University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	29/07/2021
Time	9:00 - 12:15
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** The patient or staff story provides an opportunity for the Board to reflect on the experiences of patients and staff within the Trust and understand what the Trust could do better.
3		**Minutes of Previous Meeting held on 27 May 2021**
4		**Matters Arising and Summary of Agreed Actions** To discuss any matters arising from the minutes, and to agree on the status of any actions assigned at the previous meeting.
5		**QUALITY, PERFORMANCE and FINANCE** Quality includes: clinical effectiveness, patient safety, and patient experience
5.1	9:15	**Briefing from the Chair of the Audit and Risk Committee (Oral)** Keith Evans, Chair
5.2	9:20	**Briefing from the Chair of the Finance and Investment Committee (Oral)** Jane Bailey, Chair
5.3	9:25	**Briefing from the Chair of the Quality Committee (Oral)** Tim Peachey, Chair
5.4	9:30	**Chief Executive Officer's Update and Executive Briefing (Oral)** Sponsor: David French, Chief Executive Officer
5.5	9:50	**Safeguarding Annual Report 2020/21 and Strategy 2021/22** Sponsor: Gail Byrne, Chief Nursing Officer Attendees: Juliet Pearce, Deputy Chief Nursing Officer/Debbie McGregor, Named Nurse for Safeguarding Adults/Karen McGarthy, Named Nurse for Safeguarding Children
5.6	10:05	**Complaints Annual Report 2020-21** Sponsor: Gail Byrne, Chief Nursing Officer Attendee: Ellis Banfield, Head of Experience and Involvement

5.7 **Medical Appraisal and Revalidation Annual Report including Board Statement of Compliance**
10:15
Sponsor: Paul Grundy, Chief Medical Officer

5.8 **Integrated Performance Report for Month 3**
10:25
To review the Trust's performance as reported in the Integrated Performance Report, including a spotlight on a particular area of performance.
Sponsor: David French, Chief Executive Officer

5.9 **Finance Report for Month 3**
11:10
Sponsor: Ian Howard, Interim Chief Financial Officer

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

6.1 **Feedback from the Council of Governors' (CoG) meeting on 21 July 2021 (Oral)**
11:20
Sponsor: Peter Hollins, Trust Chair

6.2 **Register of Seals and Chair's Actions for ratification**
11:30
In compliance with the Trust Standing Orders, Financial Instructions, and the Scheme of Reservation and Delegation.
Sponsor: Peter Hollins, Trust Chair

6.3 **Quality Committee Terms of Reference**
11:35
Sponsor: Peter Hollins, Trust Chair
Attendee: Karen Flaherty, Associate Director of Corporate Affairs and Company Secretary

6.4 **Trust Executive Committee Terms of Reference**
11:40
Sponsor: David French, Chief Executive Officer
Attendee: Karen Flaherty, Associate Director of Corporate Affairs and Company Secretary

7 **Any other business**
11:45
To raise any relevant or urgent matters that are not on the agenda

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

9 **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.

10 **Follow-up discussion with governors**
12:00

University Hospital Southampton
NHS Foundation Trust

Minutes Trust Board – Open Session

Date	27/05/2021
Time	9:00 - 12:15
Location	Microsoft Teams
Chair	Peter Hollins (PH), Trust Chair
Present	Dave Bennett (DB), Non-Executive Director (**NED**) Gail Byrne (GB), Chief Nursing Officer Cyrus Cooper (CC), NED Keith Evans (KE), NED David French (DAF), Chief Executive Officer Paul Grundy (PG), Chief Medical Officer Steve Harris (SH), Chief People Officer Jane Harwood (JH), NED (until item 5.10) Ian Howard (IH), Interim Chief Financial Officer Tim Peachey (TP), NED and Senior Independent Director/Deputy Chair Joe Teape (JT), Chief Operating Officer
In attendance	Karen Flaherty (KF), Associate Director or Corporate Affairs and Company Secretary Gemma Genco (GG), Head of Equality, Diversity & Inclusivity (for item 5.6) Christine Mbabazi (CM), Equality & Inclusion Adviser/Freedom to Speak Up Guardian (for item 5.8) Rebecca McKay (RMcK), Chief Operating Officer, CRN Wessex (for item 6.2) Clare Rook (CR), Deputy COO, CRN Wessex (for item 6.2) 2 governors (observing) 2 members of staff (observing) 1 member of staff (for item 2)

1 Chair's Welcome, Apologies and Declarations of Interest

The Chairman welcomed all those attending to the meeting.

2 Staff Story

Ellen Eyers, a healthcare support assistant in elderly care, who was in the second year of a nurse degree apprenticeship joined the meeting. The nurse degree apprenticeship had been a positive experience – interesting and exciting but also overwhelming at times. It had been good to combine her existing understanding and practical experience of working in a hospital with the theoretical aspect of the degree. However, balancing study and work could be challenging at times.

The Trust and Solent University had worked well together to make the transitions for nurse apprentices run smoothly although sometimes placements could have been identified and notified to students earlier in the process. Some areas had not had a nurse apprenticeship student in their team before and it would be helpful if teams could be better prepared for their first student. E-rostering could also be more complicated for students.

Ellen was also the student voice representative for her nurse degree

apprenticeship cohort and the feedback from other students was positive and students were very optimistic about their future careers. There were large numbers of healthcare assistants who were interested in applying for the nurse degree apprenticeship and this was an excellent way to develop healthcare assistants. The reach of the scheme could potentially be increased further by promoting a greater understanding of the role.

Action: SH would ask the e-rostering team to contact Ellen to get her feedback directly to see if the issues that students had experienced could be resolved.

The Board thanked Ellen for sharing her story and enthusiasm and being such a great ambassador for the nurse degree apprenticeship. While the decision for the Trust to start the nurse degree apprenticeship had been significant due to the costs involved and the length of time for nurses to graduate from the programme, it had delivered an experienced and incredibly loyal cohort of nurses working at the Trust.

3 Minutes of Previous Meeting held on 30 March 2021

The minutes of the meeting held on 30 March 2021 were approved as an accurate record of that meeting.

4 Matters Arising and Summary of Agreed Actions

The updates on the actions were noted. The actions for the Quality Committee (reference 426 and 427) could be closed as the Quality Committee would continue to provide updates on progress in its regular reports to the Board. The action relating to the register of seals and chair's actions (reference 430) had been completed and could also be closed.

The operational dashboard presented to the Finance and Investment Committee was being updated to reflect trajectories for the numbers of patients medically optimised for discharge in the hospitals (reference 428). An update would be provided in the report to the Board in July 2021.

5 QUALITY, PERFORMANCE and FINANCE

5.1 Briefing from the Chair of the Charitable Funds Committee

DB noted that changes to the terms of reference for the Charitable Funds Committee and a new charitable grants policy were included on the agenda for approval later in the meeting, which would establish a framework for the Southampton Hospital Charity to make grants to external organisations from the proceeds of the sale of Banksy's Game Changer artwork. The future spending plans for the charity would be considered at the Board meeting in July.

5.2 Briefing from the Chair of the Finance and Investment Committee

DB updated the Board on the meeting of the Finance and Investment Committee that had taken place earlier that week. The following matters had been discussed:

- achievement of a £0.1 million surplus in the first month of the financial year, with the Trust remaining on track to achieve a planned breakeven position for the first half of 2021/22;
- balancing the recovery of elective activity with the need to allow staff time to recover and overall staff wellbeing;
- the reduction in non-face-to-face outpatient appointments to around

33% due to a drop in the number of telephone appointments;
- the IT investment programme for 2021/22, ahead of finalising the long-term IT strategy and the risks linked to funding planned and anticipated projects;
- an update from UHS Pharmacy Limited, including the good progress of transformation plans and options for responding to a very rapid increase in prescriptions;
- the progress of current estates developments with some minor issues identified; and
- developing operational reporting to support financial decision-making, particularly relating to long-term capital requirements.

5.3 Briefing from the Chair of the Quality Committee

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

- the position regarding the maternity service's compliance with NHS Resolution's maternity incentive scheme prior to the review and submission of a declaration by the Board at its meeting in June 2021, including the agreed plans to meet the required standards for data submission and the neonatal nursing workforce;
- the review of the Trust's quality report for 2020/21, covering the Trust's progress and achievements, which will be included as part of the annual report and accounts;
- the quarterly patient experience report including the further work to fully understand the reasons for the number of negative comments from the Friends and Family Test for maternity services, which were centred around post-natal care and were likely to be related to access to family during the COVID-19 pandemic;
- a report from the end of life care team, including the increase in the number of patients on an end of life care pathway during the COVID-19 pandemic, improving the quality of end of life care across all divisions and developing ways to receive real-time feedback from families;
- pilots to improve the rehabilitation of patients following critical illness to address a gap in care for patients who had been seriously ill following the excellent care delivered in intensive care; and
- the annual claims report, which identified that the Trust had fewer claims than comparable trusts and provided insight into the reasons for claims including information and managing patients' expectations and work to share the learning from claims.

The Board discussed reinstating the 'listening' lunches with patients and bereaved families when this was possible.

5.4 Chief Executive Officer's Update

The Trust was incredibly busy with the highest numbers of patients ever seen in the emergency department on 17 and 24 May 2021. Elective activity levels had also recovered well and were above the national target that had been set and the Trust continued to strive to maintain the balance between the support for and wellbeing of staff against the needs of the patients waiting to be seen.

While there had been several days when there had not been any patients in the hospitals who had tested positive for COVID-19, there were now a number of patients with COVID-19 being treated in the Trust. This demonstrated the continuing importance of the Trust's COVID ZERO campaign in reducing

nosocomial outbreaks given the transmissibility of the new Delta variant.

The new strategy document, presented in draft to the council of governors at its meeting in March 2021, was due to be circulated to staff later that day. The strategy had been supported by the senior leadership team who had met at the end of the previous week ahead of the launch of the strategy.

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

- the impact of the COVID ZERO campaign on nosocomial transmission, which had reduced from 15% in the first wave to 10% in the second wave in January 2021 despite the prevalence of the more transmissible Alpha variant at the time, and the need to remain vigilant about infection control practice as restrictions were relaxed more widely;
- the national rollout of the High Volume Low Complexity (HVLC) programme led by Professor Tim Briggs to support the recovery of elective activity focussing on six areas (ophthalmology, trauma and orthopaedics including spinal surgery, ENT, urology, general surgery and gynaecology) and incorporating 29 optimal pathways to deliver transformative care, in most instances as day cases;
- improving communication with patients on waiting lists including signposting to information and more regular updates;
- the concurrence of annual reporting for 2020/21, financial planning for the remainder of 2021/22 and budget-setting including the cost improvement programme for 2021/22;
- the negotiation of the capital departmental expenditure limit (**CDEL**) for the Hampshire and Isle of Wight integrated care system (**ICS**);
- the continuation of the range of support mechanisms for staff wellbeing and the use of the staff pulse survey to seek staff views on wellbeing and the interventions available as well as the use of charitable funds from the donation of the Banksy artwork to support staff;
- contacting staff individually who had not yet received the second dose of the vaccine to identify whether they had received this elsewhere;
- the vaccination hub remained open and was helping the with community vaccination as a regional allergy centre;
- the work to develop the long-term solution for staff homeworking as staff who could work from home continued to be encouraged to do so;
- the development of recovery plans to address the waiting lists utilising funds from the accelerator fund and elective recovery fund (**ERF**); and
- performance meetings with partners to focus on elective plans, which non-executive directors were invited to attend.

5.5 Integrated Performance Report for Month 1

The integrated performance report (**IPR**) for month 1 was noted. The Board discussed the following areas:

<u>Responsive</u>

- the Wessex Cancer Alliance was the best in England across a range of indicators for cancer performance and the Trust had played a key role in that achievement as the regional surgical hub;
- the use of elective recovery funding to target additional activity for those patients who had been waiting longest alongside clinical prioritisation of patients and ensuring that a plan was in place for those patients;
- performance in ED had deteriorated slightly compared to the previous

month as attendance levels increased, however, performance had improved compared to two years ago and 87% of patients were currently seen within four hours compared to 74% of patients two years previously;
- an eight week pilot relating to ambulance diverts had commenced with Portsmouth Hospitals University NHS Trust and Hampshire Hospitals NHS Foundation Trust to establish a clearer process for escalation and batch diverts, recognising that patients may be conveyed to a hospital further from home, which could, in turn, lead to delays in discharging patients;

Effective
- the slight increase in the Hospital Standardised Mortality Ratio (**HSMR**) due to an increase in respiratory infections among elderly patients, which appeared to be COVID-19 related;
- the Trust's HSMR was much better than average; and

Action: PG would investigate the reasons for the divergence in the HSMR for the Trust and Southampton General Hospital.

Well-led
- the slight increase in staff turnover, which had been reducing, although there was nothing in the staff exit surveys giving cause for concern.

The Board also discussed how the indicators in the IPR would be impacted by the recovery plans, in particular the numbers of patients on waiting lists, and the impact that the additional funding would have on capacity and improvements. This was being developed at the request of the Finance and Investment Committee.

5.6 Equality and Diversity Update (WRES and WDES)

Gemma Genco joined the meeting for this item.

The Board noted the report including:
- the pace of progress in becoming a more inclusive employer;
- the renewed and visible commitment from senior leaders to equality, diversity and inclusion;
- the success of the staff networks;
- the work still to do to improve things for all staff groups;
- the need to continue to deliver the action plans co-produced with the staff networks; and
- broadening the focus on inclusion to encompass a wider range of equality groups including gender and to include health inequalities.

Action: The RAG rating for the percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues should be red rather than green in relation to the NHS acute trust average.

The Board discussed the reasons why BAME (Black and Minority Ethnic) staff in senior positions did not go on to senior leadership roles. Focus groups with BAME and female medical staff indicated that this may be due to there not being a natural career path into these roles and a lack of understanding about the roles. There were also cultural issues around the prestige associated with certain roles as well as constraints relating to financial commitments. The work

was continuing to understand the underlying complexities and to make senior leadership roles more accessible and better prepare people for those roles.

The percentage of staff experiencing harassment, bullying and abuse from colleagues was surprisingly high, albeit better than the NHS acute trust average. There was work continuing to understand the experience of staff and the root causes for the disproportionality of the experience of BAME and disabled staff. The appraisal process was an important part of this as a way of providing feedback with an opportunity for staff to respond.

Action: It was agreed to provide data on harassment, bullying and abuse of staff from outside the NHS to better understand how this compared to other organisations.

A new director of organisational development and inclusion had been appointed, Ceri Connor, who had previously worked as the assistant director of people at Solent NHS Trust.

5.7 Gender Pay Gap Reporting 2020

The Board noted the report on the gender pay gap and the overall gender pay gap of 24.76%, which had reduced from 26.57% in 2020.

The Board discussed how the Trust could attract, develop and retain female medical staff given the largest pay gap was in this group of staff. The Board also considered the impact of the clinical excellence awards (**CEA**) on the gender pay gap and how the process was monitored for fairness and female applicants were supported and encouraged to apply based on evidence that women found it more difficult to apply. It was hoped that the review of the CEA scheme would provide greater focus on effectiveness as the current scheme was perceived as requiring applicants to work more hours, making it more difficult for female staff, who may have caring responsibilities, to succeed.

Action: DF would establish a group to review the local CEA scheme.

IH was reviewing recruitment practices to senior finance positions, where female and BAME staff were underrepresented, to ensure that the roles were presented in a way that would appeal to a more diverse range of applicants.

5.8 Freedom to Speak Up Report

Christine Mbabazi joined the meeting for this item.

The Board noted the report, in particular the key findings of the survey of 600 Freedom to Speak Up (**FTSU**) guardians nationally and the recommendations from the National Guardian's Office. The Trust benchmarked well against the recommendations, however, there was work that could be done to understand whether individuals who spoke up felt they had experienced any detriment.

The Board commended CM on the work to resolve issues raised with her and support the culture of speaking up by doing this effectively, particularly given the complexity of some of the concerns raised. This included issues of bullying and harassment and was one way in which the Trust could address these experiences for staff. CM continued to work with the FTSU champions to encourage staff to feel confident about speaking up and to improve understanding of the confidential nature of the process.

CM described the work of the raising concerns committee, which included GB and SH as members and reviewed cases by area and for themes in order to understand trends and take preventative action.

5.9 Finance Report for Month 1

The finance report for month 1 was noted. The following areas were highlighted:

- the Trust and the ICS had each submitted a breakeven plan for the first half of 2021/22, although the Isle of Wight and Solent NHS Trusts had submitted individual deficit plans;
- the Trust had delivered a breakeven position in month 1 as planned;
- activity levels had reached 97% of pre-Coved levels of activity resulting in an estimated £5 million from the ERF;
- the Trust's CDEL position has been finalised at £50m as anticipated and spending was on track in month 1;
- the funding of the hospital discharge programme for commissioners for the first half of 2021/22 had not been confirmed and the ICS had been one of the greatest users of the programme in 2020/21; and
- a system finance report was being developed that would show where there were surpluses and deficits across the ICS.

6 STRATEGY and BUSINESS PLANNING

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

Rebecca McKay and Clare Rook from CRN Wessex joined the meeting for this item. The Trust hosted CRN Wessex and it played an important role in research and development activity at the Trust. As host, the Trust distributed the funding received by CRN Wessex to other trusts involved in research activity and provided the reporting function. This was separate from the Trust's own research activity, although it was one of the recipients of funding through CRN Wessex.

The report provided an overview of the urgent public health (**UPH**) research including COVID-19 vaccine trials, the managed recovery of non-UPH studies and the delivery of commercial research activity in 2020/21. Although 2020/21 had been very different to what had been planned, it had been a very successful year. More participants than ever had been recruited to a smaller number of studies than normal and new ways of working had been developed. Ten UPH studies had been led out of CRN Wessex. £1 million of additional fund had been received for the development of vaccine hub across Bournemouth, Southampton and Portsmouth.

The report also summarised the financial plan for 2021/22. Funding of £19.7 million had been received, an increase of £800,000 on previous years. The National Institute for Health Research had set four priorities for the year and this had been developed into a local programme of work supporting these priorities. These priorities included working more closely with primary care to build capacity and links for research and developing a team to deliver more research outside hospital settings.

The Board noted the report.

7 CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

7.1 Register of Seals and Chair's Actions

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

7.2 Emergency Planning and Business Continuity Annual Report 2020/21

The Board reviewed the Emergency Planning and Business Continuity Annual Report for 2020/21 noting that the Trust had not conducted a live exercise in 2020/21 but had been managing the COVID-19 pandemic as an incident as part of the NHS national response. This had included additional input from infection prevention and clinical leads. The Board discussed the planned exercises in the emergency department given current levels of activity.

Decision: The Board approved the Emergency Planning and Business Continuity Annual Report for 2020/21.

7.3 Charitable Funds Committee Terms of Reference

The Board reviewed the terms of reference for the Charitable Funds Committee (**CFC**), which had been amended to reflect the introduction of the grants policy to be approved by the Board later in the meeting. The proposed changes had been reviewed and approved by the CFC.

Decision: The Board approved the amendments to the terms of reference for the Charitable Funds Committee.

7.4 Trust Executive Committee Terms of Reference

The Board reviewed the amendments to the terms of reference for the Trust Executive Committee (**TEC**) to reflect changes in the membership and the committees and groups reporting to the TEC. The proposed amendments had been reviewed and approved by the TEC. The Board discussed potential changes to the membership and quorum given the size of the group. The TEC was working well, and the Trust had moved to a smaller group for a period, which had not functioned as effectively.

Decision: The Board approved the amendments to the terms of reference for the Trust Executive Committee.

8 Any Other Business

There was no other business.

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

10 Resolution regarding the Press, Public and Others

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

The meeting was adjourned.

University Hospital Southampton NHS Foundation Trust

List of action items

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 30/03/2021 5.6 Inpatient Flow - Medically Optimised for Discharge Update				
428.	Trajectory for MOFD patients	Teape, Joe	29/07/2021	Pending
	Explanation action item JT agreed to include a trajectory for MOFD patients in the regular reports to the Finance and Investment Committee. TB 27/5/21: The operational dashboard presented to the Finance and Investment Committee was being updated to reflect trajectories for the numbers of patients medically optimised for discharge in the hospitals. An update would be provided in the report to the Board in July 2021.			
Trust Board – Open Session 30/03/2021 5.7 Ockenden Review of Maternity Services				
429.	Patient story	Flaherty, Karen	31/03/2022	Pending
	Explanation action item KF to arrange a patient story from a patient using the maternity service at least once annually.			
	Explanation Flaherty, Karen This is being arranged through the maternity voices partnership lead.			
Trust Board – Open Session 27/05/2021 2 Staff Story				
483.	Student issues	Harris, Steve	29/07/2021	Pending
	Explanation action item SH would ask the e-rostering team to contact Ellen to get her feedback directly to see if the issues that students had experienced could be resolved.			

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 27/05/2021 5.5 Integrated Performance Report for Month 1				
484.	Effective - HSMR	Grundy, Paul	29/07/2021	Pending
	Explanation action item PG to investigate the reasons for the divergence in the HSMR for the Trust and Southampton General Hospital.			
Trust Board – Open Session 27/05/2021 5.6 Equality and Diversity Update (WRES and WDES)				
485.	Discrimination at work	Harris, Steve	29/07/2021	Completed
	Explanation action item The RAG rating for the percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues should be red rather than green in relation to the NHS acute trust average.			
486.	Comparison with other organisations	Harris, Steve	29/07/2021	Pending
	Explanation action item It was agreed to provide data on harassment, bullying and abuse of staff from outside the NHS to better understand how this compared to other organisations.			
Trust Board – Open Session 27/05/2021 5.7 Gender Pay Gap Reporting 2020				
487.	Local CEA scheme	French, David	29/07/2021	Pending
	Explanation action item DF would establish a group to review the local CEA scheme.			

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Safeguarding Annual Report 2020-21**			
Agenda item:	**5.5**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Date:	**29 July 2021**			
Purpose	**Assurance or reassurance** x	**Approval**	**Ratification**	**Information**
Issue to be addressed:	The safeguarding annual report summarises the key achievements and activity for 2020/2021 and highlights key areas of work for 2021/22 for adult, child and maternity safeguarding within UHSFT. This includes the Paediatric Liaison Nursing Service, and the LD and Autism Liaison Service. This year has seen an increase in activity and complexity across all services which are evident within the report and highlights the impact of Covid-19 on Safeguarding. The teams have continued to adapt their collaborative working approaches both within UHSFT and across the multi-agency partnership in order to meet this demand. The report has been written to provide high level assurance as to the safeguarding arrangements within UHSFT.			
Response to the issue:	Trust Board is asked if the report gives the required assurance around UHSFT adult (including learning disability), child and maternity safeguarding services. Summary of key points within the report include: • Progress updates and what we have achieved since the last annual report. • Activity data and analysis • Patient story for adult and child • Key areas of work for 2021/22			
Implications: (Clinical, Organisational, Governance, Legal?)	The safeguarding report outlines the strategic and operational work of the safeguarding team which encompasses clinical, organisational and governance implications			
Risks: (Top 3) of carrying out the change / or not:	Not applicable			
Summary: Conclusion and/or recommendation	The safeguarding annual report has highlighted the safeguarding team's activity for 2020/21. From a strategic and operational perspective this is pivotal to ensure we continue to improve outcomes for children and adults. The key areas of work for 2021/22, are outlined at the end of the report, and align with the safeguarding strategy standards.			

Safeguarding Annual Report 2020/2021

Karen Mcgarthy, Named Nurse Safeguarding Children

Debbie McGregor, Named Nurse Safeguarding Adults

Julie Davies, Named Midwife Safeguarding

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Introduction

This year's Safeguarding Annual Report summarises the key achievements and activity for 2020/2021 and highlights key areas of work for 2021/2022 for Adults, Children and Maternity safeguarding within UHSFT. This includes the Paediatric Liaison Nursing Service, and the Learning Disability and Autism Liaison Service. This report has been written to provide high level assurance to the Executive Team in relation to the safeguarding arrangements within UHSFT.

The UK went into a national lockdown on the 23rd of March 2020 due to the Coronavirus (COVID-19) pandemic. The Safeguarding Adult and Children's Team, amongst many other teams, moved to remote working. This required significant adaptations to continue a robust, responsive and supportive service to both UHSFT colleagues and multi-agency partners in order to promote the welfare and safeguard our vulnerable children and adult population.

There are a number of studies currently ongoing looking at the impact of COVID-19 including the variety of restrictions the UK has had in place over the last year and the impact this has had on children and adults, especially in relation to hidden harm. It is evident that from reviewing the statistics that as well as an increase in referrals to the Safeguarding Team, the level of complexity within these referrals has increased.

The teams have continued to adapt their collaborative working approach both within UHSFT and across the multi-agency partnership in order to meet this demand. However due to this increased activity and staff sickness within the team, this has had an impact on work demands . Some of the planned work streams have subsequently been put on hold in order to meet operational demands. This increase in demand upon the system has also been acknowledged across the wider Hampshire and Isle of Wight footprint. This will be reflected in this year's report.

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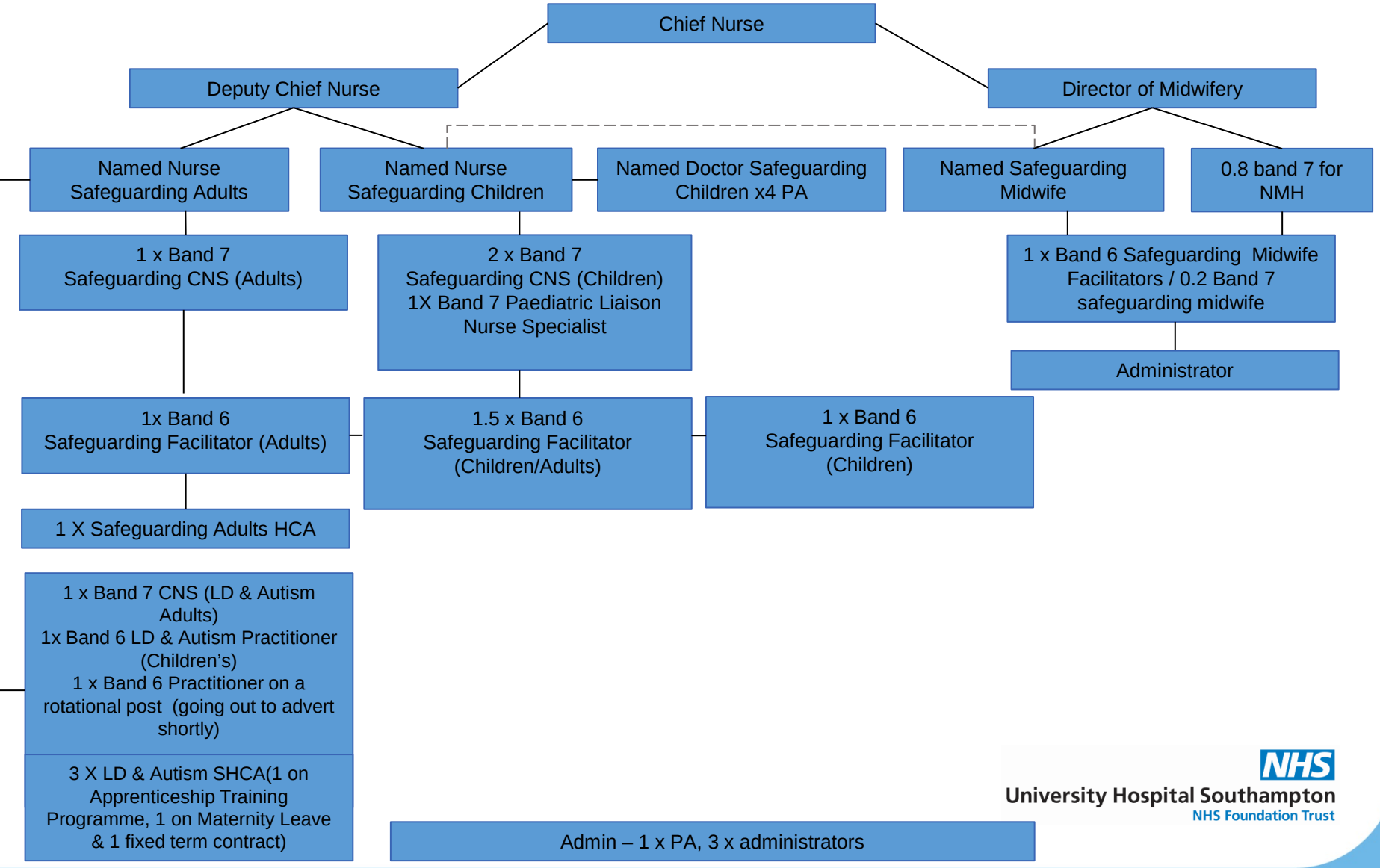
Team structure



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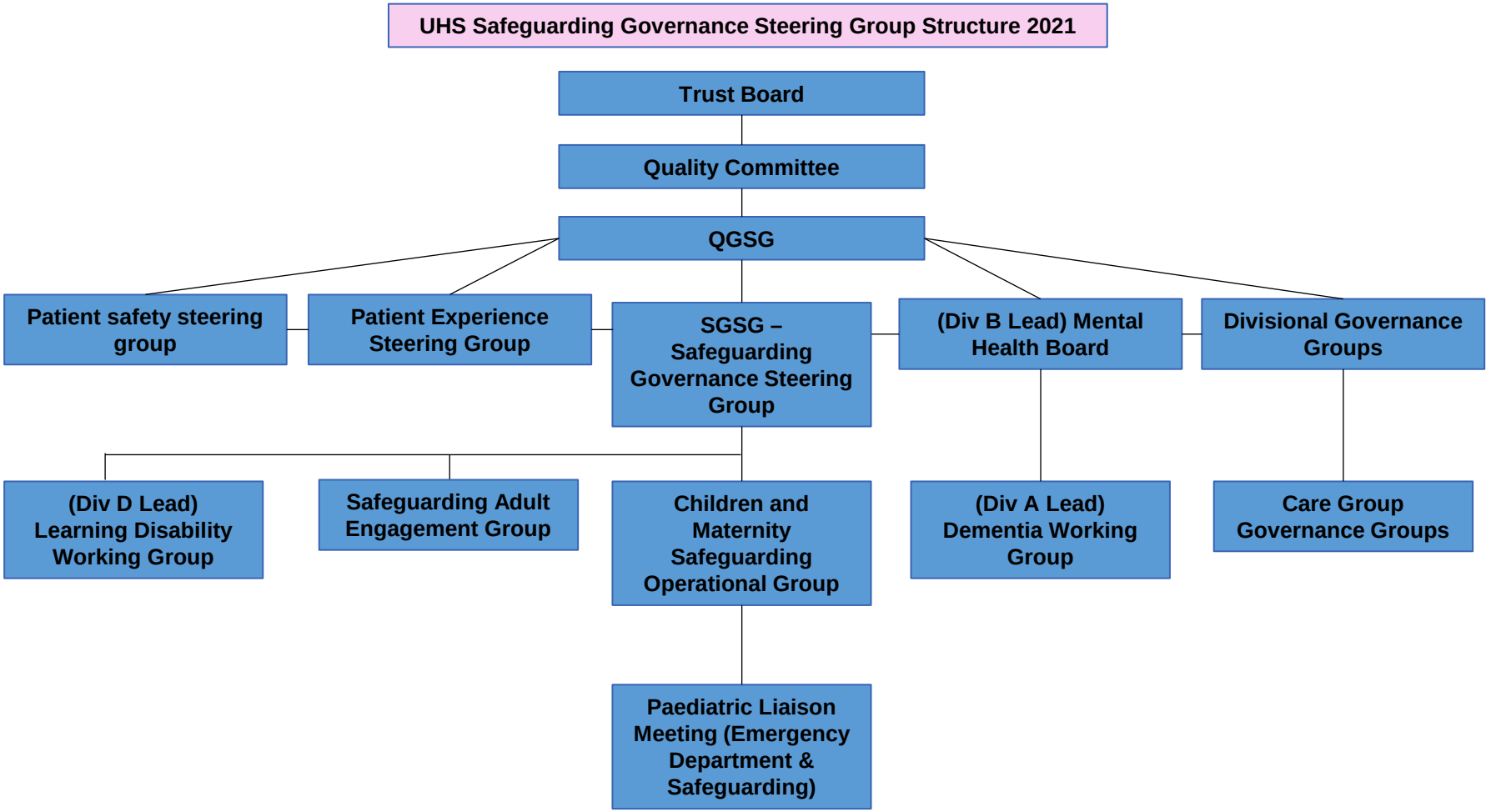
Governance structure



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Progress updates – Safeguarding

Last year (19/20) we said we would;	We have achieved (20/21);
Review and refinement of the joint safeguarding supervision policy	The Safeguarding Policy is within date, This will be reviewed in 21/22. Children's team continue to develop supervision groups. See narrative below.
Planning and implementation of the Mental Capacity Amendment Act (2019) and the Liberty Protection Safeguards	Dates have been confirmed for DAC Beechcroft, Trust's Solicitors, to deliver the remaining two legal Mental Capacity Act master classes commissioned by UHS. Work is ongoing in relation to the roll out of Level 3 Safeguarding Adults training across the Trust. The new Level 3 training will provide a detailed overview of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards in practice. Work remains ongoing with publications in relation to a new MCA information booklet for patients and their families.
Sign off and implementation of the safeguarding strategy	Completed and ratified in July 2020
Development of joint training strategy – family approach	This is a safeguarding priority to implement the joint training strategy, as is included in the Safeguarding strategy. Due to Covid-19 has been put on hold with a plan to review in 2021/2022.
Continued work with Domestic Abuse Pathfinder	Domestic Abuse Pathfinder project completed. Safeguarding leads continue to represent UHSFT and participate at domestic abuse operational and strategic forums.
Network to improve training and ensure an integrated approach with partners agencies to tackle domestic abuse and honour based abuse	Continued engagement with partners agencies to tackle domestic abuse and honour based abuse, robust representation at Southampton Strategic Group including implementation of the Domestic Abuse Bill, signed into law on 29.04 21.
Continued review/participate in work streams identified from unborn protocol audit across HIPS and embed this policy	The unborn protocol was launched in March 2021 and UHS Maternity Safeguarding Team were an integral part of developing the policy and its launch.

Progress updates – Adults Safeguarding

- Level 3 training mapped to the latest inter-collegiate document and skills for health framework remains in progress to be rolled out Trust-wide once finalised. This training will be role-profiled to all front-line staff and will provide a comprehensive overview of Safeguarding Adults, Consent, the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards in Practice.
- Work continues with publication to finalise an MCA booklet for patients and their families. UHS were given kind permission to utilise this resource from Doncaster and Rotherham.
- Work continues with colleagues in Southern Health Foundation Trust to jointly recruit a skilled Band 6 practitioner to work across both Trusts as part of a new and innovative rotational post to work across the system.
- UHSFT continue to engage with key partners across the Hampshire and Isle of Wight footprint in relation to the newly anticipated Liberty Protection Safeguards Framework. The Liberty Protection Safeguards will provide protection for people aged 16 and above who are or who need to be deprived of their liberty in order to enable their care or treatment and lack the mental capacity to consent to their arrangements.
- Work continues with the Technology Team to develop a Deprivation of Liberty Safeguards online application form to help simplify the DOLS process for frontline staff. This work is being carried out in consultation with our Local Authority DOLS teams
- The production of a patient information leaflet in relation to the Safeguarding Adults Agenda remains in progress. It is envisaged that the resource, once finalised, will prove a helpful guide for patients, explaining the Safeguarding process when a referral has been made
- A quick guide to information sharing within the Safeguarding Adults Area has been produced by the Safeguarding Adults team. This has been reviewed and approved by the Trust's Information Governance Team and subsequently shared for further feedback.

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Progress updates – Children's Safeguarding

- Audits – Bruising Protocol re-audit, Safeguarding Proforma audit, Child Exploitation audit and ICON. The Bruising Protocol re-audit and the ICON audit within ED was completed alongside the Bruising Protocol audit. The audits demonstrated a good level of assurance with UHSFT safeguarding processes, recommendations and actions are currently being shared at divisional and safeguarding meetings. Due to Covid-19, the Safeguarding Proforma audit, Child Exploitation audit and ICON audit within Child Health has been put on hold. At the time of writing this report, these audits have resumed.
- As with adult safeguarding to continue to engage with key partners across the Hampshire and Isle of Wight footprint in relation to the newly anticipated Liberty Protection Safeguards Framework. To continue work to improve and embed the application of the Mental Capacity Act (2005) in practice to ensure successful implementation of the Liberty Protection Safeguards (LPS) which applies to 16-17 year olds.
- Level 3 adult safeguarding training will be role-profiled to all front-line staff, including staff who work predominately with children. The training will provide a comprehensive overview of Safeguarding Adults, Consent, the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards in Practice. However, level 3 safeguarding training on 16/17 year olds is available for staff to access and staff have received regular updates via comms ensuring staff are kept abreast of proposed LPS implementation. Currently, all clinical staff are profiled to complete mandatory level 2 MCA training.
- Work continues with the technology team to improve and refine Apex children's referrals , this includes a children's dashboard and the building of the information sharing form (ED liaison form) onto APEX. Due to Covid-19 and competing demands for the technology team this has been on hold, however at the time of writing this report, this work stream has resumed.
- The Level 3 safeguarding training reporting on the Virtual Learning Environment (VLE) and revised training guidance went live on 04.01.21.

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Progress updates – Maternity and Neonatal Safeguarding

- Launch of Child Protection Information Share (CP-IS) in maternity in August 2020. Further work has been identified with the interface with the CP-IS system with the wider trust.
- The Safe Sleep and ICON audit is nearing completion and will be ready to be presented by September 2021. The FGM audit has been delayed due to workload, but the audit will be prioritised for completion by end of Dec 2021.
- A safeguarding training package has been launched for Maternity and Neonatal Newly Qualified Midwives and Nurses alongside the Level 3 training on VLE. Work continues to integrate harmful practices policies and training with the wider trust and partner agencies.
- In March 2021 the HIPS Unborn Protocol was launched. A Multi–agency Strategic Group will continue to meet to discuss on-going feedback and a plan to re-audit in 2021/22.
- In June 2021 Badgernet maternity system was introduced and the safeguarding pre and post-birth planning and parenting observation have been integrated within this system. The introduction of Badgernet and how this will interface with the APEX system will need to be reviewed.
- Develop safeguarding network across SHIP for maternity safeguarding leads, this has continued with shared work around Badgernet and HIPS policies.
- In December 2020 the South East Named Midwife network was launched This is a quarterly forum where we share good practice, ideas and practice challenges/trends and feed into the National Safeguarding Networks.

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Progress Updates - Learning Disability (LD) / Autism

- Ongoing development of easy read information for patients; regular meetings commenced in December 2020 with patient experience & publications to look at top pieces of patient information and to formulate an action plan of creating and producing more trust approved easy read patient information. Meetings will continue in 2021
- Resubmitted EPR development form 2019 and discussed with Clinical Oversight and Prioritisation Group to restart Development of ApEx application (put on hold due to COVID19) – added to APEX backlog Aug 2020.
- Early development plans for webinars and virtual champion network for UHS; linking with neighbouring trusts for ideas.
- Maintaining links with our Volunteers and re-establishing roles – x 3 volunteers
- GA pathway development for CT scans; initial meeting held November 2020 (Div. Head Nursing & Radiology); ongoing.
- Leading on South Acute Nurses Network – first meeting held March 2021 with good representation across Hampshire, Portsmouth, IOW and Channel Island.
- New project; Pathway Matron and Divisional Clinical Director (Division B) to develop patient pathway.

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Key achievements - Safeguarding Adults

- Despite the increase in terms of capacity and demand on the Safeguarding Adults team and the complexity of cases seen, the team have focussed on prioritising putting patients first in terms of their immediate safety and protection planning.
- A new Deprivation of Liberty Assurance process has been developed to ensure a more timely and robust process for sharing DOLS data with Local Authority colleagues. This has been fed back to the Trust's Head of Clinical Quality Assurance.
- All staff within the Trust have been correctly role-profiled for Prevent (Counter-Terrorism) training mapped to the Prevent Competency framework.
- A continuous focus on ED – to ensure that Safeguarding concerns are recognised and referred in line with due process with ongoing support for the VAST team. This includes a new process where assault data is now also shared with the Safeguarding team to allow for scrutiny and assurance in terms of adults and children at risk.
- Six-weekly meetings established with HR to ensure that there is regular oversight of managing allegation concerns in relation to staff who are in a position of trust.
- A review into how the Safeguarding Adults team can engage with clinicians across the Trust in relation to the Safeguarding Adults Agenda. This has resulted in the newly-formed Safeguarding Adults Engagement Group, which will align with Trust's Governance Processes.
- Participation in National Safeguarding Awareness Week reiterating the importance of Safeguarding being everyone's business.
- Established Safeguarding Adults supervision for the team led by the Named Nurse.
- Six-weekly meetings established with Local Authority DOLS colleagues.
- Further support with embedding of the 4LSAB Multi-Agency Risk Management Framework (MARM) into practice.
- Continued engagement with the Local Safeguarding Adults Boards and participation in Statutory Reviews.

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Key achievements- Safeguarding Children

- The electronic APEX referral system which was launched in July 2019 has enabled staff to review UHS Safeguarding Children actions and has enabled accurate capture of key performance indicators. This process has significantly supported practice during the pandemic and has enabled effective remote working for the team. The Paediatric Liaison Team, who are working towards the Information Sharing Form being developed on APEX, reviewed their processes in collaboration with ED safeguarding leads in response to the pandemic ensuring all paperwork is now managed electronically.
- ICON and Safe Sleep was launched across Child Health and the Emergency Department in November 2019. Regular communications and training was delivered to staff during the pandemic. As the majority of parents/carers were not having face to face contacts in the community during the pandemic, upskilling staff knowledge and skills to support families who presented at UHSFT was a key Public Health promotion message.
- Embedding Local safeguarding Children Partnership (LSCP) guidance, protocols, recommendation from multiagency audits and Child Safeguarding Practice Reviews (formerly known as Safeguarding Children Reviews) at UHSFT. This included an agenda item on the Children and Maternity Safeguarding Governance Group, included in the quarterly SGSG reports and Divisional Governance reports, shared at Child Health Sisters Meetings and Safeguarding Champions Meetings and embedded in Level 3 Safeguarding Children Training.
- Revised Level 3 Safeguarding Children Guidance and the required minimum 12 hours reporting on the UHSFT Virtual Learning Environment went live on 4th January 2021.
- In 2020/21 Southampton Safeguarding Children Partnership (SSCP), Southampton Practice and Improvement Group (SPIG), the priority themes have been intra-familial CSA (Child Sexual Abuse) and multi-agency safeguarding of black and minority ethnic children. The priority themes align with the National Joint Targeted Area Inspection (JTAI) themes. Analysis has been completed and submitted by UHSFT on these themes to SPIG which has enabled a multiagency review of all submissions to; identify any themes, recommendations and actions across the partnership. The final reports have been submitted to the SSCP Board.
- Section 11 - KEEPING CHILDREN SAFE. Under Section 11 of the Children's Act 2004, every other year UHSFT are required to complete the Hampshire, Isle of Wight, Portsmouth & Southampton (HIPS) Safeguarding Children Partnerships Section 11 self-assessment tool and this was submitted on 4th January 2021 . For this year, the HIPS Section 11 self-assessment had been reviewed and slimmed down to ensure that the standards remained relevant, and that the process took account of system-wide pressures arising from Covid-19.

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Key achievements - Safeguarding Children continued

- UHSFT had some positive feedback from the panel including:
  'The practices identified to support disabled children were noted as good'.
  'The panel noted evidence of good practice in this standard particularly around the Youth and Young Adult Forum'

  As part of the self assessment, staff were also asked to complete a survey, 63 returns were completed, and as this was during the peak of Covid-19, this could be considered as a good response. UHSFT had some positive assurance from the survey including:
  - Staff being clear about their responsibilities in identifying children with unmet needs or in need of protection from abuse. (Physical, Emotional, Sexual, Neglect, Exploitation).
  - Staff knowing who to speak to at UHSFT if they have a concern regarding the safety or welfare of a child.

  The self assessment has identified 3 standards which require improvement and the feedback requested reassurance on 3 further standards submitted. The actions plans are being monitored at the SGSG.

- Bruising protocol re-audited in 2020. The audit report finalised on Trust Audit Tracker and at the time of writing this report recommendations and actions have been/are being shared at various Governance Groups – ED Governance Group, Divisional Governance Groups and the Safeguarding Governance Steering Group. (SGSG)

- Was not Brought Audit 2019 – recommendations and actions completed and the Was not Brought Policy has been updated to reflect the audit findings and ratified at the policy group.

- Looked After Children (LAC) audit. This has been completed as part of the Standard NHS contract schedule- Safeguarding Children (including Looked after Children) & Adult and Mental Capacity Act Safeguarding Schedules and shared at the SGSG and with commissioners. For children identified as looked after through the ED CP-IS pathway, the audit demonstrated a high level of assurance on the actions taken to safeguard.

- Level 3 face to face safeguarding children training was adapted to deliver this on Teams. This ensured that staff could still access training so that they were able to meet their statutory and mandatory requirements during the pandemic.

Key achievements for Maternity and Neonatal Safeguarding

- The launch of the HIPS wide Unborn Protocol in March 2021. Maternity Safeguarding contributed to all aspects of the review and the launch of the Unborn Protocol and took the lead on two of the work streams.

- Alongside the Safeguarding Children's Team, the level 3 Safeguarding Children Guidance has been updated and in addition, we have developed a training package to offer further support to Newly Qualified Midwives and new starters.

- Introduction of safeguarding competencies in the NNU for all Nursing/Midwifery staff, Band 4 and over. The aim is to improve the baseline knowledge of safeguarding in the Neonatal Unit (NNU).

- Continued to facilitate group supervision via Microsoft Teams to NEST Midwifery Teams, universal and core Midwifery and Neonatal staff when indicated or on request by staff. NNU offer group safeguarding supervision alongside the NNU psychologist. This has been increased to every other month to improve accessibility.

- Launch of ‘Badgernet’ a UK Maternity Patient Data Management across the Maternity SHIP (Southampton, Isle of Wight, Portsmouth and Hampshire). This is an integrated maternity system and we have worked alongside the Digital Maternity Working Group to ensure that our current safeguarding processes (UHS and HIPS policies and procedures) are transferred and integrated into Badgernet. We have also developed user guidance and step by step guides for midwifery staff to support the transition to Badgernet and have planned training sessions to support midwives with documentation of safeguarding concerns and safeguarding plans on Badgernet.

Key achievements for Maternity and Neonatal Safeguarding continued

- ICON and Safe Sleep. We continue to embed the messages from these key initiatives into our service to raise awareness to staff and our service users. The Neonatal Safeguarding Lead offers a rolling ICON & Safe Sleep training via Microsoft Teams for NNU, Midwifery and now Child Health staff. All new parents are routinely offered Safe Sleep and ICON advice and signposting at key touch points in the antenatal and postnatal period. Any family whom we identify as having increased risk factors in the postnatal period are given a safe sleep and ICON pack on hospital discharge or following a home birth. Babies discharged from the neonatal unit or transitional care have a Safe Sleep risk assessment before discharge/transfer. This ensures that those families who are more at risk of experiencing SIDS, received more information and signposting tailored to their needs. This also allows for clearer documentation regarding what has been discussed with parents. We are in the final processes of completing an audit of ICON and Safe Sleep.

- UHSFT is the pilot site for the launch of the SHIP perinatal mental health pathway screening tool in November 2020. The aim of the tool is to standardise mental health screening across maternity services and to raise awareness of perinatal mental health and ensure early intervention and signposting to the correct level of support for expectant mothers and fathers. This is currently being audited and the results will be collated by August 2021 and presented to SHIP that month.

- The Specialist Perinatal Midwives have also re-commenced Perinatal Mental Health Champions Day which is open to maternity to UHS maternity staff and other maternity units.

- Contribution to the Section 11 Audit.

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Key achievements- Learning Disability (LD) / Autism

- Ongoing support of patients, families/carers and clinicians for planned, emergency admissions and outpatient appointments across the trust
- Facebook groups; Autism Patient Forum & Learning Disability Forum
- Workplace groups; Support Group for Autistic Employees & Learning Disability & Autism Champions
- Ongoing management of LD & ASC flags/passport/AI needs/mortality data spreadsheet
- Supporting LeDeR Reviewers (telephone support, remote access to medical notes & Structured Judgement Reviews / Patient Safety Scoping)
- Year 3 NHSI and NHS England Benchmarking Learning Disability Improvement Standards; data collection opened November 2020 and completed March 2021. Awaiting report.
- Liaison with & development of a training session for intensive care medicine trainees (delivered Oct 2020)
- Successful recruitment to the paediatric liaison post – post commenced 19th October 2020
- Successful recruitment to SHCA maternity cover – post commenced November 2020 until October 2021
- Nurse vacancy (full time B7)
- 1 x B4 on Nurse training (commenced September 2020); awaiting backfill.
- Reduced service / staffing on risk register March 2021
- Exploring admin role to support service
- Mailshot of Hospital Passports to all patients known/with LD flag: 700+ sent out, approx. 70 returned plus 70 electronic
- Launch of Newsletter; two produced so far, third in development
- OMG (One minute guides)
- Creation of accessible information; Covid testing (drive thru / home testing),EEG (Neurophysiology),Scans (Radiology), Visiting restrictions

Key achievements- Learning Disability (LD) / Autism continued

- Established paediatric service with on-going work to raise profile
- IT updates including admission alerts for children flagged with LD/ASC
- Paediatric nurse practitioner has supported over 200 children and their family with pre admission planning, inpatient support and discharge since October 2020. This also includes; building relationships with the different clinical areas, providing support to staff and introducing strategies / approaches to the teams to meet the needs of children with a learning disability and/or autism.
- Reimplementation of the hospital passport for child health.
- Successful bid for charity funding for resources and have proposal for a new sensory break out room for JADW alongside ceiling track hoists for our orthopaedic ward which have both been on-going suggestions from parents to improve their child's hospital stay.
- Future projects include; learning disability and autism champion training, Makaton training for staff working in the LD / Autism team /child health, LD and autism friendly environment and development of best practice pathways for interventions such as blood tests and admissions.
- Summary of positive feedback attached separately.
- Ongoing participation in IMEG/scoping/LeDeR processes/ complaints processes
- Learning Disability & Autism Working group (via Teams)
- Learning Disability Friendly Ward Working group; in partnership with SHFT & WHCCG - virtual meeting held June 2020; Meeting held December 2020 to re establish links with commissioners and those participating in scheme.
- Learning Disability Friendly Ward task and finish group; UHS (To recommence January 2021)
- Treat me Well Group; re established regular virtual meetings end of 2020/continuing in 2021
- Service development focused areas; Radiology / Neurophysiology
- Learning Disability Partnership Board; virtual meetings every 2 months 2020 / 2021.
- Participation in Sunflower lanyard working group.
- Liaison with Carers Lead UHS.

Key achievements – Adults, Children and Maternity

- Awareness raising communication events (topics included Domestic Abuse, ICON, ACES (Adverse Childhood Experiences) held throughout National Safeguarding Awareness Week in November 2021.

- Response to supporting UHSFT staff and families during Covid-19 pandemic with production of weekly briefing, ICON advice and safe sleep advice in relation to Covid-19 pandemic, and Domestic Abuse. Developed new ways of working collaboratively and supporting staff within a framework to keep families safe.

- Despite remote working, daily team meetings have remained in place virtually with the wider team, to review work stream priorities and update on service delivery.

- Planned monthly meetings with Maternity, Children, Adult and Emergency Department to progress and align processes, including policy and guidance. This meets one of the Safeguarding Strategy work streams.

- Induction training- The Corporate Safeguarding Team (adults, children and maternity) have completed a virtual recording outlining UHSFT safeguarding requirements. This went live on 11th January 2021 and is now included in all induction programmes. The 5 minute recording outlines that safeguarding is everyone's responsibility, what could be a safeguarding concern, how to be professionally curious, how to act on concerns, ensuring the voice of the child or adult at risk is kept at the centre of the process and the importance of escalation if we do not think the right decision has been made to safeguard an adult/child

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Safeguarding Story – Children

Timmy is a 4-month old baby who was initially transferred to UHSFT hospital from a local external hospital due to an acute respiratory tract infection.
On admission, a referral was made on APEX to the Safeguarding Children Team due to safeguarding concerns. UHSFT Safeguarding Nurse gained further information from the ward: Timmy was born preterm at Princess Anne Hospital and transferred to the Neonatal Unit. Health needs were diagnosed antenatally, but the severity was not known until birth and Timmy required surgery. Due to his condition he had to be nursed intensively including a short time at home. The ward advised that on X-rays there was an incidental finding of various healing fractures initiating the referral to the safeguarding team. The Safeguarding Team initiated safeguarding processes, contacting Children's Services and ensuring parents were made aware of the processes. Multiagency partnership working including a meeting to discuss findings and investigate the timescale of the injuries. It was initially assessed that the injuries would have occurred at the local external hospital or at home as they were assessed as healing fractures. A Social Worker was allocated to Timmy and his family. Timmy underwent further tests. After a period of time, Timmy was discharged back to the local external hospital.
Reflecting good practices:
Robust communications between all professionals local and external, to safeguard Timmy, even though it was difficult to ascertain where Timmy was when he sustained his fractures. It was eventually ascertained some of the fractures were due to birth trauma. The UHSFT risk team was informed to ensure this was escalated and a report completed. Named Doctor and Named Nurse had oversight over this case throughout the process including the risk management in maternity and also with local Authority LADO, but agreed that discussion with the local external hospital for them to discuss with their LADO.

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Safeguarding Story – Children continued

This case demonstrated the UHSFT values – Patients first, Working together and Always improving:
Patient first: Timmy was always at the forefront of all discussions to continue to safeguard him. Children's Services had vocalised that perhaps Timmy could go home when ready. UHSFT Safeguarding Team reiterated that because it could not be established if the injuries occurred in another health environment or at home, this was not appropriate at that time.

Working together: During Timmy's stay in UHSFT, there was communication between Parents, Social Workers, UHSFT Children's Safeguarding Team, Health Visitor, Doctors and Nurses within UHSFT, Local external hospital, Radiology and Princess Anne Hospital (including Maternity Safeguarding). Timmy was eventually discharged back to local external hospital with continuation of plan between local external hospital and Children's Services

Always improving: UHSFT Children's Safeguarding Team discussed with the Neonatal Team and Maternity Safeguarding Team, re the fractures seen, which was documented in his birth notes. We advised the completion of a report form. This has been now completed in retrospect.

The safeguarding story has been updated since originally published.

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Safeguarding Story - Adult

Jane (pseudonym name) presented to UHS by ambulance following a 999 call being made by her partner. He reported that Jane had fallen down the stairs and on assessment the ambulance crew found Jane to have a Glasgow Coma Scale (GCS) Score of 3/15. This is the lowest possible score on the scale. On assessment at UHS she was noted to have significant bruising to her face and upper body which the clinician did not feel was consistent with the mechanism described by the partner. As a result this case was brought to the attention of the UHS Safeguarding Adults Team (SAT), who liaised with several multi-agency partners including the Local Authority and Police to assess and manage any immediate risk to the patient.

Jane required extensive neurosurgical and orthopaedic interventions however by the time she was out of surgery a multi-agency protection plan had been established ensuring that any information was only communicated when a password was provided. This password was shared with professionals involved in supporting Jane so as not to hinder necessary and effective communication. Janes details and location were also anonymised. All of this was completed with the support of the Local Authority and Police as Jane was intubated and ventilated and not able to communicate her wishes. A best interest decision making process was clearly recorded in accordance with the Mental Capacity Act (2005). It was agreed that enquiry into Janes social risks and support in managing these should take place under Section 42 of the Care Act (2014). Due to Janes complex clinical needs at the time the Local Authority requested UHS Safeguarding Adults Team lead protection planning for this patient.

UHS Safeguarding Adults Team went about reviewing Jane's historical interactions with local healthcare providers. An assessment for hidden harm was also undertaken and no other adults or children were found to be at risk. In scoping this patient the Safeguarding CNS noted a number of historical presentations with injuries across a number of unrelated services however an escalating pattern was noted leading up to Janes current presentation. This information was shared with the Police in accordance with Schedule 8(3) of the Data Protection Act (2018) and this in connection the findings of the Police investigation at that point provided enough evidence for the patients partner to be detained.

Safeguarding Story – Adults continued

As Jane recovered over a period of months due to the extent of her injuries she was supported in Domestic Abuse assessment and advocacy by UHS Safeguarding Adult Team. A number of catch up meetings were held chaired by a Clinical Nurse Specialist in the team to ensure that the clinical teams, Police and Local Authority were kept updated on each services involvement. Jane was present at all of these meetings.

It became evident that Jane had a dependant relationship with her partner and she relied on him to financially and to facilitate social contact which he limited. Her partner also cultivated an alcohol dependence to maintain a level of control over Jane. At the time she did not perceive this as unusual and did not consider herself to be the victim of Domestic Abuse. However as she started to reflect on the nature of her relationship a significant number of disclosures were made about Physical, Sexual, Financial and Psychological Abuse. Whilst she was unable to recall the events that led to her admission to UHS, multi-agency discharge planning took place which ensured that Jane was able to undertake rehabilitation as required and eventually was discharged to a new safe address where community support continues.

This case in particular highlights the importance of professional curiosity by health professionals. None of what followed would have been possible without the suspicion that something was not right and the initiative to raise the concern. Largely due to well established links with the various multi-agency partners involved in this case it is a good example of how communication and partnership working are essential to a positive outcome in Safeguarding Adults. It also highlights the complexity of these cases where the individual does not simply make a disclosure and may not even consider themselves to be experiencing abuse.

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Patient Stories – Learning Disability (LD) / Autism

Over the past year, we have supported two patients with an Autistic Spectrum Condition along their journey through diagnosis and treatment.

A lady in her thirties was diagnosed with breast cancer. She became incredibly nervous in the hospital environment, and struggled to communicate her needs when she was anxious. From her initial diagnosis, throughout her mastectomy and post-operative care, we had provided support for her and her husband. She was able to call the office at any time for advice, and was accompanied to her appointments and built a strong relationship with our LD Autism Team. The patient has been thankful for our involvement and ability to negotiate reasonable adjustments for her, and continues to do very well.

A young patient of 19 has been working extensively with the team in the past year. This patient also has an Autistic Spectrum Condition, and can suffer with high anxiety. Since 2020, he has been admitted to ED over 120 times. He has a history of cardiac conditions, and felt out of control. Since engaging with the team on a daily basis, with telephone support and visits, he had developed a bond with each member of the team. He is taking on a volunteer post within the team to help highlight ways to support those with an Autistic Spectrum Condition. His admissions are fewer and further between, as he has the reassurance of our support.

Activity – Safeguarding Adults

Safeguarding Referrals = **1635 – 20/21** (9% increase from 19/20 -1503)

DoLS = **589 – 20/21** (6% increase from 19/20 - 555)

Total number of SAMA cases: 23 (360% increase from 19/20 - 5)

Training delivered; adult sessions = 26 / joint adult & child sessions = 10

Statutory Activity

- **6 statutory scoping's for SAR's 4 of these however were IMRs which required more detailed analysis of the events including a review of policies and learning.** (9 – 19/20)
- **Supported with 1 court of protection case this year (1 – 19/20)**

AER's screened: 471 (42% decrease from 19/20 - 807)

Complaints screened: 20 (150% increase from 19/20 - 8)

Section 42 enquiries: 99 (23% decrease from 19/20 - 129)

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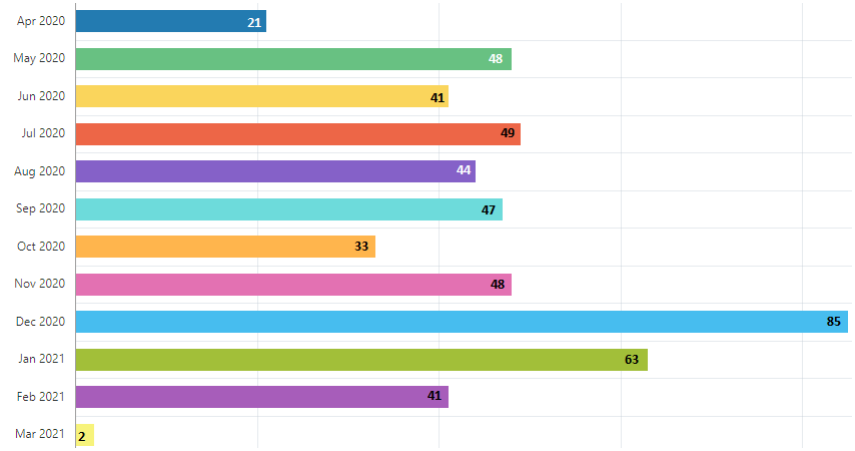
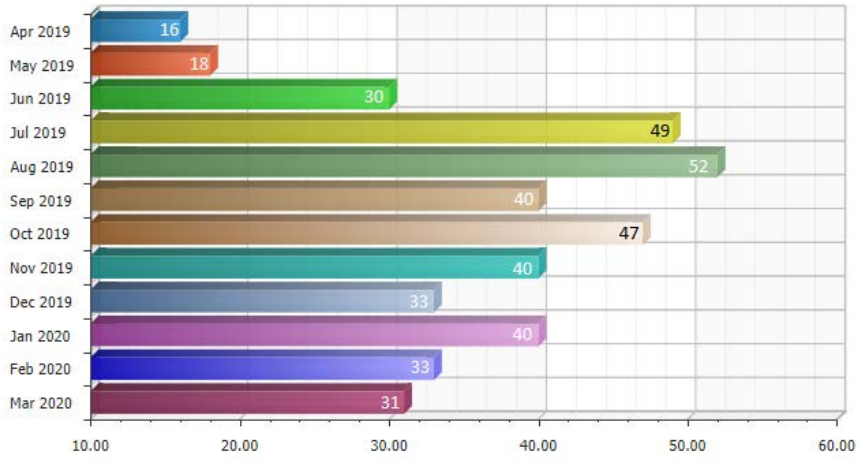
Activity – Safeguarding Adults

ApEX referrals made by users working in ED for all quarters



This graph shows ED referral figures for **20/21 (523)** which shows a **22%** increase on ED referrals from the previous year



This graph shows the ED referral figures **(429)** for **19/20** as a comparison

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Analysis of Safeguarding Adults data

- The **9%** increase in referrals into the Safeguarding Adults team reflects the operational workload and the impact of the Covid-19 pandemic. The referral numbers, however, do not recognise the complexity of many of the referrals which are multi-faceted and the time taken to manage these complex cases in conjunction with our Local Authority colleagues

- There has been a **6%** increase in applications relating to DoLS referrals. There remains a delay, however, in authorisation by the Supervisory Body which is recognised and reflected on the Trust's Risk Register.

- There has been substantial increase **360%** in SAMA referrals (concerns in relation to members of staff who are in a position of trust). This has also been noted by other provider organisations across the system. This increase in referrals has had a significant impact on the workload where collaboration with HR is required to review risks and decide whether any restrictions to practice are required. It is likely that the impact of the pandemic has also contributed to this increase where individuals' home and working life have been impacted by Covid-19.

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Analysis of Safeguarding Adults data continued

- The number of complaints screened and responded to by the Safeguarding Adults Team has more than doubled (**150%**)**.** It is unclear at present the impact of the pandemic on this significant increase.

- AER's screened by the Safeguarding Adults Team allow for a Safeguarding lens to be cast over incidents reported within the Trust. The reduced figure for this year (**42%**) were caused by a systems fault, where permissions to view were restricted for a period of time. This was escalated on a number of occasions and finally resolved.

- The team continue to work with technologist on how best to record on APEX in terms of new updates and improvements.

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Activity – Safeguarding Children

20/21 Safeguarding referrals to UHSFT Safeguarding Team = 1524 (1764 in 19/20) . This is strongly indicative of the national lockdowns. Of these referrals 165 referrals were assessed as being at the criteria of actual harm and 140 referrals of being suspected harm. This indicates the complexity of the cases referred to the team. The highest reason for referral to the UHSFT Safeguarding Team was consistently children with a mental health issue and parents admitted to UHSFT. The referrals require multiagency partnership working with social services and police and many would result in meetings in order to put a plan in place to safeguard the child.

Telephone/email advice = 453 (666 19/20), indicative of the national lockdowns

Serious Incident reporting = 60 (for unexpected child deaths, non-accidental injury, complex cases and distributed to key leads within the organisation).This is an increase from 41 in 2020/21, evidencing the increased level of complexity of referrals to the Safeguarding Children Team.

AER's screened: 119 (120 in 19/20)

Statutory Activity

- 27 requests for statutory scoping's for Serious Case Reviews. These requests are predominately from Southampton, Hampshire and Portsmouth Safeguarding Children Partnerships
- Of the 27 requests submitted, the Safeguarding Team have contributed to 13 of these, due to the child/sibling/parents receiving care at UHSFT. This is an increase from 10 in 2020/21

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Activity – Safeguarding Children

Total number of LADO cases = 29 (this includes UHSFT and staff not employed by UHSFT). This is fairly consistent with last years referrals of 32

Paediatric Liaison Nurse Specialist (PLNS) Team, triaged 3759 (3766 in 2019/20)

PLNS reviewed 16,449 Emergency Department attendance letters to ensure all children who are aged 0-17 years have had an ISF completed where appropriate (25463 in 2019/20)

The Princess Anne Neonatal Unit (NNU) is one of the largest units in the country caring for up to 23 intensive and high dependency beds and 14 special care cots; The PLNS Team have been responsible for disseminating 1423 NNU Reports (new admissions and updates) in 2020/21 (1243 in 2019/20)

Safeguarding Children Training Level 3 – 20 (32 sessions delivered in 19/20)

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Analysis of Safeguarding Children data

- Safeguarding children referrals have reduced since last annum. This is likely to be attributed to the 2 national lockdowns when routine admissions and ED attendances were significantly reduced.
- UHSFT Serious Incidents template was commenced in April 2019, the aim to ensure UHSFT senior management oversight of cases referred to the Safeguarding Children Team. The data indicates that although the referral rates to the team were reduced the level of complexity has significantly increased.
- The Number of ED letters generated for all children attending the department was significantly reduced in 2020/21, this is a likely reflection of the 2 lockdowns due to Covid-19. However the number of ISF's completed were fairly consistent between 2019/2020 and 2020/2021. This provides a good level of assurance that children or adults (who are parents/carers) who were seen within the department, actions were taken to safeguard and promote their welfare.
- The number of safeguarding training sessions was reduced and is a reflection of the requirement to put training on hold during the peak of the pandemic

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Activity Maternity 2020-21

- Maternity Liaison Forms = 938 forms (decrease of 1.8 % since 2019-20)
- Mash referrals submitted = 229 (decrease of 36% since 2019-20)
- Unborn/New-born's Subject to Child Protection Plan= 80 (increase of 2.5 % from 2019-20)
- Unborn/New-born's subject to Child in Need Plan = 66 (decrease of 12% from 2019-20)
- Baby's removed from birth from mother =1 (75% decrease since 2019-20)
- Number of Baby's placed in single Foster Care on Discharge from Hospital = 19 (increase of 11.7 % since 2019/20)
- Number of Mother and Baby Placement Foster Care on Discharge = 13 (18.7 % increase on 2019/20)

Activity Maternity 2020-21 continued

- Number of FGM-cases highlighted to service 22 (increase of 13% in FGM cases since 2019-20)
- FGM Information Share (FGM-IS) = 19 (216% increase since 2019-20)
- Teenage Pregnancy numbers at conception:

  Under 16 years = 26 (increase of 271% since 2019-20)

  Aged 17-18 years = 71 (increase of 222% since 2019-20)
- Domestic Abuse current and historic disclosures = 349 (50 new disclosures this pregnancy) (reflects an increase of 67% from 2019-20 statistics 2019-20)
- UHSFT Serious incidents template completed involving maternity safeguarding = 10

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Analysis of Maternity data

In 2019 the Maternity Safeguarding Team changed the system of data collection to allow more scrutiny. As a result there was marked increases in the data collected for the 2019/20 annual report. The safeguarding system of data has now been embedded for 2 years and the levelling of the 2020-21 statistics reflects this.

As with national data in the Q1 period there was a reduction in MASH referrals but in each subsequent period of reporting there has been a small increase. This again reflects national data and the impact of the Covid-19 pandemic and the move out of periods of lockdown.

The rate of teenage pregnancies has increased significantly throughout this annual report period. This has previously highlighted and whether school closures and changes to contraceptive services have impacted on this has been highlighted at forums.

Analysis of Maternity data continued

The increase in FGM-IS data reflects the introduction of FGM-IS maternity in August 2019 whereby statistic were not collected for the whole year. This year the statistics were collected for the whole year and accounts for the rapid increase.

The increase in domestic abuse statistics again reflects the national trend of increasing levels reported by agencies since the start of the pandemic. There is plan for a local and national guidance on the collection domestic abuse statistics following the introduction of the Domestic Abuse Act in April 2021

As with children's safeguarding there has been an increase in templates for scoping for Serious Case Reviews.

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Referrals – Learning Disability (LD) / Autism Liaison Team

Month	LD	Autism	LD & Autism	Inappropriate	Mortality	Total	Q total
April 19	57	9	0	7	0	73	240
May 19	68	9	5	6	0	88	
June 19	51	10	7	10	1	79	
July 19	68	10	7	17	1	103	279
Aug 19	64	6	2	14	0	86	
Sept 19	64	7	5	16	0	90	
Oct 19	78	14	2	29	2	122	304
Nov 19	80	14	8	24	1	103	
Dec 19	52	19	8	25	0	79	
Jan 20	80	14	8	36	0	137	338
Feb 20	70	11	10	26	0	115	
Mar 20	49	14	6	16	1	86	
Total	781	137	68	226	6	1,161	

Month	LD	Autism	LD & Autism	Inappropriate	Mortality	Total	Q total
April 20	57	4	6	11	6	84	232
May 20	35	4	6	13	0	58	
June 20	62	8	2	16	2	90	
July 20	63	10	2	21	2	98	276
Aug 20	57	9	5	19	2	92	
Sept 20	49	9	4	24	0	86	
Oct 20	67	17	1	21	2	108	293
Nov 20	54	20	4	16	2	96	
Dec 20	60	23	3	1	2	89	
Jan 21	60	30	3	13	3	109	295
Feb 21	53	28	1	9	1	92	
Mar 21	59	22	1	10	2	94	
Total	676	184	38	174	24	1096	

- Higher mortality noted inline with covid19 death 2020/21.
- Increased number of autism referrals shows a greater awareness of this service.
- Referrals are deemed ‘inappropriate’ when on triage, its is established that the individual does not have an LD and / or autism. This is always fed back and the staffnet page has been updated to clearly reflect referral criteria.
- All mortalities of those with an LD and / or autism are identified at the Internal Medical Examiners Group. A mini review is then undertaken by the team in partnership with patient safety to ensure there is no immediate learning identified.
- All deaths have been referred to LeDeR as per national protocol.
- 6% decrease in referrals from 19/20 – 20/21.

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Training Compliance

Trust Annual report Data as of 21.04.21

	Div. A %	Div B %	Div C %	Div D %	THQ	Trust Total	Trust Target
Safeguarding Adults level 1 (3yr)	89.5%	91.4%	93.9%	92.9%	85.8%	91.4%	>85%
Safeguarding Adults level 2 (3yr)	80.4%	85.3%	87.1%	83.5%	70.3%	83.2%	>85%
Mental Capacity Act level 1	68.7%	76.0%	81.4%	79.4%	76.9%	78.5%	>85%
Mental Capacity Act level 2	52.6%	62.1%	62.8%	54.3%	43.1%	57.3%	>85%
Prevent levels 1&2	80.2%	91.5%	93.1%	82.5%	87.7%	88.4%	>85%
Child Protection (Level 1) (3Yr)	73.5%	83.2%	91.7%	88.2%	88.1%	85.9%	>85%
Child Protection (Level 2) (3Yr)	80.3%	84.3%	88.1%	83.9%	71.5%	82.7%	>85%
Child Protection (Level 3) (3Yr)	75.3%	58.4%	78.7%	73.3%	72.3%	73.9%	>85%

Level 2 MCA training compliance figures has been escalated to the Divisional Training Leads and discussed at SGSG
The impact of the pandemic on statutory and mandatory training compliance is also recognised.
The Trust's Training department have additionally been contacted to ensure there have been no difficulties flagged with accessing the training on VLE, no access problems has been confirmed.
Further work to break down compliance figures into relevant staff groups is also underway to allow for further analysis.
Training compliance will continue to be monitored.

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Key areas of work for 2021/22

Joint

- Review and refinement of the joint safeguarding supervision policy
- Planning and implementation of the Mental Capacity Amendment Act (2019) and the Liberty Protection Safeguards
- Review and update safeguarding strategy

Adult specific

- Continue work to improve and embed the application of the Mental Capacity Act (2005) in practice to ensure successful implementation of the Liberty Protection Safeguards (includes further development of legal master classes and simulated training)
- Development of a safeguarding adult leaflet for patients and visitors to align to the principles of 'making safeguarding personal'
- Completion and launch of level 3 safeguarding adult training

Children's

- Audits – safeguarding proforma audit, child exploitation audit, ICON and Safe sleep.
- As with adults, continue work to improve and embed the application of the Mental Capacity Act (2005) in practice to ensure successful implementation of the Liberty Protection Safeguards which applies to 16-17 year olds
- Continue to improve the use of technology – APEX, children's dashboard and ISF
- Review and update Safeguarding Children Policy

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Key areas of work 2020/21 continued

LD / Autism

Further roll out of the LD friendly ward initiative

On-going input in to the development and pilot of national mandatory LD and autism training packages

Maternity

- Audit of Safe Sleep, ICON, CP-IS and FGM
- Review of Maternity Safeguarding Policy
- Review Substance Misuse Policy

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Glossary

The glossary refers the key words or terms that are used within this annual report.

LSAB Local Safeguarding Adults Boards covering Southampton and Hampshire

LSCP Local Safeguarding Children Partnerships (formerly Boards) covering Southampton and Hampshire.

CCG Clinical Commissioning Groups covering Southampton and Hampshire

Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need.

ASC Autistic Spectrum Condition

Child Safeguarding Practice Review (previously known as Serious Case Review (SCR) is undertaken by a safeguarding children board when a serious case of child abuse takes place. The criteria for review are outlined in Working Together 2015. The aim is for agencies and individuals to learn lessons to improve the way in which they work

Child Protection Information Share (CP-IS) a programme to assist information sharing between the local authority and heath. CP-IS identifies and safeguards unborn babies and children who are subject to a child protection plan when attending unscheduled healthcare settings in England

DoLS (Deprivation of Liberty Safeguards) are measures to protect people who lack the mental capacity to make certain decisions for themselves. They came into effect in April 2009 using the principles of the Mental Capacity Act 2005, and apply to people in care homes or hospitals where they may be deprived of their liberty.

Glossary continued

Domestic Homicide Reviews DHR are commissioned by local Safer Communities Partnerships in response to deaths caused through cases of domestic violence. They are subject to the guidance issued by the Home Office in 2006 under the Domestic Violence Crime and Victims Act 2004. The basis for the domestic homicide review (DHR) process is to ensure agencies are responding appropriately to victims of domestic abuse offering and/or putting in place suitable support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

Hate Crime Defined as any crime that is perceived by the victim, or any other person, to be racist, homophobic, transphobic or due to a person's religion, belief, gender identity or disability. It should be noted that this definition is based on the perception of the victim or anyone else and is not reliant on evidence.

ISF (Information Sharing Form) A UHSFT hospital system whereby clinicians in ED assess risk (red flags) and identify children/adults where an ISF should be completed. The Paediatric liaison Nursing service assess all completed ISFS to ensure all actions are taken to safeguard the child, this includes sharing the information with external health agencies (GP, Health Visitor, School Nurse) and social services for allocated cases.

JTAI (Joint Target Area Inspection) Examine how well agencies work together in a local area to help and protect children. Inspectors consist of CQC, Ofsted, HM Inspectorate of Probation and HM Inspectorate of Constabulary

LADO (**Local Area Designated Officer)** Involved in the management and oversight of individual cases of allegations of abuse made against those who work with children as set out in the allegations against people who work with children procedure. Their role is to give advice and guidance to employers and voluntary organisations; liaise with the Police and other agencies, and monitor the progress of cases to ensure that they are dealt with as quickly as possible consistent with a thorough and fair process.

Glossary continued

LeDeR -The Learning Disability Mortality Review Programme Established to drive improvement in the quality of health and social care service delivery for people with learning disabilities (LD) by looking at why people with learning disabilities typically die much earlier than average

Looked After Child (LAC) is a child who is accommodated by the local authority, a child who is the subject to an Interim Care Order, full Care Order or Emergency Protection Order; or a child who is remanded by a court into local authority accommodation or Youth Detention Accommodation. In addition where a child is placed for adoption or the local authority is authorised to place a child for adoption - either through the making of a Placement Order or the giving of Parental Consent to Adoptive Placement - the child is a Looked After child.

Looked After Children may be placed with parents, foster carers (including relatives and friends), in Children's Homes, in Secure Accommodation or with prospective adopters.

LPS The new **Liberty Protection Safeguards** was due to come into force in October 2020 (currently delayed due to Covid 19 pandemic) via the Mental Capacity (Amendment) Act 2019. The LPS will replace the Deprivation of Liberty Safeguards (DoLS) as the system to lawfully deprive somebody of their liberty

MARM (Multiagency Risk Assessment Framework) supports management of cases relating to adults where there is a high level of risk but the circumstances may sit outside the statutory adult safeguarding framework but for which a multi-agency approach would be beneficial.

Glossary continued

Mental Capacity Act (2005) provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they may lack capacity in the future. It sets out who can make decisions, in which situations, and how they should go about this.

Mental capacity refers to whether someone has the mental capacity to make a decision or not.

NEST A team of midwives with reduced caseload number specifically to support woman with additional social or significant mental health problems. The team provide bespoke care of the families designed around their individual needs

PREVENT is the government's counter-terrorism strategy, whose aim is to:

- respond to the ideological challenge of terrorism and the threat from those who promote it
- prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support
- Work with sectors and institutions where there are risks of radicalisation that needs to be addressed.

SAMA: The Care Act (2014) requires that any employers who are also providers of care and support, not only have a duty to the at risk adult, but also a responsibility to take action in relation to the employee when allegations of abuse are made against them.
To ensure a consistent, fair, proportionate and transparent approach, the Local Safeguarding Adults Board has developed an allegations management framework, strongly advocating that Trust's have a Safeguarding Allegation Management Advisor (SAMA).

Glossary continued

Serious Adult Review (SAR) is undertaken by a safeguarding adults when a serious case of adult abuse takes place. The aim is for agencies and individuals to learn lessons to improve the way in which they work.

SIRI (serious incident requiring investigation) is a term used for serious incidents in the NHS requiring investigation. It is defined as an incident that occurred in relation to NHS-funded services resulting in serious harm or unexpected or avoidable death of one or more patients, staff, visitors or members of the public.

SUDI (Sudden Unexpected Death in Infants) is deemed to have occurred where there is no known pre-existing condition which would make the death predictable.

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Report to the Trust Board of Directors				
Title:	**Complaints Annual Report 2020-21**			
Agenda item:	**5.6**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Ellis Banfield, Head of Experience & Involvement**			
Date:	**26 July 2021**			
Purpose	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** ✓
Issue to be addressed:	All NHS providers are required to produce an annual complaints report. This duty is set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.			
Response to the issue:	The report summarises complaints activity across 2020/21. It provides a break down of complaints received, complaint management efficiency, and a review of themes. • Complaints management was interrupted by national suspension of complaints processes. The team recovered performance by December 2020. • Volume of complaints received was expectedly lower in the period • COVID19 related concerns and themes were prevalent There have been no PHSO upheld cases in the period due to the pandemic disrupting Ombudsman services.			
Implications: (Clinical, Organisational, Governance, Legal?)	Producing an annual complaints report is a regulatory requirement.			
Risks: (Top 3) of carrying out the change / or not:	n/a			
Summary: Conclusion and/or recommendation	Trust Board is asked to note the annual complaints report.			

WE'RE LISTENING

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ANNUAL COMPLAINTS REPORT

2020/21

RETROSPECTIVE

PERFORMANCE

LOOKING FORWARDS

"All patients, from every background and walk of life, will experience the same **world-class standard of care** at UHS"

Experience of care team

INTRODUCTION

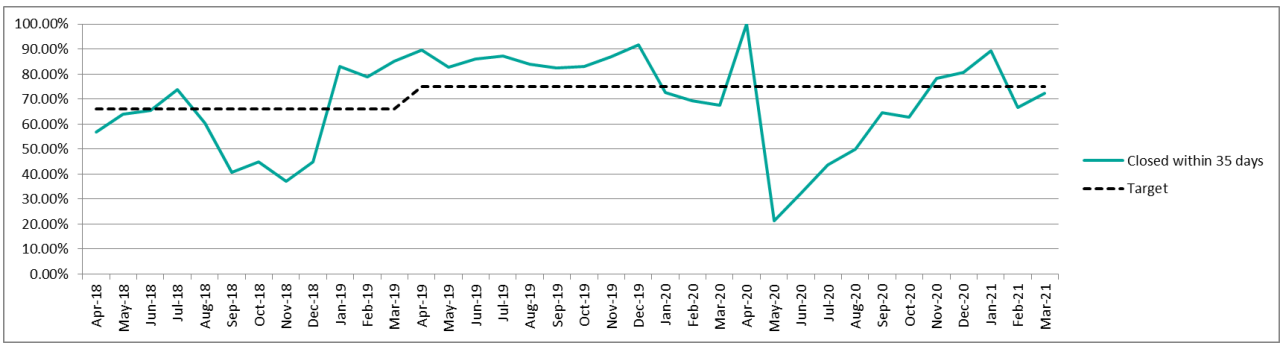
Ellis Banfield
Head of Experience & Involvement

We often get overly focused on functional responses to learning from complaints by looking for specific actions and improvements we can make. Although this is important, a deeper value of complaints is how we, as an organisation, listen. Sometimes in the attempt to identify actions, improvements, and emerging trends, we risk overlooking what a complaint is – a highly personal and individual expression of feeling. Anger and sadness, yes, but also vulnerability, doubt, and fear. Many complaints are a subjective account of an experience of care that has left the individual feeling that they have no other way to make themselves heard. This is the deeper value of complaints – a measure of how much we, as an organisation, are prepared to properly listen to somebody who wants, quite simply, to be heard.

Our complaints process tries to balance the need to identify actions to improve care with the ability to listen, reflect, and recognise that each and every one of us can learn from the experiences of others. The questions we, as an organisation, need to ask are whether we are willing to make ourselves uncomfortable by listening authentically to experiences that aren't good: are we willing to listen, to hear, and to validate experiences that find us falling short? When I reflect back on our complaints process, on our PALS service, on our patient feedback and involvement channels, I do really think that 'we're listening' in the best possible way.

Impact of COVID-19

One of the biggest impacts of the pandemic was on how quickly and effectively we were able to manage and respond to complaints. On the chart below, the improvement made to the complaints process at the beginning of 2019 was maintained consistently until COVID-19 struck and complaints management was paused nationwide in May 2020. Getting back on track took the best part of half a year as the backlog stretched the team's resources.



We have a fantastic complaints team, and we are now ready to build on some of our successes of the past year and work towards delivering a 'best in the NHS' complaints service. I'm immensely proud of how the team have responded in 2020/21 and look forward to supporting them through the next year.

Please note that due to the impact of the pandemic, there were no upheld Parliamentary & Health Service Ombudsman cases in 2020/21.

MEET THE COMPLAINTS TEAM

Working together to put patients first

WE'RE LISTENING

Vicki Havercroft-Dixon

Head of Patient & Family Relations

"I'm responsible for the complaints, PALS, and bereavement teams and this gives me a good view of concerns and complaints to pick out themes and opportunities for learning"

Shona Small

Complaints Manager

"I am the Trust's complaints manager and my role is to ensure that complaints are managed efficiently, within agreed timescales, and to a high standard"

Hayley Yeomans

Complaints Coordinator

"My role is to act as the main point of contact for both the complainant and staff involved. I listen to the complainant's concerns and agree with them what needs to be investigated"

Clare McCormick

Complaints Coordinator

"What I enjoy about the role is being able to empathise, and build trust and understanding to support patients, families, and carers in achieving the best chance of resolution"

Ellen Millard

Complaints Editorial Assistant

"My job involves drafting, editing, and proofreading response letters to ensure that they are easy to understand, contain relevant information, and strike the right balance between fact and empathy"

Experience of care team

LOOKING BACK AT THE PAST YEAR

Shona Small
Complaints Manager

Although the past year has been challenging, we are really lucky that my team are experienced and extremely good at what we do: each complaint coordinator is a qualified complaints investigator and our editorial assistant is qualified and accredited in her field. This expertise has helped us respond to the consistent challenges of the pandemic.

We have worked hard during COVID-19 and we have all adapted to working from home by maintaining good relationships. We pride ourselves on our good communication through Teams, emails, and phone, but also our regular 'walk and talk' meetings that we do outside to ensure we are all supported.

We have maintained good productivity levels despite the impact of the pandemic, the loss of onsite office space, and team members being seconded to short-term projects. We are continually reviewing how best to deliver our service, and we've managed to get back on track following a significant backlog of complaints due to the pandemic.

Key achievement

We had the opportunity in 2020 to recruit to a new role – a first in the NHS, to our knowledge – of a complaints editorial assistant. This post brought into the team professional and accredited proofreading, editing, and writing experience that has elevated the quality of our written responses even further.

Evaluating our service

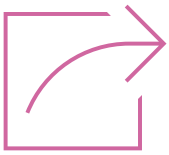
One of the things we've done over the past year is to try to get feedback from complainants about the complaints process. In 2019 we ran an extremely valuable patient complaint panel where service users helped us to review our processes and identify improvements. We've recently launched a complaints survey that all complainants have the opportunity of completing. Although responses are limited, we have seen that:

- All respondents reported being given a single point of contact for managing their complaint
- 91% of respondents said they felt confident their care would not be affected by making a complaint
- 82% said they felt listened to and taken seriously
- 27% felt they could have been kept better informed – an impact, perhaps, of the pandemic
- 91% said the response they received was personal and specific to their concerns

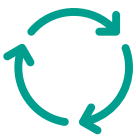
I look forward to building on these results in the coming year as we work to get fully back on track and continue to deliver a high-quality complaints service.

In numbers

345
Complaints received



32
Working days on average to respond



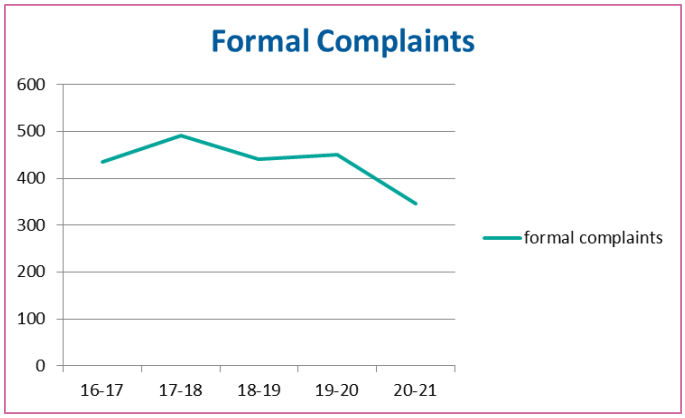
23
Dissatisfied and reopened complaints

WE'RE LISTENING

COMPLAINTS ACTIVITY

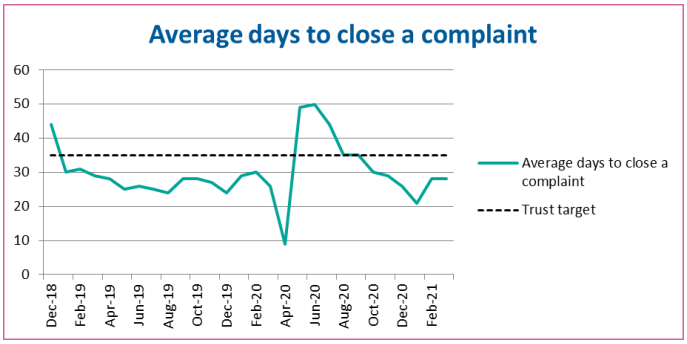
Complaints received

Prior to 2020/21, the Trust received an average of 450 complaints a year. During the pandemic year **345** formal complaints were received – a drop of 105 compared to the previous year. This reflects the response to the pandemic, lower patient numbers due to suspended services, and a national pause on complaints management. The biggest drop-off occurred in the first quarter of the year, before the rate of complaints steadily returned to pre-pandemic numbers.



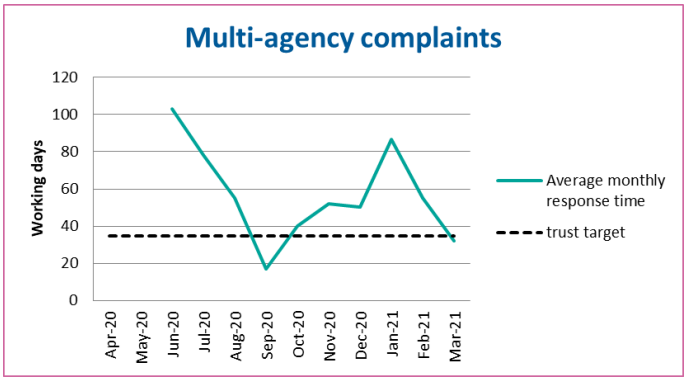
Complaints management

The national pause to complaints management had an unavoidable impact on response times. A backlog of complaints, from before the pandemic and during, needed to be cleared and this work is reflected in the drop in the numbers of complaints being closed within 35 working days in the first 6 months of the year, where it took an average of 37 days to close a complaint. In the second half of the year, the team got back within target and averaged 27 days per complaint.



Multi-agency complaints

Historically, multi-agency complaints (those involving multiple organisations) have always been more challenging to manage as each organisation has different timeframes and priorities. The pandemic has made these even more difficult to complete in a timely manner. In June 2020 we decided to record these complaints separately to better monitor them. From June 2020 to March 2021, we responded to these with an average response time of 57 days – 25 days longer than internal complaints.



THEMES AND TRENDS

We received 345 formal complaints in 2020/21 and trying to find themes and trends within and across 345 very individual experiences is challenging. We report our complaints data to NHS England every quarter and submit a breakdown of complaint themes according to nationally-defined categories: communication, clinical treatment, access to services, and more. Although the categories help reporting, to understand the concerns being raised, a deeper dive is required.

Ellis Banfield
Head of Experience & Involvement

One of the most prominent things that jumps out of a review of our complaints is how complaints often have multiple themes within them. For example, some of our patients had reason to complain as they felt their diagnosis was delayed and their symptoms not recognised early enough. Woven into these complaints are concerns about communication, both its timeliness and its empathy, as well as other aspects of care, such as pain management. One aspect of a complaint is often the driver behind others: poor communication or pain management often influences how other elements of care are experienced and reported within complaints. It is clear when reading these letters that these different aspects of complaints are often so interlinked and interrelated as to make simple categorisation challenging.

Clearly the pandemic was the ever-present backdrop to all our activity over the past year and the complaints we received reflect this vividly. COVID-19 and the response to it put strain on the important partnership between patients, staff, and families and this effect is unmistakable in many of our complaints. The visiting restrictions put greater focus on the need to communicate effectively and clearly with both patients – many deprived of immediate family support during care and treatment – and families, who were at a distance outside the hospital. While we implemented initiatives such as virtual visiting, a messaging service, and a patient drop-off property pod, we did not always get it right and keep patients and families connected in the way they wanted. Our complaints evidence the challenges for families in contacting the ward, being involved in discussions about treatment, and being kept up-to-date about their relative's care. Our responses from staff document just how challenging it was working in the hospital during the pandemic but testify to their ongoing commitment to getting it right for patients and their families.

Respecting religious rites and customs, especially at the end of life, in death, and in bereavement, is immensely important to us, but we also had to learn and adapt our practices in response to COVID-19 and the need to ensure we remained committed to helping our patients of different faiths. Feedback in our complaints have helped us achieve this: for example, in response to a complaint about preparation of bodies for Islamic funerals, Siraj, our spiritual care manager and Muslim chaplain, will now be teaching this at nurse study days.

Visiting restrictions proved challenging for patients, families, and staff. The complaints, for example, from adult children about their parents admitted with dementia and other vulnerabilities expressed a clear worry about ensuring the care was appropriate for their parent, but also highlighted feelings of helplessness and detachment. Attempting repeated calls to wards for updates proved frustrating for families and staff alike, and in some instances intensified communication problems. We continued to evolve our visiting policy both on feedback from families and staff, as well as aligning with national policy and guidance. We tried to ensure that compassionate visiting was offered and introduced a range of support for carers to continue to be involved and support the delivery of care.

THEMES AND TRENDS

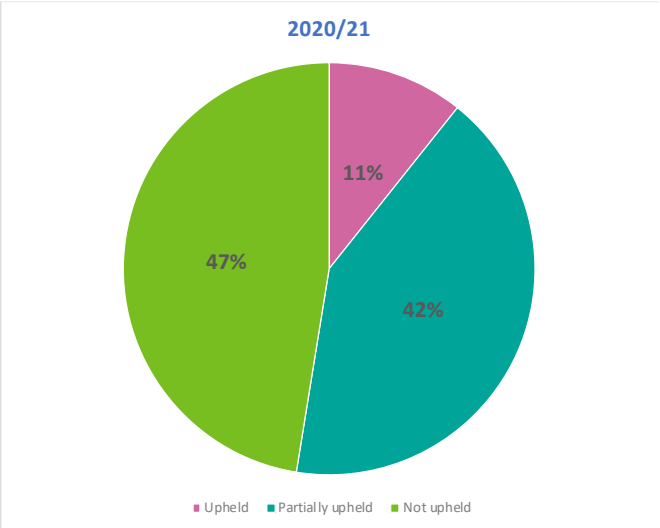
Our response to the pandemic also had an impact seen in some of our multi-agency complaints. These complaints highlighted situations in which patients and families were often given different information by different care providers. For example, a relative being told by the GP they would be able to travel in the ambulance with their parent only to be told this wasn't allowed by the ambulance crew, compounded by no information being provided on admittance about what support was available at hospital. Navigating through each organisations' processes and policies was clearly challenging for the relative and highlights the importance of thinking about the interconnectivity of organisations through the healthcare system.

Some of our most challenging complaints were those involving the end of life, as although all our staff are completely committed to getting it right for patients and families, on the occasions when things do go wrong, the impact can be deep and traumatic. Delayed treatment, the impact of hospital-acquired COVID-19, and unexpected or rapid deterioration leading to death all greatly impacted families and staff involved in care. There were occasions where communication was perceived to fall short, and where families felt outside the decision-making process and not empowered, such as during DNACPR discussions and decisions. In our investigations and responses we were not always able to agree with the complainant's views, but we recognised the emotional distress bereavement can cause and explained our position clearly, empathetically, and signposted to further support and advice.

We've taken learning from these complaints and have adjusted our visiting policy, looked at availability and timeliness of anticipatory care plan drug prescriptions, and sought to redouble our efforts to keep families involved. We relaunched our end of life care programme board in late 2020 to provide assurance, oversight, and learning, review complaints and hear directly from families about their experiences.

Upheld complaints

In every complaint we investigate, we look at whether we can uphold the complaint (agree with the complainant on all points of concern), partially uphold it (agree on aspects of concern), or not uphold it (where we find no failings and cannot agree with the complainant). The chart to the right shows how many complaints were **upheld (11%), partially upheld (42%), and not upheld (47%)**.



WHAT WE ARE DOING NEXT

The pandemic has certainly been a challenging period in which to manage complaints, but there are now some real opportunities for us to build on the changes we've made to our processes and practices and continue to work towards making complaints count.

Vicki Havercroft-Dixon
Head of Patient & Family Relations

In 2021 a new set of NHS Complaints Standards was developed by the Parliamentary and Health Service Ombudsman to set out a quicker, simpler, and more streamlined complaints handling service. The standards are being piloted across a number of Trusts before being nationally rolled out in 2022. We have applied to be a pilot in the second phase of the rollout. While we believe in our complaints processes and have confidence we handle complaints well, a national agreed standard can only help improve the overall experience of people making complaints to NHS organisations and we are fully supportive of this.

Documentation of learning and actions

One of our early priorities, identified through our initial gap analysis, is to improve the documentation of our learning from complaints and to make this learning more widely available. Working with divisional teams, our aim is to ensure learning and actions are recorded on the action plan module of our Safeguard system. This will lead to better assurance and oversight that actions are being completed and will allow us to feed back the positive steps we are taking to complainants and the public.

Early resolution

Resolving complaints early has long been an organisational objective and we do it well. The pandemic introduced new challenges: we found that although complainants were willing to try a resolution meeting, many of them wanted these face-to-face and did not want to do it virtually via Teams or Zoom. As restrictions ease, we want to bring back resolution meetings as an effective way of managing complaints and have applied for funding to put the team on mediation and conflict resolution training to better equip them with the tools to manage these meetings successfully.

Complaint ownership

Our complaints coordinators Hayley and Clare play a vital role in managing investigations, but there are some complaints that can be answered by one individual, often directly. Ellen, our complaints editor, will start working with clinicians to offer writing support where a direct written response will resolve a complaint quickly and effectively.

Making complaints inclusive

In 2018 we took steps to ensure that information about how to make complaints was available in accessible formats such as braille, large print, different languages, and audio recordings.
A review of our complaints demographics still shows below expected levels of diversity in those who complain. We recognise that we need to give more attention to ensuring that people from different backgrounds have the confidence in the system to speak up and share their experiences. We will be working hard in 2021/22 to ensure that there are no barriers to accessing our complaints service.

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Medical Appraisal and Revalidation Annual Report including Board Statement of Compliance**			
Agenda item:	**5.7**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Author:	**Liz Brown, Medical HR Operations Manager**			
Date:	**29 July 2021**			
Purpose	**Assurance or reassurance**	**Approval** x	**Ratification**	**Information** x
Issue to be addressed:	NHS England and NHS Improvement cancelled the 2019/20 Annual Organisation Audit and are also standing down the 2020/21 exercise. Organisations can report appraisal data via the simplified annual board report and the Statement of Compliance.			
Response to the issue:	Medical appraisals were stood down for much of 20/21 to allow clinicians to support the Trust response to the pandemic, missed appraisals were therefore considered an approved deferment. When able, individuals were encouraged to participate in the appraisals process, using the Appraisal 2020 model developed by NHS England. This appraisal format encouraged a greater focus on individual health and wellbeing in recognition of the exceptional stresses that the COVID-19 pandemic has placed on healthcare workers.			
Implications: (Clinical, Organisational, Governance, Legal?)	The responsible officer (RO) has a statutory duty to ensure compliance with NHS England and GMC requirements for appraisal and revalidation. The Chief Medical Officer is the RO for the Trust.			
Risks: (Top 3) of carrying out the change / or not:	Compliance with the The Medical Profession (Responsible Officers) Regulations 2010 (as amended) and related guidance.			
Summary: Conclusion and/or recommendation	The Board is asked to note the summary information included in this report and acknowledge the interim changes to the national reporting requirements. The Board is asked to approve the “Statement of Compliance” at Appendix A, confirming that the organisation, as a designated body, is in compliance with the medical profession regulations.			

University Hospital Southampton NHS Foundation Trust

Designated Body Annual Board Report

Section 1 – General:

The board of University Hospital Southampton NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: Return was not requested centrally due to COVID-19. Action from last year: Renewed focus on quality of appraisal records and plan for improvements in the next cycle. Comments: Further impact of the pandemic and a national instruction to stand appraisals down for much of the year meant this was not achieved for all. Action for next year: Renewed focus on quality and compliance with appraisal supported by a new appraisal platform.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: None Comments: Yes Action for next year: None

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: An alternative platform for Revalid or the procurement of a new system is required, either option will require investment. The system solution will need to include improved functionality for patient feedback. Comments: Funding secured, and a procurement process is underway, contracting and implementation planned for the summer / autumn months. Action for next year: Roll out and embed the new appraisal system, mandating usage of the online system will ensure greater governance and visibility

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: A system solution for continued management is required. Comments: Connections are manually managed by the Medical HR team centrally. Procurement of a system was delayed due to the pandemic. Solution sourced and in contracting stage. Action for next year: Procure, roll out and utilise all functionality of a new appraisal system

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: None Comments: Policies monitored and national guidance changes incorporated as required. Action for next year: None

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: Continuation of the local patient feedback project, in conjunction with system reviews. Comments: A peer review has not taken place since January 2019. The patient feedback project was implemented and paused due to the pandemic. The appraisal software system will support patient feedback collection. Action for next year: Doctors will collect patient feedback through the appraisal software system, once procured the UHS team will work with developers to ensure electronic collection is accessible, this includes development of a QR code.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Consider ways to improve the central management of this group and opportunities to further support or develop. Comments: Enlisted support of local appraisers to facilitate access to appraisal and CPD, this is difficult to manage for individuals that undertake limited work in multiple areas. Action for next year: Support requests for access to this group via the central team.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: Agree a system to formally manage approved postponements. Comments: The national pause to appraisals and the COVID approved deferments meant this action was not fully implemented. Action for next year: Appraisal leads to publish process and the appraisal software platform will support the management of deferments or postponements within the AOA framework.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Understand how the appraisal leads, care group clinical leads and divisional clinical directors can actively manage the appraisal cycle. Comments: Doctors with overdue appraisals are contacted and reminded of their responsibility to complete their appraisal. A list of doctors with an overdue appraisal of 3 months or more without an acceptable reason will be submitted to the RO and the monthly Decision Making Group meeting. The circumstances of each case will be reviewed with action determined. The Trust reserves the right to undertake appropriate action where a doctor fails to take sufficient steps to participate in the appraisal process. Action for next year: Appraisal leads to publish process and the appraisal software platform will support the management of deferments or postponements within the AOA framework.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: None Comments: The Trust's Medical Appraisal and Revalidation policy is compliant with national policy and has been approved via the central policy ratification group. Action for next year: None

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: None Comments: There are currently 150 trained consultant appraisers, responsible for 865 Appraisals per annum for consultants and senior doctors, this is within the national recommended ratio. Fellows are appraised by their education supervisor and the appraisal process also covers a formal end of placement review. Action for next year: None

5. Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year: None Comments: The appraisal leads deliver a range of in-house training, regular appraisal leads meetings are held for information sharing and development. A proportion of all appraisal documentation is reviewed via a structured review form; feedback is given to individual appraisers. Action for next year: None

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: None Comments: All doctors are asked to rate the quality of appraisal and the suitability of the appraiser. A proportion of all appraisal documentation is reviewed by the care group lead appraiser. The medical HR team review all form 4s submitted. Finding discussed with the Decision Making Group. Action for next year: None

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: None Comments: During the period 1 April 2020 – 31 March 2021 the RO made 45 positive recommendations and 12 deferral recommendations. 126 were auto deferred by the GMC. Action for next year: None

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: None Comments: 126 individuals were automatically deferred by the GMC in line with pandemic protocols. The 12 deferrals submitted by the RO were made to enable doctors to collect additional evidence to support the revalidation decision. Where a deferral was recommended, the doctor was notified with confirmation of the actions required. Action for next year: None

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: None Comments: Complaints and serious incidents are discussed and reflected upon as part of the process. Local and Divisional governance reports are reviewed at the Quality Governance Steering group, the group reports to the Trust Executive Committee and the Board. Action for next year: None

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: None Comments: : Management teams monitor performance of teams and review complaints and incidents at monthly governance meeting. An annual report of any doctor with more than three complaints is presented to the Chief Medical Officer. Activity data is available from divisional analysts at the request of doctors in advance of appraisal. Action for next year: None

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: None Comments: Concerns regarding a doctor's performance or conduct are managed through the Handling of Concerns Relating to the Conduct and Performance of Doctors and Dentists Policy. Concerns are addressed accordingly with support from HR. The Trust has a lead for Patient Safety, and a Deputy Chief Medical Officer, who both assist the Chief Medical Officer with any escalations or serious concerns, through a formal process. Action for next year: The policy is due to be reviewed in July 2022.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[2].

Action from last year: None Comments: Concerns regarding a doctor's performance or conduct are managed through the Handling of Concerns Relating to the Conduct and Performance of Doctors and Dentists policy. Concerns are addressed accordingly with support from HR. The Trust has a lead for Patient Safety, and a Deputy Chief Medical Officer, who both assist the Chief Medical Officer with any escalations or serious concerns, through a formal process. Analysis in line with protected characteristics has been carried out and shared in appropriate forums. Action for next year: None

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].

Action from last year: None Comments: A process is in place for transferring information and concerns between the RO and other ROs where UHS connected Doctors undertake regular work. Action for next year: None

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: None Comments: The UHS policy for Handling of Concerns Relating to the Conduct and Performance of Doctors and Dentists is in line with Maintaining High Professional Standards guidance. All policies are ratified by the relevant Trust 'expert' group following consultation with all applicable groups. This also applies to all clinical governance and safeguarding policies and processes. Action for next year: None

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Continue regular auditing practices to ensure compliance with NHS Employers mandatory checks that are in place for all new starters. Comments: The medical HR team is responsible for undertaking pre-employment checks, in line with NHS Employers mandatory standards. The temporary resourcing team are responsible for ensuring that appropriate pre-employment documents are provided for any temporary workers, supplied via a locum agency. Action for next year: None

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

1. **General review of last year's actions**

Whilst work has commenced on the actions set last year, progress has been slower than anticipated. Activities will need to restart later this year, once resources can be diverted from the pandemic response.

2. **New Actions:**

- Renewed focus on quality and compliance with appraisal in line supported by a new appraisal platform.
- Roll out and embed the new appraisal system, mandating usage of the online system will ensure greater governance and visibility
- Doctors will collect patient feedback through the appraisal software system; once procured the UHS team will work with developers to ensure electronic collection is accessible, this includes development of a QR code.
- Continue to improve support available to bank doctors, enabling access to appraisal and development.
- Implement and improved process to manage deferments or postponements, ensuring accurate recording within the AOA framework.

3. **Overall conclusion:**

Appraisal compliance at 31st March 2021 was 95%, the positive compliance rate was mostly due to the high number of approved deferments with the appraisal cycle in response the pandemic. Where appraisals have taken place the Appraisal 2020 form has been utilised.

The pandemic response greatly delayed several key projects, including the procurement of an appraisal system and implementation of an improved patient feedback system. A tender process is nearly complete and an IT solution to support appraisal, patient feedback collation, 360 multi-source feedback and revalidation will be implemented for the third quarter. The appraisal platform will allow real time accurate reporting and improve visibility of appraisal compliance for the RO.

Statement of Compliance

The Board of University Hospital Southampton NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Chief executive or chairman

Official name of designated body: University Hospital Southampton NHS Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Integrated Performance Report 2021/22 Month 3**			
Agenda item:	**5.8**			
Sponsor:	**Chief Executive Officer**			
Date:	**29 July 2021**			
Purpose:	**Assurance or reassurance Y**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	The report aims to provide assurance: • Regarding the successful implementation of our strategy • That the care we provide is safe, caring, effective, responsive, and well led			
Response to the issue:	The Integrated Performance Report reflects the current operating environment and is aligned with our strategy.			
Implications: (Clinical, Organisational, Governance, Legal?)	This report covers a broad range of trust 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

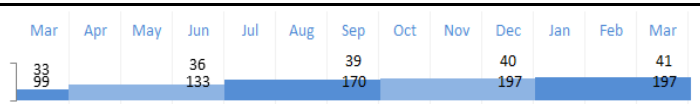
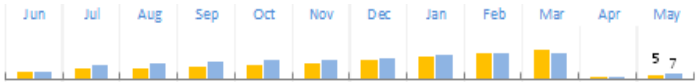
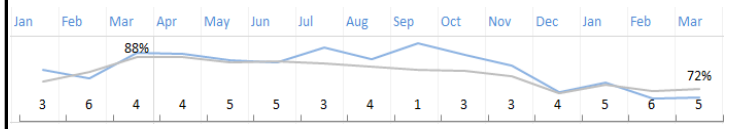
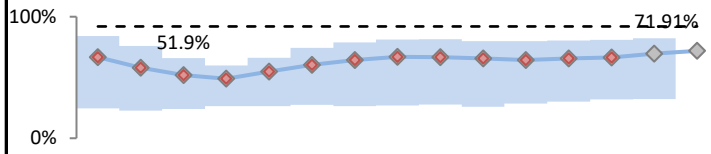
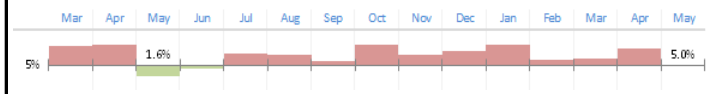
covering up to

June 2021

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

Report Guide

University Hospital Southampton NHS
NHS Foundation Trust

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

University Hospital Southampton NHS Foundation Trust

Introduction

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

The report aims to provide assurance:

- Regarding the successful implementation of our strategy
- That the care we provide is safe, caring, effective, responsive, and well led

This month the structure of the report has been modified to better reflect the ambitions within 'Our Strategy 2025', and support the strategic discussions of the Board:

- A 'Spotlight' section has been introduced to enable more detailed consideration of any topics that are of particular interest or concern
- The indicators that are presented monthly have been aligned with the five themes within our strategy
- The total number of indicators presented has been reduced, and the selection of indicators amended, with the aim of:
  - Better reflecting our strategic commitments
  - Reducing duplication; recognising that some indicators were also presented to the Board and its Committees in other reports, and that other indicators relate to subjects that are appropriate for monitoring by Executive Committees

This month there are some new indicators where data collection has not yet started, or reporting is currently being developed, these will be addressed over the coming month.

Our indicators and this report structure will continue to be regularly reviewed, and feedback would be welcome.

June 2021 Summary

This month the 'Spotlight' section features:

1. Cancer waiting times performance, by service
Cancer waiting times performance has been good in comparison to other NHS hospitals but has not met the national standards as consistently as we would want, and there are significant variations between different services (tumour sites) within the Trust.

2. Referral to treatment (RTT) waiting times
Referral to treatment waiting times and the size of our RTT waiting lists have experienced major impacts during the pandemic. It is exceedingly challenging to address the clinical priorities, and improve this aspect of patient experience.

Highlights to note in the appendix containing indicators by strategic theme include:

• 19 Clostridium Difficile infections year to date, compared to a target of 15
• Zero healthcare acquired / probable COVID-19 infections in May and June
• Unprecedented high Emergency Department attendances, and a further modest decline in performance to 83% in June
•Completed appraisal rates of 88% for medical staff and 79% for non-medical staff

'Never Events' will now be reported here on an exceptional basis if they occur. There were two never events in June (having had none occur in the previous year), these were:

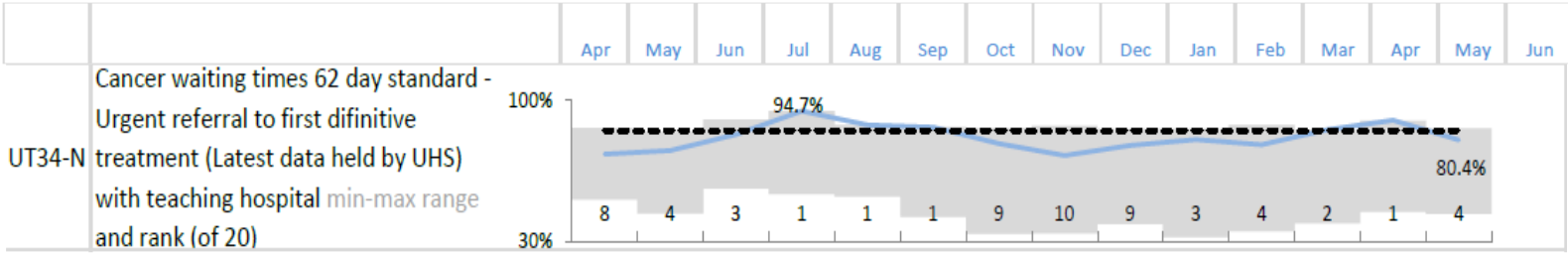
• One wrong side block (anaesthetic injection to the wrong side of the body, requiring correct injection prior to surgery)
• One wrong site surgery (removal of the 'wrong' mole)

Neither patient came to significant harm but both investigations highlighted key learning points that would have prevented the incidents. Actions are being taken to reinforce adherence to practices required when undertaking invasive procedures, including the 'stop before you block' process and 'stop points for safety'. Both incidents are also reported as SIRIs in June data.

University Hospital Southampton NHS Foundation Trust

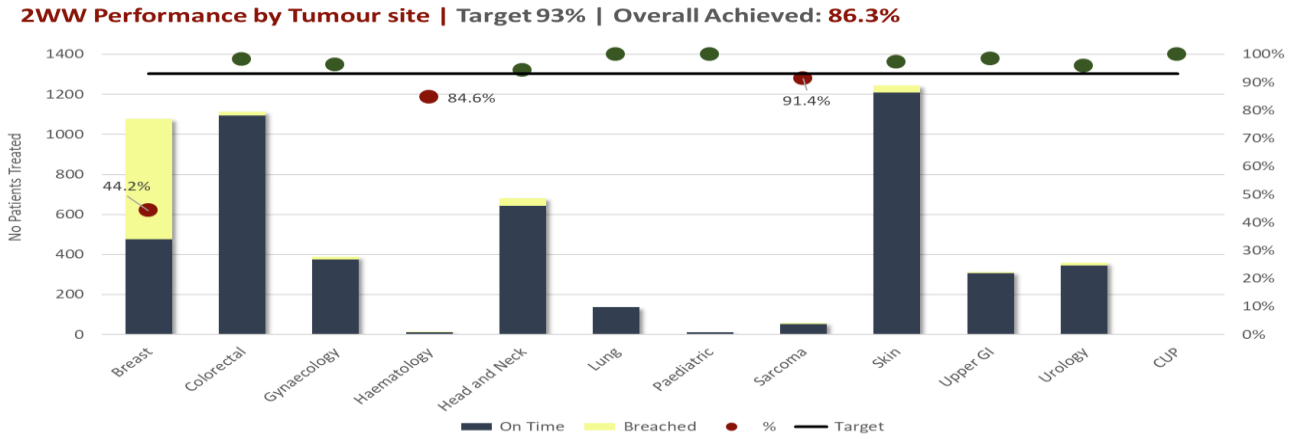
Spotlight Subject - Cancer Waiting Times Performance, by Service

The Wessex Cancer Alliance is the top performing alliance in England, and UHS currently benchmarks extremely well against peers having responded well to challenges during the pandemic.

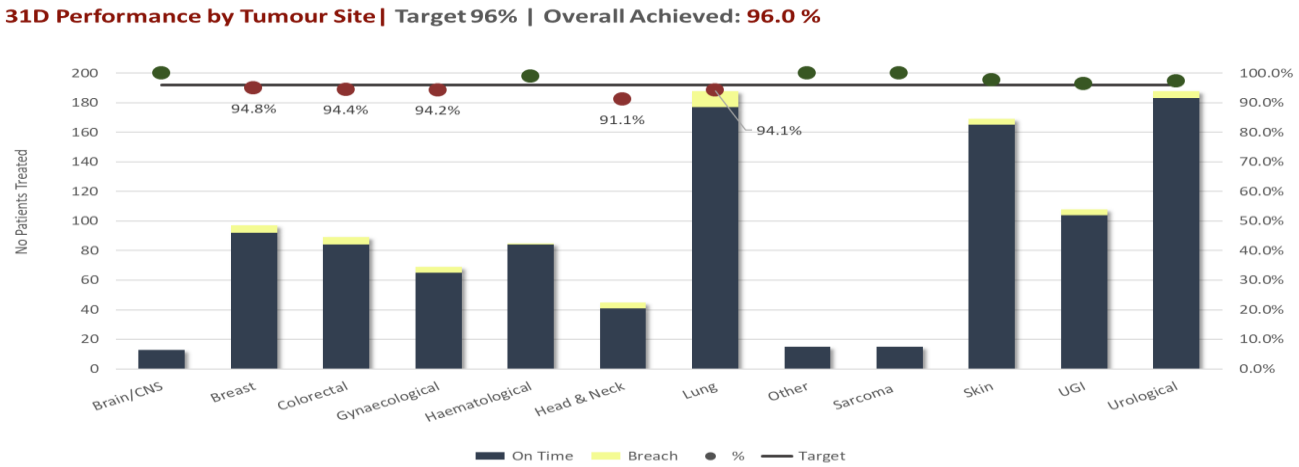


We are however concerned regarding the developing risks to available capacity during this summer, as a result of COVID-19 admissions, COVID-19 sickness, and also isolation by staff, at a time when many clinicians will also have planned in advance to take some annual leave.

Achieving first appointments within 14 days of referral (2WW) is typically good. Predicted Q1 performance is significantly below the standard in the breast service, linked to trends in demand, and low flexibility (because almost all 'non-cancer' breast referrals are also due to be seen within 14 days). A locum surgeon has been in post since June, and substantive recruitment of two surgeons has been approved in July, as a response to this challenge.



Once a cancer treatment plan has been agreed, this is normally started within the 31 day standard. Additional theatre capacity in the second half of the year will improve resilience, as will the completion of the LINAC replacement programme in Radiotherapy. Further investment in Radiotherapy may also be considered this year, in response to increasing demand, and the complexity of modern treatments.

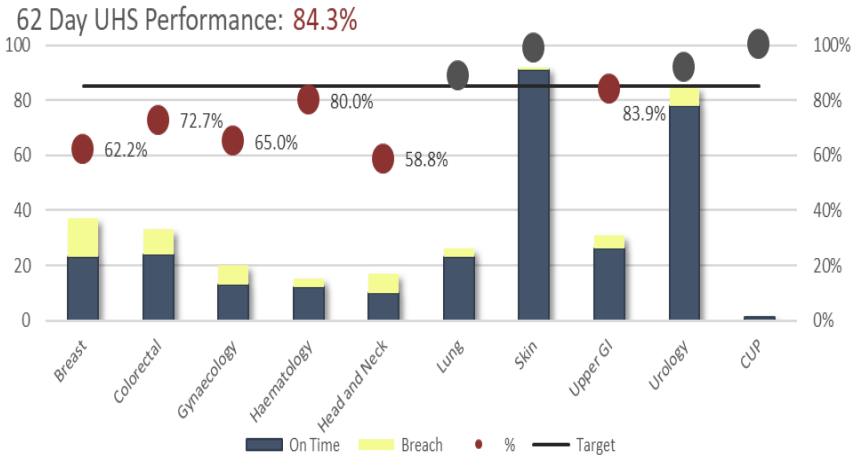


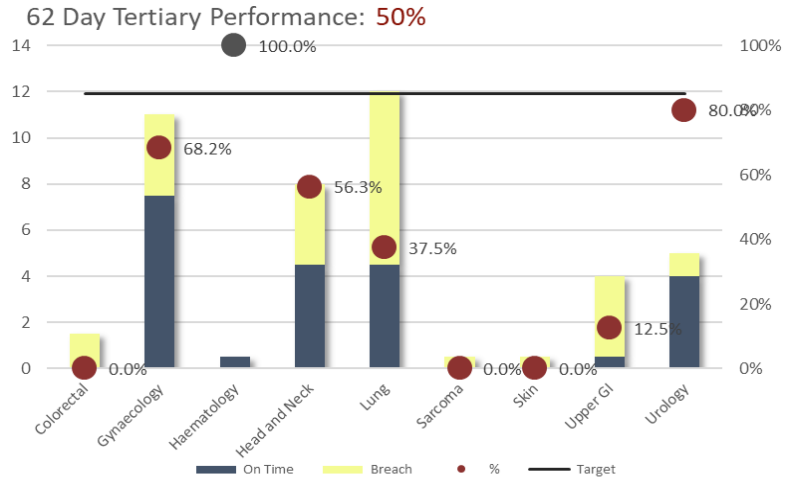
With initial appointments, and treatments performing relatively well, our timeliness performance challenges mainly relate to the pathways of investigation, diagnosis and 'staging' of disease in order to determine the appropriate treatment.

The following charts show timeliness performance for the whole cancer pathway, from referral to start of first definitive treatment, against the 62 day standard (Quarter 1 Predicted). It can be seen that:

1. Performance varies significantly between the cancer services, and several are well below the national standard expected of trusts. Overall Trust performance is improved as a result of good performance in high volume cancer services such as Urology and Skin. This pattern is not unusual amongst hospitals, and some cancer services experience significantly greater challenges to commence treatment within 62 days than others (for example due to the type and number of investigations that are clinically appropriate).

2. Performance is significantly better for patients referred directly to UHS, than it is for the minority of patients referred to other hospitals in our area and subsequently transferred to UHS for specialist treatment that is not available elsewhere ('Tertiary' pathways). This pattern would be expected because such patients are likely to have more complex needs than the average for their service. It is also likely that achieving the pathway across two or more hospitals increases challenges in care co-ordination, and to pathway improvement work.

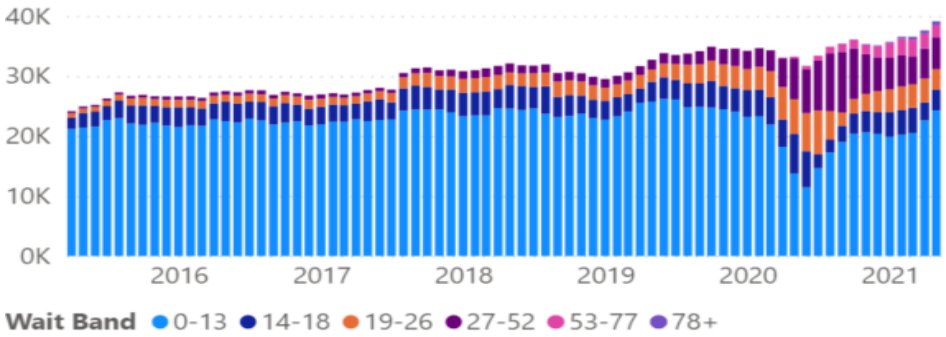




Whilst many of the performance levels at service level have been persistent over a number of years they are not inevitable, as demonstrated by significant improvements in Urology in recent years. Our intention is to work with Tumour site MDT leads to further improve performance and to achieve the national standards in each service as well as the Trust as a whole. This will include benchmarking performance at service level to identify those areas with the greatest opportunity for improvement and suitable peer hospitals we might learn from.

Spotlight Subject - Referral to treatment (RTT) waiting times

Both the volume of hospital activity, and new referrals to hospital services, have changed significantly during the pandemic. The net result has been a significant rise in the total size of the waiting list, and also the number of patients waiting exceptionally long periods for treatment to be provided (for example 53 weeks or more, 78 weeks or more). 72% of patients are waiting less than 18 weeks compared to the national target which remains 92%, yet UHS performance is better than the average of the teaching hospitals we benchmark against.

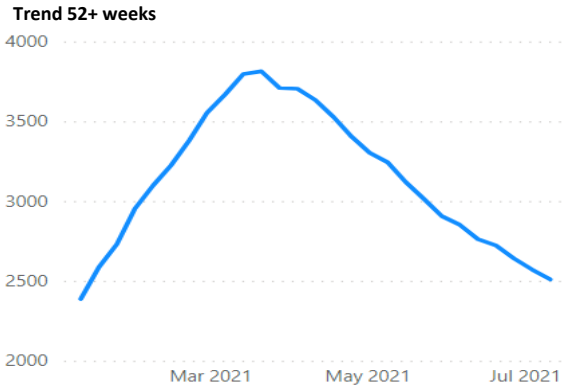


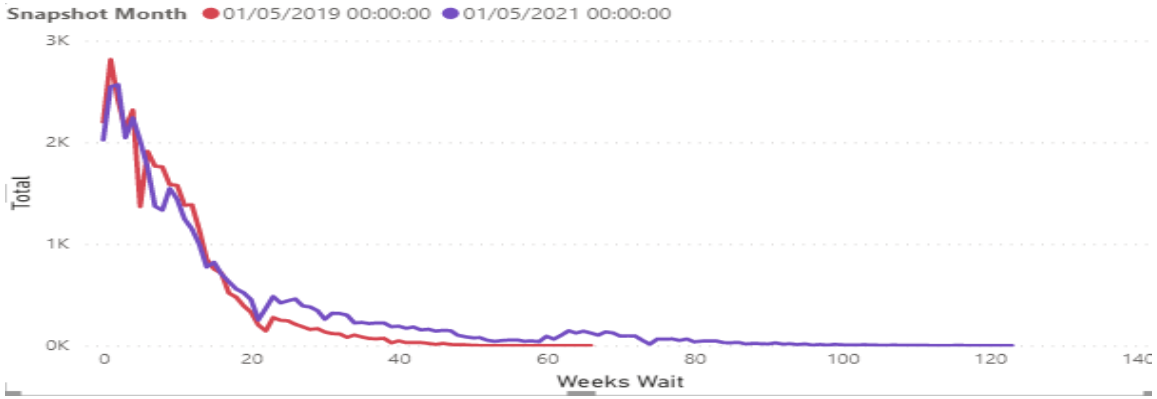
Future waiting times and numbers depend upon both the level of referrals, and hospital activity, that might be achieved. Elective referral levels have returned to those pre-pandemic, and it is highly uncertain to what extent a surge of additional demand might or might not occur as a result of needs not met during the pandemic. UHS is seeking to maximise elective activity levels appropriately, alongside service transformation including advice and guidance, patient initiated follow-up, and shared decision making. HIOW ICS has been designated an 'Accelerator System', has been allocated additional funding in 2021/22, and is expected to achieve activity levels equivalent to 110% of those in 2019/20. Our recent activity levels, expressed in relation to the 2019/20 equivalent, are as follows:

	M1 Performance %	M2 Performance %	M3 Performance % Estimate
Elective	**91%**	**105%**	**88%**
Outpatients	**110%**	**117%**	**101%**

Note: Assesment of the financial tariff value of activities
Note: M2/M3 performance impacted by change in position of 'half-term' between years

Unfortunately, it is anticipated that despite these activity levels, and recent reductions in patients waiting over 52 weeks, the cohort of long waiting patients will grow further before it reduces. This reflects higher numbers of patient approaching a 52 week wait currently, which in turn is the result of referrals increasing faster than hospital activity at the end of the first 'lockdown' in June 2020.





The following tables set out the current waiting list size at the end of June 2021, and the number of patients currently waiting >78 weeks. The 10 largest specialties are shown in each case, and the Trust total. Patients waiting are split between those known to be waiting for an admission, and all others.

The waiting list as a whole is primarily populated by outpatient care, and includes many of our largest volume specialties.

The waiting list >78 weeks is of greatest concern and is primarily populated by inpatient care, and involves surgical specialties where many of the patients have lower clinical urgency compared to others, require inpatient bed capacity, and are less appropriate for treatment outside an acute hospital setting with full facilities.

Capacity constraints are likely to continue to adversely impact upon recovery despite UHS investments in bed capacity in 2020/21, and in theatre capacity in 2021/22.

Our available capacity is allocated and prioritised in a clinically led process which considers the clinical urgency and risk to the patients waiting. Patients are assigned to clinical priority groups according to national guidance. For example over 1,300 of the patients waiting for admission have been categorised 2 (the second most urgent category, should be operated on within 1 month), and their average wait from prioritisation is 6 weeks, and RTT wait 12 weeks.

Count of RTT ID	Incomplete type (grouped)		
Specialty	Referral and Still on Pathway	Waiting for Admission	Grand Total
130 - OPHTHALMOLOGY	4991	936	5927
502 - GYNAECOLOGY	2234	909	3143
110 - TRAUMA AND ORTHOPAEDIC	1117	1800	2917
400 - NEUROLOGY	2335	40	2375
101 - UROLOGY	1107	655	1762
330 - DERMATOLOGY	1269	364	1633
104 - COLORECTAL SURGERY	1274	343	1617
214 - Paediatric Orthopaedics	1138	448	1586
120 - EAR NOSE & THROAT	922	622	1544
140 - ORAL SURGERY	1046	339	1385
Grand Total	**31057**	**9768**	**40825**

>78 Weeks

Specialty	Referral and Still on Pathway	Waiting for Admission	Grand Total
110 - TRAUMA AND ORTHOPAEDIC	5	276	281
120 - EAR NOSE & THROAT	21	123	144
140 - ORAL SURGERY	2	54	56
502 - GYNAECOLOGY	1	40	41
104 - COLORECTAL SURGERY	3	23	26
171 - PAEDIATRIC SURGERY		22	22
108 - SPINAL SURGERY SERVICE	2	12	14
101 - UROLOGY	3	10	13
150 - NEUROSURGERY	3	7	10
100 - GENERAL SURGERY		10	10
Grand Total	**63**	**626**	**689**

UHS is collaborating in ICS led efforts to respond to this elective care challenge, which significantly exceeds any in the last decade. Significant strategies being pursued by the ICS include:

1. An Elective Activity Care Hub (EACH) to co-ordinate care. The intention is that it will ensure equity of patient experience, enable long waiting patients in challenged specialties to be offered treatment in capacity across the ICS, and reduce the number of patients experiencing the longest waits. Challenges are likely to include shortfalls in available capacity being widespread across the ICS and NHS currently, and patient preferences to remain with their current services / locations despite a wait.

2. An Elective Care Hub would provide additional surgical treatment (theatres and beds) for patients across the ICS in a location 'protected' from emergency pressures. It is likely the facility would focus on high volume 'routine' surgery in a limited number of specialties. Challenges are likely to include the time it may take to create the additional capacity, and ensuring that it is clinically appropriate to treat the types of procedures and patients who are waiting >52 weeks there (greater flexibility already exists for less complex surgery).

UHS is focused on doing all it can within our own facilites in the meantime, including the following strategies:

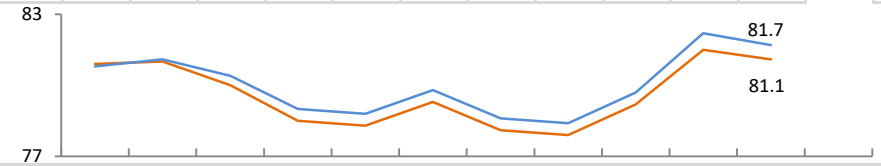
A. Opening additional physical capacity including theatres and outpatients (including eye unit expansion)

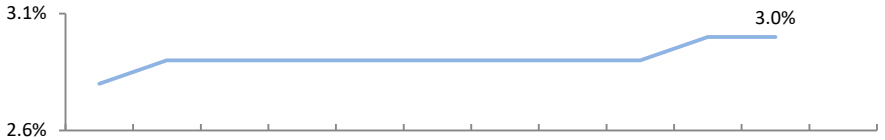
B. Optimising productivity / transformation of pathways through our facilities, including improvement progammes in theatres and outpatients

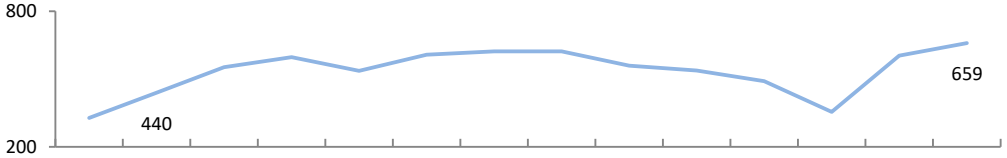
C. Significant recruitment to additional clinical and support roles, supported by 2021/22 NHS financial framework

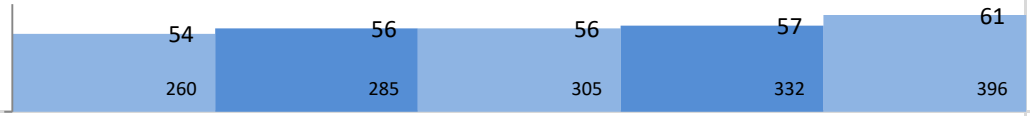
D. Continuing to prioritise based upon clinical priority, and implement important advances in healthcare including new medical and surgical treatments e.g. NICE approved drugs in Neurology, recommended expansion of criteria for Transcatheter Aortic Valve Implantation

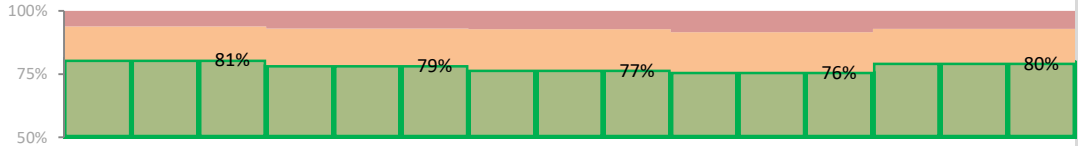
Outcomes		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Monthly target	YTD
UT1-N	HSMR - UHS HSMR - SGH																≤100	
UT2	HSMR - Crude Mortality Rate																-	
UT3	Emergency readmissions within 30 days of discharge from hospital (exclude cancer/chemotherapy, obstetrics)																-	
UT4-L	Cumulative Specialities with Outcome Measures Developed																+1	
UT5	Developed Outcomes RAG ratings																-	











Safety		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Monthly target	YTD
UT6-N	Cumulative Clostridium difficile	24 18	27 32	30 39	35 43	42 50	48 52	54 55	60 57	70 63	5 7	11 16	15 19				5	19
UT7	**Healthcare-acquired COVID infection**: COVID-positive sample taken >14days after admission (validated)	28	12	1	0	0	0	8	0	10	39	2	5	0	0	0	-	0
UT8	**Probable hospital-associated COVID infection**: COVID-positive sample taken >7 days and <=14 days after admission (validated)	24	13	1	0	0	0	7	2	6	59	2	2	1	0	0	-	1
UT9	Pressure ulcers category 2 per 1000 bed days	0.35														0.26	-	-
UT10	Pressure ulcers category 3 and above per 1000 bed days	0.39														0.23	-	-
UT11-N	Medication Errors (severe/Moderate)	4														3	≤3	7

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Monthly target	YTD
UT12	Antibiotic usage per 1000 admissions This year vs. last year		8,500 5,360 4,625 1,500												5,626 3,782		-	-
UT13	Serious Incidents Requiring Investigation (SIRI) (based upon month reported as SIRI, excluding Maternity)		40 0	4											7		-	17
UT14	Serious Incidents Requiring Investigation - Maternity		5 0	0											1		-	-
UT15	Number of high harm falls per 1000 bed days		0.2 0.0	0.078											0.115		-	-
UT16	% patients with a nutrition plan in place		100% 80%												93.9%		-	-
UT17	Red Flag staffing incidents		50 0	10											8		-	-

Patient Experience		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Monthly target	YTD
UT18-N	FFT Negative Score - Inpatients	0.0%														0.4%	≤5%	-
UT19-N	FFT Negative Score - Maternity			2.6%												4.5%	≤5%	-
UT19-N - A correction has been made to the data reported in the IPR for Feb 2021																		
UT20	Total UHS women booked onto a continuity of carer pathway															41.1%	-	-
UT21	Total BAME women booked onto a continuity of carer pathway															63.5%	-	-
UT22	% Patients reporting being involved in decisions about care and treatment	87.0%														88.0%	≥90%	-
UT23	% Patients with a disability/ additional needs reporting those needs/adjustments were met (total number questioned included at chart base)	100.0%														93.0%	≥90%	-
		39	57	153	215	133	164	174	178	240	77	63	110	289	251	266		
UT23 - Performance is a scored metric with a "Yes" response scoring 1, "Yes, to some extent" receiving 0.5 score and other responses scoring 0.																		
UT24	Overnight ward moves with a reason marked as non-clinical (excludes moves from admitting wards with LOS<12hrs)	82.57		28												27	-	-
		42.67																
		2.77																

Access Standards

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Monthly target	YTD
UT25-N	Patients spending less than 4hrs in ED - SGH Main ED (Type 1 and UCH) Major Trauma Centres (Type 1) Rank of 8->	93.6%														83.3% 75.11%	≥95%	-
		2	5	3	3	4	2	2	1	1	1	2	3	3	3	3		
UT26	Average (Mean) time in Dept - non-admitted patients	02:11														03:02	-	-
UT27	Average (Mean) time in Dept - admitted patients	03:21														04:00	-	-
UT28-N	% Patients on an open 18 week pathway (within 18 weeks) with teaching hospital min-max range and rank (of 20)	51.9%														71.9%	≥92%	
		14	14	7	6	7	7	10	10	10	9	9	8	7	8			
UT29	Total number of patients on a waiting list (18 week referral to treatment pathway)	31709														40825	-	-
UT30	Patients on an open 18 week pathway (waiting 52 weeks+) with teaching hospital min-max range and rank (of 20)	618														2436	-	-
		13	13	11	11	11	10	9	6	6	6	5	4	4	4			

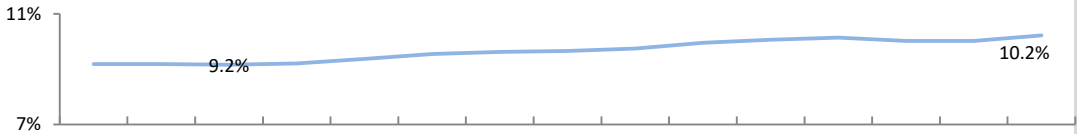
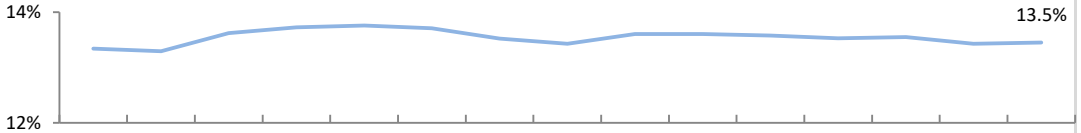
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Monthly target	YTD
UT31	Patients on an open 18 week pathway (waiting 78 weeks+)	1000		1												689	-	-
		0																
UT32	Patients waiting for diagnostics	11,000		6985												10009	-	-
		4,000																
UT33-N	% of Patients waiting over 6 weeks for diagnostics with teaching hospital min-max range and rank (of 20)	80%		42.4%												18.1%	≤1%	-
		0%		3	7	7	9	13	14	14	11	12	9	10	10	10	9	
UT34-N	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Latest data held by UHS) with teaching hospital min-max range and rank (of 20)	100%			94.7%											80.4%	≥85%	-
		30%		8	4	3	1	1	1	9	10	9	3	4	2	1	4	
UT35-N	31 day cancer wait performance - decision to treat to first definitive treatment (Latest data held by UHS)	100%		97.9%												97.6%	≥96%	-
		80%																
UT36-N	31 day cancer wait performance - Subsequent Treatments of Cancer (Latest data held by UHS)	100%		96.2%												94.1%	≥95.3%	
		80%																

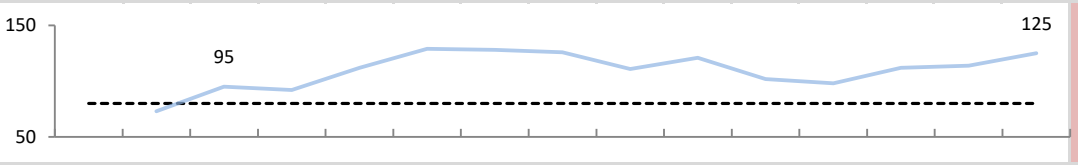
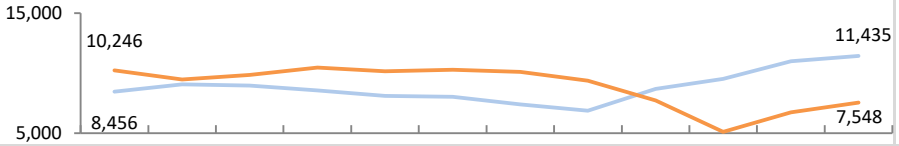
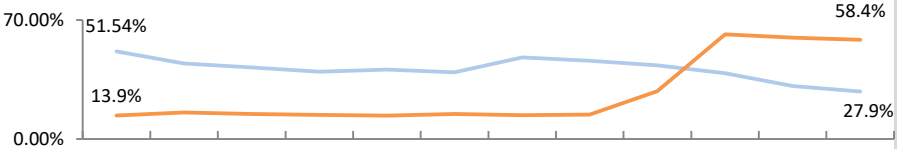
UT36-N Target is the weighted average of the national targets for treatment with surgery, radiotherapy and drug treatment

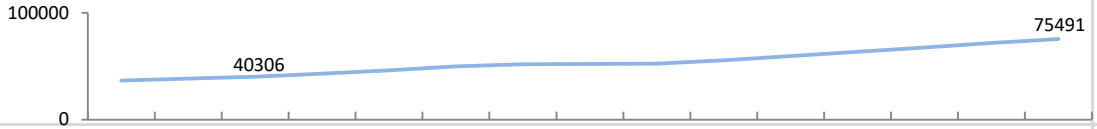
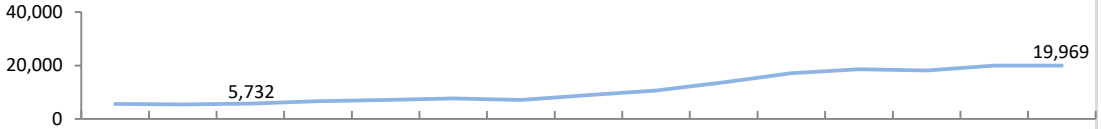
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Monthly target	YTD	YTD target
PN1-L	Comparative CRN Recruitment Performance - non-weighted			2			5			9			10			10	Top 10		
PN2-L	Comparative CRN Recruitment Performance - weighted			2			2			7			8			5	Top 5		
PN3-L	Comparative CRN Recruitment - contract commercial			13			17			7			2			12	Top 10		
PN4-L	Percentage of R&D income target achieved	in development															100%		

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Monthly target	YTD	YTD target
Workforce Capacity																			
WR1-L	Substantive Staff - Turnover	13.60%	12.9%													12.6%	≤12%		
		12.91%																	
		12.21%																	
WR2-L	All Staff vacancies																		
	Nursing Vacancies (registered nurses only in clinical wards)	20%		15.77%												12.17%			
		0%		6.0%												4.8%			
WR3-L	workforce numbers plan vs actual	In development																	
WR4-L	Staff - Sickness absence (total expressed as a percentage)	7.50%															≤3.4%		
		4.49%		3.1%												3.4%			
		3.8%																	
		3.10%																	
		2.50%																	
Enjoy Working Here																			
WR5-L	Appraisals completed - Rolling 12-months	100%														87.6%			
	Non-Medical Staff			76.92%												79.17%			
	Medical Staff			65.5%															
		50%																	
WR6-L	% of staff recommend UHS as a place to work:	80%															≥76%		
	UHS Quarterly staff FFT									77.0%									
	National NHS Staff Survey	70%																	
WR7-L	Staff survey engagement score	8																	
	National NHS Staff Survey									7.3									
		0																	

WR7-L - Maximum score = 10, Average of "Acute and Acute&Community", group is 7

Compassion and Inclusion		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Monthly target	YTD	YTD target
WR8-L	% of Band 7+ staff who are Black and Minority Ethnic																15% by 2023		
WR9	% of Band 7+ Staff who have declared a disability or long term health condition																-		
WR10	Pulse survey % of staff recommend UHS as a place to work- White British staff compared with all other ethnic groups combined	Data available from August 2021 - new monthly staff survey																	
WR11	Pulse survey % of staff recommend UHS as a place to work- Disabled compared with non disabled / prefer not to answer	Data available from August 2021 - new monthly staff survey																	
WR12	Pulse survey % of staff recommend UHS as a place to work- Sexuality = Heterosexual compared with all other groups combined	Data available from August 2021 - new monthly staff survey																	

Local Integration		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Monthly target	YTD	YTD target
NT1	Number of inpatients that were medically optimised for discharge (monthly average)																≤80	-	-
NT1 - changed source from live position to validated snapshot to align with external reporting																			
NT2	Emergency Department activity - type 1 This year vs. last year																-	-	-
NT3	Percentage of virtual appointments as a proportion of outpatient consultations This year vs. last year																-	-	-

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Monthly target	YTD	YTD target
Digital																			
FN1	My Medical Record - UHS patient accounts																-		
FN2	My Medical Record - UHS patient logins																-		
FN3	Patients choosing digital correspondence	In development															-		
FN4	Reduction in transcription through implementation of voice recognition software	In development															-		
Our Role in the Community																			
FN6	% staff living locally	In development															-		
FN7	% staff living in deprived areas	In development																	

Report notes - Nursing and Midwifery staffing hours - June 2021

Our staffing levels are continuously monitored and we will risk assess and manage our available staff 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 worked to appropriately manage the COVID-19 surge into April in line with national guidance

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. Both mothers and babies are now included in our occupancy levels which will have impacted the care hours per patient day for comparison in previous months.

Over the last year a growing number of our clinical areas started to move and change specialty and size to respond to the changing COVID-19 situation (e.g. G5-G9, Critical Care and RHDU). With the COVID-19 position changing again in June some additional ward changes have taken place which have been responsive and swift in nature and the data in some cases may not be fully reflective of all of these changes.

Wards Full Name		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	CHPPD Registered midwives/ nurses	CHPPD Care Staff	CHPPD Overall	Comments
Critical Care	Day	23247	19100	5688	3921	82.2%	68.9%	25.9	5.0	30.9	Staffing appropriate for number of patients; Safe staffing levels maintained.
Critical Care	Night	22231	19326	4753	3511	86.9%	73.9%				Staffing appropriate for number of patients; Safe staffing levels maintained.
SUR E5 Lower GI	Day	1435	1365	738	786	95.1%	106.5%	4.5	2.7	7.2	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
SUR E5 Lower GI	Night	690	667	334	454	96.7%	136.1%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
SUR E5 Upper GI	Day	1456	1116	770	1009	76.7%	131.0%	4.1	3.7	7.8	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
SUR E5 Upper GI	Night	690	682	316	585	98.8%	184.8%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
SUR E8 Ward	Day	1917	2078	1411	1261	108.4%	89.4%	4.9	3.7	8.6	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
SUR E8 Ward	Night	966	1012	1037	1074	104.8%	103.6%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
SUR F11 IF	Day	1947	1481	757	982	76.0%	129.7%	4.6	3.5	8.1	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
SUR F11 IF	Night	690	690	690	656	100.0%	95.0%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
SUR Acute Surgical Unit	Day	1426	939	698	837	65.9%	120.1%	10.8	7.1	17.9	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
SUR Acute Surgical Unit	Night	690	747	690	276	108.3%	40.0%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
SUR Acute Surgical Admissions	Day	2211	1395	524	1526	63.1%	291.6%	3.5	3.6	7.1	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
SUR Acute Surgical Admissions	Night	1047	932	690	886	89.0%	128.4%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
SUR F5 Ward	Day	1922	1471	1252	1339	76.5%	106.9%	4.2	3.3	7.5	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
SUR F5 Ward	Night	1035	1012	690	656	97.8%	95.0%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.

Wards Full Name		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	CHPPD Registered midwives/ nurses	CHPPD Care Staff	CHPPD Overall	Comments
CAN C4 Solent Ward Clinical Oncology	Day	1350	1293	955	1253	95.8%	131.2%	4.1	4.5	8.6	Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAN C4 Solent Ward Clinical Oncology	Night	1047	957	690	1163	91.4%	168.6%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAN C6 Leukaemia/BMT Unit	Day	2784	2466	77	493	88.6%	645.0%	7.0	1.1	8.1	Staffing appropriate for number of patients.
CAN C6 Leukaemia/BMT Unit	Night	1971	1884	0	198	95.6%	Shift N/A				Safe staffing levels maintained.
CAN C6 TYA Unit	Day	743	789	318	108	106.1%	Shift N/A	9.1	0.7	9.8	Safe staffing levels maintained.
CAN C6 TYA Unit	Night	663	652	0	0	98.4%	Shift N/A				Safe staffing levels maintained.
CAN C2 Haematology	Day	2226	2542	1063	1006	114.2%	94.6%	6.3	3.0	9.2	Increase in acuity/dependency of patients in the month; Safe staffing levels maintained.
CAN C2 Haematology	Night	1725	2098	1028	1188	121.6%	115.7%				Increased night staffing to support raised acuity; Additional staff used for enhanced care - Support workers.
CAN D3 Ward	Day	1703	1725	719	1021	101.3%	142.1%	4.7	3.2	7.9	Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAN D3 Ward	Night	1013	1070	664	877	105.7%	132.2%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
ECM Acute Medical Unit	Day	5655	5567	4562	4475	98.4%	98.1%	11.6	7.8	19.4	Safe staffing levels maintained; Additional beds open in the month.
ECM Acute Medical Unit	Night	4653	5662	3427	3130	121.7%	91.3%				Safe staffing levels maintained; Additional beds open in the month.
MED D5 Ward	Day	1170	1606	1695	1360	137.2%	80.2%	3.5	2.9	6.4	Additional staff used for enhanced care - RNs; Safe staffing levels maintained by sharing staff resource.
MED D5 Ward	Night	1024	1154	911	916	112.8%	100.5%				Additional staff used for enhanced care - RNs; Safe staffing levels maintained by sharing staff resource.
MED D6 Ward	Day	1074	1104	1467	1492	102.9%	101.7%	3.1	3.7	6.8	Staff moved to support other wards; Additional staff used for enhanced care - Support workers.
MED D6 Ward	Night	690	1038	915	1078	150.4%	117.8%				Increased night staffing to support raised acuity; Additional staff used for enhanced care - Support workers.
MED D7 Ward	Day	658	801	900	1065	121.9%	118.4%	3.4	3.7	7.1	Staff moved to support other wards; Skill mix swaps undertaken to support safe staffing across the Unit.
MED D7 Ward	Night	679	713	311	609	105.1%	196.3%				Increased night staffing to support raised acuity; Patient requiring 24 hour 1:1 nursing in the month.
MED D8 Ward	Day	997	1315	1488	1253	132.0%	84.2%	3.5	3.2	6.6	Safe staffing levels maintained; Safe staffing levels maintained.
MED D8 Ward	Night	690	1023	922	874	148.3%	94.7%				Increased night staffing to support raised acuity; Staff moved to support other wards.
MED D9 Ward	Day	1123	1520	1563	1419	135.3%	90.8%	3.1	3.2	6.2	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained; Increased night staffing to support raised acuity.
MED D9 Ward	Night	1024	876	916	1043	85.5%	113.9%				Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month.
MED E7 Ward	Day	999	1245	1355	1499	124.6%	110.6%	2.8	3.8	6.6	Increase in acuity/dependency of patients in the month; Safe staffing levels maintained; Staffing appropriate for number of patients.
MED E7 Ward	Night	690	887	1239	1348	128.5%	108.9%				Increase in acuity/dependency of patients in the month; Safe staffing levels maintained; Staffing appropriate for number of patients.

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MED Respiratory HDU	Day	2298	1546	520	440	67.3%	84.7%	18.8	4.4	23.2	Staffing appropriate for number of patients.
MED Respiratory HDU	Night	2071	1480	336	267	71.4%	79.5%				Staffing appropriate for number of patients.
MED C5 Isolation Ward	Day	1192	942	1209	499	79.1%	41.3%	9.8	5.9	15.7	Staffing appropriate for number of patients.
MED C5 Isolation Ward	Night	1035	757	334	524	73.1%	157.1%				Safe staffing levels maintained.
MED D10 Isolation Unit	Day	1091	877	1153	1126	80.3%	97.6%	3.1	3.7	6.8	Safe staffing levels maintained; Staff moved to support other wards.
MED D10 Isolation Unit	Night	667	691	690	715	103.6%	103.6%				Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month.
MED G5 Ward	Day	990	1262	1833	1527	127.4%	83.3%	2.9	2.9	5.8	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
MED G5 Ward	Night	1024	1001	690	736	97.8%	106.7%				Support workers used to maintain staffing numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
MED G6 Ward	Day	1029	1140	1770	1809	110.7%	102.2%	2.9	3.6	6.5	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
MED G6 Ward	Night	1024	979	725	764	95.6%	105.4%				Support workers used to maintain staffing numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
MED G8 Ward	Day	1032	1204	1823	1665	116.7%	91.3%	2.8	3.4	6.2	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
MED G8 Ward	Night	1012	897	886	851	88.6%	96.1%				Support workers used to maintain staffing numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
MED G9 Ward	Day	1040	1095	1786	1760	105.3%	98.5%	2.9	3.5	6.3	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
MED G9 Ward	Night	1011	977	690	748	96.6%	108.3%				Support workers used to maintain staffing numbers; Safe staffing levels maintained by sharing staff resource.
MED Bassett Ward	Day	1307	918	2337	1778	70.3%	76.1%	3.1	5.0	8.1	Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month; Staffing plan set higher than national standards.
MED Bassett Ward	Night	886	748	1024	966	84.4%	94.4%				Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month; Staffing plan set higher than national standards.

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CHI High Dependency Unit	Day	1569	1174	0	0	74.8%	Shift N/A	15.6	0.0	15.6	Non-ward based staff supporting areas; Beds flexed to match staffing; Staffing appropriate for number of patients.
CHI High Dependency Unit	Night	1035	1058	0	0	102.2%	Shift N/A				Safe staffing levels maintained.
CHI Paed Medical Unit	Day	1878	1626	304	767	86.6%	252.4%	8.6	4.4	13.0	Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained.
CHI Paed Medical Unit	Night	1651	1390	638	777	84.2%	121.7%				Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained.
CHI Paediatric Intensive Care	Day	6055	4775	591	295	78.9%	50.0%	30.1	2.4	32.5	Patient requiring 24 hour 1:1 nursing in the month.
CHI Paediatric Intensive Care	Night	5520	4552	518	449	82.5%	86.7%				Patient requiring 24 hour 1:1 nursing in the month.
CHI Piam Brown Unit	Day	3708	2908	209	98	78.4%	46.7%	13.4	0.3	13.7	Non-ward based staff supporting areas.
CHI Piam Brown Unit	Night	1369	1051	0	0	76.8%	Shift N/A				Staffing appropriate for number of patients.
CHI Ward E1 Paed Cardiac	Day	2005	2222	602	647	110.9%	107.5%	10.8	2.4	13.2	Safe staffing levels maintained.
CHI Ward E1 Paed Cardiac	Night	1380	2087	345	300	151.2%	87.0%				Safe staffing levels maintained.
CHI Ward G2 Neuro	Day	745	694	-12	48	93.2%	-400.0%	8.2	0.5	8.7	Safe staffing levels maintained; HCA's not required.
CHI Ward G2 Neuro	Night	720	696	0	44	96.7%	Shift N/A				Safe staffing levels maintained.
CHI Ward G3	Day	2311	1928	1645	745	83.4%	45.3%	8.3	2.7	11.0	Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Safe staffing levels maintained.
CHI Ward G3	Night	1643	1424	979	338	86.7%	34.5%				Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Safe staffing levels maintained.
CHI Ward G4 Surgery	Day	2312	2560	1173	919	110.7%	78.4%	10.9	3.0	13.9	Safe staffing levels maintained.
CHI Ward G4 Surgery	Night	1650	2006	640	356	121.6%	55.7%				Safe staffing levels maintained.
W&N Bramshaw Womens Unit	Day	1114	941	688	664	84.5%	96.5%	6.4	4.8	11.2	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained; Beds flexed to match staffing.
W&N Bramshaw Womens Unit	Night	690	679	656	564	98.3%	86.0%				Safe staffing levels maintained.
W&N Neonatal Unit	Day	6677	4859	1656	1030	72.8%	62.2%	10.1	2.3	12.4	Safe staffing levels maintained; Professional judgement used when staffing is compromised itu patients nursed 1:2..
W&N Neonatal Unit	Night	5270	4054	1320	1034	76.9%	78.3%				Safe staffing levels maintained; Professional judgement used when staffing is compromised itu patients nursed 1:2..
W&N PAH Maternity Service	Day	8300	7579	2590	1949	91.3%	75.3%	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..
W&N PAH Maternity Service	Night	5224	4529	1525	1460	86.7%	95.8%				Numbers do not fully reflect the integrated midwifery service demand. Safe staffing levels maintained by sharing staff resource across the services..

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CAR CHDU	Day	4971	4265	1725	1240	85.8%	71.9%	15.8	4.6	20.4	Staff moved to support other wards; This ward has a high number of side rooms and if acuity/dependency of patients is raised Registered nurse or support workers are required to special on night duty; Skill mix swaps undertaken to support safe staffing across the Unit.
CAR CHDU	Night	3863	3624	1034	1067	93.8%	103.2%				Staff moved to support other wards; This ward has a high number of side rooms and if acuity/dependency of patients is raised Registered nurse or support workers are required to special on night duty; Skill mix swaps undertaken to support safe staffing across the Unit.
CAR Coronary Care Unit	Day	2550	2813	1048	1083	110.3%	103.3%	11.3	4.4	15.7	Safe staffing levels maintained; Staffing plan set higher than national standards; Band 4 staff working to support registered nurse numbers.
CAR Coronary Care Unit	Night	2234	2393	891	935	107.1%	104.9%				Safe staffing levels maintained; Staffing plan set higher than national standards; Band 4 staff working to support registered nurse numbers.
CAR Ward D4 Vascular	Day	1648	1319	1065	1314	80.0%	123.4%	4.0	4.2	8.2	Safe staffing levels maintained; Staff moved to support other wards; Additional staff used for enhanced care - Support workers.
CAR Ward D4 Vascular	Night	758	1015	990	1106	133.9%	111.7%				Increased night staffing to support raised acuity; This ward has a high number of side rooms 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 - Support workers.
CAR Ward E2 YACU	Day	1508	1380	845	920	91.5%	108.9%	4.4	3.6	8.0	Safe staffing levels maintained; Additional staff used for enhanced care - Support workers; .
CAR Ward E2 YACU	Night	660	696	330	759	105.4%	230.0%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers; Increased night staffing to support raised acuity.
CAR Ward E3 Green	Day	1462	1452	1393	1173	99.3%	84.2%	3.6	3.2	6.8	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Staff moved to support other wards.
CAR Ward E3 Green	Night	649	772	774	769	119.0%	99.3%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Staff moved to support other wards.
CAR Ward E3 Blue	Day	1103	1278	1139	894	115.9%	78.5%	4.0	3.5	7.4	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
CAR Ward E3 Blue	Night	661	639	660	793	96.7%	120.2%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
CAR Ward E4 Thoracics	Day	1595	1396	1253	1118	87.5%	89.2%	4.8	3.3	8.1	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
CAR Ward E4 Thoracics	Night	991	1013	413	568	102.2%	137.7%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
CAR Ward D2 Cardiology	Day	1333	886	664	1061	66.5%	159.8%	3.3	4.6	7.9	Safe staffing levels maintained; Additional staff used for enhanced care - Support workers; Staff moved to support other wards.
CAR Ward D2 Cardiology	Night	661	532	660	902	80.5%	136.6%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers; Staff moved to support other wards.
NEU Acute Stroke Unit	Day	1471	1562	2564	2622	106.2%	102.3%	3.2	5.1	8.3	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.
NEU Acute Stroke Unit	Night	990	1144	1650	1612	115.6%	97.7%				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.
NEU Regional Transfer Unit	Day	1192	881	405	364	73.9%	89.8%	11.7	8.2	19.8	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.
NEU Regional Transfer Unit	Night	660	555	671	641	84.1%	95.5%				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.
NEU ward E Neuro	Day	1848	1531	1064	1244	82.9%	116.9%	3.6	3.4	7.0	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.
NEU ward E Neuro	Night	1320	1166	990	1287	88.3%	130.0%				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.
NEU HASU	Day	1523	1321	361	471	86.7%	130.3%	7.4	2.5	10.0	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.
NEU HASU	Night	1320	1199	341	396	90.8%	116.1%				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.
NEU Ward D Neuro	Day	1906	1603	1891	1977	84.1%	104.6%	4.2	5.0	9.3	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.
NEU Ward D Neuro	Night	1320	1434	1649	1627	108.6%	98.7%				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.

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SPI Ward F4 Spinal	Day	1542	1340	1020	1277	86.9%	125.1%	3.8	3.9	7.6	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 Ward F4 Spinal	Night	990	924	1001	1045	93.3%	104.4%				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.
T&O Ward Brooke	Day	1006	1108	1097	844	110.2%	76.9%	3.7	3.4	7.2	Safe staffing levels maintained; Staff moved to support other wards; Skill mix swaps undertaken to support safe staffing across the Unit.
T&O Ward Brooke	Night	690	690	690	817	100.0%	118.3%				Safe staffing levels maintained; Staff moved to support other wards; Skill mix swaps undertaken to support safe staffing across the Unit.
T&O Trauma Admissions Unit	Day	890	778	730	625	87.4%	85.6%	28.3	23.5	51.8	Staffing appropriate for number of patients; Staff moved to support other wards; Safe staffing levels maintained by sharing staff resource.
T&O Trauma Admissions Unit	Night	660	639	660	550	96.8%	83.3%				Staffing appropriate for number of patients; Staff moved to support other wards; Safe staffing levels maintained by sharing staff resource.
T&O Ward F1 Major Trauma Unit	Day	2291	2487	1985	1750	108.6%	88.2%	4.9	4.0	8.9	Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards; Safe staffing levels maintained by sharing staff resource.
T&O Ward F1 Major Trauma Unit	Night	1726	1694	1724	1677	98.2%	97.3%				Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards; Safe staffing levels maintained by sharing staff resource.
T&O Ward F2 Trauma	Day	1579	1369	1887	1942	86.7%	102.9%	3.2	4.6	7.8	Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards; Skill mix swaps undertaken to support safe staffing across the Unit.
T&O Ward F2 Trauma	Night	990	905	1320	1367	91.4%	103.5%				Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards; Skill mix swaps undertaken to support safe staffing across the Unit.
T&O Ward F3 Trauma	Day	1621	1397	1829	1967	86.2%	107.6%	3.6	5.1	8.8	Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards; Skill mix swaps undertaken to support safe staffing across the Unit.
T&O Ward F3 Trauma	Night	990	915	1320	1331	92.4%	100.8%				Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards; Skill mix swaps undertaken to support safe staffing across the Unit.
T&O Ward F4 Elective	Day	1377	1347	1201	785	97.8%	65.3%	4.5	3.4	7.9	Staffing appropriate for number of patients; Safe staffing levels maintained by sharing staff resource; Skill mix swaps undertaken to support safe staffing across the Unit.
T&O Ward F4 Elective	Night	990	683	716	737	69.0%	103.0%				Staffing appropriate for number of patients; Safe staffing levels maintained by sharing staff resource; Skill mix swaps undertaken to support safe staffing across the Unit.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Finance Report 2021-22 Month 3**			
Agenda item:	**5.9**			
Sponsor:	**Ian Howard – Interim Chief Financial Officer**			
Author:	**Ian Howard – Interim Chief Financial Officer**			
Date:	**29 July 2021**			
Purpose	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	The finance report provides a monthly summary of the key financial information for the Trust.			
Response to the issue:	The Trust continues to report an on-plan financial position of break-even. **Elective Recovery Framework (ERF):** • Elective Recovery Framework achievement of £2.6m is estimated, based on activity of circa 92% of pre-Covid levels of activity for Elective and Outpatients. This compares to a baseline expectation of 80%. (M2 achievement of 108% vs. 75% baseline target). This is thought to be a result of a mixture of: o The target increased from 75% to 80%. o Half-term occurred in week 1 of June 21, compared to May 2019 baseline (meaning baseline was lower in May, higher in June). This is estimated to have a circa £1m impact. o Increased levels of annual leave and staff isolating o Pressure from non-elective and ED activity o Increasing numbers of Covid-19 patients on wards o Additional theatres opened in late June • This is below the 110% target for elective and outpatient activity by July as per the accelerator programme ambitions. • Updated ERF guidance will be discussed as part of the financial planning paper and has been excluded from M3 reporting and forecasting as per national instruction. **M3 Forecast Review:** • We undertake a quarterly review of the Trust forecast position. • The revised ERF guidance and increased baseline will reduce the income forecast by £2m per month, which is a significant impact to the Trust's bottom line. However, the Trust was making an underlying margin on ERF in Q1. • Overall, given the stability of the year to date position, the Trust are in a strong position to achieve the break-even plan position for H1. • The forecast for H2 will be reviewed as part of the H2 planning process.			

	Capital: • Whilst spend is broadly on-plan year to date, a forecast review has identified potential opportunities to bring forward elements of spend from future years. **ICS finance position:** • All organisations are currently reporting a break-even position. A verbal update will be provided to the Committee on the underlying position within the ICS. An ICS finance report will be made available to the Committee but is not ready for UHS paper deadlines. **Other financial issues:** • The finance team are undertaking further investigations with Pharmacy regarding use of drugs that are included within block contracts. The value has spiked in recent months, resulting in a cost pressure.
Implications: (Clinical, Organisational, Governance, Legal?)	• Financial implications of availability of funding to cover growth, cost pressures and new activity. • Organisational implications of remaining within statutory duties.
Risks: (Top 3) of carrying out the change / or not:	• Financial risk mainly linked to the uncertainty of 21/22 funding arrangements. • Cash risk linked to volatility above
Summary: Conclusion and/or recommendation	Trust Board is asked to note this report.

2021/22 Finance Report - Month 3

Report to:	**Board of Directors and Finance & Investment Committee** **June 2021**
Title:	**Finance Report for Period ending 30/06/2021**
Author:	**Philip Bunting, Acting 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 June 2021, the Trust reported a surplus of £0.1m, which was favourable to the trust's breakeven plan by £0.1m.

2. Elective Recovery Framework (ERF) income is estimated at £2.6m for June; however this has not yet been confirmed and is dependent on wider system achievement and NHSI validation. This was down from £6m the previous month. ERF achievement is now estimated at £14.3m YTD.

3. In month, £4.2m (£2.7m pay and £1.5m non pay) was incurred on additional expenditure relating to Covid-19. This was higher than May due to £0.9m of Covid vaccination costs and £0.6m of Covid testing costs which are directly reclaimable plus the full capture of in-envelope costs for NHSE/I reporting required in M3. Within the trusts block funding is a non-recurrent fixed element for Covid costs which will continue throughout H1.

4. The main underlying themes seen in M3 were :
   - Elective income increased but performance against plan reduced to 93% as the plan reflects the increase in working days from May to June. Non elective income remained consistent at 103% of planned levels.
   - A&E attendances have continued to increase and are now above pre-Covid levels, with record attendances in main ED throughout June.
   - Outpatient income was down to 105% of planned levels in June although up 4% month on month.
   - Drugs and devices expenditure was high in month with £2.2m over performance reported on pass through items, higher than the £1m over performance in M2. This is mirrored by additional income.
   - Trust underlying performance remains at close to breakeven levels after adjusting for one off items.

Finance: I&E Summary

The financial position for M3 was a surplus of £0.1m which was favourable to plan by £0.1m.

Both other income and clinical supplies expenditure were lower than plan due to reduced saliva-testing activity compared to plan and other income was also lower due to H1 HEE income less than forecast. The increase in other non pay was partially driven by increased energy costs and overseas recruitment.

Substantive pay costs were slightly down on plan as were bank and agency costs. Recovery plans are expected to drive up pay and clinical supplies spend further however.

Block drugs costs were 1.2m over in month and are an area of investigation for the trust. Expenditure on pass through drugs and devices was £2.2m higher than plan although is offset by income. Volatility in homecare drugs invoicing is driving variances in both pass through and non pass through drugs spend.

		Current Month			Cumulative			H1 Plan / Forecast		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
NHS Income:	Clinical	69.0	68.9	0.1	205.9	201.2	4.7	412.8	406.4	6.4
	Pass-through Drugs & Devices	8.5	10.6	(2.1)	25.5	30.8	(5.3)	50.9	61.6	(10.7)
Other income	Other Income excl. PSF	15.2	13.6	1.6	45.5	38.9	6.6	90.9	77.8	13.1
	Top Up Income	0.8	1.4	(0.7)	2.4	3.5	(1.1)	4.7	6.9	(2.2)
Total income		**93.4**	**94.4**	**(1.0)**	**279.2**	**274.3**	**4.9**	**560.6**	**552.7**	**6.7**
Costs	Pay-Substantive	46.9	44.9	(2.0)	140.8	135.5	(5.3)	281.5	273.0	(8.5)
	Pay-Bank	4.0	3.8	(0.2)	11.9	10.4	(1.4)	23.7	21.8	(1.9)
	Pay-Agency	1.2	0.9	(0.4)	3.7	2.6	(1.1)	7.5	5.2	(2.3)
	Drugs	4.3	5.9	1.6	13.0	15.2	2.2	26.0	30.4	4.4
	Pass-through Drugs & Devices	8.5	10.6	2.1	25.5	30.8	5.3	50.9	61.6	10.7
	Clinical supplies	11.1	8.5	(2.6)	32.0	25.2	(6.8)	65.1	51.9	(13.2)
	Other non pay	14.2	16.9	2.7	42.7	45.5	2.8	85.4	90.9	5.5
Total expenditure		**90.2**	**91.4**	**1.1**	**269.6**	**265.2**	**(4.3)**	**541.4**	**534.9**	**(5.3)**
EBITDA		**3.2**	**3.1**	0.1	**9.6**	**9.1**	0.5	**19.2**	**17.8**	1.4
EBITDA %		3.4%	3.2%	0.2%	3.4%	3.3%	0.1%	3.4%	3.2%	0.2%
	Depreciation / Non Operating Expenditure	3.2	3.1	(0.1)	9.6	9.3	(0.3)	19.3	18.6	(0.6)
Surplus / (Deficit)		**(0.0)**	**(0.1)**	0.1	**(0.0)**	**(0.2)**	0.2	**(0.1)**	**(0.8)**	**0.8**
Less	Donated income	0.1	0.0	0.1	0.3	0.0	0.2	0.5	0.0	0.5
Add Back	Donated depreciation	0.1	0.1	0.0	0.3	0.4	0.1	0.6	0.9	0.3
Net Surplus / (Deficit)		**0.0**	**0.1**	**(0.1)**	**0.0**	**0.2**	**(0.2)**	**0.0**	**0.0**	**(0.0)**

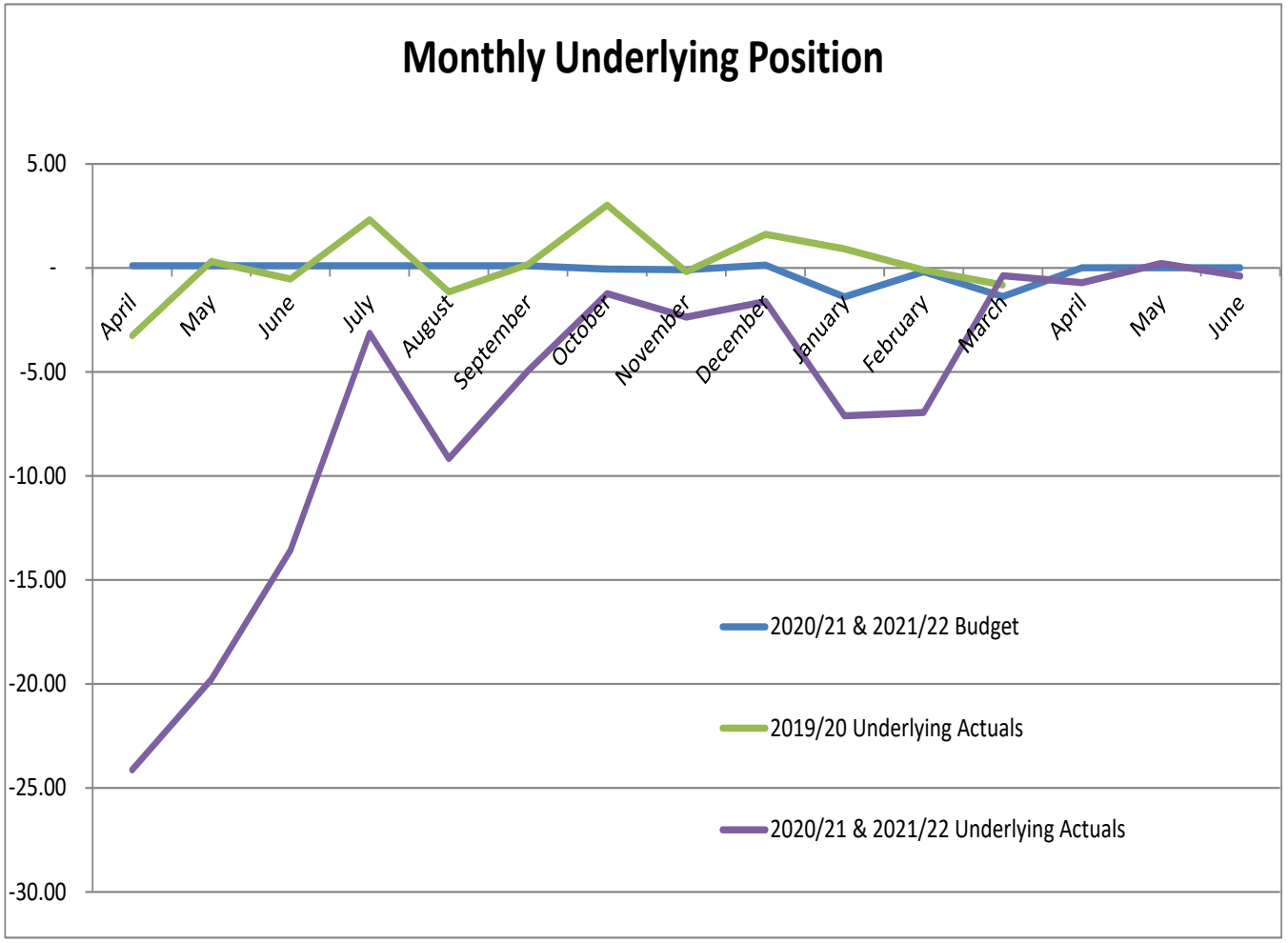
Monthly Underlying Position

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

We are now operating at a position where we would be earning marginally more under PbR than the current block. However, we are also earning ERF, which would not be payable under PbR for activity below 100% of contract.

After adjusting the income position to be reflective of what would prevail under PbR it is clear that the underlying position is close to breakeven and has been throughout Q1.

However, with future funding arrangements unclear and in particular ERF and additional Covid-19 funding being non recurrent, we should exercise caution over the Trust's underlying position going forwards.



University Hospital Southampton NHS
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Clinical Income

Clinical income for June was £2.5m favourable to plan and including Non NHS income was £2.8m favourable to plan. Most of the Trust's income remains fixed with confirmed block contract funding in place for at least the first half of the financial year.

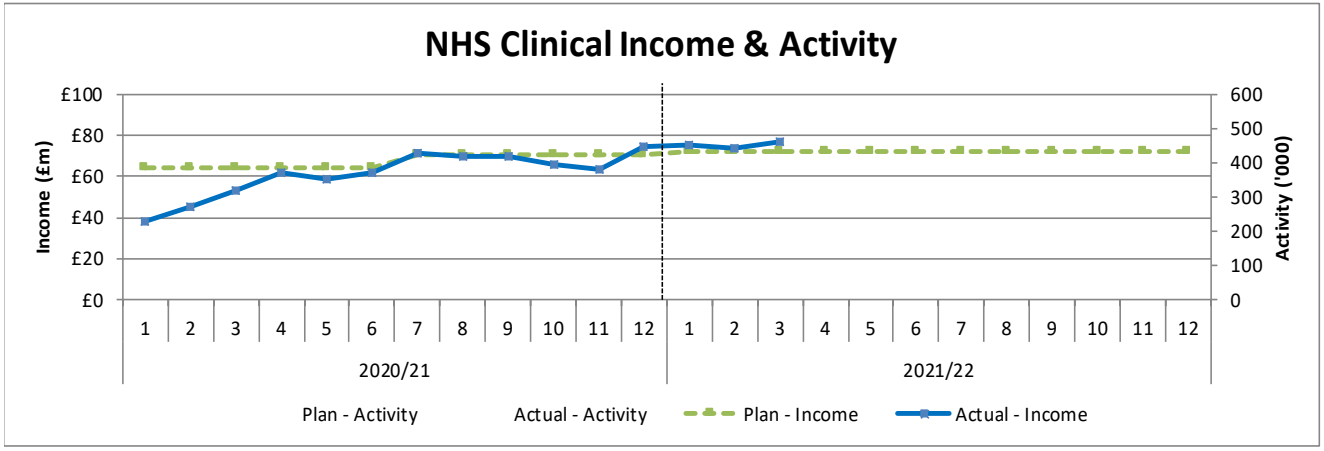
June has seen a increase in activity from May although against a rising plan the increase was not as large as anticipated. Plans for 21/22 have been phased to account for the variation in calendar and working days in relevant POD Groups. Elective income increased, but against plan reduced to 93% of planned levels having been over 100% in May. Non elective activity remained at 103% of planned level, and A&E attendances continue to be high, back to pre-Covid levels, having shown a downward trend for much of the previous financial year.

Outpatient income remains strong at over 100% of planned levels although not as high against plan as in May.

The graphs overleaf show trends over the last 15 months and the impact of Covid-19 as well as the recovery to pre Covid levels of activity in many areas.

(Fav Variance) / Adv Variance

POD GROUP	2021/22 In Month Plan £000s	In Month Estimate £000s	In Month Variance £000s	YTD Plan £000s	YTD Estimate £000s	YTD Variance £000s	2019/20 YTD Actuals £000s
NHS Clinical Income							
Elective Inpatients	£13,159	£12,217	£942	£36,486	£35,106	£1,380	£34,648
Non-Elective Inpatients	£18,845	£19,473	(£627)	£57,164	£58,305	(£1,141)	£53,300
Outpatients	£7,718	£8,057	(£339)	£21,401	£23,516	(£2,116)	£20,763
Other Activity	£11,571	£11,046	£526	£34,375	£34,040	£335	£31,602
Blocks & Financial Adjustments	£5,450	£4,704	£746	£14,860	£11,117	£3,742	£2,620
Other Exclusions	£7,503	£9,025	(£1,522)	£21,540	£25,219	(£3,679)	£12,045
Pass-through Exclusions	£8,485	£10,550	(£2,065)	£25,454	£30,800	(£5,346)	£27,565
Subtotal NHS Clinical Income	*£72,731*	*£75,071*	*(£2,340)*	*£211,279*	*£218,103*	*(£6,824)*	*£182,543*
Additional funding	£5,848	£5,848	£0	£17,544	£17,544	£0	
Covid block adjustments	(£1,614)	(£1,500)	(£113)	£583	(£3,659)	£4,242	
Total NHS Clinical Income	**£76,965**	**£79,418**	**(£2,453)**	**£229,406**	**£231,988**	**(£2,582)**	**£182,543**
Non NHS Clinical Income							
Private Patients	£45	£356	(£311)	£1,136	£1,788	(£652)	£1,081
CRU	£208	£255	(£47)	£625	£498	£127	£631
Overseas Chargeable Patients	£66	£34	£32	£198	£93	£104	£390
Total Non NHS Clinical Income	**£319**	**£645**	**(£326)**	**£1,958**	**£2,379**	**(£421)**	**£2,102**
Grand Total	**£77,285**	**£80,064**	**(£2,779)**	**£231,364**	**£234,368**	**(£3,003)**	**£184,645**



University Hospital Southampton NHS
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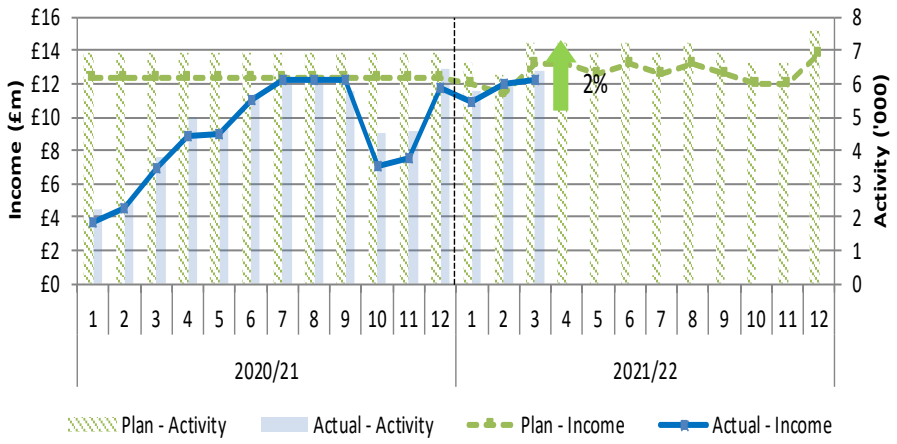
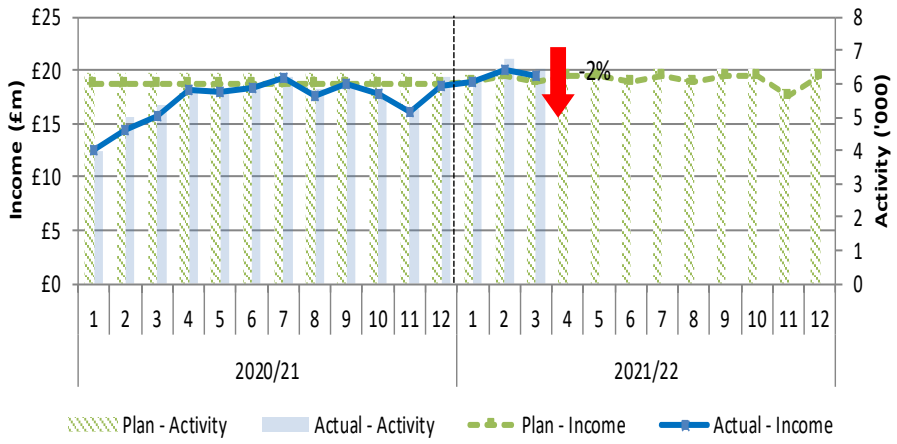
Clinical Income

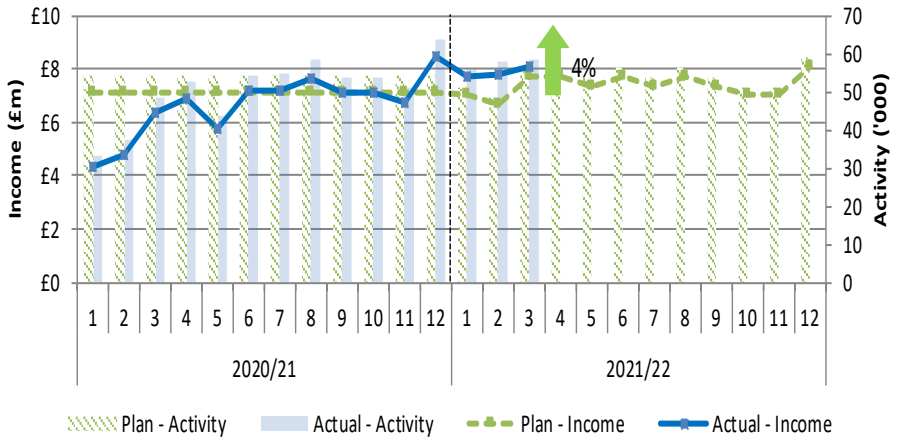
Elective spells



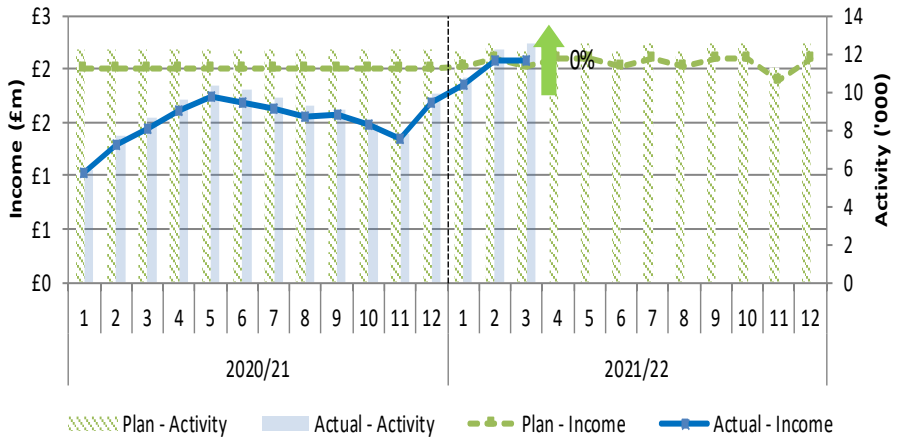
Non elective spells



Outpatients

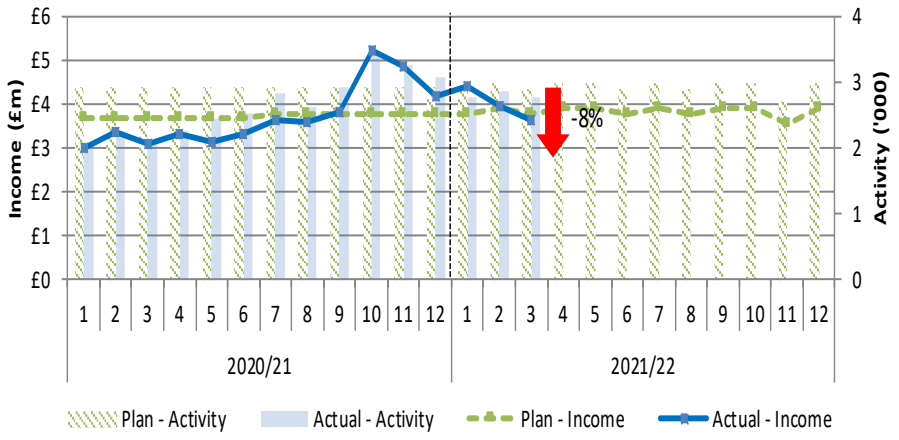


A&E

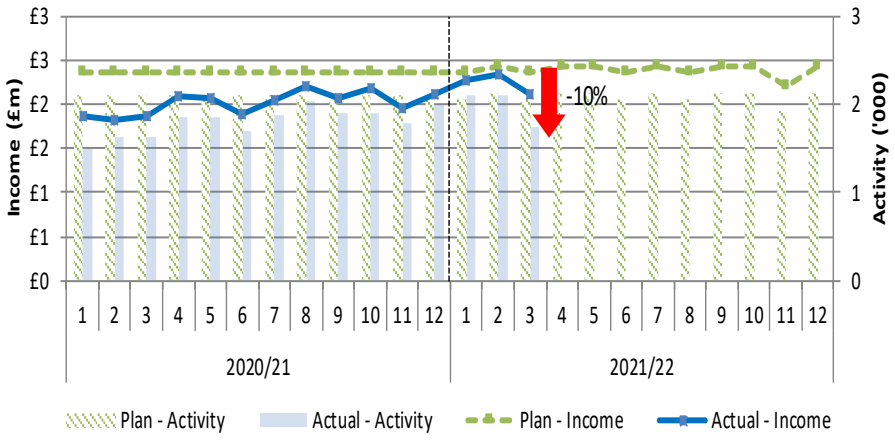


Clinical Income

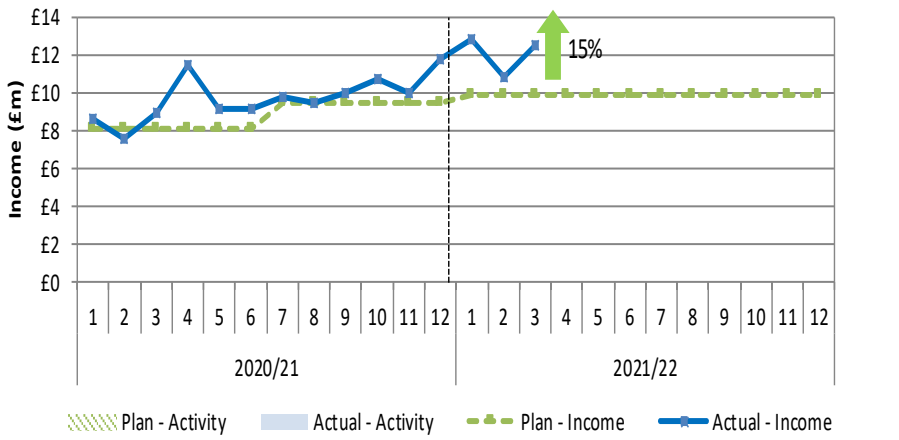
Adult critical care



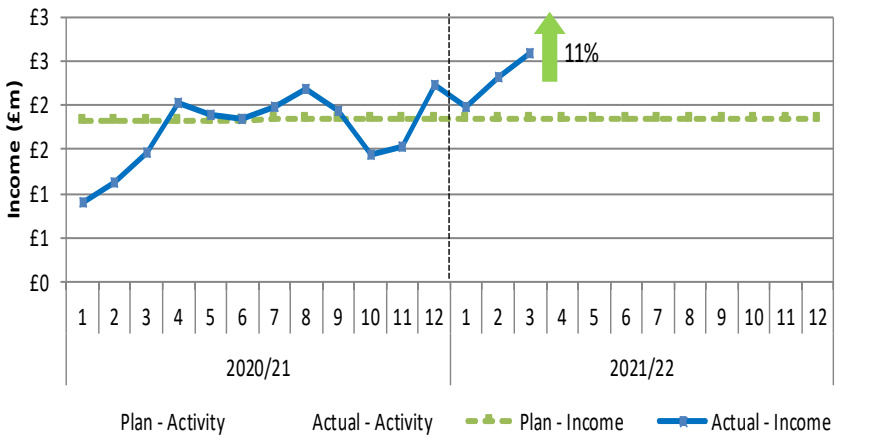
Neonatal & paediatric critical care



Tariff excluded drugs



Tariff excluded devices



University Hospital Southampton NHS
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Income and Activity

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

Elective activity in June represents 93% of planned income levels, down from 105% in May. Recovery planning is targeting improvement in all areas but will be governed by clinical priority.

Non Elective activity levels in June was at 103% of planned levels, the same as in May.

Elective Activity as % of Plan

		Activity as % of Plan						Income as % of Plan					
		2020/21			2021/22			2020/21			2021/22		
Division	Care Group	10	11	12	1	2	3	10	11	12	1	2	3
DIVISION A	OPHTHALMOLOGY	38%	77%	91%	99%	96%	104%	41%	30%	95%	101%	99%	105%
	SURGERY	50%	45%	77%	64%	84%	67%	58%	65%	101%	84%	107%	80%
DIVISION A Total		45%	38%	82%	77%	89%	78%	54%	57%	100%	87%	105%	86%
DIVISION B	CANCER CARE	66%	61%	76%	72%	75%	74%	58%	54%	71%	78%	78%	93%
	SPECIALIST MEDICINE	88%	92%	106%	99%	107%	95%	90%	94%	110%	106%	114%	103%
DIVISION B Total		81%	82%	97%	91%	97%	88%	78%	79%	96%	96%	101%	100%
DIVISION C	CHILD HEALTH	73%	81%	106%	103%	111%	97%	64%	88%	128%	116%	119%	88%
	WOMEN'S HEALTH	63%	68%	107%	78%	94%	92%	65%	70%	101%	81%	102%	95%
DIVISION C Total		71%	77%	106%	96%	106%	96%	64%	84%	121%	107%	115%	90%
DIVISION D	CARDIOVASCULAR & THORACIC	54%	57%	85%	92%	110%	105%	55%	58%	78%	83%	105%	101%
	NEUROSCIENCES	78%	69%	103%	105%	103%	93%	73%	54%	100%	101%	112%	88%
	RADIOLOGY	50%	64%	75%	67%	83%	69%	52%	69%	82%	76%	75%	72%
	TRAUMA & ORTHOPAEDICS	29%	31%	85%	83%	92%	94%	27%	25%	93%	91%	101%	101%
DIVISION D Total		54%	56%	87%	88%	98%	91%	52%	51%	85%	87%	103%	96%
Total		**65%**	**66%**	**93%**	**88%**	**97%**	**88%**	**58%**	**62%**	**96%**	**92%**	**105%**	**93%**

Non Elective Activity as % of Plan

		Activity as % of Plan						Income as % of Plan					
		2020/21			2021/22			2020/21			2021/22		
Division	Care Group	10	11	12	1	2	3	10	11	12	1	2	3
DIVISION A	OPHTHALMOLOGY	41%	64%	62%	81%	77%	87%	38%	68%	64%	75%	83%	85%
	SURGERY	72%	71%	88%	90%	96%	90%	85%	76%	95%	94%	101%	101%
DIVISION A Total		71%	70%	87%	90%	95%	90%	83%	75%	94%	94%	100%	100%
DIVISION B	ACUTE MEDICINE	115%	101%	107%	99%	110%	107%	118%	110%	112%	102%	104%	110%
	CANCER CARE	93%	99%	123%	112%	114%	120%	81%	98%	111%	108%	105%	107%
	EMERGENCY MEDICINE	86%	84%	94%	102%	106%	103%	113%	90%	82%	96%	95%	106%
	SPECIALIST MEDICINE	92%	107%	92%	63%	102%	86%	64%	103%	89%	64%	90%	68%
DIVISION B Total		98%	92%	102%	102%	108%	106%	111%	103%	104%	101%	102%	108%
DIVISION C	CHILD HEALTH	71%	65%	84%	95%	122%	130%	78%	66%	89%	87%	111%	107%
	WOMEN'S HEALTH	86%	81%	98%	93%	91%	99%	88%	88%	104%	103%	98%	110%
DIVISION C Total		82%	76%	94%	93%	101%	108%	85%	80%	99%	97%	102%	109%
DIVISION D	CARDIOVASCULAR & THORACIC	77%	72%	98%	102%	108%	88%	76%	67%	100%	108%	105%	81%
	NEUROSCIENCES	91%	88%	107%	100%	102%	96%	104%	88%	102%	88%	99%	107%
	RADIOLOGY	65%	66%	93%	97%	94%	92%	61%	69%	86%	86%	83%	79%
	TRAUMA & ORTHOPAEDICS	89%	69%	91%	106%	114%	111%	118%	83%	81%	117%	117%	120%
DIVISION D Total		83%	75%	98%	102%	107%	97%	91%	76%	96%	102%	104%	96%
Total		**88%**	**83%**	**97%**	**98%**	**104%**	**103%**	**96%**	**86%**	**99%**	**100%**	**103%**	**103%**

University Hospital Southampton NHS
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Income and Activity

Outpatient activity in June was at 105% of planned levels, down from 116% in May.

Outpatient Activity as % of Plan		Activity as % of Plan						Income as % of Plan					
		2020/21			2021/22			2020/21			2021/22		
Division	Care Group	10	11	12	1	2	3	10	11	12	1	2	3
DIVISION A	OPHTHALMOLOGY	97%	96%	112%	104%	106%	108%	100%	99%	115%	109%	112%	108%
	SURGERY	86%	80%	106%	92%	105%	95%	80%	77%	99%	91%	104%	97%
DIVISION A Total		92%	89%	109%	98%	106%	102%	90%	88%	107%	100%	108%	102%
DIVISION B	ACUTE MEDICINE	108%	90%	91%	91%	142%	99%	113%	94%	95%	82%	140%	93%
	CANCER CARE	126%	125%	152%	141%	140%	130%	124%	123%	150%	129%	129%	123%
	EMERGENCY MEDICINE	59%	61%	88%	132%	126%	55%	61%	61%	89%	124%	132%	62%
	SPECIALIST MEDICINE	107%	100%	132%	117%	138%	109%	101%	96%	127%	114%	123%	107%
DIVISION B Total		115%	110%	140%	126%	139%	117%	111%	107%	136%	120%	126%	113%
DIVISION C	CHILD HEALTH	105%	95%	118%	104%	117%	92%	106%	96%	119%	103%	111%	91%
	SUPPORT SERVICES	77%	78%	87%	85%	93%	77%	73%	73%	83%	80%	85%	77%
	WOMEN'S HEALTH	96%	88%	115%	111%	112%	97%	95%	89%	115%	109%	108%	100%
DIVISION C Total		95%	88%	108%	101%	109%	89%	98%	91%	114%	102%	107%	92%
DIVISION D	CARDIOVASCULAR & THORACIC	101%	96%	121%	125%	131%	114%	100%	95%	118%	124%	130%	113%
	NEUROSCIENCES	109%	94%	117%	100%	115%	95%	109%	95%	118%	99%	111%	97%
	RADIOLOGY	107%	129%	172%	176%	204%	122%	85%	104%	138%	202%	233%	127%
	TRAUMA & ORTHOPAEDICS	72%	62%	88%	93%	100%	101%	70%	61%	92%	110%	121%	117%
DIVISION D Total		95%	86%	111%	109%	118%	104%	97%	88%	113%	112%	121%	108%
Total		**100%**	**94%**	**118%**	**109%**	**118%**	**104%**	**100%**	**95%**	**119%**	**109%**	**116%**	**105%**

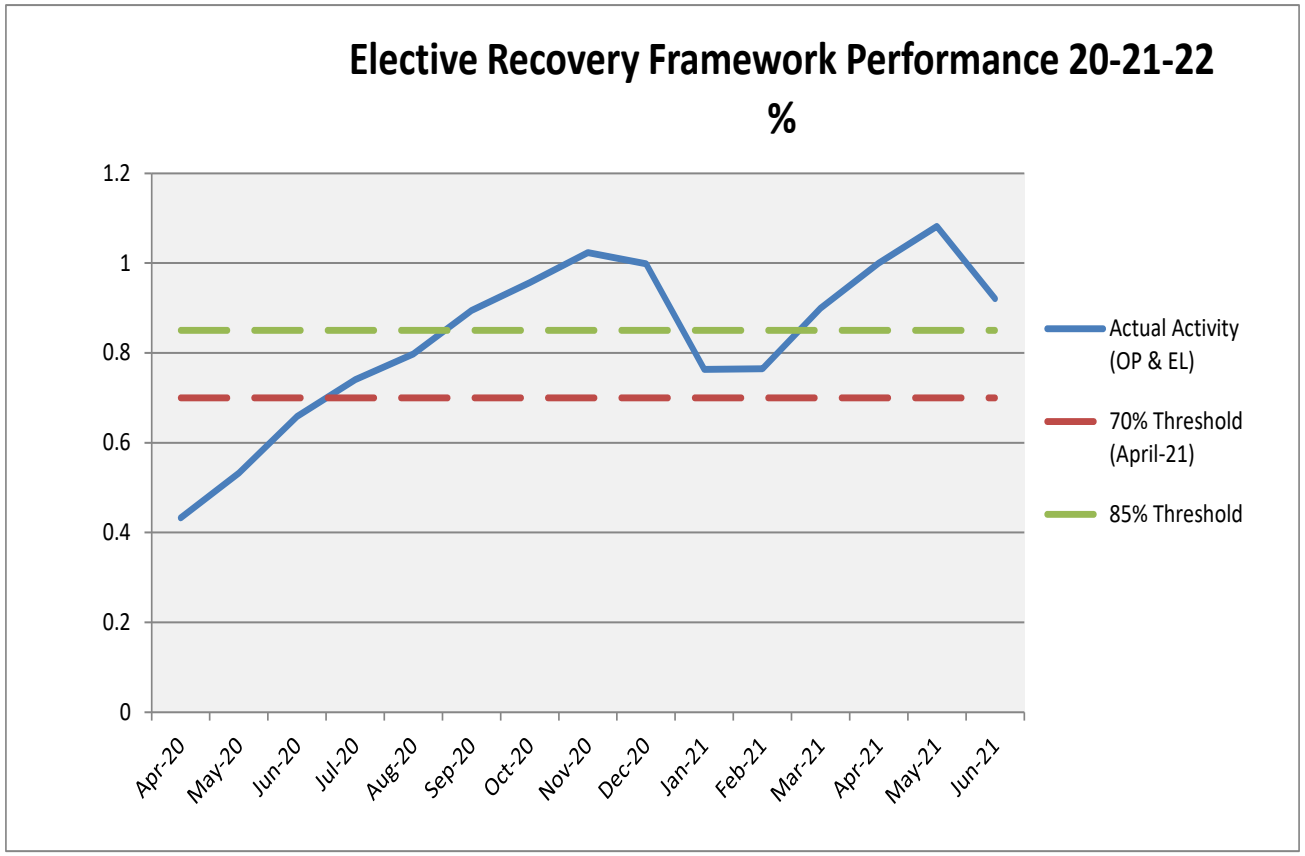
Elective Recovery Fund 21/22

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

The graph shows the equivalent trends through 20/21 and estimated performance for June. This indicates performance of 92% of baseline activity which is 12% over the target threshold of 80% in June. This would yield an estimated £2.6m additional income if paid at tariff.

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

The 20% premium has already been agreed with ICS partners will be centrally pooled rather than allocated directly to providers. It is therefore expected that £14.3m of ERF income flows directly to UHS YTD.



	ERF Achievement - Elective/Daycase/Outpatients (£'000)				ERF Top-up		
Month	Baseline	Actuals	Variance	%	100% Top Up	20% Top Up	Total
Apr-21	£ 18,770	£ 18,786	£ 15	*100%*	£ 5,646	£ 566	£ 6,213
May-21	£ 18,276	£ 19,792	£ 1,516	*108%*	£ 6,085	£ 852	£ 6,937
Jun-21	£ 21,464	£ 19,760	-£ 1,704	*92%*	£ 2,589	£ 303	£ 2,892
YTD Total	**£ 37,046**	**£ 38,578**	**£ 1,532**	***104%***	**£ 14,321**	**£ 1,721**	**£ 16,042**

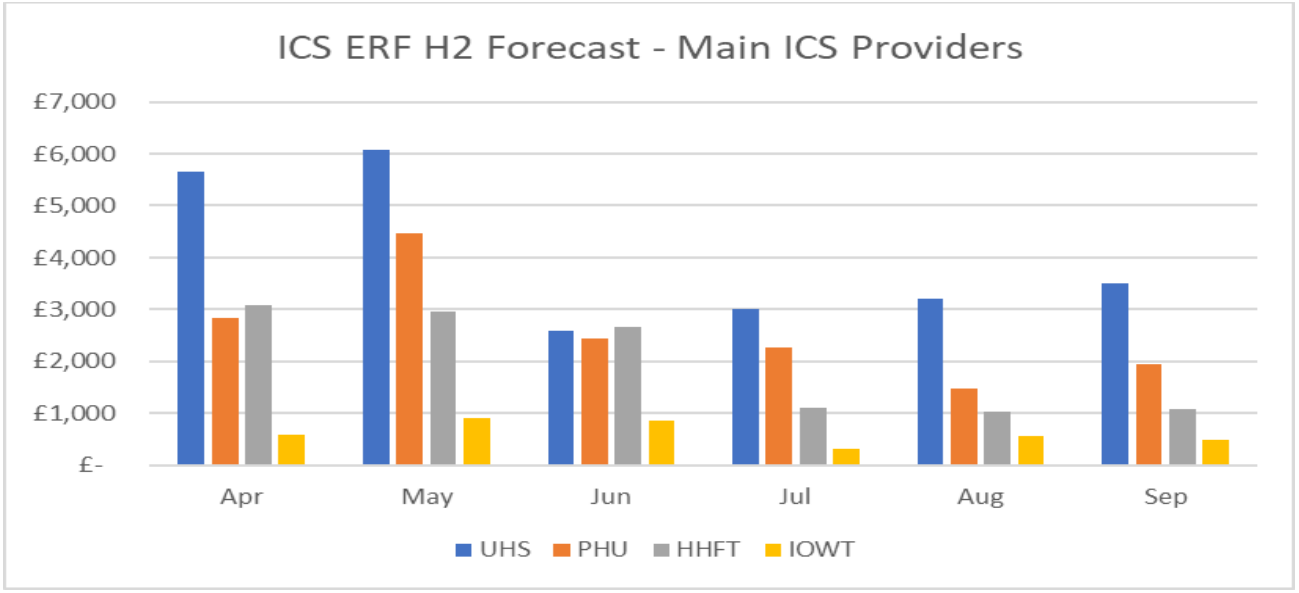
ICS Elective Recovery Fund 21/22

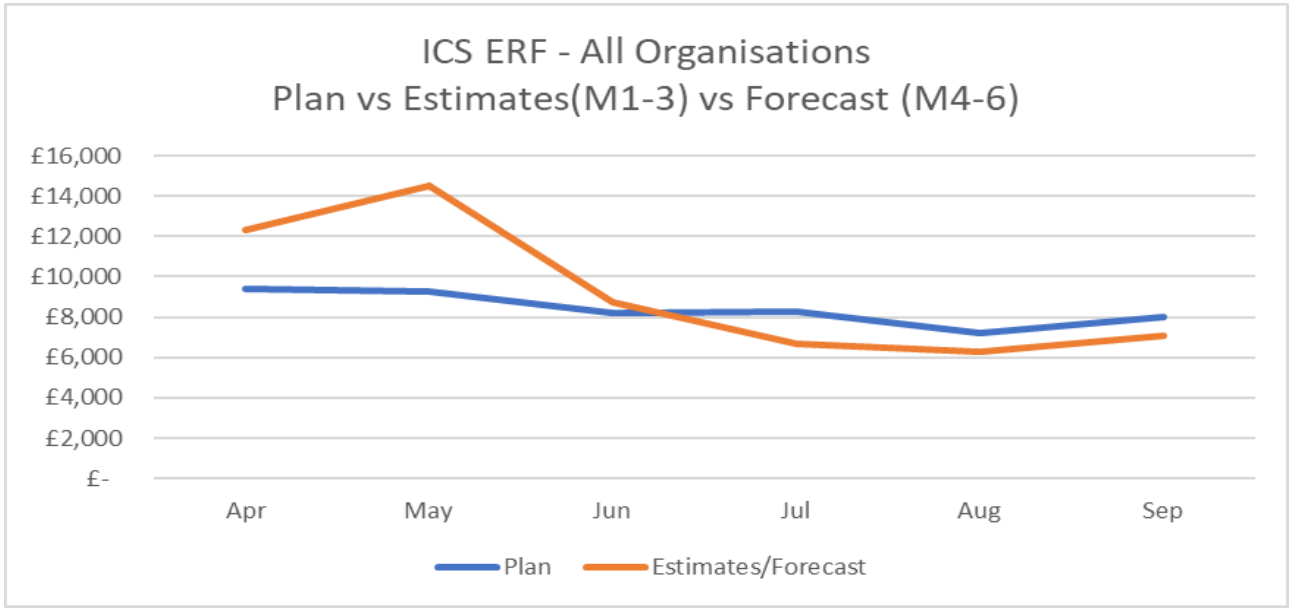
ICS current estimated performance and forecast is shown for the 4 main Providers for the Elective Recovery Framework (ERF). April – June numbers are all currently based on local assessment and awaiting national validation.

It should be noted that the Q2 forecast has been adjusted following the NHSI/E announcement that the targets for July, August and September will increase from a baseline of 85% to 95% hence the trajectory indicating below plan performance for these months.

At M3 the ICS has collectively reported £35.3m in ERF income vs an original (unadjusted) plan of £26.8m.

The revised H1 forecast is £55.3m against an original (unadjusted) plan of £50.3m. This includes circa £7m estimated impact of accelerator programmes on ERF income.

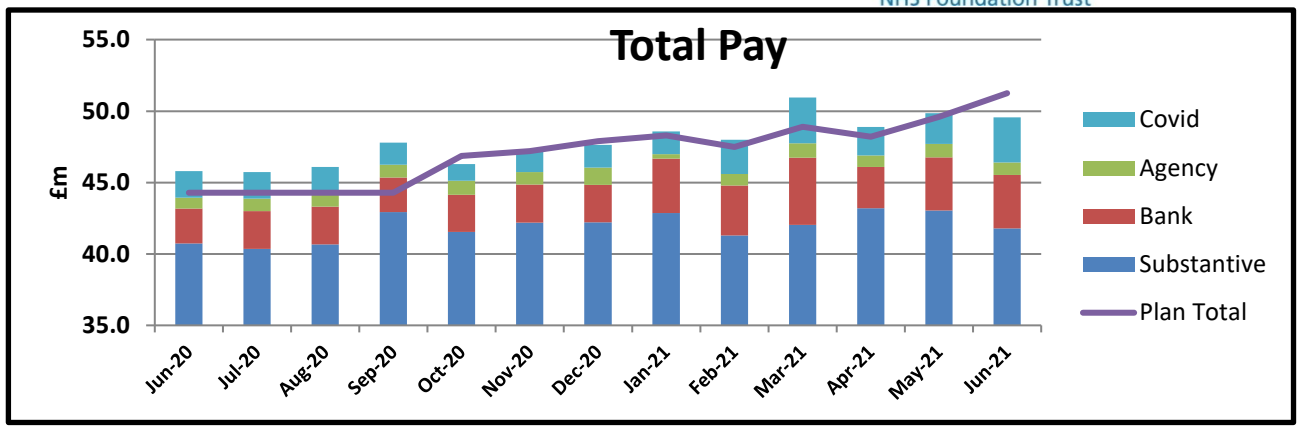


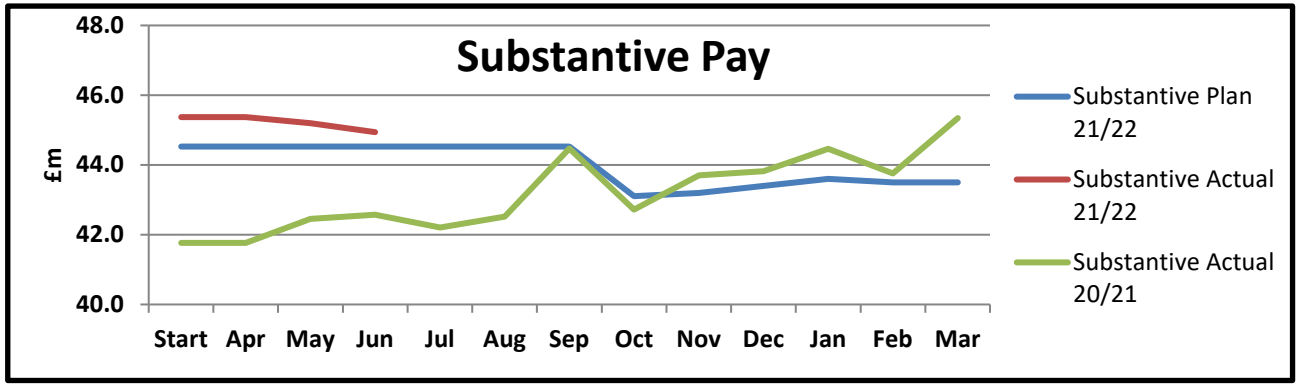


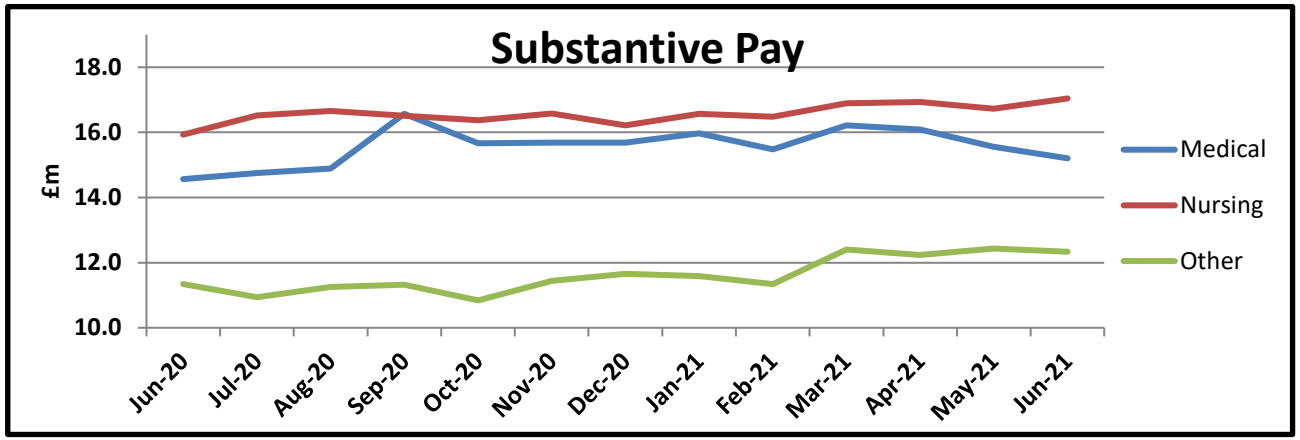
Substantive Pay Costs

Total pay expenditure in June was £49.6m. This was slightly lower (£0.3m) than in May. The main decrease was in substantive medical staff costs plus a small fall in agency spend.

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



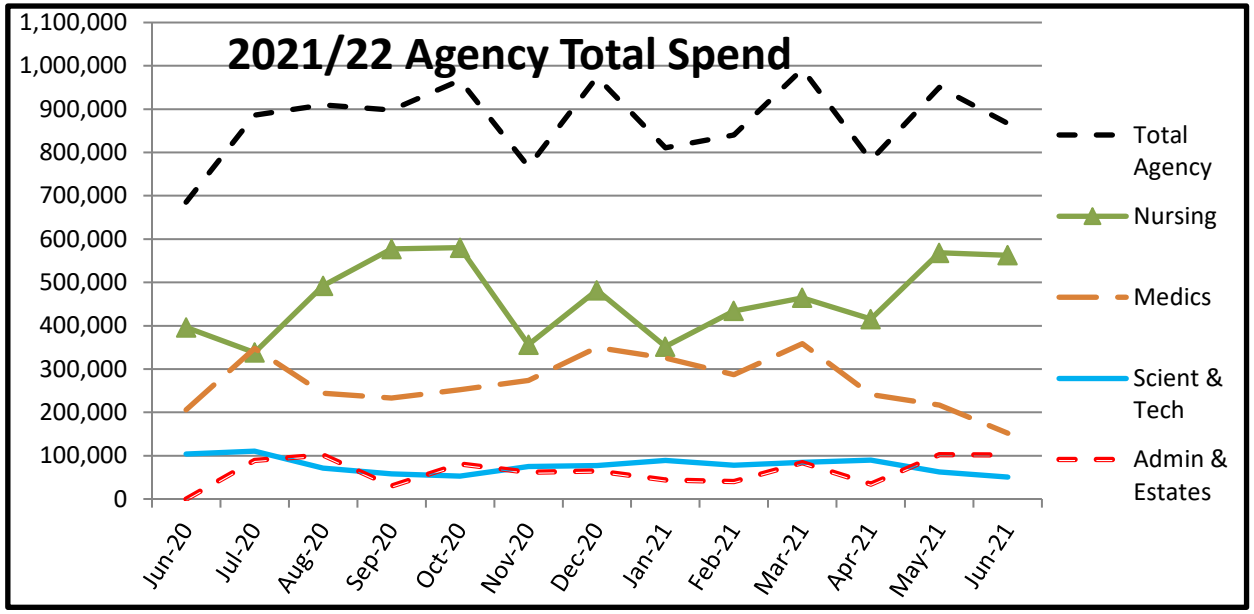


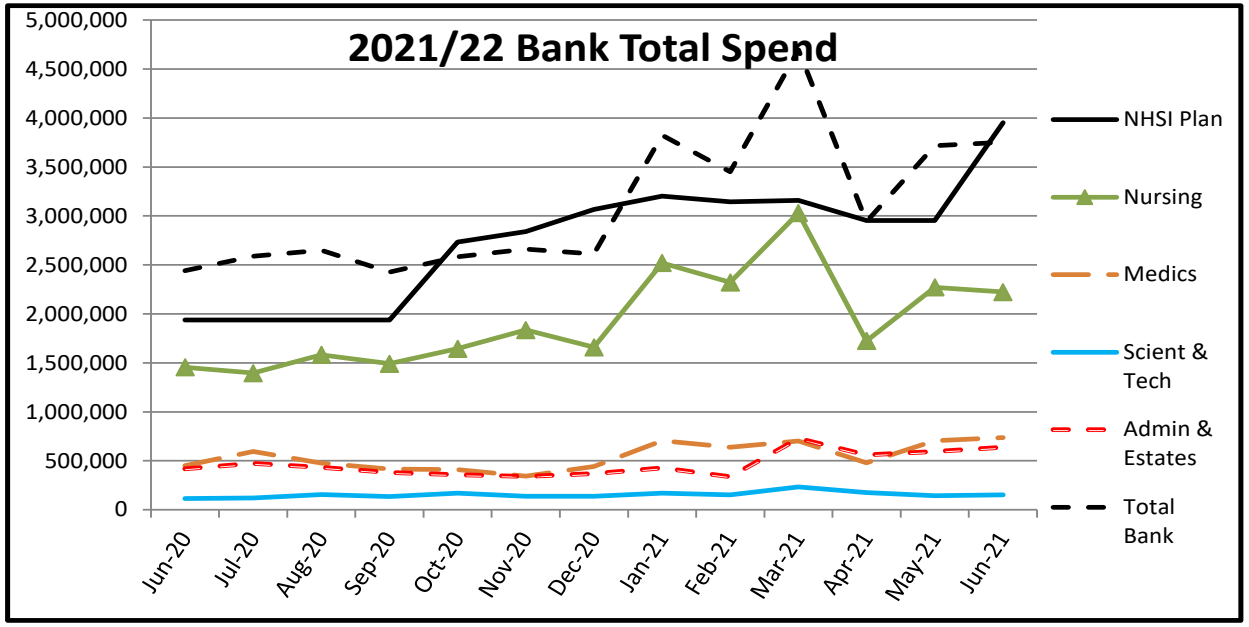


Temporary Staff Costs

Agency spend has fallen slightly month on month by £0.1m with the fall mainly in medical staff.

Expenditure on bank staff has remained flat month on month both in total and across all staff groups. The plan adjustment within the bank graph relates to rebasing the plan following resubmission to NHSI inclusive of the accelerator funding and associated ERF. This had not been captured in the previous plan submission.



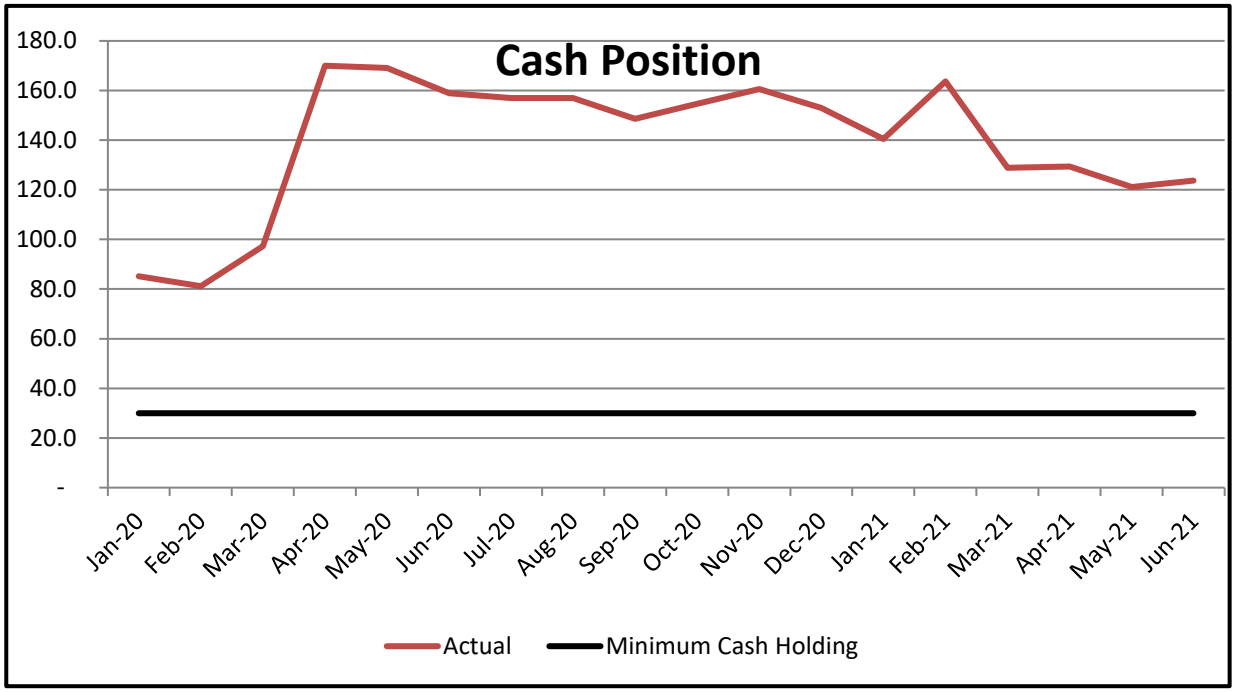


Cash

The cash balance increased slightly in June to £123.7m.

There are no foreseen material movements forecast now the cash regime has adjusted back to pre-covid levels with block income paid in the month for which it is due. We may however see some in-month volatility as we move to a more "normal" period and the working capital position stabilises.

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



Capital Expenditure

(Fav Variance) / Adv Variance

Expenditure on internally funded capital schemes for the year to M3 was £11.5m against a budget of £11.8m.

The largest expenditure in M3 was the vertical extension theatres scheme where large amounts of equipment was purchased. Other areas where expenditure was high were the ED expansion scheme where most phase 1a costs have now been incurred.

The vertical extension theatres scheme is currently forecast to outturn at £1m below plan, plus only £0.4m is forecast to be spent on the NICU pendants scheme, with remaining costs incurred in 22-23. Expenditure on other schemes means that UHS is forecasting to spend all of its CDEL funding.

The forecast shows expenditure of £2.5m over plan based on the expectation of receiving £2m of external funding for community diagnostic hubs and an allowable overspend of £0.5m on medical equipment that is part of the accelerator funding scheme.

	Month			Year to Date			Full Year (Forecast)		
Scheme	Plan £000's	Actual £000's	Var £000's	Plan £000's	Actual £000's	Var £000's	Plan £000's	Actual £000's	Var £000's
Fit out of E level. Vertical Extension - Theatres	2,707	2,566	141	7,003	6,129	874	11,941	10,950	991
Strategic Maintenance	258	344	(86)	774	842	(68)	6,183	6,183	0
ED Expansion and Refurbishment	827	774	53	2,081	1,203	878	5,791	5,629	162
Wards	0	0	0	0	0	0	4,000	4,000	0
Ophthalmology OPD	50	170	(120)	50	219	(169)	3,303	3,241	62
Maternity Induction Suite	0	(2)	2	0	(0)	0	2,000	2,000	0
NICU Pendants	0	0	0	0	0	0	896	355	541
Oncology Ward	0	194	(194)	861	428	433	861	797	64
Decorative / Environment Improvements	21	0	21	63	0	63	500	500	0
Side Rooms	90	72	18	490	512	(22)	490	512	(22)
Information Technology Programme	250	261	(11)	750	673	77	5,000	5,000	0
Other Projects	380	90	290	1,033	694	339	3,060	2,782	278
Pathology Digitisation	59	5	54	177	17	160	1,171	1,171	0
Medical Equipment	42	178	(136)	126	418	(292)	1,000	1,016	(16)
Accelerator Funded Equipment	0	0	0	0	0	0	0	460	(460)
Slippage	(516)	0	(516)	(1,948)	0	(1,948)	(5,035)	(843)	(4,192)
Total Trust Funded Capital excl Finance Leases	**4,168**	**4,652**	**(484)**	**11,460**	**11,135**	**325**	**41,161**	**43,753**	**(2,592)**
Finance Leases - IISS	0	32	(32)	0	32	(32)	5,230	2,765	2,465
Finance Leases - MEP	92	179	(87)	276	179	97	2,200	2,183	17
Finance Leases - Other Equipment	75	7	68	225	55	170	1,500	1,500	0
Finance Leases - Opthalmology OPD	0	0	0	0	0	0	1,166	1,166	0
Finance Leases - Divisonal Equipment	0	37	(37)	50	106	(56)	475	500	(25)
Donated Income	(88)	(5)	(83)	(264)	(17)	(247)	(1,921)	(1,596)	(325)
Total Trust Funded Capital Expenditure	**4,247**	**4,901**	**(654)**	**11,747**	**11,490**	**257**	**49,811**	**50,271**	**(460)**
Fit out of E level. Vertical Extension - Theatres	154	154	0	398	398	0	700	700	0
Maternity Care System (Wave 3 STP)	96	404	(308)	288	510	(222)	1,917	1,917	0
Digital Outpatients (Wave 3 STP)	41	25	16	123	25	98	814	814	0
LIMS Digital Enhancement	38	0	38	114	0	114	455	455	0
Community Diagnostic Hub	0	0	0	0	0	0	0	2,000	(2,000)
Total CDEL Expenditure	**4,576**	**5,484**	**(908)**	**12,670**	**12,423**	**247**	**53,697**	**56,157**	**(2,460)**

Statement of Financial Position

(Fav Variance) / Adv Variance

The June statement of financial position illustrates net assets of £451.3m which is stable compared to May 2021.

The downward movement on receivables is mainly due to the clearance of Rapid Testing invoices by DHSC plus the removal of VAT due to the reclassification of the project to a business activity. This is a one-off correction.

The upward movement on payables is driven by £4m additional accrued costs not yet invoiced. Payables is becoming a greater focus area for the NHS and an improvement plan is being developed to help tackle this down to Better Payment Practice Code (BPPC) compliant levels.

Statement of Financial Position	2020/21 YE Actuals £m	2021/22 M2 Act £m	2021/22 M3 Act £m	2021/22 MoM Movement £m
Fixed Assets	415.4	420.1	425.6	5.5
Inventories	14.7	15.6	15.9	0.3
Receivables	71.3	81.6	77.9	(3.7)
Cash	129.0	121.0	123.6	2.6
Payables	(171.5)	(174.5)	(180.2)	(5.7)
Current Loan	(2.8)	(2.7)	(2.7)	0.0
Current PFI and Leases	(9.0)	(8.8)	(8.8)	0.0
Net Assets	**447.1**	**452.2**	**451.3**	**(1.0)**
Non Current Liabilities	(18.3)	(17.9)	(17.5)	0.4
Non Current Loan	(8.5)	(8.0)	(7.8)	0.3
Non Current PFI and Leases	(36.3)	(35.0)	(34.7)	0.3
Total Assets Employed	**384.0**	**391.4**	**391.3**	**(0.1)**
Public Dividend Capital	246.0	246.0	246.0	0.0
Retained Earnings	114.0	121.3	121.3	(0.1)
Revaluation Reserve	24.0	24.0	24.0	0.0
Other Reserves	0.0	0.0	0.0	0.0
Total Taxpayers' Equity	**384.0**	**391.4**	**391.3**	**(0.1)**

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:	**29 July 2021**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification** **Y**	**Information**
Issue to be addressed:	This is a regular report to notify the Board of use of the seal and actions taken by the Chair in accordance with the Standing Financial Instructions and Scheme of Delegation for ratification.			
Response to the issue:	The Board has agreed that the Chair may undertake some actions on its behalf.			
Implications: (Clinical, Organisational, Governance, Legal?)	Compliance with The NHS Foundation Trust Code of Governance (probity, internal control) and UHS Standing Financial Instructions and Scheme of Delegation.			
Risks: (Top 3) of carrying out the change / or not:				
Summary: Conclusion and/or recommendation	The Board is asked to **ratify** the application of the seal.			

1 Signing and Sealing

1.1 **Loan Agreement** between University Hospital Southampton NHS Foundation Trust and UHS Estates Limited for the sum of £10,080,000 to support the costs of Build of E Level Theatres – Vertical Extension and the Ophthalmology Outpatient Expansion. Seal number 234 on 6 July 2021. The loan agreement was approved by the Board at its meeting on 29 June 2021.

1.2 **Lease** between University Hospital Southampton NHS Foundation Trust (Landlord), Electricity Network Company Limited (Tenant) and Prime Infrastructure Management Services 4 Limited (Grantor) relating to land for use as an electricity substation including cable easements at Adanac Park, Southampton. Seal number 235 on 13 July 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:	**Quality Committee Terms of Reference**			
Agenda item:	**6.3**			
Sponsor:	**Tim Peachey, Chair of Quality Committee**			
Author:	**Karen Flaherty, Associate Director of Corporate Affairs and Company Secretary**			
Date:	**29 July 2021**			
Purpose	**Assurance or reassurance**	**Approval** **X**	**Ratification**	**Information**
Issue to be addressed:	Recently approved changes to the terms of reference for the Quality Governance Steering Group highlighted that changes to governance structure introduced around the time of the Trust's response the COVID-19 pandemic had not yet been reflected in the current governance structures for the Trust. These include accountability and reporting lines for the following committees/groups: • End of Life Steering Group • Infection Prevention Committee • Mental Health Board. The Infection Prevention Committee had paused during the COVID-19 pandemic, with responsibilities transferring to Infection Control Gold command. The Mental Health Board had previously reported to Quality Governance Steering Group and the End of Life Steering Group had previously reported to the Trust Executive Committee.			
Response to the issue:	It is proposed that each of the End of Life Steering Group, Infection Prevention Committee and Mental Health Board report to the Quality Committee alongside the Quality Governance Steering Group. This reflects current reporting arrangements for these areas in practice, with quarterly or biannual reports to the Quality Committee already taking place. It also reflects the significance of these areas in terms of the potential impact on the quality of care and patient experience and the consequential regulatory focus. These changes have been reflected in the structure chart in Appendix A to the terms of reference. The structure chart has also been updated to reflect the current reporting arrangements to the Quality Governance Steering Group. Unfortunately changes to a structure chart are not highlighted when using tracked changes. A few other minor changes identified when these were reviewed have also been made to the terms of reference at this time.			
Implications: (Clinical, Organisational, Governance, Legal?)	The terms of reference ensure that the purpose and activities of the Quality Committee are clear and support transparency and accountability in the performance of its role.			
Risks: (Top 3) of carrying out the change / or not:	1. Non-compliance with the National Health Service Act 2006 and the Trust's constitution relating to the composition of Board committees.			

	2. Non-compliance with good practice around the governance and assurance of quality within NHS organisations. 3. The Board of Directors and the Committee may not function as effectively or receive the required information and assurance 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 Quality Committee and are recommended to the Board of Directors for approval.

Quality Committee Terms of Reference

Version: ~~2~~3

Date Issued:	~~28 January~~29 July 2021
Review Date:	November 2021
Document Type:	~~Committee~~ Terms of Reference

Contents

Document Status

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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 Chair 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

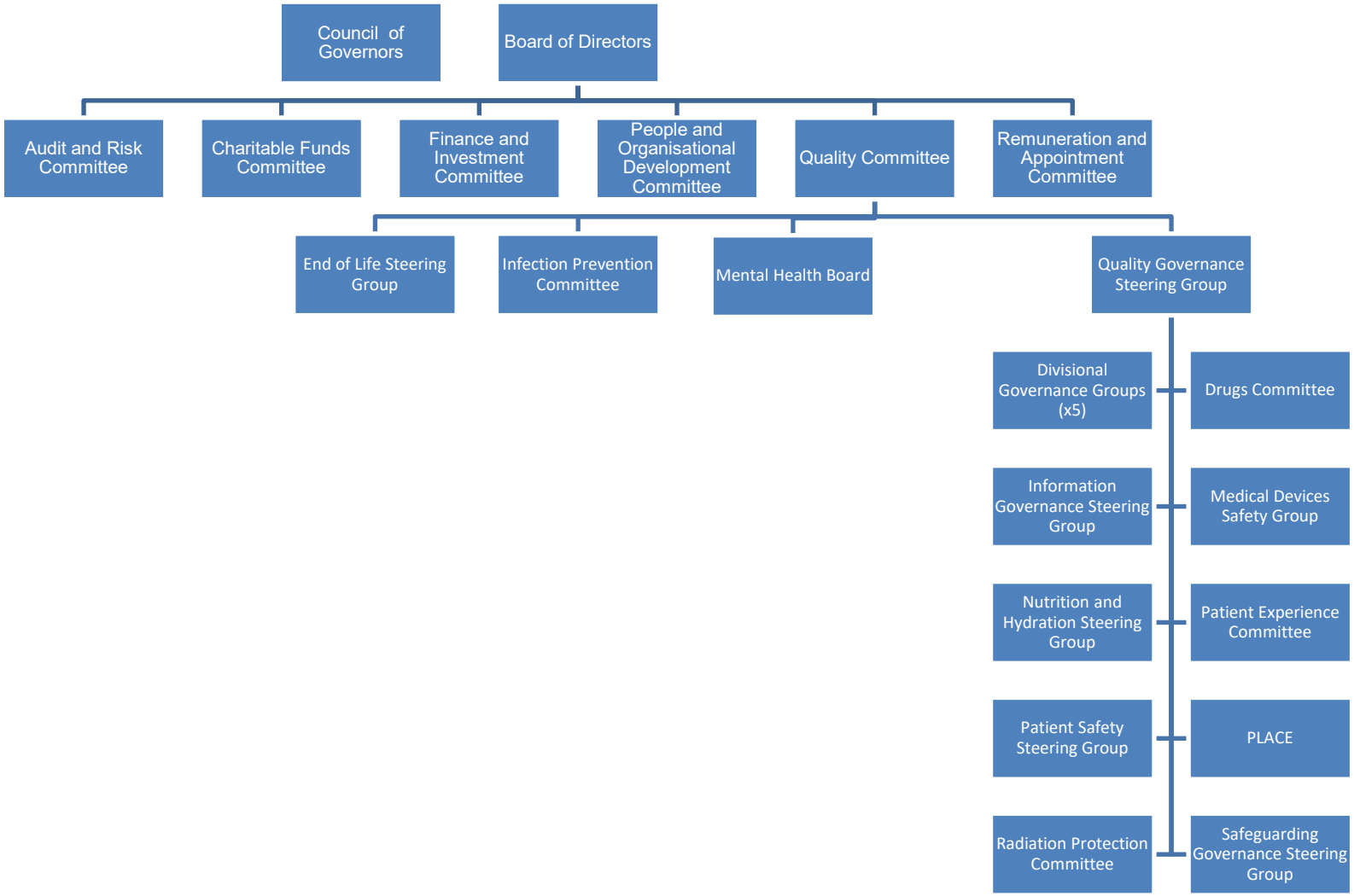
10.6 NHS Foundation Trust Code of Governance

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 Committee
People and Organisational Development Committee
Quality Committee
Remuneration and Appointment Committee
End of Life Steering Group
Infection Prevention Committee
Mental Health Board
Quality Governance Steering Group
Divisional Governance Groups (x5)
Drugs Committee
Information Governance Steering Group
Medical Devices Safety Group
Nutrition and Hydration Steering Group
Patient Experience Committee
Patient Safety Steering Group
PLACE
Radiation Protection Committee
Safeguarding Governance Steering Group

Quality Committee Terms of Reference	Version: ~~32~~

Document Monitoring Information	
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Responsible Committee:	Quality Committee
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Target audience:	Board of Directors, Quality Committee, NHS Regulators, Staff
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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
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Type of document:	~~Committee~~ Terms of Reference
Does this document replace or revise an existing document?	Yes
Should this document be made available on the public website?	Yes
Is this document to be published in any other format?	No

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Trust Executive Committee Terms of Reference**			
Agenda item:	**6.4**			
Sponsor:	**David French, Chief Executive Officer**			
Author:	**Karen Flaherty, Associate Director of Corporate Affairs & Company Secretary**			
Date:	**29 July 2021**			
Purpose	**Assurance or reassurance**	**Approval** **X**	**Ratification**	**Information**
Issue to be addressed:	Following some changes to supporting governance structures, it is proposed that the structure chart in Appendix A of the terms of reference has been updated to reflect the committees and groups reporting to the Trust Executive Committee (**TEC**). It is proposed that: • the End of Life Steering Group is removed from the current reporting structure for the TEC and reports directly to the Quality Committee. This reflects current reporting arrangements for these areas in practice, with biannual reports to the Quality Committee already taking place. It also reflects the significance of these areas in terms of the potential impact on the quality of care and patient experience and the consequential regulatory focus; and • the Private Healthcare Services Programme Board, which previously reported to the TEC, has been reinstated in the structure chart and will report biannually on its strategy and performance to the TEC as well as providing copies of minutes and escalating other issues to the TEC as necessary. The quorum requirements for the TEC have also been updated to ensure appropriate divisional and executive director representation for decision-making at meetings. Minor typographical changes identified during the review are also marked up on the terms of reference for approval.			
Response to the issue:	The proposed draft terms of reference are attached and have been approved by the TEC. These terms of reference are subject to final approval by the Trust's Board of Directors to provide additional assurance on the constitution of the TEC given its responsibility for developing and implementing the strategy adopted by the Board and the operational management of the Trust.			
Implications: (Clinical, Organisational, Governance, Legal?)	The terms of reference ensure that the purpose and activities of the TEC are clear and support transparency and accountability in the performance of its role.			

Risks: (Top 3) of carrying out the change / or not:	1. Executive, divisional and broader clinical leadership are involved in decision-making in areas of strategic and operational significance at UHS. 2. Non-compliance with the Trust's standing financial instructions and policies relating to the specific responsibilities of the TEC. 3. The Trust and the TEC may not function as effectively without terms of reference in place.
Summary: Conclusion and/or recommendation	The Board of Directors is asked to approve the terms of reference following review by the TEC.

University Hospital Southampton NHS
NHS Foundation Trust

Trust Executive Committee Terms of Reference

Version: ~~4~~5

Date Issued:	~~27 May~~29 July 2021
Review Date:	December 2021
Document Type:	Terms of Reference

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1. Role and Purpose

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

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

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

2. Constitution

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

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

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

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

3. Membership

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

3.1.1 the Chief Executive Officer;

3.1.2 all other Executive Directors;

3.1.3 the Deputy Medical Directors;

3.1.4 the Director of Planning, Performance and Productivity;

3.1.5 all Divisional Clinical Directors;

3.1.6 all Divisional Directors of Operations;

3.1.7 all Divisional Heads of Nursing and Professions;

3.1.8 the Director of Midwifery;

3.1.9 the Director of Research and Development;

3.1.10 the Director of Education;

3.1.11 the Deputy Director of Nursing for Quality;

3.1.12 the Director of Informatics;

3.1.13 the Director of Estates, Facilities & Capital Development;

3.1.14 the Director of Communications;

3.1.15 the Deputy Chief Operating Officer;

3.1.16 the Covid Mass Testing Project Lead;

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

3.1.18 the Dean of Medicine, University of Southampton.

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

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

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

4. Attendance and Quorum

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

4.2 The quorum for a meeting will be ten members including at least four (4) executive directors and at least one (1) representative from each division. A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

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

5. Frequency of Meetings

5.1 The Committee will meet monthly and otherwise as required.

6. Conduct and Administration of Meetings

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

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

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

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

7. Duties and Responsibilities

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

7.1 *Objectives and strategy*

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

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

7.2 *Performance and operations*

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

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

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

7.2.4 The Committee will optimise the allocation of resources.

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

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

7.3 *Resources*

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

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

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

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

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

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

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

7.4 *Governance and risk management*

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

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

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

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

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

~~7.6~~7.5 ***Innovation***

~~7.6.1~~7.5.1 The Committee will identify and support the execution of innovation in the delivery of services and areas of activity.

~~7.7~~7.6 ***Policies***

~~7.7.1~~7.6.1 The Committee will consider, and approve as appropriate, policies identified by the Chief Executive Officer for its consideration.

8. Accountability and Reporting

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

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

9. Review of Terms of Reference and Performance and Effectiveness

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

10. References

10.1 National Health Service Act 2006

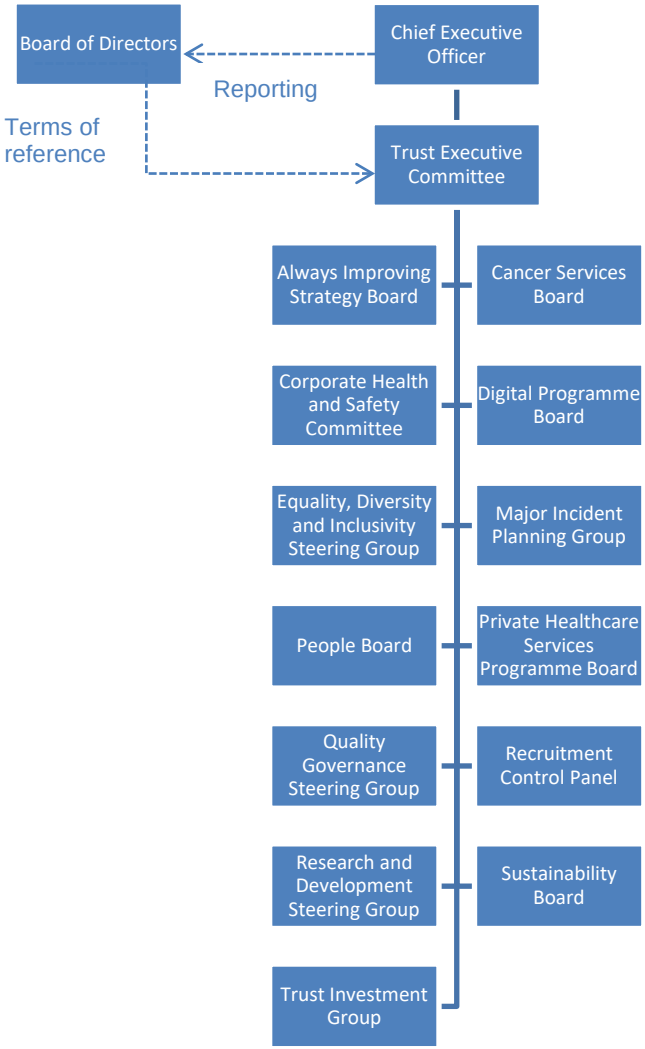
10.2 NHS Foundation Trust Code of Governance

10.3 NHS foundation trust accounting officer memorandum (August 2015)

10.4 NHS Oversight Framework

10.5 Standing Financial Instructions

Appendix A


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

Trust Executive Committee Terms of Reference	Version: 45

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