University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	28/01/2021
Time	9:00 - 11:45
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		**Patient Story** To receive feedback from patients, carers or other stakeholders about their experience of the Trust's services.
3		**Minutes of Previous Meeting held on 26 November 2020**
4		**Matters Arising and Summary of Agreed Actions** To discuss any matters arising from the minutes and to agree on the status of any actions assigned at the previous meeting.
5		**QUALITY, PERFORMANCE and FINANCE** Quality includes: clinical effectiveness, patient safety, and patient experience
5.1	9:20	**Briefing from the Chair of the Audit and Risk Committee (Oral)** Keith Evans, Chair
5.2	9:25	**Briefing from the Chair of the Quality Committee (Oral)** Tim Peachey, Chair
5.3	9:30	**Chief Executive Officer's Update (Oral)** Sponsor: David French, Interim Chief Executive Officer
5.4	9:45	**Integrated Performance Report for Month 9** To review the Trust's performance as reported in the Integrated Performance Report and the Quarterly Patient Safety/Experience/ Infection Prevention and Control Report. Sponsor: David French, Interim Chief Executive Officer
5.5	10:30	**Finance Report for Month 9** Sponsor: Ian Howard, Interim Chief Financial Officer
5.6	10:40	**Update on Plan to Address Violence and Aggression against Staff (Oral)** Sponsor: Joe Teape, Chief Operating Officer

5.7 **Response to Ockenden Review of Maternity Services**

10:45 Sponsor: Gail Byrne, Chief Nursing Officer
Attendee: Suzanne Cunningham, Director of Midwifery

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

6.1 **Feedback from the Council of Governors' (CoG) Meeting 20 January 2021 (Oral)**

11:00 Sponsor: Peter Hollins, Trust Chair

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

11:10 In compliance with the Trust's Constitution, Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation.
Sponsor: Peter Hollins, Trust Chair

6.3 **Trust Board Committee Terms of Reference**

11:15 i) Audit and Risk Committee
ii) Quality Committee
Sponsor: Peter Hollins, Trust Chair
Attendee: Karen Flaherty, Associate Director of Corporate Affairs & Company Secretary

7 **Any Other Business**

11:25 To raise any relevant or urgent matters that are not on the agenda

8 **To note the date of the next meeting: 30 March 2021**

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

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**

11:30

University Hospital Southampton
NHS Foundation Trust

Minutes Trust Board – Open Session

Date	26/11/2020
Time	9:00 - 12:10
Location	Microsoft Teams
Chair	Peter Hollins (PTH)
Present	Jane Bailey (JB), Non-Executive Director (**NED**) and Senior Independent Director/Deputy Chair Dave Bennett (DB), NED Gail Byrne (GB), Chief Nursing Officer Cyrus Cooper (CC), NED Keith Evans (KE), NED David French (DAF), Interim Chief Executive Officer Steve Harris (SH), Chief People Officer Jane Harwood (JH), NED Ian Howard (IH), Interim Chief Financial Officer Tim Peachey (TP), NED Derek Sandeman (DS), Chief Medical Officer Joe Teape (JT), Chief Operating Officer
In attendance	Julie Brooks, Head of Infection Prevention Unit (Item 3.6) Rosemary Chable, Deputy Director of Nursing, Education and Workforce (Item 3.5) A patient (Item 2) Karen Flaherty (KF), Associate Director Corporate Affairs and Company Secretary Nitin Mahobia, Director of Infection Prevention Unit (Item 3.6) Christine Mbabazi, Equality and Inclusion Adviser/Freedom to Speak Up Guardian (Item 3.4) Val Sevier, CQC Inspector and Mental Health Advocate, Care Quality Commission (observing) 7 governors (observing) 3 members of staff (observing)

1 Chair's Welcome, Apologies and Declarations of Interest

The Chairman welcomed all those attending to the meeting, particularly Val Sevier from the Care Quality Commission, who would be observing the meeting and DF and IH, who were attending their first meeting of the Trust Board in the roles of Interim Chief Executive Officer and Interim Chief Financial Officer, respectively.

2 Patient Story

A patient was welcomed to the meeting to share her experience of the treatment and care received at Southampton General Hospital following a road traffic accident in August 2019. Her experience from the time she arrived at the hospital, through intensive care and on the ward had been very good and she had received fantastic care delivered with kindness and compassion. Her

injuries had been assessed quickly and thoroughly on arriving at hospital by the team who were waiting for her and she had been particularly impressed by the person coordinating the large team so calmly. She remembered there being a nurse present whenever she woke while in intensive care and family members had been able to stay with her, both of which had been reassuring and comforting. She had also received physiotherapy in intensive care. All her concerns had been taken seriously and responded to promptly and the updates and explanations she had been given were always clear and she had been included in decisions at all times.

There had been a couple of less positive features. The first was the manner in which the severity of her condition and prognosis were communicated to her family. This could have been done with greater sensitivity as this had been quite frightening for them to hear. Her family had provided feedback at the time and this had been dealt with immediately. Communication on the timing of her transfer to another setting for rehabilitation had not been good.

The Board thanked the patient for recounting her experience and had been struck by her incredible honesty and resilience. In response to a question, the patient confirmed that she had received some psychological support at the end of her stay when she was on the ward but not while in intensive care. The patient also provided an update on how she was doing currently and the Board wished her well in her continued recovery and plans for the future.

3 QUALITY, PERFORMANCE and FINANCE

3.1 Briefing from Chair of Finance and Investment Committee

JB provided an overview of the Finance and Investment Committee meeting earlier that week, highlighting:

- the difficulty of future budget-setting given the uncertainty outside the block contract;
- the ability to maintain activity at recovered levels given changes in the support provided by the independent sector and the risks associated with the second wave of Covid-19;
- the challenge to plans for the recovery of levels of activity in Ophthalmology, which had also been discussed by the Quality Committee;
- the decline in the percentage of appointments held virtually and maintaining these at an appropriate level given the positive response to this advance during the pandemic;
- monitoring the work on ‘Always Improving Value for Money’ through the review of major projects;
- the review of those risks in the Board Assurance Framework (**BAF**) that the committee was responsible for monitoring; and
- the review of the terms of reference.

3.2 Briefing from Chair of People and Organisational Development Committee

JH provided an update on the first meeting of the People and Organisational

Development Committee that she had chaired. The Committee had considered:

- the recommendations on addressing violence and aggression to staff including additional security support when patients abscond and a red card system for patients and visitors;
- the continuation of the support provided to staff during the pandemic around health and wellbeing;
- progress on inclusivity including the new leadership and mentoring scheme;
- the risks relating to people and organisational development; and
- the development the forward plan for the committee including an open discussion around the people plan at its next meeting in December.

3.3 Briefing from Chair of Quality Committee

TP provided an overview of the Quality Committee meeting earlier that week, highlighting:

- the further investigation of the reasons for the quality indicator for 'patients feeling involved in care decisions' remaining under target;
- that complaints handling had continued to improve and response times were almost back to the same levels as prior to the pandemic, during which complaints had been put on hold;
- the work and continuing development of the Patient Support Hub;
- the low level of responses to the Friends and Family Test, although survey scores remained high;
- the assurance provided by the update on safety and quality improvements within maternity services and the potential impact of changes to the standards underpinning NHS Resolution's maternity incentive scheme as these would be more difficult to achieve and the timescale for this remained uncertain;
- the review of quality indicators, including explanations and updates on progress of any outliers;
- the update on the acuity/deteriorating patient workstreams in 2020, which were performing well, and which identified the need to move to an electronic escalation process to improve the timeliness of response to events, the risk of relating to early recognition of the signs a patient's condition may be deteriorating when patients were not in the right area and the individualised approach to decisions around resuscitation;
- the review of the revised infection prevention and control board assurance framework and clinical outcomes for cardiology and thoracic surgery; and
- the review of the clinical assurance framework, a highly effective tool for risk management which was being shared with system partners for implementation, although a drop in the submission of data by specialties was being followed up.

3.4 Freedom to Speak Up Report

Christine Mbabazi presented the update on Freedom to Speak Up (**FTSU**) in the Trust for information. There had an increase in the number of cases, demonstrating that staff felt able to speak up, including 13 cases of concerns

relating to Covid-19 following changes to ways of working in the Trust in response to the pandemic and more recent changes to the guidance around shielding when pregnant. There were also 20 cases of concern relating to bullying and harassment, which was a similar level to other trusts, and remained a longstanding issue in some areas that needed to be addressed.

The Board thanked Christine Mbabazi for the report and discussed the following areas:

- the support provided by FTSU Champions in signposting and following up on concerns;
- using Speak Up Month in October to contact Black and Minority Ethnic (**BAME**) staff;
- highlighting areas where there was a higher incidence of concerns or themes had been identified in future reports to the Board and the work being done to support those areas;
- the importance of feeding back on to individuals raising concerns on actions taken to demonstrate the credibility, transparency and fairness of the process and that their concerns have been listened to; and
- the use of the FTSU Steering Group to review cases in detail and provide assurance around the Trust's culture in relation to speaking up and more generally.

The Board agreed that it was important to keep under consideration the extent to which increasing numbers of cases reflected improved reporting on one hand and deteriorating behaviour on the other.

3.5 Annual Ward Staffing Nursing Establishment Review

Rosemary Chable presented the annual nurse staffing review to the Board for information.

Although the usual six monthly 'light touch' review was not carried out in March/April as planned due to the Covid-19, each ward had reviewed its nursing establishment as part of the overall Trust response to the pandemic. The annual review had provided an opportunity to speak to matrons about their experiences during the pandemic and the agility and flexibility that had been shown. It had been heartening to hear how well leaders understood staffing and responded to acuity on the wards. Staffing had become much more of a shared concern through the pandemic, with the introduction of the staffing hub providing greater awareness and a more agile response.

In response to questions from the Board, it was clarified that:

- the FTSU Guardian worked with the Deputy Director of Nursing, Education and Workforce to triangulate concerns with staffing data and any 'red flags';
- the budget-setting process around staffing levels at night was to update the permanent establishment for areas, while the more immediate response had been to use agency and staff from other areas to address these issues; and
- the ability to recruit nursing staff was the most significant constraint on staffing - budgets was not the constraint.

3.6 Revised Infection Prevention and Control Board Assurance Framework

The infection prevention and control board assurance framework, the self-assessment of compliance with Public Health England and other Covid-19 related infection prevention and control guidance devised by NHS England (**NHSE**) and NHS Improvement (**NHSI**), had first been presented to the Board in May 2020. The framework had been updated and gaps in assurance and actions to mitigate or control risks had been identified and documented in the revised infection prevention and control board assurance framework presented to the Board.

Through the 'COVID ZERO' campaign and the work of the infection control team through the pandemic, the completed self-assessment provided a great deal of assurance to the Board. The Trust had also been contacted by the regional nursing team from NHSE and NHSI to understand the work being done to prevent nosocomial infection as examples to be shared nationally. There were a couple of areas that were not identified in the framework but which were important in ensuring the efficiency and effectiveness of infection control: good nursing leadership and human factors. A command and control approach was not as effective as winning the hearts and minds of staff.

The Board noted the assurance provided by the self-assessment and the areas requiring future assurance:

- completion of documentation;
- additional monitoring, audits and spot checks to ensure consistent compliance with infection prevention and control measures; and
- all staff receiving appropriate training or refresher training as required.

3.7 Integrated Performance Report for Month 7

The integrated performance report for month 7 was noted for information. Overall performance was positive, balancing the recovery of elective activity and management of Covid-19.

The Board discussed the following areas:

<u>Responsive</u>

- the increase in the number of patients waiting more than 52 weeks, although this was in line with predictions submitted to NHSE/NHSI and this trend was evident at other similar hospitals;
- the work to increase capacity, including the use of virtual appointments, which had levelled off at 30% of all appointments;
- the challenge to increase diagnostic capacity, although the numbers of patients waiting more than six weeks for a diagnostic test had improved, and could be an area for in-depth review by the Board at a future meeting, with additional funding potentially available nationally for CT/MRI capacity even though this was a managed service at the Trust;
- the impact of clinical prioritisation on patients who have been waiting longest and exploring in-sourcing options for this group;

- the difficulty in activating surge capacity in intensive care while elective activity was ongoing, with ten operations cancelled in one week earlier in the month;

Caring

- the decrease in the percentage of mothers receiving continuity of care, however, an innovative approach targeting BAME staff and the NEST (Needing Extra Support Team) meant that the Trust was close to reaching the 35% target;

Effective

- checking the drop in screening, which was carried out by Pharmacy, to confirm whether this was related to Covid-19;

Well-led

- that appraisal rates remained low, although staff had been reminded and recognised the importance of continuing to have these conversations;
- the increase in nursing vacancies for registered nurses due to a marginal increase in the rate of vacancy; and
- the need to reverse the deterioration in performance against the research indicators, which would be picked up in the review by the Finance and Investment Committee in December, in terms of the support required to deliver against this key strategic objective, ahead of the review of the research and development strategy by the Board in January 2021.

The Board requested a greater emphasis on the analysis and synthesis of the information presented in the integrated performance report, particularly about any future implications for the Trust. It would also be helpful to have a more systematic presentation of the comparative data referred to in the narrative of the report.

ACTION: (1) Executive Directors would review the availability of comparative data available that could be incorporated into the integrated performance report and developing a broader analysis of the information presented; and (2) DS would check whether there would be an increase in the number of processes for which there was outcomes data.

3.8 Inpatient Flow - Medical Optimised for Discharge Update

An update was provided on the position relating to patients medically optimised for discharge and planned work being led by both external partners and within the Trust. There was a lot of work to do as a system to provide capacity in community settings and meet the targets that had been set. However, there had been progress in the past two years with the number of patients with Delayed Transfers of Care (DTOC) reducing from 200 two years ago, to 100 a year ago and to 47 currently.

In addition to the actions as a system outlined in the report, the Trust would be focusing on the following actions:

- establishing credible inpatient flow data that would be shared weekly;
- adapting clinical criteria to be used consistently across all inpatient areas in the Trust;
- establishing a specialty performance structure around long length of stay (LLOS), medically optimised for discharge (MOFD) and failed discharge and reviewing performance with clinical teams; and
- reviewing the discharge process, defining what good looks like and adopting this consistently.

The approach would need to optimise the use of IT but it was important to have a consistent and systematic approach to understand the next step and the reason for the delay for each patient rather than overall numbers.

While there was universal support for the plan, there were concerns about the capability of the system to deliver the actions set out in the paper. It was agreed that an update on progress was provided sooner that the six months proposed in the report and that system partners should be invited to join the Board for a discussion to understand the constraints on delivery, how realistic the targets were and how the partners in the system could work together differently, including using the voluntary sector, employing staff on NHS contracts and using a system budget to invest in more care out of hospital.

ACTIONS: (1) JT would present an update on progress in three months. (2) PTH would invite representatives of partner organisations to a future board meeting or study session.

3.9 Corporate Objectives 2020-21 Quarter 2 Update

The Board noted the update on progress against the planned milestones for the second quarter as part of the delivery of the corporate objectives for 2020/21.

It was clarified that the report reflected progress as at the end of September, particularly with reference to the progress against the milestones for supporting the physical and mental wellbeing of staff, which had been identified as a priority by the Board. The update on the operational response to the second wave of Covid-19 in the closed session of the Board meeting provided a summary of the current position on the health and wellbeing support available to staff and demonstrated that a lot had been achieved since the end of September. However, it would be hard to mark this as completed while Covid-19 continued to have an impact on the mental health and wellbeing of staff, which the Board acknowledged.

The Board also recognised that the work on shared decision-making was recommencing having been paused during the pandemic utilising a grant from the system awarded in recognition of the Trust's achievements in this area.

The executive directors had been reflecting on what they wanted to achieve in the coming months and the objectives for the remainder of 2020/21 would be

presented at the next meeting of the Board in January 2021. This would include linking these objectives to the strategic objectives in the BAF.

3.10 Finance Report for Month 7

The finance report for month 7 was noted for information. The following areas were highlighted:

- this was the first month reporting on the move into phase 3 of the Covid-19 funding regime without the safety net of a minimum breakeven guarantee;
- the Trust reported a deficit of £0.2 million and remained on target to deliver a £3 million deficit for the second half of 2020/21 as planned;
- costs were expected to increase as the recovery plans and winter plans were fully implemented;
- the retrospective payment for month 6 had not yet been received and audits were taking place at other trusts around the country;
- increases in Payment by Results (PbR) equivalent activity, which had been valued at 98% of block contracted including elective income representing 97% of planned levels;
- guidance was still awaited on the elective incentive scheme and income had not been adjusted for this;
- monthly income for the mass testing project was £550,000; and
- capital expenditure was £2.1 million below budget - £30.4 million against a plan of £32.5m excluding externally funded schemes - and the Trust was pushing to meet this plan given the uncertainty remaining over capital expenditure limits in 2021/22.

Overall, there was reason to be cautiously optimistic about the overall financial position with costs under control and activity going well, however, income was less certain outside the block contract and Covid-19 could put activity at risk, particularly intensive care capacity. The risk relating to activity carried out in the independent sector was also highlighted as the NHS contract with Spire Healthcare Group plc would terminate on 21 December 2020 and the Trust was unlikely to secure the same capacity as currently as the independent sector sought to restart private activity. The month 7 results for other trusts in the region were not yet available, however, these were likely to show a larger deficit and a risk around assumed savings given the south east region had a £40-60 million planned deficit.

ACTION: IH would review expanding the paper previously presented to the Finance and Investment Committee to show capital expenditure on major projects extending beyond the financial year.

4 CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

4.1 Register of Seals, and Chair's Actions

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

4.2 Trust Board Committees Terms of Reference

i) Finance and Investment Committee

The Finance and Investment Committee had agreed amendments to the terms of reference to reflect the move from a cost improvement programme to the 'Always Improving Value for Money' programme and the name of the Estates and Facilities Governance Committee to the EFCD Compliance & Governance Group.

RESOLVED: Subject to these amendments, the Board approved the terms of reference for the Finance and Investment Committee.

ii) Remuneration and Appointment Committee

The Remuneration and Appointment Committee had agreed amendments to paragraphs 3.2 and 3.5 of the terms of reference to provide clarity that no executive director or manager would be present for the consideration of any decisions relating to their appointment or removal, terms of service or remuneration.

RESOLVED: Subject to these amendments, the Board approved the terms of reference for the Remuneration and Appointment Committee.

4.3 Board Assurance Framework (BAF)

The Board reviewed the report.

While the presentation and content of the BAF were good, there were concerns that the narrative around the risks did not clearly identify whether these were within the control of the Trust, how the risk could be managed and what the actions were aiming to achieve.

It was noted that the corporate strategy and strategic objectives were being reviewed and the Board would then revisit the BAF to reflect the risks relevant to the new strategic objectives.

5 Any Other Business

An update was provided on the current position on Covid-19. During the first wave of the pandemic there were 180 patients with Covid-19 in the hospital, 35 of whom were in intensive care. There were 41 patients with Covid-19 in the Trust today (down from 57 the previous week), 12 of whom were in intensive care. The challenge was continuing elective activity at the same time as managing Covid-19 – in the first wave there had been 600 empty beds in the hospital. The Trust was performing well although it had been difficult to respond quickly to the surge in cases by moving staff into intensive care when other areas of the hospital were operating fully.

Daily incident management was in place with input from senior clinicians. The Trust had worked hard to improve in those areas in which it had not performed as well during the first wave, particularly communications. The Trust was performing well around infection prevention and control and rapid patient testing. The Trust was also supporting other trusts locally by taking patients from other hospitals and holding patients ready to be repatriated, which

presented an ongoing risk to the Trust.

Staff were very tired and the second wave felt more like a siege, whereas the first wave had felt like a battle. The public were less sympathetic than in the first wave due to the backlog in treatment with more incidents of aggression against staff. The executive and management team were getting regular feedback on how staff were feeling through various wellbeing initiatives but could not ask for a better response from staff.

6 To note the date of the next meeting: 28 January 2021

RESOLVED: 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.

7 Follow-up discussion with Governors

The following responses were provided to questions and comments from governors during the discussion.

- The waiting list for Ophthalmology was increasing as although activity levels had improved, these were currently at 75% of pre-Covid levels due to nature of the outpatient areas and the requirement for social distancing. Capacity in Ophthalmology was currently the most significant clinical risk at the Trust. High risk cases were being prioritised and there had been only one case of potential harm to a patient as a result of delays in seeing patients. The Trust was exploring novel solutions for treating patients and recruitment would also be challenging in this specialty. However, this should not result in appointments being cancelled the day prior to a clinic as in the example provided by a governor.

  ACTION: JT requested further details of the example cited in order to investigate this further.
- The impact on recruitment due to the UK's exit from the EU related to support roles rather than qualified staff recruitment. However, there had been a 30% increase in applications to the NHS in the past six months. The impact was potentially greater in terms of retention of existing staff from the EU and the Trust had done a lot of work supporting and encouraging these staff members to stay.
- The military doctors contracted by the Trust were employed on a supernumerary basis due to the possibility that they could be called into service at short notice but provided invaluable knowledge and support to the Trust.
- The need to ensure that a strong message from the Board and senior management around the Trust's ethos and behaviour was reflected in the Trust's equality, diversity and inclusion strategy.
- The number of volunteers had reduced as the Trust had not been able

to deploy volunteers in clinical areas as many were in higher risk categories for Covid-19 and in the earlier stages of the pandemic their deployment would not have been appropriate when visitors were not permitted into the hospitals.

- It was difficult to provide more details around the case of bullying and harassment referred to in the FTSU Guardian's report given the need to protect the confidentiality of the person raising the concern. However, there had been work on the culture in two areas including training and changes to management. Where this had been going on for a very long time as alleged, it could take some time for the impact of changes to be felt.
- An update was provided on the Council of Governors' Membership Engagement Working Group meeting the previous week and the work to engage with younger people including a planned membership engagement event to be held virtually with local university students in February/March 2021.
- An update was provided on the Council of Governors' Patient/Staff Experience Working Group meeting the previous day including the work of the Patient Support Hub and the support provided by volunteers in that area.

University Hospital Southampton NHS Foundation Trust

List of action items

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 26/11/2020 3.7 Integrated Performance Report for Month 7				
349.	Comparative data	Executive Directors	28/01/2021	Pending
	Explanation action item Executive Directors to review the availability of comparative data available that could be incorporated into the integrated performance report and developing a broader analysis of the information presented.			
350.	Outcomes data	Sandeman, Derek	28/01/2021	Pending
	Explanation action item DS to check whether there would be an increase in the number of processes for which there was outcomes data. Update 14/1/21: Plan for achieving actions measurement in all specialities in UHS strategy to deliver over 5 years.			
Trust Board – Open Session 26/11/2020 3.8 Inpatient Flow - Medical Optimised for Discharge Update				
351.	Progress update	Teape, Joe	25/02/2021	Pending
	Explanation action item JT to present an update on progress in three months.			
Trust Board – Open Session 26/11/2020 3.8 Inpatient Flow - Medical Optimised for Discharge Update				
352.	Partner organisations	Hollins, Peter	28/01/2021	Pending
	Explanation action item PTH to invite representatives of partner organisations to a future board meeting or study session.			

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 26/11/2020 3.10 Finance Report for Month 7				
353.	Capital expenditure on major projects	Howard, Ian	28/01/2021	Pending
	Explanation action item IH to review expanding the paper previously presented to the Finance and Investment Committee to show capital expenditure on major projects extending beyond the financial year.			
Trust Board – Open Session 26/11/2020 8 Follow-up discussion with Governors				
354.	Cancelled appointments in Ophthalmology	Teape, Joe	28/01/2021	Pending
	Explanation action item JT requested further details of the example cited in order to investigate this further.			

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Integrated Performance Report 2020/21 Month 9**			
Agenda item:	**5.4**			
Sponsor:	**Chief Executive**			
Date:	**28 January 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:	For the year 2020/21 the Integrated Performance Report has adapted to reflect the current operating environment. In particular we have aligned it with the Care Quality Commission Key Lines of Enquiry and then cut it again to reflect delivery of our Strategic Goals and annual corporate objectives.			
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.			

Integrated KPI Board Report

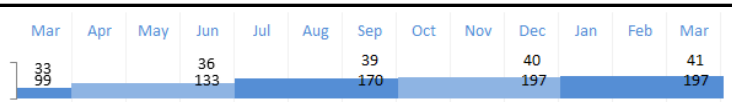
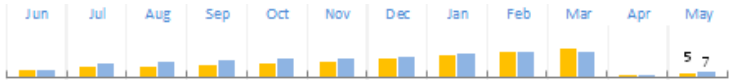
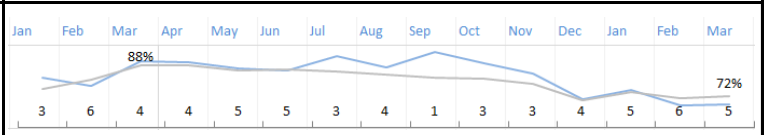
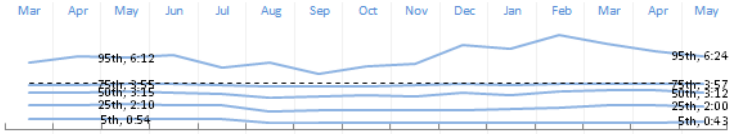
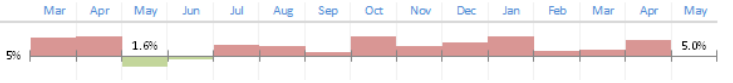
covering up to

Dec 2020

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 Percentiles		A line percentiles chart is used to represent the distribution of a variable. The 50th percentile shows the median value, we also show the 5th, 25th (lower quartile), 75th (upper quartile) and 95th centiles.
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 Trust Integrated Performance Report is presented to the Trust Board each month.
For the year 2020/21 the Integrated Performance Report has adapted to reflect the current operating environment. In particular we have aligned it with the Care Quality Commission Key Lines of Enquiry and then cut it again to reflect delivery of our Strategic Goals and annual corporate objectives in order to:

- Demonstrate that we can assure ourselves 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.

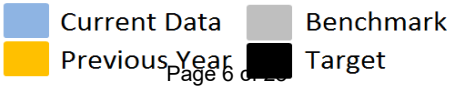
December 2020 Summary

During December the direct impact of COVID-19 infections upon the Trust increased significantly, with confirmed COVID-19 patients increasing from 44 patients (9 of which were in intensive / high care) to 123 patients (40 of which were in intensive/ high care) at the end of the month. Services for patients with other conditions were largely maintained in the first half of the month, with modest impacts in the latter part of the month (when elective activity volumes are normally reduced due to Bank Holidays and other absence levels). Non-elective spell volumes overall were approximately 93%, and Elective spells at all hospital sites were approximately 96%, of December 2019 levels.
During January the impact of COVID-19 infections has increased at great pace, reaching a peak (to date) of 322 confirmed COVID-19 inpatients on the 15th January. Further, up to date, information will be provided by the Chief Operating Officer at the Board meeting.

Key aspects of performance for consideration this month include:

• Activity levels in outpatient and elective care were similar to pre-covid levels at UHS, and higher (relative to pre-Covid levels) than a majority of comparable hospitals.
• There were further indications that our waiting list size had stabilised (prior to the January impact of COVID-19), but the number of patients waiting over 52 weeks for treatment is continuing to grow.
• Emergency Department timescales compare very well both with peers and UHS historical performance, in the context of reduced attendance volumes
• Healthcare acquired COVID-19 infections increased in December, to levels last seen in May.
• Maternity patient feedback continues to indicate concerns, which relate primarily to care and support in the postnatal period. This report contains a summary of the substantial reponse from the service.
• Medical (WL3) and non-medical (WL2) appraisal rates have both improved in the most recent month, medical rates demonstrate very significant improvement, though both remain below target / pre COVID-19 rates.
• Quarter 3 Research performance is reported this month, and demonstrates strong achievement, particularly in respect of the response to COVID-19 including studies related to both vaccination and treatment interventions.

• Emergency Department timeliness remained above 90% (RE 9 and 10) and UHS had the best performance out of 8 'peer' Major Trauma Centres for Type 1 attendances (RE9). Attendance numbers remained below 80% of the normal level (RE 8), whilst enhanced infection control precautions remained in place.
• As indicated in previous reports, the referrals measure (RE 12) has now been reviewed and adjusted for a known change in recording practice. The graph indicates the trend excluding the additional referrals registered to facilitate booking of previous 'walk-in' services during the pandemic. We believe that referral numbers in December 2020 were 87% of those in December 2019 (on a like for like measurement basis).
• The percentage of patients waiting up to 18 weeks from referral to treatment was 67% in both November and December (RE 14), In November UHS continued to be 10th out of a group of 20 teaching hospitals on this measure. The total number of patients waiting is above pre-Covid levels, but reduced by 190 patients this month.
• The number of patients waiting more than 52 weeks (RE16) has increased from 40 at the end of March, to 2092 at the end of December (an increase of 255 patients in the last month). Similar trends are being experienced widely, and UHS has moved from 13th in February to 6th best in November (in a group of 20 Teaching hospitals), but we are very concerned by this and intend to increase capacity once the current wave of COVID-19 has subsided.
• The percentage of patients waiting more than 6 weeks for a diagnostic test (RE 21) improved further, from 31% to 32%, whilst the total number of patients waiting remained stable.
• Cancer performance measures for November indicate that UHS 62 day performance (RE 22) has declined by a further 1% and is 5th amongst our 10 'peer' teaching hospitals at 77%. 31 day performance (RE 23) has deteriorated significantly to 91% following 6 months above the national target of 96%, this deterioration is mainly the result of capacity challenges within the Gynaecology service, provisional data indicates that 31 day performance returned to target levels in December. The number of patients still waiting with pathways greater than 104 days (RE 24) has remained stable.
• Charts RE 28-31 now show activity benchmarking against a group of other teaching hospitals using data that is submitted nationally (on a monthly basis in arrears). The charts indicate that UHS is delivering higher levels of activity recovery compared to the majority of 'comparable' hospitals. Such performance may be influenced by both the actions taken by each hospital, and the scale of COVID-19 related demand on their services, in each month.



RESPONSIVE

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Target
RE1	Non-elective Spells (including CDU)			6,691												6,194	-
RE2-L	Non Elective LOS - Rolling 12 months (Solid) Monthly (Dashed)			6.38												5.75	-
RE3	Number of patients medically optimised for discharge															138	-
RE4-N	Longer LOS Census average (Patients with LOS >=21days)			191												130	-
RE5-I	Adult midday bed occupancy		94.6%												83.5%		90-95%
RE6	Last minute cancelled operations not readmitted within 28 days			27												10	-
RE7	Last minute cancelled operations			87												74	-

RESPONSIVE

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	QTD	Q Target
RE8	Total ED Attendances	12,000 / 5,000		11586												9008	-	-
RE9-N	Patients spending less than 4hrs in ED - SGH Main ED (Type 1 and UCH)	91% / 82% / 73%		76.3%												91.15%	91.9%	95%
	Major Trauma Centres (Type 1) Rank of 8->	4	5	3	6	5	3	2	5	3	3	4	2	2	1	1		
RE10-N	Patients spending less than 4hrs in ED - UHS Total (includes SGH all types)	91.74% / 84.1% / 76.43%		78.3%												91.75%	92.23%	95%
RE11-N	Total time spent in ED - Percentiles UHS Total			90th, 5:56												90th, 3:59	-	-
				Mean, 3:29												Mean, 2:55		
RE12	Accepted Referrals	27000 / 0		20144												17258	-	-
RE13	Elective spells (excluding daycase)	2,000 / 0		1,570												1,500	-	-

Current Data Benchmark
Previous Year Target

RESPONSIVE

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Target
RE14-N	% Patients on an open 18 week pathway (within 18 weeks) with teaching hospital min-max range and rank (of 20)	100% 0%		79.5%											10 of 20	66.69%	>=92%
RE15-N	Total number of patients on a waiting list (18 week referral to treatment pathway)	38000 30000		34605												35126	
RE16-N	Patients on an open 18 week pathway (waiting 52 weeks+) with teaching hospital min-max range and rank (of 20)	7500 0		22											1837	2092	
		13	13	15	15	15	13	13	13	11	11	11	10	9	6		
RE17	Face to face outpatient attendances	56,882 50,000 0													39,093		-
RE18	Non-face to face outpatient attendances	50,000 0	9,423												25,735		-
RE18 - Latest month is awaiting approx ~3k outpatient attendances to be reported																	
RE19	Average weeks waited for first outpatient appointment	12.00 7.00		8.7												8.3	-

Current Data Benchmark
Previous Year Target

RESPONSIVE

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Target /Dec	no.patients to recover	QTD
RE20-N	Patients waiting for diagnostics			7431											9605		-	
RE21-N	% of Patients waiting over 6 weeks for diagnostics with teaching hospital min-max range and rank (of 20)			2.5%										11 of 20	32.27%		<=1%	
RE22-N	62 day Performance Benchmark (data reported nationally at due dates) Teaching Hospitals vs. UHS Total .....Rank(of 10)->	8	6	80.4% 74.7% 4	5	6	5	5	1	2	1	1	1	4	76.6% 72.7% 5	N=> 90% L=> 85%	N = 26 L= 16 of 191.5	79%
RE23-N	31 day cancer wait performance (latest data held by UHS)														91.23%	N=> 96%	N=39 of 821	97.52%
RE24-N	Snapshot of waits > 104 days (from referral on a 62 day pathway)	52	41	29	35	27	29	11	25	36	17	9	11	25	24	-	-	-
RE25-N	28 Day Faster Diagnosis		78%												88%	=>75 %	-	83.70%

Current Data Benchmark
Previous Year Target

RESPONSIVE

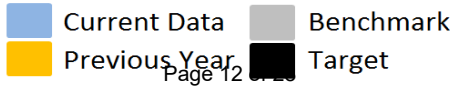
		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly Target	QTD
RE26	My Medical Record - UHS patient logins			5,596												10,568	-	-
RE27	Number of Estates Help desk requests and percentage completed on time			1724												1558	-	-
				77.2%												89.7%	>85%	90.7%
RE28	Elective inpatient activity - % of same month last year															88.3%		
	UHS															77.9%		
	Corporate peer average																	
	----------Rank-->							3	3	2	2	2	2	2	2			
RE29	Non-elective inpatient activity - % of same month last year															92.2%		
	UHS															83.9%		
	Corporate peer average																	
	----------Rank-->							5	3	4	4	2	2	2	3			
RE30	1st outpatient attendances - % of same month last year															87.0%		
	UHS															80.7%		
	Corporate peer average																	
	----------Rank-->							2	2	2	2	2	2	2	2			

RE28-RE30 corporate peers group size = 7

Current Data Benchmark
Previous Year Target

RESPONSIVE

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly Target	QTD
RE31	FU outpatient attendances - % of same month last year UHS Corporate peer average ----------Rank-->							6	3	2	2	1	1	2	5	94.3% 93.3%	-	-



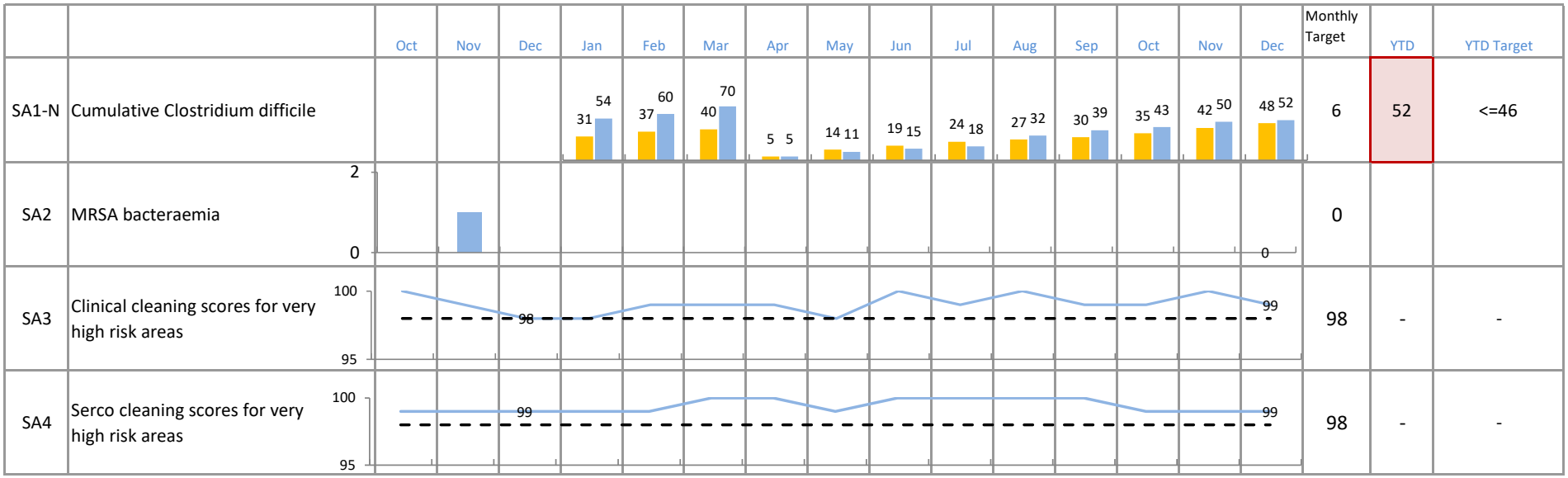
• The cumulative total of Clostridium Difficile infections is now 52, compared to a full year target of <=64. Investigations identified that the number of cases reported to Board this year have been over-stated despite the correct information remaining within the infection prevention team. The process has now been corrected and we apologise to the Board for this error. CDiff infections will continue to be closely monitored, and any avoidable root causes or patterns addressed.

• 9 cases of 'probable' transmission (SA6) and 14 cases of 'healthcare-acquired' COVID-19 (SA5) occurred in UHS inpatient services during December, this has been associated with a significant increase in the number of patients admitted with COVID-19 , and emergence of a new more transmissible variant of the virus. Infection control measures have been reinforced - for example the wearing of masks by patients if they can be tolerated, and extended – for example through an increase in the frequency of Covid testing of all non symptomatic inpatients.

• The continued avoidance of MRSA Bacteraemia, and pressure ulcers causing moderate/severe harm, and very low levels of high harm falls due to omissions in care, are all encouraging.

• The percentage of patents with a nutritional plan in place in recent months (98% in November) is very pleasing.

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly Target	YTD	YTD Target
SA1-N	Cumulative Clostridium difficile				31 54	37 60	40 70	5 5	14 11	19 15	24 18	27 32	30 39	35 43	42 50	48 52	6	52	<=46
SA2	MRSA bacteraemia																0		
SA3	Clinical cleaning scores for very high risk areas			98												99	98	-	-
SA4	Serco cleaning scores for very high risk areas			99												99	98	-	-



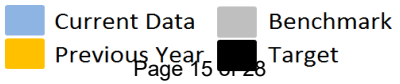
SAFE

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	month target	YTD	YTD Target
SA5	**Healthcare-acquired COVID infection**: COVID-positive sample taken >14days after admission	0	0	0	0	0	20	30	14	1	0	0	0	9	4	14	0	72	-
SA6	**Probable hospital-associated COVID infection**: COVID-positive sample taken >7 days and <=14 days after admission	0	0	0	0	0	26	24	14	1	0	0	0	6	3	9	0	57	-
SA7	Number of pressure ulcers causing moderate/severe harm															0	-	0	-
SA8-N	Medication Errors (severe/Moderate)															2	<=3	21	<=27
SA9	Antibiotic usage per 1000 admissions			5,230										4,605					
SA10	Serious Incidents Requiring Investigation (SIRI)		9													6	-	45	-
SA11	Number of high harm falls (omissions in care)	1	3	1	3	0	0	0	0	0	2	0	0	0	0	0	-	2	-
SA12	% patients with a nutrition plan in place		96.10%												98.36%		-	-	-

Current Data Benchmark
Previous Year Target

SAFE

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	month target	YTD	YTD Target
SA13	Red Flag staffing incidents			65												14	-	-	-
SA14	Number of statutory and mandatory maintenance jobs planned and percentage completed on time			222												258			
																96.9%	>95%	-	>95%



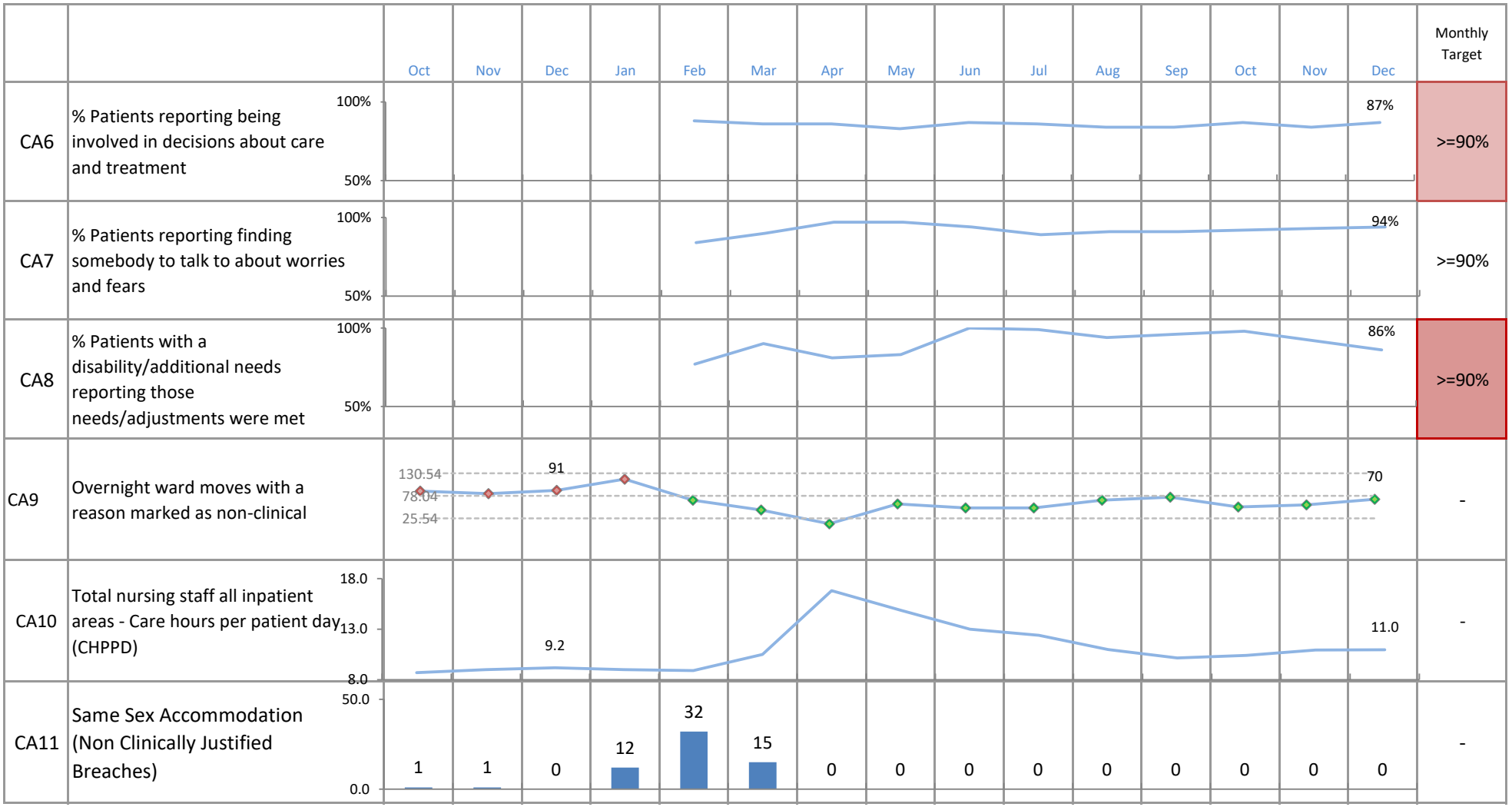
• Inpatient feedback continues to be good, and significantly better than 'target'.
• Maternity patient feedback continues to indicate concerns, with a further deterioration in December. Adverse feedback relates mainly to the postnatal period, and our service recognise that women with newborn babies are likely to receive less effective overall support during the pandemic - including from friends, family and the wider community.
• UHS Maternity
o are determined to provide the best support they reasonably can as a service
o have completed improvements based upon patient feedback in the summer - including welcoming information and extra staff at night to support women learning to breast feed, and
o have further listening and improvement activities planned - including 'whose shoes' event with a focus on postnatal care, work with the Local Maternity System Postnatal Group on the 'Wessex Healthier Together' App, and the Maternity Voices Partnership Chair independently seeking women's views of the service (currently focusing on BAME women).
• The proportion of complaints resolved within 35 days has improved further, and achieved the target in both November and December.
• The percentage of patients with a disability/additional needs reporting that those needs / adjustments were met fell to 86% in December, compared to the target of 90%. The number of patients providing feedback on this measure is relatively small; performance will continue to be monitored and the information examined for further information to guide potential improvements.

CARING

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly Target
CA1-N	FFT Negative Score - Inpatients	5%		0.4%												0.28%	<=5%
CA2-N	FFT Negative Score - Maternity	5%		0.0%												10.48%	<=5%
Maternity FFT scheme has not been operating since March due to Covid 19 but is expected to recommence in October 2020 with first national results published in January 2021																	
CA3-N	Maternity - Continuity of Care			8.2%												11.7%	>=35%
CA4-L	Complaints per 1000 units	1.30		0.26												0.23	<1.2
CA5-L	% Complaints closed within 35 days	80%		92%												82%	>=70%

Current Data Benchmark
Previous Year Target

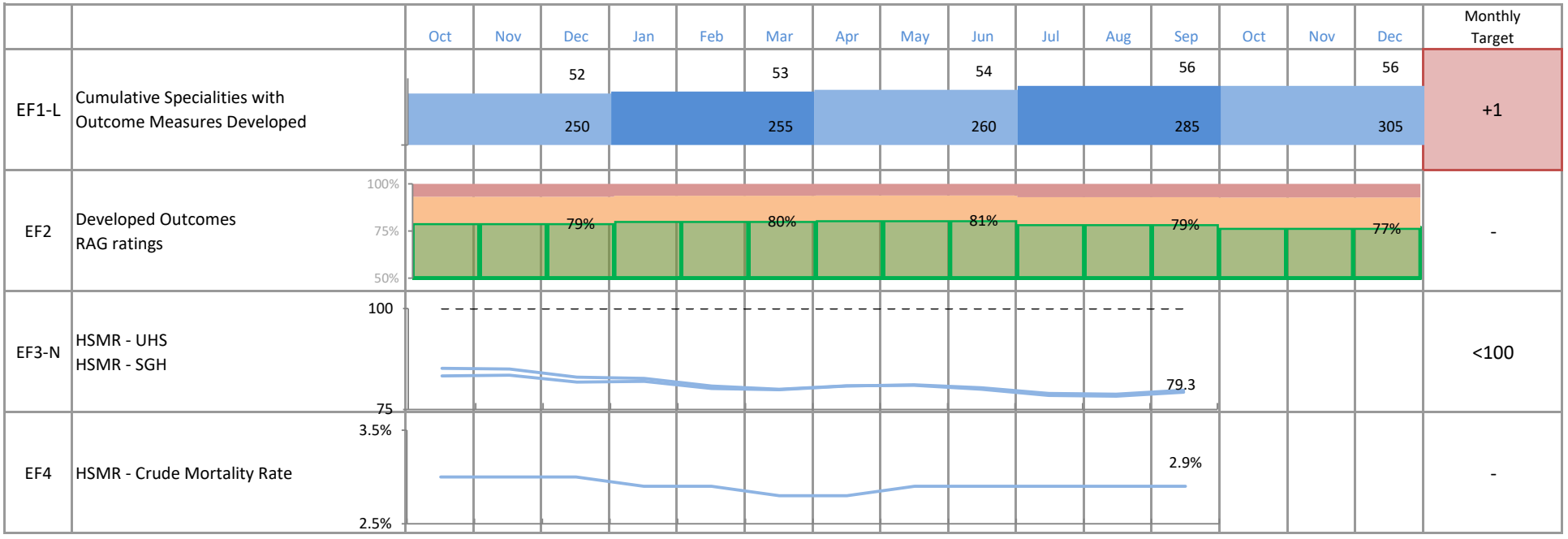
CARING


Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Monthly Target
CA6
% Patients reporting being involved in decisions about care and treatment
100%
50%
87%
>=90%
CA7
% Patients reporting finding somebody to talk to about worries and fears
100%
50%
94%
>=90%
CA8
% Patients with a disability/additional needs reporting those needs/adjustments were met
100%
50%
86%
>=90%
CA9
Overnight ward moves with a reason marked as non-clinical
130.54
78.04
25.54
91
70
-
CA10
Total nursing staff all inpatient areas - Care hours per patient day (CHPPD)
18.0
13.0
8.0
9.2
11.0
-
CA11
Same Sex Accommodation (Non Clinically Justified Breaches)
50.0
0.0
1
1
0
12
32
15
0
0
0
0
0
0
0
0
0
-
Current Data
Previous Year
Benchmark
Target

EFFECTIVE

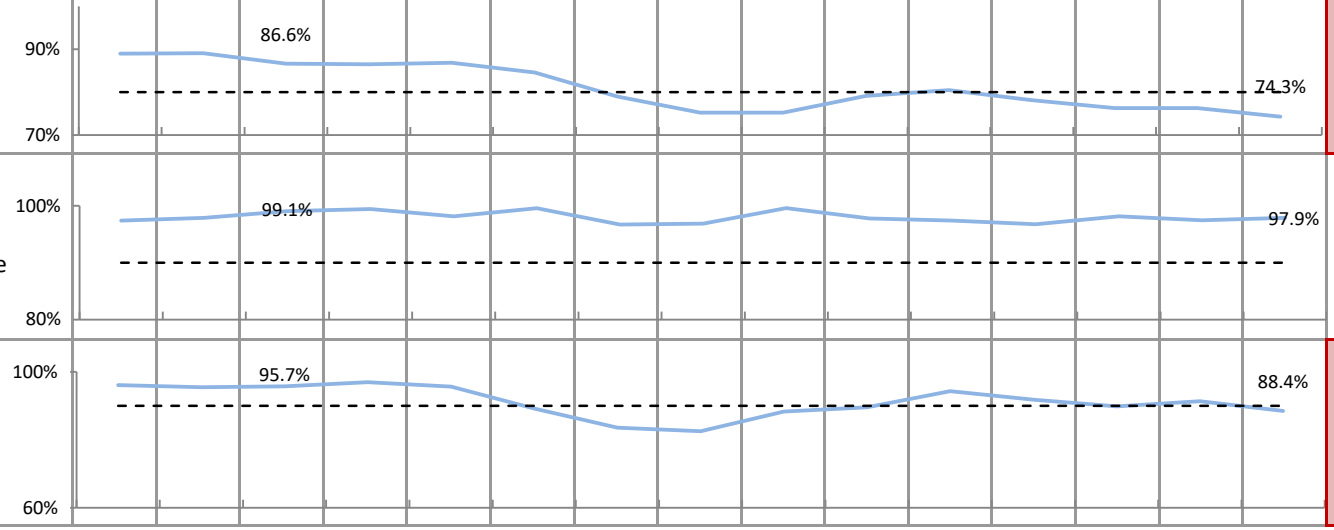
• The number of registered UHS outcome measures continued to increase significantly in number this quarter (though not the number of specialities involved). The percentage of measures rated 'green' has declined slightly and is now at 77% compared to 79% one year ago (EF1, EF2).

• The % of eligible patients screened for smoking and harmful alcohol consumption declined during the first wave of COVID-19 and did not fully recover prior to a more recent decline to 74% in December. Performance will continue to be monitored, and we will seek an improvement once the impact of current COVID-19 pressures reduce.



EFFECTIVE

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly Target
EF5-N	Percentage of patients screened for alcohol and smoking															74.3%	>80%
EF6-N	% patients screened & found to have either moderate or high alcohol dependence given advice or referral															97.9%	>90%
EF7-N	% patients screened & found to smoke given brief advice or a medication offer															88.4%	>90%



Current Data Benchmark
Previous Year Target

WELL LED

• December saw a substantial improvement in medical appraisal rates (WL3) to 80% within 12 months. Non-medical rates (WL2) demonstrated modest improvement to 76%. Current COVID-19 pressures do however represent a challenge to our improvement expectations in both staff groups.

• Overall sickness absence (WL6) remained stable compared to November and slightly above target.

• A new measure has been added to the report (WL7) showing the percentage of staff absent from work related to COVID-19 sickness or self-isolation, this increased in December to 2.7%.

• Information on the number of apprenticeships started at UHS has been updated this month, and demonstrates a recovery in quarterly numbers to pre-Covid levels.

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly Target
WL1-L	Substantive Staff - Turnover	13.81%		13.6%												12.4%	<=12%
		13.05%															
		12.29%															
WL2-L	Staff - Non-medical appraisals completed - Rolling 12-months			84.33%												76.34%	=>92%
		70%															

Current Data Benchmark
Previous Year Target

WELL LED

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly Target
WL3-L	Staff - Medical appraisals completed - Rolling 12-months	100.00% / 50.00% / 0.00%														80.00%	
WL4-L	Staff vacancies	20.00% / 0.00%		6.49%												5.87%	
WL5-L	Nursing Vacancies (registered nurses only in clinical wards)	20.00% / 0.00%		14.17%												15.30%	
WL6L	Staff - Sickness absence (total expressed as a percentage)	4.49% / 3.7% / 2.97%		3.71%												3.54%	<=3.4%
WL7	Staff – Absence related to Covid-19 sickness or self-isolation (expressed as a percentage)	10% / 0%														2.68%	

Current Data | Benchmark
Previous Year | Target

WELL LED

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly Target
WL8-L	Staff FFT - % of staff recommend UHS as a place to work. (Quarterly)						73.3%										>=76%
WL9N	Staff FFT response rate				25%												30%
WL10-L	% of Band 7+ staff who are Black and Minority Ethnic			9.0%												9.8%	15% by 2023
WL11	% of Band 7+ staff who are Disabled															13.61%	

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

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
WL12-L	Statutory & Mandatory Training Achieving Target	7 / 5	7 / 5	7 / 5	7 / 5	7 / 5	7 / 5	7 / 5	6 / 6	6 / 6	6 / 6	6 / 6	6 / 6	6 / 6	6 / 6	6 / 6	-
WL13-L	Number of Apprenticeship Starts			53			28			23			44			49	-

Current Data | Benchmark
Previous Year | Target

Research

• During the pandemic the National Institute for Health Research (NIHR) Clinical Research Network (CRN) have decided not to assess the normal performance metrics, and instead have been tracking:

o COVID-19 study set up and delivery, and

o The proportion of existing open studies restarting recruitment of patients

• In Q3, UHS ranked 5th for recruitment to COVID Urgent Public Health (UPH) studies, and 1st for the number of UPH studies opened and recruited to.

• In June 2020, following NIHR restart framework guidance, UHS began the process of restarting studies which were paused to recruitment. At the end of Q3 we have:

o Re-opened 69% of the pre COVID-19 portfolio, and

o Re-opened or closed 78% of portfolio studies in total (against an NIHR ambition of 80 % by 31st March 2021).

• Comparative CRN recruitment performance by specialty (WL 14) is not meeting target, and is impacted by the change in proportions towards COVID-19 study specialities (with a preponderance of recruitment in infection, children, critical care and respiratory).

• In Q2 UHS ranked 2nd for weighted CRN recruitment (WL 15), which reflects the early response Southampton (UHS in collaboration with the University of Southampton) made to the pandemic – recruiting swiftly to a number of interventional studies. In Q3 UHS ranked 7th, a change which reflects recruitment by a number of Trusts to a few large observational studies as well as a recent focus on commercial vaccine studies at UHS (commercial studies do not contribute towards weighted recruitment significantly).

• In Q3 UHS ranked 7th (up from 17th in Q2) for contract commercial study recruitment (WL 16), this improvement reflects significant recruitment to the commercial COVID vaccine studies currently running at both the Hampshire and Dorset Vaccination Hubs under UHS auspices.

• At present we do not appear on course to deliver the year end target for the proportion of commercial and non-commercial studies closing on time and to recruitment target (WL 17). Performance has been significantly impacted by the pandemic, with many studies paused to recruitment for several months. We anticipate that a significant number of studies will extend their recruitment period, and grant funders have indicated that they will be receptive to requests for time extensions related to the COVID-19 national research response.

• NIHR CRF & BRC publications for Q2 2020/21 numbered 141. This is a significant reduction compared to the previous year, as would as was expected due to the considerable focus on COVID-19 research activity in Southampton.

WELL LED

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly Target
WL14-L	Comparative CRN Recruitment Performance by clinical specialty			52%			56%			52%			28%			36%	
WL15-L	Comparative CRN Recruitment Performance - weighted			6			5			2			2			7	Top 5
WL16-L	Comparative CRN Recruitment - contract commercial			13			13			13			17			7	Top 10
WL17-L	Proportion of studies closing in FY on time and to recruitment target - non-commercial			65%			88%			50%			43%			45%	>=80%
WL18	NIHR CRF & BRC cumulative publications, financial year to date			329			452			120			261				

Current Data
Previous Year
Benchmark
Target

Changes and Corrections

Section	KPI	KPI Name	Type	Detail
Well led	WL7	The percentage of COVID-19 related absences of staff, either through sickness or self-isolation	addition	addition of new metric giving the COVID-19 related absences as a percentage of headcount.
Safe	SA1-N	Cumulative Clostridium difficile	correction	2020/21 values amended to correct values, in previous KPI Board Report (December 2020) a corporate reporting error was inadvertently inflating the correct values that are maintained by the Infection Prevention team
Safe		Number of partially/fully accredited wards	removed	The accreditation visit process is suspended due to Covid 19. The measure is suspended therefore, whilst an alternative accreditation process is developed.
Responsive	RE2-L	Non Elective LOS	Change	Added the monthly LOS metric as a dashed line to the existing rolling 12 month average chart

Nursing and midwifery staffing hours - December 2020

Report notes
Our staffing levels are monitored daily and we will risk assess and fill any gaps to ensure that safe staffing levels are always maintained

The total hours planned is our planned staffing levels to deliver care across all of our areas but does not represent a baseline safe staffing level. We plan for an average of one registered nurse to every five or seven patients in most of our areas but this can change as we regularly review the care requirements of our patients and adjust our staffing accordingly.

Staffing on intensive care and high dependency units is always adjusted depending on the number of patients being cared for and the level of support they require. Therefore the numbers will fluctuate considerably across the month when compared against our planned numbers. This is particularly relevant as we work to appropriately manage the next COVID-19 surge.

Enhanced Care (also known as Specialling)
Occurs when patients in an area require more focused care than we would normally expect. In these cases extra, unplanned staff are assigned to support a ward. If enhanced care is required the ward may show as being over filled.
If a ward has an unplanned increase or decrease in bed availability the ward may show as being under or over filled, even though it remains safely and appropriately staffed.

CHPPD (Care Hours Per Patient Day)
This is a measure which shows on average how many hours of care time each patient receives on a ward /department during a 24 hour period from registered nurses and support staff - this will vary across wards and departments based on the specialty, interventions, acuity and dependency levels of the patients being cared for. In acute assessment units, where patients are admitted , assessed and moved to wards or theatre very swiftly, the CHPPD figures are not appropriate to compare.

The maternity workforce consists of teams of midwives who work both within the hospital and in the community offering an integrated service and are able to respond to women wherever they choose to give birth. This means that our ward staffing and hospital birth environments have a core group of staff but the numbers of actual midwives caring for women increases responsively during a 24 hour period depending on the number of women requiring care.

Since the last 2 weeks in March our clinical areas started to change specialty and size to respond to the changing COVID-19 situation (e.g. G5-G9, Critical Care and RHDU). Whilst there was a period during September to December when wards re-stablished and services were restarted, during December a suite of further changes took place to plan for the next COVID-19 surge. These changes have often been swift in nature. The data in some cases therefore may not be

WARD		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses %Filled	Unregistered staff %Filled	Registered midwives/ nurses CHPPD	Care Staff CHPPD	CHPPD Overall	Comments
C4 (Solent ward)	Day	1353.2	1459.7	1018.2	1055.5	107.9%	103.7%	5.0	4.1	9.1	Safe Staffing levels maintained
C4 (Solent ward)	Night	1071.5	945.0	701.5	943.8	88.2%	134.5%				Safe Staffing levels maintained
C8	Day	2892.2	2785.8	164.5	326.8	96.3%	198.6%	8.4	1.1	9.5	Safe Staffing levels maintained
C6	Night	2026.5	1998.0	0.0	287.8	98.6%	Shift N/A				Safe Staffing levels maintained
C6 (Teenage Cancer Trust unit)	Day	767.8	717.1	354.8	99.0	93.4%	27.9%	9.9	0.9	10.8	Safe Staffing levels maintained
C8 (Teenage Cancer Trust unit)	Night	660.5	640.2	0.0	22.5	96.9%	Shift N/A				Safe Staffing levels maintained
C2	Day	1263.5	1768.5	941.0	815.5	140.0%	86.7%	6.2	3.5	9.6	Safe Staffing levels maintained
C2	Night	1069.5	1117.3	713.0	805.0	104.5%	112.9%				Safe Staffing levels maintained
D3	Day	1671.2	1789.4	781.0	979.7	107.1%	125.4%	5.0	3.2	8.3	Safe Staffing levels maintained
D3	Night	1041.3	1046.3	686.3	833.5	100.5%	121.5%				Safe Staffing levels maintained
Critical Care	Day	22293.6	23459.4	5867.5	4171.8	105.2%	71.1%	28.2	4.7	32.9	Safe staffing levels maintained; Staffing appropriate for number of patients.
Critical Care	Night	21814.5	22312.8	4907.7	3450.1	102.3%	70.3%				Safe staffing levels maintained; Staffing appropriate for number of patients.
E5A	Day	1359.5	992.9	725.7	1069.2	73.0%	147.3%	3.9	3.6	7.4	Safe Staffing levels maintained
E5A	Night	713.0	668.7	356.5	470.5	93.8%	132.0%				Safe Staffing levels maintained
E5B	Day	1496.5	1172.0	771.5	1426.7	78.3%	184.9%	3.9	4.0	7.9	Safe Staffing levels maintained
E5B	Night	710.5	707.9	356.5	494.5	99.6%	138.7%				Safe Staffing levels maintained
F10 E	Day	1378.5	941.3	538.8	1043.5	68.3%	193.7%	5.3	4.6	9.9	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
F10 E	Night	518.5	702.5	368.0	392.5	135.5%	106.7%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
F11	Day	1996.2	1549.4	781.9	775.5	77.6%	99.2%	4.7	3.1	7.8	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
F11	Night	713.0	724.5	713.0	718.5	101.6%	100.8%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
ASU	Day	1499.0	937.0	845.5	722.0	62.5%	85.4%	8.0	5.7	13.7	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Staffing appropriate for number of patients.
ASU	Night	932.0	639.5	483.0	386.0	68.6%	79.9%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Staffing appropriate for number of patients.
F6	Day	2313.9	1502.1	555.9	1392.8	64.9%	250.5%	3.6	3.5	7.1	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
F6	Night	1069.0	913.5	712.2	914.4	85.5%	128.4%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
F5	Day	1945.8	1523.9	1315.0	1195.0	78.3%	90.9%	4.2	3.5	7.7	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
F5	Night	1069.5	887.5	713.5	783.0	83.0%	109.7%				Safe staffing levels maintained
E9	Day	1079.2	846.1	490.3	378.5	78.4%	77.2%	6.5	3.5	10.0	Safe staffing levels maintained
E9	Night	713.0	667.0	356.5	437.0	93.5%	122.6%				Safe staffing levels maintained
Acute medical unit	Day	3543.6	3760.8	3255.6	3613.9	106.1%	111.0%	9.3	7.7	17.0	Safe staffing levels maintained; Safe staffing levels maintained by sharing staff resource; Band 4 staff working to support registered nurse numbers.
Acute medical unit	Night	3562.0	4346.5	2494.5	3104.0	122.0%	124.4%				Safe staffing levels maintained; Safe staffing levels maintained by sharing staff resource; Band 4 staff working to support registered nurse numbers.
D5	Day	1272.5	1429.2	1758.0	1410.0	112.3%	80.2%	3.6	3.5	7.1	Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained; increase in acuity/dependency of patients in the month.
D5	Night	1069.5	1068.8	945.3	1078.5	99.9%	114.1%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained; increase in acuity/dependency of patients in the month.
D6	Day	1095.0	1207.8	1553.0	1341.0	110.3%	86.3%	2.8	3.2	6.0	Increase in acuity/dependency of patients in the month; Safe staffing levels maintained.
D6	Night	713.0	725.0	949.5	908.5	101.7%	95.7%				Increase in acuity/dependency of patients in the month; Increased night staffing to support raised acuity.
D6	Day	711.5	836.1	1146.0	1140.5	117.5%	99.5%	3.6	4.1	7.7	Increase in acuity/dependency of patients in the month; Safe staffing levels maintained.
D6	Night	714.5	738.5	345.0	632.0	103.4%	183.2%				Increase in acuity/dependency of patients in the month; Increased night staffing to support raised acuity; Safe staffing levels maintained.
D8	Day	1033.4	1278.3	1518.0	1387.5	123.7%	91.4%	3.3	3.6	6.9	Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained; increase in acuity/dependency of patients in the month.
D8	Night	713.0	797.5	945.5	900.0	111.9%	95.2%				Increased night staffing to support raised acuity; increase in acuity/dependency of patients in the month.
D9	Day	1202.0	1460.8	1643.0	1479.5	121.5%	90.0%	3.5	3.5	7.0	Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained; increase in acuity/dependency of patients in the month.
D9	Night	1046.5	1025.0	953.0	973.0	97.9%	102.1%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained; increase in acuity/dependency of patients in the month.
E8M	Day	1083.0	1058.5	1306.0	1154.5	97.7%	88.4%	3.2	3.1	6.3	Increase in acuity/dependency of patients in the month; Safe staffing levels maintained.
E8M	Night	714.0	852.5	713.5	681.8	119.4%	95.6%				Increase in acuity/dependency of patients in the month; Increased night staffing to support raised acuity; Safe staffing levels maintained.
E7	Day	1032.5	1236.2	1167.3	1576.3	119.7%	135.0%	3.0	3.3	6.3	Additional beds open in the month; increase in acuity/dependency of patients in the month; Safe staffing levels maintained.
E7	Night	713.0	977.8	1068.5	850.5	137.1%	79.6%				Additional beds open in the month; increase in acuity/dependency of patients in the month; Safe staffing levels maintained.
Respiratory high dependency unit	Day	2415.0	1280.3	494.0	652.0	53.0%	132.0%	19.0	7.3	26.3	Beds flexed to match staffing; Staff moved to support other wards; Safe staffing levels maintained by sharing staff resource.
Respiratory high dependency unit	Night	2139.0	1204.0	356.5	310.5	56.3%	87.1%				Beds flexed to match staffing; Staff moved to support other wards; Safe staffing levels maintained by sharing staff resource.
C5	Day	1231.7	1386.0	1278.0	787.0	112.5%	61.6%	9.1	4.7	13.8	Increase in acuity/dependency of patients in the month; Safe staffing levels maintained.
C5	Night	1069.5	991.5	356.5	426.5	92.7%	119.6%				Increase in acuity/dependency of patients in the month; Safe staffing levels maintained.
D10	Day	1097.0	1000.0	1303.0	1222.5	91.2%	93.8%	3.7	4.0	7.7	Increase in acuity/dependency of patients in the month; Safe staffing levels maintained.
D10	Night	697.0	794.3	713.0	747.3	114.0%	104.8%				This ward has a high number of siderooms and if acuity/dependency of patients is raised Registered nurse or support workers are required to special on night duty; Additional staff used for enhanced care - RNs; Safe staffing levels maintained.
F7	Day	1092.4	1086.4	1511.0	1659.0	99.5%	109.8%	3.0	4.1	7.1	Band 4 staff working to support registered nurse numbers; increase in acuity/dependency of patients in the month; Safe staffing levels maintained by sharing staff resource.
F7	Night	713.0	689.5	483.0	756.8	96.7%	156.7%				Safe staffing levels maintained; increase in acuity/dependency of patients in the month.
G5	Day	1059.5	1047.5	1877.3	1671.5	98.9%	89.0%	2.8	3.2	6.0	Band 4 staff working to support registered nurse numbers; increase in acuity/dependency of patients in the month; Safe staffing levels maintained by sharing staff resource.
G5	Night	1069.5	1000.5	701.5	655.5	93.5%	93.4%				Safe staffing levels maintained by sharing staff resource; increase in acuity/dependency of patients in the month.
G6	Day	1077.4	1041.5	1876.0	1582.0	96.7%	84.3%	2.8	3.5	6.3	Band 4 staff working to support registered nurse numbers; increase in acuity/dependency of patients in the month; Safe staffing levels maintained by sharing staff resource.
G6	Night	1038.5	831.5	793.5	770.5	80.1%	97.1%				Safe staffing levels maintained by sharing staff resource; increase in acuity/dependency of patients in the month.
G7	Day	739.9	774.5	1275.7	1186.0	104.7%	93.0%	3.9	5.3	9.2	Band 4 staff working to support registered nurse numbers; increase in acuity/dependency of patients in the month.
G7	Night	713.0	690.5	954.5	782.5	96.8%	82.0%				Safe staffing levels maintained by sharing staff resource; increase in acuity/dependency of patients in the month.
G8	Day	1101.4	1062.4	1935.0	1609.5	96.5%	83.2%	3.2	4.4	7.6	Band 4 staff working to support registered nurse numbers; increase in acuity/dependency of patients in the month; Safe staffing levels maintained by sharing staff resource.
G8	Night	954.5	793.5	1069.5	989.0	83.1%	92.5%				Safe staffing levels maintained by sharing staff resource; increase in acuity/dependency of patients in the month.
G9	Day	1092.3	970.5	1891.0	1740.0	88.8%	92.0%	3.3	4.6	7.9	Band 4 staff working to support registered nurse numbers; increase in acuity/dependency of patients in the month; Safe staffing levels maintained by sharing staff resource.
G9	Night	1058.0	954.5	977.5	901.5	90.2%	92.2%				Safe staffing levels maintained by sharing staff resource; increase in acuity/dependency of patients in the month.

Nursing and midwifery staffing hours - December 2020

Report notes
Our staffing levels are monitored daily and we will risk assess and fill any gaps to ensure that safe staffing levels are always maintained

The total hours planned is our planned staffing levels to deliver care across all of our areas but does not represent a baseline safe staffing level. We plan for an average of one registered nurse to every five or seven patients in most of our areas but this can change as we regularly review the care requirements of our patients and adjust our staffing accordingly.

Staffing on intensive care and high dependency units is always adjusted depending on the number of patients being cared for and the level of support they require. Therefore the numbers will fluctuate considerably across the month when compared against our planned numbers. This is particularly relevant as we work to appropriately manage the next COVID-19 surge.

Enhanced Care (also known as Specialling)
Occurs when patients in an area require more focused care than we would normally expect. In these cases extra, unplanned staff are assigned to support a ward. If enhanced care is required the ward may show as being over filled.
If a ward has an unplanned increase or decrease in bed availability the ward may show as being under or over filled, even though it remains safely and appropriately staffed.

CHPPD (Care Hours Per Patient Day)
This is a measure which shows on average how many hours of care time each patient receives on a ward /department during a 24 hour period from registered nurses and support staff - this will vary across wards and departments based on the specialty, interventions, acuity and dependency levels of the patients being cared for. In acute assessment units, where patients are admitted , assessed and moved to wards or theatre very swiftly, the CHPPD figures are not appropriate to compare.

The maternity workforce consists of teams of midwives who work both within the hospital and in the community offering an integrated service and are able to respond to women wherever they choose to give birth. This means that our ward staffing and hospital birth environments have a core group of staff but the numbers of actual midwives caring for women increases responsively during a 24 hour period depending on the number of women requiring care.

Since the last 2 weeks in March our clinical areas started to change specialty and size to respond to the changing COVID-19 situation (e.g. G5-G9, Critical Care and RHDU). Whilst there was a period during September to December when wards re-stablished and services were restarted, during December a suite of further changes took place to plan for the next COVID-19 surge. These changes have often been swift in nature. The data in some cases therefore may not be

WARD		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses %Filled	Unregistered staff %Filled	Registered midwives/ nurses CHPPD	Care Staff CHPPD	CHPPD Overall	Comments
Paediatric high dependency unit	Day	1624.0	1207.0	0.0	0.0	74.3%	Shift N/A	13.2	0.0	13.2	Non-ward based staff supporting areas; Beds flexed to match staffing; Safe staffing levels maintained.
Paediatric high dependency unit	Night	1069.5	1140.5	0.0	0.0	106.6%	Shift N/A				Safe staffing levels maintained.
Paediatric medical unit	Day	1810.0	2181.5	318.3	661.2	120.5%	207.8%	18.8	5.7	24.5	Additional beds open in the month; Safe staffing levels maintained.
Paediatric medical unit	Night	1705.0	1786.5	682.0	550.0	104.8%	80.6%				Additional beds open in the month; Safe staffing levels maintained.
Paediatric intensive care unit	Day	6164.2	5112.0	528.0	309.5	82.9%	58.6%	31.4	2.4	33.8	Non-ward based staff supporting areas; Beds flexed to match staffing; Safe staffing levels maintained.
Paediatric intensive care unit	Night	5704.0	4970.8	540.5	471.5	87.1%	87.2%				Beds flexed to match staffing; Safe staffing levels maintained.
Plam Brown ward	Day	3860.0	2833.2	115.0	0.0	73.4%	0.0%	13.1	0.0	13.1	Non-ward based staff supporting areas; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained; Beds flexed to match staffing.
Plam Brown ward	Night	1425.5	1081.4	0.0	11.5	75.9%	Shift N/A				Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained; Beds flexed to match staffing.
E1	Day	1637.5	1576.0	1128.0	575.0	96.2%	51.0%	9.7	3.2	12.9	Staffing appropriate for number of patients; Safe staffing levels maintained.
E1	Night	1069.5	1288.8	707.3	363.3	120.5%	51.4%				Staffing appropriate for number of patients; Safe staffing levels maintained.
G2	Day	768.7	768.0	0.0	0.0	99.9%	Shift N/A	11.2	0.0	11.2	Safe staffing levels maintained.
G2	Night	717.8	765.0	0.0	0.0	106.6%	Shift N/A				Safe staffing levels maintained.
G3	Day	2353.5	2081.0	1710.0	678.0	88.4%	39.6%	9.5	2.6	12.2	Band 4 staff working to support registered nurse numbers; Non-ward based staff supporting areas; Staffing appropriate for number of patients.
G3	Night	1705.0	1509.0	1012.0	315.0	88.5%	31.1%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained; Staffing appropriate for number of patients.
G4	Day	2407.5	2138.0	1254.0	803.0	88.8%	64.0%	9.8	3.2	13.0	Band 4 staff working to support registered nurse numbers; Non-ward based staff supporting areas; Beds flexed to match staffing; Safe staffing levels mainintained.
G4	Night	1705.5	1596.5	682.0	407.0	93.6%	59.7%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
Bramshaw women's unit	Day	1145.5	998.0	716.7	503.2	87.1%	70.2%	7.0	3.5	10.4	Band 4 staff working to support registered nurse numbers; Non-ward based staff supporting areas; Staffing appropriate for number of patients.
Bramshaw women's unit	Night	713.0	713.0	356.5	345.0	100.0%	96.8%				Safe staffing levels maintained.
Neonatal unit	Day	6751.4	5396.2	1685.5	1207.5	79.9%	71.6%	11.6	2.4	14.0	Safe staffing levels maintained; ; ; Professional judgement used when staffing is compromised itu patients nursed 1:2.
Neonatal unit	Night	5445.0	4414.5	1364.0	825.0	81.1%	60.5%				Safe staffing levels maintained; ; ; Professional judgement used when staffing is compromised and itu patients nursed 1:2.
Maternity service	Day	8628.5	8253.8	3217.5	2246.0	95.7%	69.8%	5.6	1.6	7.2	Numbers do not fully reflect the integrated midwifery service demand. Safe staffing levels maintained by sharing staff resource across the services
Maternity service	Night	5410.8	5040.3	2037.0	1471.0	93.2%	72.2%				Numbers do not fully reflect the integrated midwifery service demand. Safe staffing levels maintained by sharing staff resource across the services
Cardiac high dependency unit	Day	4259.4	4073.6	2357.5	1279.8	95.6%	54.3%	15.8	4.6	20.4	Staff moved to support other wards; Skill mix swaps undertaken to support safe staffing across the Unit; Skill mix swaps undertaken to support safe staffing across the Unit; commenced critical care POD model of working .
Cardiac high dependency unit	Night	3567.5	3517.8	1420.8	948.8	98.6%	66.8%				Skill mix swaps undertaken to support safe staffing across the Unit; Band 4 staff working to support registered nurse numbers.
Coronary care unit	Day	1559.7	2211.4	1134.0	941.3	141.8%	83.0%	10.5	3.8	14.3	Increase in acuity/dependency of patients in the month; Band 4 staff working to support registered nurse numbers; , Increased acuity in CCU assessmnet bay for covid mitigation necessitating additional RN each shift.
Coronary care unit	Night	1420.0	2065.3	847.0	627.8	145.4%	74.1%				Increase in acuity/dependency of patients in the month; Skill mix swaps undertaken to support safe staffing across the Unit.
D4	Day	1813.2	1518.7	1102.7	1219.5	83.8%	110.6%	4.5	4.5	9.0	Staff moved to support other wards; Support workers used to maintain staffing numbers.
D4	Night	797.0	779.5	1023.0	1080.8	97.8%	105.6%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
E2	Day	1592.0	1324.7	838.3	1048.8	83.2%	125.1%	4.2	3.3	7.5	Staff moved to support other wards; Additional staff used for enhanced care - RNs; Band 4 staff working to support registered nurse numbers.
E2	Night	682.0	684.3	341.0	550.0	100.3%	161.3%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
E3 Green	Day	1544.5	1560.0	1449.2	1168.4	101.0%	80.6%	3.3	3.0	6.3	Safe staffing levels maintained by sharing staff resource; Safe staffing levels maintained; Staff moved to support other wards.
E3 Green	Night	682.0	594.0	800.8	803.0	87.1%	100.3%				Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
E3 Blue	Day	1106.2	1118.5	1154.5	985.8	101.1%	85.4%	3.7	3.6	7.3	Skill mix swaps undertaken to support safe staffing across the Unit.
E3 Blue	Night	671.0	694.3	671.0	748.0	103.5%	111.5%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
E4	Day	1528.1	1402.2	1177.5	1155.5	91.8%	98.1%	4.5	3.2	7.7	Safe staffing levels maintained by sharing staff resource; Band 4 staff working to support registered nurse numbers.
E4	Night	1012.0	1012.0	440.0	549.5	100.0%	124.9%				Staffing appropriate for number of patients; Additional staff used for enhanced care - Support workers.
D2C	Day	462.5	243.8	247.0	300.8	52.7%	121.8%	4.4	5.4	9.8	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
D2C	Night	220.0	176.0	220.0	221.0	80.0%	100.5%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
Acute stroke unit	Day	1499.0	1634.5	2753.0	2734.5	109.0%	99.3%	3.2	5.6	8.9	Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
Acute stroke unit	Night	1023.0	917.0	1701.5	1767.5	89.6%	103.9%				Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
Regional transfer unit	Day	1014.4	808.5	307.4	163.5	79.7%	53.2%	23.1	9.1	32.2	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
Regional transfer unit	Night	681.0	575.0	682.0	385.0	84.4%	56.5%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
E Neuro	Day	1968.2	1423.3	1065.3	1671.8	72.3%	156.9%	3.8	4.4	8.2	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
E Neuro	Night	1364.0	1197.0	1034.0	1353.0	87.8%	130.9%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
Hyper acute stroke unit	Day	1573.0	1257.5	326.5	685.0	79.9%	209.8%	9.4	5.3	14.7	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
Hyper acute stroke unit	Night	1364.0	946.0	344.0	563.5	69.4%	163.8%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
D neuro	Day	2031.5	1772.5	1941.8	1737.8	87.3%	89.5%	4.9	5.3	10.2	Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
D neuro	Night	1353.0	1265.0	1705.0	1573.0	93.5%	92.3%				Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
SPI F4 Neuro	Day	1636.2	1540.6	862.5	1344.0	94.2%	155.8%	5.4	4.5	9.9	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
SPI F4 Neuro	Night	1023.0	1321.5	1022.5	1033.5	129.2%	101.1%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
Brooke ward	Day	1095.0	1064.5	565.0	780.7	97.2%	138.2%	4.8	4.5	9.3	Safe staffing levels maintained; Staffing appropriate for number of patients.
Brooke ward	Night	1069.5	724.5	356.5	874.0	67.7%	245.2%				Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
Trauma Assessment Unit	Day	928.1	702.0	750.2	737.7	75.6%	98.3%	20.6	21.7	42.3	Staff moved to support other wards; Skill mix swaps undertaken to support safe staffing across the Unit.
Trauma Assessment Unit	Night	683.3	617.3	678.3	652.5	90.3%	96.2%				Safe staffing levels maintained; Skill mix swaps undertaken to support safe staffing across the Unit.
F1	Day	2447.0	2067.7	1961.2	1988.0	84.5%	101.4%	4.5	4.8	9.3	Increase in acuity/dependency of patients in the month; Patient requiring 24 hour 1:1 nursing in the month.
F1	Night	1782.0	1638.0	1782.5	1923.5	91.9%	107.9%				Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month.
F2	Day	1647.5	1403.0	1970.5	2067.2	85.2%	104.9%	3.2	5.1	8.3	Increase in acuity/dependency of patients in the month; Skill mix swaps undertaken to support safe staffing across the Unit.
F2	Night	1023.0	825.0	1359.0	1533.5	80.6%	112.8%				Additional staff used for enhanced care - RNs; Skill mix swaps undertaken to support safe staffing across the Unit; Patient requiring 24 hour 1:1 nursing in the month.
F3	Day	1605.2	1433.3	1876.5	1865.3	89.3%	99.4%	3.7	5.8	9.5	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Patient requiring 24 hour 1:1 nursing in the month.
F3	Night	1023.5	808.3	1364.0	1661.5	79.0%	121.8%				Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month.
F4	Day	1435.0	1264.5	1242.3	1055.5	88.1%	85.0%	4.0	4.0	8.0	Increase in acuity/dependency of patients in the month; Skill mix swaps undertaken to support safe staffing across the Unit.
F4	Night	1034.0	561.0	660.5	770.5	54.3%	116.7%				Additional staff used for enhanced care - Support workers; Patient requiring 24 hour 1:1 nursing in the month.

Item 5.5

University Hospital Southampton NHS
NHS Foundation Trust

2020/21 Finance Report - Month 9

Report to:	**Board of Directors and Finance & Investment Committee** **December 2020**
Title:	**Finance Report for Period ending 31/12/2020**
Author:	**Philip Bunting, Interim Deputy Director of Finance**
Sponsoring Director:	**Ian Howard, Interim 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 December 2020, the Trust reported a surplus of £0.1m. This is consistent with plan after adjusting for a £1.6m 'allowable loss' on other operating income that has not materialised in month.

2. The Trust has reforecast the year end position and is anticipating to deliver a **breakeven** position for the second half of 2020/21 (£8.7m deficit before adjusting for allowable items) against a planned deficit position of £3m.

3. In month, £2.8m (£1.6m pay and £1.2m non pay) was incurred on additional expenditure relating to Covid-19. This was up marginally on November due to increased agency spend (£0.3m). Emerging pressures late in month mean this figure is likely to increase in January. £0.5m of the in-month spend relates to Covid testing costs which are now directly reclaimable on a pass through basis and continue to be billed as a retrospective top-up.

4. The main themes seen in M9 were :
   - If payment had continued on a payment by results basis the trust would have received £1.7m less income. This gap has improved by £1.2m from November; however November was a shorter month. Expectations are this gap will increase moving into Q4 due to Covid related pressures.
   - Elective income was indicatively 97% of planned levels , inclusive of independent sector activity. This position was supported by a high case-mix, with activity at 84%. Outpatient equivalent income remained strong at 96% of planned levels .
   - The Trust continues to incur additional income & expenditure relating to the Chilworth project.
   - Pay costs increased £0.4m from November with a noticeable increase within agency spend (£0.3m). This particularly related to critical care who had supported regional surge requirements late in month.
   - Clinical supplies spend and other non pay costs normalised following a spike in November. Non pay costs include £2.7m relating to the Chilworth project that is not within plan but fully funded.
   - Other operating income continued to meet pre-Covid levels (excluding the Chilworth project); however risks are expected within Q4 due to Covid volumes increasing and reduced capacity.

University Hospital Southampton NHS
NHS Foundation Trust

Finance: I&E Summary (H2)

UHS is being monitored against a half-year financial plan following a M1-6 period of retrospective top-up to break-even. The financial position for M9 was a surplus of £0.1m, which was favourable to plan by £1.6m before adjustments, inclusive of contribution from the Chilworth project.

Income was £5.4m favourable to plan which includes £3.5m of Chilworth project income. Other income sources within education, R&D and pathology also continue to recover to pre-covid levels.

Pay costs overall were broadly on plan. Agency spend increased by £0.3m in month in response to Covid pressures. Non pay costs across clinical supplies and other non pay were £4m adverse to plan although this contains £2.7m of Chilworth project non-pay expenditure (fully funded).

The forecast for months 7-12 has been reviewed and amended to breakeven after accounting for an allowable miss relating to other operating income (£4.75m), for which funding is anticipated, and an anticipated annual leave accrual increase (£4m).

Within Q4 increased covid costs are expected to be offset by reduced clinical supplies spend as elective work is supressed. A broadly flat run rate is therefore expected.

Half-Year Position

		Current Month			M7 - 9 Actuals			M7 - 12		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
NHS Income:	Clinical	59.5	59.9	(0.4)	178.4	178.2	0.1	356.7	356.4	0.3
	Pass-through Drugs & Devices	11.6	11.7	(0.1)	34.9	36.1	(1.2)	69.9	72.2	(2.3)
Other income	Other Income excl. PSF	8.5	13.2	(4.7)	25.6	37.6	(12.0)	51.1	71.3	(20.2)
	Top Up Income	0.4	0.5	(0.1)	1.1	1.4	(0.4)	2.1	2.9	(0.8)
Total income		**80.0**	**85.3**	**(5.4)**	**239.9**	**253.8**	**(13.9)**	**479.8**	**502.9**	**(23.1)**
Costs	Pay-Substantive	43.4	43.8	0.4	129.8	130.2	0.5	262.4	261.4	(1.0)
	Pay-Bank	3.1	2.6	(0.5)	8.6	7.9	(0.8)	18.1	15.7	(2.4)
	Pay-Agency	1.4	1.2	(0.1)	3.5	3.1	(0.4)	7.9	6.2	(1.7)
	Drugs	1.0	1.6	0.6	3.0	2.8	(0.2)	6.0	5.6	(0.4)
	Pass-through Drugs & Devices	11.6	11.7	0.1	34.9	36.1	1.2	69.9	72.2	2.3
	Clinical supplies	7.7	7.4	(0.2)	25.0	23.9	(1.2)	50.2	48.3	(1.9)
	Other non pay	9.9	14.0	4.2	29.6	40.4	10.8	59.5	84.2	24.7
Total expenditure		**78.0**	**82.4**	**4.4**	**234.5**	**244.4**	**9.8**	**474.0**	**493.6**	**19.6**
EBITDA		**1.9**	**2.9**	(1.0)	**5.4**	**9.5**	(4.0)	**5.8**	**9.3**	(3.5)
EBITDA %		2.4%	3.4%	(1.0%)	2.3%	3.3%	(1.1%)	1.2%	1.8%	(0.6%)
	Depreciation	2.0	2.1	0.0	6.1	5.7	(0.4)	12.2	11.4	(0.9)
	Non Operating Income/Expenditure	1.4	0.7	(0.7)	4.1	2.9	(1.2)	8.1	6.6	(1.4)
Surplus / (Deficit)		**(1.5)**	**0.1**	**(1.6)**	**(4.8)**	**0.5**	**(5.2)**	**(14.5)**	**(8.7)**	**(5.8)**
Of Which:	Other Income Allowable Deficit	(1.6)	-	1.6	(4.8)	-	4.8	(9.5)	(4.8)	4.8
	Annual Leave Accrual	-	-	0.0	-	-	0.0	(2.0)	(4.0)	(2.0)
Adjusted Surplus / (Deficit)		**0.1**	**0.1**	**(0.0)**	**(0.0)**	**0.5**	**(0.5)**	**(3.0)**	**0.0**	**(3.0)**

Finance: I&E Summary (FY)

The financial position illustrated within the table shows the consolidated position for 2020/21 including the M1-9 position together with the full year forecast.

The M1-9 position includes within it the top-up regime payments that were enacted during the first wave of Covid. This provided a safety net of £36m to cover Covid costs which totalled £21.4m during the first half of the year in additional to shortfalls in other operating and clinical income.

The full year forecast couples both phase 1 and phase 3 financial regimes illustrating the prevailing breakeven forecast that is currently anticipated from months 7-12. This is after the £8.7m 'allowable miss' items are deducted.

Making assertions from plan variances is somewhat tricky when reviewing the full year plan as the plan for M1-6 was centrally set and largely not reflective of areas of anticipated pressure or growth as a result of Covid.

Full-Year Position

		M1 - 9 Actuals			Full Year Forecast		
		Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
NHS Income:	Clinical	503.3	494.4	8.8	681.6	672.7	9.0
	Pass-through Drugs & Devices	96.8	103.4	(6.6)	131.7	139.5	(7.8)
Other income	Other Income excl. PSF	84.3	84.7	(0.3)	109.8	118.4	(8.6)
	Top Up Income	1.1	37.4	(36.4)	2.1	38.8	(36.7)
Total income		**685.4**	**719.8**	**(34.5)**	**925.3**	**969.4**	(44.1)
Costs	Pay-Substantive	377.6	386.2	8.6	510.2	517.4	7.1
	Pay-Bank	20.3	23.4	3.1	29.8	31.2	1.4
	Pay-Agency	10.4	8.0	(2.4)	14.8	11.1	(3.7)
	Drugs	10.6	9.0	(1.6)	13.6	11.8	(1.8)
	Pass-through Drugs & Devices	96.8	103.4	6.6	131.7	139.5	7.8
	Clinical supplies	49.2	56.0	6.8	74.4	80.5	6.1
	Other non pay	95.8	107.3	11.5	125.7	151.1	25.5
Total expenditure		**660.7**	**693.3**	**32.6**	**900.2**	**942.5**	42.4
EBITDA		**24.7**	**26.6**	(1.9)	**25.1**	**26.8**	(1.7)
EBITDA %		3.6%	3.7%	(0.0%)	2.7%	2.8%	(0.0)
	Depreciation	19.2	18.2	(0.9)	25.2	23.9	(1.3)
	Non Operating Income/Expenditure	9.8	7.8	(1.9)	13.8	11.6	(2.2)
Surplus / (Deficit)		**(4.2)**	**0.5**	**(4.7)**	**(13.9)**	**(8.7)**	**(5.2)**
	Other Income Allowable Deficit	(4.8)	0.0	4.8	(9.5)	(4.8)	4.8
	Annual Leave Accrual	-	-	0.0	(2.0)	(4.0)	(2.0)
Adjusted Surplus / (Deficit)		**0.5**	**0.5**	**0.1**	**(2.4)**	**0.0**	**(2.4)**

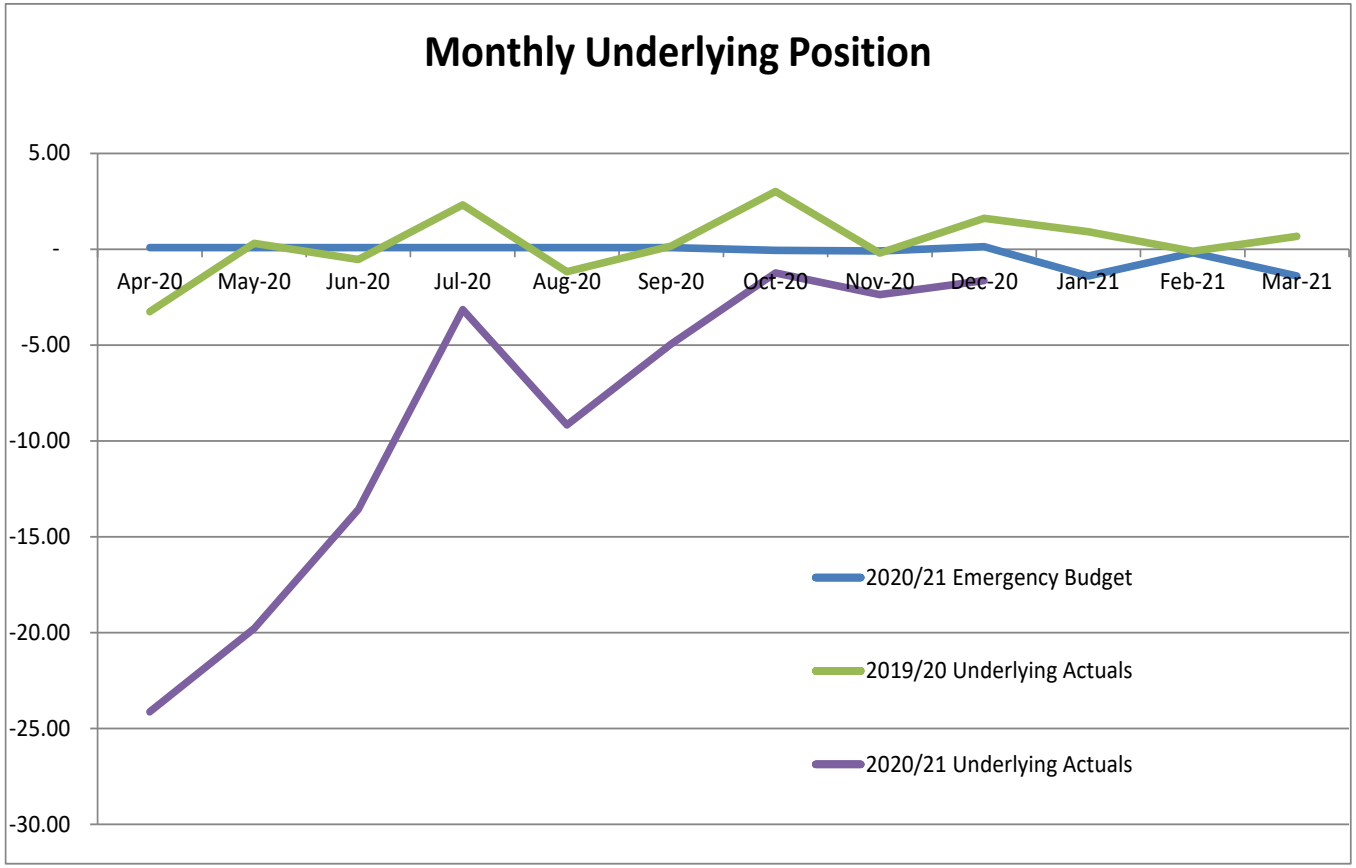
Underlying Run Rate Position

These graphs show the actual underlying position for the trust:

The following have been removed from December 20/21 position:

- (-) The block contract uplift of £1.7m in month (£70.3m YTD) which represents the value of income over and above that which would have prevailed under PbR.
- (+/-) material one off items of expenditure. These net to zero in month.

This illustrates that if the trust reverted to PbR and covid income and expenditure are adjusted out a deficit of £1.7m in month would have prevailed. This remains consistent with November. Currently the block contract mechanism provides security against any underperformance. This gap is expected to increase moving into Q4 as covid volumes again mean that elective work has been supressed.



Clinical Income

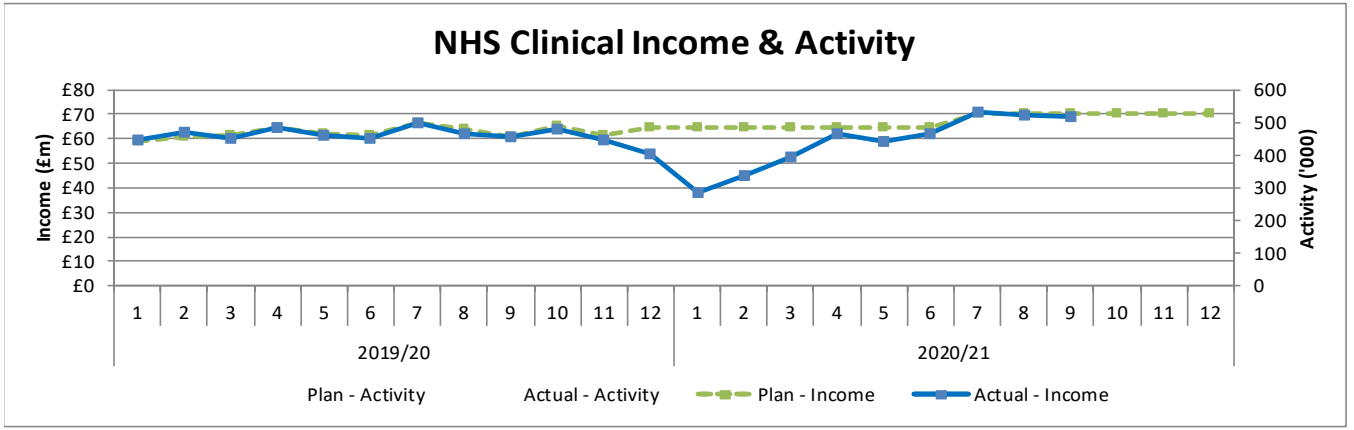
(Fav Variance) / Adv Variance

Clinical income for the month of December was £0.4m favourable to plan. Much of this income is now fixed with confirmed block contract funding in place for the remainder of the financial year. Channel Islands income was however ahead of expectations, driving this variance.

December has seen a decrease in the quantity of activity from November owing to the impact of Christmas and of rising numbers of Covid patients towards the end of the month. Elective PbR equivalent income increased however, representing 97% of planned levels (up from 96% in November) but this has been driven by a larger proportion of activity in higher cost areas rather than an increase in overall activity. Non elective values increased to 99% of plan level, in contrast to a reduction in A&E attendances with lock down restrictions likely to be a contributing factor. Outpatient income dropped marginally below 100% for the first time in four months.

The graphs overleaf show trends over the last 21 months and the impact of Covid-19 as well as the recovery to pre Covid levels of activity in many areas.

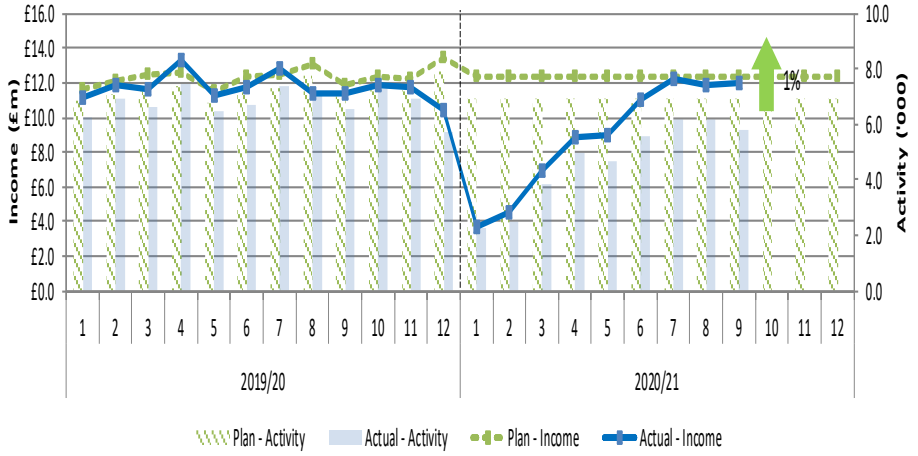
	2020/21						2019/20
POD GROUP	In Month Plan £000s	In Month Estimate £000s	In Month Variance £000s	YTD Plan £000s	YTD Estimate £000s	YTD Variance £000s	YTD Actuals £000s
NHS Clinical Income							
Elective Inpatients	£12,393	£12,014	£379	£111,540	£80,208	£31,332	£106,537
Non-Elective Inpatients	£18,725	£18,542	£183	£168,522	£152,567	£15,955	£162,861
Outpatients	£7,128	£6,826	£302	£64,157	£57,242	£6,915	£62,519
Other Activity	£11,387	£10,233	£1,153	£101,994	£83,531	£18,463	£97,099
CQUIN	£669	£603	£66	£6,019	£4,964	£1,055	£6,398
Blocks & Financial Adjustments	(£349)	(£173)	(£175)	£551	£2,952	(£2,401)	£84
Other Exclusions	£4,046	£4,642	(£595)	£34,191	£28,551	£5,640	£2,951
Pass-through Exclusions	£11,650	£11,741	(£91)	£96,770	£103,360	(£6,590)	£86,601
Subtotal NHS Clinical Income	*£65,649*	*£64,428*	*£1,222*	*£583,743*	*£513,375*	*£70,368*	*£525,050*
M7-M12 additional funding	£5,452	£5,452	£0	£16,357	£16,357	£0	
Covid block adjustments	£0	£1,722	(£1,722)	£0	£68,604	(£68,604)	£0
Total NHS Clinical Income	**£71,102**	**£71,602**	**(£500)**	**£600,100**	**£598,335**	**£1,764**	**£525,050**
Non NHS Clinical Income							
Private Patients	£316	£364	(£48)	£3,852	£2,944	£908	£3,541
CRU	£154	£133	£21	£1,878	£1,474	£404	£1,904
Overseas Chargeable Patients	£120	£4	£116	£1,122	£679	£443	£1,206
Total Non NHS Clinical Income	**£590**	**£501**	**£89**	**£6,852**	**£5,097**	**£1,755**	**£6,651**
Grand Total	**£71,692**	**£72,103**	**(£411)**	**£606,952**	**£603,432**	**£3,519**	**£531,701**



Clinical Income

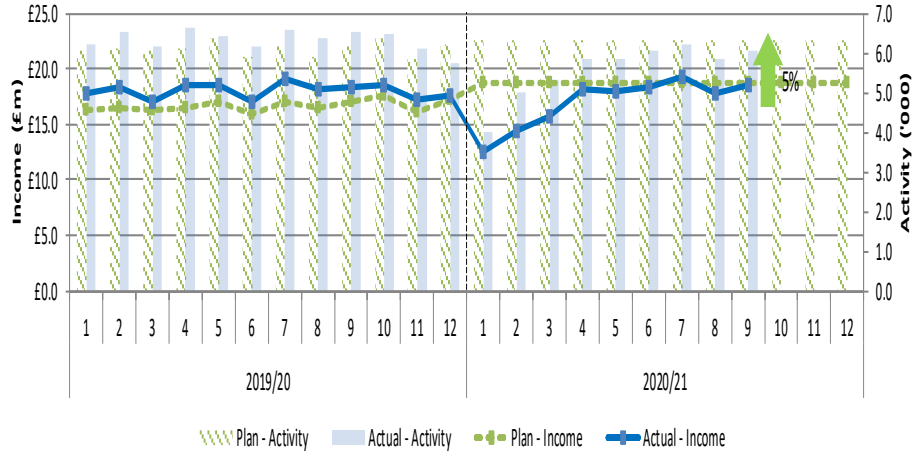
Elective spells

In month -1,127 activity, -£379,185
YTD -20,606 activity, -£31,331,715



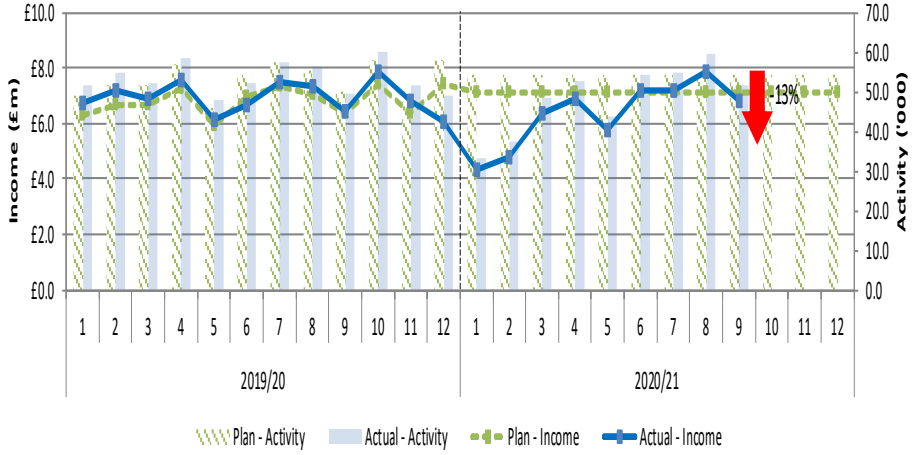
Non elective spells

In month -257 activity, -£182,562
YTD -6,691 activity, -£15,954,724



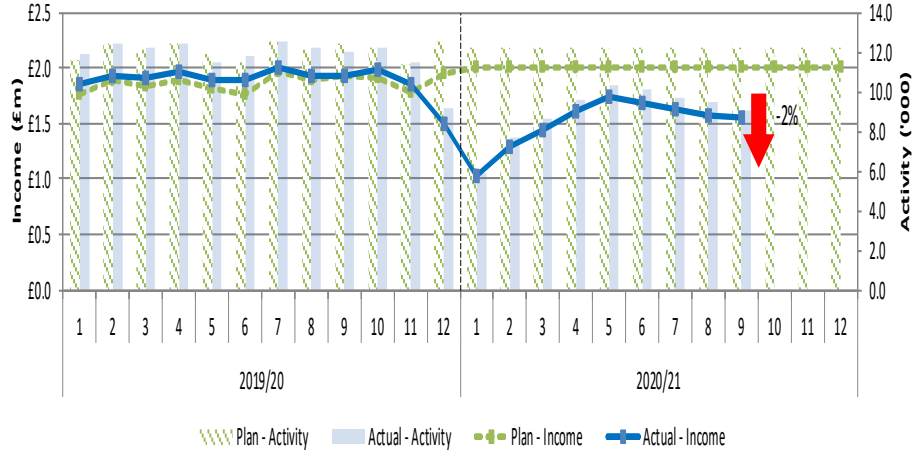
Outpatients

In month -2,218 activity, -£302,235
YTD -49,648 activity, -£6,914,642



A&E

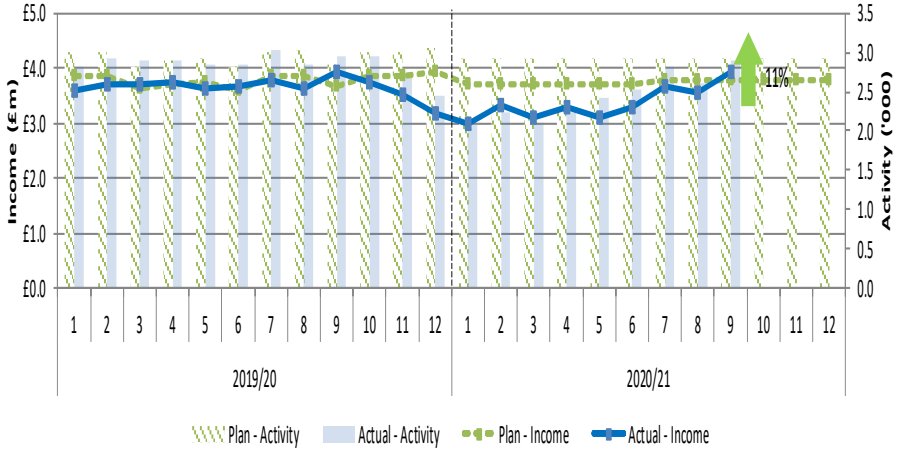
In month -3,196 activity, -£443,432
YTD -29,895 activity, -£4,398,088



Clinical Income

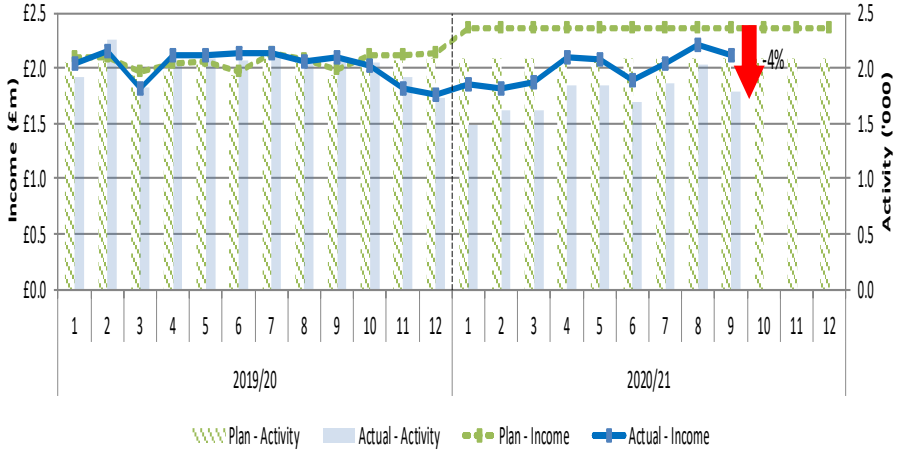
Adult critical care

In month -20 activity, +£168,814
YTD -4,347 activity, -£3,255,990



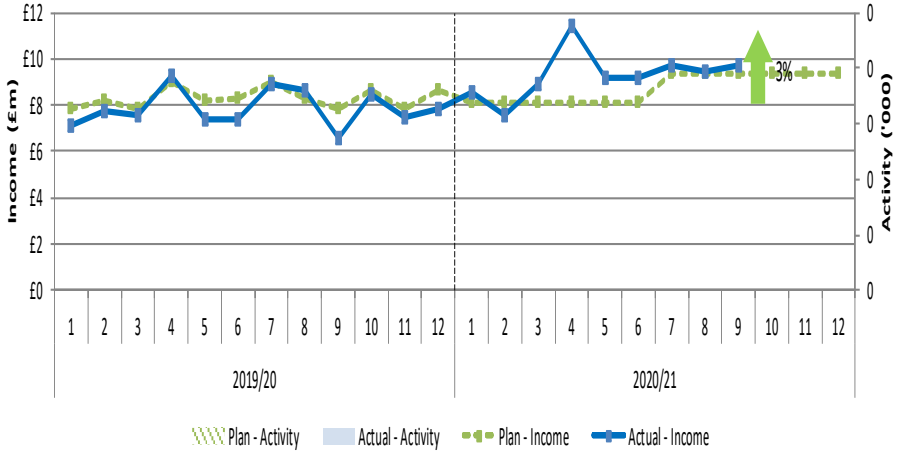
Neonatal & paediatric critical care

In month -310 activity, -£227,320
YTD -3,024 activity, -£3,200,758



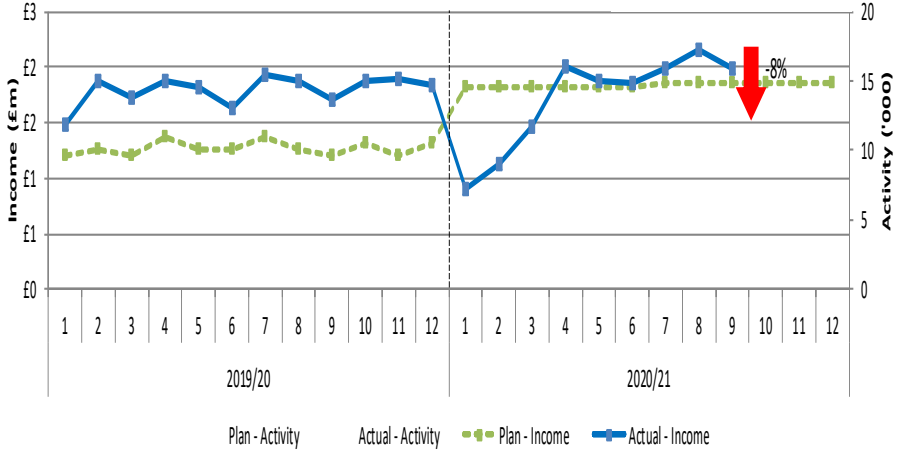
Tariff excluded drugs

In month +£402,218
YTD +£6,969,085



Tariff excluded devices

In month +£134,893
YTD -£1,098,640



University Hospital Southampton NHS
NHS Foundation Trust

Income and Activity

The tables shown illustrate by division and care group the % of the activity and income plan being achieved across the first 9 months for Elective, Non Elective and Outpatient Activity.

Elective activity has decreased in December but mainly in lower cost areas. Income has increased slightly and now represents 97% of planned levels.

The majority of Care Groups are now exceeding 80% of planned activity levels whilst many are at around 100%.

Outpatient activity dropped below planned levels in December for the first time since August.

Elective Activity as % of Plan		Activity as % of Plan				Income as % of Plan			
Division	Care Group	6	7	8	9	6	7	8	9
DIVISION A	CANCER CARE	69%	71%	68%	76%	68%	75%	72%	74%
	SURGERY	79%	85%	82%	75%	88%	102%	97%	89%
DIVISION A Total		74%	78%	76%	76%	84%	96%	91%	85%
DIVISION B	OPHTHALMOLOGY	70%	90%	94%	93%	71%	88%	98%	95%
	SPECIALIST MEDICINE	78%	87%	93%	82%	81%	91%	98%	87%
DIVISION B Total		76%	88%	93%	85%	78%	90%	98%	90%
DIVISION C	CHILD HEALTH	93%	94%	96%	92%	105%	97%	102%	99%
	WOMEN'S HEALTH	89%	96%	115%	88%	92%	106%	117%	100%
DIVISION C Total		92%	94%	101%	91%	102%	100%	106%	99%
DIVISION D	CARDIOVASCULAR & THORACIC	97%	108%	99%	92%	96%	106%	97%	101%
	NEUROSCIENCES	92%	100%	86%	102%	95%	104%	84%	122%
	RADIOLOGY	75%	81%	74%	60%	72%	91%	80%	62%
	TRAUMA & ORTHOPAEDICS	76%	92%	93%	85%	77%	98%	104%	105%
DIVISION D Total		86%	96%	89%	86%	89%	102%	95%	102%
Total		**81%**	**88%**	**89%**	**84%**	**89%**	**99%**	**96%**	**97%**

Outpatient Activity as % of Plan		Activity as % of Plan				Income as % of Plan			
Division	Care Group	6	7	8	9	6	7	8	9
DIVISION A	CANCER CARE	130%	121%	132%	124%	128%	119%	129%	122%
	SURGERY	89%	90%	100%	88%	86%	88%	93%	81%
DIVISION A Total		109%	105%	115%	105%	108%	104%	112%	103%
DIVISION B	ACUTE MEDICINE	105%	86%	99%	82%	111%	91%	105%	86%
	EMERGENCY MEDICINE	158%	67%	90%	115%	152%	67%	89%	116%
	OPHTHALMOLOGY	88%	93%	94%	95%	90%	95%	96%	96%
	SPECIALIST MEDICINE	105%	111%	120%	97%	98%	102%	112%	94%
DIVISION B Total		97%	102%	107%	96%	95%	99%	105%	95%
DIVISION C	CHILD HEALTH	109%	108%	130%	96%	108%	107%	131%	95%
	SUPPORT SERVICES	79%	83%	81%	74%	72%	77%	74%	69%
	WOMEN'S HEALTH	100%	102%	108%	98%	98%	101%	105%	100%
DIVISION C Total		98%	99%	110%	90%	100%	101%	115%	94%
DIVISION D	CARDIOVASCULAR & THORACIC	97%	102%	107%	91%	98%	100%	107%	92%
	NEUROSCIENCES	104%	102%	121%	99%	103%	101%	120%	99%
	RADIOLOGY	119%	133%	172%	101%	95%	108%	138%	77%
	TRAUMA & ORTHOPAEDICS	102%	91%	106%	84%	102%	90%	104%	82%
DIVISION D Total		101%	99%	112%	91%	101%	98%	111%	92%
Total		**101%**	**101%**	**111%**	**96%**	**101%**	**101%**	**110%**	**96%**

Income and Activity

Non Elective activity levels increased in December with income up to 99% of planned after dipping in November. Covid admissions are included within non elective and are thought to have a tariff income shortfall driving a variation between income % and activity % in earlier months.

Non Elective Activity as % of Plan		Activity as % of Plan				Income as % of Plan			
Division	Care Group	6	7	8	9	6	7	8	9
DIVISION A	CANCER CARE	102%	107%	97%	100%	94%	94%	84%	87%
	SURGERY	90%	95%	84%	86%	99%	107%	97%	104%
DIVISION A Total		93%	98%	88%	90%	97%	102%	92%	98%
DIVISION B	ACUTE MEDICINE	94%	103%	96%	112%	99%	109%	102%	114%
	EMERGENCY MEDICINE	103%	102%	95%	93%	96%	100%	85%	88%
	OPHTHALMOLOGY	66%	68%	66%	70%	81%	70%	64%	75%
	SPECIALIST MEDICINE	77%	114%	89%	125%	47%	129%	79%	127%
DIVISION B Total		98%	102%	94%	101%	97%	106%	96%	106%
DIVISION C	CHILD HEALTH	102%	98%	95%	94%	93%	99%	83%	88%
	WOMEN'S HEALTH	84%	89%	87%	102%	94%	95%	91%	109%
DIVISION C Total		89%	92%	89%	100%	94%	96%	88%	101%
DIVISION D	CARDIOVASCULAR & THORACIC	84%	99%	90%	85%	85%	101%	92%	88%
	NEUROSCIENCES	109%	102%	100%	100%	123%	113%	99%	109%
	RADIOLOGY	73%	65%	92%	65%	55%	62%	80%	62%
	TRAUMA & ORTHOPAEDICS	114%	102%	102%	82%	111%	113%	109%	96%
DIVISION D Total		99%	98%	96%	86%	99%	104%	97%	93%
Total		**95%**	**98%**	**92%**	**96%**	**98%**	**103%**	**95%**	**99%**

Elective Incentive Scheme

Elective Incentive Scheme computations for September 2020 have been issued from NHS England in the last month. The methodology applied has differed slightly from that which had been calculated locally as activity comparisons have been amended to reflect the last week of the month rather than the full month.

It continues to be split into three strands for Elective, Daycase and OP Procedures (1), Outpatients (2) and Independent Sector activity (3).

As of yet no values have been transacted within accounts and finalised confirmation for September is not expected until late January. The STP has also yet to fully agree on the basis for sharing any benefits.

No estimates have yet been made on October data onwards following the release of this new process of calculation.

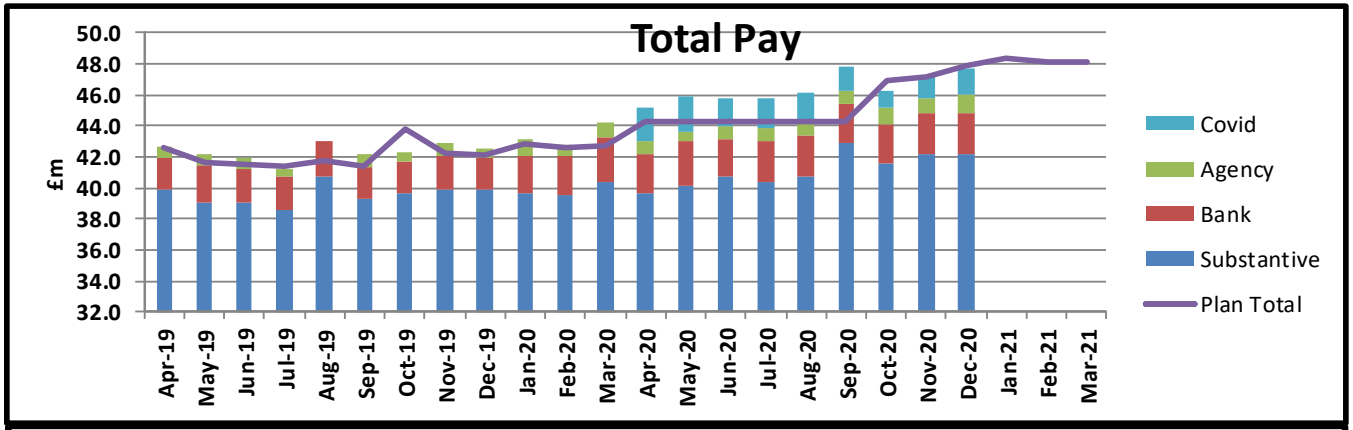
Elective Incentive Scheme Update

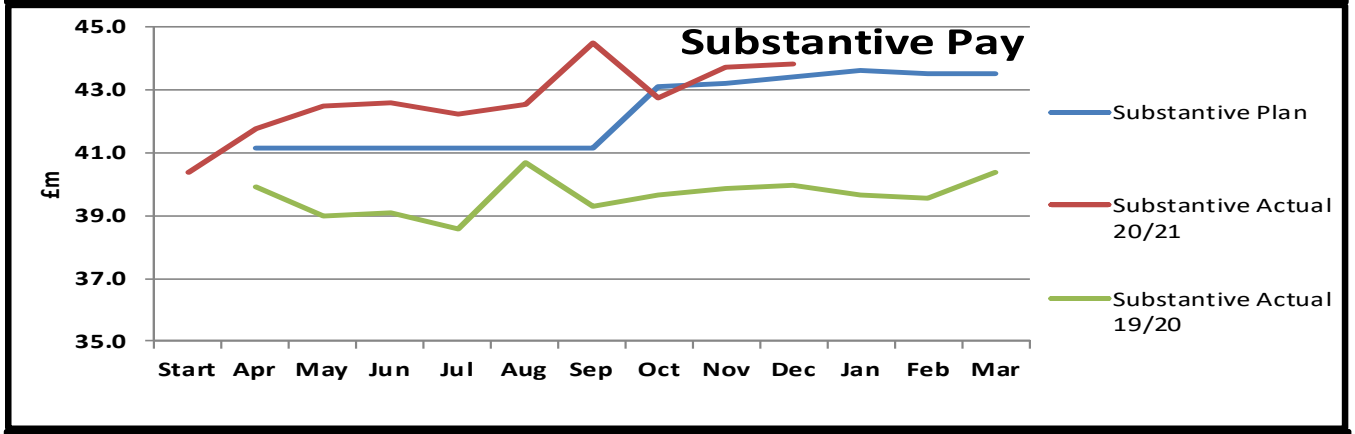
- NHSI has shared a first iteration of workings for September 2020 performance. The information was shared for the purposes of reviewing accuracy and checking of baselines only.
- The scheme has been amended to reflect last week of the month only (19/20 v 20/21) reflecting an expected improvement recovery trajectory (this methodology will apply for October also).
- The scheme will be suspended if Covid-19 volumes exceed 15% of occupied beds and therefore likely will only apply for Sept 2020 – Nov/Dec 2020. We are unclear whether this rule applies at organisation or STP level.
- We are awaiting both confirmation of the impact on UHS and HIOW, and guidance on reporting the impact within forecast positions. The current guidance states the impact should be excluded from reported positions.

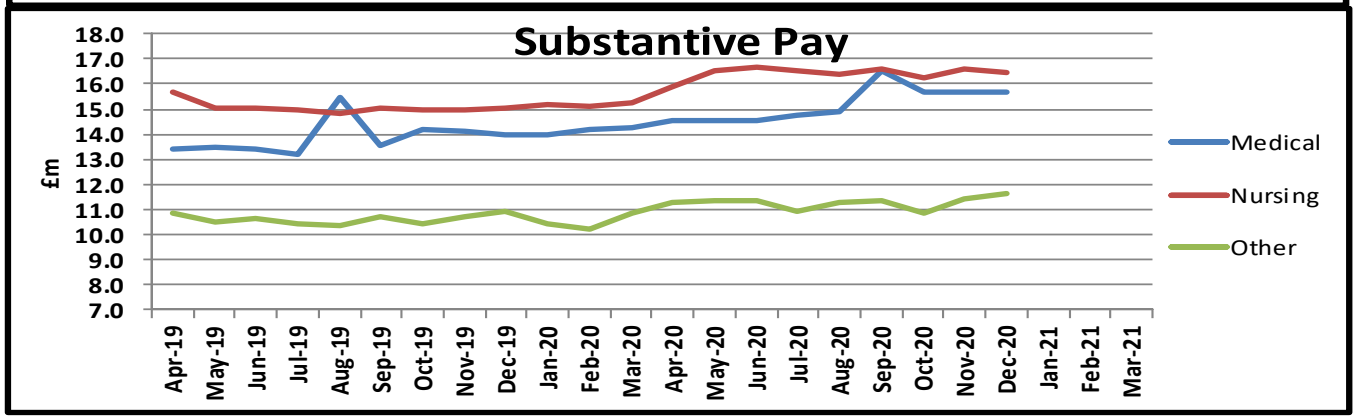
Substantive Pay Costs

Total pay expenditure in December was £47.6m (up £0.4m from November). This was marginally less than planned costs with elements of spend related to activity recovery currently on hold. Covid related staffing expenditure increased marginally in December to £1.6m in month. This was mainly driven by critical care agency usage for surge beds.

Pay costs are forecast to further increase across Q4 as covid pressures and winter demands all drive additional resource requirements. Supressed costs related to reduced elective activity may offset these increases to some extent however. Vaccine hub costs are also anticipated to increase markedly for January; however these are recoverable from NHSE.







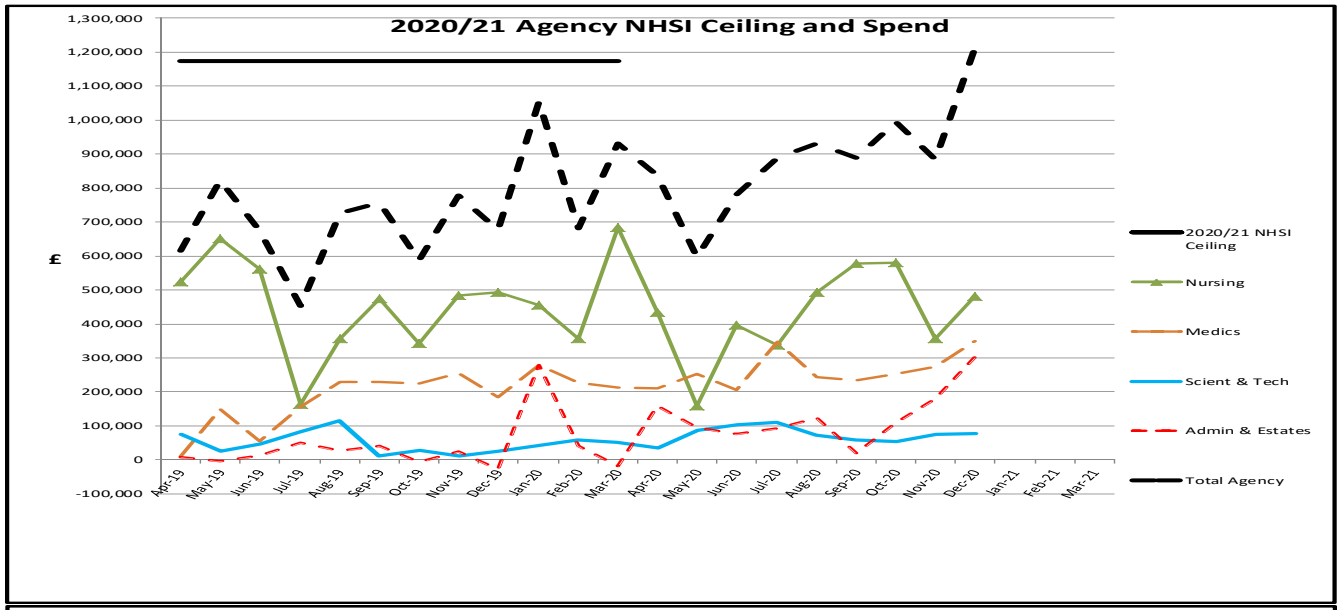
University Hospital Southampton NHS
NHS Foundation Trust

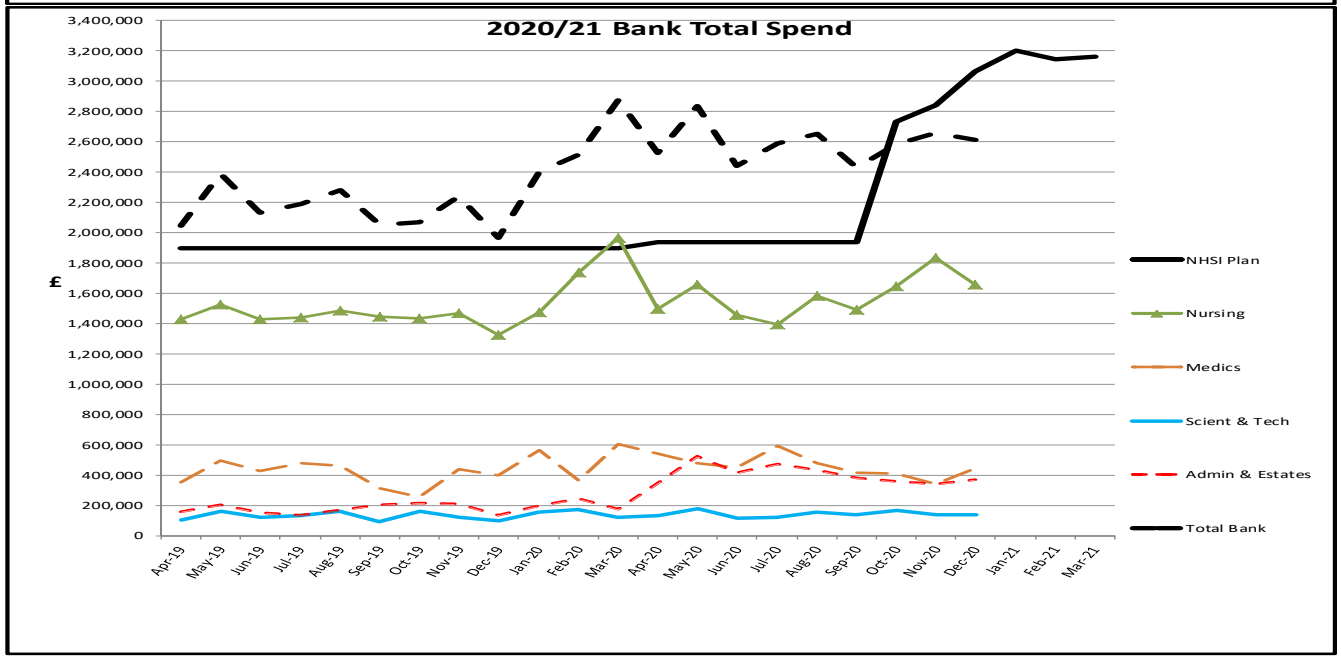
Temporary Staff Costs

Agency spend has increased to over £1.2m in month an increase of £330k on November. All staff groups saw increases in agency staff costs in month primarily due to the increasing number of Covid-19 patients and other covid related activities.

Staffing requirements were previously flexed down in many elective focused service areas as all non essential activity was paused in the first wave. Since May however agency costs have generally been on an upward trend returning to pre-Covid levels. These are likely to further increase moving into winter as covid activity increases in addition to continued functioning of the elective programme in tandem where capacity allows.

Expenditure on bank staff remained flat at £2.6m in month. A small decrease in nursing of £177k was largely offset by increased spend on medic, admin and estates staff of £130k. This continues to be above average levels of spend in 19/20 with A&C usage for doors driving a step change.





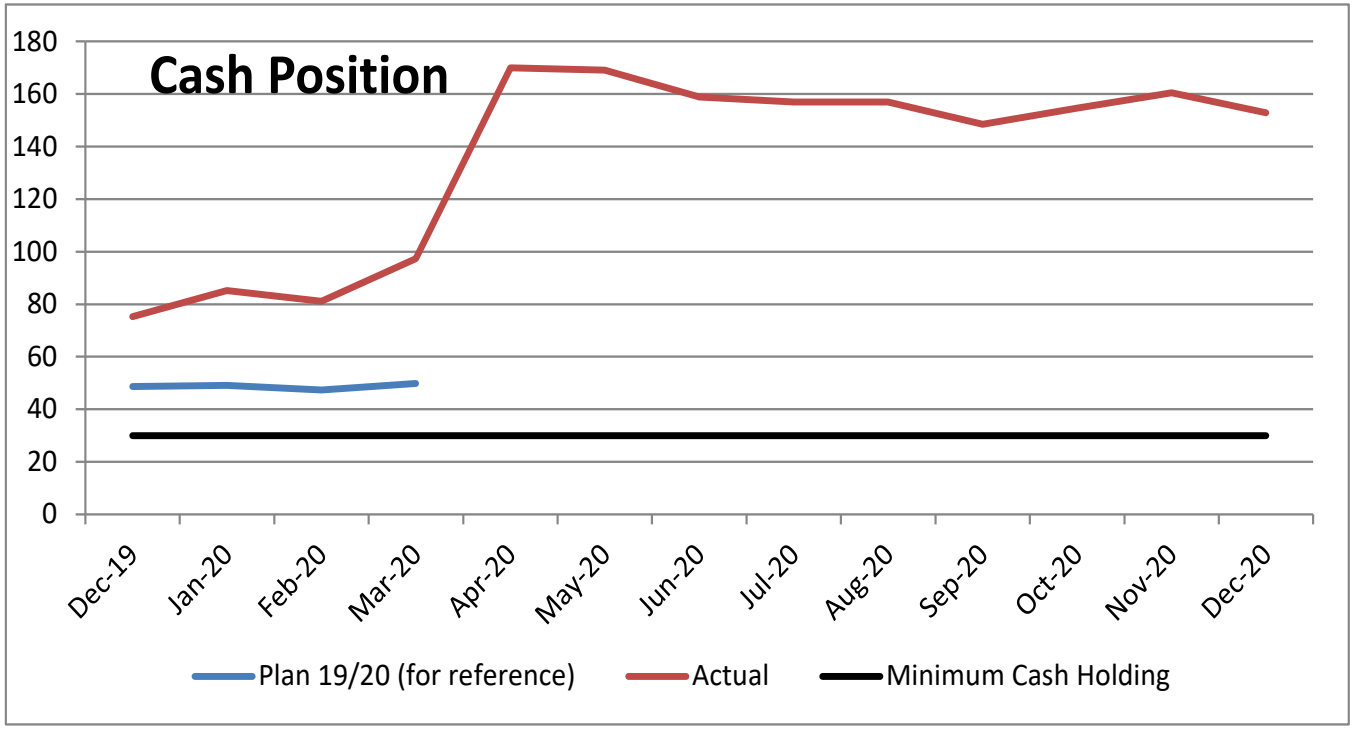
Cash

The cash balance decreased marginally to £152.9m in December. This is primarily linked to movements in working capital and fixed assets, including the purchase of Adanac Park.

Cash remains broadly stable and has done since the move to block contract payments in advance. The interim regime is not expected to continue, with a return to payments made in month anticipated, rather than in advance, cash will then reduce back by c£67m.

A downward trend is anticipated as capital programme costs exceed non-cash I&E items. Several material external drawdowns are expected in Q4 however for centrally funded capital projects meaning cash could be volatile through the next 3 months.

The Trust is also still awaiting cash to fund Covid-19 related capital expenditure.



University Hospital Southampton NHS
NHS Foundation Trust

Capital Expenditure

The capital expenditure position for the year to December shows expenditure of £49.9m against a plan of £46.6m, £3.2m above that budgeted. Excluding externally funded schemes and Covid 19 related expenditure, the expenditure is £42.1m against a plan of £41.9m, £0.2m ahead of budget.

The £9.1m of expenditure in month 9 was driven by the £4.2m purchase of land at Adanac Park.

We are currently forecasting to spend all our internally funded capital budget. Accounting for the full cost of the Adanac Park land (£3.4m > budget), bringing forward replacement of Linac 6 (£1.5m) and the lease costs of the modular buildings relating to the ED expansion scheme (£1.9m > budget) should offset slippage in other areas, notably the refurbishment of the existing GICU (GICU expansion scheme, £2.5m slippage), the vertical extension E level theatres (£3.7m slippage) and IISS leases, where the delivery of an MRI scanner will be later than planned (£1m slippage).

(Fav Variance) / Adv Variance

	Month			Year to Date			Full Year		
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
Childrens Hospital/ED Adult Resus	0	103	(103)	1,004	1,409	(405)	1,141	1,409	(268)
IT Schemes	789	642	147	5,517	3,242	2,275	7,142	6,392	750
Strategic Maintenance	383	430	(47)	2,603	2,653	(50)	3,750	3,750	0
Medical Equipment Panel	100	146	(46)	663	579	84	1,000	970	30
GICU Expansion	655	111	544	10,022	9,544	478	12,128	9,584	2,544
Fit out of E Level, Vertical Extension	1,738	111	1,627	4,982	1,357	3,625	5,013	1,357	3,656
Refurbish Eye Theatre	516	6	510	1,471	1,664	(193)	1,849	1,849	0
Theatre K Plant Room	0	59	(59)	334	733	(399)	334	733	(399)
Spend to Save	21	190	(169)	748	790	(42)	810	1,610	(800)
Radiotherapy Equipment	0	0	0	700	605	95	700	700	0
Decorative Improvements / Staff Fund	50	0	50	450	22	428	600	272	328
ED offices and minors space	0	0	0	586	16	570	586	16	570
Fit out of E &F level North Wing Courtyard	0	(1)	1	1,207	622	585	1,207	627	580
East Wing Annex Shell	0	90	(90)	350	459	(109)	1,490	650	840
Oncology Ward Build	639	522	117	5,074	5,203	(129)	5,782	5,867	(85)
Side Rooms	133	460	(327)	532	561	(29)	932	575	357
Adanac Park	0	4,073	(4,073)	0	4,207	(4,207)	830	4,207	(3,377)
Other Projects	197	636	(439)	2,577	3,147	(570)	3,168	5,702	(2,534)
Assumed Slippage	(245)	0	(245)	(694)	0	(694)	(1,423)	(1,897)	474
Total Trust Funded Capital excl Finance Leases	**4,976**	**7,578**	**(2,602)**	**38,126**	**36,813**	**1,313**	**47,039**	**44,373**	**2,666**
Finance Leases - Medical Equipment Panel	250	122	128	1,350	522	828	2,200	2,200	0
Finance Leases - Divisional Equipment	41	0	41	377	0	377	500	100	400
Finance Leases - IISS	0	0	0	3,335	3,379	(44)	5,535	4,499	1,036
Finance Leases -ED Expansion	0	0	0	0	0	0	0	1,900	(1,900)
Finance Leases - Other	300	235	65	1,319	1,972	(653)	2,265	3,300	(1,035)
Donated Asset Additions	(270)	0	(270)	(2,576)	(565)	(2,011)	(3,482)	(2,315)	(1,167)
Total Trust Funded Capital Expenditure (CDEL Allocation)	**5,297**	**7,935**	**(2,638)**	**41,931**	**42,120**	**(189)**	**54,057**	**54,057**	**0**
Energy Efficiency	85	0	85	1,412	1,667	(255)	1,667	1,667	0
Fit out of E Level, Vertical Extension	0	396	(396)	0	622	(622)	5,000	4,300	700
ED Expansion and Refurbishment	0	427	(427)	0	1,001	(1,001)	0	9,000	(9,000)
Backlog Maintenance	216	5	211	1,080	69	1,011	1,730	1,730	0
Endoscopy Room	0	302	(302)	0	436	(436)	0	1,650	(1,650)
Digital Maternity (STP Wave 3)	169	13	156	845	19	826	1,350	0	1,350
Digital Outpatients (STP Wave 3)	73	0	73	365	0	365	589	164	425
HSLI Enterprise Wide Scheduling	37	14	23	333	53	280	444	310	134
Cyber Security	0	0	0	0	8	(8)	0	33	(33)
Pathology Digitisation	135	9	126	675	9	666	1,080	90	990
Coronavirus Equipment and Works	0	2	(2)	0	3,875	(3,875)	0	3,875	(3,875)
Total CDEL Expenditure	**6,012**	**9,101**	**(3,089)**	**46,641**	**49,879**	**(3,238)**	**65,917**	**76,876**	**(10,959)**

University Hospital Southampton NHS
NHS Foundation Trust

Statement of Financial Position

(Fav Variance) / Adv Variance

The December statement of financial position illustrates net assets of £444.2m which is £1.6m up when compared to November.

Accounts payables balances are distorted when compared to 2019/20 as they include £67m of deferred income as block contract payments are currently paid in advance.

The payment in advance regime has been confirmed as ending in March 2021. The block payment for April will be received in April, with no block payment received in March.

Statement of Financial Position	2019/20 YE Actuals £m	2020/21 M8 Act £m	2020/21 M9 Act £m	2020/21 MoM Movement £m
Fixed Assets	379.0	404.2	411.4	7.2
Inventories	15.2	15.9	16.5	0.6
Receivables	73.0	65.9	61.0	(5.0)
Cash	97.3	160.5	152.9	(7.6)
Payables	(115.6)	(193.1)	(186.9)	6.2
Current Loan	(3.3)	(3.6)	(3.6)	(0.0)
Current PFI and Leases	(7.4)	(7.2)	(7.0)	0.2
Net Assets	**438.2**	**442.7**	**444.2**	**1.6**
Non Current Liabilities	(20.4)	(24.9)	(26.9)	(2.0)
Non Current Loan	(11.5)	(9.1)	(8.9)	0.3
Non Current PFI and Leases	(33.4)	(34.6)	(34.5)	0.1
Total Assets Employed	**372.9**	**374.0**	**374.0**	**(0.0)**
Public Dividend Capital	220.7	221.3	221.3	0.0
Retained Earnings	132.0	132.5	132.5	(0.0)
Revaluation Reserve	20.2	20.2	20.2	0.0
Other Reserves	0.0	0.0	0.0	0.0
Total Taxpayers' Equity	**372.9**	**374.0**	**374.0**	**(0.0)**

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**UHS Maternity Services Review of the Ockenden Report**			
Agenda item:	**5.7**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Suzanne Cunningham, Director of Midwifery and Professional Lead for Neonatal Services** **Marie Cann, Safety and Quality Assurance Midwifery Matron**			
Date:	**28 January 2021**			
Purpose	**Assurance or reassurance** ✓	**Approval**	**Ratification**	**Information** ✓
Issue to be addressed:	The first report by Donna Ockenden into the emerging findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust was released on the 10 December 2020; a second and final report is due out later in the year. The Ockenden report has highlighted a number of emerging themes and therefore has released 'local actions for learning and immediate and essential actions for the Trust and the wider maternity system in advance of the completion of the final report. The objective of these local actions for learning and immediate and essential actions are to be carefully considered by all maternity services in England with an aim to reduce cases of harm to mothers and babies. In response to the report NHSE has asked for assurance that the Trust has acknowledged and responds to the reports 'immediate and essential actions' and the 6 actions below. This report is provided to the committee members as assurance of the completion of the following: **1.** 'Assurance Assessment Tool' which by the 15 February 2021 must be shared with the Trust Board and Local Maternity System (LMS) – Appendix 1 (end of the report) UHS Maternity Service 'Local Actions for Immediate and Essential Actions'. **2.** Actions arising out of Care Quality Commission (CQC) inspections and any other reviews that have been undertaken of maternity services have also been revisited **3.** A maternity workforce gap analysis is completed and set out plans to meet BirthRate Plus (BR+) standards **4.** Review of workforce and planning **5.** Review of midwifery leadership **6.** Refreshed view of the actions set out in the Morecambe Bay report. For additional detailed assessment information please see Appendix 2 – Ockenden assessment and assurance tool.			
Response to the issue:	The UHS Maternity Service (UHS service this point onwards) has taken seriously the information contained in the report and the background evidence from families and in response to the interim Ockenden report. To note that the UHS service provides regular assurance to the Trust Board and Committees Governance structures providing regular reporting to the Quality Committee, an Annual Maternity Service report and bi-monthly Maternity Safety Champions meetings. In support of this report and review, the Maternity Safety Champions have been involved in the review of the Ockenden report.			

Assurance about the 'Immediate and essential actions' was confirmed by UHS Interim Chief Executive and Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) Local Maternity System (LMS) Chair on 21 December 2020 and shared with NHSE.

The UHS services have fully reviewed and assessed the complex and far reaching actions within the Ockenden report and have completed the required gap analysis.

1. Assurance Assessment Tool

The Assurance Assessment Tool contains 7 'Immediate and Essential Actions' which have been fully reviewed by the UHS service and the UHs service can confirm the following:

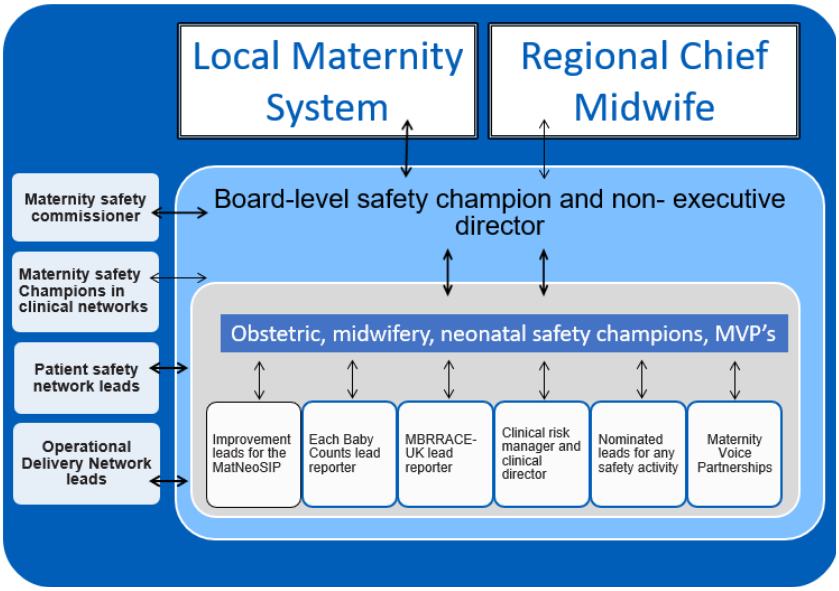
1.1 Enhanced Safety

a) A plan to implement the 'Perinatal Clinical Quality Surveillance Model'
b) All maternity serious incidents (SIs) are shared with Trust Boards at least monthly and the LMS; in addition to reporting, as required, to Healthcare Safety Investigation Branch (HSIB).

The Perinatal Clinical Quality Surveillance Model sets out a set of 5 principles for improving oversight for effective perinatal clinical quality. These include stronger partnerships in local places between the NHS, local government and others; provider organisations being asked to step forward in formal collaborative arrangements; developing strategic commissioning with a focus on population health outcomes and the use of digital and data to drive system working.

The UHS Trust is being asked to seek greater oversight quality drawing on multiple sources of intelligence relating to maternity services, through the Maternity and Neonatal Safety Champions and Maternity Voices Partnerships (Table 1). The Safety Champions currently meet with the Executive maternity safety champion bi-monthly to discuss quality issues from the maternity and Neonatal service.

Table 1



Additional information should be provided through a minimum data set dashboard containing information relating to CQC maternity ratings; Maternity Safety Support Programme; findings of review of all perinatal deaths using the real time data monitoring tool; findings of review of all cases eligible for referral to HSIB; report on incidents, training and staffing; Service user voice feedback; Staff feedback from frontline champions and walkabouts; concern or request for action made directly with Trusts; Coroner Regulation 28; progress in achievement of Clinical Negligence Scheme for Trusts (CNST) 10 safety actions; proportion of midwives with 'agree or strongly agree' on whether they would recommend their trust and proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good.

The UHS service is currently gathering the data to produce a minimum data set for the members of the committee, which will be shared at future meetings and with the Maternity Safety Champions.

In regards to section b) there are current avenues in place i.e. the Serious Incident Scrutiny Group (SISG) to share SIs with the Board, however the UHS service is reviewing the assurance framework to improve the communication of information.

1.2 Listening to women and their families

a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services
b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly
c) Maternity services must ensure that women and their families are listened to with their voices heard
d) Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards
e) The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.

The UHS service can confirm that there is an MVP in place to collaboratively work with and to coproduce local maternity services. There are planned ongoing meetings with the MVP and the maternity patient experience team to ensure women are an integral part of the developments. The recent use of Social Media Networks to improve communication with women has been a success enabling the service to react promptly to information.

In regards to section b) the service can additionally confirm that it has in place an Executive Director with specific responsibility for maternity services Gail Byrne, Chief Nursing Officer, and a named non-executive Director, Dr Tim Peachey, to support the independent challenge to the oversight of maternity and neonatal services.

Sections d) and e) the 'independent senior advocate role' further information will be required by both the UHS service and the LMS in order to support this role and embed into the service. Currently the UHS service would utilise the support of Patient Advice and Liaison Service (PALS) if an occasion arises. HSIB provide independent investigation of serious incidents and work with parents to ensure they have their questions answered.

1.3 Staff training and working together

a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week
b) The report is clear that joint multi-disciplinary training (MDT) is vital and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a multi-disciplinary training schedule is in place
c) Confirmation that funding allocated for maternity staff training is ring-fenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety.

The UHS service can confirm that the requirements for section a) have been met and will continue to be supported to ensure safety. The service can also confirm that there is a full schedule in place for the provision of MDT which includes all staff groups and is continually monitored by the Maternity Practice Education team.

The Maternity Service funding for education is ring-fenced for maternity safety training. The Trust has always received the refund from CNST with no remedial actions required. We believe there is no requirement for the Trust to directly reinvest this into the maternity service unless a remedial investment payment is made. Maternity Service receives appropriate investment through the usual Trust governance budget setting process.

1.4 Managing complex pregnancy

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place
b) Understand what further steps are required by your organisation to support the development of Maternal Medicine Specialist Centres

Within UHS service all women are triaged by a midwife following self-referral to the service with clear guidance for those with complexity requiring named consultant leads.

In regards to section b) the service understands the steps that are required and have made excellent regional progress towards a Maternal Medicine Regional Network with the Maternal Medicine Centre in Southampton. Further work is required in developing medical links for pregnancy throughout entire region which will be enhanced by further clarity in the funding streams this was expected for 2021 but has now been delayed. Further recognition of the Obstetric Physician at the Maternal Medicine Centre and Obstetric side to Maternal Medicine team will also support Maternal Medicine Centre development. Enhanced collaboration and engagement from medical specialties (working alongside obstetric specialties) is also work in progress.

1.5 Risk assessment throughout pregnancy

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

Within UHS services there is a formal risk assessment at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional. The risk assessment includes ongoing review of the intended place of birth, based on the developing clinical picture supported by specific UHS service guidance in place to support women and staff on ensuring appropriate place of birth.

1.6 Monitoring fetal wellbeing

a) Implement the Saving Babies Lives (SBL) bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with SBL bundle version2 and national guidelines.

The UHS service can confirm that it has in place a lead obstetrician with a responsibility for meeting the requirements for SBLv2 element 4 and there is recruitment in place to provide 0.4 whole time equivalents (WTE) second midwifery lead to lead best practice, learning and support. Once this recruitment is in place the UHS service would meet the requirements.

1.7 Informed consent

a) Every Trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.

The UHS service has available maternity information and pathways on the UHS Public Website which is regularly reviewed. The service has further ambitions to develop the information and signposting further however, the Trust website requires some additional developed before this can be achieved. The UHS service has asked the Midwifery Patient Experience lead to review the information and to ensure information is contemporary and complete.

Overall the UHS service can confirm that it meets the requirements for the 7 Immediate and Essential Actions of the Assurance Assessment Tool. There are some additional actions required for the elements required within Saving Babies Lives v2 to be complete however these are planned to be in place in readiness for the submission of the NHS Resolution CNST in July 2021.

2. Actions Arising out of Care Quality Commission (CQC) Inspections – Appendix 3

The UHS service was last inspected in 2019 and the service is currently rated 'Good' overall and includes the New Forest Birth Centre (Table 2). The service can confirm that there is an 'improvement plan' in place to address the findings of the CQC's regulatory requirements and any other actions required. Although the immediate requirements have been actioned there are some ongoing actions in place by the Estates team for window, induction of labour room and bathroom replacement and Informatics team for IT improvements. The UHS service has fully reviewed the requirements and currently meets with the expectations required by the CQC.

Table 2

Ratings for Princess Anne Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Requires improvement Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Overall*	Requires improvement Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019

Ratings for New Forest Birthing Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Overall*	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019

3. Undertake a Maternity Workforce Gap Analysis to meet BirthRate Plus (BR+) Standards

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

UHS services can confirm that it currently utilises BirthRate Plus (BR+) as a framework for workforce planning and strategic decision making to ensure safe staffing levels. The last assessment was undertaken in 2018 and suggested an overall clinical establishment based on a midwife/birth ratio of 1:24, calculated against an annual birth rate of 5500 births. Over the last 2 years, the service has been working with midwife/birth ratios that are more suggestive of 1:26.

The annual birth rate has however been seen to drop and as such the overall staffing establishment now sits more in line with the recommended midwife to birth ratio of 1:24 as advocated by BR+ if the birth rate remains around 5200. This takes into account around 10% of the total clinical "midwifery" WTE that are qualified support staff and who are working across postnatal services. Operational and maternity workforce performance indicators now suggest a position of compliance against BR + standards. The service is currently undertaking a review of the current WTE staffing establishment across UHS services ensuring that staff are being deployed and utilised in the correct way. This will be done with the support of BR +. The UHS service can confirm that once this work has been completed it would meet with the expectations.

4. Review of Midwifery Leadership – Appendix 4

The midwifery leadership requirements ask maternity services to have a Director of Midwifery in every Trust; regional and national lead midwives; more consultant midwives; specialist midwives in every Trust; fund ongoing midwifery leadership development and professional input into the appointment of midwife leaders.

The UHS service has fully reviewed the requirements and currently meets with the expectations.

	5. Refreshed view of the actions set out in the Morecambe Bay Report – Appendix 5 The independent investigation established to review the management, delivery and outcomes of care provided by the maternity and neonatal services of the University Hospitals of Morecambe Bay NHS Foundation Trust between January 2004 and June 2013 was fully reviewed by the UHS service in 2015. A full gap analysis was completed at the time and actions from the recommendations implemented. As part of this work the UHS service has again fully reviewed the recommendations and can confirm that the compliance has been maintained and that since 2013 has improved with significant changes within UHS services have taken place in the provision of MDT training; professional development opportunities for staff groups; working across LMS to improve common policies, systems and standards; collaborative working with MVP and clear structures for leadership and oversight within the UHS service. The review assures that UHs service currently meets with the expectations.
Implications: (Clinical, Organisational, Governance, Legal?)	The interim Ockenden report calls upon all maternity services at local, regional and national levels to make significant improvements within maternity services. The report requires regulators and professional bodies including the Care Quality Commission, The Royal College of Obstetricians and Gynaecologists, The Royal College of Midwives, The Royal College of Anaesthetists and The Royal College of Paediatrics and Child Health to strengthen their collective efforts to work collaboratively to ensure rapid action and implementation of these Local Actions for Learning and Immediate and Essential Actions in order that they translate into safer maternity care across England. Implications for not meeting the requirements include all Governance frameworks and clinically by impacting on improving outcomes for women and babies.
Risks: (Top 3) of carrying out the change / or not:	The risk implications for the UHS Trust and the maternity service sit within a number of frameworks including: • Failure to meet the Maternity Safer Care requirements including the NHS Resolution CNST requirements and SBLs • Failure to meet the CQC Well-led Framework • Risk to the reputation of the Trust.
Summary: Conclusion and/or recommendation	The UHS Service has found the Ockenden report helpful for the all clinical teams and the service areas and will utilise this review to continue to work to improve the quality of the services provided to women and their families. Trust Boards have asked to robustly assess and challenge the assurances provided and to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. To confirm that the UHS Trust will complete a planned UHS Maternity Quality Review lead by the UHS Head of Clinical Quality Assurance as soon as the COVID situation improves. Overall the UHS Maternity Service can confirm that it has reviewed the Ockenden report and are taking any immediate actions to ensure compliance. There will be continued and greater reporting via the Trust Quality Governance Steering Group (QGSG) and other Trust Committee meetings to enable oversight and leadership. The UHS service welcomes continued internal and external monitoring of completion of the actions and that additional information will be made available as required. The UHS service will look to share information with the LMS and externally to relevant stakeholders as required including the MVP.

	NHS England has stated that in order to ensure consistency and equity across England, they are developing a national model for a network of advocates. This ensures that the right people are in these roles improving maternity services in line with the Ockenden report. They will be producing a framework, including a standard job description, training package and principles for establishing a network. They will develop a clear process so that women and families know how to contact the advocates. This will also include mechanisms for contracting advocates so they remain independent and how these will be funded. The Maternity Service are seeking support from the committee members for the following, 1. Agree a framework of reporting for following moderate and serious maternity incidents; Perinatal Mortality Report tool; Early Notification Scheme; Red Flag incidents and evidence of listening to families. 2. Oversight of the 'Provider Board Level Measures (Transforming Perinatal Safety requirements). 3. Support for the 'Senior Advocate role' that is in development.

Appendix 1 – UHS Maternity Service 'Local Actions for Immediate and Essential Actions'

University Hospital Southampton NHS Foundation Trust

Key	
GREEN	*Complete*
AMBER	*Actions in progress*
RED	*No current actions in place*

No	Recommendation	*Core components*	UHS Maternity		
			RAG	Process in Place	Plan to Implement
1	**1) ENHANCED SAFETY Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks.** **Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.**	*a) A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly*		Data for January collection is currently in place and being collected.	January data will be available February 2021
		b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB		All maternity SI - reports are currently reviewed by the Trust Serious Incident Scrutiny Group (SISG) on a case by case basis. Moving forward will be reviewed at Quality Committee quarterly.	Reporting to the LMS.

2	**2) LISTENING TO WOMEN AND FAMILIES** **Maternity services must ensure that women and their families are listened to with their voices heard.**	*a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services*		The UHS maternity service has a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. The MVP chair commenced her role in August 2019 and has been working in co-production on various projects. She is currently working with MVP to get feedback from our Black and Asian women and have recently co-produced communications material as part of the support package to BAME women during covid (evidence: poster and flyers).	Implemented.
		b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.		The maternity service has a non-exec director in place.	Implemented.

3	**3) STAFF TRAINING AND WORKING TOGETHER** **Staff who work together must train together.**	*a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. At 0800 and 2000*		UHS maternity service have Consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. There is no Consultant presence at the night time ward round 3 nights a week.	Implemented.
		b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.		Multidisciplinary training and working occurs – the UHS maternity service has a planned programme of PROMPT training. PROMPT is an externally validated course.	Implemented.
		c) Confirmation that funding allocated for maternity staff training is ring-fenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.		External funding allocated for the training of maternity staff, is ring-fenced – The maternity service funding for Education is ring-fenced for maternity safety training.	Implemented.
4	**4) MANAGING COMPLEX PREGNANCY** **There must be robust pathways in place for managing women with complex pregnancies**	*a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place*		All women are triaged by a midwife following self-referral to service with clear guidance for those with complexity requiring named consultant leads.	Implemented.

	Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.	*b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres*		The UHS maternity service understands what steps are required and have made excellent regional progress towards a maternal medicine regional network with the maternal medicine centre in Southampton. This has had good engagement from many of the regions maternity centres. Support and collaboration continues to be extended to those centres waiting for further engagement. However, overall the service have many examples of region wide collaborative obstetric medicine process and pathways and are working with NHS England in the national and local vision and developments.	Implemented.
5	**5) RISK ASSESSMENT THROUGHOUT PREGNANCY** **Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.**	*a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance*		The UHS maternity service risk assesses and complete and record information at every contact. This includes ongoing review and discussion of intended place of birth.	Implemented.

6	**6) MONITORING FETAL WELLBEING** **All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in foetal monitoring.**	*a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.*		The maternity service is currently implementing the SBL bundle and a working team is in place to undertake this work.	Current recruitment to the Audit Midwife position to support implementation of SBL bundle. Implementation of the new Digital system to improve data collection. Current recruitment of the 0.4 WTE Fetal Monitoring lead position by jan 31st. Continued review and monitoring required of external information and changes in practice in relation to SBL.
7	**7) INFORMED CONSENT** **All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.**	*a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.*		UHS has a plethora of mediums of patient information to support informed consent including online resources such as Wessex Healthier Together, the Trust maternity webpages, Social media, Dad Pad, MY Birthplace App and Baby Buddy but also leaflets provided to women at various stages of their care bot trust and national versions. UHS encourages women and their families to be actively involved in their care and decision making and will support with additional needs as required. Birth preferences are supported through consultant midwife clinics and women's choices about care providers is also	Implemented.

				respected as we support women with independent midwives.	
8	**Additional Information**	*We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.*		The UHS maternity service has a regular clinical effectiveness to review the current released national guidance. The UHS maternity service Quality team (with other stakeholders) reviews national guidance or recommendations and implements actions as appropriate. Completed gap analysis are submitted to the UHS Trust Clinical Effectiveness team. The UHS maternity service and the UHS Trust Clinical Effectiveness team hold an annual review of all guidance and outcomes against compliance called CEOSG. Support of the Consultant midwives in implementing national guidance. Current digital capture of data to assure compliance.	Implemented.

Appendix 2

Maternity services assessment and assurance tool

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair (MVP) to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

Section 1

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.

- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	• **Clinical change** - Maternity service has a dashboard which is shared through the Quality committee. The new suggest dashboard will now be shared at Quality Committee and the Local Maternity System Board. • **External clinical specialist opinion** -Wessex Stillbirth Review Group provide external review of stillbirths (Pre COVID). HSIB provide independent safety reviews on all maternal or neonatal deaths, intrapartum still births and neonatal brain injuries. The Neonatal Network groups provide opinion on Neonatal outcomes for neonatal deaths reviewed regionally by the Child death review panel and regional review using the MBRRACE perinatal mortality review tool (PMRT). Local maternity System (LMS) - is implementing a scrutiny panel on a monthly basis to review all SI's and HSIB cases. This team will assure learning is shared and implemented across the LMS. Meeting attended by Obstetric & Midwifery Safety Champions, Consultant Midwives from each Trust and LMS Safety Champion and Clinical Lea • **All maternity SI** - reports are currently reviewed by the Trust Serious Incident Scrutiny Group (SISG) on a case by case basis. Moving forward will be reviewed at Quality Committee quarterly.
Describe how we are using this measurement and reporting to drive improvement?	• Feedback from users of the service through the MVP. • Reports to local and Trust governance framework meetings. • Local sharing of learning via email or posters. • Maternity Academy in place. • Local process for HSIB action plans to hold improvement to account with measurable outcomes. Also HSIB newsletter implemented to share learning. Golden thread of learning from cases identified, shared regionally, QI improvements discussed and shared back on a regional level.

How do we know that our improvement actions are effective and that we are learning at system and trust level?	• Board Level Data set review • A reduction in stillbirths. • Active Quality Improvement group and supporting resources. • Continual review of safety incidents and any thematic findings. • External review of outcomes through GIRFT and NMPA System level example shared PPH data and discussed through forums such a WICN. • Regional guideline consensus such as Wessex AN pathways. • Sharing audit findings at regional meetings such as maternal medicine network, intrapartum and fetal medicine network.
What further action do we need to take?	• Clinical change - Ensure the 'provider level measures' are included in the current dashboard. Agree dates for this to be reviewed • External clinical specialist opinion - Ensure continued external clinical specialist opinion is established through LMS • All maternity SI - Ensure LMS have quarterly reports from SI's occurring in the Maternity Service. Additional actions, • Relaunch the QI group within the Maternity Service. • Revisit the SCORE culture survey findings. • Embed new digital maternity system June 2021 • Consider revision stillbirth group to be a mortality group (perinatal committee as per perinatal surveillance model) for cases outside HSIB remit.
Who and by when?	• UHS Division C Risk & Patient Safety Team • Local Maternity System as most recommendation quarterly then in place by April 2021 (other than digital)

What resource or support do we need?	• Ongoing support for BadgerNet implementation. • Possible investment into risk and patient safety.
How will mitigate risk in the short term?	N/A

Immediate and essential action 2: Listening to Women and Families

Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:
Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities: (a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. (b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.	
What do we have in place currently to meet all requirements of IEA 2?	• **Independent senior advocate role** – the UHS maternity service has contact with the local MVP. The Trust also has PALS to support parents with complaints. The role of the senior Advocate is not clear in the toolkit but a Job description is being developed by NHSE. • **Advocate -** must be available to families – HSIB coordinate independent investigations and link with parents to ensure their questions are addressed in the reviews; HSIB facilitates a tripartite meeting with families following an investigation. MVP chair currently receives feedback from women in the locality in a limited capacity. The service has an award winning bereavement team who also provide and advocate for families, facilitating their questions in the review cases where the outcome has been poor- although this is not an independent role, there are merits to this approach as the team and the women have a different level of Trust. • **Non-executive director** - The UHS maternity service has a non-exec director in place.
How will we evidence that we are meeting the requirements?	• Feedback through Birth Afterthoughts and other sources is monitored through the Maternity Patient Experience Lead. • Feedback from MVP fed directly to DoM to be addressed through Birth Afterthoughts. Social Media channels active which allows for immediate and timely response to issues. • Feedback from Women through the HSIB processes is fed into governance meetings. Women's feedback and learning is shared at mandatory training. We have re-reviewed cases / action plans where patient feedback has highlighted unrecognised areas of concern.

How do we know that these roles are effective?	• Reduction in number of complaints. • Actions through the rapid response of social media comments. Positive support on social media from women and their families who have accessed the service. • Feedback from parents through HSIB Quarterly meetings. Continue with joint HSIB parent and Trust meetings to discuss investigations improving FFT results. Improving national maternity survey results.
What further action do we need to take?	• Independent senior advocate role – Ensure that the MVP is aware and has access to the Trust Board and the LMS but recognise that the senior advocate role needs to be developed. • Advocate must be available to families - Ensure that parents are aware of PALS. Additional actions, • MVP to be part of the co-design of services. • Ensure the quality of women's feedback included in mandatory training covering all staff including medical trainees
Who and by when?	• Maternity Patient Experience Lead
What resource or support do we need?	• May need to support some training for MVP to understand the NHS and the different forums etc.

How will we mitigate risk in the short term?	The lack of independent senior advocate role is partially mitigated by- • Active MVP group • HSIB • External expert as part of PMRT review process • Consultant Midwifery support • Duty of Candour compliance • Birth Afterthoughts process • Complaints response/ PALS • Review of FFT data • Review and action NHS Choices feedback • Social media information sharing and responses to queries • Communications attend maternity service senior team Covid meetings and ensure timely dissemination of information via social media

Immediate and essential action 3: Staff Training and Working Together

Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities: (a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. (b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	
What do we have in place currently to meet all requirements of IEA 3?	• **Multidisciplinary training and working occurs** – the UHS maternity service has a planned programme of PROMPT training. PROMPT is an externally validated course • **Multidisciplinary ward rounds on the labour ward** - the UHS maternity service have Consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. There is no Consultant presence at the night time ward round 3 nights a week • **External funding allocated for the training of maternity staff, is ring-fenced** – the UHS maternity service funding for Education is ring-fenced for maternity safety training.
What are our monitoring mechanisms?	• Training and education records. • Trust VLE system. • Consultant rotas for Labour ward cover twice a day • Leads for training review and monitor. • MDT collaboration in training highlights human factors and communication challenges between disciplines- such examples have included the implantation of lanyards to identify roles in an emergency during COVID due to extra PPE, allocation of a person to care for the baby during an emergency. System wide emergency proformas developed. • We are able to use funding to target areas of learning identified in cases above that which is annually funded within the Trust - Newborn Life Support training is a good example of this.

Where will compliance with these requirements be reported?	• Increase or maintenance of education and training compliance numbers. Achievement of a role specific training needs analysis. • Reduction in the feedback from investigation about senior involvement in cases and maintain a helicopter view. • Consistency in care planning for women. Obstetric trainee feedback demonstrates good support form consultant level in practice. • Maintenance of educational opportunities from funding.
What further action do we need to take?	• Increased reporting to the LMS. • Further job planning and workforce support to resource Consultant Present at LW ward round for a further 3 nights a week* There is a need to increase the head room to allow for the extra safety training required for midwives. Review of protected SPA time to support medical staff to attend training?
Who and by when?	• W&N Care Group Clinical Lead • Director of Midwifery. Local Deanery lead.
What resource or support do we need?	• LMS in providing oversight and leadership. Trust Workforce support to increase time for training. • Funding for increased Consultant provision. • Ongoing support from the finance department to ring-fence funding monies.
How will we mitigate risk in the short term?	• Consultant cover includes a 5pm ward round where it is not covered in the evening. • There is a 'Resident on Call' (ROC) overnight. • Current Training and Education programmes. • Current records for staff training on VLE. • Guidance in place.

Immediate and essential action 4: Managing Complex Pregnancy

There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4?	• **Women with complex pregnancies**: All women are triaged by a midwife following self-referral to service with clear guidance for those with complexity requiring named consultant leads. • Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team - All areas of medical complexity have clear guidance about early pregnancy management referral pathways and subsequent care. If required there is an early robust referral system which makes subsequent appropriate appointments with medical staff. • **The tertiary level Maternal Medicine Centre**: The UHS maternity service understands what steps are required and have made excellent regional progress towards a maternal medicine regional network with the maternal medicine centre in Southampton. This has had good engagement from many of the regions maternity centres. Support and collaboration continues to be extended to those centres waiting for further engagement. However, overall the service has many examples of region wide collaborative obstetric medicine process and pathways and is working with NHS England in the national and local vision and developments.
What are our monitoring mechanisms?	• The maternal medicine network have developed collaborative regional guidance, enables complex case discussions and developed communication within the region between obstetricians but also beginning to open pathways with other medical specialities across the region. • The relationship between midwives and women's named obstetricians allow excellent communication and care planning outside of the schedule for appointments- this allows fast responsive care delivery for the woman's needs but also to support her wishes. • There is good evidence of continuous service development with collaboration of specialist outside maternity in supporting women's care.

Where is this reported?	• Improved reporting and monitoring of incidents. Example: recent COVID practices have demanded swift implementation across a service with frequent guidance changes - this is only possible with established pathways and great team communication across specialities. This learning feeds into regional guideline consensus through various clinical forums.
What further action do we need to take?	• Improved network working across the LMS. • Further work is required in developing medical links for pregnancy throughout entire region which will be enhanced by further clarity in the funding streams (expected 2021) and, as suggested, complete region wide consistent engagement from all interested parties. Further recognition of the obstetric physician at the maternal medicine centre and obstetric side to maternal medicine team will also support maternal medicine centre development. Enhanced collaboration and engagement from medical specialties (working alongside obstetric specialties) is also work in progress. NHS Resolution Maternity Incentive Scheme (MIS) Safety Action 6 SBL, • Implement audits for each element of NHS Resolution MIS Safety Action 6 compliance, through a process matrix with the recruitment of the SBL audit midwife. • Ensure submission of MSDS data from specification standards when required by NHS Digital.
Who and by when?	• Consultant Obstetric Lead maternal medicine network. • Saving Babies Lives Audit Midwife.
What resources or support do we need?	Support from LMS to continue embedding the network and expectations of the network delivery programme.

How will we mitigate risk in the short term?	NHS Resolution MIS Safety Action 6 SBL, • **Element 1 Reducing Smoking** – Women are being referred to smoking cessation services and data is being reviewed to ensure compliance with appendix H. Public Health Midwife in place to support all services for the maternity departments. Further audits required to establish compliance. • **Element 2 Identification of Fetal Growth Restriction** – Further actions are required to be in line with requirements. Further audits required to establish compliance. • **Element 3 Reduced Fetal Movement** – Full compliance. Review of all women who attended triage / MDAU with reduced fetal movements to ensure they had the appropriate documentation and computerised CTG completed. Audit undertaken by the Consultant Midwife 2020. • **Element 5 Reducing Preterm Births** – All requirements in place except for a guideline.
Immediate and essential action 5: Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway. • All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional • Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	
Link to Maternity Safety actions: **Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?**	
Link to urgent clinical priorities: a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.	

What do we have in place currently to meet all requirements of IEA 5?	• **All women must be formally risk assessed** - Women within the maternity Service are risks assessed at antenatal contacts are supported by our guidance and documentation. • **Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture** – the Maternity Service has a guideline in place to support women and staff on ensuring appropriate place of birth. There is an embedded online resource (Wessex healthier together) to support women's decision making on planned place of birth and social media forums for each birth setting.
What are our monitoring mechanisms and where are they reported?	• Review of incidents reported. • Audit and Quality improvement projects to be established. • Through the Maternity and Trust Governance framework. • Previous audit and report undertaken as part of midwifery led pathway action plan.
Where is this reported?	• Improved reporting through the Clinical Effectiveness process and monitoring of incidents is required.
What further action do we need to take?	• Undertake an audit to confirm compliance. • All women must be formally risk assessed at every antenatal contact – to remind staff through the 'Theme of the Week', of the requirement to continually risk review. • Risk assessment must include ongoing review of the intended place of birth – to remind staff through the 'Theme of the Week', of the requirement to continually assess intended place of birth.
Who and by when?	• Consultant Midwife. • Community Midwifery Matrons.

What resources or support do we need?	None
How will we mitigate risk in the short term?	• Audit has been undertaken in 2020.

Immediate and essential action 6: Monitoring Fetal Wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.
The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities: a) Implement the saving babies' lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	
What do we have in place currently to meet all requirements of IEA 6?	• **Dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.** The UHS maternity service has a clear structure in place expressing the senior team and there escalation processes in place. The service has an identified Consultant lead for Fetal Monitoring and in addition a Fetal Monitoring lead midwife is currently being recruited. The service has a TNA with process for training and competency testing for all staff in fetal surveillance which is updated annually. The UHS Maternity Service works in collaboration across a Local Maternity System (LMS) to ensure there is a good interface with external units and fetal monitoring in labour is a core topic on the Wessex Intrapartum Care Network (WICN). The maternity service welcomes and works collaboratively with external agencies to ensure good practice is in place. Current fetal monitoring cases are shared in MQUEST to support wider learning.
How will we evidence that our leads are undertaking the role in full?	• Reporting to UHS local and Trust meetings. • Reporting to SBL group meetings. • Reports to training and education meetings. • Shared learning opportunities from across the learning networks. • Shared network opportunities from across SHIP LMS. • Presentation to UHS Local MQuest and Neonatal meetings. • Maternity Newsletters. • Attendance at Local and National Webinar opportunities.

What outcomes will we use to demonstrate that our processes are effective?	• Improved process measures: 90% annual attendance for all relevant staff to training and passing the competency document. • A reduction in the number of clinicians who fail the competency test and need developmental action plans. • Outcome measures: Reduction in the number of babies admitted to the neonatal unit with HIE where misinterpretation or of fetal wellbeing played a contributing role. • Reduction in the number of babies born with abnormal cord gas result where misinterpretation of fetal monitoring in labour was a contributing factor. • Improved outcomes for women and babies. • Improved reporting systems within the maternity systems. • Improved reporting and monitoring of incidents. • Improved training and education.
What further action do we need to take?	• To ensure recruitment of the 0.4 WTE Fetal Monitoring lead position. • Continued implementation of SBL. • Continued review and monitoring required of external information and changes in practice. Recruitment to the Fetal Monitoring leads by 31st Jan. • Formalised pathway/process for reporting of incidents where interpretation of fetal wellbeing played a significant role. • Review the provision of fetal surveillance training at UHS in comparison to other units within LMS and Wessex. • Work continue to work with clinical engineering to ensure an adequate, safe and functioning provision of CTG monitors across the service to provide safe care.

Who and by when?	• Labour Ward Midwifery Matron • Care Group Clinical Lead. • Consultant Midwife. • UHS Division C Risk & Patient Safety Team
What resources or support do we need?	None
How will we mitigate risk in the short term?	• Current training for fetal surveillance (monitoring) in place. • Guidance in place. • Staff reporting of incidents where interpretation of fetal wellbeing played a significant role. • Continued implementation of SBL's. • Continued implementation of the NHSR Safety Action. • Reporting through the Maternity Safety Champions.

Immediate and essential action 7: Informed Consent

All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care

Women's choices following a shared and informed decision-making process must be respected

Link to Maternity Safety actions: **Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?**	
Link to urgent clinical priorities: a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.	
What do we have in place currently to meet all requirements of IEA 7?	• UHS has a plethora of mediums of patient information to support informed consent including online resources such as Wessex Healthier Together, the Trust maternity webpages, Social media, Dad Pad, MY Birthplace App and Baby Buddy but also leaflets provided to women at various stages of their care by trust and national versions. • UHS encourages women and their families to be actively involved in their care and decision making and will support with additional needs as required. Birth preferences are supported through consultant midwife clinics and women's choices about care providers is also respected as we support women with independent midwives.

Where and how often do we report this?	• Reports to local and Trust meetings. • Reports to SBL meetings. • Reports to training and education meetings. • Shared learning opportunities from across the learning networks. • Shared network opportunities from across SHIP LMS. • Local MQuest and Neonatal meetings. • Maternity Newsletters. • Local and National Webinar opportunities. • There is ongoing adaptation of consent documentation, patient information leaflets and significant investment in expertise in online resources. Women's feedback and involvement directly influences the co-creation of this information. • The significant increase in consultant midwife appointments is testimony to the dedication to support women's choice. • Maternity is part of a Trust shared decision making initiative. • There has been a lengthy MDT discussion recently following the changes by the GMC regarding consent and the impacts within maternity.
How do we know that our processes are effective?	• Reduction in the number of incidents where interpretation of fetal wellbeing played a significant role. • Improved outcomes for women and babies. • Improved reporting systems within the maternity systems. Improved reporting and monitoring of incidents. • Improved training and education. • The significant increase in consultant midwife appointments is testimony to the dedication to support women's choice. Maternity is part of a Trust shared decision making initiative. • The UHS service has received plaudits from women recognising the support they have received and conversely do not have complaints about choice and informed decision making.

What further action do we need to take?	• Review of the Public Website information to ensure the information is up to date. • Relaunch of the QI project 'Now is the Time to Ask' in collaboration with the National scheme 'ask 3 questions'.
Who and by when?	• Consultant Midwife • Maternity Patient Experience Lead
What resources or support do we need?	None
How will we mitigate risk in the short term?	• Continue ongoing Quality Improvements in this area as it is constantly evolving. • Review of any incidents as required.

Section 2	
MATERNITY WORKFORCE PLANNING	
Link to Maternity safety standards: **Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard** **Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?**	
We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.	
What process have we undertaken?	• UHS maternity services have developed a systematic process for workforce planning in the form of a monthly dashboard. This live data is reflective of total staff unavailability to include vacancy rates, sickness ratios, maternity leave and study time, all of which is compared alongside the budgeted versus actual staffing establishment overall. These are monitored in monthly performance with DMT. • UHS maternity services currently utilise BR + as a framework for workforce planning and strategic decision making to ensure safe staffing levels. The last assessment of UHS by BR + in 2018 suggested an overall clinical establishment based on a midwife/birth ratio of 1:24, calculated against an annual birth rate of 5500 births. Over the last 2 years, UHS have been working with midwife / birth ratios that are more suggestive of 1:26. The annual birth rate has however been seen to drop and as such the overall staffing establishment has to be regularly reviewed. 1:24 as advocated by BR +. This takes into account around 10% of the total clinical "midwifery" wte that are qualified support staff and who are working across postnatal services. Operational and maternity workforce performance indicators now suggest a position of compliance against BR + standards if the birth rate remains below 5200.

How have we assured that our plans are robust and realistic?	• The data recorded within the monthly dashboard is lifted directed from maternity E-rostering / ESR systems. As such the staffing ratios are recorded in real time and will represent staffing levels in their most accurate form. • By utilising the BR + acuity tool we are confident that safe care is achieved by ensuring 1:1 care for women in labour and observing a supernumerary position for the labour ward coordinator.
How will ensure oversight of progress against our plans going forwards?	• The monthly dashboard not only records an accurate position for midwifery staffing at the current time but also offers a projected forecast for staff unavailability in the months going forward. This ensures and supports an ongoing process for rolling recruitment, involving both qualified and unqualified staff groups. • A review of the current WTE staffing establishment across UHS maternity services will ensure that staff are being deployed and utilised in the correct way. This will be done with the support of BR +. The internal reviews of staffing are shared with the board in the annual report and through the quality committee.
What further action do we need to take?	• To ensure that effective measures are continued to be taken in ensuring an accurate account of midwifery staffing at any one time. This will enable vacancies and gaps within the workforce to be accounted for and managed accordingly. • A detailed report outlining the current position in respect of midwifery staffing to be submitted to Trust Board.
Who and by when?	• Midwifery Operational Manager.
What resources or support do we need?	• Continued support from the maternity E-rostering lead and midwifery matron team with regards workforce planning. • Continued support from BR + team, UHS workforce department and the maternity E-rostering lead.

How will we mitigate risk in the short term?	None

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

The UHS maternity Service has reviewed itself against the RCM Manifesto Standards and these are contained the in the attachment.

Appendix A
MIDWIFERY LEADERS

The UHS maternity Service has reviewed itself again against the **Care Quality Commission (CQC) Improvement Plan**

Appendix B -
Updated CQC Improv

The UHS maternity Service has reviewed itself again against the **Morecombe Bay report**

Appendix C -
Updated Morecambe

NICE GUIDANCE RELATED TO MATERNITY	
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.	
What process do we have in place currently?	• The UHS maternity service has a regular clinical effectiveness to review the current released national guidance. • The UHS maternity service Quality team (with other stakeholders) reviews national guidance or recommendations and implements actions as appropriate. Completed gap analyses are submitted to the UHS Trust Clinical Effectiveness team. • The UHS maternity service and the UHS Trust Clinical Effectiveness team hold an annual review of all guidance and outcomes against compliance called CEOSG. • Support of the Consultant midwives in implementing national guidance. • Current digital capture of data to assure compliance for some National requirements.
Where and how often do we report this?	• Reports and gap analysis to local and Trust meetings including Governance. • Shared network opportunities from across SHIP LMS. • Maternity Newsletters.
What assurance do we have that all of our guidelines are clinically appropriate?	• Reduction in the number of incidents. • Improved outcomes for women and babies including stillbirths. • Improved training and education based on the release of national guidance. • Continuous audit against national and local recommendations with local outcomes compared to both regional and research outcomes. Ongoing review of recommendations enables timely change between NICE publications such examples include changes to GBS prophylaxis recommendations and further discussions around wound dressings post caesarean.

What further action do we need to take?	• Attendance at the UHS CEOSG meeting in May 2021 to provide assurance to the UHS Trust clinical Effectiveness group. • Increased reporting to the LMS. • Improve information to women and their families and make available on the public website. • Improved digital system to improve data capture (June 2021).
Who and by when?	• Director of Midwifery • UHS Quality team. • Consultant Midwives. • W & N care group lead. • SBL Audit Midwife.
What resources or support do we need?	None
How will we mitigate risk in the short term?	N/A

Appendix 3 – Updated CQC Improvement Plan

CQC Area of Concern (MUST DO)	What do we have in place currently to meet all requirements?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?	RAG Rating
M9 Safe Regulation 12 The provider must ensure that the environment and equipment are kept clean and fit for purpose. Infection control procedures are in place and adhered to in order to control and minimise the risks of cross infection.	• Burley ward - clinical cleanliness rated as 99% • Lyndhurst ward - clinical cleanliness rated as 99% • Labour ward - clinical cleanliness rated as 99% • Broadlands Birthing Centre - clinical cleanliness rated as 99% To provide an environment and equipment that are kept clean and fit for purpose. Compliance of both clinical and domestic cleanliness will be measured through the Trust existing reporting processes and monitoring will take place through the Governance systems and processes. The aim to achieve the Trust accepted target of above 95% compliance with noncompliance being escalated through the appropriate forums monthly.	• New Matrons are in place for the clinical areas and have clinical cleanliness as a focus within their role) - Action complete. • Matrons to review of current processes for ensuring the environment and equipment is kept clean and fit for purpose) - Action complete • Meeting to be held with the maternity service and the Infection Prevention team - Action complete. • Matrons to identify appropriate clinical leads are in place to ensure there is continual monitoring - Action complete. • Matrons to design appropriate reporting process for where there is a deficit. • Monthly Matron meetings established as a forum for discussing Clinical Indicators including cleanliness) - Action complete. • Clinical 'walkabouts' to be developed throughout maternity by both clinical staff and users of the service (15 Steps) - Action complete. • Meeting with the Head of Estates to review the findings of the CQC (see M13 below) - Action complete. • Estates concerns to be reflected on the Estates Risk Register) - Action complete.	Reduce infection prevention incidents.	Jan 2021 - Continued monitoring and reporting by Infection Prevention.	Director of Midwifery and Infection prevention leads	Continued support from the UHS Trust Infection Prevention and Estates teams.	Continued monitoring in place.	

M10 The provider must ensure emergency equipment are maintained safely and all necessary checks are completed to safeguard patients.	To provide emergency equipment in all areas that is maintained safely and that all necessary checks are completed to safeguard patients Compliance of the equipment 'check list' will be measured through the Trust existing 'checklist template' and monitoring will be by the Matrons and Clinical leads. The aim to achieve the Trust accepted target of 100% compliance, with noncompliance being escalated immediately and through the appropriate forums monthly.	• Matrons to review of current processes for ensuring that the emergency equipment are maintained safely and all necessary checks are completed to safeguard patients) - Action complete. • Matrons to identify appropriate clinical leads are in place to ensure there is continual monitoring - Action complete. • Matrons to design appropriate reporting process for where there is a deficit. • Matrons to design appropriate escalation process for where there is a deficit including immediate checking of equipment where this has not occurred - Action complete.	Improve patient safety in the provision of emergency equipment.	Jan 2021 - Continued monitoring and reporting by Matrons.	Midwifery Matrons	Continued review by the Midwifery Matrons and addressing deficits where identified.	Continued monitoring in place.	
M11 Safe Regulation 15 (f) The provider must ensure that arrangements are in place for the safe transfer of women within the maternity unit.	To provide arrangements for the safe transfer of women within the maternity unit. Compliance of the safe transfer of women will be monitored through the Trust existing reporting processes and through the Governance systems and processes. The aim to achieve a process for the safe transfer at all times with noncompliance being escalated through the appropriate reporting systems and monitored monthly.	• To have a 'Protocol' in place for when there is a lift failure) - complete. • Swipe card lift call to be in place – complete May 2019. • 'Transfer button' (to take priority lift calls directly to D level) to be in place – complete May 2019. • To have regular scrutiny and monitoring of the risk register entry. • Meeting with the Head of Estates to review the findings of the CQC – complete May 2019. • Arrange a meeting with estates to review the current status of the lift and address any action required to ensure serviceability of lifts. • To have in place a 'Maternity Transfer' guideline in place - Action complete. • Review of risk and procedures within maternity services relating to transfers within the Princess Anne Hospital. • The maternity services have regular meetings with the Estates team to ensure there is regular review of Estates issues - Action complete. • Estates concerns will be shared within the Governance processes within the	Improve patient safety in the provision of emergency transfer.	Jan 2021 - Continued monitoring and reporting by Matrons.	Midwifery Matrons	None	Continued monitoring in place.	

		maternity service, including the Risk Register Scrutiny Group and the Trust Quality Governance Steering Group (QGSG) as part of reporting - Action complete.						
M12 Safe Regulation 15 (c) The provider must ensure that security of the premises is managed effectively and have the appropriate level of security needed in relation to the services being delivered.	To provide arrangements for the security of the premises is managed effectively and have the appropriate level of Security. Compliance of the effectiveness of security measures will be through the Trust existing reporting processes and monitoring through the Governance systems and processes. The aim would be to achieve appropriate levels of security with concerns being escalated through the appropriate reporting systems and monitored monthly.	• To review and update the existing 'Missing Baby' Policy to be completed by July 2019. • To repeat the staff briefing relating to missing babies once the policy is in place. • Meeting with the Head of Security to review the findings of the CQC – complete May 2019. • The maternity service to have regular meetings with the Security team to ensure there is regular review of concerns. Where appropriate these concerns will be shared through the Governance processes within the maternity services, including the Risk Register and the Trust Quality Governance Steering Group (QGSG) as part of reporting. • Review and upgrade to CCTV cover to be completed by June 2019. • Regular 'mystery visitors' to undertake testing of access to clinical and non clinical areas of the Princess Anne Hospital to be in place by June 2019. • Staff to be updated on their responsibility in regards to security to be in place by June 2019. • Security review of the Princess Anne Hospital by December 2019.	Improve patient safety in the provision of security.	Jan 2021 - Continued monitoring and reporting by Matrons.	Director of Midwifery and Security leads	Continued support from the UHS Trust Estates teams.	Complete but with ongoing actions from Estates	

M13 Safe Regulation 15 (b) The provider must ensure premises are suitable for the service provided, including the layout and fit to deliver care and treatment must meet people's needs.	To provide suitable premises for the provision of care and treatment that meet people's needs.	• To have a Risk Register entry in place with actions and controls in place for any concerns raised i.e. Bathrooms and Showers on ward areas and Induction of Labour room) - Action complete. • Meeting with the Head of Estates to review the findings of the CQC) - Action complete. • Meeting with the Head of Security to review the findings of the CQC (see M12 above) - Action complete. • Arrange a specific meeting with estates to review the current estates of the Princess Anne Hospital to assess the gaps and prepare a schedule of proposed works that will be considered as part of the Trusts Capital prioritisation - Action complete. • Ensure risk register entries are representative of the current position and have actions in place to address. • To review Estates attendance at the Care Group Risk Register Scrutiny Group meeting – by July 2019 - Action complete. • The maternity service to have regular meetings with the Estates teams to ensure there is regular review of concerns. Where appropriate these concerns will be shared through the Governance processes within the maternity service, including the Risk Register and the Trust Quality Governance Steering Group (QGSG) as part of reporting - Action complete.	Improve patient safety in the provision of Estates.	Jan 2021 - Continued monitoring and reporting by Matrons.	Director of Midwifery and Estates	Continued support from the UHS Trust Estates teams.	Complete but with ongoing actions from Estates	
CQC Area of Concern (SHOULD DO)								
S19 Safe The service should ensure that staff in the community have access to information to support and	• Since the CQC visit action has been undertaken to ensure that the New Forest Birth Centre and community settings have access to IT systems to support and provide women with safe and effective care to meet their	To provide staff access to Trust IT systems at the Princess Anne Hospital to ensure there is an ability to obtain information to support and provide women with safe and effective care to meet their needs. Failure in accessing the IT systems would be recorded through the	Improve patient safety in the provision of IT.	Jan 2021 - Continued IT instillation of Wi-Fi access across the	Director of Midwifery and IT	Continued support from the UHS Informatics and	Complete but with ongoing actions from IT	

provide women with safe and effective care to meet their needs.	needs.. • Staff within the Princess Anne Hospital have access to information to support and provide women with safe and effective care to meet their needs to support and provide women with safe and effective care to meet their needs.	Trust Incident Reporting Process and IT Helpdesk with incident reporting being monitored on a monthly interval as part of the maternity risk and patient safety meetings. Maternity representation at the Trust Digital Committee to be in place to ensure an avenue for escalation. Actions already taken to address include the following • All staff in the community setting have remote access to the IT systems. • All staff in the community setting have 'Smart Phones', which have the ability to access IT systems. • All Birthing Centres and Hubs have access to the IT systems. • The maternity service is represented at the Trust Digital Committee and reports to and escalates as required. • There are 'Community Coordinators at the NFBC and at the Princess Anne Hospital who can obtain information for staff who are experiencing connectivity concerns. • There is Admin support provided for the above settings who troubleshoot IT issues. • IT concerns are reported through the Trust Incident Reporting process. • IT concerns are reported through the IT helpdesk system. • Staff are able to access the Princess Anne Hospital staff to access information or advice. • Monitoring of incidents related to IT access to be undertaken monthly through the risk and patient safety group.		maternity areas.		Estates teams.		

S20 Safe The service should ensure medicines are stored at the correct temperatures in the day care unit.	This relates to the fridge in the Induction of Labour Room as the 'day care unit' does not have a drug fridge.	To provide medicines that have been stored at the correct temperatures. Compliance of the 'Drug Fridge Temperature check list' will be measured through the Trust existing 'fridge monitoring and escalation checklist' with monitoring by the Matrons and Clinical leads. The aim to achieve the Trust accepted target of 100% compliance, with noncompliance being escalated immediately and through the appropriate forums monthly. Actions already taken to address include the following • Matrons to review of current processes for ensuring that the drug fridges are maintained safely and all necessary checks are completed. • Matrons to identify appropriate clinical leads are in place to ensure there is continual monitoring. • Matrons to design appropriate reporting process for where there is a deficit. • Matrons to ensure appropriate escalation process are taking place for where there is a deficit including immediate checking of equipment where this has not occurred.	Improve patient safety in the provision of medicines.	Jan 2021 - Continued monitoring and reporting by Matrons.	Midwifery Matrons	Continued review by the Midwifery Matrons and addressing deficits where identified.	Complete - with ongoing monitoring	
New Forest Birth Centre - S21 Safe Develop their IT system enabling staff in the community to have access to information to support and provide women with safe and effective care to meet their needs.	Since the CQC visit action has been undertaken to ensure that the New Forest Birth Centre and community settings have access to IT systems to support and provide women with safe and effective care to meet their needs.	To provide staff access to Trust IT systems at the New Forest Birth Centre and community settings to ensure there is an ability to obtain information to support and provide women with safe and effective care to meet their needs. Failure in accessing the IT systems would be recorded through the Trust Incident Reporting Process and IT Helpdesk with incident reporting being monitored on a monthly interval as part of the maternity risk and patient safety meetings. Maternity representation at the Trust Digital Committee to be in place to ensure an avenue for escalation. Actions already taken to address include the following • All staff in the above settings have remote access to the IT systems.	Improve patient safety in the provision of IT.	Jan 2021 - Continued IT instillation of Wi-Fi access across the maternity areas.	UHS Informatics Team	Continued support from the UHS Trust Informatics team.	Complete - with ongoing actions by Informatics	

		• All staff in the above settings have 'Smart Phones', which have the ability to access IT systems. • All Birthing Centres and Hubs have access to the IT systems. • The maternity service is represented at the Trust Digital Committee and reports to and escalates as required. • There are 'Community Coordinators at the NFBC and at the Princess Anne Hospital who can obtain information for staff who are experiencing connectivity concerns. • There is Admin support provided for the above settings who troubleshoot IT issues. • IT concerns are reported through the Trust Incident Reporting process. • IT concerns are reported through the IT helpdesk system. • Staff are able to access the Princess Anne Hospital staff to access information or advice. • Monitoring of incidents related to IT access to be undertaken monthly through the risk and patient safety group.						
New Forest Birth Centre - S22 Safe Review midwife staffing to ensure women and babies receive timely support when needed.	To review the provision of staffing at the New Forest Birth Centre to ensure women and babies receive timely support when needed. The aim to achieve appropriate staffing levels based on the NICE endorsed framework for workforce planning, with noncompliance being escalated through the appropriate Governance systems and processes.	• Completion of the NICE endorsed Birthrate Plus workforce review tool. • Completion of the maternity Services Workforce review. • Implementation of the intrapartum acuity tool • Completion of the NHS Resolution Clinical Negligence Scheme for Trust (CNST) criteria 5 - Can you demonstrate an effective system of midwifery workforce planning?	Improve patient safety in the provision of safe staffing levels.	Jan 2021 - Continued monitoring and reporting by Matrons.	Midwifery Matrons	Continued support from the maternity service senior team and the wider UHS Trust Workforce team.	Continued monitoring in place.	

S23 Safe Support staff to complete maternity specific training such as management of women in the birthing pool.	• 100% of New Forest Birth Centre leads have received maternity specific training such as management of women in the birthing pool. • 90% of support workers at the New Forest Birth Centre leads have received maternity specific training such as management of women in the birthing pool. 100% compliance will be achieved in June 2019.	To provide staff access to maternity specific training such as management of women in the birthing pool at the New Forest Birth Centre. The maternity service accepted performance target is 90% compliance and this is monitored through the Practice Education Team. Compliance of less than 90% would be escalated through the Governance systems and processes. Actions already taken to address include the following • That the safe management of women in the birthing pool forms part of mandatory training. Previously this has been on 'PROMPT Obstetric Emergency' training sessions. In 2021 this will be part of 'Moving and Handling' training which will contain a training film, practical and competency declaration for emergency pool evacuations - Action complete. • Review and update of the 'Specialist Training for Midwives Guideline' and 'Waterbirth guideline' - Action complete. • Training compliance is reported monthly to leads and shared quarterly to Education and Governance forums - Action complete.	Improve patient safety in the provision of appropriate training and education.	Jan 2021 - Continued monitoring and reporting by the Practice Education teams.	Maternity Practice Education Team	None	Continued monitoring in place.	

Appendix 4 - UHS Midwifery Leadership (RCM Manifesto Standards)

MIDWIFERY LEADERSHIP (RCM Manifesto standards)	What process have we undertaken?	How have we assured that our plans are robust and realistic?	How will ensure oversight of progress against our plans going forwards?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?	RAG Rating
Director of Midwifery in every trust: Every trust should have a Director of Midwifery, with a Head of Midwifery in every maternity unit within the organisation. This would help protect people from the risk posed by dysfunctional maternity services by enabling problems to be identified and escalated more quickly.	The Director of Midwifery is a leader and advocate for safe, high quality maternity care, managing the strategic and operational delivery of UHS maternity services and is accountable to the Chief Nurse and DDO in Division C. There is a deputy role which primarily focuses on the operational delivery of the service; this role is being developed into a head of Midwifery role for the new financial year.	There is a deputy role which primarily focuses on the operational delivery of the service; this role is being developed into a head of Midwifery role for the new financial year. Director of Midwifery development programme in 2019-2021 with HEE in place.	The Safety Champion Meetings. Trust reporting committees.	None.	Director of Midwifery.	Continued oversight from the senior team within the maternity service and the wider UHS Trust leads.	None.	Compliant
Regional & national lead midwives: A lead midwife at a senior level in all parts of the NHS, both nationally and regionally.	N/A for UHS maternity service.	N/A for UHS maternity service.	N/A for UHS maternity service.	N/A for UHS maternity service.	N/A for UHS maternity service.	N/A for UHS maternity service.	N/A for UHS maternity service.	Compliant
More consultant midwives: We would like to see at least one consultant midwife in every maternity unit. For those responsible for providing services in remote and rural areas, one option could be to appoint a consultant midwife across more than one trust / health board, providing consistency and clarity of	UHS had the first Consultant Midwives in the UK in 2000. This clinical leadership role has developed with 2 substantive Consultant Midwife posts and training places for two trainees as part of the local HEE development program.	Continued recruitment and retention to this important role.	To remain an essential role within any workforce review of the maternity service.	None.	Director of Midwifery.	Continued oversight from the senior team within the maternity service and the wider UHS Trust leads in ensuring the continuation of the Consultant	None.	Compliant

professional guidance for this very specific kind of midwifery service.						Midwives.		
Specialist midwives in every trust: A range of specialist midwife roles should be the norm in every trust / health board across the United Kingdom. The mix of specialisms will depend upon the needs of the service locally. Midwives should have access to and be able to draw upon these midwives' skills and experience as they strive to deliver and improve care e.g.: smoking cessation FGM specialist substance misuse mental health specialist	UHS has a range of specialist midwives for perinatal mental health, public health which includes smoking cessation, domestic violence and substance misuse, safeguarding which includes female genital, mutilation, bereavement and fetal medicine. The service also provides continuity of care for vulnerable women in Southampton which is al so considered a specialist role.	Continued recruitment and retention to these important specialist roles. Review has been undertaken by BirthRate Plus.	The Safety Champion Meetings. Trust reporting committees.	None.	Director of Midwifery and the Operational Midwifery Manager.	Continued oversight from the senior team within the maternity service and the wider UHS Trust leads in ensuring the continuation of the specialist Midwives roles.	None.	Compliant
Strengthening midwifery leadership in education & research: Lead Midwives for Education (LMEs) are experienced, practising midwife teachers who lead on the development, delivery and management of midwifery education programmes 13. They help to ensure high standards in midwifery education and are a vital intermediary between the professional regulator (the Nursing and	Although this is primarily a University standard the maternity service supports the development of lectures through secondments to the university.	Midwives form an integral part of the Trust research programme and we work in partnership with Bournemouth University to host Clinical doctorate students.	Regular Educational meetings both locally and across the LMS.	None.	Practice Education Lead.	Continued collaborative working with the university.	None.	Compliant

Midwifery Council) and the universities.								
Fund ongoing midwifery leadership development: A commitment to fund ongoing midwifery leadership development.	The maternity service has an excellent regional reputation for our preceptorship programme. This leads on to an internal B6 development programme alongside opportunities to develop in to band 7 roles. The Trust provides opportunities for leadership development and we currently have 3 midwives on the NHS leadership framework Mary Seacole course, 3 midwives on the Diversity emerging leaders programme, 1 midwife on the Windrush Programme. We have been successful in competing for a place on the national Each Baby counts leadership course. We have supported midwives on the 2 consultant midwife trainee and Director of Midwifery development programme in 2019-2021 with HEE.	Continued recruitment and retention to development and leadership roles.	To ensure development and leadership are within any workforce review of the maternity service.	None.	Director of Midwifery and the Operational Midwifery Manager.	Continued oversight from the senior team within the maternity service and the university.	None.	Compliant
Professional input into the appointment of midwife leaders: Directors and Heads of Midwifery must have the skills, experience and credibility to lead and manage maternity services. The appointment of the right individual is an important matter, and selection procedures within the NHS should be focused on ensuring that the right people get into	This would be standard practise at UHS – no appointment made since 2017.	Continued recruitment and retention to development and leadership roles to ensure there are leaders of the future. Director of Midwifery development programme in 2019-2021 with HEE in place.	The Safety Champion Meetings. Trust reporting committees.	None.	Director of Midwifery and the Operational Midwifery Manager.	Continued oversight from the senior team within the maternity service and the wider UHS Trust leads.	None.	Compliant

the right jobs.								

Appendix 5 – Morecombe Bay Report

The Report of the Morecambe Bay Investigation	What do we have in place currently to meet all requirements ?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?	RAG Rating
Admit the extent and nature of the problems that have previously occurred, and should apologise to those patients and relatives affected, not only for the avoidable damage caused but the length of time to bring to light the failures.	N/A for UHS Maternity Service.	N/A	N/A	N/A	N/A	N/A	N/A	
Review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies.	Regular review of the Specialist Training Policy (against professional and regulatory requirements) currently in place within maternity services. UHS has a governance process around any additional skills developed into a role outside the usual scope which includes agreement for the skill but also evidence of training and competency assessment. Competency programme in place. Previous compliance with NHSR requirements. PROMPT Multi professional training undertaken annually by staff. Midwives working within HDU undertake specific training and	Improved planning of training and education programmes to meet the needs of the individual and the service. Improvements in safety Consultant rotas for Labour ward cover Improvement in safety through leads for Practice and Education review and monitor	Previous compliance with NHSR safety action. Increase or maintenance of education and training compliance numbers. Maintenance of educational opportunities from funding.	Audit compliance with training and upkeep of skills within the HDU team	Practice Education team, Labour Ward environments Matron- June 2021	Expansion of Trust headroom in recognition of the training needs in maternity	Continued monitoring of current Training and Education programmes. Current records for staff training on VLE. Guidance in place.	

	updates in ITU. Anaesthetists involved in training opportunities. Annual appraisal for staff. Regular reports to Governance on training compliance. Professional Midwifery Advocates in place. Medical workforce revalidation. Midwifery revalidation in place. Education Lead for medical, midwifery and neonatal workforce. Quality improvement projects and opportunities available.	escalating issues.						
Trust should draw up plans to deliver the training and development of staff identified as a result of the review of maternity, neonatal and other staff, and should identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice.	• **In addition to above:** Regular review of workforce reviews within maternity services to identify key requirements i.e. Better Births and Public Health. The Trust provides opportunities for leadership development and we currently have 3 midwives on the NHS leadership framework Mary Seacole course, 3 midwives on the Diversity emerging leaders programme, 1 midwife on the Windrush programme. We have been successful in competing for a place on the national Each Baby counts leadership course. We have supported midwives on the 2 consultant midwife trainee and Director of Midwifery development programme in 2019-2021 with HEE. Medical trainees work across other units in the region Regional working amongst obstetric consultants via the maternity network Consultant midwives ensure sharing of practice/clinical issues with other units in the region via Consultant midwives meetings.	Improved recruitment and retention programme. Improved collaborative working across the LMS. Improved provision of workforce opportunities.	Previous compliance with NHSR safety action. Increase or maintenance of education and training compliance numbers. Maintenance of educational opportunities from funding. Use of BirthRate Plus system. Use of Red Flags reporting.	Continued review of development opportunities.	Midwifery Operational Manager. Director of Midwifery. Consultant Midwife and Practice Education Team	None	N/A	

	'Labour Line' development in partnership with the SHIP LMS and SCAS.							
Identify requirements for continuing professional development of staff and link this explicitly with professional requirements including revalidation.	Yearly staff appraisals. Revalidation process supported by the Professional Midwifery Advocates linked against the NMC requirements and standards. Each midwife has 1 day per year to have specialist training necessary for their role and in accordance with revalidation by agreement with their line manager Quality improvement coaches trained to support CPD. Leadership programmes in place. Opportunities for internal B6 development programme alongside opportunities to develop in to band 7 roles. Ongoing education and development programmes for staff. Quality improvement projects and opportunities available.	Improved learning and professional opportunities. Improved recruitment and retention programme. Improved collaborative working across the LMS. Improved provision of workforce opportunities.	Previous compliance with NHSR safety action. Increase or maintenance of education and training compliance numbers. Use of BirthRate Plus system. Use of Red Flags reporting.	Continued review of development opportunities.	Midwifery Operational Manager. Director of Midwifery. Consultant Midwife and Practice Education Team	None	N/A	
Identify and develop measures that will promote effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities.	PROMPT training (multidisciplinary) Multi professional guideline development occurs Use of guideline consultation groups across all specialities. Each Baby Count QI programmes. Quality improvement projects and opportunities available. All specialities included in TOR and represented at Care Group meetings (Maternity Services; Intrapartum Care Committee, Risk and Patient Safety, Clinical Governance) Weekly meetings between the fetal medicine department and the neonatal team to discuss impending complex deliveries, both from maternal and neonatal point of view.	Minutes of these meetings shared as appropriate with maternity team and with LMS/ networks	Previous compliance with NHSR safety action. Increase or maintenance of education and training compliance numbers. Increased in wider service working across all sites and LMS. Improved safety through use of the	Recognise that this is a constant evolution and the feedback of new starters can influence these structures with fresh perspectives. We need to remain open to change- Trust values 'always improving' and 'working collaboratively'.	N/A	None	N/A	

	Daily liaison between the neonatal unit coordinator and the midwifery counterpart about anticipated deliveries and expected workload. Daily communication between neonatal coordinator and post-natal ward midwifery lead. Shared perinatal Educational meetings on monthly basis – midwives, neonatal team, obstetrics and anaesthetics. Monthly stillbirth review group, neonatal, obstetrics and midwives input. Monthly antenatal diagnosis group meetings occur (WANDA) with attendance from fetal medicine, ultrasound, genetics, neonatal, paediatric surgeons, obstetrics. Divisional Education group.		BirthRate Plus system. Improved safety through use of Red Flags reporting.					
Trust should draw up a protocol for risk assessment in maternity services around place of birth. The protocol should involve all relevant staff groups, including midwives, paediatricians, obstetricians and those in the receiving units within the region. The Trust should ensure that individual decisions on delivery are clearly recorded as part of the plan of care, including what risk factors may trigger escalation of care, and that all Trust	Guidance in place to support staff in relation to risk assessment, place of birth and when to refer, including the following – - Timings and indication for obstetric referral guideline - Antenatal framework guideline - Which obstetrician referral guideline - Place of birth guideline Planning birth meeting for women requesting to birth at the New Forest Birth Centre with Consultant Midwife Formal risk assessment at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional - Women within the maternity Service are risk assessed at antenatal contacts. Risk assessment must include ongoing review of the intended place of birth, based on the	Review of incidents reported. Audit and Quality improvement projects to be established. Through the Maternity and Trust Governance framework. Previous audit and report undertaken as part of midwifery led pathway action plan.	Improved outcomes for women and babies. Improved reporting systems within the maternity systems. Improved reporting and monitoring of incidents. Evidence from practice and case reviews shows women are receiving appropriate antenatal care for their needs and women	Undertake an audit to confirm compliance. All women must be formally risk assessed at every antenatal contact – to remind staff through the 'Theme of the Week', of the requirement to continually risk review. Risk assessment must include ongoing review of the intended place of birth – to remind staff through the	Consultant midwife and Community Matrons.	None	Mitigation in the short term includes, • Review of incidents reported. • Audit has been undertaken in 2020.	

staff are aware that they should not vary decisions without a documented risk assessment.	developing clinical picture – the Maternity Service has a guideline in place to support women and staff on ensuring appropriate place of birth. There is an identified consultant for women with complex pregnancies. Day assessment triage and use of BSOTS in place. Written pathways support clinicians to refer appropriately. Wessex Antenatal pathways in place.		are birthing in an appropriate place for the individual needs. Personal choices to birth in environments other than those recommended are supported through the consultant midwife clinics.	'Theme of the Week', of the requirement to continually assess intended place of birth.				
Follow risk assessment protocols on place of delivery, transfers and management of care, and that effective multidisciplinary care operates without inflexible demarcations between professional groups.	Transfer guidance in place including RAG rating of urgency of transfer categories to support decision making and communication . Monitoring of transfer incidents or delays in transfer. Formal risk assessment at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional - Women within the maternity Service are risk assessed at antenatal contacts. Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture – the Maternity Service has a guideline in place to support women and staff on ensuring appropriate place of birth. Collaborative work with LMS and SCAS.	Improved risk and patient safety. Improved maternity pathway management of women. Ongoing audit and reporting as part of the MLP action plan.	Previous compliance with NHSR safety action. No increase in incidents. Improved documentation of healthcare records through audits. No increase in the number of serious incidents reviewed.	This has been recognised in part in separate HSIB reports and there are associated action plans regarding this.	Consultant Midwife. W&N care group lead. Practice education and governance teams	None	Learning shared in practice. Individual conversations with midwives as needed. HSIB newsletter and MQUEST sharing to raise awareness of themes.	

Trust should identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience.	The Trust and maternity service has in place a Recruitment and Retention Strategy. The UHS maternity service uses BirthRate Plus to ensure a balanced and sustainable workforce with the requisite skills and experience. Regular staffing and workforce reporting.	Regular reporting through the BirthRate Plus system and monitoring of Red Flags.	Improved recruitment and retention. Improved safety through sustainable staffing. Improved safety through the reporting of Red Flags.	Continued regular workforce reviews.	Midwifery Operational Manager	Continued support from the BirthRate Plus team.	Current monitoring in place. BirthRate Plus in place.	
Developing better joint working between main hospital sites, including the development and operation of common policies, systems and standards.	The Trust and the LMS regularly seek assurance and information relating to the UHS maternity service. The UHS maternity service reviews all guidance and assesses recommendations and standards to ensure compliance. The UHS maternity service regularly reports to Trust Clinical effectiveness meetings on its compliance with Trust standards including audits and or monitoring as required.	Maternity Safety Champions in place. Regular Trust reporting in place.	Improved safety through the Maternity Safety Champions. Previous compliance with NHSR safety actions.	Continued reporting and assurance reviews.	Director of Midwifery	Continued support from the wider UHS Trust and LMS in providing oversight and leadership.	Maternity Safety Champions in place	
Trust should seek to forge links with a partner Trust, so that both can benefit from opportunities for learning, mentoring, secondment, staff development and sharing approaches to problems. This arrangement is promoted and sometimes facilitated by Monitor as 'buddying' and we endorse the approach under these circumstances.	The UHS maternity service works within the Southampton, Hampshire Isle of Wight and Portsmouth Maternity LMS. As part of this system there is collaborative working and sharing of information. Reviews of other maternity services have taken place prior to COVID.	Regular review of learning from other maternity services i.e. CQC reports both in the LMS and external to the LMS.	Improved safety through the Maternity Safety Champions. Improved quality assurance and gap analysis reports are in place.	Continued reporting and assurance reviews.	Director of Midwifery and Maternity Quality Teams	None.	Collaborative LMS working.	

Trust should review the structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from incidents, identifying any residual conflicts of interest and requirements for additional training. The Trust should ensure that robust documentation is used, based on a recognised system, and that Board reports include details of how services have been improved in response. The review should include the provision of appropriate arrangements for staff debriefing and support following a serious incident.	The UHS maternity service continually structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from incidents, and ensure there is regular reporting to Trust Board meetings. Learning is identified from incidents and these learning opportunities are shared locally and wider across LMS / Wessex. Maternity Safety Champions in place. Debriefing and support avenues in place both within the maternity service and in the Trust.	Maternity Safety Champions in place. Regular Trust reporting in place.	Improved safety through the Maternity Safety Champions. Previous compliance with NHSR safety actions. Improved learning from SI. Improved support of staff following an incident. Improved feedback for women and families.	Continued reporting and assurance reviews.	Patient Safety and Risk Team and Maternity Quality Teams	Continued support from the wider UHS Trust and LMS in providing oversight and leadership.	Maternity Safety Champions in place	

Trust should review the structures, processes and staff involved in responding to complaints, and introduce measures to promote the use of complaints as a source of improvement and reduce defensive 'closed' responses to complainants. The Trust should increase public and patient involvement in resolving complaints, in the case of maternity services through the Maternity Services Liaison Committee	The UHS maternity service continually reviews information by complaints and ensure there is regular reporting to maternity meetings and Trust Board meetings. There is an effective Patient Experience team in place to review feedback from all avenues. PICKER Survey undertaken. Maternity Voices Partnership in place.	Regular MVP meetings. Regular UHS Patient Experience meetings.	Improved safety through the Maternity Safety Champions. Improved maternity assurance to Trust of maternity services complaints.	To ensure that the MVP forms part of the co-design and development of the maternity service.	Divisional Governance Team and Maternity Quality Teams	Continued support from the wider UHS Trust in providing oversight and leadership.	Monitoring of the Patient Experience	

Trust should review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support.	• Yearly staff appraisals. • Supported by the Professional Midwifery Advocates linked against the NMC requirements and standards. • Training and Education programmes in place. • Leadership programmes in place. • Opportunities for internal B6 development programme alongside opportunities to develop in to band 7 roles. • Ongoing education and development programmes for staff • Training needs matrix developed for different staff groups dependent on skills needs e.g. NLS for midwives supporting community births. • Quality improvement projects and opportunities available. • Each Baby Counts Secondee looking at escalation recent expansion of consultant obstetric anaesthetic cover until 8pm. • Junior medical workforce have a process in place to ensure no lost educational opportunities. • Maternity training covers all staff groups including Obs staff, anaesthetists, theatre staff and Neonatologists. • MDT training includes all grades of staff.	Drivers and reporting avenues as follows, • Improved patient safety and risk management. • Improved team working. • Improved learning and professional opportunities. • Improved recruitment and retention programme. • Improved collaborative working across the LMS. • Improved provision of workforce opportunities.	Effectiveness measures include, • Previous compliance with NHSR safety action. • Increase or maintenance of education and training compliance numbers. • Increased in wider service working across all sites and LMS. • Improved safety through the reporting of BirthRate Plus. • Improved safety through the reporting of Red Flags reporting.	Further actions required include, • Continued review of development opportunities. • Continued review of patient safety incidents. • Continued review of roles across the LMS or other secondments.	Director of Midwifery and Midwifery Operational Manager	None	Mitigation in the short term includes, • Continued monitoring of workforce requirements. • BirthRate Plus. • Staffing guidance in place. • Training and Education guideline in place.	

Trust should continue to prioritise the work commenced in response to the review of governance systems including clinical governance, so that the Board has adequate assurance of the quality of care provided by the Trust's services.	The UHS maternity service continually reviews and prioritise work and ensure there is regular reporting to Trust Board meetings. • The Trust Executive teams undertake walkabouts of the maternity service.	Drivers and reporting avenues as follows, • The regular review of clinical governance recommendations and standards. • Regular reporting within the maternity service and wider Trust and LMS.	Effectiveness measures include, • Improved reporting to Trust Board Committees on safety in maternity. • Previous compliance with NHSR Safety Actions. • Improved safety through the Maternity Safety Champions.	Further actions required include, • Continued reporting and assurance reviews.	Director of Midwifery and Maternity Quality Teams	Continued support from the wider UHS Trust in providing oversight and leadership.	Mitigation in the short term includes, • Ongoing reporting to Trust Board.	
Trust should ensure that middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality,	• Clinical leaders and senior management within the neonatal and maternity service are able to access appropriate leadership development in response to their designated roles and responsibilities. Mentorship and Coaching is also available across the Trust. • Maternity service has identified executive and non executive leads with oversight of the maternity service.	Drivers and reporting avenues as follows, • Reports to Trust Board Committees.	Effectiveness measures include, • Improved reporting to Trust Board Committees on safety in maternity. • Previous compliance with NHSR Safety Actions. • Improved safety through the Maternity Safety Champions.	Further actions required include, • Improved use of 'Coaching' within the maternity service.	Director of Midwifery and Midwifery Operational Manager	Continued support from the wider UHS Trust in providing oversight and leadership.	Mitigation in the short term includes,	

Improve the physical environment of the delivery suite including particularly access to operating theatres, an improved ability to observe and respond to all women in labour and en suite facilities; arrangements for post-operative care of women also need to be reviewed.	• Improvement of Estates in the labour ward environment undertaken, including new recovery room adjacent to operating theatres. • Improvements to maternity assessment Unit which is adjacent to labour ward. • There are plans in place to improve the environment for the MDAU and IOL rooms. • Prior to COVID Estates had undertaken walkabouts and reviewed the Estates.	Drivers and reporting avenues as follows, • Reports to Trust Board Committees to include findings regarding Estates.	Effectiveness measures include, • Improved safety for staff and patients. • Improved compliance with H&S requirements.	Further actions required include, • Once COVID improves to arrange Estates walkabouts.	Director of Midwifery and Trust Estates	Continued support from the wider UHS Trust in providing oversight and leadership.	Mitigation in the short term includes,	
Clear national standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels, including, but not limited to, clinical directors, clinical leads, heads of service, medical directors, nurse directors.	N/A for UHS Maternity Service.	Drivers and reporting avenues as follows, • The UHS maternity service undertakes regular review of national guidance and ensure there is leadership and ownership of recommendations and standards.	Effectiveness measures include, • The UHS maternity service undertakes regular reporting to the Trust Clinical effectiveness team to provide assurance.	None	Locally - Midwifery Quality Team	Continued support from the wider UHS Trust in providing oversight and leadership.	N/A	
Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, including executive directors, middle managers and nonexecutives.	N/A for UHS Maternity Service.	Drivers and reporting avenues as follows, • The UHS maternity service undertakes regular reporting to the Trust Executive leads on national guidance to provide assurance.	Effectiveness measures include, • The UHS maternity service undertakes regular reporting to the Trust Executive to provide assurance.	None	Locally - Midwifery Quality Team	None.	N/A	

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Register of Seals and Chair's Actions**			
Agenda item:	**6.2**			
Sponsor:	**Peter Hollins, Trust Chair**			
Date:	**28 January 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 Scheme of Delegation for ratification.			
Response to the issue:	The Board has agreed that the Chair may undertake some actions on its behalf. There have been no Chair's actions since the last report.			
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 Reservation and 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.			

1 Signing and Sealing

1.1 **Parental Guarantee** between University Hospital Southampton NHS Foundation Trust (Guarantor) and Siemens Financial Services Limited relating to the purchase of a LINAC machine via lease through UHS Estates Limited (UEL). Seal number 218 on 8 January 2021.

2 Chair's Actions

There have been no Chair's Actions since the last report.

3 Recommendation

The Board is asked to **ratify** the application of the Seal.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Trust Board Committee Terms of Reference**			
Agenda item:	**6.3**			
Sponsor:	**Peter Hollins, Trust Chair**			
Author:	**Karen Flaherty, Associate Director of Corporate Affairs and Company Secretary**			
Date:	**28 January 2021**			
Purpose	**Assurance or reassurance**	**Approval** **X**	**Ratification**	**Information**
Issue to be addressed:	The terms of reference for all Board committees should be reviewed regularly, and at least once annually, to ensure that these reflect the purpose and activities of each committee. The terms of reference of the Audit and Risk Committee and the Quality Committee have been reviewed by each committee.			
Response to the issue:	As well as changes to the formatting and structure of the terms of reference to fit in with the style of other Trust documentation, particularly as it is intended to publish these terms of reference on the UHS website, changes have been made to: • fully reflect the principles agreed around the Board committee structures agreed by the Board in November 2019; • update the membership and/or attendees; and • remove duplication and slight inconsistencies within the terms of reference.			
Implications: (Clinical, Organisational, Governance, Legal?)	The terms of reference ensure that the purpose and activities of the Audit and Risk Committee and Quality Committee are clear and support transparency and accountability in the performance of its role and, in the case of the Audit and Risk Committee, comply with the National Health Service Act 2006 and The NHS Foundation Trust Code of Governance.			
Risks: (Top 3) of carrying out the change / or not:	1. Non-compliance with the National Health Service Act 2006, The NHS Foundation Trust Code of Governance and the Trust's constitution relating to the composition of Board committees. 2. Non-compliance with the Trust's standing financial instructions and policies relating to the specific responsibilities of the Audit and Risk Committee. 3. The Board and each 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 Audit and Risk Committee and the Quality Committee, as applicable, are recommended for approval.			

University Hospital Southampton NHS
NHS Foundation Trust

Audit and Risk Committee Terms of Reference

Version: 3

Date Issued:	28 January 2021
Review Date:	January 2022
Document Type:	Committee Terms of Reference

Contents Paragraph		Page

Appendices		Page

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 Audit and Risk Committee (the **Committee**) is responsible for overseeing, monitoring and reviewing corporate reporting, the adequacy and effectiveness of the governance, risk management and internal control framework and systems and areas of legal and regulatory compliance at University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**) and the external and internal audit functions.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities both generally and in support of the annual governance statement.

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 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 will primarily utilise the work of internal audit, external audit and other assurance functions. It is also 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 independent non-executive directors of the Trust (other than the chair of the Board). The Committee will consist of not less than three members, at least one of whom will have recent and relevant financial experience, ideally with a qualification from one of the professional accountancy bodies.

3.2 The Board will appoint the chair of the Committee from among its members (the **Committee Chair**). The Committee Chair will not be the senior independent director or deputy chair of the Board. 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. However, the following will be invited to attend meetings of the Committee on a regular basis:

3.3.1 representative(s) from the external auditor;

3.3.2 representative(s) from the internal auditor;

3.3.3 representative(s) from the local counter fraud service;

3.3.4 Chief Financial Officer;

3.3.5 Chief Nursing Officer; and

3.3.6 Associate Director of Corporate Affairs/Company Secretary.

3.4 The Chief Executive will be invited to attend meetings of the Committee, at least annually, to discuss with the Committee the process for assurance that supports the annual governance statement.

3.5 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.

3.6 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 Company Secretary in advance.

4.2 The quorum for a meeting will be two 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 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.

5.2 At least once each financial year the Committee will meet with representatives of the external and internal auditors without management being present to discuss their remit and any issues arising from their audits.

5.3 Outside of the formal meeting programme, the Committee Chair will maintain a dialogue with key individuals involved in the Trust's governance, including the chair of the Board, the Chief Executive, the Chief Financial Officer, the Chief Nursing Officer, the external audit lead partner and the head of internal audit.

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, or at the request of external or internal auditors if they consider it necessary.

6.2 The agenda of items to be discussed at the meeting will be agreed by the Committee Chair with support from the Chief Financial Officer and the Company Secretary. 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 ***Integrated Governance, Risk Management and Internal Control***

7.1.1 The Committee will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (clinical and non-clinical), that supports the achievement of the Trust's objectives. In particular, the Committee will review the adequacy and effectiveness of:

7.1.1.1 all risk and control related disclosure statements (in particular the annual governance statement), together with the head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board;

7.1.1.2 the underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of annual disclosure statements; and

7.1.1.3 the policies and arrangements for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reviews, reporting and self-certifications, including the NHS Constitution, the Trust's NHS provider licence, registration with the Care Quality Commission and the Trust's constitution, standing orders and standing financial instructions and management of conflicts of interest.

7.2 ***Internal Audit***

7.2.1 The Committee will ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Accounting Officer and Board. This will be achieved by:

7.2.1.1 considering the provision of the internal audit service and the costs involved;

7.2.1.2 reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in any risk assessment;

7.2.1.3 considering the major findings of internal audit work (and the appropriateness and implementation of management responses) and ensuring coordination between the internal and external auditors to optimise audit resources;

7.2.1.4 ensuring the internal audit function is adequately resourced and has appropriate standing within the Trust; and

7.2.1.5 monitoring the effectiveness of internal audit and carrying out an annual review.

7.3 ***External Audit***

7.3.1 The Committee will review and monitor the external auditors' integrity, independence and objectivity and the effectiveness of the external audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's response to their work. This will be achieved by:

7.3.1.1 considering the appointment and performance of the external auditors, including providing information and recommendations to the council of governors in connection with the appointment, reappointment and removal of the external auditors in line with criteria agreed by the council of governors and the Committee;

7.3.1.2 discussing and agreeing with the external auditors, before the external audit commences, the nature and scope of the audit as set out in the annual external audit plan;

7.3.1.3 discussing with the external auditors their evaluation of audit risks and assessment of the Trust and the impact on the audit fee;

7.3.1.4 reviewing all external audit reports, including reports addressed to the Board and the council of governors, and any work undertaken outside the annual external audit plan, together with any significant findings and the appropriateness and implementation of management responses; and

7.3.1.5 ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services taking into account relevant ethical guidance.

7.4 ***Financial Reporting***

7.4.1 The Committee will monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

7.4.2 The Committee will ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board.

7.4.3 The Committee will review the annual report and financial statements before these are presented to the Board in order to determine their completeness, objectivity, integrity and accuracy and the letter of representation addressed to the external auditors from the Board. This review will cover but is not limited to:

7.4.3.1 the annual governance statement and other disclosures relevant to the work of the Committee;

7.4.3.2 areas where judgment has been exercised;

7.4.3.3 appropriateness and adherence to accounting policies and practices;

7.4.3.4 explanation of estimates or provisions having material effect and significant variances;

7.4.3.5 the schedule of losses and special payments, which will also be reported on separately during the financial year;

7.4.3.6 any significant adjustments resulting from the audit and unadjusted audit differences; and

7.4.3.7 any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

7.5 ***Counter Fraud***

7.5.1 The Committee will review the effectiveness of arrangements in place for counter fraud, anti-bribery and corruption to ensure that these meet the NHS Counter Fraud Authority's standards and the outcomes of work in these areas, including reports and updates on the investigation of cases from the local counter fraud service.

7.6 ***Raising Concerns/Freedom to Speak Up***

7.6.1 The Committee will review the effectiveness of the arrangements in place for allowing staff and contractors to raise (in confidence) concerns and possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently with appropriate follow-up action and safeguards in place for those who raise concerns.

7.6.2 The Committee will ensure that the Trust's policy reflects the minimum standards for raising concerns set out by NHS Improvement and that the arrangements in place are regularly audited.

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 The Committee will report to the Board at least annually on its work in support of the annual governance statement, specifically commenting on:

8.2.1 the fitness for purpose of the board assurance framework;

8.2.2 the completeness and maturity of risk management in the Trust;

8.2.3 the integration of governance arrangements;

8.2.4 the appropriateness of the self-assessment of the effectiveness of the system of internal control and the disclosure of any significant internal control issues in the annual governance statement.

8.3 The Trust's annual report will include a section describing the work of the Committee in discharging its responsibilities including:

8.3.1 the significant issues that the Committee considered in relation to financial statements, operations and compliance, and how these issues were addressed;

8.3.2 an explanation of how the Committee has assessed the effectiveness of the external audit process and the approach taken to the appointment or reappointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and

8.3.3 if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.

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 in consultation with the council of governors.

10. References

10.1 National Health Service Act 2006

10.2 NHS Foundation Trust Code of Governance

10.3 NHS Foundation Trust Annual Reporting Manual

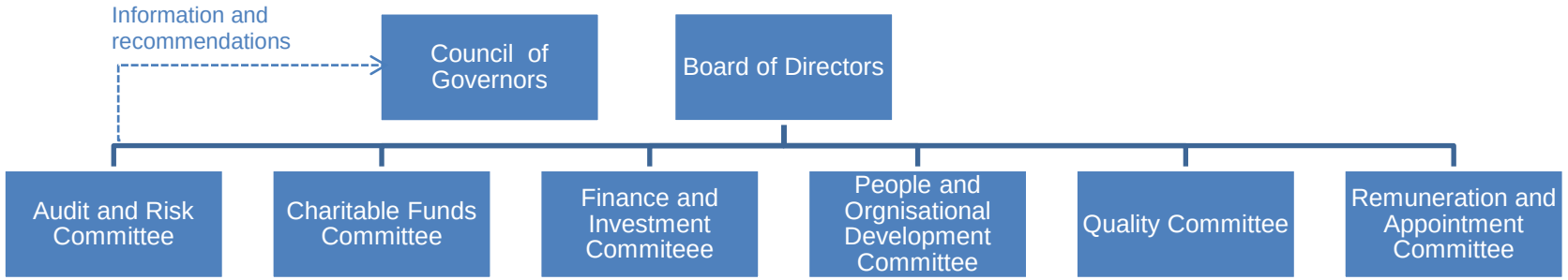
10.4 National Audit Office Code of Audit Practice

10.5 Public Sector Internal Audit Standards

10.6 NHS Counter Fraud Authority's counter fraud standards

10.7 NHS Improvement guidance on Freedom to Speak Up

Appendix A


Information and recommendations
Council of Governors
Board of Directors
Audit and Risk Committee
Charitable Funds Committee
Finance and Investment Commiteee
People and Orgnisational Development Committee
Quality Committee
Remuneration and Appointment Committee

Document Monitoring Information	
Approval Committee:	Board of Directors
Date of Approval:	28 January 2021
Responsible Committee:	Audit and Risk Committee
Monitoring (Section 9) for Completion and Presentation to Approval Committee:	January 2022
Target audience:	Board of Directors, Audit and Risk Committee, NHS Regulators, Staff and Public
Key words:	Audit, Risk, Committee, Board, Terms of Reference
Main areas affected:	Trust-wide
Summary of most recent changes if applicable:	Reformatting, attendees
Consultation:	Council of Governors, Internal Audit, External Audit, Counter Fraud
Number of pages:	8
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
NHS Foundation Trust

Quality Committee Terms of Reference

Version: 2

Date Issued:	28 January 2021
Review Date:	November 2021
Document Type:	Committee Terms of Reference

Contents Paragraph		Page

Appendices		Page

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 Quality Committee (the **Committee**) is responsible for overseeing, monitoring and reviewing the adequacy and effectiveness of all aspects of the clinical governance arrangements of University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**), including the governance, risk management and internal control framework and systems supporting the delivery of safe, high quality, patient-centred care.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of assurance regarding the adequacy and effectiveness of all aspects of clinical governance with a particular focus on quality: patient safety, patient experience and outcomes.

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 the 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 three independent non-executive directors of the Trust, at least one of whom will have a clinical background;

3.1.2 the Chief Nursing Officer;

3.1.3 the Chief Medical Officer; and

3.1.4 the Chief Operating 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 other non-executive directors to chair the meeting.

3.3 To ensure that non-executive directors hold the majority of votes on the Committee, only two of the executive director members of the Committee shall be invited to vote on any matter. The Committee Chair will have a second and casting vote in the event of a tie.

3.4 Subject to paragraph 3.3 above, 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:

3.4.1 Deputy Director of Nursing (Quality);

3.4.2 Medical Director; and

3.4.3 patient representative.

3.5 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.

3.6 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 of the Committee in advance.

4.2 The quorum for a meeting will be three members, including two non-executive directors and either the Chief Nursing Officer or the Chief Medical Officer. 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 eight times each year (at regular intervals throughout the 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 Chief Nursing Officer and the Chief Medical Officer. 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 ***Patient Safety***

7.1.1 The Committee will review the aggregated analysis of adverse events (including serious incidents requiring investigation (SIRIs) and never events), complaints, claims and inquests to identify common themes and trends and gain assurance that appropriate actions are being taken to mitigate risk and reduce harm.

7.1.2 The Committee will seek assurance on the Trust's safeguarding systems.

7.1.3 The Committee will receive assurance from internal audit on quality and safety reviews.

7.2 ***Patient Experience***

7.2.1 The Committee will consider reports from the Patient Experience team, the Complaints team, the Patient Advice and Liaison Service and other sources of feedback (including Healthwatch) on all formal and informal patient feedback, both positive and negative, and consider action in respect of matters of concern.

7.2.2 The Committee will consider the results, issues raised and trends in all patient surveys and any patient impacting surveys of the Trust's estate, such as Patient-Led Assessments of the Care Environment (PLACE) that may impact on clinical quality and to seek assurance on the development and implementation of improvement plans.

7.3 ***Patient Outcomes***

7.3.1 The Committee will review the annual clinical audit programme and recommend its approval to the Board, and monitor its delivery.

7.3.2 The Committee will receive details of all national clinical audits where the Trust is identified as an outlier or potential outlier. This will include, but is not limited to, mortality outlier alerts.

7.4 ***Quality Improvement***

7.4.1 The Committee will make recommendations to the Board on the determination of quality priorities annually and monitor progress against these priorities.

7.4.2 The Committee will promote safety and excellence in patient care and monitor the implementation and delivery of the Always Improving Strategy and quality improvement activity.

7.5 ***Performance Monitoring***

7.5.1 The Committee will advise the Board on the appropriate quality and safety indicators and benchmarks for inclusion in the Trust's key performance indicators and supporting data quality for these measures.

7.5.2 The Committee will support the ongoing monitoring of ward quality and safety dashboards, to provide assurance from ward to Board.

7.5.3 The Committee will regularly review operational performance where there is ongoing non-compliance with referral and waiting time standards set out in the NHS Constitution or the NHS Oversight Framework.

7.5.4 The Committee will seek assurance that improvement targets are supported by achievable action plans and support the implementation of the Trust's Clinical Strategy.

7.5.5 The Committee will monitor progress in implementing action plans to address shortcomings in the quality of services, where identified.

7.6 ***Risk***

7.6.1 The Committee will ensure that risks to patients are minimised through the application of comprehensive clinical risk management systems.

7.6.2 The Committee will monitor risks identified in the Trust's Board Assurance Framework that have been allocated for oversight by the Committee.

7.6.3 The Committee will triangulate patient safety, quality and clinical risk issues with operational, financial and workforce performance, addressing areas of concern or deteriorating performance as required.

7.6.4 The Committee will commission and oversee assurance deep dives into specific identified risks at the request of either the Committee Chair or the chair of the Board.

7.7 ***Reporting***

7.7.1 The Committee will review the Trust's quality accounts/quality report and any other key non-financial governance submissions to national bodies before these are presented to the Board for approval.

7.7.2 The Committee will receive all reports about the Trust produced by the Care Quality Commission (the **CQC**) and seek assurance on the processes in place to ensure compliance with CQC fundamental standards and the actions being taken to address any recommendations and other issues identified by the CQC.

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 The Committee will report to the Audit and Risk Committee at least annually on its work in support of the annual governance statement, specifically commenting on the quality accounts/quality report and the appropriateness of the self-assessment of the effectiveness of the system of internal control and the disclosure of any significant internal control issues in the annual governance statement.

8.3 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 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and related guidance from the Care Quality Commission

10.3 Care Quality Commission (Registration) Regulations 2009 and related guidance from the Care Quality Commission

10.4 Health Act 2009

10.5 National Health Service (Quality Accounts) Regulations 2010

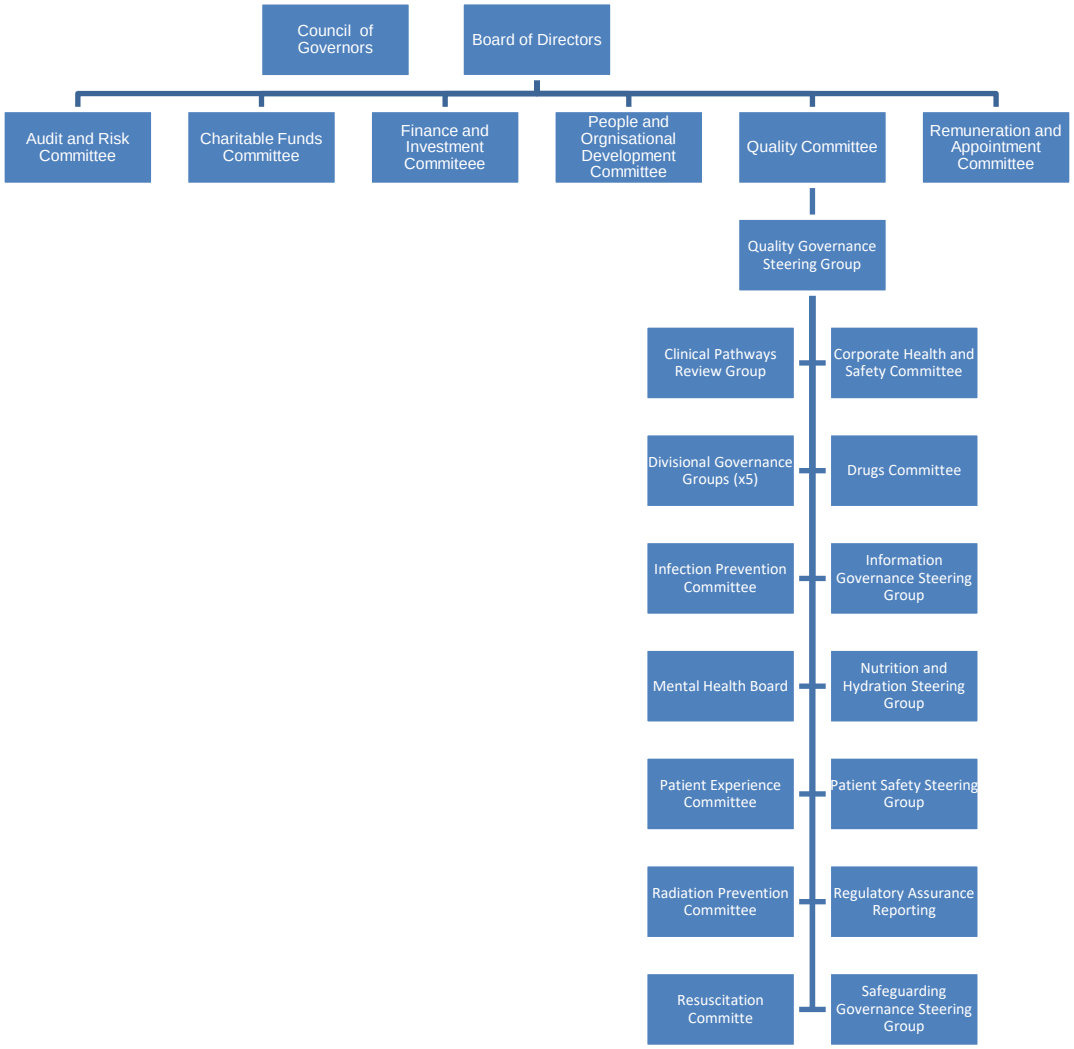
10.6 NHS Foundation Trust Code of Governance

10.7 NHS Oversight Framework

10.8 NHS Foundation Trust Annual Reporting Manual

10.9 NHS Improvement's requirements for quality accounts

Appendix A


Council of Governors
Board of Directors
Audit and Risk Committee
Charitable Funds Committee
Finance and Investment Commiteee
People and Orgnisational Development Committee
Quality Committee
Remuneration and Appointment Committee
Quality Governance Steering Group
Clinical Pathways Review Group
Corporate Health and Safety Committee
Divisional Governance Groups (x5)
Drugs Committee
Infection Prevention Committee
Information Governance Steering Group
Mental Health Board
Nutrition and Hydration Steering Group
Patient Experience Committee
Patient Safety Steering Group
Radiation Prevention Committee
Regulatory Assurance Reporting
Resuscitation Committe
Safeguarding Governance Steering Group

Document Monitoring Information	
Approval Committee:	Board of Directors
Date of Approval:	28 January 2021
Responsible Committee:	Quality Committee
Monitoring (Section 9) for Completion and Presentation to Approval Committee:	November 2021
Target audience:	Board of Directors, Quality Committee, NHS Regulators, Staff
Key words:	Quality, Governance, Committee, Board, Terms of Reference
Main areas affected:	Trust-wide
Summary of most recent changes if applicable:	Reformatting, members and attendees, presentation of Committee role and duties and responsibilities
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