyship training has been rolled out across the organisation with good uptake. A review of long term illness and disability has been undertaken to utilise external expertise to help review our approaches to reasonable adjustments.	
Key assurances	**Gaps in assurances**
Great place to work including focus on wellbeing Annual NHS staff survey and introduction of quarterly pulse engagement surveys. Guardian of Safe Working Hours report to Board. Regular communications monitoring report Wellbeing guardian. Staff Networks. Exit interview process. Wellbeing Guardian and wellbeing champion. **Building an inclusive and compassionate culture** Freedom to Speak Up reports to Board. Qualitative feedback from staff networks data on diversity. Annual NHS staff survey and introduction of quarterly pulse engagement. Listening events with staff, regular executive walkabouts, talk to David session. Insight monitoring from social media channels. Allyship Programme. Gender Pay Gap reporting. External freedom to speak up and employee relations review.	Maturity of staff networks Maturity of datasets around EDI, and ease of interpretation Areas for improvement identified through the annual staff survey (March 2024) – remedial action reflected within the People objectives for 2024/25. NHSE review of surgical training has resulted in enhanced monitoring from the GMC. Full action plan being implemented including completion of workshops with all consultants working within the area. An independent external review has highlighted issues relating to culture, capability, and capacity within the UHS portering service. Work is underway to address these concerns including negotiations with the Unite union who are undertaking a strike ballot of its members within the UHS portering team.
Key actions	
Building an inclusive and compassionate culture Deliver year 2 objectives of the Inclusion and Belonging strategy by March 2025:	

This includes:

- To get to 85% of all staff having completed the Actional Allyship Training by March 2025.
- To implement the 1st phase recommendations of the Inclusive Recruitment Programme
- To deliver improvement plan in terms of experience of people with disabilities and long-term illness.
- To deliver a programme of work to meet the NHSE Sexual Safety Charter standards and increase sexual safety at UHS.
- Refresh the underpinning behaviours of our Trust Values and produce a new behaviours framework. This will underpin future leadership development and OD interventions.

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
834	Muslim patients, staff and visitors will have a detrimental experience if UHS cannot provide appropriate prayer facilities	2 x 5 = 10	2 x 2 = 4	31/12/2025

World class people

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

Monitoring committee: People & Organisational Development Committee	**Executive leads:** CPO

Cause	Risk	Effect
If there is: • Limited ability to recruit staff with suitable skills to support education; • Lack of current national education financing and changes in the way the education contract will function; • Inflexibility with apprenticeship regime;	This may be: • A lack of development for staff affecting retention and engagement; • Reduced staff skills and competencies; • Inability to develop new clinical practices.	This could result in: • An adverse impact of quality and effectiveness of patient care and safety; • An adverse impact on our reputation as a university teaching hospital; • Reduced levels of staff and patient satisfaction.

Category	Appetite	Status
Workforce	Open *The current risk rating is within tolerable appetite and the target risk rating is within optimal appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Long term target (I x L)	
3 x 3 9	April 2022	4 x 3 12	December 2024	3 x 2 6	March 2025

Risk progression: (previous 12 months)	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24
	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12

Current assurances and updates

- This risk has been reviewed in December 2024 with no revisions to the ratings or targets required.
- A review is underway within T&D to look at the infrastructure and longterm workforce plan.
- Lack of/tighter restrictions in national funding, alongside inflexibility within the apprenticeship regime, remains a significant concern as this may present a reduction in opportunities for staff development, particularly for level 7 apprenticeships.
- NHSE have undertaken a follow up visit regarding the experience of surgical resident doctors and a full report is expected.

Key controls	Gaps in controls
Education Policy	Quality of appraisals
New leadership development framework, apprenticeships, secondments	Limitations of the current estate and access to offsite provision
In-house, accredited training programmes	Access to high-quality education technology
Provision of high quality clinical supervision and education	Estate provision for simulation training
Access to apprenticeship levy for funding	Staff providing education being released to deliver education, and undertake own development
Access to CPD funding from NHSE WTE and other sources	Releasing staff to attend core training, due to capacity and demand
Leadership development talent plan 2024/25	Releasing staff to engage in personal development and training opportunities
Executive succession planning	Limited succession planning framework, consistently applied across the Trust.
VLE relaunched to support staff to undertake self-directed learning opportunities.	

TNA process completed for 2024/25.	Areas of concern in the GMC training survey National CPD guidance for 2024/25: scope of application is limited by rigid national rules. New national education funding contract published for consultation 29 Feb. Reduced resources and higher levels of control included.
Key assurances	**Gaps in assurances**
Annual Trust training needs analysis reported to executive. Trust appraisal process GMC/NETs Survey Education review process with NHSE WTE. 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. Review of implications for education and training infrastructure from national workforce plan. There is a reported inability of staff to participate in statutory, mandatory, and other training opportunities.

Key actions

To increase the proportion of appraisals completed and recorded to 85% and increase staff quality perceptions on appraisal by March 2025.

Take specific targeted action to improve areas of low satisfaction in the GMC survey.

To continue to build the education strategic partnerships and capacity for delivery of the NHS workforce plan and UHS People Strategy Including:

- Continuing to develop our formal partnership with the new UTC
- Developing a partnership agreement with South Hampshire Colleges Group
- Developing a stronger partnership with Solent University
- Reviewing the education infrastructure requirements to support increases in placement capacity and quality (including T Level placements), preceptorship, apprenticeships and internationally educated registrants.
- Preparing UHS for changes to the national apprentice model in 25/26

To continue to develop the skills and capability of line managers through roll out of the leadership and management framework. Specifically to:

- Deliver a second year of leadership development framework including Strategic and Senior Leaders programmes, Operational Leaders and Implement Team Leaders Programmes.
- Run 2nd cohort of Human Leaders and integrate psychology and trauma informed approaches to leadership programmes.
- Roll out of a targeted programme of development for Care Group Clinical Lead

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
173	Patients may not be safeguarded appropriately if staff are unaware of their duties and do not have the correct knowledge and skillset due to being non compliant with Safeguarding Adults, MCA, & DOLs training.	3 x 3 = 9	3 x 1 = 3	31/12/2025
777	Loss of externally funded Obs and Gynae ultrasound training	2 x 3 = 6	2 x 2 = 4	01/10/2024
833	Safeguarding children Statutory Training Compliance Levels are below required.	4 x 3 = 12	4 x 1 = 4	31/05/2025

Integrated networks and collaboration

4a) We do not implement effective models to deliver integrated and networked care, resulting in suboptimal patient experience and outcomes, increased numbers of admissions, and increases in patients' length of stay

Monitoring committee: Quality Committee	**Executive leads:** CEO, CMO, Director of Strategy & Partnerships

Cause	Risk	Effect
Historical structures and culture have not encouraged or enabled collaborative networked pathways.	Growth in benign non-specialist activity could prevent UHS capacity being available for tertiary activity which can only be done at UHS.	Waiting times and outcomes for our tertiary work would be adversely impacted. Efficiencies arising from consolidation of specialities would not be realised.
Category	**Appetite**	**Status**
Effectiveness	Cautious *The current risk rating sits within the tolerable risk appetite and the target risk rating sits within the optimal risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Long term target (I x L)	
3 x 3 9	April 2022	3 x 3 9	December 2024	3 x 2 6	April 2025

Risk progression: (previous 12 months)	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24
	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9

Current assurances and updates

This risk has been continually reviewed and updated with the executive leads throughout 2024/25 and minor changes made to the controls, assurances, and actions, to ensure it is up to date. Significant work is underway to advance integrated and networked care and progress continues to be made. There is an expectation that this will take time to establish and embed as it is a complex workstream due to the number and nature of stakeholders and the need to engage and negotiate with them, both internally and externally.

During the latest review it has been considered whether the target date for risk mitigation, which is April 2025, should be revised. At present it has been agreed that no change is required, as although (as set out above) this workstream is continually evolving and it is anticipated that this will take a long time, it is also anticipated that key priority workstreams such as Upper GI and Ophthalmology will show made positive advancements and risk reductions by the start of the next financial year.

It is noted that, as referenced within BAF entry 1a, a current strain on capacity at UHS is the increasing number of requests for mutual aid in respect of elective recovery. This further highlights the importance of integrated care and networked pathways to aid mitigation of this issue and resultant risk, ensuring that provision of care is responsive to patient need and that the right patient is seen in the right place and at the right time.

Key controls	Gaps in controls
• Key leadership role within local ICS • Key leadership role within local networked care and wider Wessex partnership • UHS strategic goals and vision • Establishment and development of Hampshire and Isle of Wight Acute Provider Collaborative (HIoW APC) to drive improvements in outcomes. • Establishment of UHS Integrated Networks and Collaboration Board • Collaborative CMO/ Director of Strategy meetings have begun/ are being arranged with partner organisations to agree priorities and ensure there	• Potential for diluted influence at key discussions • Arrangements for specialised commissioning – delegated from centre to ICS – historically national and regional, rather than local. • Engagement and pace from organisations we are looking to partner with is not within our control. • Resource within the UHS clinical programme team can prove challenging. • Resource and capacity within clinical services can also prove difficult, for example pelvic floor has been chosen as a clinical speciality focus, however

is executive commitment to delivering network models. • ICS agreement on clinical specialty focus including dermatology, ophthalmology, UGI and pelvic floor. • Support for networks from clinical programme team continues. Integrated networks and collaboration project management post recruited to. • Clinical leaders ICS forum has been started, this group is an opportunity to gain clarity on board level agreement on network opportunities and ways forward. • Participation in the Tim Briggs 'Further Faster' initiative is helpfully facilitating clinically led discussions with increased pace for dermatology, orthopaedics, ENT, spinal and ophthalmology. The primary purpose of the initiative is to increase productivity by, for example, increasing the number of cataracts performed on a list. Positive outcomes are being seen from this work as UHS has successfully increased the number of cataract operations undertaken which has resulted in an increased number of referrals due to reduced waiting times, with NHS referrals now outweighing private referrals Further targeted work includes introduction of a Single Point Of Access for ENT to establish a network for procedures of limited clinical value. The UHS CEO is the SRO for this project and is ensuring alignment with UHS and overall ICB strategy. • Network arrangements in Urology, pelvic floor and plastics have also been prioritised for focus during 2024/25. • A new programme oversight role has been appointed to the ICB to enable progress on clinical networks. We are engaging with this post; sharing priorities, opportunities and challenges with a view moving forward networks within HIOW ICB. • The 'Acute Clinical Services Operating Model programme' has been initiated with agreed focus areas from providers and the ICB, these are Breast surgery, Upper GI, Pelvic floor, Urology, Ophthalmology, Dermatology and Orthodontics	capacity at UHS is a challenge as evidenced on the operational risk register.
Key assurances	**Gaps in assurances**
• CQC and NHSE/I assessments of leadership • CQC assessment of patient outcomes and experience • National patient surveys • Friends and Family Test • Outcomes and waiting times reporting. Included within cases for change being built for networks. • Integrated networks and collaborations Board set up for regular meetings at executive level.	• Trusts all under significant operational and financial pressure which is challenging prioritisation on elective networking. • Specialised Commissioning budget delegation deferred externally until April 2025. • Ability to network is difficult and manifests in capacity challenges. • Currently there are no established metrics regarding the establishment of networks due to the significant length of time it takes to set the networks up, however work is underway to set up quarterly objectives and consider KPIs to evidence whether networks being set up are on track.
Key actions	
Urology Area Network plan agreed. Progress had stalled due to lack of programme management resource and clinical lead stepping down. This programme has now picked up again and new workstreams have been agreed. Challenges to moving forward related to aligning clinician's availability across multiple organisations.	

Business case for future working of the Southern Counties Pathology Network due for consideration by Trust Board towards the end of Q4 2024/25. This is in consideration of what savings may be achieved as provider of managed equipment.

Business case development for aseptic services and the Winchester elective hub by HIoW APC has been approved and is moving into the implementation phase. Alongside this a business case for a Southampton elective hub has been written and reviewed at TIG, with plans to take this to Trust Board in March 2025. In parallel, discussions across the region are underway.

NHSE has approved the business case for the Elective Hub, this is a significant step forward and now moving ahead. This is expected to open May 2025.

Mr AK, Ophthalmology clinical lead, leading ongoing improvement work focussed on theatre productivity and point of access for cataract referral.

A high level options paper has been developed for Upper GI across UHS and UHD. This has been shared with executives and broadly agreed between CMOs and Directors of strategy. A detailed options appraisal to follow this which UHS are committed to provided, but will require continued engagement from UHD too. The ICB and NHSE South East region have also requested that UHS work in collaboration with Portsmouth in consideration to UGI and as of December 2024, 3 consultant meetings have been held between UHS and Portsmouth to progress this.

We have agreed to join in a collaborative with Salisbury NHSFT, enabling joint governance of clinical networking arrangements between our two organisations and regular review of opportunities. Principles for collaboration and TORs for a board have been developed. We are waiting on Salisbury's response on these to move forward with arranging regular board meetings.

A Pelvic floor networks away day was held at the end of May 2024 and was well attended by representatives across care settings and the region. A paper outlining the model in more detail is in draft in preparation for sharing with all linked providers and ICBs.

Work has begun on reviewing the Plastics model for UHS and Salisbury. A detailed review has been completed of activity against plan for all plastics services. An away day has been held to discuss challenges and opportunities and to gain agreement on a way forward. A case for change paper is now being developed, setting out proposal for a single plastics service between Salisbury and UHS. Plastic leadership has been strengthened within UHS to support this change, oversight will now sit within division D.

Planning underway to increase performance and meet targets for the Elective Recovery Fund supported by a common assumption across the system and leadership from David French for the ICS elective programme.

The strategic intent is to bring the two ISTCs (RSH and St Mary's) back into NHS control when the current contracts with PPG expire. Work is underway to align with commissioners and to support the change contractually.

Once networks have been established, define a core set of KPI metrics to be monitored and reported through INC board.

Following conversations between clinical leads at UHS and HHFT regarding future networking opportunities that may arise because of and in advance of the development of a new HHFT hospital in North Hampshire (2032 onwards), individual speciality clinical leads have been asked to continue exploring and progressing this.

Foundations for the future

5a) We are unable to deliver a financial breakeven position resulting in:

- **Inability to move out of the NHS England Recovery Support Programme.**
- **NHS England imposing additional controls/undertakings.**
- **A reducing cash balance impacting the Trust's ability to invest in line with its capital plan, estates/digital strategies, and in transformation initiatives.**

Monitoring committee: Finance & Investment Committee	**Executive leads:** CFO

Cause	Risk	Effect
Due to existing and growing financial pressures including unfunded activity growth, system pressures (NCtR), workforce growth above funded levels, and challenges with the NHS payment infrastructure.	There is a risk that we will be unable to deliver a financial breakeven position;	This may result in the measures outlined above regarding the Recovery Support Programme, and the Trust's inability to invest and grow due to a reducing cash balance.
Category	**Appetite**	**Status**
Finance	Cautious *The current risk rating sits outside of the stated risk appetite, however the target risk rating is within the tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		**Current risk rating (I x L)**		**Long term target (I x L)**	
4 x 5 20	April 2022	4 x 5 20	December 2024	3 x 3 9	April 2025

Risk progression: (previous 12 months)	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24
	4 x 5 20	4 x 5 20	4 x 5 20	3 x 5 15	3 x 5 15	3 x 5 15	3 x 5 15	3 x 5 15	3 x 5 15	3 x 5 15	3 x 5 15	3 x 5 15

Current assurances and updates

- This risk has been reviewed by the Chief Finance Officer in December 2024 and the risk rating has increased from 15 (moderate x certain) to 20 (severe x certain). This is in consideration of the continued financial pressures across the organisation and wider system, including the organisation's decreasing cash balance. This is aligned with the Trust's risk scoring matrix which was recently updated to provide greater focus on the potential impact of a risk.
- Due to the significantly decreasing cash balance it is anticipated that UHS will seek support from NHSE to help address this. A cash flow forecast review has been undertaken and this is scheduled to be reviewed at the Finance & Investment Committee in December 2024.
- Following the financial self-assessment undertaken and submitted to NHSE in June 2024, NHSE had written to the HIOW ICB to express concern that boards have not fully complied with their undertakings to date and further work and improvements are required. In response, a further self-assessment has been undertaken at UHS and submitted to the HIOW ICB who will then share this with the NHSE regional team by the end of January 2025.
- UHS have submitted a Financial Recovery Plan to HIOW ICB and NHS England. This includes actions required by UHS as well as what needs to be true in the wider system to deliver an ongoing break-even position.
- Commencing in Q3 2024/25, UHS is working with Deloitte to review non pay spend and identify opportunities to maximise benefits, and this work remains underway. A report will be presented to Finance & Investment Committee in December.
- As an additional mitigation to the financial pressures, UHS is planning to initiate MARS (Mutually Agreed Resignation Scheme) in line with national terms. This is likely to be communicated in December 2024 with voluntary applications from staff electing to participate open until January 2025.

Key controls	Gaps in controls
Internal • Financial strategy and Board approved financial plan. • Trust Savings Group (TSG) oversight of CIP programme. • Transformation Oversight Group (TOG) overseeing delivery of transformation programmes including financial benefits. • Implementation of revised recruitment controls, including setting revised divisional Affordable Workforce Limits • Robust business planning and bidding processes • Robust controls over investment decisions via the Trust Investment Group and associated policies and processes • Monthly VFM meetings with each Care Group **System wide/external** Financial Recovery Programmes / Transformation Programmes: • Planned Care • Urgent & Emergency Care • Discharge • Local Care • Workforce • Mental Health Formation of new Delivery Units & mapping of UHS resources to support delivery. Improved “grip and control” measures with consistent application across all organisations.	**Internal** • Remaining unidentified and high-risk schemes within CIP programme. • Ability to control and reduce temporary staffing levels. **System wide/external** • Elements of activity growth unfunded via block contracts. • Reliance on external organisations and partners to support reductions in NCTR and Mental Health. Emerging NHS HIOW transformation programmes focus on this but currently lack detail to provide assurance.
Key assurances	**Gaps in assurances**
• Regular finance reports to Trust Board & F&IC. • Full financial report for the system to Trust Board. • Divisional performance on cost improvement reviewed by senior leaders – quarterly. • Trust Savings Group oversight of financial recovery plan and CIP programme actions • F&IC visibility and regular monitoring of detailed savings plans • Capital plan based on cash modelling to ensure affordability. • Regular reporting on movements in overall productivity.	• Current short-term nature of operational planning • System wide plans under development to work collaboratively focussing on reduction in NCTR, and mental health, however there remains a lack of assurance around the detail to ensure delivery. • Lack of reporting on system transformation initiatives to individual Trust Boards. • Concern over any further industrial action not incorporated into plan. • Formation of Trust delivery units may take resource away from Trust programmes / lack of additional resource to deliver programmes.
Key actions	
• Finalise 24/25 plan to be agreed with NHSE - complete • Set Divisional/Directorate budgets and ensure appropriate sign-off of budgets, inclusive of revised AWL limits – complete. • Reset CIP and transformation programmes based on 24/25 targets - complete. • Review formation of Delivery Units to support system transformation programmes. • Reset organisational focus onto flow, theatres and outpatients' transformation programmes. • Continue to implement and monitor workforce controls throughout 2024/25 to slow growth and reduce spend.	

Foundations for the future

5b) We do not adequately maintain, improve, and develop our estate to deliver our clinical services and increase capacity

Monitoring committee: Finance & Investment Committee	**Executive leads:** COO

Cause	Risk	Effect
If the cost of maintenance of our estate outweighs the available funding or does not offer value for money, or the works are too extensive to be able to complete without disruption to clinical services.	There is a risk that our estate will prohibit delivery and expansion of clinical services. Key areas of concern are an insufficient electrical supply, aged electrical systems, inadequate and aged ventilation systems, and aged water and sewage distribution.	This would result in an inability to meet the growing needs of our patients and potential health and safety risks to patients, staff and visitors if the estate is not fit for purpose.
Category	**Appetite**	**Status**
Effectiveness	Cautious *The current risk rating sits outside of our stated risk appetite. The target risk rating sits within our tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Long term target (I x L)	
4 x 4 16	April 2024	4 x 5 20	December 2024	4 x 2 8	April 2027

Risk progression: (previous 12 months)	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24
	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20

Current assurances and updates

This risk has been reviewed with the Chief Operating Officer, and Director of Estates, Facilities and Capital Development, in December 2024 with no revisions to the ratings or target dates required. This continues to be a critically rated risk for the organisation with the limiting factor in mitigation being adequate funding. This gap in mitigation is also evidenced within the operational risk register:

- Since the board last received this report, 5 new operational risks (3 of which are critical) have been raised regarding aging equipment which requires replacement, however there is no funding identified to undertake this.
- However, all risks identified are assessed individually to ascertain and document the mitigations which are in place / planned, to ensure that the risk is managed.

Key controls	Gaps in controls
Multi-year estates planning, informed by clinical priorities and risk analysis	Missing funding solution to address identified gaps in the critical infrastructure.
Up-to-date computer aided facility management (CAFM) system	Missing funding solution to address procurement of new system. Requires new CAFM system installing to fully understand gaps and address outstanding assets.
	Timescales to address risks, after funding approval.
	Continuing revenue budget pressures to reduce costs as infrastructure is getting more costly to maintain
Asset register (90% in place)	Operational constraints and difficulty accessing parts of the site affecting pace of investment including refurbishment.
Maintenance schedules	Lack of decant facilities
Trained, accredited experts and technicians	

Asset replacement programme Construction Standards (e.g. BREEM/Dementia Friendly Wards etc.) Six Facet survey of estate informing funding and development priorities Estates masterplan 22-23 approved. Clear line of sight to Trust Board for all risks identified.	Reactive system requires re-prioritisation review. Planned maintenance will drop out of the asset register work. Recruitment controls inhibiting recruiting to key roles. Derogation policy to be introduced. Lack of Estates strategy for the next 5 years. Missing funding solution to deliver strategy.
Key assurances	**Gaps in assurances**
Compliance with HTM (Health Technical Memorandums) / HBN (Health Building Notes) monitored by estates and reported for executive oversight Patient-Led Assessments of the Care Environment. Reported to QGSG. Statutory compliance audit and risk tool for estates assets Monitoring at Finance and Investment Committee, including progress of capital investment and review of critical infrastructure risk and updates to Six Facet survey Quarterly updates on capital plan and prioritisation to the Board of Directors	The annual six facet survey has recently been completed and is being used to facilitate risk-based prioritisation of funding through the Trust Investment Group (TIG). This has highlighted 17 new operational risks which are being assessed ahead of addition to the operational risk register.
Key actions	
Commence work on the estates strategy following the finalisation and agreement of the estates masterplan, including engagement with all clinical and non-clinical divisions. Being developed alongside the ICB infrastructure plan. Currently paused as funding has been withdrawn, but this is currently under consideration as to how to move this forward. Identify future funding options for additional capacity in line with the site development plan. Delivery of 2024/25 capital plan Implement the HIOW elective hub. Deliver £4.2m of critical infrastructure backlog maintenance. £3.5m in 2025/26. Agree plan for remainder of Adanac Park site Site development plan for Princess Anne hospital.	

Linked operational risks

No.	Title	Initial Date	Current risk rating	Target risk rating	Target Date
16	Estates Maintenance PPM Programme	26/06/2019	4 x 2 = 8	4 x 1 = 4	29/11/2024
34	Imminent failure of the pharmacy logistics robot	22/07/2019	3 x 5 = 15	2 x 2 = 4	06/12/2024
75	Site wide electrical infrastructure resilience	05/03/2019	4 x 3 = 12	4 x 1 = 4	31/01/2025
157	Site wide electrical infrastructure resilience, HV and LV.	05/03/2019	4 x 3 = 12	4 x 1 = 4	30/11/2024
260	Insufficient space in the induction of Labour Suite.	28/10/2019	4 x 4 = 16	3 x 1 = 3	31/12/2025
421	There is a risk that the Trust does not appropriately manage or maintain its assets.	28/08/2020	4 x 3 = 12	4 x 1 = 4	31/12/2024
489	Inadequate ventilation in in-patient facilities increases the risk of nosocomial infection and may result in a suboptimal experience for patients and staff who are subject to uncomfortable and excessive environmental temperatures	07/02/2021	5 x 3 = 15	5 x 1 = 5	31/03/2026

727	Black start electrical test	25/07/2023	5 x 2 = 10	5 x 1 = 5	30/11/2024
732	Sitewide obsolete nurse call systems	08/08/2023	4 x 3 = 12	4 x 1 = 4	30/04/2025
773	Impact of the Building Safety Act (2022) on Capital Project Delivery	24/01/2024	3 x 3 = 9	3 x 2 = 6	31/12/2024
817	Lack of UPS backup on power failure	28/05/2024	5 x 3 = 15	5 x 1 = 5	31/03/2025
818	Centralised Chilled water system - power supply resilience	28/05/2024	5 x 2 = 10	5 x 1 = 5	31/03/2025
846	PAH – General ward areas and Neonatal Unit air handling units beyond service life	11/10/2024	5 x 3 = 15	5 x 1 = 5	01/12/2025
851	Lab and Path Chiller 1 Aged and Not Operational	06/11/2024	5 x 3 = 15	5 x 1 = 5	01/12/2025
853	Lab and Path Chilled Water Pumps	06/11/2024	5 x 3 = 15	5 x 1 = 5	01/12/2025
854	P.M.S Computer room AC Chillers	06/11/2024	5 x 3 = 15	5 x 1 = 5	01/12/2025

Foundations for the future

5c) Our digital technology or infrastructure fails to the extent that it impacts our ability to deliver care effectively and safely within the organisation

Monitoring committee: Finance & Investment Committee	**Executive leads:** COO

Cause	Risk	Effect
If there are inhibitors to implementing and sustaining digital technology either due to funding, capacity, technology, or resource constraints	This could mean that our digital technology or infrastructure is unable to support the Trust in delivering clinical, financial, or operational objectives. Key areas of concerns are the ability to provide reliable and fit for purpose hardware and infrastructure, defence against cyber threats, and being able to recruit and retain the right number of staff with the right skill mix.	Resulting in an inability to provide and maintain the digital infrastructure required to facilitate outstanding patient care, and leading to incidents which would require reporting to national governing bodies.

Category	Appetite	Status
Technology & Innovation	Open *The current risk rating is within the tolerable risk appetite and the target risk rating is within the optimal risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
3 x 4 12	April 2022	4 x 3 12	December 2024	3 x 2 6	April 2027

Risk progression: (previous 12 months)	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Nov 24	Dec 24
	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12

Current assurances and updates

This risk has been reviewed with the Chief Operating Officer and Chief Information Officer in December 2024. The risk rating and target has been confirmed to be correct with no alterations required and the risk controls and assurances (and gaps) have been updated.

Key actions which are progressing which aid in mitigation of this risk are:

- The air conditioning in the ICU and Old Nurses Home data centres has been upgraded, enhancing its resilience. The air conditioning for the A-Level communications room is also now under review.
- The rollout of the Windows 11 and RAM upgrade is progressing well with over 1000 devices completed. A capital plan is being developed for those devices where upgrade is not suitable and this is anticipated towards the end of 2024/25.
- Cyber software upgrades are being accelerated using investment from 2024/25 capital.

Key controls	Gaps in controls
Failure in physical network infrastructure • All Digital UPS tested. • Investment cases for key infrastructure (air cooling and data centres) being developed. ICU and ONH air conditioning has been upgraded to support this. • Replacement of key infrastructure on a case-by-case basis once it fails.	**Failure in physical network infrastructure** • The current Data Centre is end of life and requires a capital plan for replacement. • There is currently no phased replacement of switch and network equipment due to absence of funding. • Windows 10 is end of life in October 2025 with no funding available to replace all devices with

	Windows 11. Some mitigations underway and ongoing including purchase of additional RAM and hard drives, and upgrading suitable equipment, however not all equipment is suitable for this.
Cyber Risk • Cyber security infrastructure refreshed and in place. • Staff training on cyber risks, with regular refreshers and clear policies. • Key cyber roles recruited to, with one remaining outstanding.	**Cyber Risk** • Funding: cyber security and recovery capability requires ongoing investment and development. • Ability to enforce more robust training due to lack of time for staff training. • Penetration testing contract being pulled forward to 2024/25.
Single points of failure in staffing • Partial implementation of Digital workforce plan. • Prioritisation of key posts. • Upskilling existing staff to provide cross cover.	**Single points of failure in staffing** • Financial constraints impacting ability to implement workforce plan needed to underpin strategy. This, alongside the rigidity of the AFC banding structure, can result in difficulties attracting skilled staff in a competitive industry.
Implementation and sustainability of digital technology • Inpatient noting for nursing has been rolled out to all appropriate wards, and further developments are being made. Doctors rollout planned for 2025/26. • Single EPR business case via NHS England EPR Investment Board.	**Implementation and sustainability of digital technology** • Funding to cover the development programme, improvements, and clinical priorities.
Loss of access to critical IT systems • Absolute back-ups of data created. • Business continuity plans developed for Digital team and Wards. • Robust system and regression testing completed on system developments. • Scenario testing completed.	**Loss of access to critical IT systems** • Time to fully stress test business continuity plans.
Key assurances	**Gaps in assurances**
Finance oversight provided by the Finance and Investment Committee. Quarterly Digital Board meeting, chaired by the CEO. Digital risks and actions reviewed weekly on UHS Digital leadership team call. UHS Digital risk and benefit manager in post to manage digital risk alongside operational Digital teams. UHS Digital projects and programmes follow standardised project management delivery mechanism which includes risk management embedded as part of their delivery processes (APM, Prince2, Agile, etc).	Funding to cover the development programme, improvements, and clinical priorities. Difficulties in understanding benefits realisation of digital investment. ICS digital strategy yet to be agreed. UHS digital strategy to be reviewed (runs until 2026 but requires prior review). Digital team provide guidance to clinical services developing BCPs but the team do not review these at service/ward level due to time and capacity.

Standardised change control, testing, and assurance processes implemented across the Development team. NHSE annual DPST assessment completed to highlight gaps in services. Business Continuity Plans in place for clinical areas in the event of IT outages.	

Key actions

- Ongoing recruitment of key Digital resource to mitigate operational risk.
- Inpatient noting for doctors scheduled for 2025/26.
- Replacement of key clinical systems to more modern systems: Alcidion scheduled in April 2025
- Lessons learned from LIMS project being shared across UHS Digital, Estates, and other major project teams.
- Procurement of Single EPR across HIOW to provide a more modern EPR.
- Identify opportunities for funding for digital transformation and programmes.
- Acceleration of cyber software upgrades.

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
129	Workforce Resourcing - UHS does not have sufficient Clinical Safety Officer cover for deployment and use of clinical systems. This is detailed within legislation: - DCB0129: Clinical Risk Management - Its Application in the Manufacture of Health IT Systems, and - DCB0160: CRM - Its Application in the Deployment and Use of Health IT Systems.	4 x 3 = 12	2 x 2 = 4	31/03/2025
282	Workforce Resourcing - There is a risk that the ophthalmology service is not appropriately supported by IT systems to safely deliver current activity.	3 x 4 = 12	2 x 2 = 4	20/01/2025
556	Workforce Resourcing - Risk to provision of Pathology test results (all departments) if there are delays or errors in the implementation of the new Path IT system	4 x 3 = 12	4 x 1 = 4	31/12/2024
634	Accommodation / Infrastructure - Fibre optic cabling at the ONH	4 x 3 = 12	4 x 3 = 12	29/09/2025
650	Accommodation / Infrastructure - The trust's data and communications centre facilities are no longer suitable for supporting mission-critical IT services. There is an element of resilience across the network but all of the facilities described have significant problems.	4 x 4 = 16	3 x 1 = 3	29/09/2025
653	Accommodation / Infrastructure - No suitable IT storage and distribution space available within the footprint of SGH	3 x 4 = 12	3 x 3 = 9	27/01/2025
676	Cyber Security - UHS does not sufficiently manage the increased threat from cyber risk.	4 x 4 = 16	2 x 3 = 6	31/12/2025
677	Workforce Resourcing - Insufficient resilience in the UHS network team to support mission critical infrastructure.	5 x 3 = 15	2 x 3 = 6	30/12/2024
679	Accommodation / Infrastructure - Single point of failure on the UHS network (external connections)	4 x 3 = 12	4 x 1 = 4	31/03/2026
709	Workforce Resourcing - There is inconsistency in the sharing and coding of co-morbidities, diagnoses, allergies and past medical history within and between different clinical systems - potentailly resulting in critical patient information being missed pre, during and post treatment	3 x 4 = 12	2 x 1 = 2	30/12/2024
736	Accommodation / Infrastructure - Supply of Multitone Devices - Bleeps	3 x 4 = 12	1 x 2 = 2	29/09/2025

757	Cyber Security – If there are unsupported server operating systems this could expose the Trust to cyber attack.	4 x 2 = 8	2 x 1 = 2	31/12/2024
800	Cyber security – Clinical care may be compromised if data cannot be accessed via the iPads in secondary locations.	3 x 4 = 12	2 x 1 = 2	30/12/2024
802	Accommodation / Infrastructure - A/C in the A Level comms room (DR)	3 x 3 = 9	2 x 2 = 4	30/12/2024
829	Cyber Security - Windows 11 Roll-out before Win10 EOL	4 x 3 = 12	2 x 2 = 4	14/10/2025

Foundations for the future

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

Monitoring committee: Trust Executive Committee	**Executive leads:** CMO

Cause	Risk	Effect
If we fail to deliver the current decarbonisation plan and build upon it to meet 2032 target.	This could lead to increased costs, reputational damage and potentially subject UHS to national scrutiny, as well as adding to risks of worse health for our local population and staff, and increased risk of major climate change consequences.	Resulting in higher costs, reduced national standing and reduced resilience to climate change
Category	**Appetite**	**Status**
Technology & Innovation	Open *Both the current and target risk rating is within the optimal risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Long term target (I x L)	
2 x 3 6	April 2022	2 x 3 6	December 2024	2 x 2 4	December 2024

Risk progression: (previous 12 months)	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24
	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6

Current assurances and updates

The risk has been reviewed in December 2024 with no revisions to the risk rating required. A full review of the risk and target is also planned with the sustainability leads in early Q4 2024/25.

Key controls	**Gaps in controls**
Governance structure including Sustainability Board Clinical Sustainability Lead Head of Sustainability and Energy Appointment of Executive, Non-Executive and Council of Governors Lead(s) for Sustainability in post. Green Plan	Clinical Sustainability Plan/Strategy (CSP) Long-term energy/decarbonisation strategy Communications plan. Capacity and reach of the clinical sustainability lead as there are not designated leads/champions within each speciality to influence this change. Do not have a fully funded plan to achieve the national targets set out.
Key assurances	**Gaps in assurances**
Progress against the NHS direct emission net zero target by 2040, with an ambition to reach an 80% reduction by 2028 to 2032. Progress against the NHS indirect emissions target to be net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039. Quarterly reporting to NHS England and NHS Improvement on sustainability indicators. Green Plan and Clinical Sustainability Programme has been approved by Trust Investment Group and Trust Board.	Definition of and reporting against key milestones.

Key actions
Agree further funding requirements to commence the delivery of the strategies and identify opportunity. (Explore Low carbon skills funding) Progress improvements to the Trust's estate and energy supply, including use of funding from the Public Sector Decarbonisation Scheme. Continue to further develop metrics and establish governance processes in respect of the Trust's Green Plan and other related strategies. Finalise energy performance contract to deliver a responsive and progressive energy plan.

University Hospital Southampton NHS Foundation Trust

Agenda item 7.1	Report to the Trust Board of Directors, 7 January 2025
Title:	Annual Assurance Report for the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) 2024
Sponsor:	Joe Teape, Chief Operating Officer / Accountable Emergency Officer
Author:	John Mcgonigle, Head of Emergency Planning

Purpose

(Re)Assurance	Approval	Ratification	Information
x			x

Strategic Theme

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

Executive Summary:

This report is provided to the Trust Board as a final report regarding the 2024 NHS England Emergency Preparedness, Resilience and Response (EPRR) assurance process.

UHS reported full compliance in 60 out of the 62 core standards as part of the self-assessment, with an overall assurance rating of 'Substantially Compliant' (97%). This maintains the assurance position reported in 2023. The standards rated 'Partially Compliant' are detailed below, and progress of the improvement plan shall be monitored and reported upon at EPRR Delivery Group (EPRR-DG) with regular updates provided to Quality Governance Steering Group (QGSG):

- **Lockdown:** Lockdown procedures at UHS are critical as outlined in the Terrorism (Protection of Premises) Bill. Although UHS has a comprehensive lockdown plan, it is essential to evaluate current measures against available resources and the specific characteristics of the premises to ensure practicality. Immediate priorities include establishing zoning and ward lockdowns using a combination of human resources and digital access control, focusing on high-risk and vulnerable patients' areas and critical infrastructure. To advance this action plan, a lockdown planning group will be formed in early 2025 while the EFCD leadership team continues to explore digital perimeter lockdown options.

- **Business Continuity Audit:** The UHS Head of Emergency Planning will initiate a review of the organisation's Business Continuity Management System (BCMS) to enhance its development and delivery. This review will include a comprehensive audit and compliance program aligned with the International Organisation for Standardisation (ISO) 22301 standard. The audit program will systematically assess the effectiveness of the BCMS, ensuring it meets all required elements based on risk assessments. This initiative aims to identify areas for improvement and ensure the BCMS aligns with UHS's overall objectives, thereby enhancing operational resilience and continuity of services during disruptions.

Appendix 1 provides an overview of the process for 2024, the level of assurance and outlines the EPRR improvement plan. The Trust Board is asked to consider and approve this report.

Contents:

Appendix 1 - Annual Assurance Report for the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) 2024

Risk(s):

1. Financial constraint to delivery of Trust-wide digital perimeter lockdown.

Equality Impact Consideration:	N/A

Appendix 1 - Annual Assurance Report for the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) 2024

1. Overview of Assurance Process

UHS has been required to assess itself against the NHS core standards for EPRR, of which there are 62 within the following 10 domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Cooperation
9. Business continuity
10. Chemical Biological Radiological Nuclear (CBRN)

As part of the self-assessment, UHS reported full compliance in 60 out of the 62 core standards, with an overall assurance rating of 'Substantially Compliant' (97%). This maintains the assurance position reported in 2023.

On 30 September 2024, the UHS Deputy Emergency Planner attended the ICB led EPRR peer review, together with other Hampshire and Isle of Wight acute trust EPRR Leads. This 'check and challenge' process was facilitated by the ICB to ensure a consistent approach to evidence was taken.

2. Areas for Improvement

The standards rated 'Partially Compliant' are detailed below. These standards require further actions for the Trust to be fully compliant and an improvement plan has been put in place to address these areas:

Lockdown
It was recognised that whilst UHS has a Trust wide lockdown plan, there is further focus required on achieving lockdown (perimeter / zoning / ward / departmental) level. It was also recognised there is some further work required on how this is communicated to areas, and the command and control arrangements surrounding this. Work on this will continue through 2025 and monitored through the EPRR Delivery Group (EPRR-DG).

Business Continuity Audit
Following the EPRR team attendance at International Organisation for Standardisation (ISO) 22301 Lead Implementer course, it was recognised there are improvements to make in terms of internal audit processes for business continuity (BC). Work is to continue through 2025 in relation to BC internal audit process to align with the ISO 22301 standard. The progress of the improvement plan shall be monitored and reported upon at EPRR Delivery Group (EPRR-DG) with regular progress updates provided to Quality Governance Steering Group (QGSG).

3. Deep Dive – Cyber

Each year, NHS England provide a 'Deep Dive' area to assess and for 2024, this year's focus was Cyber resilience. The assessment of these standards does not count towards the organisations overall assurance rating but has provided the Trust with a steer in terms of areas

for improvement. The EPRR team will work closely with the UHS Digital team in the coming year to review and improve the following areas:

- Development of resilient communication practices to ensure compliance with national guidance.
- Cyber and digital resilience to be included in the business continuity training package to strengthen arrangements.
- Whilst critical functions and dependencies are detailed within the UHS Digital Business Continuity Plan (BCP), it is recognised the accuracy of the list may require validation.

4. Areas of Good Practice

As part of the assurance process, Trusts were asked to also highlight areas of good practice during 2024. Notable developments and areas of good practice throughout 2024 include the following:

Training and Exercising: UHS have delivered further command training sessions to complement the programme of training delivered in 2023, as well as a number of exercises this year:

- Incident Command Continuing Professional Development (CPD) took place in January/ February 2024 to enhance and build upon incident response within the organisation. This included an evacuation tabletop exercise testing arrangements within the Incident Response and Evacuation plans. This was well attended by the tactical and strategic command cohort and has established a good training structure going forward.

- Exercise Mephitis, which was a no-notice Chemical Biological Radiological Nuclear (CBRN) exercise was held in July 2024. This tested the Emergency Department and other hospital team's response to a self-presenting contaminated casualty. This was attended by personnel from SCAS who observed the exercise and acted as critical friends. It was the first exercise of its kind at UHS and also one of its first in the region. Lessons identified and progress of embedding the learning will be monitored through the CBRN Operational Preparedness Group. Overall, the exercise successfully highlighted the capability of UHS to receive a self-presenting CBRN casualty out of hours.

- UHS took part in the regional command exercise in September testing the capability to stand-up the UHS Incident Control Centre (ICC). This identified some improvements to internal processes to be reflected in the Incident Response Plan and future training.

Planning:

- Evacuation plan underwent a significant re-write incorporating learning from across the emergency planning environment locally, regionally, and nationally.

- Mass casualty plan was rewritten in 2024. The planning arrangements were reviewed through the lens of when we are most operationally challenged (capacity / other incident), incorporating a particular focus on the UHS out-of-hours response.

Business Continuity: Work progressed on electrical resilience assessments across the organisation to ensure successful testing of electrical infrastructure. This included a proactive approach to command protocols for these pre-planned projects which have potential to result in Business Continuity (BC) incidents.

Collaborative Working: Continuation of collaborative working with partners in HIOW over the last year e.g. peer review / consultation of planning arrangements, supporting exercises (Exercise Scintilla and PHU evacuation and BBEC exercises).

University Hospital Southampton NHS Foundation Trust

Agenda Item 7.2 Report to the Trust Board of Directors, 7 January 2025	
Title:	Register of Seals and Chair's Actions Report
Sponsor:	Jenni Douglas-Todd, Trust Chair
Author:	Craig Machell, Associate Director of Corporate Affairs

Purpose

(Re)Assurance	Approval	Ratification	Information
		x	

Strategic Theme

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

Executive Summary:

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.

The Board has agreed that the Chair may undertake some actions on its behalf.

There have been no Chair's actions since the last report.

The report provides compliance with The NHS Foundation Trust Code of Governance (probity, internal control) and UHS Standing Financial Instructions and Scheme of Delegation.

Contents:

Report

Risk(s):

N/A

Equality Impact Consideration:	N/A

1 Signing and Sealing

1.1 **Building Contract** (JCT Standard) between University Hospital Southampton NHS Foundation Trust (the Employer) and Concept Building Services (Southern) Ltd (the Contractor) relating to the West Wing Air Handling Units Installation works. Seal number 285 on 8 November 2024.

2 Recommendation

The Board is asked to ratify the application of the seal.