University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	27/05/2021
Time	9:00 - 13:00
Location	Microsoft Teams
Chair	Peter Hollins

1	9:00	**Chair's Welcome, Apologies and Declarations of Interest** To note apologies for absence, and to hear any declarations of interest relating to any item on the Agenda.
2		**Staff Story** The patient or staff story provides an opportunity for the Board to reflect on the experiences of patients and staff within the Trust and understand what the Trust could do better.
3	9:15	**Minutes of Previous Meeting held on 30 March 2021**
4		**Matters Arising and Summary of Agreed Actions** To discuss any matters arising from the minutes, and to agree on the status of any actions assigned at the previous meeting.
5		**QUALITY, PERFORMANCE and FINANCE** Quality includes: clinical effectiveness, patient safety, and patient experience
5.1	9:25	**Briefing from the Chair of the Charitable Funds Committee (Oral)** Dave Bennett, Chair
5.2	9:30	**Briefing from the Chair of the Finance and Investment Committee (Oral)** Dave Bennett, Chair
5.3	9:35	**Briefing from the Chair of the Quality Committee (Oral)** Tim Peachey, Chair
5.4	9:40	**Chief Executive Officer's Update (Oral)** Sponsor: David French, Chief Executive Officer
5.5	10:00	**Integrated Performance Report for Month 1** To review the Trust's performance as reported in the Integrated Performance Report Sponsor: David French, Chief Executive Officer
5.6	10:45	**Equality and Diversity Update (WRES and WDES)** Sponsor: Steve Harris, Chief People Officer Attendee: Gemma Genco, Head of Equality, Diversity & Inclusivity

5.7 **Gender Pay Gap Reporting 2020**

11:05 Sponsor: Steve Harris, Chief People Officer
Attendee: Kirsty Durrant, Strategic HR Projects Manager

5.8 **Freedom to Speak Up Report**

11:25 Sponsor: Gail Byrne, Chief Nursing Officer
Attendee: Christine Mbabazi, Equality & Inclusion Adviser/Freedom to Speak Up Guardian

5.9 **Finance Report for Month 1**

11:45 Sponsor: Ian Howard, Interim Chief Financial Officer

6 **STRATEGY and BUSINESS PLANNING**

6.1 **CRN: Wessex 2020/21 Annual Report and 2021/22 Annual Plan**

11:55 Sponsor: Paul Grundy, Chief Medical Officer
Attendees: Rebecca McKay, Chief Operating Officer, CRN: Wessex/Clare Rook, Deputy COO, CRN: Wessex

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

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

12:15 In compliance with the Trust Standing Orders, Standing Financial Instructions, and the Scheme of Reservation and Delegation.
Sponsor: Peter Hollins, Trust Chair

7.2 **Emergency Planning and Business Continuity Annual Report 2020/21**

12:20 Sponsor: Joe Teape, Chief Operating Officer

7.3 **Charitable Funds Committee Terms of Reference**

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

7.4 **Trust Executive Committee Terms of Reference**

12:35 Sponsor: David French, Chief Executive Officer
Attendee: Karen Flaherty, Associate Director of Corporate Affairs and Company Secretary

8 **Any Other Business**

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

9 **To note the date of the next meeting: 29 July 2021**

10 Resolution regarding the Press, Public and Others

Sponsor: Peter Hollins, Chair

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

11 Follow-up discussion with governors

12:45

University Hospital Southampton
NHS Foundation Trust

Minutes Trust Board – Open Session

Date	30/03/2021
Time	9:00 - 12:05
Location	Microsoft Teams
Chair	Peter Hollins (PH)
Present	Dave Bennett (DB), Non-Executive Director (**NED**) Gail Byrne (GB), Chief Nursing Officer Cyrus Cooper (CC), NED Keith Evans (KE), NED David French (DAF), Interim Chief Executive Officer Paul Grundy (PG), Interim Chief Medical Officer Steve Harris (SH), Chief People Officer Jane Harwood (JH), NED (until item 5.10) Ian Howard (IH), Interim Chief Financial Officer Tim Peachey (TP), NED and Senior Independent Director/Deputy Chair Joe Teape (JT), Chief Operating Officer
In attendance	Brenda Carter (BC), Assistant Director of People (for item 5.8) Ellen Copson (EC), Associate Professor of Medical Oncology, University of Southampton and Honorary Medical Oncology Consultant (for item 2) Kirsty Durrant (KD), Strategic HR Projects Manager (for item 5.8) Karen Flaherty (KF), Associate Director or Corporate Affairs and Company Secretary Sarah Herbert (SHe), Divisional Head of Nursing and Professions, Division B (for item 5.9) Sandra Hodgkyns (SHo), Head of Emergency Planning Response and Resilience/Security (for item 5.9) Stephanie Ramsey (SR), Director of Quality and Integration (Chief Quality Officer and Chief Nurse), NHS Southampton City CCG (for item 5.6) 3 governors (observing) 3 members of the public (observing) 5 members of staff (observing) 1 member of the public (for item 2)

1 Chair's Welcome, Apologies and Declarations of Interest

The Chairman welcomed all those attending to the meeting.

The following declaration of interests for GB were reported to the Board:

- Chair of the Directors of Nursing Group, University Hospital Association;
- Chair of the Wessex Patient Safety Collaborative; and
- Member of the Policy Board, NHS Employers.

The Board also noted that DB was no longer a director of Davox Consulting Limited.

2 Patient Story

The patient story was told by the husband of a patient who sadly died in early 2020 following treatment for cancer at the Trust. As a result of the treatment she had received at the Trust following a diagnosis in April 2017, her life had

been extended by over three years.

In terms of areas for improvement, better communication of his wife's initial diagnosis would have helped her and her family to come to terms with the diagnosis more quickly. Following their arrival at hospital, they were being asked lots of questions and his wife was being sent for tests and scans without being given information about what concerns the clinicians had or potential diagnoses. The diagnosis was also delivered on the ward just prior to a visit from a relative and with better planning this could have been done more sensitively by providing a better environment in which to have the conversation and more time for his wife to absorb the information.

Once his wife met the specialist team, including the specialist nurse, she felt more reassured and was given hope by the availability of different treatment options. The Trust's appointment of a dedicated specialist nurse for his wife's particular cancer shortly after her diagnosis made a huge difference. The specialist nurse was always present when his wife met the consultants and would check if there was anything he or his wife needed and provided practical advice and support, which meant that he and his wife were able to spend more time together.

GB reiterated the importance of specialist nurses across different patient pathways and the Trust continued to invest in more specialist nurses. While acknowledging that there was a shortage of private spaces to speak with patients and their families, through its End of Life Care Steering Group the Trust had identified a number of rooms across the hospitals to enable clinicians to go somewhere private in situations like these. The cancer service also continued to adapt to changes in cancer care and the needs of patients, with patients now living longer. Maggie's Southampton had recently opened at the Southampton General Hospital site to provide help and support for those living with cancer, although the services it offered were currently reduced as a result of the Covid-19 pandemic.

The Board expressed its gratitude for sharing the story with such strength and dignity.

3 Minutes of Previous Meeting held on 28 January 2021

The minutes of the meeting held on 28 January 2021 were approved as an accurate record of that meeting.

4 Matters Arising and Summary of Agreed Actions

The updates on the actions were noted. The action relating to cancelled appointments in ophthalmology (reference 354) had been followed up and could be closed, as could the actions relating to patients medically optimised for discharge (reference 351 and 393) and the Ockenden report (reference 395), which were included as items on the agenda later in the meeting. The action relating to patient nutrition (reference 394) would be reviewed at the next meeting of the Quality Committee, which would then report to the Board.

The Board agreed that the actions relating to specialty outcomes (reference 350 and reference 326) should be combined, with the paper due to be presented to the Board at its meeting in April 2021.

5 QUALITY, PERFORMANCE and FINANCE

5.1 Briefing from the Chair of the Audit and Risk Committee

KE updated the Board on the meeting of the Audit and Risk Committee held on 15 March 2021:

- the external audit work had commenced and there were no issues to report at this early stage;
- the internal auditors had reviewed referral to treatment (**RTT**) data quality and while data inaccuracies had been identified in the sample testing, these had not impacted on patients clinical treatment or on Trust's the overall performance against the RTT target, and in most instances had resulted in the Trust overreporting on pathways; and
- updates had been provided on progress against the recommendations in the board governance review and the ongoing review of the data security and protection toolkit.

5.2 Briefing from the Chair of the Finance and Investment Committee

DB provided an overview of the Finance and Investment Committee meeting the previous day, highlighting:

- that funding for the loss of other income and additional accruals of annual leave that staff had been unable to take due to the Covid-19 pandemic had been received;
- the update on the planning process for 2021/22 following the publication of new national guidance that sought to achieve a balance between restoring services and reducing backlogs while supporting staff recovery;
- the review of the most recent operational productivity dashboard, from which it had been difficult to draw any meaningful conclusions given the impact of the Trust's response to the most recent wave of the Covid-19 pandemic in the previous months; and
- the business case for the expansion of the outpatients area in ophthalmology, which would be considered by the Board later in the meeting.

5.3 Briefing from the Chair of the Quality Committee

TP provided an update on the meeting of the Quality Committee held on 15 March 2021 focusing on the following areas:

- the increase in waiting times for diagnostics and plans to recover performance, with a review of patient harm to be completed once patients who had waited longer than six weeks had been seen;
- the review of a 'never event' relating to a retained swab including the recommendations for a number of sensible actions that had already been implemented;
- the latest update on experience of care including the Trust's accreditation as a Veteran Aware NHS trust;
- the recommendations for reporting on maternity safety following the Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust, which would be considered by the Board later in the meeting;
- the urgent investigation of aspergillus infections in the intensive care unit to establish whether there was a link to an earlier leak in a pipe above the ceiling in that area;
- the latest report on clinical outcomes, with the Board to receive a full

report at its meeting in April 2021; and
- the review of the committee's effectiveness.

5.4 Chief Executive Officer's Update

The Trust had taken part in the national day of reflection and one minute's silence on 23 March 2021 to commemorate the anniversary of the first national lockdown due to the Covid-19 pandemic. This had given staff an opportunity to pause and reflect on the loss of life over the previous year, including patients and staff. There were currently 20 patients in the hospital who had tested positive for Covid-19, three of which were in intensive care. An average of three or four patients with Covid-19 were being admitted daily, which highlighted the importance of continuing to follow the rules as lockdown measures were eased. Staff were being encouraged to take annual leave and wellbeing conversations were taking place with every member of staff.

Second doses of the Covid-19 vaccine were being administered to Trust staff and staff at health and social care partners. 92% of frontline staff and 90% of all staff had received at least one dose of the vaccine, including 88% of BAME (Black and Minority Ethnic) staff. Staff who had not yet received the vaccination were being contacted individually to understand the reasons for this and provide additional information where appropriate.

As well as planning for the recovery of services in the short term, the Trust was carrying out long-term modelling of future demand and capacity supported by external consultants and architects, which would form the basis of the Trust's estates masterplan for the main hospital site. In advance of this work, the corporate objectives for 2021/22 would be presented to the Board at its meeting in April 2021.

The Trust had performed exceptionally well in its recent external accreditation of endoscopy by the Joint Advisory Group on GI Endoscopy (**JAG**), providing one of the best submissions reviewed by JAG.

Each of the executive directors provided an update in turn, covering the following areas:

- reopening of theatres in Southampton General and Princess Anne Hospitals, replacing the current additional capacity in the independent sector from 1 April 2021;
- four 'Always Improving' quality improvement projects relating to the emergency department (**ED**), discharge of patients medically optimised for discharge (**MOFD**), theatres and outpatients;
- the launch of the 'Always Improving' strategy with staff in June 2021;
- the review of patients who had been waiting for surgery, in particular those in priority level 2 (surgery that can be deferred for up to four weeks);
- modelling of the potential impact on the waiting list of GP referrals returning to more normal levels and patients potentially presenting with more advanced disease than if they had seen their GP earlier;
- the business intelligence programme to improve prospective as well as retrospective reporting;
- allowing time for teams to readjust to working together as part of the recovery process with additional support from the Trust for those teams experiencing challenges;
- plans to safely reopen the hospitals to visitors, particularly while the

Trust continued to admit patients with Covid-19;

- re-energising the COVID ZERO campaign to ensure that the infection control measures continued to be followed rigorously even as the number of cases reduced, with a nosocomial infection the previous week acting as a timely reminder of the risk;
- the successful renegotiation of the limit on expenditure (**CDEL**) for 2020/21 through which the Trust had been able to access additional capital and the negotiation of the allocation of CDEL across the integrated care system (**ICS**) for 2021/22; and
- the current projects in development including theatres, the private patient unit, ophthalmology and the pathology laboratory information system.

The Board noted that that the Trust would need to establish how it would balance the needs of those patients who had been waiting longest for treatment with the clinical prioritisation process already in place as it planned for the recovery of activity.

5.5 Integrated Performance Report for Month 11

The integrated performance report (**IPR**) for month 11 was noted. During February 2021 the direct impact of Covid-19 infections upon the Trust continued to be significant. There were 263 patients in the hospital with Covid-19 at the start of February and 129 at the end of the month. The number of patients in intensive care reduced from 67 at the beginning of the month to 39 by the end of February. This compared to the first wave of Covid-19 pandemic, when the number of patients with Covid-19 in the hospital peaked at 173 and 38 in intensive care. This also had an impact on elective activity within the Trust, which was 42% of the level in February 2020.

The Board discussed the following areas:

<u>Responsive</u>

- while the Trust's ED was performing well comparatively, it was not meeting the performance target on the length of time patients spent in ED, despite attendances at 71% of the normal level;
- this was principally due to patients presenting with mental health conditions and surges of high acuity patients, however, new junior doctors had also joined ED in February who were not used to the level of attendances;
- leadership in ED was central to managing the department in these situations particularly the effective operation of the consultant of the day model to ensure that decisions regarding patients were made in a timely manner;
- performance in ED had improved overall as 87% of patients were currently seen within four hours with an average daily attendance of 345 patients compared to 78% of patients two years ago when the average daily attendance was 350 patients;
- to continue to improve performance and the flow of patients through ED the Trust was ensuring that specialties adhered to the one hour standard for referrals;
- infection control measures remained in place, including respiratory assessment and rapid testing in ED and the acute medical unit, although it was difficult to establish whether this had a material impact on performance as ED had performed consistently well during the

period of the pandemic;
- activity in ED had increased in March 2021 as lockdown restrictions had eased;
- while the number of non-face-to-face outpatient appointments had increased following the first wave of the pandemic, some of these had not been full appointments but rather an opportunity to check in with patients;
- the use of non-face-to face outpatient appointments varied by condition and specialty and was more appropriate for some of these than others, however, the Trust was seeking to learn from those clinicians who had used these types of appointment successfully as part of its quality improvement work in outpatients;
- feedback from patients non-face-to face appointments had been positive on the basis that their care was continuing, however, limited work had been done to assess effectiveness in terms of the experience and outcome of these appointments; and
- although cancer performance measures remained stable, both the Trust and the Wessex Cancer Alliance had performed well comparatively and ranked as second highest performing in their respective peer groups.

Safe
- the unusually high number of medication incidents reported with moderate or severe harm in February and the actions taken in response to these; and
- ensuring that staff continued to report incidents, particularly as they returned to their normal areas of work following the pandemic.

Caring
- the number of overnight ward moves for non-clinical reasons given that most patient moves during this period would be related to patients admitted with Covid-19;
- the percentage of patients with a disability or additional needs reporting that those needs were met had reduced and there were resource challenges in this area currently with a vacancy in one of the two adult learning disabilities nursing roles, although the recruitment process was underway; and
- increasing the number of vulnerable women on a continuity of carer pathway given the benefit to all these women in terms of the quality of oversight in maternity.

ACTIONS: (1) GB would review the non-clinical reasons for overnight ward moves and provide an overview to the Quality Committee. (2) The Quality Committee would review the resourcing required to increase the percentage of vulnerable women on a continuity of carer pathway and update the Board.

Well-led
- the impact of research activity on outcomes, more detail of which would be provided in the report on clinical outcomes at the meeting of the Board in April 2021.

The Board's review of the IPR, led by TP, would report to the Board in May 2021 with a candidate IPR.

5.6 Inpatient Flow - Medically Optimised for Discharge Update

SR joined the meeting for this item.

The Board noted the current performance against the process improvement trajectories and key performance indicators agreed by the system, system plans in the light of current performance and the Trust's internal work programme for MOFD. The Board was interested to learn what the Trust could be doing differently or better in order to help improve performance as a system.

The work to date had made a significant impact as the system responded to discharge an increased number of patients with more complex needs such as stroke patients, patients with challenging behaviours, patients requiring more intensive therapy and homeless patients. There was a specific issue with discharging to care homes at weekends and providing the necessary clinical support to these care homes to enable discharge. The main areas of focus for the Trust were to speed up processes and ensure patients MOFD were ready to be discharged earlier in the day as this would make it easier for services in the community to respond. While there was a target to get to 40-60 patients MOFD in hospital, no specific timescales had been set.

ACTION: JT agreed to include a trajectory for MOFD patients in the regular reports to the Finance and Investment Committee.

Funding was also likely to be an issue in the future as additional national funding provided during the Covid-19 pandemic to support the discharge of patients would be withdrawn at the end of June 2021.

The Board recognised that system partners were aligned in their aim to address the delays in discharging patients MOFD and prevent potential patient harm as a result. However, the Board suggested a more holistic view of the issue would be beneficial when reviewing future resourcing, taking into account the revenue and capital implications and the consequences in terms of hospital capacity and addressing the current backlog of patients waiting for treatment. This analysis may identify where investment was needed to support discharge, including additional capacity, albeit that the ambition remained 'home first' when discharging patients in order to assess ongoing needs more accurately and reduce dependency.

The meeting was adjourned briefly to allow for a break.

5.7 Ockenden Review of Maternity Services

The Board noted the update on progress on the emerging findings and recommendations of the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust released on 10 December 2020. The Trust had rated its progress against two of the recommendations as red, with no actions currently in place, and nine of the recommendations as amber, where actions were still in progress. Completion of these recommendations was dependent the Trust's submission to NHS Resolution's maternity incentive scheme which would be made by mid-July 2021 and therefore other trusts would be in a similar position. The Trust had received feedback on the information submitted to NHS England and NHS Improvement, which had been positive overall.

A template had been designed to report to the Board and the local maternity

service (**LMS**) on maternity safety, which would incorporate a summary of serious incidents (**SIs**) and moderate harm incidents. This report would be submitted to the Board maternity safety champions and LMS on a monthly basis. The Board maternity safety champions would also meet with complainants before the referral of a complaint to the Parliamentary and Health Service Ombudsman. It was proposed that reporting to the Board on maternity safety issues including SIs and moderate harm incidents, the perinatal mortality report tool, early notification scheme, red flag incidents, staff concerns and evidence of listening to families including complaints would take place quarterly following review of the information by the Quality Committee. The frequency of reporting to the Board was in line with the recommendations in the Ockenden review although not with the guidance issued subsequently.

The Board was keen to ensure it maintained a good understanding of the culture and patient experience in the maternity service given the impact of each on the quality of the service. Proposals to regularly survey staff would be considered later in the meeting. In addition the Board requested that the regular patient story should include maternity at least once annually.

ACTION: KF to arrange a patient story from a patient using the maternity service at least once annually.

DECISION: The Board agreed:

- to receive a quarterly report on maternity safety issues; and
- that all SIs and moderate harm incidents would be provided to the Board maternity safety champions and LMS.

5.8 UHS Staff Survey Results 2020 Report

BC and KD joined the meeting for this item.

The results of the NHS staff survey 2020 were noted by the Board. The survey had been completed by staff between September and November 2020. Overall the Trust's results were at or above the acute trust average in nine out of ten themes. 77% of staff would recommend the Trust as a place to work and 87% of staff agreed that care of patients was the top priority for the Trust. Performance on health and wellbeing had significantly increased compared to 2019. However, the survey had also identified some areas for improvement. The areas with statistically significant decreases in performance compared to the 2019 staff survey results were:

- Equality, diversity and inclusion;
- Immediate managers;
- Violence; and
- Team working.

In response to a question from a NED, it was clarified that only a small number of incidents of violence against staff from managers and colleagues reflected in the staff survey results were reported leading to an investigation. The reporting through the Trust's Freedom to Speak Up processes had identified incidents involving microaggressions rather than acts of violence. Work was also ongoing to improve leadership skills within the organisation, which would set out expectations regarding values and behaviours.

Over 1,000 free text comments had been submitted from staff as part of the survey and a national analysis of themes was being prepared, which would

provide further insight into how staff were feeling following the first wave of the pandemic.

The Board supported more regular surveying of staff, particularly around the areas of improvement identified, recognising that things had changed since the survey was carried out six months ago and would continue to change.

5.9 Plan to Address Violence and Aggression against Staff

SHe and SHo joined the meeting for this item.

The Board noted the update on the progress made since the previous update in September 2020. This included closer working with Hampshire Constabulary, proposed changes to security arrangements, staff training and staff support. These plans aimed to reduce incidents of violence and aggression against staff and provide support to staff in the management of violence and aggression and following any incidents. The Board recognised that violence and aggression against staff would never be eliminated entirely as the Trust provided care to individuals with mental health issues, brain injuries, dementia and who lacked capacity who may find it difficult to control their behaviour. It was important, however, that violent and aggressive behaviour was challenged consistently when appropriate.

The Board supported the approach to exclude violent and aggressive individuals from the Trust when they repeatedly displayed unacceptable behaviour that it was not possible to manage through de-escalation, anticipatory care planning and the challenging behaviour protocol. While not formally approving the funding for the plans set out in the paper, the Board noted the importance of investment in this area in order to support staff. A further update on progress would be provided in December 2021.

5.10 Finance Report for Month 11

The finance report for month 11 was noted. The following areas were highlighted:

- the Trust has received the payments for the loss of other income, additional accruals of annual leave that staff had been unable to take due to the Covid-19 pandemic and the elective incentive scheme;
- the Trust remained on track to achieve a breakeven position for 2020/21 as did the other trusts in the Hampshire and Isle of Wight ICS; and
- the Trust's balance sheet position remained strong, which placed the Trust in a good position to address likely pressures in 2021/22.

6 CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

6.1 Register of Seals and Chair's Actions for ratification

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

ACTION: IH would follow up on the Wessex Clinical Research Network and the assisted conception service items in the paper as these were not single tender actions required to be reported in accordance with the Trust's Standing Financial Instructions.

6.2 Amendment to Constitution for CCG Merger

With effect from 1 April 2021, the individual Clinical Commissioning Groups

(**CCGs**) within Hampshire and the Isle of Wight were to merge to create a new NHS Hampshire, Southampton and Isle of Wight CCG. The Council of Governors (**CoG**) included an appointed governor from each of NHS Southampton City CCG and NHS West Hampshire CCG and as a result of the merger these two organisations would cease to exist.

It was proposed that the Trust should reflect the merger in the composition of the CoG, by amending the composition of the CoG in Annex 3 of the Trust's constitution to remove the Appointed Governor from each of NHS Southampton City CCG and NHS West Hampshire CCG and include an Appointed Governor from NHS Hampshire, Southampton and Isle of Wight CCG in their place. A separate review of the composition of the CoG would be undertaken as part of the annual review of the Trust's constitution to ensure that the overall composition of the CoG remains representative and reflected the changes to NHS governance structures.

DECISION: The Board approved the amendment to the Trust's constitution with effect from 1 April 2021, subject to the approval of the CoG at its meeting on 31 March 2021.

7 Any Other Business

There was no other business.

8 To note the date of the next meeting: 27 May 2021

9 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 for the Practice and Procedure of the Board of Directors, representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.

The meeting was adjourned.

University Hospital Southampton NHS Foundation Trust

List of action items

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 30/03/2021 5.5 Integrated Performance Report for Month 11				
426.	Caring - overnight ward moves	Byrne, Gail Peachey, Tim	27/05/2021	Pending
	Explanation action item GB would review the non-clinical reasons for overnight ward moves and provide an overview to the Quality Committee.			
427.	Caring - vulnerable women	Byrne, Gail Peachey, Tim	27/05/2021	Pending
	Explanation action item The Quality Committee would review the resourcing required to increase the percentage of vulnerable women on a continuity of carer pathway and update the Board.			
Trust Board – Open Session 30/03/2021 5.6 Inpatient Flow - Medically Optimised for Discharge Update				
428.	Trajectory for MOFD patients	Teape, Joe	27/05/2021	Pending
	Explanation action item JT agreed to include a trajectory for MOFD patients in the regular reports to the Finance and Investment Committee.			
Trust Board – Open Session 30/03/2021 5.7 Ockenden Review of Maternity Services				
429.	Patient story	Flaherty, Karen	31/03/2022	Pending
	Explanation action item KF to arrange a patient story from a patient using the maternity service at least once annually.			

University Hospital Southampton
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Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 30/03/2021 6.1 Register of Seals and Chair's Actions for ratification				
430.	Follow up	Howard, Ian	27/05/2021	Pending
	Explanation action item IH would follow up on the Wessex Clinical Research Network and the assisted conception service items in the paper as these were not single tender actions required to be reported in accordance with the Trust's Standing Financial Instructions.			

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Integrated Performance Report 2021/22 Month 1**			
Agenda item:	**5.5**			
Sponsor:	**David French, Chief Executive Officer**			
Date:	**27 May 2021**			
Purpose	**Assurance or reassurance Y**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	This report is intended to support the Trust Board in assuring that: • the care we provide is safe, caring, effective, responsive and well led in the context of the COVID-19 pandemic • at the same time we continue our journey toward our vision of World Class Care for Everyone.			
Response to the issue:	The Integrated Performance Report reflects the current operating environment and is aligned with the Care Quality Commission Key Lines of Enquiry.			
Implications: (Clinical, Organisational, Governance, Legal?)	This report covers a broad range of trust services and activities. It is intended to assist the Board in assuring that the Trust meets regulatory requirements and corporate objectives.			
Risks: (Top 3) of carrying out the change / or not:	This report is provided for the purpose of assurance.			
Summary: Conclusion and/or recommendation	This report is provided for the purpose of assurance.			

University Hospital Southampton NHS
NHS Foundation Trust

Integrated KPI Board Report

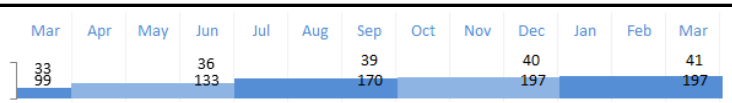
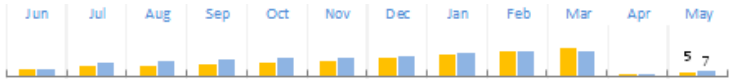
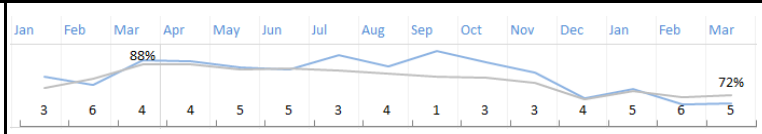
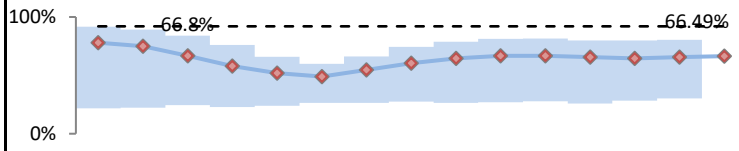
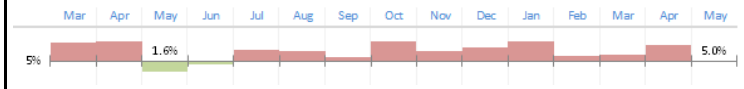
covering up to

April 2021

Sponsor - Andrew Asquith, Director of Planning, Performance and Productivity,
andrew.asquith@uhs.nhs.uk

Report Guide

University Hospital Southampton NHS
NHS Foundation Trust

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

Introduction

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

• Provide assurance that the care we provide is safe, caring, effective, responsive and well led in the context of the COVID-19 pandemic

• Ensure that at the same time we continue our journey toward our vision of World Class Care for Everyone.

We adjust / add to these indicators – informing the Board and keeping a comparative narrative – as the situation changes as we work through these unusual circumstances.
The structure of the report is currently being reviewed in order that it can better reflect the ambitions within 'Our Strategy 2025', and to support the strategic discussions of the Board.

April 2021 Summary

During April the direct impact of COVID-19 infections upon the Trust reduced further.
Patients with a confirmed COVID-19 diagnosis during their admission:

• Started the month at 48 (11 of which were in intensive care / high care)
• Finished the month at 24 (5 of which were in intensive care / high care)

The phased resumption of the elective admissions continued within NHS facilities, and the additional access to independent sector theatres and beds that had been secured by NHS England during the pandemic terminated at the end March.

Key aspects of performance for consideration this month include:

• The total number of patients on the RTT waiting list increased by over 1,000 patients to 37,613 in April. There are over 3,000 patients waiting over 52 weeks for treatment and over 500 patients waiting over 78 weeks. Our benchmarking confirms that we are continuing to perform well in comparison to our peer group.

• The crude mortality rate and Hospital Standardised Mortality Ratio (HSMR) both increased significantly in January (though HSMR remained significantly better than would be expected on average in the NHS). Patient details have been requested in order that the recorded diagnosis can be checked as a first step in investigation. It may be relevant that January saw a peak in COVID-19 occupancy.

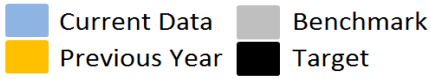
• UHS 62 day performance (RE 23) improved to 86.5% (better than our local target and the national target applying to the majority of 62 day pathways). UHS was the best performing trust amongst our 10 'peer' teaching hospitals in March.

• Emergency Department timeliness deteriorated slightly to 87% (RE 9) whilst remaining 3rd best amongst 8 benchmark trusts. Attendance numbers increased further to the highest levels since the COVID-19 pandemic started (RE 8).

• Elective spell volumes (excluding daycases, at SGH/PAH only) (RE 13) recovered further, yet remained below those in Autumn 2020. Two SGH theatres are currently closed due to building works and are due to reopen in June.

• The total number of patients on the RTT waiting list increased by over 1,000 patients this month. The cohort of patients who have waited over 52 weeks (RE 16) reduced by over 300 patients, whilst those waiting over 78 weeks (RE 17) increased by over 100 patients. We remain concerned by this situation and are focussed on improving the situation as soon as possible for our patients. Our benchmarking (in a group of 20 Teaching hospitals) confirms that we are continuing to perform well in comparison to our peer group.

• Cancer performance measures for March indicate continued improvement in performance:
o UHS 62 day performance (RE 23) improved to 86.5% (better than our local target and the national target applying to the majority of 62 day pathways). UHS was the best performing trust amongst our 10 'peer' teaching hospitals again this month.
o 31 day performance (RE 24) was maintained above the target at 97.6%.



RESPONSIVE

		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target
RE1	Non-elective Spells (discharged, including CDU)			4,128												6,292	-
RE2-L	Non Elective LOS - Rolling 12 months (Solid) Monthly (Dashed)			6.49												5.45	-
RE3	Number of inpatients that were medically optimised for discharge (monthly average)			76												122	-
RE4-N	Longer LOS Census average (Patients with LOS >=21days)	203.38	160.86	118.33	73											145	-
RE5-I	Adult midday bed occupancy	98.2%	84.6%	71.1%	82.6%											79.0%	90-95%
RE6	Last minute cancelled operations not readmitted within 28 days			40												6	-
RE7	Last minute cancelled operations			5												35	-

Current Data Benchmark
Previous Year Target

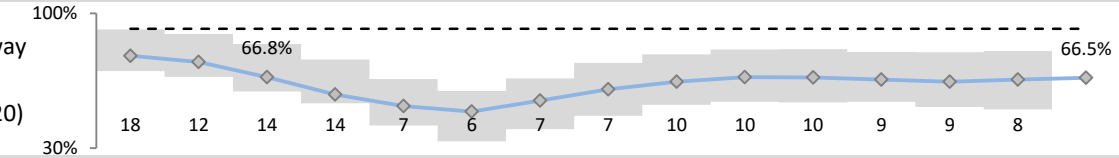
RESPONSIVE

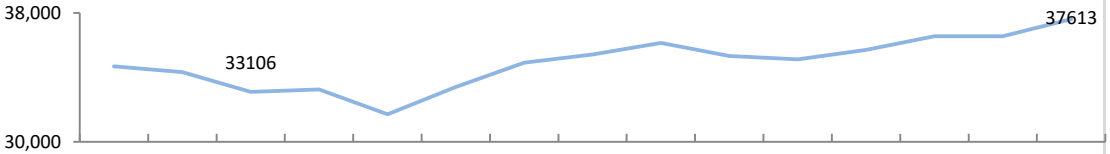
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	QTD	Q target
RE8	Total ED Attendances	12,000		5735												10663	-	-
		5,000																
RE9-N	Patients spending less than 4hrs in ED - SGH Main ED (Type 1 and UCH)			90.2%												87.2%	87.2%	95%
	Major Trauma Centres (Type 1)	92%														81.30%		
	Rank of 8->	84%																
		76%																
		5	3	2	5	3	3	4	2	2	1	1	1	2	3	3		
RE10-N	Patients spending less than 4hrs in ED - UHS Total (includes SGH all types)			91.1%	91.1%											88.0%	88.0%	95%
		92.22%																
		85.5%																
		78.82%																
RE11-N	Total time spent in ED - Percentiles UHS Total			90th, 4:00												90th, 4:59	-	-
				Mean, 2:45												Mean, 3:04		
RE12	Accepted Referrals (excluding -initiated by consultant responsible)	27,000		8,013												19,100	-	-
		0																
RE13	Elective spells (excluding daycase, onsite SGH/PAH only)	2,000		446												1,438	-	-
		0																

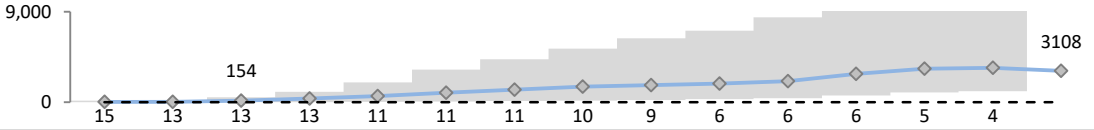
Current Data
Previous Year
Benchmark
Target

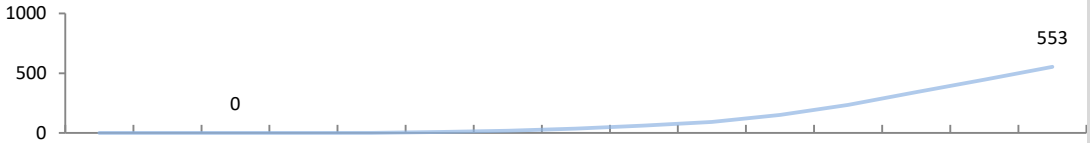
RESPONSIVE

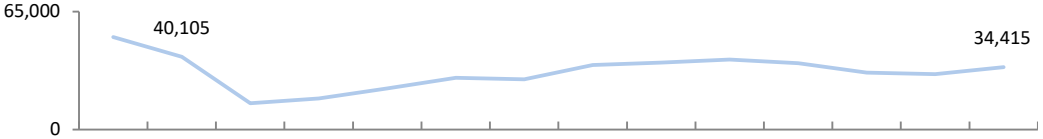
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Target
RE14-N	% Patients on an open 18 week pathway (within 18 weeks) with teaching hospital min-max range and rank (of 20)	18	12	14	14	7	6	7	7	10	10	10	9	9	8		>=92%
RE15-N	Total number of patients on a waiting list (18 week referral to treatment pathway)																
RE16-N	Patients on an open 18 week pathway (waiting 52 weeks+) with teaching hospital min-max range and rank (of 20)	15	13	13	13	11	11	11	10	9	6	6	6	5	4		
RE17	Patients on an open 18 week pathway (waiting 78 weeks+)																
RE18	Face to face outpatient attendances																-
RE19	Non-face to face outpatient attendances																-
RE19 - Latest month is awaiting approx ~3k outpatient attendances to be reported																	
RE20-N	Average weeks waited for first outpatient appointment																-

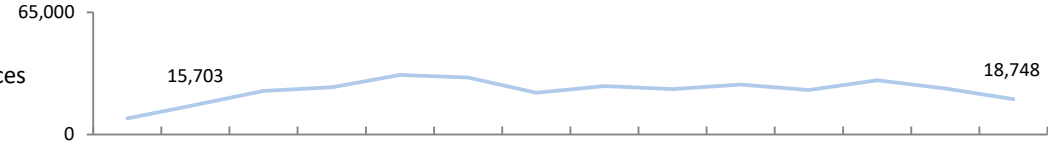


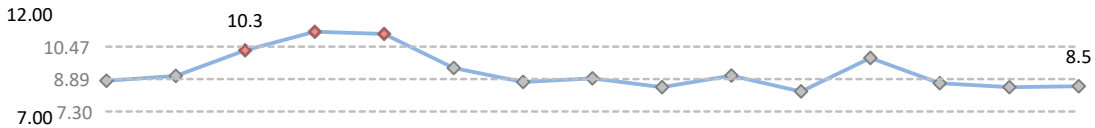












Current Data | Benchmark
Previous Year | Target

RESPONSIVE

		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Target /Apr	Patients to recover target	QTD
RE21-N	Patients waiting for diagnostics			4317											9563	-		
RE22-N	% of Patients waiting over 6 weeks for diagnostics with teaching hospital min-max range and rank (of 20)	12	10	3	7	7	9	13	14	14	11	12	9	10	10		<=1%	
RE23-N	62 day Performance Benchmark (data reported nationally at due dates, combined metric - standard/screening/upgrade) Teaching Hospitals vs. UHS Total Rank(of 10)->	6	5	3	1	1	1	1	1	5	7	4	2	1	1	N=> 90% L=> 85%	N = 7 L= 0 of 197	80%
RE24-N	31 day cancer wait performance (Latest data held by UHS, Combined measure – First and Subsequent Treatments of Cancer)			92.2%											97.6%	N=> 96%	N=0 of 948	97.41%
RE25-N	Snapshot of waits > 104 days (from referral on a 62 day pathway)	27	29	11	25	36	17	9	11	25	24	17	13	16	22	-	-	-
RE26-N	28 Day Faster Diagnosis			82.7%											87.5%	=>75 %	-	84.16%

Current Data | Benchmark
Previous Year | Target

RESPONSIVE

		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	QTD
RE27	My Medical Record - UHS patient logins	5,566														18,182	-	-
RE28	Number of Estates Help desk requests and percentage completed on time	997														1,592	-	-
		89.6%														84.7%	>85%	86.2%
RE29	Elective inpatient activity - % of same month pre COVID-19	35.3%														90.4%		
	UHS															85.1%		
	Corporate peer average																	
	Rank-->	3	3	2	2	2	2	2	1	1	4	4	2					
RE30	Non-elective inpatient activity - % of same month pre COVID-19	66.6%														95.0%		
	UHS															95.42%		
	Corporate peer average																	
	Rank-->	5	3	4	4	2	2	2	3	2	2	5	4					
RE31	1st outpatient attendances - % of same month pre COVID-19	51.7%														96.2%		
	UHS															93.77%		
	Corporate peer average	47.20%																
	Rank-->	2	2	2	2	2	2	2	2	2	2	2	3					
RE32	Follow up outpatient attendances - % of same month pre COVID-19	70.3%														108.9%	-	-
	UHS															102.8%		
	Corporate peer average	63.6%																
	Rank-->	6	3	2	2	1	1	2	2	1	1	4	5					

RE29-32 corporate peers group size = 7

Current Data | Benchmark
Previous Year | Target

SAFE

- Only a single case of probable hospital associated COVID-19 acquisition >7 days occurred in April (SA 6).
- Our measure related to pressure ulcers was amended this month to distinguish between category 2 and 3 ulcers, regardless of level of 'harm' (SA 7/8).

		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Target	YTD	YTD target
SA1-N	Cumulative Clostridium difficile				14 11	19 15	24 18	27 32	30 39	35 43	42 50	48 52	54 55	60 57	70 63	5 7	5	7	<=5
SA2	MRSA bacteraemia																0		
SA3	Clinical cleaning scores for very high risk areas																98	-	-
SA4	Serco cleaning scores for very high risk areas																98	-	-
SA5	**Healthcare-acquired COVID infection**: COVID-positive sample taken >14days after admission (validated)																0	0	-
SA6	**Probable hospital-associated COVID infection**: COVID-positive sample taken >7 days and <=14 days after admission (validated)																0	1	-
SA7	Pressure ulcers category 2 per 1000 bed days																-	-	-

Current Data
Previous Year
Benchmark
Target

SAFE

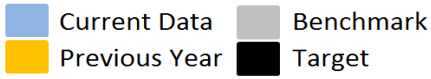
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Target	YTD	YTD target
SA8	Pressure ulcers category 3 and above per 1000 bed days	0.32														0.36	-	-	-
SA9-N	Medication Errors (severe/Moderate)	1														1	<=3	1	<=3
SA10	Antibiotic usage per 1000 admissions	8,015														4,309			
SA11	Serious Incidents Requiring Investigation (SIRI) (based upon month reported as SIRI)	1														5	-	90	-
SA12	Number of high harm falls (omissions in care)	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	-	2	-
SA13	% patients with a nutrition plan in place															95.1%	-	-	-
SA14	Red Flag staffing incidents			2												15	-	-	-
SA15	Number of statutory and mandatory maintenance jobs planned and percentage completed on time			128												213			
		100.0%		96.4%												93.4%	>95%	-	>95%

Current Data
Previous Year
Benchmark
Target

• Inpatient feedback (CA 1) continues to be good and significantly better than target.

• Maternity patient negative feedback (CA 2) continues to be worse than target; 6.6% compared to the target of <=5%. Performance will continue to receive close monitoring. We expect national data to be available to enable benchmarking in the near future.

• The measurement of the percentage of patients with a disability/additional needs reporting that those needs/adjustments were met (CA 11) has been corrected for an omission this month. In previous months one of the surveys that ask this question and combine to form the measurement had been omitted from the calculation. The resulting percentage scores have not changed significantly.



CARING

		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target
CA1-N	FFT Negative Score - Inpatients	5%		0.8%												0.6%	<=5%
CA2-N	FFT Negative Score - Maternity	5%		#N/A												6.6%	<=5%
CA2-N - please note the questions asked in the Maternity FFT changed in April 2020 so performance will not be comparable.																	
CA4-L	Complaints per 1000 units	1.30		0.2												0.3	<1.2
		0.00															
CA5-L	% Complaints closed within 35 days	80%		100.0%												72.4%	>=70%
		0%															
CA6	Total UHS women booked onto a continuity of carer pathway	100%														41.5%	
		0%															
CA7	Total BAME women booked onto a continuity of carer pathway	100%														65.6%	
		0%															

Current Data
Previous Year
Benchmark
Target

CARING

		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target
CA8	Total vulnerable women (living within 10% most deprived decile) booked onto a continuity of carer pathway															40.0%	
CA9	% Patients reporting being involved in decisions about care and treatment			86.0%												85.0%	>=90%
CA10	% Patients reporting finding somebody to talk to about worries and fears			97.0%												93.0%	>=90%
CA11	% Patients with a disability/ additional needs reporting those needs/adjustments were met (total number questioned included at chart base)	30	165	81.0% 39	57	153	215	133	164	174	178	240	77	63	110	89.0% 289	>=90%
CA11 - Performance is a scored metric with a "Yes" response scoring 1, "Yes, to some extent" receiving 0.5 score and other responses scoring 0.																	
CA12	Overnight ward moves with a reason marked as non-clinical (excludes moves from admitting wards with LOS<12hrs)			10												29	-
CA13	Total nursing staff all inpatient areas - Care hours per patient day (CHPPD)			16.8												10.8	-

Current Data
Previous Year
Benchmark
Target

EFFECTIVE

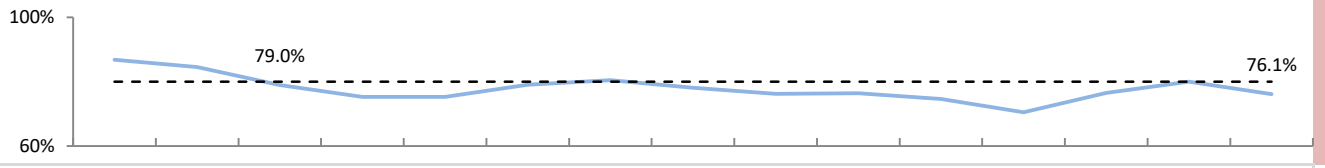
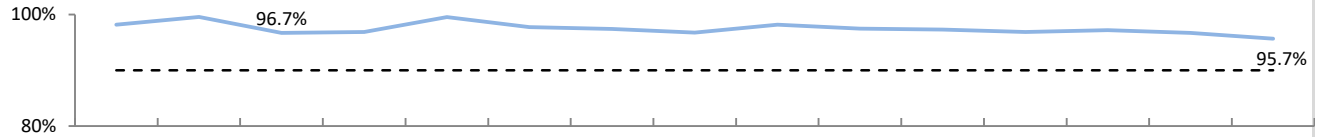
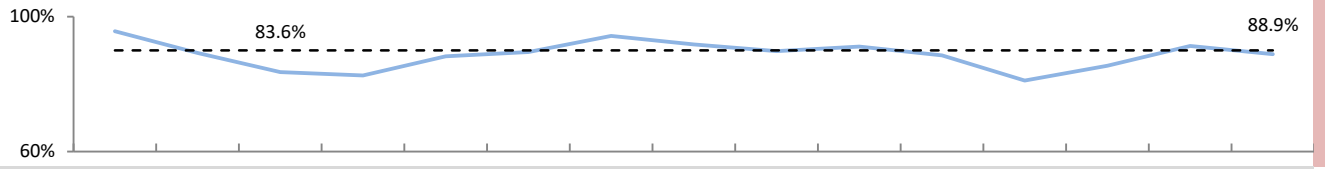
• The crude mortality rate (EF 4) and Hospital Standardised Mortality Ratio (HSMR) (EF 3), both increased significantly in January (though HSMR remained significantly better than would be expected on average in the NHS). More deaths than 'expected' are reported in General Medicine, Respiratory Medicine and Medicine for Older People, with a primary diagnosis of 'viral infection'. Information for 97 patients has been requested in order that the recorded diagnosis can be checked as a first step in investigation.

• Measures relating to patients screened for smoking and harmful alcohol consumption (EF 5), with those found to smoke and given brief advice or a medication offer (EF 7), stalled in their recovery following the COVID-19 peak in January and are currently slightly below target.

		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target
EF1-L	Cumulative Specialities with Outcome Measures Developed	255	53			54			56			56			57		+1
EF2	Developed Outcomes RAG ratings	80%				81%			79%			77%			76%		-
EF3-N	HSMR - UHS HSMR - SGH														82.2 81.5		<100
EF4	HSMR - Crude Mortality Rate														3.0%		-

Current Data
Previous Year
Benchmark
Target

EFFECTIVE

		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target
EF5-N	Percentage of patients screened for alcohol and smoking																>80%
EF6-N	% patients screened & found to have either moderate or high alcohol dependence given advice or referral																>90%
EF7-N	% patients screened & found to smoke given brief advice or a medication offer																>90%

Current Data
Previous Year
Benchmark
Target

WELL LED

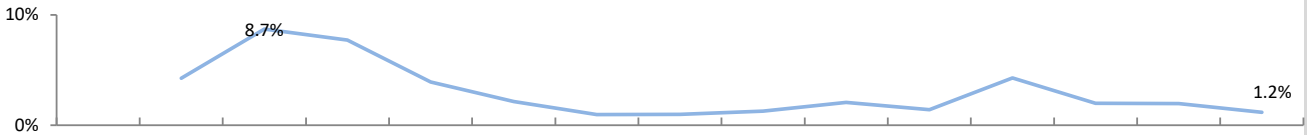
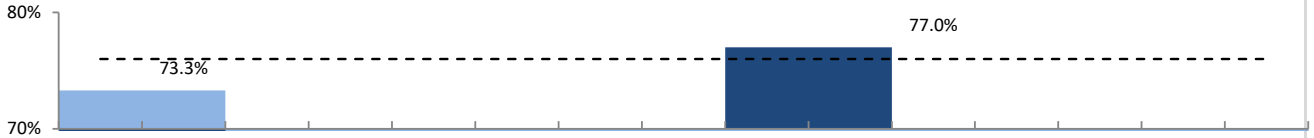
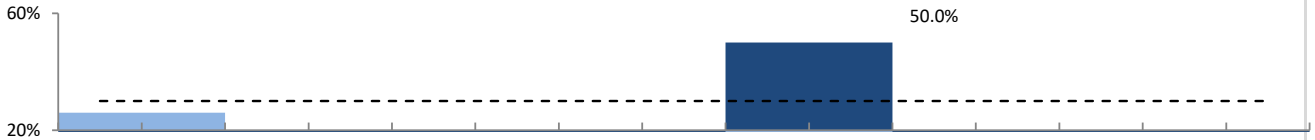
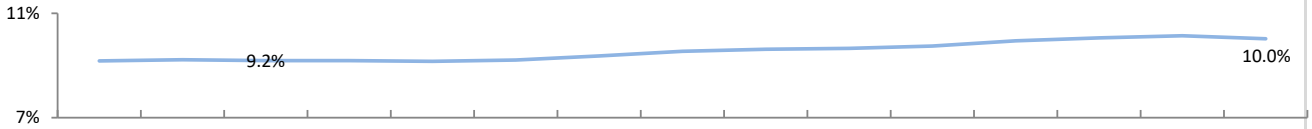
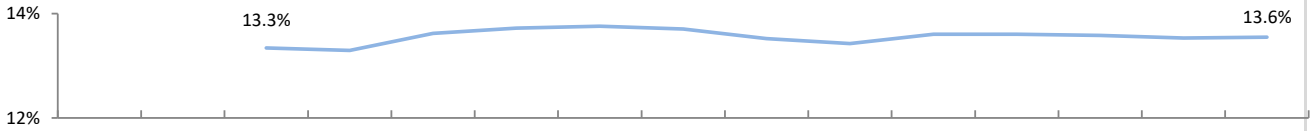
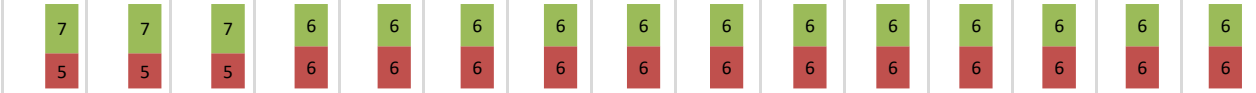
• Non-medical appraisal rates (WL 2) have continued their modest rate of recovery to 81%, but still remain significantly below the target of 92%.

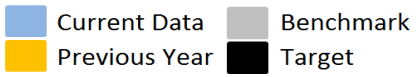
• Overall sickness absence (WL 6) reduced to 3%, which is within target, whilst COVID-19 related absence (WL 7) reduced to 1% of employed time during the month of April.

		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly Target
WL1-L	Substantive Staff - Turnover	13.83%		13.4%												12.3%	<=12%
		12.92%															
		12.22%															
WL2-L	Staff - Non-medical appraisals completed - Rolling 12-months			77.7%												81.2%	=>92%
		70%															
WL3-L	Staff - Medical appraisals completed - Rolling 12-months	100%														95.0%	
				73.2%													
		0%															
WL4-L	Staff vacancies	20%															
				5.9%												3.4%	
		0%															
WL5-L	Nursing Vacancies (registered nurses only in clinical wards)	20%														12.4%	
				8.4%													
		0%															
WL6-L	Staff - Sickness absence (total expressed as a percentage)	7.50%		5.8%													<=3.4%
		4.45%														3.0%	
		3.7%															
		3.04%															
		2.50%															

Current Data Benchmark
Previous Year Target

WELL LED

		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly Target
WL7	Staff – Absence related to Covid-19 sickness or self-isolation (expressed as a percentage of all employed hours)																
WL8-L	% of staff recommend UHS as a place to work: UHS Quarterly staff FFT National NHS Staff Survey																>=76%
WL9-N	Response rate of - staff recommend UHS as a place to work: UHS Quarterly staff FFT National NHS Staff Survey																30%
WL10-L	% of Band 7+ staff who are Black and Minority Ethnic																15% by 2023
WL11	% of Band 7+ Staff who have declared a disability or long term health condition																-
WL12- QI training programme, and reporting, is currently temporarily suspended as team members support urgent change programmes as part of our Covid 19 response and recovery																	
WL12-L	Statutory & Mandatory Training Achieving Target																-
WL13-L	Number of Apprenticeship Starts																-



WELL LED

		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target
WL14-L	Comparative CRN Recruitment Performance by clinical specialty		56%			52%			28%			36%			40%		>=70.0%
WL15-L	Comparative CRN Recruitment Performance - weighted		5			2			2			7			8		Top 5
WL16-L	Comparative CRN Recruitment - contract commercial		13			13			17			7			2		Top 10
WL17-L	Proportion of studies closing in FY on time and to recruitment target - non-commercial		88%			50%			43%			45%			42%		>=80%
WL18	NIHR CRF & BRC cumulative quarterly publications	600															
		0				137 120			246 261			329 424			452 562		

Current Data
Previous Year
Benchmark
Target

Changes and Corrections

Section	KPI	KPI Name	Type	Detail
Responsive	RE29-32	Activity metrics - % of same month pre COVID-19, UHS and corporate peer average	change	metrics previously looked at same month in the previous year however from March 2021 that would be comparing with activity during the COVID-19 pandemic. Metrics adjusted to look at pre-COVID-19 period (March 2019 - Feb 2020)
Safe	SA7	Pressure ulcers category 2 per 1000 bed days	change	Metric for pressure ulcers "Number of pressure ulcers causing severe/moderate harm" has been replaced by these 2 metrics.
Safe	SA8	Pressure ulcers category 3 and above per 1000 bed days	change	
Caring	CA11	% Patients with a disability/ additional needs reporting those needs/adjustments were met (total number questioned included at chart base)	correction	One survey was missing 'tags' used to amalgamate figures for this metric, this has now been resolved causing an uplift in the number of responses in this metric
Caring	CA14	Same Sex Accommodation (Non Clinically Justified Breaches)	removal	Metric removed from the report, no longer measured

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Equality and Diversity Update – WRES and WDES**			
Agenda item:	**5.6**			
Sponsor:	**Steve Harris – Chief People Officer**			
Author:	**Gemma Genco – Head of Equality, Diversity and Inclusion**			
Date:	**27 May 2021**			
Purpose	**Assurance or reassurance** X	**Approval**	**Ratification**	**Information**
Issue to be addressed:	It is well documented that the experience of black and minority ethnic staff, and staff who have a disability is less favourable than white and non-disabled comparators. To deliver our aspiration of World Class Care for all, one of our Trust Corporate Goals is to drive towards being an expert and inclusive employer. In addition to a strong research base evidencing the benefits of Workforce inclusivity to organisational performance and patient care, it is a moral imperative to address any societal and structural disadvantage faced by minority groups. The NHS introduced a set of standard measures to measure progress in this area. The Workforce Race Equality Standard (WRES) was first introduced in 2014 and has been an annual reporting requirement for all NHS Trusts. In 2019 the Workforce Disability Equality Standard (WDES) was also introduced to collect similar metrics measuring the experience of disabled staff. This report summarises our current position and progress against the action plans co-produced with the Staff Networks to address the findings the data highlighted. In addition the report includes an update on of progress across equality, diversity and inclusion over the past few months.			
Response to the issue:	How is the data collected? The WDES and WRES data is collected using the 2019 Annual Staff Survey results, and by analysing our employment records on ESR and our data collected on recruitment and shortlisting. Key findings: • The experience overall of disabled and BAME staff is less favourable than white and non-disabled comparators. • There has been a significant growth in disclosure of disabilities and long term conditions due to the efforts to protect staff during COVID. Staff registered on ESR has grown from 3.1% to 14.8% of staff (355 to 1750).			

	• There is under representation of staff in BAME backgrounds at senior bands, although there has been growth. There is under representation of BAME colleagues in senior medical positions in the Trust. • Both disabled and BAME staff are less likely to be shortlisted and appointed to roles than white and non-disabled comparators. • BAME and disabled staff face higher levels of discrimination, abuse and harassment from patients, services users and staff than comparator colleagues. • BAME staff are less likely to enter formal disciplinary processes than white colleagues. • Disabled staff are less likely to enter formal capability processes than non-disabled colleagues. **Our response** To deliver on the co-produced action plans whilst applying an organisational development approach to develop a better culture of inclusion and inclusion for all staff, but especially so for minority or seldom heard groups.
Implications: (Clinical, Organisational, Governance, Legal?)	The following implications should be noted: • **Culture** - Requirement to ensure inclusivity and belonging becomes a central focus of the implementation of the UHS response to the NHSi People Plan. To ensure it is a central tenant to the launch of a cultural review and the subsequent activities to support development of identified gaps. • **CQC** - To note that the CQC well led domain, and achieving outstanding, requires excellence to be demonstrated in this field. It is likely the CQC will increase their scrutiny of Diversity and Inclusion activities when conducting inspections. • **Governance** - Ensuring inclusivity becomes core in our organisational governance will be key. The plan proposes to ensure this is reviewed as part of our performance management processes within Divisions, Care Groups and through Divisional Governance. Provision and analysis of data at local level will be important to achieve this. • **WRES/WDES** - NHS Trusts are required to submit data against the Workforce Race Equality Standard (WRES) and Workforce Disability Standard which measures improvements on race inclusivity in the workforce. This will form the basis UHS will use to measures its success. • **Diverse voice** - UHS will look for opportunities to ensure diverse thought is included in decision making. The Lead for the BAME Network will become a standing member of People and OD Committee. • **Legal framework** - UHS must continue to ensure it complies with its legal duties under the Equalities Act (2010).

Risks: (Top 3) of carrying out the change / or not:	Inability to recruit, develop and train a diverse and inclusive workforce that is necessary to meet our strategic goals To improve our staff satisfaction survey results further, action on the staff experience and perception with regards to equality and diversity is imperative.
Summary: Conclusion and/or recommendation	Whilst the Committee should be assured that good progress is being made against the action plans, support for the following is being requested to ensure that all actions are met with maximum impact: • Provide continued commitment to the plans and work to support the delivery. • To remain committed to support the promotion, engagement and discussion of the issues at Corporate and Divisional level. • To champion success stories. • To continue to support staff to attend network events

Executive Summary

The past year has been momentous in terms of equality, diversity, and inclusion as the impact of the global events of the Covid-19 pandemic and George Floyd's death (Black Lives Matter) brought into stark reality the inequalities that exist within our communities and workplaces. It has acted as a catalyst to reflect on our progress to date and look deeply and honestly into those areas where we must do better.

The Networks gained their voices during the past year, trusting and engaging with Senior Leaders to help us understand where and why inequalities lie, to share lived experiences of working at UHS to help inform the action we needed to take as a matter of urgency. Action plans were co-produced and approved at Trust Board with a renewed commitment from senior leaders to do more, to pursue the sense of belonging that the pandemic has created that we've not felt in quite the same way before.

The action plans are underpinned by the WRES and WDES data which will help us to monitor our progress in shifting the culture of inclusivity and belonging, in increasing our representation and hearing diverse voices whilst protecting the health and wellbeing of our staff.

The executive team and senior leaders are also growing their links with LGBTQ+ network group, with participation growing from their voices in key UHS meetings.

There has been significant progress during the last year, however the challenge of improving our inclusion and belonging across the Trust remains a critical priority with much more work to do.

1.0 Background

1.1 Drawing on the unprecedented experience of the pandemic and the WRES/WDES results the Trust co-produced these action plans with both the One Voice (BAME) staff network and the Longterm Illness and Disability (LID) Staff Network. The full plans are in appendix B and C.

1.2 In October, this Committee and Trust Board agreed/approved the following 3 key ambitions in relation to equality, diversity and inclusion over the next 3 years

- A shift in our culture to increase staff experience, inclusivity and belonging, and shifting this to core business of our day to day management of Trust business
- Growing and nurturing talent to grow representation in leadership positions, and ensuring diverse voice in running the Trust
- Protecting the health and wellbeing of our staff through reductions in bullying, harassment, and aggression experienced

1.3 To help us accomplish these ambitions the actions plans are based around 8 core themes:

- Leadership from the top
- Developing our culture
- Embedding into our governance
- Increasing capacity to lead change
- Nurturing talent and creating opportunity
- Growing leaders from within medical pathways
- Protecting our staff from discrimination and abuse
- Supporting wellbeing

1.4 This paper provides an overview of our progress against these themes.

2.0 WRES and WDES Overview

2.1 Workforce Race Equality Standards (WRES)

2.1.1 The table below indicates how UHS performed against the national Trust average in 2020. You will note that UHS compares favourably with the national Trusts average. However we are not within the top performing Trusts and must also acknowledge that for indicators 2, 5 and 8 we have scored lower than in the previous year. Actions to redress this were included in the co-produced action plan in September.

2.1.2 One notable success is the Trust's continued progress to improve the number of BAME staff in Band 7 and above posts. As at 1st April 2021, 10% of BAME staff were in these bands, equating to around a 1% year on year rate of improvement.

Table 1.

WRES Indicator	NHS Trust average 2020	UHS 2019	UHS 2020	above/below NHS Acute Trust average
1: Percentage of staff in all Bands	21%	17.7%	19.19%	
2: Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants	1.61	1.09	1.17	
3: Relative likelihood of BME staff entering the formal disciplinary process compared to white staff	1.16	0.85	0.68	
4: Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff	1.14	0.94	0.89	
5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	27.9% - White 30.3% - BME	24% - White 25% - BME	25.5% - White 28.0% - BME	
6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	23.6% - White 28.4% - BME	22% - White 28% - BME	21.0% - White 25.7% - BME	
7: Percentage of staff believing that trust provides equal opportunities for career progression or promotion	86.9% - White 71.2% - BME	91% - White 74% - BME	91.3% - White 82.1% - BME	
8: Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	6.0% - White 14.5% - BME	6.0% - White 13% - BME	5.3% - White 15.4% - BME	
9: BME board membership	91.6% - White 8.4% - BME	84.6%- White 15.4% - BME	84.6% - White 15.4% - BME	

The national WRES report can be found here: https://www.england.nhs.uk/wp-content/uploads/2021/02/Workforce-Race-Equality-Standard-2020-report.pdf

2.2. Workforce Disability Equality Standards (WDES)

2.2.1. The national WDES Team are yet to publish their annual report for comparison. However, UHS has been cited on a number of occasions as an example of best practice in relation to significantly increasing declarations rates for staff with disabilities. UHS saw disability declarations rise from 3.1% in 2019 to 14.8% in 2020.

2.2.2. This is directly attributed to the successful Covid-19 risk assessment campaign encouraging increased disclosure and subsequently recording this on ESR. It would appear that this was a missed opportunity for most NHS Trusts and affords us an advantage of better knowledge of our staff with disabilities by which to undertake targeted interventions to improve experience for this staff group.

2.2.3. The 2020 staff survey results showed a significant ongoing gap in the LID staff compared to their counterparts. Extract from the Staff survey results are contained in appendix A.

2.2.4. A similar comparison to the WRES data will be included in the next submission to Trust Board once the national report is available which has been delayed.

3.0 Progress against the equality action plans

3.1 Below sets out a brief outline of the progress against the actions contained within the co-produced action plans which have been designed to improve the experience of our BAME staff and those with long-term illnesses and disabilities.

3.2 The plans contain the same 7 overarching themes, the impact of which will be measured by our performance against the WRES/WDES indicators in September 2021. It will also be measured through our 2021 National Staff Survey results.

3.3 Leadership from the top

3.3.1 To achieve greater inclusion in Trust decision making all Network leads are now installed as members of People related committees/boards, providing a representative voice in all people related decisions

3.3.2 The EDI committee has been reinstated with revised Terms of Reference. Progress against the action plans is monitored and held to account here. Executive and senior managers remain committed to regular dialogue with the Networks.

3.3.3 In addition some of the Executive team have taken it upon themselves to meet with staff across the Trust from minority groups to gain a better understanding of the experiences and the barriers they face. Senior leaders are also demonstrating their commitment to their own learning around EDI issues through online blogs and posts which are generating a wider conversation about EDI across the Trust with a notable shift in the culture of inclusion.

3.3.4 The Board and other senior leaders across the Trust have also actively committed to a reciprocal mentoring programme linked to the Inclusive Leadership programme. Feedback from both mentee and mentor on the whole is very positive with mentees reporting a productive support mechanism, particularly around career progression. Mentors are gaining an insight into the experiences of staff from minority groups.

3.3.5 Representatives from our network groups are embedded in key decision making structures at the Trust. They are standing attendees at the HR policy group, recruitment and retention group, UHS people board, EDI committee, and the People and OD committee (a formal committee of the Trust Board). Their voice helps shape strategy, policy and practice across the people agenda.

3.4 Developing our culture

3.4.1 The OD and Inclusion Team have started initiating a number of interventions that are beginning to influence a greater culture of belonging. Trust Board recently received 2 study sessions on inclusive leadership and actionable allyship which has challenged current ways of thinking and behaviours. This was phase 1 of a wider cultural intervention on actionable allyship, with phase 2 scheduled to commence from July.

3.4.2 The Trust's response to the pandemic on the whole has also driven this culture shift as new ways of working have enabled managers to have a much more holistic and compassionate approach to how they manage their teams.

3.5 Embedding into our governance

3.5.1 In April WRES/WDES data was introduced at Divisional Partnership Meetings and Divisional Management meetings. These will appear as a regular agenda item to encourage management teams to deep dive the data and develop action plans and appropriate interventions to respond to what the data shows.

3.5.2 This is a significant step forward in helping staff to understand the EDI agenda and is already having an impact on conversations and curiosity. Divisional Leads are seeking support from Head of EDI for support in interrogating and understanding data to design the next steps.

3.5.3 This is all an important step in making inclusion a core business metric in how systematically we judge our collective performance at all levels of the Trust.

3.6 Increasing capacity to lead change

3.6.1 An interim Director of OD and Inclusion has been in place since October 2020. An OD team has been established and went live as of January 2021. A substantive Director of OD and Inclusion has now been appointed and is due to start at the Trust in July.

3.6.2 The team is continuing establish and embed itself, whilst also recruiting additional members to complete the skills required to lead to change across the organisation. The team is working collaboratively with other teams such as Comms and Transformation to ensure our workstreams are aligned and support each other's work to successfully lead change.

3.7 Nurturing talent and creating opportunity

3.7.1 The Inclusive Leaders programme, delivered by People Opportunities is at a midway point. The programme provides for 2 cohorts (Bands 5/6, and Consultants and Band 7+) with the programmes running simultaneously. There are 5 Action Learning Sets from each cohort and participants have identified and are developing interventions that support the aims of the action plan.

3.7.2 Participants are also receiving additional support such as priority access to CV writing, application and interview preparation courses and their progress will be closely monitored. This new element of the programme coupled with the reciprocal mentoring is proving invaluable as several participants have secured promotions and secondment opportunities in addition to the soft skills they are developing.

3.7.3 The Staff Network leads have received a number of workshops from an EDI consultant, including Infrastructure and Leadership, Personal Power and Empowerment, Facilitating Conversations on Everyday Racism (and other isms). People Opportunities has also recently been commissioned to provide further developmental support for the network leads and their members that will support their sustainability and influence. The Trust has committed to providing funded protected time of 1 day per week for Network leads.

3.8 Growing leaders from within medical pathways

3.8.1 A series of focus groups have taken place with medical staff who are female and/or from minority ethnic backgrounds to explore the barriers to career progression. The issues raised ranged from a lack of knowledge about senior roles or career paths, balancing work and family life, not feeling fully included or valued by colleagues, lack of confidence in discussing/negotiating issues around pay.

3.8.2 Consideration is now being given as to how the Trust works towards removing these barriers and empowering medical staff to explore careers as senior leaders.

3.8.3 The Trust is developing a new approach to talent management and succession planning with an external partner. This will also focus on medical leadership, including how diverse talent can be identified and nurtured more effectively.

3.9 Protecting our staff from violence and aggression

3.9.1 There has been significant progress with activities that support protecting our staff. A new exclusion policy has recently been approved for patients (with capacity) that repeatedly act violently or aggressively. The No Excuse for Abuse campaign has been revamped and a task and finish group has been established to focus on:

- How we support reporting for discrimination based violence and aggression
- How we actually support staff
- How we deal with incidents in the moment

3.9.2 The Comms are set to imminently launch the Report and Support campaign that includes information and support hub for staff.

3.9.3 Other measures including additional security staff are being placed in our ED function.

3.10 Recruitment and Selection process

3.10.1 An external EDI Consultant conducted a review of the recruitment and selection process drawing primarily on the experiences of staff which identified the biases or barriers that they encountered.

3.10.2 Working with the recruitment and retention group and network leads, The HR team collaboratively developed changes to the process which were agreed at Trust Board in March. This included rules on transparency of advertisement, independence of panel members, quality of decision making, and use of selection mechanisms.

3.11 Supporting Wellbeing

3.12 The Trust introduced a Wellbeing Lead during the pandemic to lead and support the development of the numerous wellbeing interventions to support staff.

3.13 Wellbeing interventions have been numerous and include:

- A Shielding Staff Listening Group, providing connection, support and advice run mt the LID Staff Network
- Increased TRiM support, especially in response to reported violence and aggression incidents based on discrimination.
- Introduction of wellbeing conversations, Time to Think, Time to Share, Safe Space, specialist psychological support to help staff reflect on the past year and think about their wellbeing moving forward.
- Bespoke support for overseas staff joining the Trust, including buddying and Teams contact during the quarantine period and providing groceries deliveries.

3.14 The Networks have been regularly involved in dialogues around appropriate support for our staff from ethnic minorities to ensure cultural sensitivity and for staff with disabilities to ensure we acknowledge and provide support that is useful and appropriate to the range of positions people have found themselves as the result of their or family members disabilities.

3.15 During May a wellbeing pulse survey will be run. Basic demographic information will help to identify position on wellbeing, and particularly healing post COVID 19, of our diverse colleagues.

4.0 Other equality, diversity and inclusion updates

4.1 Gender Pay Gap

4.2 The overall gender pay gap at UHS has reduced to 24.76% from 26.57% in 2020. Jo Mountfield (Director of Education and Workforce) has also lead detailed analysis on composition of job plans for female and BAME consultants to look for variations and trends. No trends were found of concerns with regards to allocation of direct clinical care programmes activities, or supporting professional activities programmed activities.

4.3 Note was taken though on the impact and structure of the Clinical Excellence Awards scheme process. Whilst the application and distribution of awards has always been closely monitored at UHS, the construct of the scheme nationally, how awards are assessed, and the criteria for application may discourage female applications. The scheme is currently under national review in consultation with the BMA.

4.4 One Voice Staff Network – National recognition

4.4.1 Our One Voice Network has been identified nationally as a network which has positively developed. John Norton, Chair of the One Voice Network has been invited to speak at the NHSE/I National BAME Staff Network webinar to share the journey and learning as we become an increasingly inclusive employer.

4.5 Exemplar site on Covid Vaccinations

4.5.1 88% of our BAME staff have received a Covid vaccination, and the uptake was rapid from within diverse communities. This success has earned us recognition nationally as an exemplar site. A range of interventions including an informative communications campaign, Q&A sessions, attendance of trusted experts at the One Voice network meetings to address fears, providing choice on vaccinations, and sharing community communications led to this achievement.

4.5.2 The core COVID 19 vaccination team was multi-disciplinary and also diverse which strengthen the collaborative and engaging approach taken.

4.5.3 Our most vulnerable staff were prioritised to receive the vaccine first in December 2020 which included those with high COVID age and BAME staff on high risk pathways. Our media publications externally focused on BAME staff receiving the vaccine to support confidence internally and externally in these communities.

4.6 System Working / Turning the Tide

4.6.1 The Trust is actively supporting systems working on a number of EDI workstreams. In particular we are involved in developing and delivering on the NHSE/NHSISE Turning the Tide strategy.

5.0 Next Steps

5.1 Continuing delivery of our plans of action. Monitoring and measurement of all actions set out in the action plans will continue to take place through the EDI committee, with TEC, and Trust Board receiving assurance updates throughout the year.

5.2 The Chief Nursing Officer and Chief Medical officer are giving consideration to broaden our inclusion focus to include health inequalities. This will specifically look to understand how our diverse patient groups access our services, how waiting times distribute, and ultimately the quality outcomes they receive. It is aimed that analysis would be on the broadest possible basis taking into account deprivation in addition to ethnicity, age, gender etc.

5.3 Trust Board members are asked to take an active role in supporting our cultural change and to bring their teams with them on the journey. This includes continuing the focus on inclusion as a core aspect of performance governance within Divisional infrastructure.

5.4 Trust Board members are also asked to continue to support staff to engage in network events and meetings to ensure wideset possible engagement on the inclusion agenda.

5.5 Trust Board members are asked to continue reflecting on their own leadership behaviours and learning from the actionable allyship study sessions, actively starting, stopping or changing behaviours to role model inclusive behaviours.

Appendix A – WDES scores from 2020 staff survey

Workforce Disability Equality Standard	Demographic	UHS 2018	UHS 2019	UHS 2020	Acute and Acute&Community Trust Average 2020
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Non-Disabled	23.3%	25.0%	25.2%	24.5%
	Disabled	32.3%	30.8%	30.0%	30.9%
Percentage of staff experiencing harassment, bullying or abuse from manager in last 12 months	Non-Disabled	9.1%	8.0%	9.1%	10.8%
	Disabled	15.3%	15.8%	13.7%	19.3%
Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months	Non-Disabled	16.6%	16.4%	16.2%	17.8%
	Disabled	26.3%	24.6%	26.7%	26.9%
Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	Non-Disabled	45.4%	45.5%	46.9%	45.8%
	Disabled	50.8%	49.1%	49.6%	47.0%
Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	Non-Disabled	89.2%	90.7%	88.8%	86.3%
	Disabled	86.1%	85.4%	84.9%	79.6%
Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Non-Disabled	21.9%	18.9%	23.6%	23.4%
	Disabled	30.2%	31.2%	33.1%	33.0%
Percentage of staff satisfied with the extent to which their organisation values their work	Non-Disabled	56.0%	56.4%	54.9%	49.3%
	Disabled	46.8%	44.5%	42.7%	37.4%
Percentage of disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work	Disabled	81.5%	77.9%	79.8%	75.5%
Staff engagement score (0-10)	Non-Disabled	7.5	7.4	7.4	7.1
	Disabled	7.1	7.0	6.9	6.6

Appendix B

BAME Plan of Action 2020/21 (updated May 2021)

Area	Proposed Action	Executive Champion	Responsible officer	Deadline/ Status
Leadership from the top	**Clear Board Commitment** Board (CEO) to provide a clear public position statement on EDI (race), including an acknowledgment and apology that progress has not been sufficient despite efforts. The statement to outline actions the Board are committed to and actively working towards. Review and revise strategy and action plan in light of recent events and feedback.	Chief Executive Officer	Chief People Officer	Review Sept 2021 **In progress**
	Inclusion in Trust decision making Provide opportunities for Network Leads to attend senior leadership events and Trust Board. Standing invites for Network Leads to: • People and OD Sub Board Committee • UHS People Board • HR Policy Group • BAME representation at the Clinical Executive Group		Chief People Officer	**Achieved**
	EDI Committee Revise and reinstate post Covid-19 the EDI Committee (Chaired by (Interim) CEO)		Chief Executive Officer	**Achieved**
	Increased information on the issue Introduce a dedicated page on EDI related content in Core Brief providing updates, raising awareness of WRES, WDES etc., work of the Networks, sharing news and stories etc.		Chief People Officer (with Head of EDI)	Review September 2021 **In progress**

	Deliver on following themes identified from post Covid-19 Freedom To Speak Up BAME survey and WRES data: **1) Equal Opportunities and Recruitment**: The implementation and embedding of new recruitment practices. **2) Employee Relations**: Identify mechanisms and root causes of the disproportionality of BME staff experiencing discrimination, harassment, bullying and abuse. **3) Staff Experience**: Improve the day-to-day experience of working at the Trust for BME staff.		Chief People Officer Freedom To Speak Up Guardian	Review September 2021 **In progress**
	Ongoing dialogue and engagement Exec and Senior managers to commit to regular dialogue with the One Voice Network, i.e. monthly with option for extraordinary meetings as appropriate.		Chief People Officer	**Achieved and ongoing**
	Board mentoring programme Deliver a mentoring programme involving NEDs and Exec Team members. All participants on the 'Inclusive leaders' Senior Leadership Programme will be offered a Board level reciprocal mentor.		Chief People Officer (with Head of Leadership & Development	**Achieved**
Developing our culture	**Cultural Review** Complete a Trust-wide cultural review focusing on the gaps in creating a culture of inclusion, physiological safety and belonging.	Chief Nursing Officer	Chief People Officer	Review Sept 2021 **In progress**
	A trust wide conversation Initiate an organisation-wide conversation on inclusion, including a campaign to promote success and talent in BAME and other diverse groups Use high profile leaders (Clinical and managerial) to explain their support and champion the agenda.		Chief People Officer Director of Communications	Review Sept 2021 **In progress**

	Education Provide training and support for (White) Managers in developing confidence to have conversations relating to a staff member's (race) protected characteristic through Senior Leaders forum.		Chief People Officer Head of Leadership & Development	Review Sept 2021 **In progress**
	Understanding WRES Generate greater understanding of WRES and how to use it to bring about change, i.e. understanding and acting upon gaps in progression data for BAME groups – (use the WRES Expert more) – broken down to Divisional levels and lower where appropriate.		Chief People Officer Head of EDI (WRES Expert)	Review Sept 2021 **In progress**
	Training Review and revise EDI training offered to include greater presence in induction programme (corporate and online) of unconscious bias, bystander training, having difficult conversations with people with protected characteristics, challenging micro aggressions, exploring White privilege etc. Overhaul all leadership development programmes to ensure inclusive and compassionate leadership becomes the central thread for all our leaders at UHS.		Chief People Officer Head of EDI / Head of Leadership & Development	Review Sept 2021 **In progress**
Embedding into our Performance Management	**Divisional Performance Structure** Introduce inclusion into Executive Divisional and Care Group management performance meetings to ensure this receives appropriate process. Additional focus on direct intervention where inclusivity is failing to gain suitable traction.	Chief Operating Officer	Chief People Officer (with Head of EDI)	November 2020 **Achieved**

	Performance of our leaders Performance on inclusivity will be reviewed and included in our leader's appraisal process. This will include reviewing actions taken to drive improvements in staff experience, engagement and inclusivity for diverse groups. Increasing use of multi-source feedback on leaders, including approach to inclusivity and taking action where a leader falls short.		Chief People Officer (With Head of EDI)	
Increasing capacity to lead change	**Director of OD and Inclusion** Recruit to a Senior permanent position focusing on Organisational Development and Inclusion reporting to the Chief People Officer. Seek talent through national search.	Chief Financial Offer	Chief People Officer	Jan 2021 **Achieved**
	Short term capacity Secure short term external expert resource to increase capacity on EDI (BAME) agenda.			**Achieved**
Nurturing talent and creating opportunity	**Inclusive leaders programme** Launch cohort 3 of a revised Inclusive Management Programme. Programme to focus on Senior Leaders (Consultants and B7+) and aspiring leaders (Bands 5/6).	Chief Nursing Officer	Chief People Officer Head of Leadership & Development	**Achieved**
	Developing our Network Leads Clearly define Network roles and skill up Network Leads, i.e. provide mentoring and coaching, influential leadership skills, resilience training etc., and recognise their contributions as career development. Provide dedicated time for our Network Leads to support their capacity to lead.		Chief People Officer (with Head of Leadership & Development)	Review Sept 2021 **In progress**

	Unearthing talent Develop a process for identifying and enabling people to use hidden skills, knowledge and qualifications.		Head of Resourcing / Assistant Director of People	Incorporated within new Trust Talent Management process
	Developing talent Develop a talent pipeline/talent management plan to include stretch activities, i.e. secondments, shadowing, specialist training/quals, coaching and mentoring.		Head of Resourcing / Assistant Director of People	Review Sept 2021 **In progress**
	Deep dive equality review of the Recruitment and Selection process in partnership with diverse groups. Look at each stage and deliver on recommendations arising from focus group discussions.		Head of EDI	**Achieved and ongoing**
Growing leaders from within medical pathways	Develop a talent pipeline, talent scouting and talent management plan; implement career development conversations and planning to develop clear career pathways, particularly for senior medical talent.	Chief Medical Officer	Head of Resourcing / Assistant Director of People	Review Sept 2021 **In progress**
Protecting our staff from discrimination and abuse	**Urgent review of "No Excuse for Abuse Campaign"** • Raise the profile (Internal and external) of the No Excuse for Abuse/No Bystander Campaign underpinning it by policy and training. • Audit staff experience and expectations to develop appropriate actions which might include: - A review all of related policies to support no bystanding - A review of the incident reporting process and outcomes - Development of bystander role models/champions to actively drive the campaign - Design and pilot a training programme for conflict resolution and safe bystander intervention - Ensuring appropriate support is in place for victims and witnesses of abuse • Continue to work closely with staff and police to drive prosecution and convictions where appropriate.	Chief Operating Officer	Chief People Officer (with Head of H&S / Head of EDI)	Review Sept 2021 **In progress**

	• Explore and develop a strong position/process for managing abuse directed at staff that can, at the highest level, mean that patients are excluded from treatment (not including non-capacity and life or limb treatment).			
Supporting Wellbeing	Develop a culturally appropriate wellbeing support package for BAME colleagues to access when required (psych support etc.)	Chief People Officer	Staff Wellbeing Lead	Review Sept 2021 **In progress**
	Update Overseas Induction Programme to provide more tailored support, particularly during early settling in phase. Update staffnet pages to include more local orientation and settling in information.		Recruitment Team / Head of EDI	Review Sept 2021 **In progress**
	Develop restorative practices, including offering trauma training.		Head of Spiritual Care	Review Sept 2021 **In progress**
	Provide appropriate reassurance to BAME staff (addressing concerns recently highlighted) of preparedness in event of second wave of Covid-19.		Chief People Officer	**Achieved and ongoing**

Appendix C

University Hospital Southampton NHS Foundation Trust

Acting now – Changing the future – our LID Improvement Plan

Area	Proposed Action	Executive Champion	Responsible officer	Deadline
Leadership from the top	**Clear Board Commitment** Board (CEO) to provide a clear public position statement on EDI. The statement to outline actions the Board are committed to and actively working towards. Review and revise strategy and action plan in light of recent events and feedback.	Chief Executive Officer	Chief People Officer	Review Sept 2021 **In progress**
	Inclusion in Trust decision making Provide opportunities for Network Leads to attend senior leadership events and Trust Board. Standing invites for network leads to: • People and OD sub board Committee • UHS People Board • HR Policy Group • LID Group representation at the Clinical Executive Group		Chief People Officer	September 2020 **Achieved**
	EDI Committee Revise and reinstate post COVID 19 the EDI Committee		Chief Executive Officer	October 2020 **Achieved**
	Increased information on the issue Introduce a dedicated page on EDI related content in core brief providing updates, raising awareness of WRES, WDES etc., work of the Networks, sharing news and stories etc.		Chief People Officer (with Head of EDI)	Review Sept 2021 **In progress**
	Deliver on following themes identified from post COVID Freedom To Speak Up BAME survey and WRES data:		Chief People Officer Freedom To	Review Sept 2021 **In**

	1) **Equal Opportunities and Recruitment**: The implementation and embedding of new recruitment practices. 2) **Employee Relations**: Identify mechanisms and root causes of the disproportionality of disabled staff experiencing discrimination, harassment, bullying and abuse. 3) **Staff Experience**: Improve the day-to-day experience of working at the Trust for staff with disabilities.		Speak Up Guardian	**Progress**
	Ongoing dialogue and engagement Exec and Senior managers to commit to regular dialogue with the LID Group, i.e. bi-monthly with option for extraordinary meetings as appropriate. Review appraisal form to include a direct question about a person's disability and/or long term illness and the reasonable adjustments they may require.		Chief People Officer	Ongoing
	Reciprocal board mentoring Deliver a reciprocal mentoring programme involving NEDs and Exec Team members. All participants on the 'Inclusive leaders' Senior Leadership Programme will be offered a Board level reciprocal mentor.		Chief People Officer (with Head of Leadership & Development	December 2020 **Achieved**
Developing our culture	**Cultural Review** Complete a Trust wide cultural review focusing on the gaps in creating a culture of inclusion, physiological safety and belonging.		Chief People Officer	Review Sept 2021 **In progress**
	A Trust wide conversation Initiate an organisation-wide conversation on inclusion, including a campaign to promote success and talent in Disabled and other diverse groups Use high profile leaders (Clinical and managerial) to explain their support and champion the agenda.		Chief People Officer Director of Communications	Review Sept 2021 **In progress**
	Education Provide training and support for Managers in developing confidence to have conversations relating to a staff member's disability/long-term illnesses through Senior Leaders forums. Training should cover: - Access and reasonable adjustments, including inclusive recruitment practices - Sick leave and disability leave policy - Holding constructive conversations around Wellbeing during appraisals		Chief People Officer Head of Leadership & Development	Review Sept 2021 **In progress**

	- Career development and planning Appraisal training for Managers with a mandatory 2 year refresher to ensure career development and wellbeing questions are discussed appropriately. Overhaul all leadership development programmes to ensure inclusive and compassionate leadership becomes the central thread for all our leaders at UHS.			
	Understanding WDES Generate greater and wider understanding of WDES and how to use it to bring about change, i.e. understanding and acting upon gaps in progression data for disabled staff groups – broken down to Divisional levels and lower where appropriate.		Chief People Officer Head of EDI	Review Sept 2021 **In progress**
	Training Review and revise EDI training offered to include greater presence in induction programme (corporate and online) of unconscious bias, bystander training, having difficult conversations with people with protected characteristics, challenging micro aggressions etc.		Chief People Officer Head of EDI / Head of Leadership & Development	Review Sept 2021 **In progress**
Embedding into our Performance Management	**Divisional Performance Structure** Introduce inclusion into Executive Divisional and Care Group management performance meetings to ensure this receives appropriate process. Additional focus on direct intervention where inclusivity is failing to gain suitable traction	Chief Operating Officer	Chief People Officer (with Head of EDI)	Review Sept 2021 **In progress**
	Performance of our leaders Performance on inclusivity will be reviewed and included in our leaders' appraisal process. This will include reviewing actions taken to drive improvements in staff experience, engagement and inclusivity for diverse groups. Increasing use of multi-source feedback on leaders, including approach to inclusivity. Senior leaders to participate in "A day in the life of..." using this experience to influence and develop an inclusive leadership style.		Divisional Directors Head of EDI	

Increasing capacity to lead change	**Director of OD and Inclusion** Recruit to a Senior permanent position focusing on Organisational Development and Inclusion reporting to the Chief People Officer. Seek talent through national search.	Chief People Officer	Chief People Officer	Jan 2021 **Achieved**
Nurturing talent and creating opportunity	**Inclusive leaders programme** Launch cohort 3 of a revised Inclusive Management Programme with up to 25% of participants being drawn from staff with disabilities and long-term illnesses Programme to focus on Senior Leaders (Consultants and B7+) and aspiring leaders (Bands 5/6).	Chief Nursing Officer	Chief People Officer Head of Leadership & Development	Starting November 2020 **Achieved**
	Developing our Network leads Clearly define Network roles and skill up network leads, i.e. provide mentoring and coaching, influential leadership skills, resilience training etc., and recognise their contributions as career development. Provide dedicated time for our Network leads to support their capacity to lead.		Chief People Officer (with Head of Leadership & Development)	Review Sept 2021 **In progress**
	Unearthing talent Develop a process for identifying and enabling people to use hidden skills, knowledge and qualifications. Long term career planning for staff that are or will be facing a situation where they are unable to continue in their current career path/jobs.		Head of Resourcing / Assistant Director of People	Incorporated in new Trust Talent Management process
	Developing talent Develop a talent pipeline/talent management plan to include stretch activities, i.e. secondments, shadowing, specialist training/quals, coaching and mentoring. Support for staff with disabilities and/or long term illnesses in order to better prepare for the career and wellbeing appraisal conversation.		Head of Resourcing / Assistant Director of People	Eview Sept 2021 **In progress**
	Deep dive equality review of the Recruitment and Selection process in partnership with diverse groups. Look at each stage and deliver on recommendations arising from focus group discussions.		Head of EDI	October 2020 **Achieved**

Growing leaders from within medical pathways	Develop a talent pipeline, talent scouting and talent management plan; implement career development conversations and planning to develop clear career pathways, particularly for senior medical talent.	Chief Medical Officer	Head of Resourcing / Assistant Director of People	Review Sept 2021 **In progress**
Protecting our staff from discriminatio n and abuse	**Urgent review of "No Excuse for Abuse Campaign"** • Raise the profile (Internal and external) of the No Excuse for Abuse/No Bystander Campaign underpinning it by policy and training. • Audit staff experience and expectations to develop appropriate actions which might include: - A review all of related policies to support no bystanding - A review of the incident reporting process and outcomes - Development of bystander role models/champions to actively drive the campaign - Design and pilot a training programme for conflict resolution and safe bystander intervention - Ensuring appropriate support is in place for victims and witnesses of abuse • Continue to work closely with staff and police to drive prosecution and convictions where appropriate. • Explore and develop a strong position/process for managing abuse directed at staff that can, at the highest level, mean that patients are excluded from treatment (not including non-capacity and life or limb treatment).	Chief Operating Officer	Chief People Officer (with Head of H&S / Head of EDI)	Review Sept 2021 **In progress**
Supporting Wellbeing	Develop an appropriate wellbeing support package for disabled colleagues to access when required (psych support etc.)	Chief People Officer	Staff Wellbeing Lead	Review Sept 2021 **In progress**
	Develop a protocol and guidance for managers to better support staff shielding and/or working from home which will include: - Regular contact (Individually and included in team meetings/events) - Provision of essential equipment to work from home - Inclusive conversation around redeployment, changes to work patterns and environment, medical suspension		Staff Wellbeing Lead / Head of EDI / LID Group Leads	Review Sept 2021 **In progress**
	Provide reassurance to Disabled staff, addressing concerns recently highlighted and lessons learned of preparedness for the second wave of Covid-19.		Chief People Officer	Ongoing

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Gender Pay Gap Reporting 2020**			
Agenda item:	**5.7**			
Sponsor:	**Steve Harris, Chief People Officer**			
Author:	**Kirsty Durrant, Strategic HR Projects Manager**			
Date:	**27 May 2021**			
Purpose	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	All organisations with over 250 employees are required to produce their gender pay gap data, with a snapshot date of 31st March 2020. This is to be published on an external website, and through the government portal, by 30th September 2021. Trust Board are asked to consider the data contained in the report, and the reason for the gender pay gap at UHS.			
Response to the issue:	UHS remain committed to continuing its programme of equality, diversity and inclusivity. Nationally, the continued growth of entry of females into the medical profession will drive a change in the overall composition of the medical workforce, and subsequently close the gender pay gap over time. Locally, UHS continue to consider how it attracts candidates to all roles, seeking diverse talent to senior managerial roles, and monitoring the fair distribution of local CEAs.			
Implications: (Clinical, Organisational, Governance, Legal?)	UHS have a legal duty to report their gender pay gap data annually.			
Risks: (Top 3) of carrying out the change / or not:	The importance of ensuring a diverse and inclusive organisation is fully recognised and embraced by UHS, and continued monitoring of the gender pay gap is one of many mechanisms used to ensure this remains the case.			
Summary: Conclusion and/or recommendation	Trust Board are asked to support the publication of this data, and continue to support ongoing actions to address the gender pay gap.			

Background

All organisations with over 250 employees are required to produce their gender pay gap (GPG) data, with a snapshot date of 31st March 2020. This is to be published on an external website, and through the government portal, by 30th March 2021. This is a statutory annual requirement and employers that fail to report on time or knowingly report inaccurate data will be in breach of the regulations, leading to legal action from Equality and Human Rights Commission. The publication of the 2020 data will be the fourth year that UHS have been required to report this data. This information has been calculated in accordance with the requirements of the gender pay gap regulations.

The gender pay gap is the difference between the average pay of men and women, expressed as a percentage. The gender pay gap is different from equal pay. Equal pay is concerned with pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

Nationally, the gender pay gap has persisted for many years and while the gap has been closing, overall progress has been, and remains, very slow. The Government had introduced these reporting requirements to try and improve the rate of progress in closing this pay gap. There are many factors which contribute to, or cause, a gender pay gap, and these will vary between different employers. Some relate to wider society, such as the type of career choices men and women have typically tended to make, and some may be specific to the particular organisation.

UHS Results

The overall gender pay gap at UHS has reduced to 24.76% from 26.57% in 2020.

It is important to consider societal influences on healthcare, with UHS having a workforce profile of 74.6% female & 25.4% male. For the 2020 snapshot date, UHS also intend to carry out local ethnicity pay gap reporting, which will provide insight and transparency in this area.

For agenda for change staff the gender pay gap was 0.59%. For medical staff the gender pay gap was 11.76%.

Statutory Analysis

There are a number of statutory elements that UHS are required to publish, and these are below.

	2020	2019	2018	2017
Mean GPG	24.76%	26.58%	28.13%	28.07%
Median GPG	10.01%	10.64%	10.56%	10.05%
Mean Bonus GPG	33.70%	34.39%	38.55%	38.15%
Median Bonus GPG	33.33%	34.58%	19.93%	36.09%

	2020		2019		2018		2017	
	F	M	F	M	F	M	F	M
Upper Quartile	61.58%	38.42%	62.60%	37.40%	78.54%	21.46%	61.59%	38.41%
Upper Middle Quartile	81.13%	18.87%	81.28%	18.72%	79.18%	20.82%	83.39%	16.61%
Lower Middle Quartile	77.47%	22.53%	78.83%	21.17%	83.03%	16.97%	79.32%	20.68%
Lower Quartile	78.13%	21.87%	78.41%	21.59%	61.36%	38.64%	78.36%	38.41%

The ‘Bonus’ GPG for the UHS is based on CEA awards. Of those staff eligible to apply for CEAs (consultants), 57.6% of males and 49.32% of females received this payment.

The UHS full report is contained is Appendix A, and this will be published on our external website in line with statutory reporting requirements.

Local Clinical Excellence Awards

For 2019/20, 148 applications were received, with a higher success rate for male staff.

	Total	Women	Men
Applications received	148	69 (47%)	79 (53%)
Successful applicants	125	55 (44%)	70 (56%)
Application success rate	84%	80%	87%

Consultant Job Plans

Recently, focus groups were organised with senior medical staff to discuss activities and perceptions of work between groups within the Trust. From these focus groups, there was a consensus that there needs to be transparency in job plans. Therefore, the medical workforce team were tasked to analyse the job plans for consultants and career grade doctors Trust-wide and perform an investigation into how these might differ across genders, ethnicities and divisions.

The findings from the analysis showed that for full time doctors, at Trust level, there were no significant differences between genders or ethnicities across SPA, DCC and total PAs in the job plans. The findings showed a high statistical significance, indicating that there is homogeneity across these job plans, and that no group is doing more or less activity than the other. Although there was no significant difference at Trust level, there were some results different at a divisional level. Regarding less than full time positions, at Trust level, it was found that females conduct significantly more SPA compared to male colleagues, as well as more total PA counts in their less than full time job plans. There was no significant difference in ethnicity.

These results were presented at the Trust Executive Committee. From this, discussion on Clinical Excellence Awards (CEA) highlighted that going 'above and beyond' the job plan was the key to CEA success. The construction of CEA awards are under national review at the moment with a view to improve equity of application opportunity, likelihood to apply, and ensuring these awards remain open and accessible to all who are eligible.

It also highlighted the importance for job plans to be kept up to date and support is available to doctors when they conduct their job planning discussions.

Conclusion

Trust Board are asked to:

- Note the overall improvement to the UHS gender pay gap;
- Note the publication of this data;
- Continue to support ongoing actions to address the gender pay gap;
- Support ethnicity pay gap reporting locally to UHS.

Appendices

A: UHS Gender Pay Gap Report to be published.

University Hospital Southampton
NHS Foundation Trust

Gender Pay Gap Report 2021

Executive Summary

This is the fourth year that UHS have been required to report on their gender pay gap. In that time, work has been ongoing to support all staff to develop in their chosen roles at UHS, and to ensure that recruitment and selection for both new starters and promotions remains fair and transparent.

In 2020, which this report covers, the mean gender pay gap at UHS decreased from 26.57% the previous year to 24.76%.

Changes to the gender pay gap is largely dependent on societal trends in the different genders joining healthcare, as currently UHS have a workforce that is 74.6% female.

National Framework

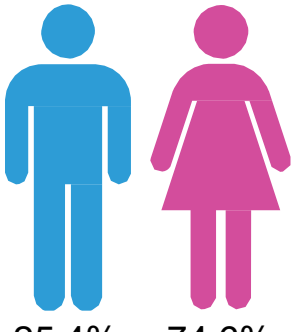
All organisations with over 250 employees are required to produce their gender pay gap data, effective on the snapshot date of 31st March 2020. This report outlines the data for University Hospital Southampton NHS Foundation Trust (UHS), as well as providing readers with further analysis of what the data means within the organisational context.

It's important to note that the pay rates for job are based on national terms and conditions and underpinning job evaluation systems based on qualification, skills competences, and responsibility the post holder will have.

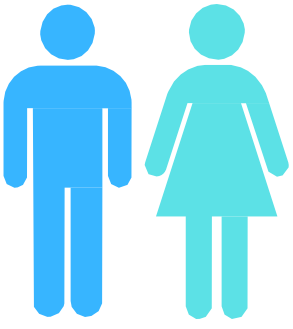
Organisational Context

University Hospital Southampton NHS Foundation Trust provides services to some 1.9 million people living in Southampton and south Hampshire, plus specialist services such as neurosciences, cardiac services and children's intensive care to more than 3.7 million people in central southern England and the Channel Islands. The Trust is also a major centre for teaching and research in association with the University of Southampton and partners including the Medical Research Council and Wellcome Trust. Every year we treat around 150,000 inpatients and day patients, including 50,000 emergency admissions. We see over 624,000 people at outpatient appointments and deal with around 135,000 cases in our emergency department. We have approximately 11,500 staff who work with us to provide these services. Under the requirements of the gender pay gap reporting, 11,271 staff were included.

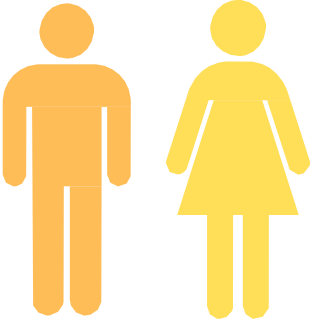
Workforce Profile



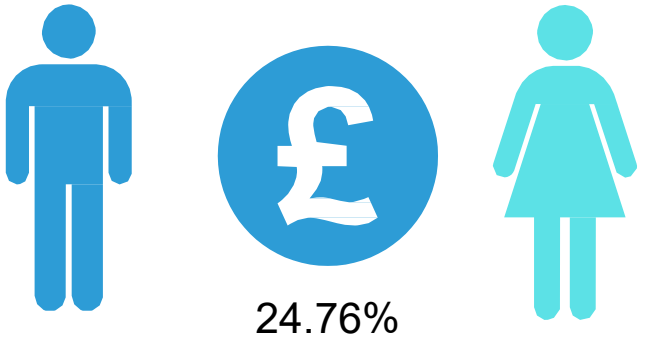
Full time staff
63.62%



Part time staff
36.38%



Mean Gender Pay Gap



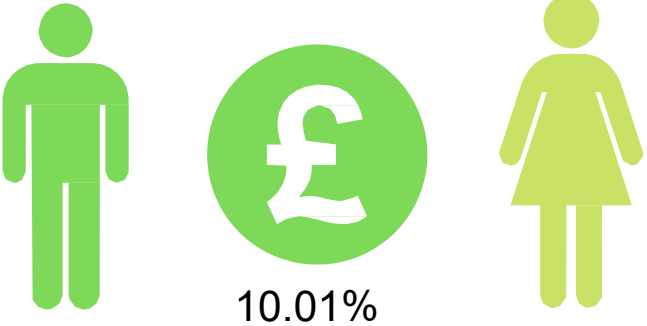
£22.45

24.76%

£5.56 p/h

£16.89

Median Gender Pay Gap



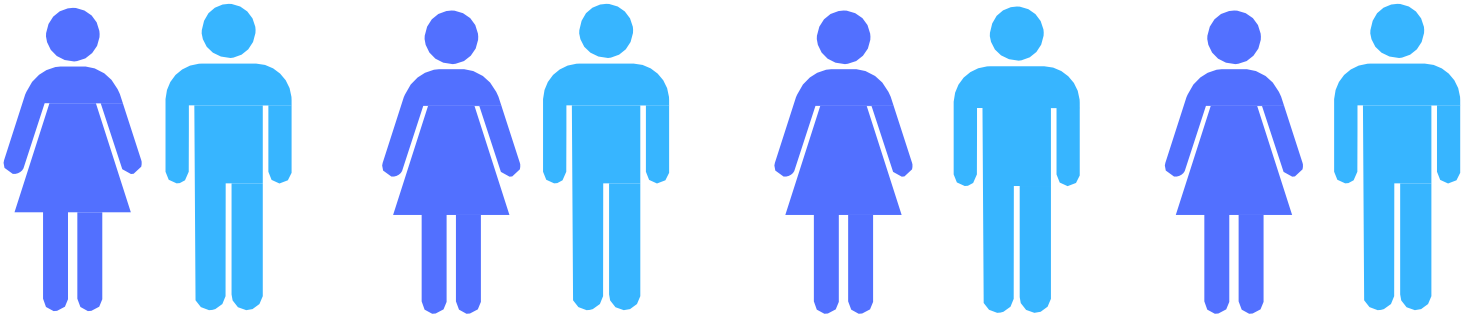
£17.08

10.01%

£1.71 p/h

£15.37

Quartile Pay Bands



61.58% 38.42%

Upper Quartile

81.13% 18.87%

Upper Middle Quartile

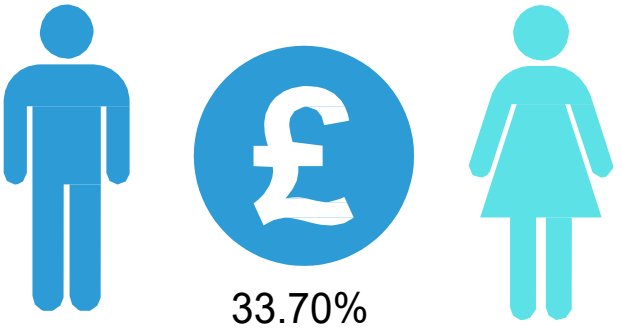
77.47% 22.53%

Lower Middle Quartile

78.13% 21.87%

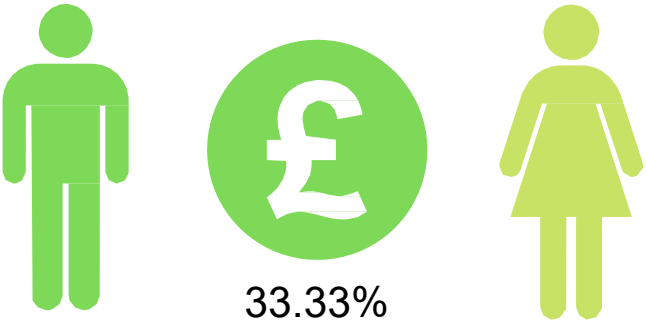
Lower Quartile

Mean Bonus Pay Gap



33.70%

Median Bonus Pay Gap



33.33%

Agenda for Change Analysis

The Trust reward strategy is to pay its staff in line with national terms and conditions for medical and non-medical employees. These terms and conditions are collectively bargained with the National Trade Unions representing NHS staff views. The Agenda for Change (AfC) system is used across the NHS to allocate job roles to set pay bands, using a job evaluation system. This was implemented in 2004, and is designed to ensure the NHS can deliver fair pay staff based on the principle of equal pay for equal work. AfC also harmonises terms and conditions of service, including but not limited to, annual leave, working hours, sick pay and unsocial hours requirements. At UHS, AfC covers all staff groups except our Medical & Dental Staff and Trust Board members. AfC pay grades are divided into 9 bands.

By analysing the AfC staff separately from the Medical and Dental staff, and Executives, UHS have a pay gap of 0.59%, with all bands except Bands 1, 3, and 8d weighted in favour of females.

	Mean				*Median*			
	Female	**Male**	**Difference**	**% Gap**	**Female**	**Male**	**Difference**	**% Gap**
Band 1	£10.75	£11.01	£0.26	2.36%	£9.98	£10.84	£0.86	7.93%
Band 2	£10.41	£9.91	-£0.50	-5.05%	£9.74	£10.42	£0.68	6.53%
Band 3	£10.45	£10.49	£0.04	0.38%	£10.34	£10.34	£0.00	0.00%
Band 4	£11.69	£11.40	-£0.29	-2.54%	£11.61	£11.16	-£0.45	-4.03%
Band 5	£15.08	£14.54	-£0.54	-3.71%	£15.07	£14.44	-£0.63	-4.36%
Band 6	£18.03	£17.25	-£0.78	-4.52%	£17.90	£17.15	-£0.75	-4.37%
Band 7	£21.18	£20.58	-£0.60	-2.92%	£21.33	£20.38	-£0.95	-4.66%
Band 8a	£24.11	£23.71	-£0.40	-1.69%	£24.63	£24.68	£0.05	0.20%
Band 8b	£28.81	£27.64	-£1.17	-4.23%	£29.42	£29.74	£0.32	1.08%
Band 8c	£34.24	£34.24	£0.00	0.00%	£35.29	£34.63	-£0.66	-1.91%
Band 8d	£40.36	£43.32	£2.96	6.83%	£41.68	£44.33	£2.65	5.98%
Band 9	£54.24	£54.10	-£0.14	-0.26%	£52.01	£53.11	£1.10	-2.07%
All AfC Staff	*£15.24*	*£15.33*	*£0.09*	*0.59%*	*£14.50*	*£13.54*	*-£0.96*	*-7.09%*

Trust Board

Members of the Trust Board are employed on terms and conditions agreed locally within the Trust. The majority of the terms, except headline rate of pay, mirror the principles of AfC. Salary is determined by a range of factors including nationally benchmarked NHS pay rates set out by NHS Improvement (the NHS Trusts performance and governance regulator), job evaluation and market forces analysis.

Our analysis does not include our Non-Executive Directors due to the nature of their employment terms with UHS. These are not employees of the Trust and are not required to be included in the reporting analysis.

There are 7 members on the Trust Board, with a mean pay gap of -11.54% (median 5.58%).

	Mean				*Median*			
	Female	**Male**	**Difference**	**% Gap**	**Female**	**Male**	**Difference**	**% Gap**
Executives	*£89.97*	*£80.66*	*-£9.31*	*-11.5%*	*£76.58*	*£81.11*	*£4.53*	*5.58%*

Medical and Dental Analysis

The Medical and Dental (M&D) Terms and Conditions work in a similar way to AfC, in which they provide a framework that is designed to deliver the principle for equal pay.
For medical staff in training (Junior Doctors) the national contract was re-negotiated in 2016. Our trust fellows are incorporated alongside their equivalent in-training colleagues.

By analysing M&D staff separately, UHS have a gender pay gap of 11.76% for medical staff (this is a substantial decrease from 15.25% in 2019). The table below shows how this pay gap changes across the grades, but is strongest within Specialty Doctors and Consultants. These numbers include the fellows as well as deanery trainees.

	Mean				***Median***			
	Female	**Male**	**Difference**	**% Gap**	**Female**	**Male**	**Difference**	**% Gap**
FY1	£14.73	£14.54	-£0.19	-1.31%	£14.82	£14.82	£0.00	0.00%
FY2	£17.37	£18.15	£0.78	4.30%	£17.02	£17.75	£0.73	4.11%
ST1/2	£21.29	£21.37	£0.08	0.37%	£21.17	£21.49	£0.32	1.49%
ST3+	£28.37	£27.63	-£0.74	-2.68%	£27.29	£26.85	-£0.44	-1.64%
SAS	£32.84	£35.86	£3.02	8.42%	£33.01	£34.12	£1.11	3.25%
Consultants	£47.56	£51.05	£3.49	6.84%	£45.93	£49.42	£3.49	7.06%
All medical staff	*£32.95*	*£37.34*	*£4.39*	*11.76%*	*£28.70*	*£35.80*	*£7.10*	*19.83%*

Historically, the trend for entrance to medical staff for training for doctors and dentists was heavily weighted towards males. This was reflective of societal trends towards the medical profession. More recently this balance has changed, and as can be seen below, the balance of male and female towards the more junior grades is becoming much more even within UHS. As these staff move through the grades, it is expected that the gender balance at consultant grade (the highest grade) will reflect the overall gender balance.

When the consultant staff are analysed by age banding, it becomes clear that the longer serving staff (and therefore higher paid in line with their terms and conditions) are predominantly male. However, in line with both national and local trends towards training, the staff now coming in at this grade are more balanced across the genders.

Age Banding	Total	Female	Male	Female %	Male %
31-40	141	72	69	51%	49%
41-45	171	66	105	39%	61%
46-50	150	62	88	41%	59%
51-55	122	33	89	27%	73%
56+	114	31	83	27%	73%

Bonus Pay Detail

Our bonus pay reporting only includes Clinical Excellence Awards (CEA's) for our NHS consultants. UHS terms and conditions do not give provision for other forms of performance related bonus for our staff. CEA's are used to recognise and reward those consultants who deliver excellence in innovation, research, safe and high quality care to patients, as well as to the continuous improvement of services. CEA's are awarded at a national and local level in line with the national guidelines. National awards and are approved by the Advisory Committee on Clinical Excellence Awards who are an advisory, non-departmental public body sponsored by the Department of Health and Social Care. National awards are for a period of up to five years where they are reviewed.

Local awards are applied for and evaluated by each NHS Trust, at UHS the review process is based on the national framework. UHS has a committee of 16 individuals who will rank and score applications. The committee is diverse in gender and ethnicity. On average 120 awards are made each year to consultants recognising the efforts that have been made. The criteria and scoring structure of CEAs is set out in the ACCEA guidance documents, available via the following link: https://www.gov.uk/government/organisations/advisory-committee-on-clinical-excellence-awards

It should be noted that junior medical staff are not eligible for national and local CEA awards.

Proportion of all staff receiving a bonus payment

8.72% 1.56%

Proportion of eligible staff receiving a bonus payment

57.60% 49.32%

Actions to address the gender pay gap

UHS is committed to continuing its programme of equality, diversity and inclusivity.

The continuing growth of entry of females into the medical profession will drive a change in the overall composition of the medical workforce, and subsequently will close the gender pay gap over time.

Local actions that UHS are taking to address the pay gap include:

- continue to consider how it attracts candidates, including advertising in more places that may help to engage more male applications, including reviewing the language used in adverts so this is not skewed towards one gender;
- continue to seek diverse talent when recruiting to senior managerial roles, to continue to provide opportunities for females to take up positions within senior management. This is already evident in the composition of the Trust's Executive Board and other senior roles;
- continue to monitor the fair distribution of local clinical excellence awards, and ensure ongoing applications from female consultants;
- continue to engage with network groups and diverse voices across the organisation to further commitments to equality and diversity;
- implementing ethnicity pay gap reporting.

Contact details for further information

Steve Harris, Chief People Officer

Report to the Trust Board of Directors				
Title:	**Freedom to Speak Up Report**			
Agenda item:	**5.8**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Christine Mbabazi, Freedom to Speak Up Guardian**			
Date:	**27 May 2021**			
Purpose	**Assurance or reassurance** **x**	**Approval**	**Ratification**	**Information** **x**
Issue to be addressed:	The paper is presented for the Board to Note. To provide an update on the Freedom to Speak Up (FTSU) agenda following the Freedom to Speak Up Guardian Survey report.			
Response to the issue:	Trust Board is asked to: • Note the recommendations provided by the National Guardian Office • Note the actions taken by the Trust • Support inclusion of FTSU in the priorities for audit in 2021/2022 • Note the positive feedback from staff of their experience speaking up to the FTSU Guardian			
Implications: (Clinical, Organisational, Governance, Legal?)	FTSU is one mechanism to support boards to create a culture where workers feel safe and able to speak up about anything that gets in the way of delivering safe, high quality care or affects their experience in the workplace. This includes matters related to patient safety, the quality of care, and cultures of bullying and harassment.			
Risks: (Top 3) of carrying out the change / or not:	N/A			
Summary: Conclusion and/or recommendation	This report is to update Trust Board on the FTSU Guardian Survey 2020 report and to provide the Board with assurance about how the FTSU agenda is implemented in the Trust.			

1. Executive Summary

The Freedom to Speak Up Guardian's (FTSU) survey is completed annually by around 600 FTSU Guardians in the country, mostly representing NHS Trusts and bodies. The Survey highlights insights into how the guardian role is implemented and supported in the organisation and what learning is needed to create a culture where speaking up becomes business as usual.

2. Purpose/Context/Introduction

The purpose of this report is to update Trust Board on the FTSU Guardian Survey 2020 report and to provide the Board with assurance about how the FTSU agenda is implemented within the Trust.

3. Key Findings of FTSU Guardian Survey 2020

- **Demographics:** The survey found that Ethnic minorities were under represented in the Guardian role. 90% of respondents identified as White, compared to 79% of the NHS workforce. 9% of respondents were from ethnic minorities in this year's survey, 17% disabled staff and 6% from the LGBT+, 89% identified as heterosexual or straight. This was higher than the NHS workforce in which 2.7% identify as LGBT+.
  UHS approach – The FTSU Guardian at UHS identifies as Black African coming from an ethnic minority group.

- 80% of respondents were part of a network of FTSU Guardians, Champions or Ambassadors in their organisations.
  UHS approach - UHS has a guardian and a network of champions with plans to increase the number of champions in the organisation. We currently have 13 FTSU champions, 70% are women and 30% men, 15% are from an ethnic minority and 23% have declared a disability. We plan on increasing the number and diversity of our champions from different staff groups to at least 22 making it 35 FTSU champions spread across different locations by the end of October.

- 94% of respondents had direct access to their chief executive or equivalent and 77% of the respondents presented to Board meetings or equivalent in person. An improvement from 66% in 2019.
  UHS approach – The UHS guardian has direct access to the chief executive, the FTSU Executive and Non-Executive has regular meetings. The guardian also presents to the Board 2-3 times a year.

4. Recommendations from FTSU Guardian Survey

4.1. Leaders should assure themselves that there are no barriers to anyone who may want to apply for the Freedom to Speak Up Guardian/Champion role: Appointment for these roles at UHS is widely advertised and is voluntary. However, there is work to be done to ensure that all staff groups are represented, which will be achieved by targeted advertising of future champion roles. These include applicants from ethnic minorities, persons with disabilities, as well as other protected characteristics, and a wider range of staff groups. This is being done by using staff network groups as well as relevant line managers.

4.2. Ring fenced time: CQC consider the commitment to the Freedom to Speak Up Guardian role, including the provision of sufficient ring-fenced time as an important element in the assessment of well-led. The Guardian role in this Trust is a fulltime role and is funded for 37.5hrs per week. The FTSU champions do not have ring-fenced time; however they are

supported by their department to attend any FTSU meetings, training, and to support staff etc.

4.3. Leaders should take steps to assure themselves that existing arrangements have the confidence of the workforce – This assurance would be best evidenced by the following:- number of concerns raised with guardian, feedback received and the processes embedded to ensure people are able to raise their concerns easily, have access to the guardian, and finally that their concerns are resolved fairly and transparently.

4.3.1. The number of concerns raised since the role began to date is 197 cases, of which 132 cases have been closed. However due to the pandemic there has been a delay in some investigations and resolving cases apart from those which relate to patient safety which have been prioritised. Cases fall into the following categories; patient safety, bullying and harassment, team dynamics and discrimination. These cases come from all staff groups, of different bands, clinical and nonclinical, doctors, consultants, nurses, porters, NHSP or agency workers.

4.3.2. When staff raise their concerns, it is important that they are dealt with fairly and transparently. For this reason, a steering group (Raising Concerns Steering Group) is responsible for the assurance and making sure that all concerns are taken seriously and resolved fairly and transparently. The attendees of this group include the Raising Concerns Executive (Chief Nursing Officer) and Non-Executive Lead, Chief People Officer, Deputy Chief Nursing Officer, Head of Employee Relations, FTSU Guardian and Champions.

4.3.3. Feedback on performance: Feedback is an opportunity to learn and improve. Anonymous feedback has been gathered by the guardian after concerns have been completed regarding the process for the person who has raised the concerns. (Please see **Appendix 1 & 2** for details).

4.3.4. The efficacy in our approach to FTSU, raising concerns and whistleblowing is to be considered for inclusion in the internal audit programme for 2021/22. The decision will be made by the Audit and Risk Committee in early June to seek external assurance for board about FTSU processes.

4.4. Leaders should work with their Freedom to speak up guardians to identify potential groups that face barriers to speaking up and work towards addressing those barriers. Respondents identified multiple groups of workers who may face barriers to speaking up. These included ethnic minority workers, LGBTQ+ workers and people living with disabilities and long-term health conditions. Actions have included joining staff networks and forums, promoting Freedom to Speak Up by variety of channels and reaching out to different groups to offer support. Last year, the Guardian sent an email to all ethnic minority staff and those living with disabilities and long term illnesses reaching out to invite them to speak up and offer support to those that needed it.

4.5. Speaking up Training for workers, managers and senior leaders: Speaking up training for all workers is an area UHS needs to embed in our training e.g. corporate induction, Line and middle manager training as well as senior management.

4.6. Detriment: Workers should be able to speak up about concerns or make improvement suggestions without experiencing detriment to themselves. Leaders must communicate that detriment will not be tolerated. We must act to prevent detriment occurring and scrutinise any cases where detriment it is reported.

5. Next Steps / Way Forward / Implications / Impact

The FTSU/raising concerns process is going to be considered for inclusion in the internal audit programme for 2021/22. The decision will be made by the Audit and Risk Committee in early June.

The FTSU Guardian is recruiting more FTSU champions from all levels and staff groups and would ask the Board for ring-fenced time for FTSU champions to be able to do this role.

The FTSU Guardian and Champion network will continue to encourage and support staff to speak up if they are concerned.

The National Guardian office has now provided training materials for all line managers. The training materials will be released in the coming months and a plan has been developed to deliver this training in the organisation.

6. Recommendation

Members of Trust Board are asked to:

- Note the recommendations provided by the National Guardian Office
- Note the actions taken by the Trust.
- Support inclusion of FTSU in the priorities for audit in 2021/2022.
- Note the positive feedback from staff of their experience speaking up to the FTSU Guardian.

Appendix 1

UHS FTSU - Anonymous feedback survey data (47 responses):

1. Given your experience of raising a concern with the Freedom to speak up Guardian, would you speak up again?

    - 84% would speak up again
    - 8% maybe
    - 8% other responses

2. How did you find out about the Freedom to Speak Up Guardian role?

    - 52% word of mouth
    - 12% staff intranet
    - 12% raising concerns policy
    - 4% posters/leaflets
    - 20% other

3. How easy was it to make initial contact?

    - 79.9% very easy
    - 16.6% easy
    - 3.5% other

4. How did you find the response from the Freedom to Speak Up Guardian?

    - 81% very easy
    - 17.3% easy
    - 1.7% ok

5. Has your concern been addressed?

    - 88% agreed that it was addressed

6. Did you feel your concern was treated confidentially?

    - 100% concerns were treated confidentially by Guardian

7. Did you feel the concern was taken seriously?

    - 96% felt that the concern was taken seriously

8. Did you receive regular feedback from the guardian about your concern?

    - 96% received regular feedback from the guardian about their concern

9. Have you suffered any detriment as a result of raising your concern?

    76% No have not suffered detriment to raising concerns
    - 24% Yes have suffered detriment to raising concerns

Appendix 2

Comments from staff who have spoken up

I would like to give feedback on the service you provided me. I had concerns that I was being side-lined, opportunities being taken away and my career progression was being blocked by my managers. On several occasions, you liaised with me on how to remain professional and how to engage with my manager. You requested my consent before sharing or escalating any issues I had raised with you.

You escalated the concerns I had raised to senior management in my department, and you represented my interest in these meetings. You kept me informed of the outcomes of meetings.
Through your input I had some positive outcome for some of the concerns I had raised.

Just to put into writing my thanks for your recent support with several of my team as our Freedom to Speak up Guardian. Clearly I only know about the staff that have disclosed this information with me, however several have given me direct feedback on how helpful and supportive you have been, which has been very helpful.

Thank you so much - I could cry with relief! I'm a bit apprehensive because I've felt relief before- after speaking with xxx, but hopefully this will work out ok.

You're very good at your job- thank you for giving me a voice!

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Finance Report 2021-22 Month 1**			
Agenda item:	**5.9**			
Sponsor:	**Ian Howard – Interim Chief Financial Officer**			
Author:	**Ian Howard – Interim Chief Financial Officer**			
Date:	**27 May 2021**			
Purpose	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	The finance report provides a monthly summary of the key financial information for the Trust.			
Response to the issue:	Overall the Trust has started the 2021/22 financial year strongly, reporting an on-plan position of break-even. **Plan:** • We submitted a break-even plan submission for Half 1 (separately on the agenda). • The ICS submitted a break-even plan, noting that Isle of Wight and Solent submitted deficit plans, off-set by a commissioner surplus. • There is some concern around the Hospital Discharge Programme for commissioners, with funding not yet confirmed nationally. **M1 Position:** • Reported an on-plan position of break-even. • Elective Recovery Framework achievement of £5m estimated for M1, based on hitting 97% of pre-Covid levels of activity for Elective and Outpatients. This compares to a baseline expectation of 70%. There is some uncertainty around this calculation due to different data sets and overall ICS position. **Capital:** • We have finalised our CDEL position as anticipated at £50m, which includes a slippage assumption of £5m. Spend is on track at M1. **Other:** • A number of discussions are on-going regarding the use of the “accelerator” fund across the ICS (separately on the agenda). • Conversations are also continuing on use of Independent Sector activity, linked to the above. This is also included in the CEO update.			

Implications: (Clinical, Organisational, Governance, Legal?)	• Financial implications of availability of funding to cover growth, cost pressures and new activity. • Organisational implications of remaining within statutory duties.
Risks: (Top 3) of carrying out the change / or not:	• Financial risk mainly linked to the uncertainty of 21/22 funding arrangements. • Cash risk linked to volatility above
Summary: Conclusion and/or recommendation	Trust Board is asked to note this report.

2021/22 Finance Report - Month 1

Report to:	**Board of Directors and Finance & Investment Committee** **April 2021**
Title:	**Finance Report for Period ending 30/04/2021**
Author:	**Philip Bunting, Acting Deputy Director of Finance**
Sponsoring Director:	**Ian Howard, Acting Chief Financial Officer**
Purpose:	**Standing Item**
	The Board is asked to note the report

Executive Summary:

In Month and Year to date Highlights:

1. In April 2021, the Trust reported a surplus of £0.1m, which was favourable to the trusts breakeven plan by £0.1m.

2. Elective Recovery Framework Income is estimated at a potential £5m for April; however this has not yet been confirmed and is dependent on wider system achievement.

3. In month, £3.1m (£2.0m pay and £1.1m non pay) was incurred on additional expenditure relating to Covid-19. This was lower than March and included £0.35m of Covid vaccination costs and £0.5m of Covid testing costs which are directly reclaimable on a pass through basis and are billed as a retrospective top-up. Within the trusts block funding is a non recurrent fixed element for Covid costs which will continue throughout H1.

4. The main underlying themes seen in M1 were :
   - Elective activity in April represents 92% of planned income levels. This is flat from March although Independent Sector activity has significantly reduced as centrally procured surge contracts have now ceased. Recovery planning is targeting improvement in all areas but will be governed by clinical priority due to capacity constraints.
   - Non Elective activity and income remains steady at close to 100% of pre-Covid levels.
   - Outpatient activity remained above pre-Covid levels at 104% of planned income and activity.
   - Drugs expenditure was high in month with £2.3m over performance reported on pass through items. These are mirrored by additional income.
   - Trust underlying performance remains at close to breakeven levels after adjusting for one off items.

Finance: I&E Summary

The financial position for M1 was a surplus of £0.1m which was favourable to plan by £0.1m.

Clinical income was lower than plan due to prudent assumptions around ERF together with below plan Channel Island activity (£0.4m). Expenditure on pass through drugs and devices was £2.3m higher than plan although is offset by income.

Both other income and clinical supplies expenditure were lower than plan due to reduced Chilworth activity. Clinical supplies spend was also supressed due to activity not yet reaching 100% of pre-covid levels.

Pay costs were favourable to plan however have increased markedly when compared to Q3 20/21. This is partly driven by vaccine hub costs however will be monitored closely throughout 21/22. Recovery plans are expected to drive up pay spend further however.

		Current Month			Cumulative			H1 Plan		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
NHS Income:	Clinical	67.7	66.2	1.6	67.7	66.2	1.6	406.4	406.4	0.0
	Pass-through Drugs & Devices	8.5	10.8	(2.3)	8.5	10.8	(2.3)	50.9	50.9	0.0
Other income	Other Income excl. PSF	15.5	13.8	1.7	15.5	13.8	1.7	92.7	92.7	0.0
	Top Up Income	0.8	0.8	0.0	0.8	0.8	0.0	4.7	4.7	0.0
Total income		**92.5**	**91.5**	**0.9**	**92.5**	**91.5**	**0.9**	**554.7**	**554.7**	**0.0**
Costs	Pay-Substantive	45.4	45.4	(0.1)	45.4	45.4	(0.1)	272.5	272.5	0.0
	Pay-Bank	3.0	2.9	(0.0)	3.0	2.9	(0.0)	17.7	17.7	0.0
	Pay-Agency	1.2	0.8	(0.5)	1.2	0.8	(0.5)	7.5	7.5	0.0
	Drugs	4.3	4.9	0.5	4.3	4.9	0.5	26.0	26.0	0.0
	Pass-through Drugs & Devices	8.5	10.8	2.3	8.5	10.8	2.3	50.9	50.9	0.0
	Clinical supplies	11.9	8.4	(3.5)	11.9	8.4	(3.5)	71.1	71.1	0.0
	Other non pay	14.8	15.3	0.5	14.8	15.3	0.5	89.0	89.0	0.0
Total expenditure		**89.1**	**88.4**	**(0.7)**	**89.1**	**88.4**	**(0.7)**	**534.8**	**534.8**	**0.0**
EBITDA		**3.3**	**3.1**	0.2	**3.3**	**3.1**	0.2	**19.9**	**19.9**	0.0
EBITDA %		3.6%	3.4%	0.2%	3.6%	3.4%	0.2%	3.6%	3.6%	0.0%
	Depreciation / Non Operating Expenditure	3.2	3.2	0.0	3.2	3.2	0.0	19.1	19.1	0.0
Surplus / (Deficit)		**0.1**	**(0.1)**	0.2	**0.1**	**(0.1)**	0.2	**0.9**	**0.9**	**0.0**
Less	Donated income	0.3	-	0.3	0.3	-	0.3	1.6	1.6	0.0
Add Back	Donated depreciation	0.1	0.1	0.0	0.1	0.1	0.0	0.8	0.8	0.0
Net Surplus / (Deficit)		**0.0**	**0.1**	**(0.0)**	**0.0**	**0.1**	**(0.0)**	**0.0**	**0.0**	**0.0**

Monthly Underlying Position

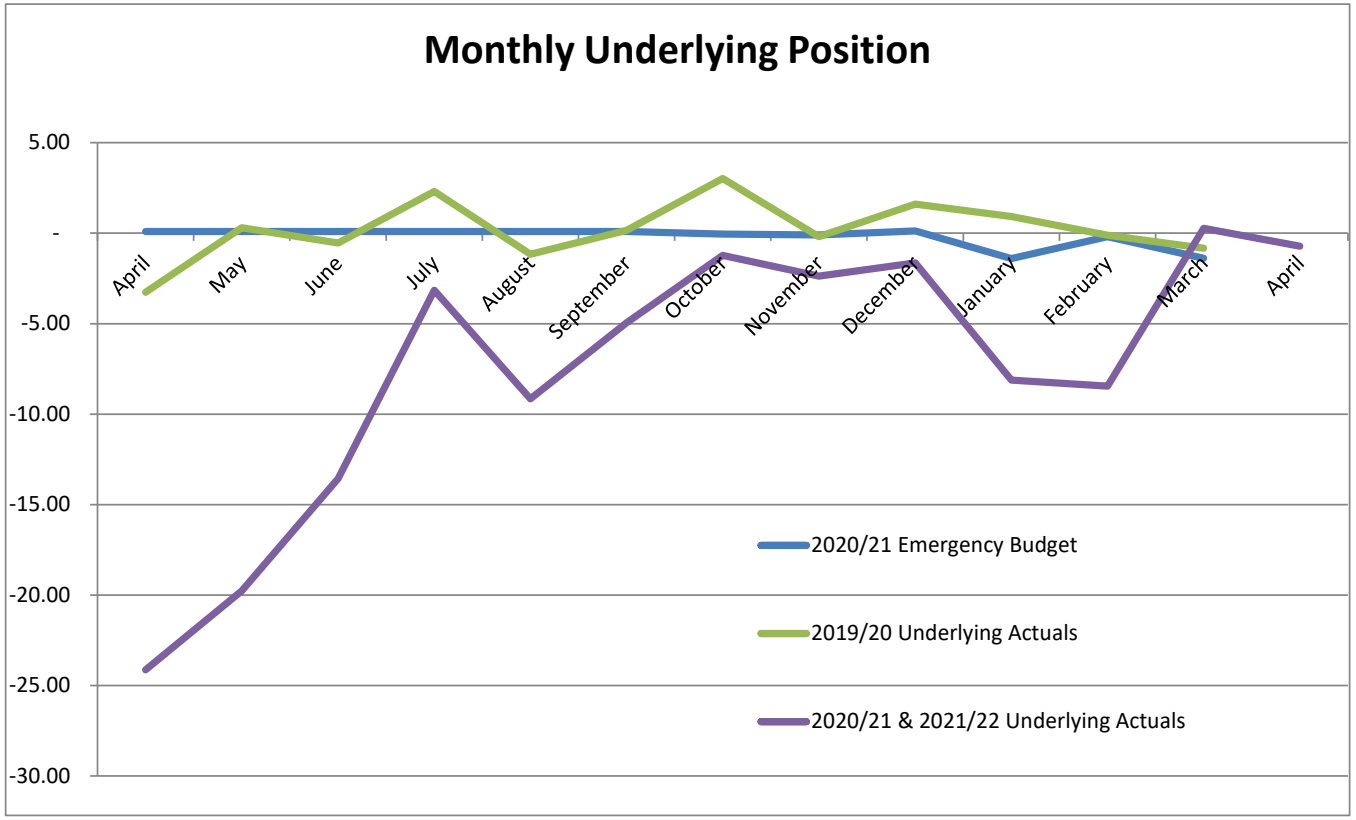
These graphs show the actual underlying position for the Trust however are heavily linked to the numbers of Covid positive patients the Trust is managing.

The following have been removed from the April 21/22 position:

- (-) The block contract uplift of £3.4m in month which represents the value of income over and above that which would have prevailed under PbR.
- (+/-) material one off items of expenditure. These total £3m in month relating to recruitment fees and provisions.

This illustrates that if the trust reverted to PbR and Covid income and expenditure are adjusted out a deficit of £4.1m in month would have prevailed.

Currently the block contract mechanism provides security against any underperformance and will continue throughout the first half of 21/22.



Clinical Income

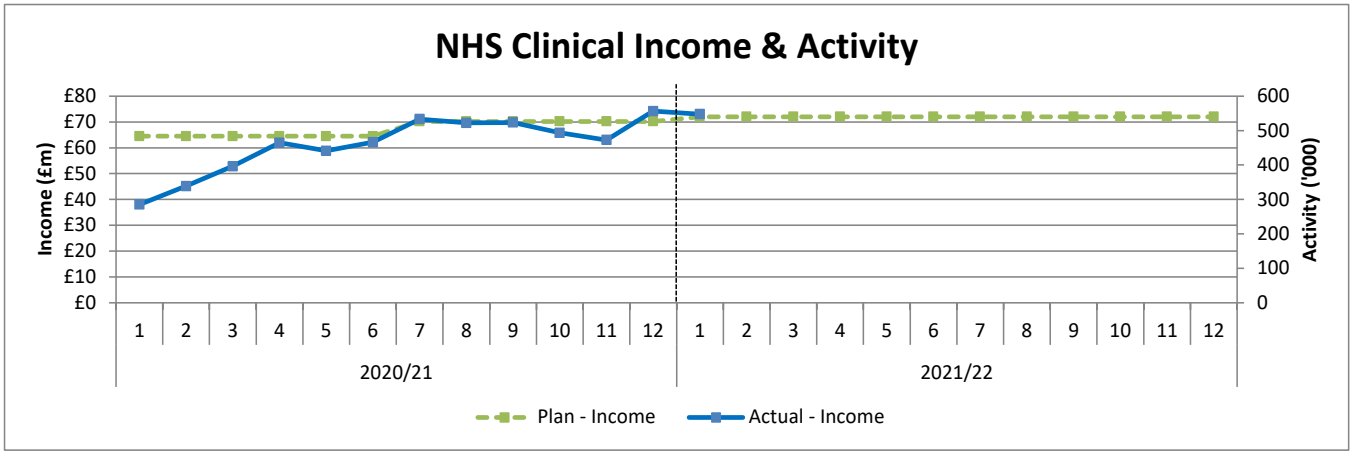
Clinical income for the month of April was £0.7m favourable to plan and including Non NHS income was £1.0m favourable to plan. This was however driven by £2.3m of pass through over performance. Most of the Trust's income remains fixed with confirmed block contract funding in place for at least the first half of the financial year.

April has seen a reduction in activity from March although much of this reduction can be attributed to 3 fewer working days in the month. Plans for 21/22 have been phased to account for the variation in calendar and working days in relevant POD Groups.

Elective income remained stable, representing 92% of planned levels. Non elective activity also remained at planned level, and A&E attendances have continued to increase and are now nearly back to pre-Covid levels. Outpatient income remains strong at over 100% of planned levels. The graphs overleaf show trends over the last 24 months and the impact of Covid-19 as well as the recovery to pre Covid levels of activity in many areas.

(Fav Variance) / Adv Variance

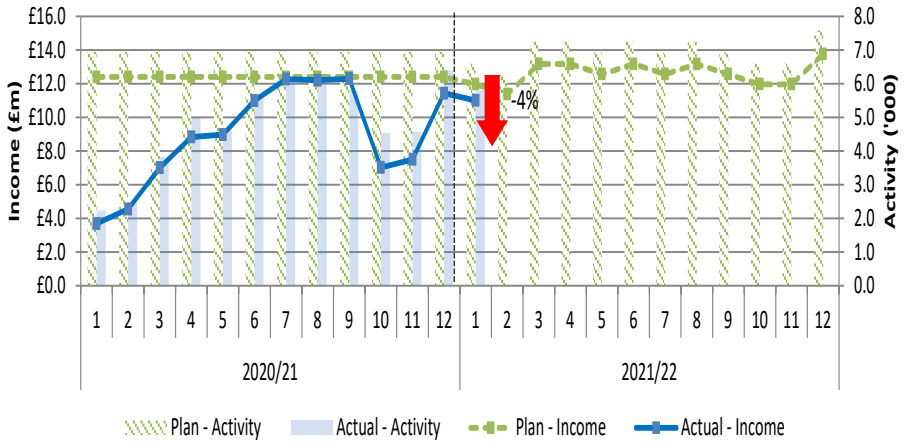
POD GROUP	2021/22 In Month Plan £000s	In Month Estimate £000s	In Month Variance £000s	YTD Plan £000s	YTD Estimate £000s	YTD Variance £000s	2019/20 YTD Actuals £000s
NHS Clinical Income							
Elective Inpatients	£11,963	£10,999	£964	£11,963	£10,999	£964	£11,220
Non-Elective Inpatients	£18,852	£18,789	£63	£18,852	£18,789	£63	£17,929
Outpatients	£7,016	£7,307	(£292)	£7,016	£7,307	(£292)	£6,729
Other Activity	£11,320	£10,860	£460	£11,320	£10,860	£460	£10,278
Blocks & Financial Adjustments	£5,618	£1,296	£4,322	£5,618	£1,296	£4,322	£1,958
Other Exclusions	£7,111	£7,649	(£538)	£7,111	£7,649	(£538)	£290
Pass-through Exclusions	£8,485	£10,781	(£2,296)	£8,485	£10,781	(£2,296)	£8,986
Subtotal NHS Clinical Income	*£70,364*	*£67,681*	*£2,684*	*£70,364*	*£67,681*	*£2,684*	*£57,776*
Non Recurrent Block Funding	£5,848	£5,848	£0	£5,848	£5,848	£0	
Covid block adjustments	£0	£3,418	(£3,418)	£0	£3,418	(£3,418)	
Total NHS Clinical Income	**£76,212**	**£76,946**	**(£734)**	**£76,212**	**£76,946**	**(£734)**	**£57,776**
Non NHS Clinical Income							
Private Patients	£545	£988	(£442)	£545	£988	(£442)	£339
CRU	£208	£125	£84	£208	£125	£84	£215
Overseas Chargeable Patients	£66	£21	£44	£66	£21	£44	£162
Total Non NHS Clinical Income	**£819**	**£1,134**	**(£314)**	**£819**	**£1,134**	**(£314)**	**£716**
Grand Total	**£77,032**	**£78,080**	**(£1,048)**	**£77,032**	**£78,080**	**(£1,048)**	**£58,492**



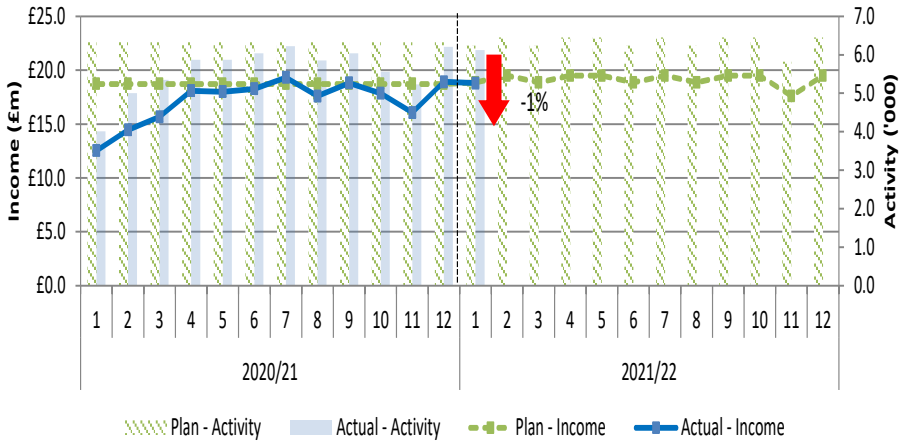
University Hospital Southampton NHS
NHS Foundation Trust

Clinical Income

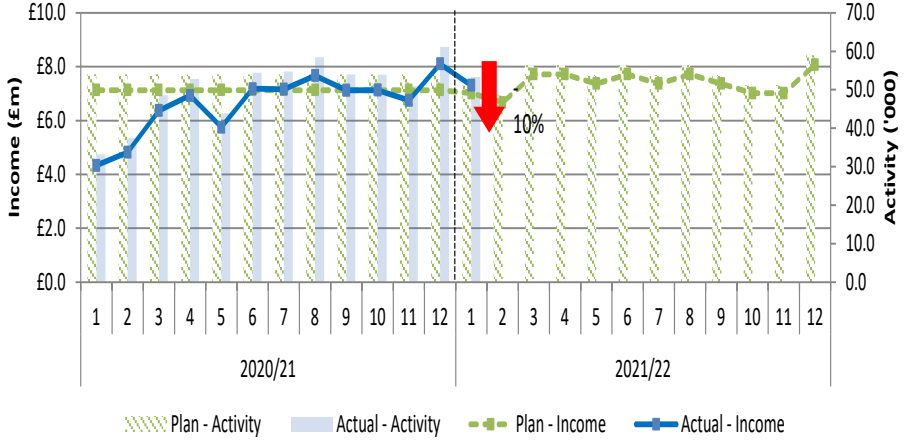
Elective spells



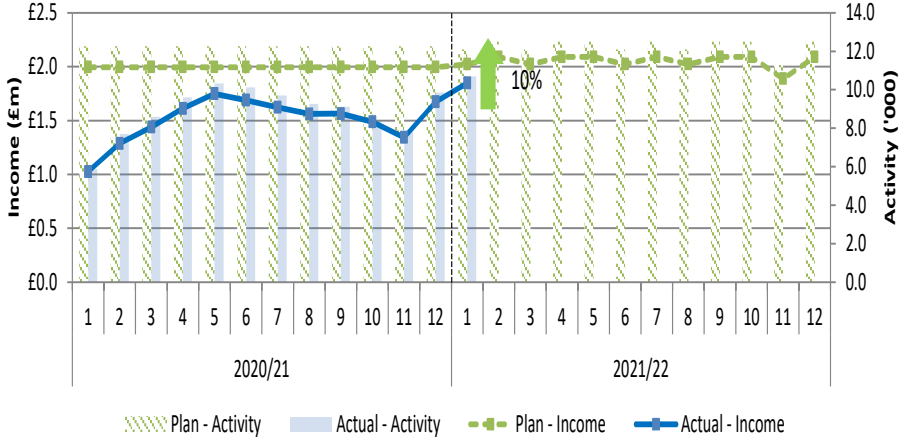
Non elective spells



Outpatients



A&E



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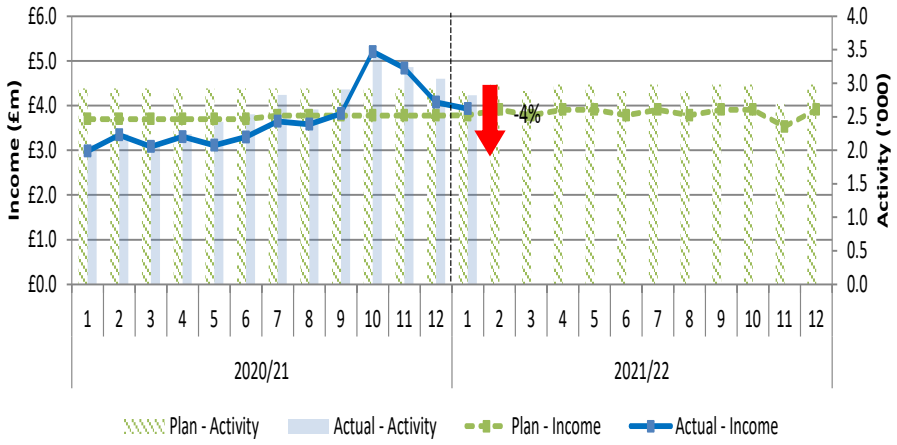
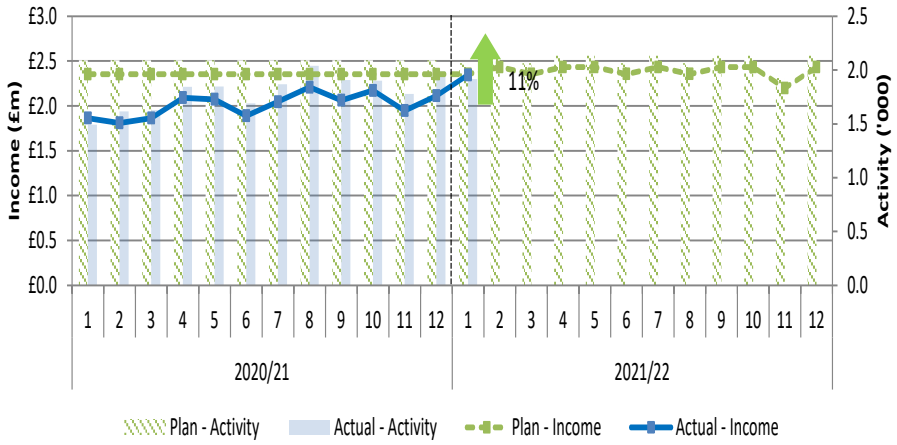
NHS Foundation Trust

Clinical Income

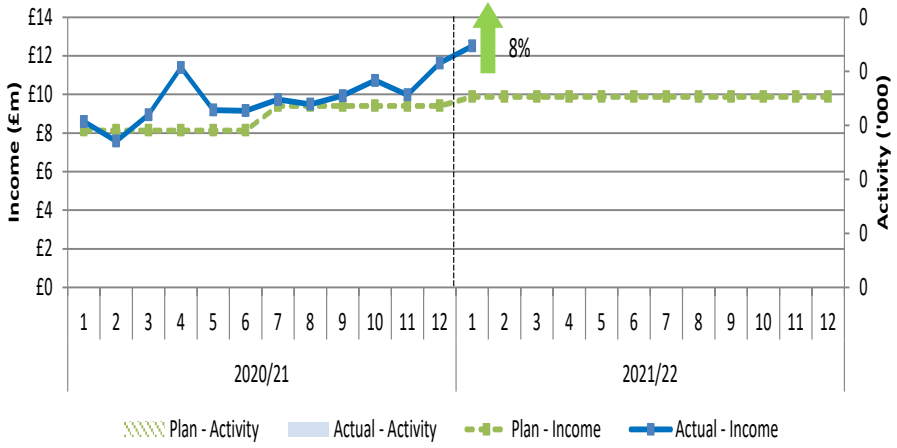
Adult critical care



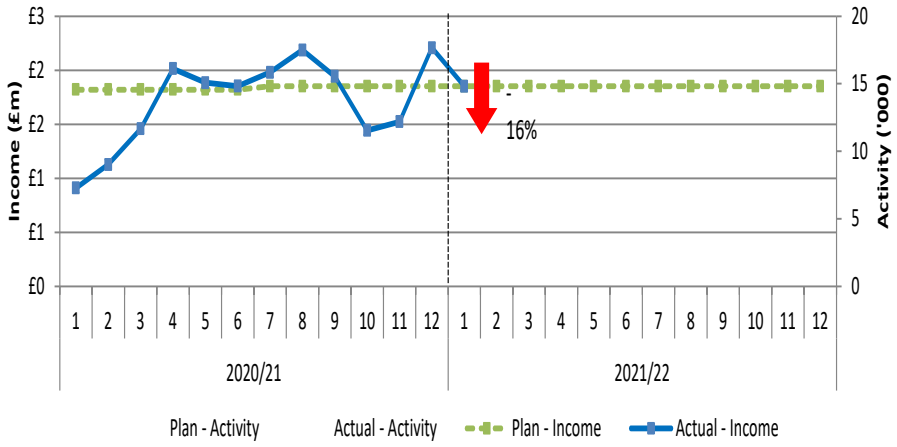
Neonatal & paediatric critical care



Tariff excluded drugs



Tariff excluded devices



Income and Activity

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

Elective activity in April represents 92% of planned income. This is static from March; however independent sector activity reduced significantly as centrally procured surge capacity ended. Recovery planning is targeting improvement in all areas but will be governed by clinical priority given capacity constraints.

Non Elective activity levels in April was at 100% of planned levels.

Elective Activity as % of Plan		Activity as % of Plan							Income as % of Plan						
		2020/21						2021/22	2020/21						2021/22
Division	Care Group	7	8	9	10	11	12	1	7	8	9	10	11	12	1
DIVISION A	OPHTHALMOLOGY	90%	95%	93%	38%	27%	90%	98%	88%	99%	95%	41%	30%	94%	100%
	SURGERY	85%	85%	76%	50%	45%	79%	64%	102%	100%	91%	58%	65%	99%	84%
DIVISION A Total		87%	89%	82%	45%	38%	83%	77%	99%	100%	92%	54%	57%	98%	87%
DIVISION B	CANCER CARE	71%	70%	70%	66%	61%	75%	76%	75%	73%	73%	58%	54%	71%	84%
	SPECIALIST MEDICINE	87%	95%	82%	88%	92%	106%	100%	91%	101%	86%	90%	94%	110%	108%
DIVISION B Total		82%	88%	78%	81%	82%	96%	92%	85%	90%	81%	78%	79%	95%	99%
DIVISION C	CHILD HEALTH	94%	96%	92%	73%	81%	104%	102%	97%	102%	103%	64%	88%	120%	114%
	WOMEN'S HEALTH	96%	112%	88%	63%	68%	106%	77%	106%	116%	96%	65%	70%	98%	81%
DIVISION C Total		94%	100%	91%	71%	77%	105%	95%	100%	106%	101%	64%	84%	114%	106%
DIVISION D	CARDIOVASCULAR & THORACIC	108%	100%	91%	54%	57%	85%	93%	106%	98%	100%	55%	58%	78%	84%
	NEUROSCIENCES	100%	88%	102%	78%	69%	96%	101%	104%	92%	121%	73%	54%	95%	107%
	RADIOLOGY	81%	77%	61%	50%	64%	71%	65%	91%	82%	66%	52%	69%	75%	70%
	TRAUMA & ORTHOPAEDICS	92%	94%	92%	28%	28%	78%	80%	98%	106%	118%	24%	25%	83%	87%
DIVISION D Total		96%	90%	87%	53%	55%	83%	86%	102%	97%	106%	50%	50%	82%	87%
Total		88%	90%	83%	65%	65%	92%	88%	99%	98%	99%	57%	60%	92%	92%

Non Elective Activity as % of Plan		Activity as % of Plan							Income as % of Plan						
		2020/21						2021/22	2020/21						2021/22
Division	Care Group	7	8	9	10	11	12	1	7	8	9	10	11	12	1
DIVISION A	OPHTHALMOLOGY	68%	66%	70%	41%	64%	62%	81%	70%	64%	75%	38%	68%	64%	75%
	SURGERY	95%	84%	86%	72%	71%	89%	91%	107%	97%	108%	85%	76%	95%	92%
DIVISION A Total		93%	83%	85%	71%	70%	87%	90%	105%	96%	106%	83%	75%	94%	91%
DIVISION B	ACUTE MEDICINE	103%	95%	111%	115%	101%	107%	101%	109%	102%	113%	118%	110%	112%	107%
	CANCER CARE	107%	96%	100%	93%	99%	123%	113%	94%	84%	88%	81%	98%	110%	108%
	EMERGENCY MEDICINE	102%	94%	91%	86%	84%	95%	103%	100%	86%	85%	113%	90%	82%	98%
	SPECIALIST MEDICINE	114%	96%	147%	92%	107%	81%	63%	129%	93%	145%	64%	103%	85%	56%
DIVISION B Total		103%	95%	100%	98%	92%	102%	103%	105%	95%	103%	111%	103%	104%	104%
DIVISION C	CHILD HEALTH	98%	95%	93%	71%	65%	84%	94%	99%	83%	98%	78%	66%	90%	88%
	WOMEN'S HEALTH	89%	87%	95%	86%	81%	98%	94%	95%	91%	105%	88%	88%	106%	102%
DIVISION C Total		92%	89%	94%	82%	76%	94%	94%	96%	88%	103%	85%	80%	100%	97%
DIVISION D	CARDIOVASCULAR & THORACIC	99%	88%	88%	77%	72%	100%	98%	101%	90%	96%	76%	67%	99%	103%
	NEUROSCIENCES	102%	97%	104%	91%	88%	107%	96%	113%	94%	105%	104%	88%	110%	92%
	RADIOLOGY	65%	90%	75%	65%	66%	91%	81%	62%	78%	72%	61%	69%	84%	77%
	TRAUMA & ORTHOPAEDICS	102%	110%	92%	87%	72%	102%	98%	113%	110%	95%	105%	80%	99%	106%
DIVISION D Total		98%	98%	92%	83%	75%	101%	97%	104%	95%	96%	89%	76%	101%	99%
Total		98%	93%	95%	88%	83%	98%	98%	103%	94%	100%	95%	86%	101%	100%

Income and Activity

Outpatient activity in April was at 104% of planned levels. This continues to perform having been either consistent or above pre-covid activity levels over the last six months.

Outpatient Activity as % of Plan		Activity as % of Plan							Income as % of Plan						
		2020/21						2021/22	2020/21						2021/22
Division	Care Group	7	8	9	10	11	12	1	7	8	9	10	11	12	1
DIVISION A	OPHTHALMOLOGY	93%	96%	95%	97%	96%	110%	109%	95%	97%	96%	100%	99%	113%	109%
	SURGERY	90%	97%	91%	86%	80%	105%	89%	88%	91%	84%	80%	77%	99%	88%
DIVISION A Total		91%	97%	93%	92%	89%	108%	100%	92%	94%	90%	90%	88%	106%	99%
DIVISION B	ACUTE MEDICINE	86%	97%	82%	108%	90%	93%	91%	91%	103%	86%	113%	94%	98%	81%
	CANCER CARE	121%	127%	118%	126%	125%	150%	133%	119%	125%	117%	124%	123%	149%	125%
	EMERGENCY MEDICINE	67%	90%	115%	59%	61%	88%	116%	67%	91%	117%	61%	61%	88%	110%
	SPECIALIST MEDICINE	111%	119%	108%	107%	100%	120%	106%	102%	112%	103%	101%	96%	115%	105%
DIVISION B Total		114%	122%	112%	115%	110%	132%	117%	109%	117%	109%	111%	107%	129%	113%
DIVISION C	CHILD HEALTH	108%	114%	104%	105%	95%	108%	93%	107%	114%	104%	106%	96%	109%	92%
	SUPPORT SERVICES	83%	86%	78%	77%	78%	88%	82%	77%	79%	72%	73%	73%	83%	76%
	WOMEN'S HEALTH	102%	108%	99%	96%	88%	113%	109%	101%	107%	101%	95%	89%	114%	108%
DIVISION C Total		99%	104%	96%	95%	88%	104%	95%	101%	108%	99%	98%	91%	108%	96%
DIVISION D	CARDIOVASCULAR & THORACIC	102%	110%	101%	101%	96%	113%	119%	100%	109%	101%	100%	95%	111%	119%
	NEUROSCIENCES	102%	114%	104%	109%	94%	113%	92%	101%	113%	103%	109%	95%	112%	92%
	RADIOLOGY	133%	174%	138%	107%	129%	127%	107%	108%	144%	112%	85%	104%	102%	101%
	TRAUMA & ORTHOPAEDICS	91%	102%	87%	77%	69%	89%	91%	90%	102%	89%	77%	69%	92%	104%
DIVISION D Total		99%	109%	98%	96%	87%	105%	102%	98%	109%	99%	98%	88%	107%	105%
Total		**101%**	**108%**	**100%**	**100%**	**94%**	**113%**	**104%**	**101%**	**108%**	**100%**	**100%**	**95%**	**114%**	**104%**

Elective Recovery Fund 21/22

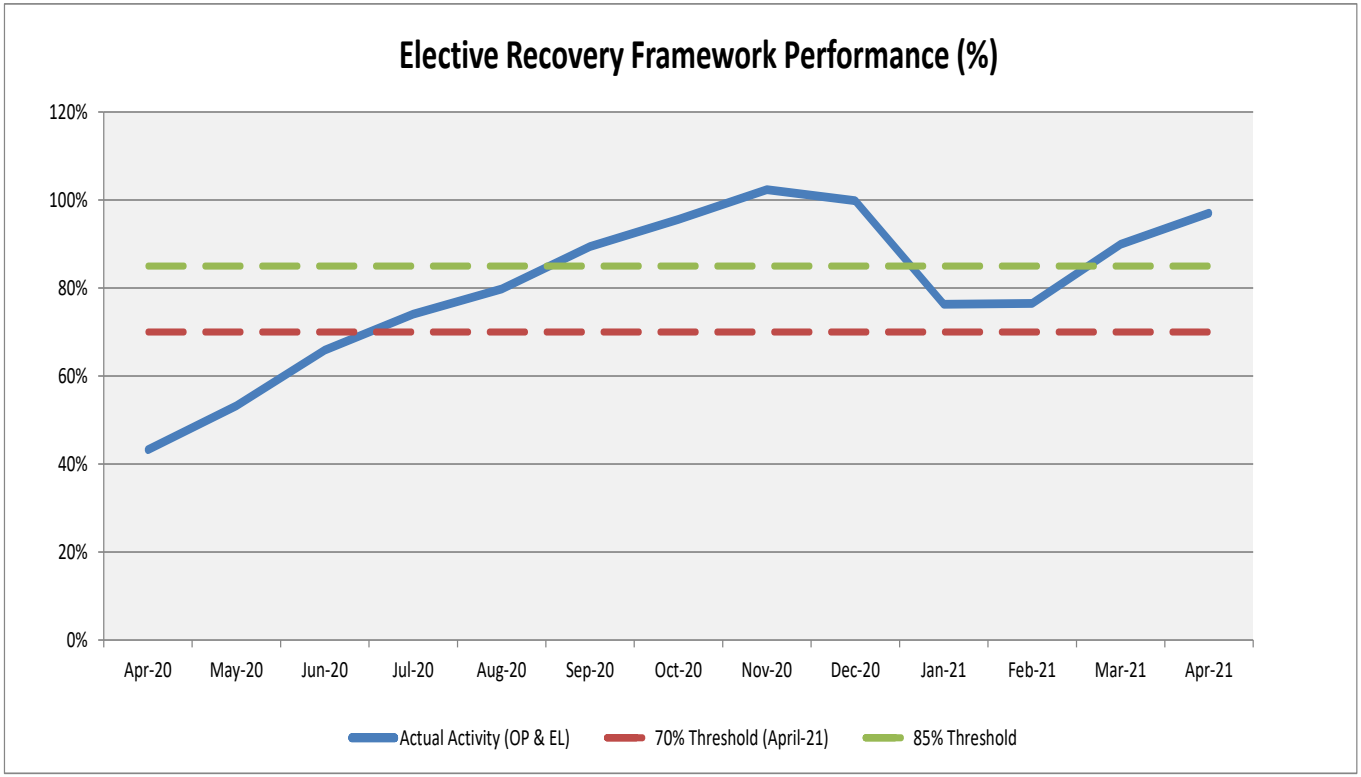
The Elective Recovery Fund has been launched as part of the 21/22 planning guidance as a mechanism for distributing £1bn of national recovery funds for Elective and Outpatient activity.

Providers are targeted with achieving threshold equivalent PbR income levels set at a % of pre-Covid income levels (Price x Activity).

The graph shows the trends through 20/21 and estimated performance for April. This indicates performance of 97% of baseline activity which is 27% over the target threshold of 70% in April. This would yield an estimates £5m additional income if paid at tariff.

It should be noted that this is an early estimate of this data and has dependencies on the performance of others from within the ICS.

The 20% premium has already been agreed with ICS partners will be centrally pooled rather than allocated directly to providers.



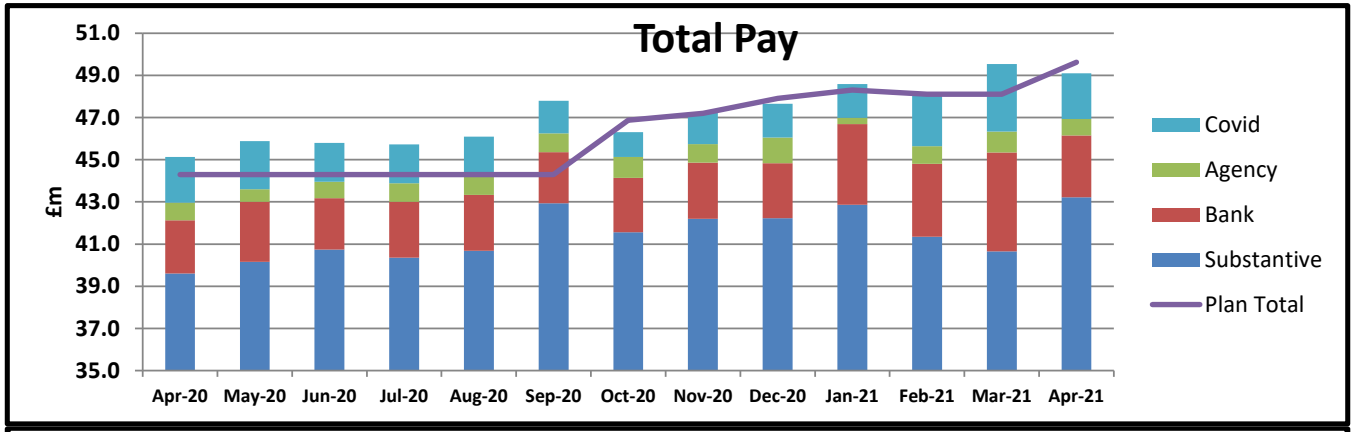
	ERF Achievement - Elective/Daycase/Outpatients (£'000)			
	Baseline	Actuals	Variance	%
April	**£18,716**	**£18,083**	**(£633)**	***97%***

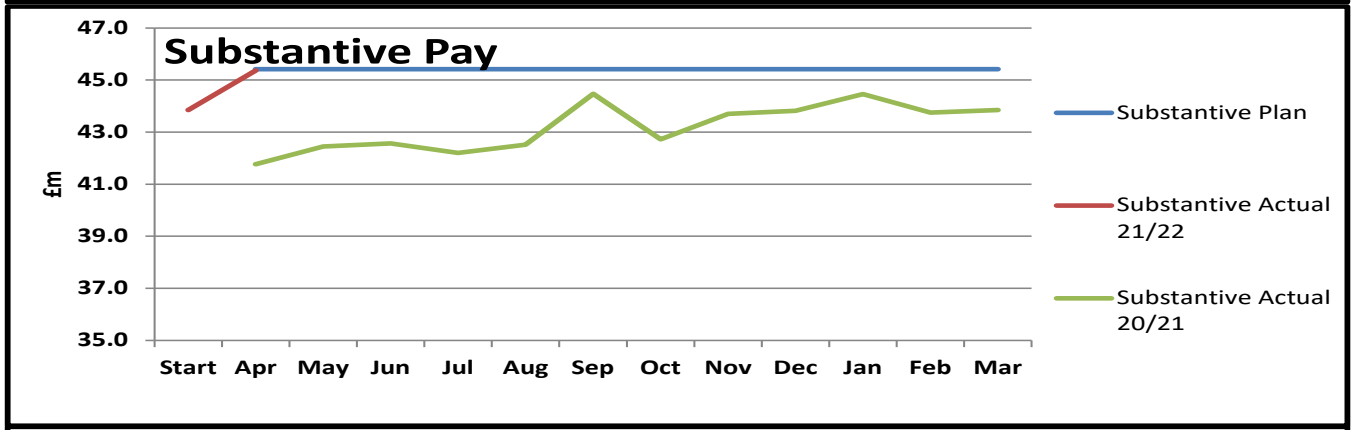
ERF Top Up (£'000)		
100% Top Up	20% Top up	Total
£4,982	£435	**£5,417**

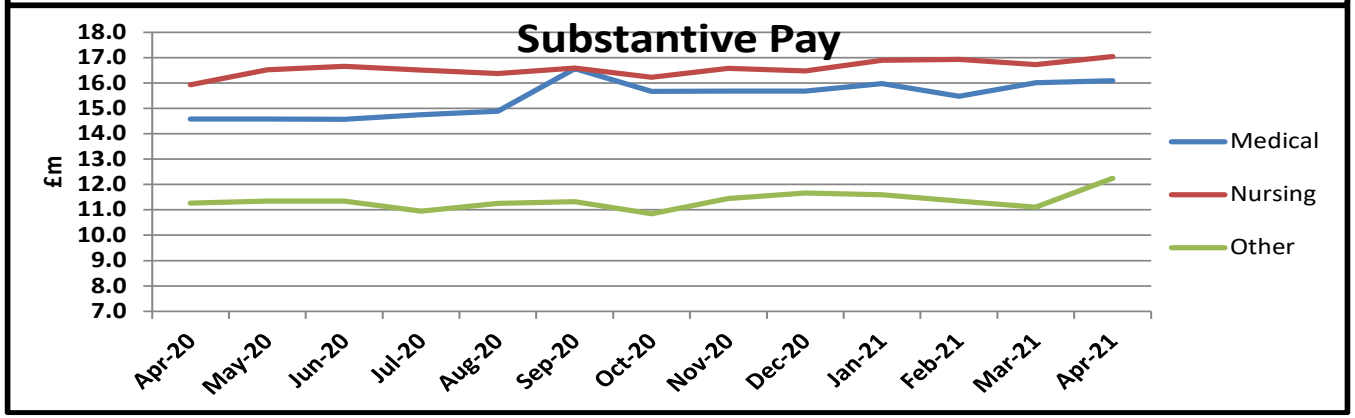
Substantive Pay Costs

Total pay expenditure in April was £49.1m. This was £0.5m lower than March costs once normalised for one offs. The primary drivers for this reduction was reduced vaccine hub costs and reduced spend within critical care as their footprint reduced in line with reduced covid demand.

Pay costs do however remain in excess of that seen last year prior to the second covid wave. These will be monitored closely going forward as costs are expected to increase as new theatre capacity comes on board this summer in addition to investment in recovery plans funded via ERF.





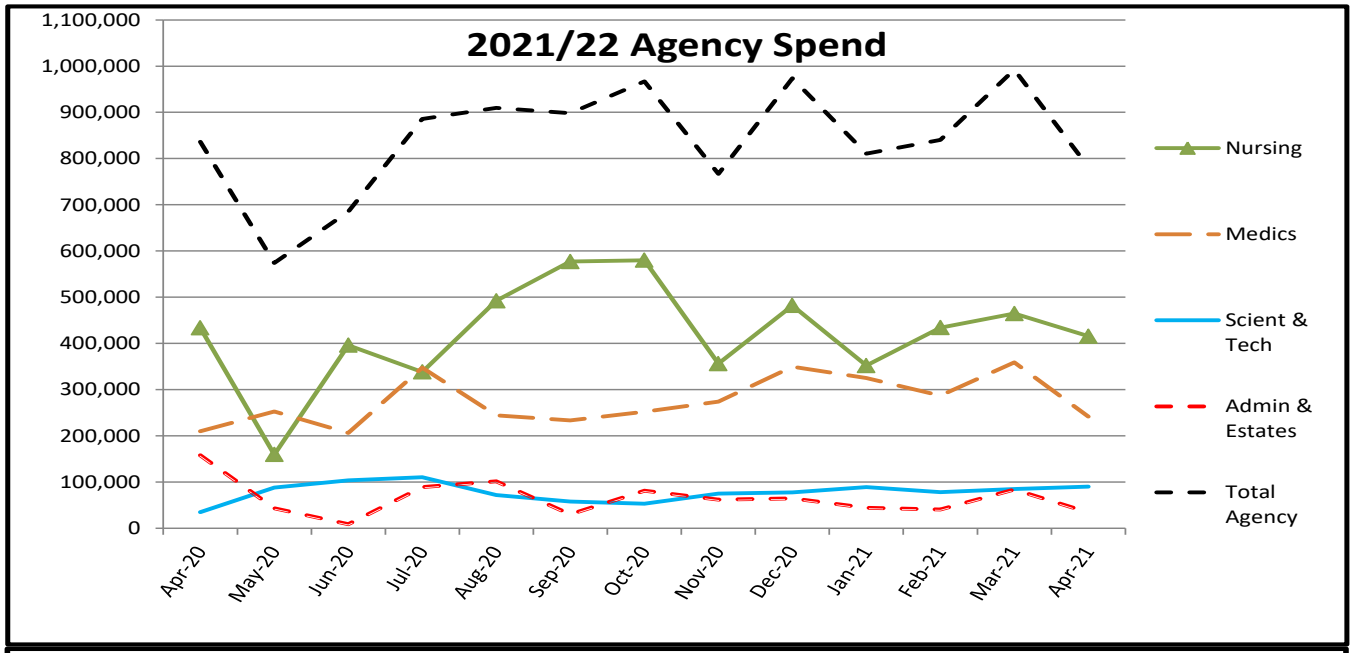


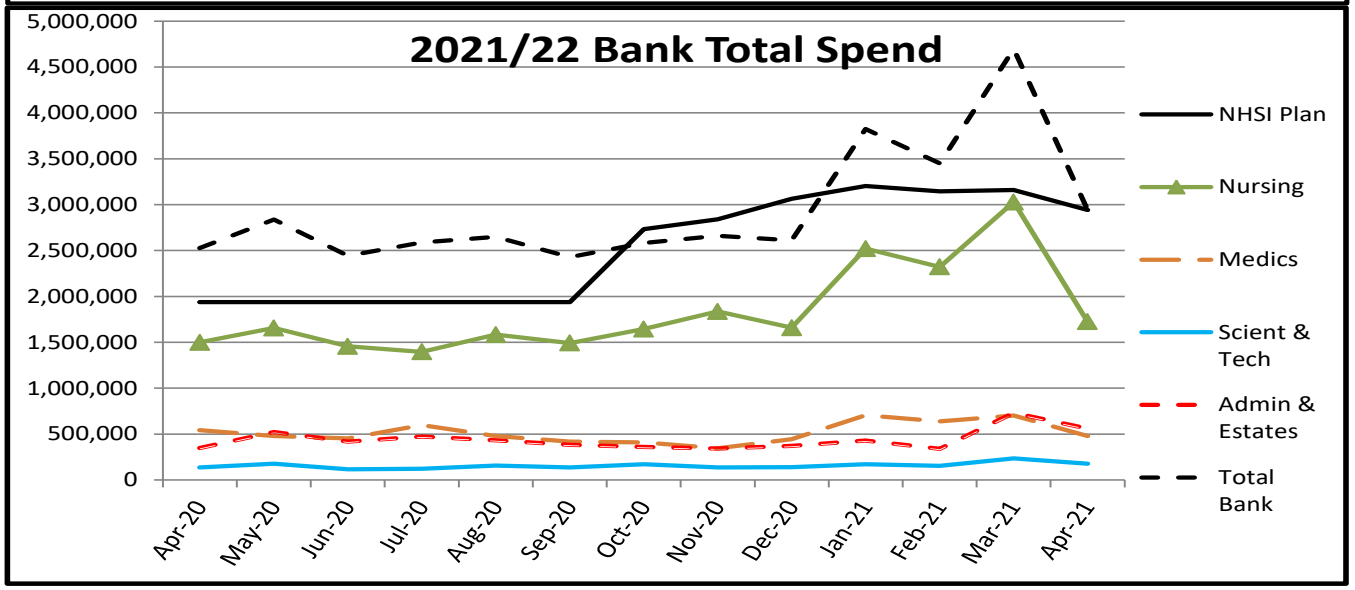
Temporary Staff Costs

Agency spend has decreased month on month by £0.2m with the largest decreases in medics, admin and estates costs.

Expenditure on bank staff has decreased significantly in month by £1.7m down from a high of £4.7m in March 2021. This is partially explained by the catch up of agency staff costs at the Vaccination Hub in March 2021 of £0.85m not repeated in April, and a decrease of £0.3m in bank staff spend in Critical Care; although decreases were seen across all staff groups.

Bank spend is expected to increase slightly in future months as elective recovery increases.



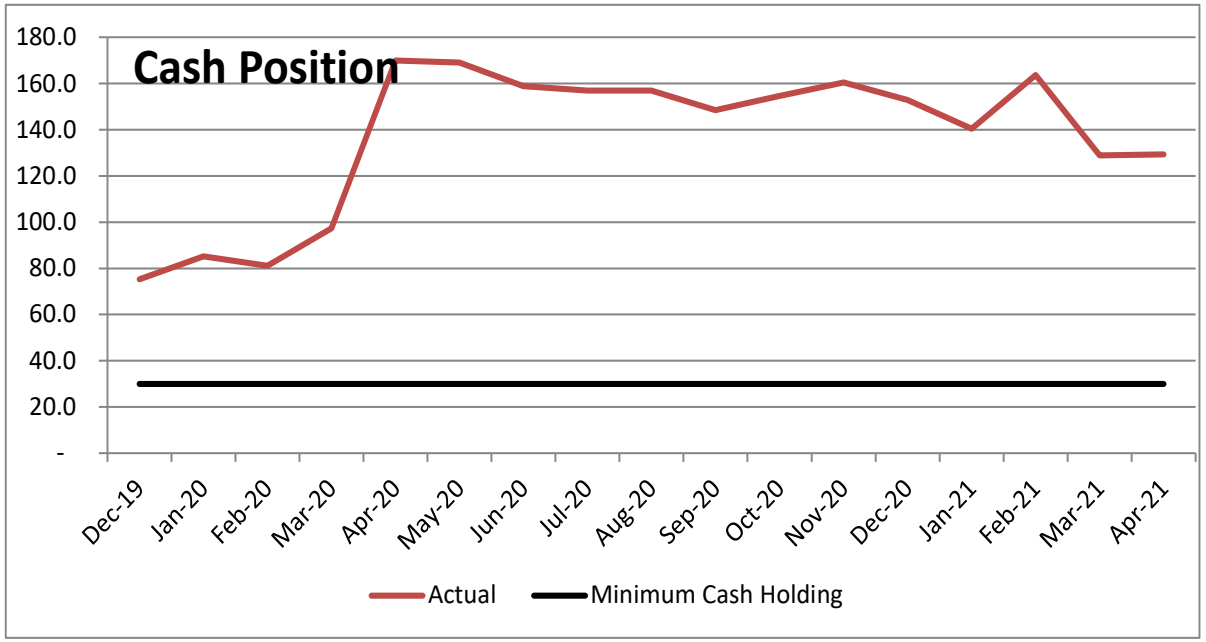


Cash

The cash balance remained stable increasing very slightly in April to £129.3m.

There are no foreseen material movements forecast now the cash regime has adjusted back to pre-covid levels with block income paid in the month for which it is due. We may however see some in-month volatility as we move to a more "normal" period and the working capital position stabilises. Payments for one-off items such as annual leave accruals will have a temporary impact on cash.

A gradual reduction is expected over the next two years as capital expenditure exceeds depreciation.



Capital Expenditure

(Fav Variance) / Adv Variance

Expenditure on internally funded capital schemes in month one was £4.0m against a budget of £3.9m. Total expenditure including externally funded schemes was £4.0m against budget of £4.2m; a small underspend of £0.1m.

There was a notable variances on the vertical extension E level theatres scheme where expenditure was £1m less than the £2.6m anticipated expenditure; however the project is still on-track to deliver on-time.

The side rooms scheme and the IT programme both spent more quickly than anticipated, but are still forecast to spend to their budget.

The forecast expenditure for the year currently equals the capital plan; £49.8m for internally funded schemes (the Trust's CDEL limit) and £53.7m including externally funded schemes. This forecast will be refined in future months.

	Month			Year to Date			Full Year (Forecast)		
Scheme	Plan £000's	Actual £000's	Var £000's	Plan £000's	Actual £000's	Var £000's	Plan £000's	Actual £000's	Var £000's
Fit out of E level. Vertical Extension - Theatres	2,583	1,557	1,026	2,583	1,557	1,026	11,941	11,941	0
Strategic Maintenance	258	375	(117)	258	375	(117)	6,183	6,183	0
ED Expansion and Refurbishment	627	505	122	627	505	122	5,791	5,791	0
Wards	0	0	0	0	0	0	4,000	4,000	0
Ophthalmology OPD	0	125	(125)	0	125	(125)	3,303	3,303	0
Maternity Induction Suite	0	0	(0)	0	0	(0)	2,000	2,000	0
NICU Pendants	0	0	0	0	0	0	896	896	0
Oncology Ward	430	107	323	430	107	323	861	861	0
Decorative / Environment Improvements	21	0	21	21	0	21	500	500	0
Side Rooms	200	384	(184)	200	384	(184)	490	490	0
Information Technology Programme	250	356	(106)	250	356	(106)	5,000	5,000	0
Other Projects	194	589	(395)	194	589	(395)	3,060	3,060	0
Pathology Digitisation	59	5	54	59	5	54	1,171	1,171	0
Medical Equipment	42	2	40	42	2	40	1,000	1,000	0
Slippage	(916)	0	(916)	(916)	0	(916)	(5,035)	(5,035)	0
Total Trust Funded Capital excl Finance Leases	**3,748**	**4,006**	**(258)**	**3,748**	**4,006**	**(258)**	**41,161**	**41,161**	**0**
Finance Leases - IISS	0	0	0	0	0	0	5,230	5,230	0
Finance Leases - MEP	92	6	86	92	6	86	2,200	2,200	0
Finance Leases - Other Equipment	75	0	75	75	0	75	1,500	1,500	0
Finance Leases - Opthalmology OPD	0	0	0	0	0	0	1,166	1,166	0
Finance Leases - Divisonal Equipment	25	0	25	25	0	25	475	475	0
Donated Income	(88)	0	(88)	(88)	0	(88)	(1,921)	(1,921)	0
Total Trust Funded Capital Expenditure	**3,852**	**4,011**	**(159)**	**3,852**	**4,011**	**(159)**	**49,811**	**49,811**	**0**
Fit out of E level. Vertical Extension - Theatres	147	0	147	147	0	147	700	700	0
Maternity Care System (Wave 3 STP)	96	23	73	96	23	73	1,917	1,917	0
Digital Outpatients (Wave 3 STP)	41	0	41	41	0	41	814	814	0
LIMS Digital Enhancement	38	0	38	38	0	38	455	455	0
Total CDEL Expenditure	**4,174**	**4,035**	**139**	**4,174**	**4,035**	**139**	**53,697**	**53,697**	**0**

University Hospital Southampton NHS
NHS Foundation Trust

Statement of Financial Position

(Fav Variance) / Adv Variance

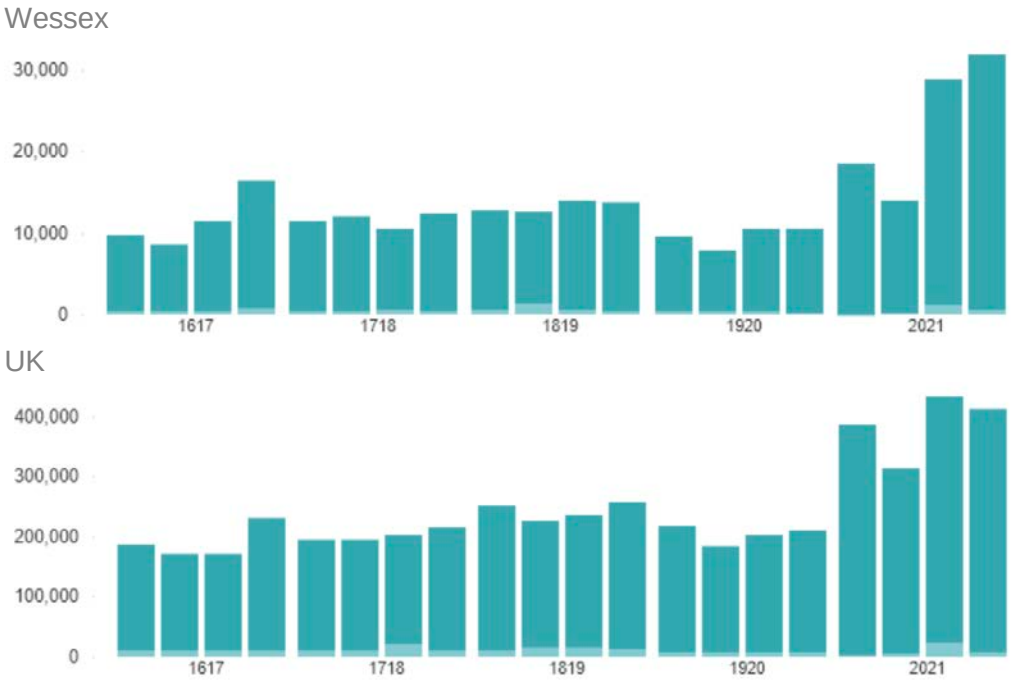
The April statement of financial position illustrates net assets of £444.6m which is stable compared to March 2021.

Most balances have remained similar from the reported 20/21 year end position with only minimal movements reported.

Statement of Financial Position	2020/21 YE Actuals £m	2021/22 M12* Act £m	2021/22 M1 Act £m	2021/22 MoM Movement £m
Fixed Assets	419.4	419.4	420.0	0.6
Inventories	14.7	14.7	14.7	0.0
Receivables	63.5	63.5	64.7	1.2
Cash	128.9	128.9	129.3	0.4
Payables	(170.4)	(170.4)	(172.5)	(2.1)
Current Loan	(2.7)	(2.7)	(2.7)	0.0
Current PFI and Leases	(9.0)	(9.0)	(8.9)	0.1
Net Assets	**444.4**	**444.4**	**444.6**	**0.2**
Non Current Liabilities	(18.3)	(18.3)	(18.7)	(0.4)
Non Current Loan	(8.5)	(8.5)	(8.2)	0.3
Non Current PFI and Leases	(36.3)	(36.3)	(35.6)	0.7
Total Assets Employed	**381.3**	**381.3**	**382.1**	**0.8**
Public Dividend Capital	246.0	243.5	244.4	0.9
Retained Earnings	120.6	120.6	120.5	(0.1)
Revaluation Reserve	17.2	17.2	17.2	0.0
Other Reserves	0.0	0.0	0.0	0.0
Total Taxpayers' Equity	**383.8**	**381.3**	**382.1**	**0.8**

* Amended after M12 Finance Report

Report to the Trust Board of Directors				
Title:	**CRN: Wessex 2020/21 Annual Report and 2021/22 Annual Plan**			
Agenda item:	**6.1**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Author:	**Graham Halls, Business Intelligence Manager, CRN Wessex** **Rebecca McKay, Chief Operating Officer, CRN Wessex**			
Date:	**27 May 2021**			
Purpose	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **x**
Issue to be addressed:	The scheduled performance report would normally cover CRN Wessex's performance against the National Institute for Health Research's (NIHR) high level objectives (HLOs) in a single financial year. These were suspended in 2020/21. Instead, this report covers urgent public health (UPH) research including COVID-19 vaccine trials, the managed recovery of non-UPH studies and the delivery of commercial research activity. CRN Wessex's annual plan for the 2021/22 financial year is also summarised. **Key achievements / issues:** ● 2020/21 has been a successful year for the network and its partner organisations. New ways of working and a cross-organisation collaborative approach has been delivered throughout the year, and has resulted in fast responses to the pandemic, higher volumes of recruitment and the establishment of three vaccine & future research hubs. ● The scope and volume of research studies delivered has fallen because the pandemic has caused staff absence and diversion to treat COVID-19 patients. The NIHR's managed recovery process, currently underway, is designed to ensure the restoration of clinical research activity that was happening pre-COVID-19. ● 93,133 research participants were recruited in Wessex in the financial year, the highest ever. Over 40,000 participants were recruited to NIHR UPH studies, with two Wessex hospitals in the top twenty UK recruiting sites. ● Ten UPH studies have been led out of Wessex; observational, treatment and vaccine studies. In total 8,373 participants have been recruited to these studies across 163 UK study sites. ● The region achieved all but one of the NIHR CRN's performance standards for 2020/21. The percentage of organisations participating in commercial research was lower than the goal, however recruitment increased on 2019/20 thanks to the commercially sponsored and funded vaccine trials.			

Response to the issue:	**1 Purpose/Context/Introduction** This report is to inform the UHS Board of the clinical research activities within CRN Wessex since the start of the COVID-19 pandemic. The report covers urgent public health research (including vaccine trials), the managed recovery of other studies and the delivery of commercially funded and sponsored research activity. The CRN Wessex annual plan for the 2021/22 financial year (Apr-Mar) is described within the report and summarised in the appendix. The timeline for this report is not limited to the 2020/21 financial year as the region's response to the pandemic has crossed two financial years to date. The period covered is provided below each chart, where applicable. **2 Key issues** **Research activity in 2020/21 and lessons learnt** Wessex has had a very strong year for research recruitment when compared to previous financial years (chart 1a). In 2020/21 **CRN Wessex partner organisations recruited 93,133 participants, one and three-quarter time higher than the previous highest figure in the 2018/19 financial year**. 2020/21 has represented a step change for Wessex (and UK) clinical research, with the pandemic acting as a catalyst for platform trials, fast site setup and Wessex-wide collaborative approaches to research delivery.  Chart 1a – NIHR CRN portfolio research recruitment by quarter over the last five financial years in Wessex and the UK for comparison. Darker blue is non-commercial; lighter is commercial. **Three new vaccine research hubs** have been established that will provide the legacy of additional research capacity post pandemic for community, primary care and high throughput research. The region has collectively supported the setup and delivery of the vaccine research programme and

urgent public health studies related to the prevention and treatment of COVID-19.

In the same manner that the pandemic disrupted clinical services, it has **seriously affected the volume and scope of studies** being delivered across the UK. Chart 1b illustrates that the number of recruiting studies within Wessex has fallen from the relatively stable levels seen in the four previous financial years. This has happened for several reasons, but most notably the restrictions on face-to-face contact with patients, absence, and the diversion of research staff to clinical services. The effect on the population is difficult to quantify but it is expected that patient outcomes will be worse due to restricted availability of clinical research treatment pathways.

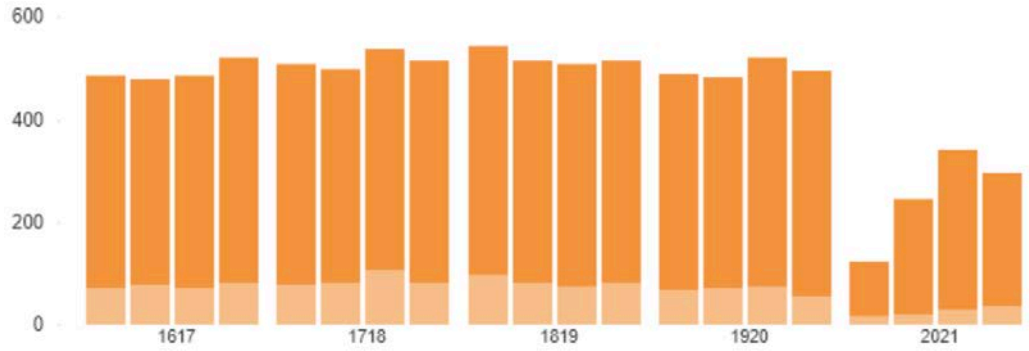


Chart 1b – NIHR CRN portfolio studies that have recruited within Wessex by quarter in the last five financial years. Darker orange is non-commercial; lighter is commercial.

CRN Wessex and its partner organisations have **adopted new ways of working** during the pandemic which will continue, including the increased use of virtual meeting tools and the establishment of research hub delivery teams.

Virtual contact using all major platforms has led to increased efficiency through reduced travel time and faster meeting scheduling. In particular, Microsoft Teams has been rolled out across the region and is used to manage the vaccine hubs and host weekly calls for CRN Wessex partners. Pandemic research has been fast moving, with amendments and trial news released very regularly. Therefore, weekly contact with R&D departments and delivery teams became essential to share changes to existing studies and enrol Wessex organisations on new COVID-19 studies. Ad-hoc regional meetings have become easier and more flexible to arrange, with the option of viewing recordings for those that can't attend.

The research management system EDGE has been utilised successfully to track the effect of the pandemic on existing portfolios, including recording the assessment of study viability under these conditions. The rollout of pandemic site statuses has enabled oversight of the pause, suspension and more recently, restart of the portfolio. As a result of the pandemic and a realisation nationally of the need to include a more diverse population in research trials, EDGE data collection is being adjusted and will be used to track ethnicity and a marker of social deprivation for future performance reviews (will be

implemented during 2021/22).

Following the announcement of the Comprehensive Spending Review, DHSC confirmed an **additional £30m of recurrent funding for LCRNs from 2021/22**.

£7.46m allocated to the LCRNs to **alleviate known cost pressures** during the financial year, e.g., inflation, apprenticeship levy charges and HEI employer pension contributions. A further £10m is allocated to **support staff retention** where posts are at risk within LCRN Partners and **allow for the recommencing/enhanced recruitment to priority studies.**

DHSC has agreed that the remaining £12.5m of the additional £30m funding provided for the 2021/22 financial year is to be used to build a new workforce - a **'CRN Direct Delivery Team'** - in each LCRN with the flexibility, capability and capacity to deliver priority research studies across broader settings, particularly outside of hospital settings. This will result in an increase in recruitment per head of population as a result of creating wider opportunities for people to participate in research, and an increase in the number of people recruited outside of a secondary care setting.

This transformation of research delivery will not be completed within one year; it is a direction of travel that, due to its CRN-wide nature, may take up to three years to become embedded into standard practice. An amount of CRN funding will be assigned to the continued development of this initiative in future years.

Wessex has received just under £2M of the £30M allocation (6%)

The CRN Direct Delivery team will be based at the three hubs established within Wessex at Bournemouth, Southampton, and Portsmouth. The substantial efforts and collaboration that went into creating the hubs and the addition funding will sustain a valuable legacy. The staff will be substantive UHS employees and line managed by CRN Wessex.

Urgent public health (UPH) research

UPH is defined by the NIHR as research that needs to take place during the emergency phases of the pandemic when infection rates are high (further information: https://www.nihr.ac.uk/covid-19/). The NIHR's goal is to gather the necessary clinical and epidemiological evidence to inform national policy and enable new diagnostics, treatments, and vaccines to be developed and tested.

The NIHR's prioritisation of research during the pandemic is shown in chart 2a.

Level 1a	Level 1a (Top Priority) – COVID-19 UPH vaccine and prophylactic studies (as prioritised by the Vaccines Task Force) and the following studies: RECOVERY/RECOVERY +; PRINCIPLE; REMAP CAP; SIREN; VIVALDI and ISARIC-CCP-UK.
Level 1b	Other COVID-19 UPH studies.

Level 2	Studies where the research protocol includes an urgent treatment or intervention without which patients could come to harm. These might be studies that provide access to potentially life preserving or life-extending treatment not otherwise available to the patient.
Level 3	All other studies (including COVID-19 studies not in Level 1a or 1b).

Chart 2a – Prioritisation of clinical research activity originally from the NIHR's Restart Framework, and since amended following advice from the DHSC Deputy Chief Medical Officer.

CRN Wessex's activities to support the UPH studies is summarised in charts 2b. Two Wessex sites, Southampton General Hospital and Queen Alexandra Hospital in Portsmouth, are within the top twenty recruiting UK trusts over this period (chart 2c).

UPH studies that have recruited	Participants recruited to UPH studies	Sites participating in UPH research
45 (58%)	40,233 (4%)	208 (5%)
Wessex	Wessex	Wessex
77	1,038,329	3,963
UK	UK	UK

Chart 2b – Key UPH research deliverables in Wessex with UK figures provided for reference: 1st April 2019 – 11th May 2021.

NHS trust	Clinical research network	UPH recruitment
Yorkshire Ambulance Service	Yorkshire and Humber	66,318
University Hospitals of Leicester	East Midlands	26,003
Barts Health	North Thames	11,189
Guy's and St Thomas	South London	9,294
University Hospitals Birmingham	West Midlands	8,897
Manchester University	Greater Manchester	7,829
Liverpool University Hospitals	North West Coast	7,359
Mid and South Essex	North Thames	7,304
Nottingham University Hospitals	East Midlands	6,980
University Hospital Southampton	Wessex	6,755
University Hospitals of North Midlands	West Midlands	5,754
Imperial College Healthcare	North West London	5,694
Pennine Acute Hospitals	Greater Manchester	5,670
East Lancashire Hospitals	Greater Manchester	5,331
East Suffolk and North Essex	Eastern	5,115
University Hospitals of Derby and Burton	East Midlands	5,004
St George's University Hospitals	South London	4,922
Portsmouth Hospitals University	Wessex	4,828

Leeds Teaching Hospitals	Yorkshire and Humber	4,538
Bedfordshire Hospitals	Eastern	4,495

Chart 2c – Top twenty highest recruiting sites for UPH research: 1st April 2019 – 11th May 2021.

Wessex recruitment to the interventional UPH studies has been benchmarked against the other clinical research networks in chart 2d. The recruitment is standardised using the hospitals admissions with confirmed COVID-19 within each network. Wessex partner organisations have supported the interventional studies well with over one in four patients being enrolled.

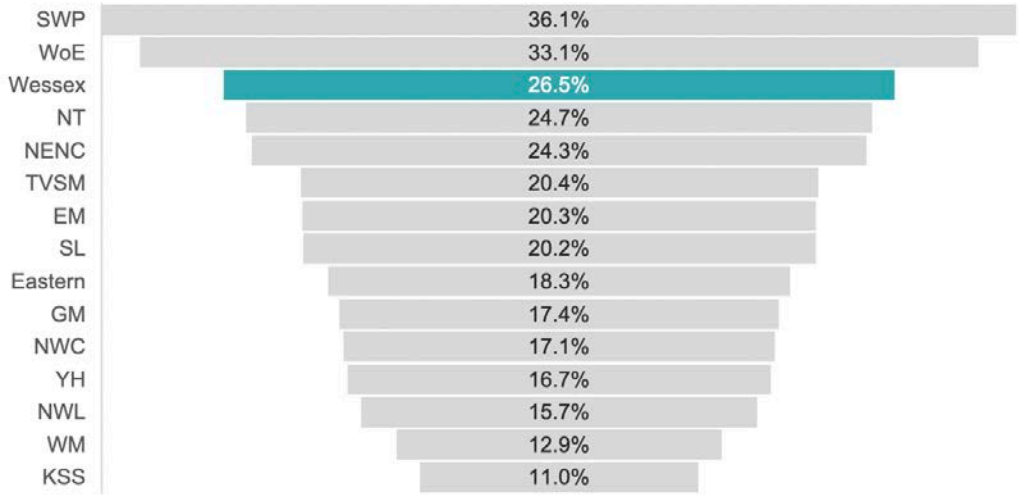
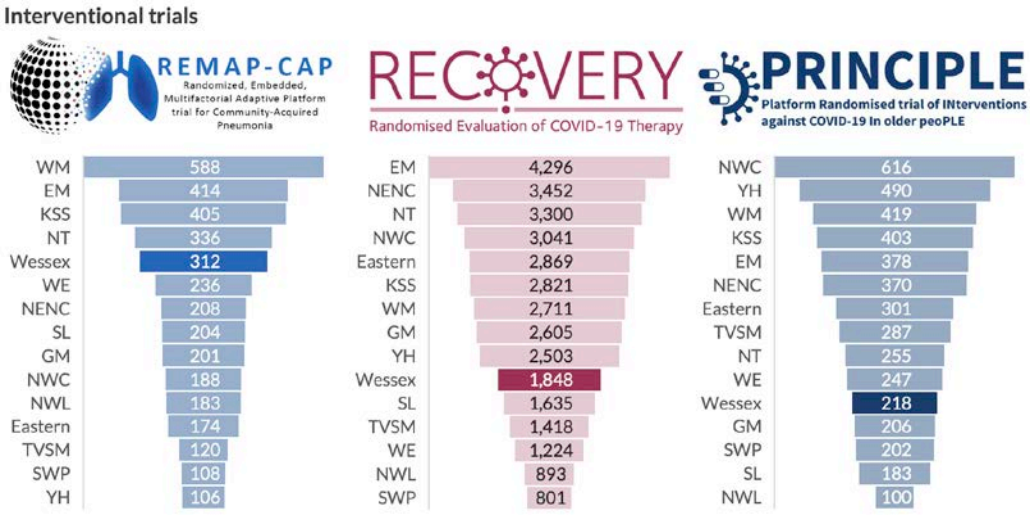


Chart 2d – Interventional UPH study recruitment as a percentage of hospital admissions with confirmed COVID-19: 17th March 2020 – 12th May 2021.

Wessex recruitment to the studies that have been assigned NIHR priority 1a has been summarised in chart 2e. The VIVALDI study, which had the lowest recruitment, initially recruited from a private care home provider that has a minimal presence in the Wessex region.



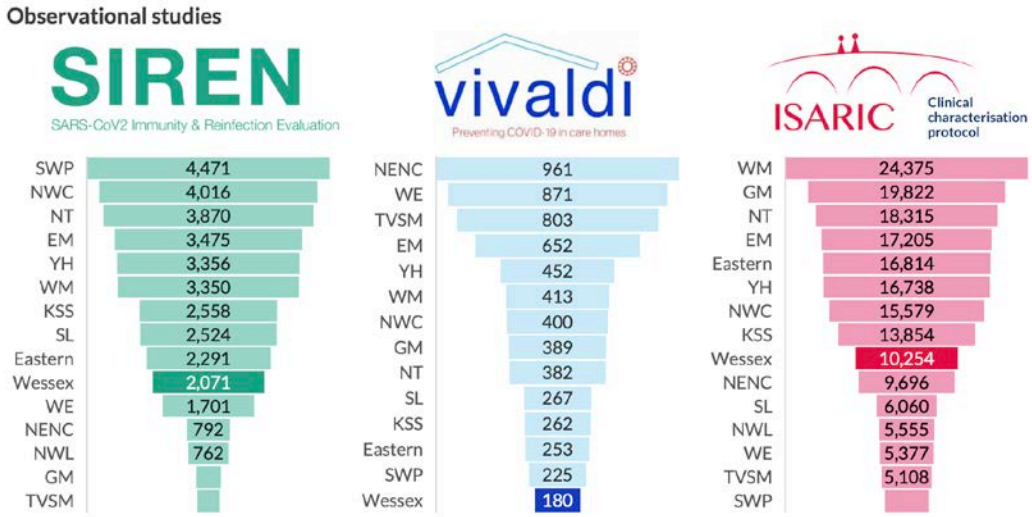


Chart 2e – Recruitment by local clinical research network to NIHR priority 1a urgent public health studies: 1st April 2019 – 11th May 2021.

Ten UPH studies have been led out of Wessex; observational, treatment and vaccine studies. In total 8,373 participants have been recruited to these studies across 163 national study sites, of which 2,214 participants were recruited within Wessex.

DHSC Recovery, Resilience and Growth Programme (RRG)

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

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

The NIHR have developed a managed recovery process to support this programme, with further details at the NIHR website. Research funders identify their most urgent studies, which are then reviewed by the national speciality leads and lead research network to determine whether they need additional support. This is done in consultation with the recruiting sites across the country. In this way research recovery can be sequenced, without affecting studies that have restarted successfully.

The restart of research sites across the region has been tracked since the beginning of the 2021/22 financial year (chart 3). The changes are slow, but the situation is improving, with the proportion of paused study sites reducing by 1.2 percent in a month. Study sites that have recruited in the last 30 days (from measurement date) will be a key measure of successful recovery. The goal is for this to return to levels seen pre-pandemic at 11.8 percent (May 2019) – approximately three times the current percentage. While this seems low, it is unlikely that every study or research site in all care settings will recruit monthly. For comparison 80 percent of Wessex recruitment in the 2019/20 financial year came from just 17 percent of the studies, therefore it is much more likely for a study to be recruiting infrequently.

Status	Apr 2021 Sites	Apr 2021 Proportion	May 2021 Sites	May 2021 Proportion	Change since Apr
In setup	202	7.0%	229	7.8%	0.8%
Open (no recent recruitment)	1,359	47.3%	1,398	47.7%	0.4%
Open (recruited in last 30 days)	92	3.2%	111	3.8%	0.6%
Paused due to pandemic	460	16.0%	435	14.8%	-1.2%
Suspended (not pandemic related)	57	2.0%	74	2.5%	0.5%
Follow up continuing as planned	705	24.5%	685	23.4%	-1.2%
Total Wessex study sites	**2,875**	**100%**	**2,932**	**100%**	0.0%

Chart 3 - Tracking the recovery of study sites within Wessex using site statuses: 1st April – 10th May 2021.

Vaccine trials

Three Wessex vaccine research hubs were set up in Hampshire (Southampton & Portsmouth) and Dorset (Bournemouth) as a collaborative system wide endeavour with £1m of pump prime funding from the Vaccine Task Force. The hubs have been supported by a successful workforce campaign, with more than 300 NHS staff involved since inception.

2,031 healthy volunteers have been recruited to twelve COVID-19 vaccine trials since April 2020. It is expected that the trials will continue for at least a year as the vaccines are trialled in combination, and in child, adolescent, and maternal patient cohorts. All volunteers require follow up visits, therefore the capacity required increases with each participant recruited and study Wessex is participating in. Chart 4 shows the trial visits that have taken place at the Southampton vaccine research hub since April 2020. Monthly data is unavailable, but a further 4,625 visits have taken place at the Bournemouth vaccine research hub over the same period. Five vaccine trials have been led out of Wessex, with the region running the most trials out of all clinical research networks.

To keep up with the progress of the vaccine trials in Wessex you can sign up for the newsletter at https://bit.ly/WessexHubnews.
In addition to the vaccine trials the research hubs will be used for non-COVID-19 research over at least the next three financial years. There are discussions underway to open other hubs within the region due to their success as a research delivery method.

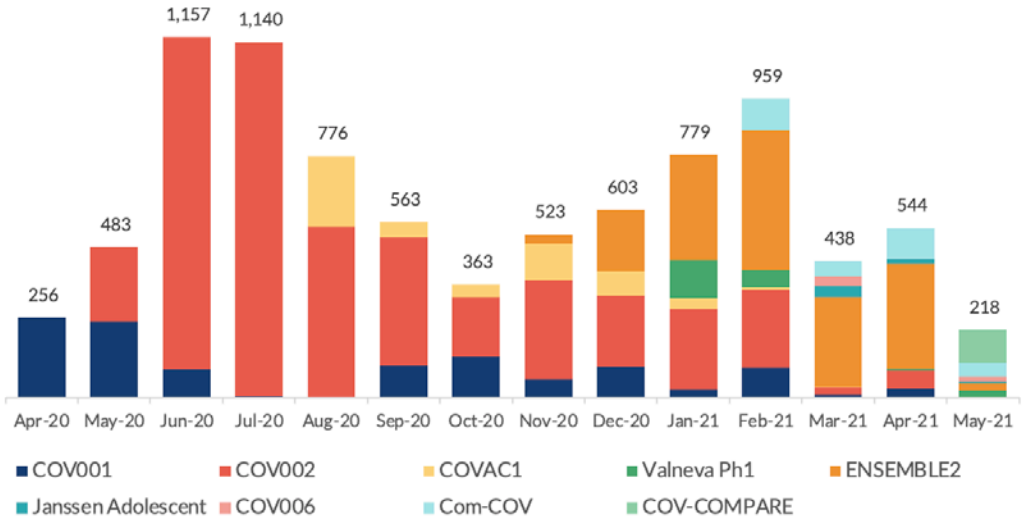


Chart 4 – Trial visits since April 2020 at the Southampton vaccine research hub only. All vaccine trials have 4-9 visits over the course of each year, so the vaccine hubs and staff have been fully engaged throughout the time period.

Commercial research activity

Commercial research activity is important to the Wessex region. It provides novel treatment options for patients, funding for research delivery and savings on treatment costs for participating organisations. It is essential therefore that commercial activity is at a minimum maintained each year within Wessex, and this is tracked in chart 5a.

There has been an increase in recruitment in the last financial year but a reduction in the number of studies (chart 1a). This is because around half of the vaccine recruitment was on to comparatively few commercially funded and sponsored trials and studies in other specialties were paused. Commercial recruitment in 2020/21 was just below the five-year average of 1,901 participants.

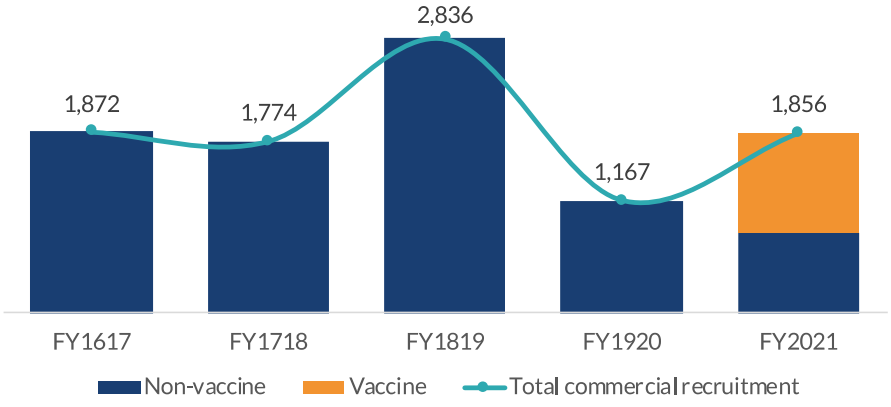


Chart 5a – Wessex recruitment on to commercially funded and sponsored research studies: last five financial years

8.1 percent of commercial study sites within Wessex are currently paused due to the pandemic (chart 5b). This is a 6.2 percent improvement from April 2021, however the percentage of sites that have recruited in the last 30 days remains low. Recovering and growing the commercial portfolio will be a key objective of CRN Wessex during the 2021/22 financial year.

Status	Apr 2021 Sites	Apr 2021 Proportion	May 2021 Sites	May 2021 Proportion	Change since Apr
In setup	53	10.8%	69	15.5%	4.7%
Open (no recent recruitment)	158	32.2%	153	34.5%	2.2%
Open (recruited in last 30 days)	6	1.2%	7	1.6%	0.4%
Paused due to pandemic	70	14.3%	36	8.1%	-6.2%
Suspended (not pandemic related)	8	1.6%	8	1.8%	0.2%
Follow up continuing as planned	195	39.8%	171	38.5%	-1.3%
Total Wessex study sites	**490**	**100%**	**444**	**100%**	0.0%

Chart 5b - Tracking the restart of commercial study sites within Wessex using site statuses: 1st April – 10th May 2021.

NIHR CRN Performance Standards in 2020/21

Chart 6 summarises Wessex performance against the NIHR CRN Performance Standards during the last financial year. All were achieved, or supported where there was no local target, except for the scope of commercial participation. Non-UPH commercial activity was paused by partner organisations due to the change in treatment pathways to support social distancing and the diversion of research staff to the pandemic response.

CRN Performance Standards in 2020/21			Ambition	Wessex
Efficient study delivery	Deliver NIHR CRN Portfolio studies to recruitment target within the planned recruitment period	Proportion of new commercial contract studies achieving or surpassing their recruitment target during their planned recruitment period, at confirmed CRN sites	70%	90%
Provider participation	Widen participation in research by enabling the involvement of a range of health and social care providers	(a) Proportion of NHS Trusts recruiting into NIHR CRN Portfolio studies	99%	100%
		(b) Proportion of NHS Trusts recruiting into NIHR CRN Portfolio commercial contract studies	70%	66%
		(c) Proportion of General Medical Practices recruiting each year into NIHR CRN Portfolio studies	45%	>45%

		(d) Number of non-NHS sites recruiting into NIHR CRN Portfolio studies	2,250 (National target)	20 (No local target)
Participant experience	Demonstrate to people taking part in health and social care research that their contribution is valued.	Number of NIHR CRN Portfolio study participants responding to the Patient Research Experience Survey each year.	12,000 (National target)	516 (No local target)
Urgent public health	Minimise set-up times for NIHR CRN UPH Portfolio studies	Study site set-up time (working days)	9	6
Restart	Restart the NIHR CRN Portfolio paused by Sponsors and Sites due to COVID-19	(a) Percentage of paused commercial contract studies that are no longer paused on 31 March 2021	80%	84%
		(a) Percentage of paused non-commercial studies that are no longer paused on 31 March 2021	80%	85%

Chart 6 – NIHR CRN performance standards for 2020/21

CRN Wessex annual plan for the 2021/22 financial year

Appendix 1 contains a summary of the CRN Wessex annual plan, which is submitted to the NIHR for approval at the beginning of each financial year.

There are four national priorities provided by the NIHR CRN that our local planned initiatives will work towards (chart 7a).

1	Deliver new and existing activities relevant to the research response to the COVID-19 pandemic: a. COVID-19 Vaccine studies b. COVID-19 Non-Vaccine studies	The first priority is COVID-19 pandemic research, to support the prevention or minimisation of a third wave and to ensure patients that contract the virus have the best possible outcomes.
2	Deliver the CRN activities in the DHSC Recovery, Resilience and Growth Programme	This priority is to deliver the RRG programme which is described earlier in this report.
3	Primary Care Research Engagement	Increasing the availability of research in primary care is one of the main objectives of the NIHR CRN's Primary Care Strategy (March 2021).

4 Review and Refresh Research Delivery (including Direct Delivery Team)	During the pandemic research delivery outside of the hospital setting expanded. This priority comes with additional external funding to create a network Direct Delivery Team over three years, who will be employees of UHS (CRN host organisation). The team will primarily operate out of the new research hubs but may also run studies in other settings such as care homes.

Chart 7a – NIHR CRN National Priorities for 2021/22

The local initiatives to support the national objectives are wide ranging and fall within the following themes:

- Workforce, Learning and Organisational Development
- Patient and Public Involvement and Engagement
- Information and Knowledge
- CRN Specialties
- Capacity building in underserved settings
- Business Development and Marketing
- Communications

The initiatives are either happening within Wessex only, in partnership with the three other clinical research networks in the South-West of England (supranetwork) or collaborating with the national CRN coordinating centre.

The NIHR CRN have introduced the high-level objectives in chart 7b, but these are yet to be confirmed by the DHSC. Future performance reports will include the network's performance against these objectives.

Objective		Measure	Ambition
Efficient Study Delivery	Deliver NIHR CRN Portfolio studies to recruitment target within the planned recruitment period	Proportion of new commercial contract studies achieving or surpassing their recruitment target during their planned recruitment period, at confirmed CRN sites	70%
Provider Participation	Widen participation in research by enabling the involvement of a range of health and social care providers	(A) Proportion of NHS Trusts recruiting into NIHR CRN Portfolio studies	99%
		(B) Proportion of NHS Trusts recruiting into NIHR CRN Portfolio commercial contract studies	Either 70% or the annual out-turn for 2020/21, whichever

			is lower
		(C) Proportion of General Medical Practices recruiting into NIHR CRN Portfolio studies	Either 45% or the annual out-turn for 2020/21, whichever is lower
		(D) Number of non-NHS sites recruiting into NIHR CRN Portfolio studies	Either 2,250 or the annual out-turn for 2020/21, whichever is lower
Participant Experience	Demonstrate to people taking part in health and social care research studies that their contribution is valued	Number of NIHR CRN Portfolio study participants responding to the Participant in Research Experience Survey, each year	Either 12,000 or the annual out-turn for 2020/21, whichever is lower
Urgent Public Health	Minimise set-up times for NIHR CRN UPH Portfolio studies	Study site set-up time (working days)	9
Recovery, Resilience and Growth	Demonstrate recovery, resilience and growth by delivering increased recruitment to NIHR CRN Portfolio studies, excluding (i) all Urgent Public Health (UPH) studies, and (ii) all non-UPH COVID-19 related) studies	(A) Number of participants recruited to commercial NIHR CRN Portfolio studies (excluding UPH studies and non-UPH COVID-19 related studies)	Annual out-turn for 2020/21 + 10%
		(B) Number of participants recruited to non-commercial NIHR CRN Portfolio studies (excluding UPH studies and non-UPH COVID-19 related studies)	Annual out-turn for 2020/21 + 10%

Chart 7b – NIHR CRN High Level Objectives for 2021/22

Implications: (Clinical, Organisational, Governance, Legal?)	All NHS organisations have a duty to their local population to deliver urgent public health and COVID-19 vaccine research. NHS organisations are also expected to participate in and support health and care research, which is currently in recovery. The NIHR provides service support funding to facilitate research activity within Wessex. The region has received additional public funding for the vaccine hubs and future research delivery. It is therefore necessary for CRN Wessex and its partner organisations to ensure that this is used effectively during the pandemic response and subsequent recovery of non-UPH studies.

Risks: (Top 3) of carrying out the change / or not:	CRN Wessex maintains a risk register which can be found in appendix three. The main identified risks relating to the subjects covered in this paper are: 1. Loss of commercial research income 2. Service pressures within the NHS and social care limiting the capacity for research 3. Further waves of pandemic adversely affecting research capacity Please review the risk register for details of the responses that are already underway or planned.
Summary: Conclusion and/or recommendation	2020/21 has been a successful year for the network and its partner organisations. New ways of working and a collaborative approach has been delivered throughout the year, and has resulted in fast responses to the pandemic, higher volumes of recruitment and the establishment of three vaccine hubs with the legacy of providing additional research infrastructure post pandemic. The UHS Board will continue to be updated on UPH research, the vaccine trials, managed recovery activities and performance quarterly. The annual report to the NIHR will be prepared in the first half of the 2021/22 financial year. The report will be shared with the board for information.

Appendix

Appendix 1 – Summary of CRN Wessex 2021/22 Annual plan

National priority	Description of planned contributions	Related local initiatives and their expected outcomes
COVID-19 Research Deliver new and existing activities relevant to the research response to the COVID-19 pandemic: a) COVID-19 Vaccine studies b) COVID-19 Non-Vaccine studies"	• Wessex supported 1,598 studies and recruited 93,133 participants (6.4% of UK CRN Portfolio) • Three research hubs spread across Wessex will continue to support the vaccine portfolio in 21/22. Single contracting process with hub and spoke working will support rapid set-up. • Wessex supported 52 UPH studies and recruited 40,287 patients (3.9%). 26.3% of admissions have been consistently recruited to interventional UPH studies. • Wessex plans to support UPH portfolio but as admissions diminish support will be diverted in a managed way to recovery, resilience, and growth activity.	Research hubs 1. Three operational research hubs with geographical coverage of the whole region
Recovery, Resilience and Growth of Clinical Research Deliver the CRN activities in the DHSC Recovery, Resilience and Growth Programme	• 159 Wessex-led studies were paused in May 2020. 85% of the studies (84% commercial only) are no longer paused. • Improved intelligence on local investigators to support more efficient study placement. • Support and development of early career researchers • Utilise vaccine hub infrastructure to support rapid set-up and delivery of research studies • Align support with national prioritisation of	**Investigator Database** 1. Collaboration with CRN CC to develop a searchable database of investigators utilising NIHR Learn and ODP **Wessex REACH Initiative** 1. Delivery of 'Year 1' actions as outlined in the Wessex REACH Initiative strategy **Developing a workforce wellbeing and resilience package** 1. Supportive wellbeing package hosted within NIHR Learn. 2. Evaluation of feedback and impact from users

National priority	Description of planned contributions	Related local initiatives and their expected outcomes
	studies to enable orderly recovery of non-COVID research with strong focus on life science industry • Work with NHS POs and local ICSs to deliver a regional research workforce recruitment campaign • Recruit to new LCRN flexible workforce posts to enable research delivery in a variety of non-NHS and alternative settings	**Wessex Clinical Research Practitioner Community** 1. Establish a regional CRP community 2. Host two virtual or face-to-face meetings **Regional research workforce recruitment campaign** 1. Launch of a collaborative research workforce recruitment campaign with Wessex POs and local ICSs 2. Recruitment to research posts within LCRN direct delivery team and in POs **Digital Participant Research Experience Survey** 1. Continue to build on lessons learnt from PRES 2020-21 by increasing partner organisation engagement. Use digital methods for delivery and feedback of PRES. **Novel techniques in PPIE** 1. Delivery of bite size learning OR coffee morning with Wessex PIN to encourage new ways of approaching PPI using examples from social care and qualitative researchers **Reaching under-served communities** 1. Engage widely across supra-region and network to identify and support research in non-traditional settings. 2. Increase diversity of those we engage with through community outreach and shared events across supra regions **Rollout of redesigned local portfolio management system** 1. EDGE version 3.0 trained research workforce across all care settings **Research targeting through multiple deprivation analysis** 1. Supranetwork D will establish whether it is possible to map our research activities in each specialty by postcode, so that when linked to data on deprivation and disease prevalence the geographical areas of greatest need can be identified. **Scoping the recording of participant demographics to identify inequalities in research** 1. Identify whether the recording of demographic data is feasible within all care settings 2. Produce a minimum dataset to support all feasible requested activities from stakeholders

National priority	Description of planned contributions	Related local initiatives and their expected outcomes
		3. Satisfy information governance requirements for the larger project 4. A project proposal in place, having been reviewed by all relevant stakeholders, including patient representatives **Social care** 1. Training and events for social care researchers using online webinars/small sessions to introduce research mindedness 2. Join supra working group and feed into national discussions about appropriate care home funding and support as led by ENRICH team 3. Embedded research post for scoping exercise in Dorset ICS. 4. Supra cross NIHR workshop to facilitate social care project discussions with RDS, ARC **Public Health** 1. Seed research project supported by Public Health consultant and embedded researchers in Local Authorities (LAs) 2. Implement recommendations from the Supporting and Enabling Research in Local Authorities (SERLA) report: (i) Create and embed strategic level appointments, including joint roles across Higher Education Institutions (HEIs) and LAs (ii) Create open data repository platform to amalgamate research evidence from public health, social care and LAs to eliminate duplication in order to address population health needs **Develop a cancer early diagnosis trial portfolio** 1. Following RDM secondment, support Southampton CTU to develop a cancer early diagnosis trial portfolio for regional delivery 2. Support set up and successful recruitment to Innovate UK-funded iDx lung cancer early diagnosis study 3. Assist in submission of grant applications for future early diagnosis trials, including planned CRUK submission this year **Introduction to research for surgery trainees** 1. Develop a programme of 1-hour virtual sessions for surgery trainees across Wessex and Thames Valley & South Midlands

National priority	Description of planned contributions	Related local initiatives and their expected outcomes
		Delivery of prioritised commercial studies 1. Local escalation plan 2. Local working group **Shared Investigator Platform (SIP)** 1. Coordinated promotion of SIP across the supra-region in order to share best practice and aid site implementation. 2. Increased number of organisation and investigators set up on SIP across both primary and secondary care. **Commercial Costings** 1. Standardised interactive costing template (iCT) validation across the supra regional network. 2. Shared best practice and creation of troubleshooting document. 3. Increased number of study resource reviewers. 4. Quicker, more consistent iCT validation. **Growing the Wessex profile** 1. New CRN Wessex social media channels on Facebook and LinkedIn. 2. Two issues of Vision magazine showcasing the work of research teams across Wessex. 3. One CRN Wessex Awards event to celebrate the contributions of research teams across the region. 4. Pilot paid digital and print advertising campaigns promoting research across the supra region. 5. Cross-NIHR comms collaborations in Wessex to produce digital and print materials which can demonstrate the contribution of Wessex in response to the COVID-19 pandemic. 6. Create an online materials bank which can be accessed by partner organisations looking to promote research to patients, the public and other stakeholders. 7. Recruit a comms and PPIE officer who can support the delivery of key NIHR engagement initiatives like PRES and the Be Part of Research campaign.

National priority	Description of planned contributions	Related local initiatives and their expected outcomes
NIHR CRN Strategic Improvement Priorities **1 Primary Care Research Engagement**	• Increase primary and secondary care collaborative working • Explore opportunities and capacity to increase research in primary care for underrepresented specialties including diabetes, stroke, and mental health. • Work in partnership with the Primary Care Research Centre considering their research themes of self-management, improving use of medicines, diagnosis and prognosis and healthcare communication • Explore new opportunities for engagement of the pharmacy workforce by considering recruitment strategies through the recently launched general practice referral pathway to the NHS Community Pharmacist Consultation Service (CPCS) • Continue to support GP practices through the Research Sites Initiative (RSI) Scheme Hold 6 monthly virtual RSI events to feedback study finding and share best practice • Continue to hold regular primary care research practitioner's forum to share best practice • Continue to hold regular RSI virtual practice visits • A supraregional strategy to ensure a	**Wessex Mental Health Network** 1. Map current and potential mental health researchers from across Community Care, Primary Care including GP leads and IAPT, Secondary Care and local Universities 2. Person identified to lead a mental health networking meeting 3. Inaugural mental health networking meeting held with attendance from multiple settings 4. Potential of a Wessex mental health research network explored **Stroke research working group** 1. Map current and potential stroke researchers from Community Care, Primary Care, Secondary Care and local Universities, with a focus on post-acute stroke care 2. Stroke research working group meeting held to explore potential of developing a homegrown research proposal led by two key researchers, Dr Jane Burridge and Louise Johnson. Attendance from multiple settings with a potential proposal in development. **NIHR School for Primary Care Research (SPCR)** 1. Explore opportunities for regional engagement and optimal delivery to studies under the umbrella of the SPCR member organisations

National priority	Description of planned contributions	Related local initiatives and their expected outcomes
	sustainable Primary Care workforce that has the required skills, experience, and attributes to deliver NIHR Portfolio studies	
2 Review and Refresh Research Delivery (including Direct Delivery Team)	• Support communications and collaboration between partner organisations to support sharing of best practice • End to end service for customers to provide assurance of effective and efficient study delivery. • Build on performance of smaller organisations in the delivery of UPH portfolio • Non-NHS service delivery via study support and embedded posts	**CRN Direct Delivery Team** See above **Research hubs** See above **Increasing equity in dementia research across the region** 1. National initiative - RATER programme. Local initiatives explored including a rater hub working remotely across organisations. 2. In close collaboration with iDeAC, development of a pan Wessex focused clinical dementia research group 3. Increased collaborative working across Wessex sites 4. Expanding research in underserved communities explored **Wessex Mental Health Network** See above **Stroke research working group** See above **Social care** See above

Appendix 2 - 2021-22 Annual Financial Business Plan CRN Wessex

CRN Wessex Financial Management				
Funding Element	**Examples**	**Description of model**	**Total CRN Funding Budget 2021/22 Budget**	**% of Total CRN Funding Budget 2021/22 Budget (Please note that these should total 100%)**
Host Top-sliced element	Core Leadership team	See organogram - Reported as LCRN Leadership and Core Business (including but not exclusively CD, COO, DCOO, RDMs, portfolio managers, workstream leads as per CSD 003, CRSL x 30,divisional leads x 6, commercial clinical lead)	£1,845,720.00	9.4%
Host Top-sliced element	Host Support costs	2% of core allocation (exc. ETC service funding)	£354,467.00	1.8%
Host Top-sliced element	LCRN Centralised Research Delivery team	As per approved plan for Transformation of Research Delivery Programme. Primary care centralised nurse team reported under primary care spend.	£833,333.00	4.2%
Block Allocations	Primary care	RSI scheme, service support costs, centralised primary care nurse team and GP locality leads with representation on CRN Wessex executive group	£1,098,383.23	5.6%
Block Allocations	Clinical support services (i.e., pharmacy),	Majority of support is for named posts on partner organisations AFPs	£378,688.84	1.9%
Block Allocations	R&D contributions	n/a reported as partner study support service		0.0%
Activity-based	Recruitment HLO 1, number of studies, activity weighting	n/a for 21/22 see comment below regarding settlement. It is based on performance related historical allocations		0.0%
Historic Allocations	PO funding previously agreed	Settlement for all partners based on historical activity and HLO attainment	£14,235,684.16	72.2%
Performance-based	HLO performance, value for money metric	n/a for 21/22 see comment above regarding settlement that is based on performance related historical allocations		0.0%

Funding Element	Examples	Description of model	Total CRN Funding Budget 2021/22 Budget	% of Total CRN Funding Budget 2021/22 Budget
Population-based	Adjustments for NHS population needs	n/a		0.0%
Project-based	Study start up	n/a reported as partner study support service		0.0%
Contingency / Strategic Funds	Funds to meet emerging priorities during the year, including targeting local health needs	Research Fellows	£780,000.00	4.0%
Other Funding Allocations	Edge	LPMS	£118,835.77	0.6%
Other Funding Allocations	PH Prevention Research Funding	Embedded research in LA and 1PA for public health consultant	£65,922.00	0.3%
Total			**£19,711,034.00**	**100.00%**

Appendix 3 – CRN Wessex Risk Register

PRE-RESPONSE (INHERENT)										POST RESPONSE (RESIDUAL)								
Risk ID	Primary category	Date raised	Risk Owner	Risk Description (to include cause/event, and effect)	Probability	Impact	Value (Pxl)	Proximity		Response Actions	Action owner(s)	Action status	Probability	Impact	Value (Pxl)	Risk status (open or closed date)	Trend (since last reviewed)
CRN 01	Financial	Apr-14	CDs/COO	**Cause: Decrease in core NIHR income**. CRN Wessex receives annual financial allocation from the NIHR CRNCC modelled on historical recruitment activity and a selection of performance metrics. (Any dip in performance can result in a fall in income if other LCRNs have maintained or increased their activity in the same period). Exacerbated by national pandemic declared in March 2020. **Event:** Leading to a reduction in funding available to support research infrastructure **Effect:** Meaning that redundancies or increasing the number vacant posts will have to be considered. This could result in disengagement of partners due to perceived loss of benefit.	4	4	16	Apr-22		1. Allocations for 21/22 released flat cash settlement 2. Model a range of budget scenarios to aid planning and forecasting 3. Conduct project with partners to improve data quality in LPMS 4. Regular communication and providing early notification to partners of potential budget reduction through business planning meetings 5. Provide clear guidance to partners on how to spend budget and offer advice and support to achieve value for money 6. Provide performance reports to partners 7. Monitor impact through executive group and partnership group 8. Allocation and reallocation of additional CRN CC Funding in 20/21 to support immediate cost pressures from vaccine, UPH and Restart requirements 9. Mobilisation of CRN Direct Delivery Team with Transformation of Research Delivery Funding £833,333	COO	All - ongoing	2	2	4	Open	Decreased
CRN 03	Performance	Apr-17	CDs/COO	**Cause: Reduction in commercial contract research**. Exacerbated by national pandemic declared in March 2020. **Event:** Leading to a reduction in the treatment options for patients from commercial research studies and reduced commercial income. **Effect:** Meaning that there will be less funding for research infrastructure and treatment opportunities for patients. In addition diminished infrastructure to support new initiatives with commercial sponsors.	4	4	16	Now		1. Dedicated Industry Manager post to promote commercial research in the network. 2. Close monitoring and support for partners with EOI process 3. Support for partners to recruit to time and target to maximise the performance metrics for delivery of commercial research 4. Reporting and discussion through executive group and partnership group 5. Allocation of contingency funding as appropriate to support infrastructure during pandemic 6. Maximise commercial vaccine activity during pandemic with the appropriate use of vaccine pump prime income 7. Engage with RRG prrogramme and managed national recovery workstreams	Commercial Lead	All - ongoing	4	4	16	Open	Static
CRN 04	Reputational	Apr-17	CDs/COO	**Cause: Contract renewal** due 31 March 2024 **Event:** Leading to **uncertainty** in Wessex research system **Effect:** Meaning that **staff seek suitable alternative employment**	3	3	9	Mar-24		1. Participate in national consultations and shape of future local networks 2. Continued communication to keep staff informed as more information becomes available 3. Contract extension by DHSC to 31 March 2024 4. CRN team ready to support re-application process	CDs	All - ongoing	1	3	3	Open	Static
CRN 05	Performance	Nov-18	CDs/COO	**Cause: Service pressures from restart of clinical services post acute clinical pressures of second wave of pandemicwithin NHS and social care** **Event:** Leading to **partner disengagement** with research agenda due to clinical and service pressures **Effect:** Meaning a **decrease in activity.** Portfolio activity may be affected due to large amount of resources needed to support clinical services and exacerbated with the response to the pandemic. (see CRN 06).	3	3	9	Now		1. WFD strategy to provide support optimal support 2. Partner collaboration to maximise capacity 3. Allocation of national contingency funding in 20/21 from CRN CC to support partner organisations 4. Support partners with RRG programme to sequence studies appropriately 5. Capture legacy of pandemic and maintain pace of research and risk based management of research to support agile research delivery. 6. Reviewed 12 May and noted shift to recovery of service pressure rather than patient acuity pressure in second wave	CDs	All - ongoing	5	3	15	Open	Increased

PRE-RESPONSE (INHERENT)									POST RESPONSE (RESIDUAL)							
Risk ID	Primary category	Date raised	Risk Owner	Risk Description (to include cause/event, and effect)	Probability	Impact	Value (Pxl)	Proximity	Response Actions	Action owner(s)	Action status	Probability	Impact	Value (Pxl)	Risk status (open or closed date)	Trend (since last reviewed)
CRN 06	Performance	Jun-20	CDs/COO	**Cause: Future waves of Covid-19 pandemic** **Event:** Leading to a **reduction in research capacity** in NHS and social care **Effect:** Meaning **recruitment** to all studies, including priority studies, may be **detrimentally affected** by a second wave of Covid infections. In *extremis* CRN funded staff may be redeployed to clinical duties and shortages in staffing will be exacerbated by staff sickness, sheilding and isolating.	4	4	16	Now	1. Agile staff deployment supported by contractual arrangements between partners and the host. New work planned for 21/22 2. Strong clinical leadership in COVID research that can motivate staff and also provide first-hand intelligence to the LRCN 3. Wessex workforce campaign to recruit additional staff to support vaccine studies 4. Active support for POs to restart non UPH studies e.g weekly calls with POs 5. Active participation in national vaccinces groups to plan staffing and logistics 6. CRN Wessex has set up a regional vaccines board, which meets weekly. Any issues from this group are raised with the National/Operational Team as appropriate. 7. Business Continuity Plan reviewed regularly.	CDs	All - ongoing	5	2	10	Open	Decreased
CRN 07	Workforce	Mar-20	CDs/COO	**Cause: Altered working patterns** prompted by response to pandemic **Event:** Leading to team that is not able to work in an opimal way **Effect:** Meaning that the performance of the Network is adversely affected	4	3	6	Now	1. All core team have laptops with webcamera and second screens as required 2. Cisco desk phones can be transferred to home or mobile phone of choice via web based control platform 3. Access to 3 web conference platforms 4. Covid-19 vaccination for core staff via host vaccination programme 5. Virus risk assessment of office space 6. Staff consultation on future working patterns drawing on lessons learnt from Covid-19 pandemic. Plans in place for hybrid working when lockdown restrictions are lifted.	COO	On going On going On going Complete	2	1	2	Open	Decreased
CRN 08	Workforce	Mar-20	CDs/COO	**Cause: Staff turnover** **Event:** Leading to gap in continuity of service provision and loss of institutional memory **Effect:** Meaning that the performance of the Network is adversely affected	2	3	6	Aug-21	1. Talent management within team 2. PDPs with identified training needs and subsequent provision of appropriate learning opportunties 3. Job shadowing opportunities 4. Succession planning, e.g deputy COO role	CDs	On going On going On going Complete	2	2	4	Open	Static

Appendix 4 – Glossary

Partner organisation abbreviations used by CRN Wessex:

- DCHFT – Dorset County Hospital NHS Foundation Trust
- DHUFT - Dorset Healthcare University NHS Foundation Trust
- HHFT - Hampshire Hospitals NHS Foundation Trust
- IOW - Isle of Wight NHS Trust
- IC – Independent contractors, including but not limited to primary care and non-NHS organisations
- PHFT - Poole Hospital NHS Foundation Trust - *replaced by the merged organisation UHD*
- PHU - Portsmouth Hospitals University NHS Trust *– previously PHT*
- SFT - Salisbury NHS Foundation Trust
- Solent – Solent NHS Trust
- SCAS - South Central Ambulance Service NHS Foundation Trust
- SHFT - Southern Health NHS Foundation Trust
- RBCH - The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust - *replaced by the merged organisation UHD*
- UHD – University Hospitals Dorset NHS Foundation Trust
- UHS - University Hospital Southampton NHS Foundation Trust

Local clinical research network or devolved nation abbreviations and 2020/21 financial year population:

- East Midlands – EM - 4,605,206
- Eastern – Eastern - 3,891,262
- Greater Manchester – GM - 3,029,318
- Kent, Surrey and Sussex – KSS - 4,654,474
- North East and North Cumbria – NENC - 2,963,018
- North Thames - NT - 5,757,668
- North West Coast – NWC - 3,950,452
- North West London – NWL - 2,075,696
- South London – SL - 3,285,629
- South West Peninsula – SWP - 2,304,291
- Thames Valley and South Midlands – TVSM - 2,397,813
- Wessex – Wessex - 2,793,224
- West Midlands – WM - 5,860,706
- West of England – WE - 2,490,339
- Yorkshire and Humber – YH - 5,560,334
- Northern Ireland – NI – 1,870,800
- Scotland – Scotland – 5,424,800
- Wales – Wales – 3,125,200

Appendix 5 – Glossary of studies mentioned within the report

Study	Title	Short summary
Com-COV	Com-COV: Comparing COVID-19 Vaccine Schedule Combinations	The purpose of this trial is to see how well people's immune systems respond when they are primed with one type of vaccine, then boosted with another and to see how good the response is when the second dose is separated from the first dose by different periods of time. Further information: https://comcovstudy.org.uk/home
COV-COMPARE (Valneva phase III)	COV-COMPARE Immunogenicity of vaccine VLA2001 compared to AZD1222	This study compares the ability of VLA2001 vaccine to generate an adequate immune response to COVID-19, to the AZD1222 (AstraZeneca) vaccine. The aim is to show that VLA2001 is superior to AZD1222. Participants will be adults aged ≥ 18 years of age. The study will run in the UK at approximately 27 sites. Further information: https://www.clinicaltrials.gov/ct2/show/NCT04864561
COV001	A phase I/II study to determine efficacy, safety and immunogenicity of the candidate Coronavirus Disease (COVID-19) vaccine ChAdOx1 nCoV-19 in UK healthy adult volunteers	The COV001 & COV002 studies will enable the study team to assess how well people of all ages can be protected from COVID-19 with this new vaccine called ChAdOx1 nCoV-19. It will also give the study team valuable information on safety aspects of the vaccine and its ability to generate good immune responses against the virus. The study team will enrol small numbers of older adults (56-70 years, then 70+ years) before expanding to large numbers of adults across all ages (18+ years). After this the study will also assess the vaccine in a small cohort of children (5-12 years). Further information: https://trials.ovg.ox.ac.uk/trials/cov001 and https://cambridge.crf.nihr.ac.uk/cov002-covid-19-vaccine-trial/
COV002	A phase 2/3 study to determine the efficacy, safety and immunogenicity of the candidate Coronavirus Disease (COVID-19) vaccine ChAdOx1 nCoV-19	
COV006	A phase 2 study to assess the safety and immunogenicity of a recombinant adenovirus-based vaccine against Coronavirus Disease (COVID-19) in children aged 6-17 years of age	The purpose of this study is to test a new vaccine against COVID-19 in children and young adults aged 6-17 years. This study assesses if children can be protected from COVID-19 with this new vaccine called ChAdOx1 nCoV-19. It will also give information on safety aspects of the vaccine and its ability to generate good immune responses against the virus, in children and young people. Further information: https://covid19vaccinetrial.co.uk

COVAC1 (Imperial)	Clinical trial to assess the safety of a coronavirus vaccine in healthy men and women	The purpose of the clinical trial, which is called COVAC1, is to evaluate whether our new self-amplifying ribonucleic acid (RNA) COVID-19 vaccine candidate is safe and whether it produces immune responses against the coronavirus, SARS-CoV-2. Further information: https://www.imperial.ac.uk/covid-19-vaccine-trial/trial-info/
ENSEMBLE-2	A Study of Ad26.COV2.S for the Prevention of SARS-CoV-2-mediated COVID-19 in Adults (ENSEMBLE 2)	ENSEMBLE 2 is a large-scale, multi-country Phase 3 trial that will study the safety and efficacy of a two-dose regimen of the investigational Janssen vaccine candidate for the prevention of COVID-19 in up to 30,000 participants worldwide. This study will test Janssen's investigational COVID-19 vaccine candidate, JNJ-78436735, also known as Ad26.COV2.S. Doctors and scientists hope it will prevent or lessen the severity of disease caused by severe acute respiratory syndrome Coronavirus-2 (SARS-CoV-2). This virus causes a disease called COVID-19. Further information: https://www.jnj.com/coronavirus/about-phase-3-study-of-our-covid-19-vaccine-candidate
ISARIC-CCP-UK	Clinical Characterisation Protocol for Severe Emerging Infection	Infectious disease is the single biggest cause of death worldwide. New infectious agents, such as the SARS, MERS and other novel coronavirus, novel influenza viruses, viruses causing viral haemorrhagic fever (e.g., Ebola), and viruses that affect the central nervous system (CNS) such as TBEV require investigation to understand pathogen biology and pathogenesis in the host. The CCP is a standardised protocol that enables data and biological samples to be collected rapidly in a globally harmonised manner. It may be used for the rapid, coordinated clinical investigation of confirmed cases of COVID-19. Further information: https://isaric.org/

Janssen Adolescent	Study of two dose levels of a COVID-19 vaccine in 12-17 year olds	The primary purpose of this study is to assess humoral immune responses of 3 dose levels of Ad26.COV2.S administered intramuscularly (IM) as a 2-dose schedule (56 days apart); Ad26.COV2.S administered IM as a single vaccination in adults (18-65 years or older) and to assess the safety and reactogenicity of Ad26.COV2.S, administered IM as 2-dose or 1-dose schedule in adolescents (12-17 years) and to test both compressed and expanded 2-dose schedules of Ad26.COV2.S (28 and 84 days apart) in adults (18-65 years or older). Further information: https://clinicaltrials.gov/ct2/show/NCT04535453
PRINCIPLE	Platform Randomised trial of INterventions against COVID-19 In older peoPLE	PRINCIPLE is a nationwide clinical study from the University of Oxford to find COVID-19 treatments for the over 50s that can be taken at home. The trial team are looking for medicines that can help people with COVID-19 symptoms get better quickly and stop them needing to go to hospital. PRINCIPLE is recruiting participants through the below website and also through GP practices across the UK. Further information: https://www.principletrial.org/
RECOVERY	Randomised Evaluation of COVID-19 Therapy (RECOVERY)	This national clinical trial aims to identify treatments that may be beneficial for people hospitalised with suspected or confirmed COVID-19. A range of potential treatments have been suggested for COVID-19 but nobody knows if any of them will turn out to be more effective in helping people recover than the usual standard of hospital care which all patients will receive. The RECOVERY Trial is currently testing some of these suggested treatments. Further information: https://www.recoverytrial.net/
RECOVERY-RS	RECOVERY Respiratory Support: Respiratory Strategies in patients with coronavirus COVID-19 – CPAP, high-flow nasal oxygen, and standard care	The RECOVERY-RS trial will compare the effectiveness of three ventilation methods; - Continuous positive airway pressure (CPAP) - High flow nasal oxygen (HFNO) - Standard care Further information: https://warwick.ac.uk/fac/sci/med/research/ctu/trials/recovery-rs/
REMAP-CAP	Randomized, Embedded, Multifactorial, Adaptive Platform trial for Community-Acquired Pneumonia	REMAP-CAP uses a novel and innovative adaptive trial design to evaluate a number of treatment options simultaneously and efficiently. This design is able to adapt in the event of pandemics, and increases the likelihood that patients will receive the treatment that is most likely to be effective for them. Further information: https://www.remapcap.org/

SIREN	SIREN - SARS-COV2 immunity and reinfection evaluation; The impact of detectable anti SARS-COV2 antibody on the incidence of COVID-19 in healthcare workers	This study aims to find out whether healthcare workers who have evidence of prior COVID-19, detected by antibody assays (positive antibody tests), compared to those who do not have evidence of infection (negative antibody tests) are protected from future episodes of infection. Healthcare workers will be followed for at least a year and their immune response to the virus causing COVID-19, called SARS CoV2, studied. Further information: https://snapsurvey.phe.org.uk/siren/
Valneva (VLA2001) phase 1/2	A Phase I/II Randomized, Two Parts, Dose-Finding Study To Evaluate The Safety, Tolerability and Immunogenicity Of An Inactivated, Adjuvanted Sars-Cov-2 Virus Vaccine Candidate (VLA2001), Against Covid-19 In Healthy Subjects	A multicentre, 3-arm randomized dose finding study in UK to evaluate safety, tolerability and immunogenicity of a vaccine candidate against Covid-19. 150 healthy volunteers will be enrolled and receive two shots of the vaccine candidate. Further information: https://valneva.com/research-development/covid-19-vla2001/
VIVALDI	Understanding SARS-CoV-2 infection, immunity and its duration in care home staff and residents in the UK (VIVALDI STUDY)	The aim of the study is to find out how many care home staff and residents have been infected with COVID-19, to inform decisions around the best approach to COVID-19 testing in the future. By testing around 6500 staff and 5000 residents across >100 care homes in England, the study will estimate the proportion who have been infected with COVID-19 in the past and have antibodies, and the proportion who are infected now. Further information: https://www.ucl.ac.uk/health-informatics/research/vivaldi-study

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Register of Seals and Chair's Actions**			
Agenda item:	**7.1**			
Sponsor:	**Peter Hollins, Trust Chair**			
Date:	**27 May 2021**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification** **Y**	**Information**
Issue to be addressed:	This is a regular report to notify the Board of use of the seal and actions taken by the Chair in accordance with the Standing Financial Instructions and Scheme of Delegation for ratification.			
Response to the issue:	The Board has agreed that the Chair may undertake some actions on its behalf. The following action has been undertaken by the Chair. All awards of contract are subject to a full tender process.			
Implications: (Clinical, Organisational, Governance, Legal?)	Compliance with The NHS Foundation Trust Code of Governance (probity, internal control) and UHS Standing Financial Instructions and Scheme of Delegation.			
Risks: (Top 3) of carrying out the change / or not:				
Summary: Conclusion and/or recommendation	The Board is asked to **ratify** the application of the seal and Chair's action.			

1 Signing and Sealing

1.1 **Lease** between University Hospital Southampton NHS Foundation Trust (the Landlord) and Wessex NHS Procurement Limited (the Tenant) relating to offices and associated storage at Southampton General Hospital, Tremona Road, Southampton SO16 6YD. Seal number 233 on 30 April 2021.

2 Chair's Actions

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

2.1 **Award of Contract** for continuous glucose monitoring for Specialist Medicine/Child Health care groups, to Dexcom for 12 months under the NHS Supply Chain Framework at a cost of £569,313.75 excluding VAT. The 12-month arrangement is to support further interrogation of the market currently not geared to support full scale procurement. A rebate mechanism has been established to deliver a cost improvement of £32,000 at the end of the 12-month term. Approved by the Chair on 30 April 2021.

3 Recommendation

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

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Emergency Planning and Business Continuity Annual Report 2020/21**			
Agenda item:	**7.2**			
Sponsor:	**Joe Teape Chief Operating Officer**			
Author:	**Sandra Hodgkyns Head of Security / Emergency Planning Response and Resilience**			
Date:	**27 May 2021**			
Purpose	**Assurance or reassurance**	**Approval** **YES**	**Ratification**	**Information**
Issue to be addressed:	This report is provided annually to Trust Board as part of our NHS England Emergency Planning Response and Resilience (EPRR) Annual Assurance process. The purpose of the report is to update Trust Board on the work of the EPRR team from 1st April 2020 to 31st March 2021.			
Response to the issue:	This paper provides the Board with assurance that during Covid, EPRR has continued to deliver, respond and improve aspects of EPRR through 2020/21. This paper provides an overview of the responses by the Emergency Planning team covering the following key areas; • Covid response Incident Command and Control (ICC) • Changes in training delivery due to Covid • Business Continuity Development and improvement • Revised Incident Response Plan (IRP) • Refreshed Terms and Conditions and Membership for the Major Incident Planning Group. •			
Implications: (Clinical, Organisational, Governance, Legal?)	The EPRR function is to ensure that the Trust meets it requirements under the Civil Contingencies Act 2004 (CCA 2004), leading the Trust with Incident Response Plans. Providing Major Incident Training for the Tactical and Strategic Commanders and those with on call Major Incident responsibility, advising Strategic and Tactical Command in their role in the event of a Major Incident or Hospital Incident Management Team (HIMT). The Head of Security/ Emergency Planning provides assurance to NHS England and our commissioners that the Trust is meeting and maintaining our assurance levels in Emergency Planning/Resilience Response in the Trust in respect of EPRR.			
Risks: (Top 3) of carrying out the change / or not:	Failure to provide assurance on our EPRR Core Standard requirements to NHS England and our Commissioner will result in our current level of * 'Substantial' - which has been maintained for a number of years, being lowered and potentially, additional scrutiny placed on the Trust in respect of EPRR. ***Overall EPRR assurance rating/criteria**			

	• **Fully -** The organisation is 100% compliant with all core standards they are required to achieve. • **Substantial** - The organisation is 89-99% compliant with the core standards they are required to achieve. • **Partial -** The organisation is 77-88% compliant with the core standards they are required to achieve. • **Non-compliant** - The organisation compliant with 76% or less of the core standards they are required to achieve. *Emergency preparedness, resilience and response annual assurance guidance (June 2019)* To note Trusts were not asked to provide evidence/assurance against the EPRR Core Standards for 2020/21. Instead there was a requirement to provide Lessons Learnt from internal reviews of Covid Wave 1 and Wave 2, which were presented to the Executive Local Health Resilience Forum (LHRF). Wave 2 was presented in April 2021. The Board will be familiar with the internal evaluation of our responses to Covid-19 as these have been separately reported to the Board. There is expectation from the collated information received by the LHRF that a health action plan will be circulated to Trusts.
Summary: Conclusion and/or recommendation	**1.1 Covid Response and ICC** In early 2020, the EPRR team were a leading part of the initial response to Covid-19 and worked very closely with the Head Infection Prevention to set up the Patient Pods for those patients/members of the public arriving back from countries with Covid who then were considered to by symptomatic. The Pods then extended to members of the public who were concerned that they may have Covid, were symptomatic or had been directed by 111. All Trusts were expected to have full Incident Control Centres (ICC) operational as part of the NHS national response, which was managed the EPRR and supported by staff who were redeployed or UHS staff who volunteered to work within the ICC. Switchboard also played a key role in managing the call load at night from 111 when the ICC closed, going to On Call EPRR only. As the Pandemic continued, staffing support was also provided from the CCG. The ICC now remains in place but is now run virtually via the EPRR Team with the Executive On Call Team out of hours. **1.2 Changes in training delivery due to Covid.** Significant progress has been made training staff across the Trust in the last year. Whilst the delivery of Strategical and Tactical On Call Major Incident Training has been difficult via Microsoft Teams, the feedback has been positive and we have been able to make changes after each session to improve the learning experience. Executives On Call now receive training over Teams and a very small group practical session. In addition, 3 Executives On Call were able to engage in new media live to camera & radio training, again the feedback was positive. For 2021 we also hope to extend our training provision to include Defensive Decision Making, with QC Mark Scoggins in joint training with the LHRP. Additionally the EPRR Lead has undertaken the above training to deliver a package to the Executive on Call Team.

Engagement for training in 2021 subject to understandable time constraints with Covid has been excellent and for more engaging than in other years.

Training session	Training delivered 2020/21
Exec on-call Major Incident Training	13 trained to date Next training session scheduled for 17/06/21
Exec on call Working with your Loggist Training **(new)**	4 trained to date Next training session scheduled for 17/06/21
Duty Manager Major Incident Training	16 trained to date Next training session scheduled for 07/06/21 (5 booked)
Duty Manager Loggist Training	16 trained to date Next training session scheduled for 07/06/21 (5 booked)

1.3 Business Continuity Development and improvement.

The Trusts overarching Business Continuity Plan (BCP) has been re written, with the addition of appendices of a Local Business Continuity Plan (LBCP) template for departmental areas. The BCP has been approved at the Major Incident Planning Group (MIPG) and all Divisions have been submitting their (LBCP) to the EPRR Team for review. Testing of individual plans will take plans annually although it will not be possible to test every plan. The MIPG will review two plans in May; 1 clinical and 1 non clinical. It is pleasing to report that now almost all areas of the Trust key business functions have local plans in place.

This new policy and unified LBCP template, along with testing, will provide Board with greater assurance on the Trust ability to response in a BC incident.

1.4 Revised Incident Response Plan (IRP)

After any incident, an IRP must be reviewed. Whilst the IRP was in date until mid-2022, the Chief Operating Officer and Head of EPRR confirmed that a complete re-write of the plan was required as the current plan was not satisfactory given our experiences of managing the pandemic. The plan is with MIPG members now for final review prior to approval by the Trust Executive Committee in June 2021.

1.5 Refreshed Terms of Reference and Membership for MIPG

During 2020, all terms and membership were reviewed to reflect the current needs of the Trust and inclusion of key staff. Attendance for MIPG has improved since the review. The MIPG reports to the Trust Executive Committee.

1.6 EPRR Team

Danielle Sinclair has joined the EPRR team. Danielle supported us in the ICC as a member of staff from the CCG and we are delighted that she has joined us. In early 2022, she has a place on the Health EPRR programme to gain her EPRR qualification.

	1.7 Next Steps as we progress into 21/22 • Completion and Submission of EPRR Core Assurance Standards • IT Business Continuity (Table top) - Exercise FIREFLY • Emergency Department Lockdown (Table top) - Exercise SHIELD • Emergency Department re-location (Live Ex) - Exercise NOMAD • Continued training for On Call Leaders to ensure that we meet our standards and continued CPD for EPRR Team • Develop Major Incident On Call Booklets for Exec On Call / DM • A complete review of all EPRR policies regardless of date. • Update the Major Incident Staffnet page • Review of 10 BCP Plans from contracted suppliers to the Trust • Review / Test LBCP This list is not exhaustive. **Recommendations** Trust Board are asked to consider and approve this annual report.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Charitable Funds Committee Terms of Reference**			
Agenda item:	**7.3**			
Sponsor:	**Peter Hollins, Trust Chair**			
Author:	**Karen Flaherty, Associate Director of Corporate Affairs and Company Secretary**			
Date:	**27 May 2021**			
Purpose	**Assurance or reassurance**	**Approval** X	**Ratification**	**Information**
Issue to be addressed:	The terms of reference of the Charitable Funds Committee have been amended to reflect the introduction of the grants policy to be approved by the Board of Directors later in the meeting. The terms of reference have been reviewed by the Charitable Funds Committee.			
Response to the issue:	The proposed changes to the terms of reference are highlighted in the attached version using tracked changes.			
Implications: (Clinical, Organisational, Governance, Legal?)	The terms of reference ensure that the purpose and activities of the Charitable Funds Committee are clear and support transparency and accountability in the performance of its role.			
Risks: (Top 3) of carrying out the change / or not:	1. Non-compliance with the Trust's constitution and the standing orders of the Board of Directors relating to the composition of Board committees. 2. Non-compliance with charities law and the Trust's standing financial instructions relating to the specific responsibilities of the Charitable Funds Committee, including the distinct duties of the Trust as corporate trustee and the management of potential conflict of interests. 3. The Board of Directors and the Committee may not function as effectively without terms of reference in place.			
Summary: Conclusion and/or recommendation	The Board of Directors is asked to approve the revised terms of reference. These have been reviewed by the Charitable Funds Committee and are recommended for approval.			

Charitable Funds Committee Terms of Reference

Version: ~~34~~

Date Issued:	~~25 February 2021~~27 May 2021
Review Date:	February 2022
Document Type:	Committee Terms of Reference

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Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled.
As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

1. Role and Purpose

1.1 The Charitable Funds Committee (the **Committee**) is responsible for exercising the functions of University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**), as sole corporate trustee of Southampton Hospital Charity (registered charity number 1051543) (the **Charity**), including overseeing the management and monitoring of charitable funds on behalf of the Trust.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of assurance regarding the administration of the Charity in accordance with applicable legislation.

1.3 The duties and responsibilities of the Committee are more fully described in paragraph 7 below.

2. Constitution

2.1 The Committee has been established by the Board. The Committee has no executive powers other than those set out in these terms of reference. It is supported in its work by other committees established by the Board and other committees and groups as shown in Appendix A.

2.2 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee.

2.3 In carrying out its role the Committee is authorised to seek reports and assurance from executive directors and managers and will maintain effective relationships with the chairs of other Board committees to understand their processes of assurance and links with the work of the Committee.

2.4 The Committee is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions.

3. Membership

3.1 The members of the Committee will be appointed by the Board and will be:

3.1.1 two non-executive directors of the Trust;

3.1.2 the Chief People Officer; and

3.1.3 the Chief Financial Officer.

3.2 The Board will appoint the chair of the Committee from among its non-executive director members (the **Committee Chair**). In the absence of the Committee Chair and/or an appointed deputy, the remaining members present will elect one of the non-executive members present to chair the meeting.

3.3 Only members of the Committee have the right to attend and vote at Committee meetings. However, the following will be invited to attend meetings of the Committee on a regular basis:

3.3.1 four fundholders, as agreed by the Executive Directors;
3.3.2 the Trust executive assigned responsibility for the Charity (if not a member of the Committee);
3.3.3 the Assistant Director of Finance;
3.3.4 the Head of Patient Experience and Involvement;
3.3.5 the Director of Southampton Hospital Charity; and

3.3.6 the Charity Funds Manager.

3.4 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas of risk or operation that are the responsibility of a particular executive director or manager.

3.5 Governors may be invited to attend meetings of the Committee.

4. Attendance and Quorum

4.1 Members should aim to attend every meeting and should attend a minimum of 75% of meetings held in each financial year. Where a member is unable to attend a meeting they should notify the Committee Chair or secretary in advance.

4.2 The quorum for a meeting will be three members, including two non-executive directors. A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4.3 When an executive director or manager is unable to attend a meeting they should appoint a deputy to attend on their behalf.

5. Frequency of Meetings

5.1 The Committee will meet at least four times each year and otherwise as required.

6. Conduct and Administration of Meetings

6.1 Meetings of the Committee will be convened by the secretary of the Committee at the request of the Committee Chair or any of its members.

6.2 The agenda of items to be discussed at the meeting will be agreed by the Committee Chair with support from the Director of Southampton Hospital Charity. The agenda and supporting papers will be distributed to each member of the Committee and the regular attendees no later than five working days before the date of the meeting. Distribution of any papers after this deadline will require the agreement of the Committee Chair.

6.3 The secretary of the Committee will minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance and any declarations of interest.

6.4 Draft minutes of Committee meetings and a separate record of the actions to be taken forward will be circulated promptly to all members of the Committee. Once approved by the Committee, minutes will be circulated to all other members of the Board unless it would be inappropriate to do so in the opinion of the Committee Chair.

7. Duties and Responsibilities

The Committee will carry out the duties below for the Trust.

7.1 ***Governance***

7.1.1 Ensure that the charitable funds held by the Trust are managed in a manner consistent with its charitable purpose relating to the National Health Service, the requirements of the relevant regulatory and statutory frameworks and the guidance set out by the Charity Commission.

7.1.2 When in this role act solely in the best interests of the Charity and in a manner consistent with the Charity Commission's requirements and expectations of charity trustees.

7.1.3 Determine the format of the information required to manage effectively the charitable funds.

7.1.4 Receive all necessary information from authorised fund signatories.

7.2 ***Strategy***

7.2.1 Oversee the Charity's strategy, governance (in accordance with the Charity Governance Code), major plans and key risks on behalf of the Trustee.

7.2.2 Review and approve annually objectives, medium term strategy and annual operating plan.

7.3 ***Fundraising***

7.3.1 Review and approve annually the overall fundraising strategy of the Charity.

7.3.2 Establish, prioritise and approve major fundraising projects and expenditure (between £50,001 - £100,000); projects and expenditure over £100,000 will require approval from the Board.

7.3.3 Safeguard donated money.

7.3.4 Ensure legacies are realised in a timely and complete manner.

7.4 ***Utilisation of Funds***

7.4.1 Approve charitable fund bids in accordance with the relevant procedures including the Trust's standing financial instructions and/or any applicable grants policy or criteria.

7.4.2 Endeavour to make an adequate return on prudent investments.

7.4.3 Establish and agree any changes to the Charity's investment policy and ensure that investment is in accordance with this policy.

7.4.4 Appoint independent advisors on investment policy as the Committee sees fit.

7.4.5 Review the appointment of investment advisors every three years and recommend any changes to the Trust Board.

7.4.6 Monitor the performance of investments and seek clarification from the investment advisors on any relevant issues.

7.4.7 Regularly review the performance of current investments in terms of income and capital appreciation.

7.5 ***Reporting***

7.5.1 Review and approve the charitable funds annual accounts and Trustees' report in accordance with the Charity Commission's Charities Statement of Recommended Practice.

7.5.2 Fully account to the Charity Commission and the public, including specific reporting requirements agreed with any donors.

7.5.3 Receive regular reports from any sub-committees the Committee has established.

8. Accountability and Reporting

8.1 The Chair of the Committee will report to the Board following each meeting, drawing the Board's attention to any matters of significance or where actions or improvements are needed.

8.2 Appendix A sets out the sub-committees that report to and support the Committee in fulfilling its duties and responsibilities.

9. Review of Terms of Reference and Performance and Effectiveness

9.1 At least once a year the Committee will review its collective performance and its terms of reference. Any proposed changes to the terms of reference will be recommended to the Board for approval.

10. References

10.1 National Health Service Act 2006

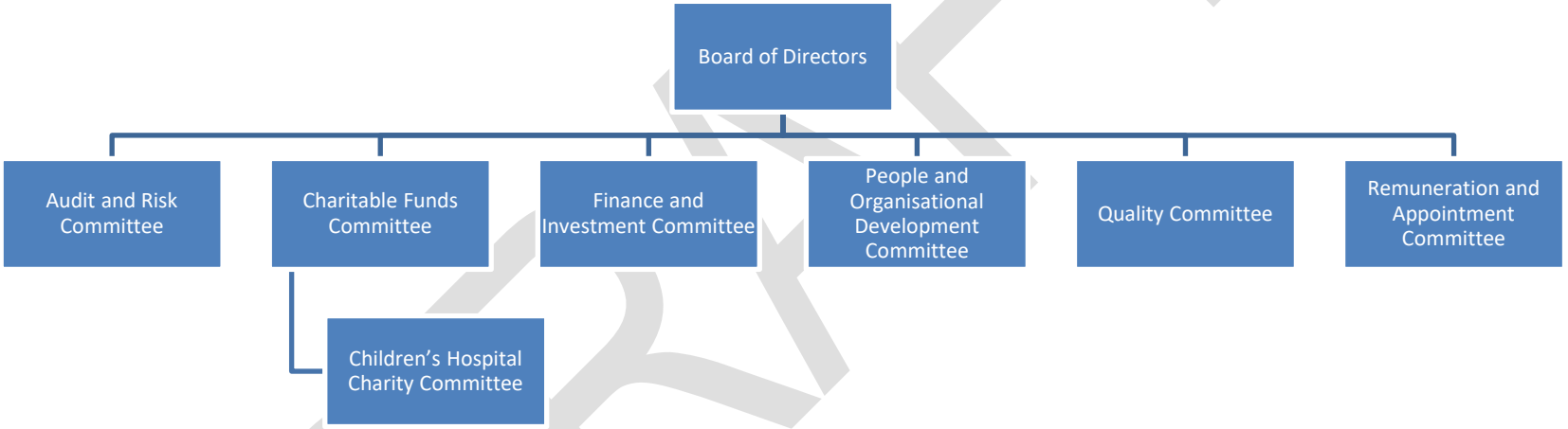
10.2 Charities Act 2011

10.3 Charities (Accounts and Reports) Regulations 2008

10.4 Declaration of Trust dated 10 November 1995 (as amended)

10.5 Standing Financial Instructions

Appendix A



Document Monitoring Information	
Approval Committee:	Board of Directors
Date of Approval:	~~25 February 2021~~27 May 2021
Responsible Committee:	Charitable Funds Committee
Monitoring (Section 9) for Completion and Presentation to Approval Committee:	February 2022
Target audience:	Board of Directors, Charitable Funds Committee, Staff
Key words:	Charitable, Charity, Funds, Committee, Board, Terms of Reference, Hospital Charity
Main areas affected:	Trust-wide
Summary of most recent changes if applicable:	Reformatting, membership, attendees and committee structure
Consultation:	Chief Nursing Officer
Number of pages:	7
Type of document:	Committee Terms of Reference
Does this document replace or revise an existing document?	Yes
Should this document be made available on the public website?	Yes
Is this document to be published in any other format?	No

University Hospital Southampton
NHS Foundation Trust

Report to the Board of Directors				
Title:	**Trust Executive Committee Terms of Reference**			
Agenda item:	**7.4**			
Sponsor:	**David French, Chief Executive Officer**			
Author:	**Karen Flaherty, Associate Director of Corporate Affairs & Company Secretary**			
Date:	**27 May 2021**			
Purpose	**Assurance or reassurance**	**Approval** **X**	**Ratification**	**Information**
Issue to be addressed:	Following some changes to roles and supporting governance structures, the membership of the Trust Executive Committee (**TEC**) and Appendix A of the terms of reference, which sets out the committees and groups reporting to TEC, have been updated. The Corporate Health and Safety Committee, the Recruitment Control Panel and the Sustainability Board have now been added as reporting to TEC. The Divisional Performance Committee and EFCD Estates Management Team have been removed from the structure as these do not formally report into TEC with divisional and estates management teams represented through membership of TEC. The changes to the membership reflect new appointments and changes to roles.			
Response to the issue:	The proposed draft terms of reference are attached and have been approved by TEC. These terms of reference are subject to final approval by the Trust's board of directors to provide additional assurance on the constitution of the committee given its responsibility for developing and implementing the strategy adopted by the Board and the operational management of the Trust.			
Implications: (Clinical, Organisational, Governance, Legal?)	The terms of reference ensure that the purpose and activities of the Trust Executive Committee are clear and support transparency and accountability in the performance of its role.			
Risks: (Top 3) of carrying out the change / or not:	1. Executive, divisional and broader clinical leadership are involved in decision-making in areas of strategic and operational significance at UHS. 2. Non-compliance with the Trust's standing financial instructions and policies relating to the specific responsibilities of the Trust Executive Committee. 3. The Trust and the Committee may not function as effectively without terms of reference in place.			
Summary: Conclusion and/or recommendation	The board of directors is asked to approve the terms of reference following review by the Trust Executive Committee.			

University Hospital Southampton NHS
NHS Foundation Trust

Trust Executive Committee Terms of Reference

Version: ~~3~~4

Date Issued:	~~7 January~~27 May 2021
Review Date:	December 2021
Document Type:	~~Committee~~ Terms of Reference

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1. Role and Purpose

1.1 The Trust Executive Committee (the **Committee**) is responsible for supporting the Chief Executive in the performance of their duties as accounting officer of University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**) and all Executive Directors in fulfilling the duties and responsibilities delegated to them by the board of directors of the Trust (the **Board**).

1.2 The Committee ensures that executive, divisional and broader clinical leadership are involved in decision-making in areas of strategic and operational significance at UHS.

1.3 The duties and responsibilities of the Committee are more fully described in paragraph 7 below.

2. Constitution

2.1 The Committee has been established by the Chief Executive. The Committee has no executive powers other than those set out in these terms of reference. It is supported in its work by other committees established by the Committee as shown in Appendix A.

2.2 The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee.

2.3 In carrying out its role the Committee is authorised to seek reports and assurance from executive directors and managers and will maintain effective relationships with the chairs of other management and Board committees to understand their processes of assurance and links with the work of the Committee.

2.4 The Committee is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions.

3. Membership

3.1 The members of the Committee will be appointed by the Chief Executive and will be:

3.1.1 the Chief Executive;

3.1.2 all other Executive Directors;

3.1.3 the ~~Medical~~ Deputy Medical Director~~s~~;

3.1.4 the Director of Planning, Performance and Productivity;

3.1.5 all Divisional Clinical Directors;

3.1.6 all Divisional Directors of Operations;

3.1.7 all Divisional Heads of Nursing and Professions;

3.1.8 the Director of Midwifery;

3.1.9 the Director of Research and Development;

3.1.10 the Director of Education;

3.1.11 the Deputy Director of Nursing for Quality;

~~3.1.12 the Deputy Director of Nursing, Education & Workforce;~~

~~3.1.13~~3.1.12 the Director of Informatics;

~~3.1.14~~3.1.13 the Director of Estates, Facilities & Capital Development;

~~3.1.15~~3.1.14 the Director of Communications;

~~3.1.16~~3.1.15 the Deputy Chief Operating Officer;

~~3.1.17~~3.1.16 the Covid Mass Testing Project Lead;

~~3.1.18~~3.1.17 the Associate Director of Corporate Affairs and Company Secretary; and

~~3.1.19~~3.1.18 the Dean of Medicine, University of Southampton.

3.2 The Chief Executive will chair of the Committee (the **Committee Chair**). In the absence of the Committee Chair and/or an appointed deputy, the remaining members present will elect one of themselves to chair the meeting.

3.3 Only members of the Committee have the right to attend and vote at Committee meetings.

3.4 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas of strategy, risk or operation that are the responsibility of that individual.

4. Attendance and Quorum

4.1 Members should aim to attend every meeting and should attend a minimum of 75% of meetings held in each financial year. Where a member is unable to attend a meeting they should notify the Committee Chair or secretary of the Committee in advance.

4.2 The quorum for a meeting will be ten members. A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4.3 When a member is unable to attend a meeting they may appoint a deputy to attend on their behalf.

5. Frequency of Meetings

5.1 The Committee will meet monthly and otherwise as required.

6. Conduct and Administration of Meetings

6.1 Meetings of the Committee will be convened by the secretary of the Committee at the request of the Committee Chair or any of its members.

6.2 The agenda of items to be discussed at the meeting will be agreed by the Committee Chair with support from the Company Secretary. The agenda and supporting papers will be distributed to each member of the Committee no later than three working days before the date of the meeting. Distribution of any papers after this deadline will require the agreement of the Committee Chair.

6.3 The secretary of the Committee will minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance and any declarations of interest.

6.4 Draft minutes of Committee meetings and a separate record of the actions to be taken forward will be circulated promptly to all members of the Committee.

7. Duties and Responsibilities

The Committee will carry out the duties below for the Trust.

7.1 ***Objectives and strategy***

7.1.1 The Committee will develop the strategy and operational plans for recommendation to the Board including strategic objectives, quality priorities and the capital plan, working for the benefit of patients, staff and other stakeholders.

7.1.2 The Committee will monitor and manage the successful execution of strategy and the delivery of strategic objectives, quality priorities and financial plans once approved.

7.2 ***Performance and operations***

7.2.1 The Committee will monitor and manage quality and safety of patient care and the delivery of patient outcomes.

7.2.2 The Committee will monitor and manage the delivery of services to nationally mandated standards.

7.2.3 The Committee will monitor and manage operational plans and budgets.

7.2.4 The Committee will optimise the allocation of resources.

7.2.5 The Committee will support the active liaison, coordination and cooperation between divisions, care groups and services.

7.2.6 The Committee will ensure that issues of equality, diversity and inclusivity are considered and addressed.

7.3 ***Resources***

7.3.1 The Committee will monitor the staff experience, identifying actions to support the positive engagement, retention and recruitment of staff.

7.3.2 The Committee will review revenue business cases of £1 million or more in value, approving those with a value of £2.5 million or less, referring those above that value to the Finance and Investment Committee for approval.

7.3.3 The Committee will review capital business cases over £2.5 million in value, approving those with a value of £5 million or less, referring those above that value to the Finance and Investment Committee for approval.

7.3.4 The Committee will approve all business cases requiring significant clinical or strategic input regardless of value.

7.3.5 The Committee will review all business cases for consultant posts and approve any business cases for the creation of new consultant posts.

7.3.6 The Committee will approve significant changes to the Trust's estate.

7.3.7 All decisions of the Trust to tender for health-related services will be reported to the Committee.

7.4 ***Governance and risk management***

7.4.1 The Committee will ensure that effective management systems and processes are in place to support the delivery of the Trust's strategy and plans.

7.4.2 The Committee will review any changes to the organisational structure of the Trust, making recommendations for change.

7.4.3 The Committee will review significant risks to the delivery of the Trust's strategy, plans and performance and monitor and manage risk management processes and internal controls.

7.4.4 The Committee will monitor and manage compliance with relevant legislation and regulations.

7.4.5 The Committee will monitor and manage the integrity of management information and financial reporting systems.

7.5 ***Innovation***

7.5.1 The Committee will identify and support the execution of innovation in the delivery of services and areas of activity.

7.6 ***Policies***

7.6.1 The Committee will consider, and approve as appropriate, policies identified by the Chief Executive for its consideration.

8. Accountability and Reporting

8.1 The Chief Executive will report to the Board following each meeting, drawing the Board's attention to any matters of significance or where actions or improvements are needed.

8.2 Appendix A sets out the sub-committees that report to and support the Committee in fulfilling its duties and responsibilities.

9. Review of Terms of Reference and Performance and Effectiveness

9.1 At least once a year the Committee will review its collective performance and its terms of reference. Any proposed changes to the terms of reference will be recommended to the Board for approval.

10. References

10.1 National Health Service Act 2006

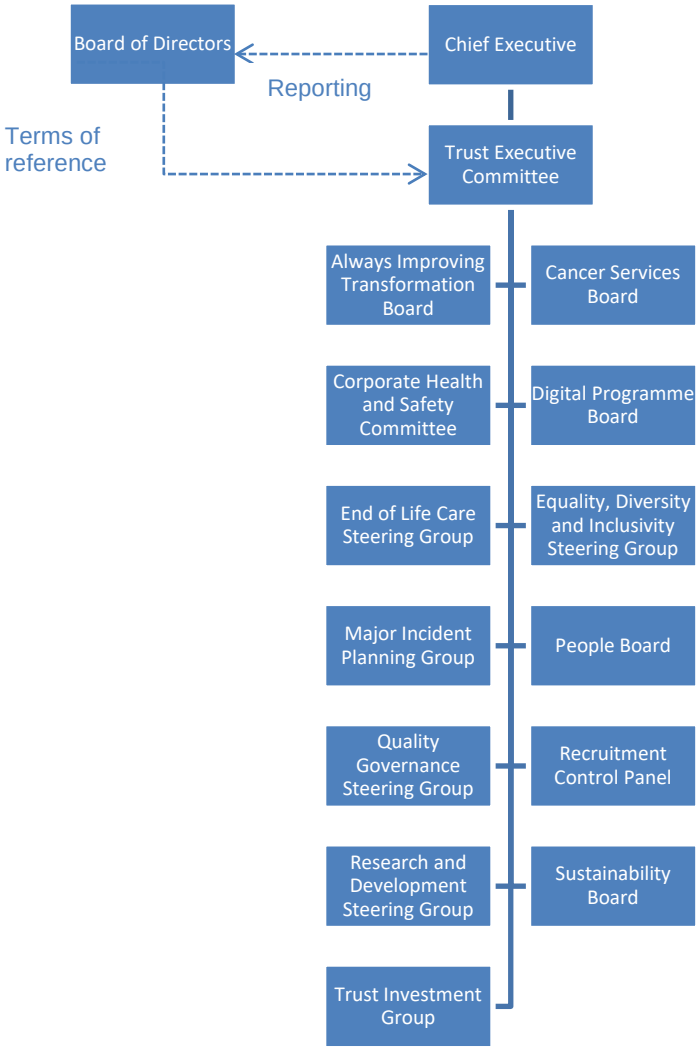
10.2 NHS Foundation Trust Code of Governance

10.3 NHS foundation trust accounting officer memorandum (August 2015)

10.4 NHS Oversight Framework

10.5 Standing Financial Instructions

Appendix A


Board of Directors
Chief Executive
Reporting
Terms of reference
Trust Executive Committee
Always Improving Transformation Board
Cancer Services Board
Corporate Health and Safety Committee
Digital Programme Board
End of Life Care Steering Group
Equality, Diversity and Inclusivity Steering Group
Major Incident Planning Group
People Board
Quality Governance Steering Group
Recruitment Control Panel
Research and Development Steering Group
Sustainability Board
Trust Investment Group

Trust Executive Committee Terms of Reference	Version: ~~3~~4

Document Monitoring Information	
Approval Committee:	Board of Directors
Date of Approval:	~~7 January~~27 May 2021
Responsible Committee:	Trust Executive Committee
Monitoring (Section 9) for Completion and Presentation to Approval Committee:	December 2021
Target audience:	Board of Directors, Trust Executive Committee, NHS Regulators and Staff
Key words:	TEC, Executive, Committee, Terms of Reference
Main areas affected:	Trust-wide
Summary of most recent changes if applicable:	~~Reformatting, membership, g~~Membership and governance structure
Consultation:	Executive Directors
Number of pages:	7
Type of document:	~~Committee~~ Terms of Reference
Does this document replace or revise an existing document?	Yes
Should this document be made available on the public website?	No
Is this document to be published in any other format?	No