University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	26/05/2022
Time	9:00 - 12:30
Location	Dean's Committee Room, C Level, SAB/MS Teams
Chair	Jane Bailey
Apologies	Cyrus Cooper
Observing	Ramkumar Shanmugasundaram, Consultant, Clinical Oncology (Nye Bevan: Making the Case for Change Programme Pre-work)

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	9:15	**Minutes of Previous Meeting held on 31 March 2022**
4		**Matters Arising and Summary of Agreed Actions** To discuss any matters arising from the minutes, and to agree on the status of any actions assigned at the previous meeting.
5		**QUALITY, PERFORMANCE and FINANCE** Quality includes: clinical effectiveness, patient safety, and patient experience
5.1	9:25	**Briefing from the Chair of the Audit and Risk Committee (Oral)** Keith Evans, Chair
5.2	9:30	**Briefing from the Chair of the Finance and Investment Committee (Oral)** Jane Bailey, Chair
5.3	9:35	**Chief Executive Officer's Report** Sponsor: David French, Chief Executive Officer
5.4	9:50	**Infection Prevention 2021/22 Annual Report** Sponsor: Gail Byrne, Chief Nursing Officer Attendees: Nitin Mahobia, Deputy Director of Infection Prevention and Control/Julie Brooks, Head of Infection Prevention Unit
5.5	10:05	**Ockenden Report - Final Report from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust** Sponsor: Gail Byrne, Chief Nursing Officer Attendee: Emma Northover, Director of Midwifery/Marie Cann, Senior Midwifery Manager

5.6 **Freedom to Speak Up Report**

10:20 Sponsor: Gail Byrne, Chief Nursing Officer
Attendee: Christine Mbabazi, Equality & Inclusion Adviser/Freedom to Speak Up Guardian

5.7 **Break**

10:35

5.8 **Integrated Performance Report for Month 1**

10:45 To review the Trust's performance as reported in the Integrated Performance Report.
Sponsor: David French, Chief Executive Officer

5.9 **Finance Report for Month 1**

11:25 Sponsor: Ian Howard, Chief Financial Officer

6 **STRATEGY and BUSINESS PLANNING**

6.1 **CRN: Wessex 2021/22 Annual Report and 2022/23 Annual Plan**

11:40 Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Clare Rook, Chief Operating Officer, CRN: Wessex

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

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

11:55 In compliance with the Trust Standing Orders, Financial Instructions, and the Scheme of Reservation and Delegation.
Sponsor: Jane Bailey, Interim Chair

7.2 **Remuneration and Appointment Committee Terms of Reference**

12:00 Sponsor: Jane Bailey, Interim Chair
Attendee: Karen Flaherty, Associate Director of Corporate Affairs and Company Secretary

8 **Any other business**

12:05 To raise any relevant or urgent matters that are not on the agenda

9 **To note the date of the next meeting: 28 July 2022**

10 **Resolution regarding the Press, Public and Others**

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

11 **Follow-up discussion with governors**

12:15

University Hospital Southampton
NHS Foundation Trust

Minutes Trust Board – Open Session

Date	31/03/2022
Time	9:00 - 12:25
Location	Microsoft Teams
Chair	Peter Hollins, (PH), Trust Chair
Present	Jane Bailey (JB), Non-Executive Director (**NED**) and Senior Independent Director/Deputy Chair Dave Bennett (DB), NED Gail Byrne (GB), Chief Nursing Officer Cyrus Cooper (CC), NED Keith Evans (KE), NED David French (DAF), Chief Executive Officer Paul Grundy (PG), Chief Medical Officer Steve Harris (SH), Chief People Officer Jane Harwood (JH), NED Peter Hollins (PH), Trust Chair Ian Howard (IH), Interim Chief Financial Officer Tim Peachey (TP), NED Joe Teape (JT), Chief Operating Officer
In attendance	Andrew Asquith (AA), Director of Planning, Performance and Productivity (for item 5.6) Julie Brooks (JB), Head of Infection Prevention Unit (for item 5.7) Brenda Carter (BC), Assistant Director of People (for item 6.1) Paul Chamberlain (PC), Deputy Director of Estates, Facilities & Capital Development (for item 6.2) Ceri Connor (CC), Director of OD and Inclusion (CC) (for items 5.10 and 6.1) Laura Cross, CQC Inspector (observing) Suzanne Cunningham (SC), Director of Midwifery (for item 5.8) Karen Flaherty (KF), Associate Director or Corporate Affairs and Company Secretary Serena Gaukroger-Woods, Head of Clinical Quality Assurance (observing) Jason Light (JL), Head of Sustainability and Energy (for item 6.2) Sophie Limb (SL), HR Project Manager (for item 5.10) Femi Macaulay (FM), Associate NED Nitin Mahobia (NM), Deputy Director of Infection Prevention and Control (for item 5.7) Christine McGrath (CMcG), Director of Strategy and Partnerships Puja Patel, Associate Director of Healthcare Scientists (shadowing GB) Jo Ward, CQC Inspector (observing) Four governors (observing) Six members of staff (observing) One member of the public (for item 2)

1 Chair's Welcome, Apologies and Declarations of Interest

The Chair welcomed all those attending the meeting. There were no apologies or new declarations of interest.

2 Patient Story

The individual sharing their story was a nurse with Solent NHS Trust, who had given birth to her third child in hospital just before Christmas.

Her baby had been delivered in theatre, however, this experience was described as 'magical'. All the staff in theatre had introduced themselves and were wearing lanyards identifying their roles. Later the same day her baby was transferred to neonatal intensive care where she was ventilated for three days and remained in hospital for seven days in total in both neonatal intensive care and the special care unit. Her daughter was doing well at home since leaving hospital.

The individual sharing their story spoke about the protocol for monitoring her baby on the maternity unit, which identified that something was wrong initially, and the care in neonatal intensive care in very positive terms as having saved her daughter's life. She also complimented the psychological support and follow-up care she has received and the work of the charities, Southampton Hospital Charity (**Charity**) and Bliss. As her daughter had been in hospital over Christmas, the presents from the Charity had been a lovely surprise and the staff on the ward had made things feel as festive and cheerful as they could. The ward had also sent photographs and films of her daughter when they could not be on the unit with her, which had made her family feel so much better.

It was suggested that having a filmed tour of the unit available as a resource for parents, showing how it looked and the cots and equipment used, would help raise awareness of the unit and what it did should it ever be needed for their babies. She also mentioned that it was important to ensure that all relevant information was held on the recently implemented maternity Badgernet IT system as there had been a problem locating a growth scan for her baby.

The Board welcomed the suggestion about making a virtual tour of the neonatal intensive care unit available and endorsed the importance of ensuring that access to all notes was available through the Badgernet IT system. Given the understandable anxiety for parents that the stories included in the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust (the **Ockenden review**) had generated about maternity services, it had been good to hear a story about when things went well and thanked the individual for sharing their story.

3 Minutes of Previous Meeting held on 27 January 2022

The minutes of the meeting held on 27 January 2022 were approved as an accurate record of that meeting.

4 Matters Arising and Summary of Agreed Actions

The updates on the actions were noted and both actions could be closed.

5 QUALITY, PERFORMANCE and FINANCE

5.1 Briefing from the Chair of the Audit and Risk Committee

KE summarised the key areas considered at the meeting of the Audit and Risk Committee earlier in January 2022. These included:

- the positive progress being made with the interim external audit work ahead of the year end;

- the review of other options for the external audit of the Trust's subsidiaries and the Charity as it would be difficult for the Trust's external auditor to complete these within the required timescales;
- a progress update from the internal auditor, which had not identified any significant issues in its latest reviews;
- the review of the board assurance framework (**BAF**), which was working well and reporting dynamically; and
- compliance with the standards of business conduct policy.

GB noted that the executive reviews had been put in place to ensure that the BAF was regularly reviewed collectively and updated.

5.2 Briefing from the Chair of the Finance and Investment Committee

JB updated the Board on the meeting of the Finance and Investment Committee (**F&IC**) held earlier that week. A number of the items considered by the F&IC were due to be considered by the Board later in the meeting.

The Trust remained on track to deliver its financial plan for 2021/22, including its capital plan. There was a level of risk to the delivery of the capital programme as the Trust had been allocated additional capital towards the end of the financial year. The operational plan for 2022/23 continued to evolve following further guidance and review and a more detailed update would be provided later in the meeting.

The F&IC had received a report about future energy purchasing arrangements at its meeting and would continue to monitor energy costs as the impact of energy price increases and inflation on the Trust was likely to be more pronounced than for many other NHS organisations as its on-site combined heat and power plant (CHP) used gas to generate electricity and heating.

The F&IC also received updates on the Trust's 'Always Improving' and digital transformation programmes and considered ways to ensure greater alignment in the delivery of these programmes.

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

The People and Organisational Development Committee (**P&ODC**) met on 16 March 2022. JB observed that the meeting had been well attended, with representatives from the staff networks and unions and the Trust's freedom to speak up guardian present.

The P&ODC had reviewed progress against the people objectives, including equality, diversity and inclusion, and the BAF and key operational risks relating to the areas within the committee's remit.

The P&ODC had also reviewed the staff survey results and the people strategy, which were to be considered by the Board later in the meeting. In particular, the committee had reflected on the ways in which the feedback and insights from staff engagement had informed the development of the people strategy and the understanding of the staff survey results. The ambition for the Trust to be considered to be one of the best employers, and not just within the NHS, was confirmed and communication of the actions taken in response to the latest staff survey would be important in achieving this.

5.4 Briefing from the Chair of the Quality Committee

TP provided an update on the meeting of the Quality Committee held earlier in March 2022. The following areas had been covered at the meeting:

- the proposed quality priorities for 2022/23, which had increased in number from four in 2021/22 to eight in 2022/23 to reflect the Trust's ambitions to deliver improvement in a range of areas based on feedback from staff and patients;
- an update on the progress against the quality priorities for 2021/22, which had included expansion of midwifery continuity of carer, staff wellbeing and recovery, management of the risks to patients whose treatment had been delayed and elective recovery and reducing healthcare associated infection (HCAI), with demonstrable progress in each of these areas;
- no further never events had been reported since the start of 2022 and there had been no MRSA (methicillin-resistant Staphylococcus aureus) cases since March 2021;
- the reporting issues as a result of the change in the process for VTE (venous thromboembolism) risk assessment had been resolved and the performance target had been met in March 2022;
- the backlog affecting patients with age-related macular degeneration (AMD) in ophthalmology had been addressed with all patients booked for repeat treatment by the end of March 2022;
- a review of endoscopy patients was being undertaken to identify if any patients who require rescoping may have been missed following a recent change to the scoring system for assessment of the quality of visualisation involving greater segmentation;
- the revised infection prevention and control board assurance framework, due to be presented to the Board later in the meeting, which had provided good evidence and overall assurance of compliance;
- the review of the clinical assurance framework, which had been developed by the Trust to assess and monitor the risks associated with the delays to treatment, and reviews of patient harm for priority 2 procedures (procedures to be performed in less than one month), which had identified that the risk of harm had been overestimated in some specialties; and
- a review of the implementation of the immediate and essential actions from the Ockenden review just over one year following publication, which demonstrated how these actions had been implemented.

The Board discussed the final report from the Ockenden review, which had been published the day before the meeting. The maternity service team would be reviewing the recommendations in the report and had been encouraged to reflect on these before taking action as part of a more holistic approach. As a large scale tertiary service with a good culture and leadership, the fundamental principles underpinning the recommendations were already in place. Areas that would need to be reviewed included:

- ensuring safe staffing and the availability of a sufficient number of trained maternity staff nationally;
- the speed of implementation of learning from incidents as often the investigation and reports took several months to be completed, particularly where investigation by Healthcare Safety Investigation Branch was required; and

- the continuation of midwifery continuity of carer given the implications that this could have on safe staffing for trusts that had been identified in the Ockenden review.

5.5 Chief Executive Officer's Report

The chief executive officer's report was noted. This included updates on:

- the success of the charitable appeal for a new intra-operative MRI (iMRI) scanner suite to be installed in Southampton Children's Hospital;
- the role of staff from the Trust's paediatric intensive care unit (PICU) bringing children with cancer from Ukraine to England for treatment;
- a visit from the chief commercial officer of NHS England and NHS Improvement (**NHSE/I**), Jacqui Rock, which highlighted how commercial activity generated additional income to support the Trust's NHS activities and innovation;
- the transfer of day-to-day theatres management to the Trust's subsidiary, UHS Estates Limited, with effect from 1 April 2022;
- the submission of the planning application for the sterile services department and aseptic unit at Adanac Park,
- asymptomatic COVID-19 testing arrangements for staff as the saliva testing programme had ended; and
- the temporary continuation of free car parking for staff.

An update was also provided on the current operational pressures in the Trust, with:

- up to eight bays closed due to COVID-19 and norovirus infections and contacts;
- five wards accommodating patients with COVID-19;
- day units accommodating inpatients;
- high levels of staff sickness due to COVID-19;
- an increase in attendances in the emergency department (**ED**); and
- elective activity being stood down.

Similar pressures were being experienced across the region and nationally within the NHS. GB had written to nursing teams to provide support and to ask staff to look out for one another. Practices to reduce nosocomial infection had been reiterated and the staffing hub was meeting several times a day to review safe staffing levels across the hospitals. Despite the removal of restrictions relating to COVID-19 outside the hospital, the continued prevalence of the virus remained evident in the hospital given the number of patients with COVID-19 in hospital and the number of staff absent due to COVID-19.

5.6 Integrated Performance Report for Month 11

Andrew Asquith joined the meeting for this item.

The integrated performance report (**IPR**) was noted. The Board reviewed the detailed information regarding diagnostic activity and performance against the national six week target. 17.8% of patients were currently waiting longer than six weeks for diagnostics, compared to 1-2% of patients prior to the COVID-19 pandemic. There had been substantial increases in diagnostic activity within the hospitals, however, despite this the Trust had struggled to keep pace with an increasing number of referrals. The cause of the increase in referrals was not yet known as referrals from primary care were at similar levels to prior to the pandemic and the increase may instead be linked to the increase in outpatient consultations. Triage of referrals from primary care was already

carried out appropriately. A longer-term rise in demand for diagnostics had been predicted and was expected nationally.

While the Trust had increased capacity in areas such as MRI, other areas, such as non-obstetric ultrasound, had been affected by recruitment difficulties and ongoing infection prevention measures had reduced capacity in other areas. The Quality Committee had requested a detailed update on diagnostic performance, including a trajectory to return to pre-pandemic levels of activity in those areas that were currently below this.

Action: JT agreed to review a breakdown of routine and urgent diagnostic activity split by modality to identify if this highlighted any potential areas of concern.

Reductions in the number of patients waiting more than 52 and 104 weeks were also reported. 31 day cancer wait performance had dipped in January 2022 on both a relative and absolute basis, due to specific challenges in breast surgery and skin cancer. However, performance had since recovered and was expected to be just below 90% in February 2022.

The ED continued to perform well among its peers for waiting times and ambulance handovers despite the growth in ED attendances. The team in ED were working to develop a plan to respond to demand, including reviewing workforce models and planning with assistance from the Trust and former presidents of the Royal College of Emergency Medicine. Achieving the four hour target for patients waiting in ED and the difficulty admitting patients to wards were inextricably linked to the flow through the hospital and, in particular, the number of patients who remained in hospital awaiting discharge.

While some of this could only be resolved by working with partners in the Hampshire and Isle of Wight (**HIoW**) integrated care system (**ICS**), the Trust was looking at ways in which patients seen in primary care could be referred directly to specialties through rapid access pathways rather than seen in ED. At present ED and the hospital more generally were bearing the risks associated with an incredibly busy ED and high numbers of patients awaiting discharge rather than seeking to balance this risk more effectively across the HIoW ICS. The reduction in funding for the hospital discharge programme in 2022/23 was likely to have a negative impact on plans to reduce the number of patients medically optimised for discharge (**MOFD**) in the hospital. The Board had previously requested a review other options to reduce patients MOFD in hospital, which was currently being developed.

The meeting was adjourned for a short break.

5.7 Infection Prevention and Control Board Assurance Framework

Julie Brooks and Nitin Mahobia joined the meeting for this item.

The infection prevention and control board assurance framework presented was the Trust's self-assessment of compliance with the UK Health Security Agency's prevention and control guidance for COVID-19 and other respiratory viral infections in health and care settings. The report provided comprehensive assurance to the Board and was supported by the Trust's low levels of nosocomial infection during the COVID-19 pandemic.

There were two areas identified where there were gaps in assurance:

- ventilation due to the hospital environment and the Trust was looking at a number of different ways to minimise risk including air purification; and
- antibiotic stewardship, with more work ongoing to reduce the use of high risk antibiotics and levels of Clostridium difficile.

The focus for the infection prevention team currently was to respond to changing guidance as the country and the NHS transitioned to a different approach of 'living with COVID'. This was likely to be one of the most difficult challenges for infection prevention in terms of balancing the risks to patients and staff of continuing or moderating existing measures to reduce the spread of infection.

The Board thanked the team for its work during the COVID-19 pandemic and guiding the Trust in responding so effectively to the risks to patients, staff and the public presented by the pandemic.

5.8 Implementation of the Morecombe Bay Investigation Report and Ockenden Review of Maternity Services and Maternity Services Workforce Plans

Suzanne Cunningham joined the meeting for this item.

The Board noted the updates in the report about:

- the actions to implement the immediate and essential actions from the first report from the Ockenden review;
- the assessment of current compliance with the findings of the independent investigation to review the management, delivery and outcomes of care provided by the maternity and neonatal services of the University Hospitals of Morecambe Bay NHS Foundation Trust published in March 2015 (the **Kirkup report**); and
- the review of the maternity workforce.

The maternity service was compliant with all but one of the seven immediate and essential actions from the Ockenden review. Compliance with these actions had been externally assessed and confirmed, however further evidence had been requested relating to the regular audit mechanisms for the risk assessment of the intended place of birth at every antenatal contact. The maternity service was working to ensure that the process was robust at all levels of entry to the service and that the risk assessment was supported by the Badgernet IT system used by staff. The methodology and data to evidence the practice was different to that currently used for the risk assessment of the pathway of care.

In view of the continued national scrutiny of all maternity services, the Trust had assessed current compliance with the Kirkup report, the findings of which had originally been reviewed following publication of the report in 2015 and reported to the Board. While the Trust had been compliant with the Kirkup report when initially assessed, three areas where improvement was required had been identified as a result of the reassessment. These related to training and awareness, which had been impacted by the COVID-19 pandemic and staffing issues, and the availability of a second theatre. Training levels were already improving and a trajectory had been set for ongoing improvement. The availability of a second theatre had re-emerged as an issue as availability had reduced due to the increase in complex gynaecological and breast surgeries.

This had been recorded as a risk on the risk register with mitigations in place. It was clarified that staff were made aware of incidents, claims and complaints and the learning from these in a variety of ways, however, the boards to demonstrate the learning required review.

The Board discussed the Trust's ability to recruit and develop staff within the maternity service and the importance of the quality of the preceptorship programme and the culture within the team, which distinguished it from other organisations. Safety was the priority for the maternity service and having an open and transparent culture was the best way to ensure this. While there was a current shortfall in the number of midwives, this was not adversely impacting the service and would be addressed with the recruitment of students in summer 2022.

As this was the last Board meeting she would attend before retiring, the Board thanked SC for her leadership as Director of Midwifery for the Trust and in the Southampton, Hampshire, Isle of Wight and Portsmouth Local Maternity System.

5.9 Finance Report for Month 11

The finance report was noted. The following areas were highlighted:

- the expected delivery of a breakeven position in 2021/22 for the Trust and HIoW ICS;
- the receipt of income from the elective recovery fund associated with the delivery of increased elective activity;
- all major capital projects were on track to deliver; and
- the financial outlook for 2022/23 would be more challenging based on the Trust's current underlying financial deficit position.

5.10 UHS Staff Survey Results 2021 Report

Ceri Connor and Sophie Limb joined the meeting for this item.

The staff survey results for 2021 were noted, including the actions to be implemented across the Trust to improve performance. The results had been reviewed by the P&ODC at its meeting earlier in March 2022. While performance overall had deteriorated, which had been expected given how difficult it had been for staff in the NHS during 2021, the number of staff participating in the survey had increased and the Trust's relative performance had improved. Increased participation in the survey provided the Trust with greater insight into how staff were feeling as well as being a key indicator of staff engagement. Staff engagement scores across the NHS had fallen marginally, however, the rate of deterioration at the Trust has been less than at other trusts.

The Trust rated on or above the benchmark average for 106 out of 112 questions. Although engagement and advocacy scores had deteriorated across the NHS, the decline at the Trust was much less. The area where the Trust had seen the greatest decline in its score was staff capacity. The scores relating to staff recognition were also lower than expected and may be related to national pay awards. Actions in relation to staff wellbeing, talent management and career progression were likely to have a positive impact on both capacity and recognition. The P&ODC was continuing to monitor the work to improve equality, diversity and inclusion in the Trust. Early indications were that progress was being made, however, there was still work to do in terms of

improving the experience of staff from black or ethnic minority backgrounds, staff with disabilities and LGBTQ+ staff.

In addition to Trust-wide actions, divisions and directorates have been asked to select three areas of focus, agree actions and present these to the chief executive officer and executive team members as part of a showcase event. The Board discussed the link between the staff survey and staff advocacy in supporting the recruitment and retention of staff to address the concerns about capacity highlighted by the staff survey. The Trust also needed to demonstrate how it had responded to the feedback in the survey in order to encourage greater participation.

Decision: The Board supported the following recommendations from the Trust Executive Committee:

- the communication of the staff survey results, celebrating areas of success and describing how the Trust would respond to staff feedback;
- the continued implementation of corporate actions included in the Trust's people strategy (to be approved later in the meeting) with progress monitored through the P&ODC and recognition of developments already agreed in other action plans across the Trust; and
- ensuring divisions and directorates consider how they could make local improvements by reviewing their results and developing local action plans, monitoring progress and providing feedback.

6 STRATEGY and BUSINESS PLANNING

6.1 UHS 5-year People Strategy

Brenda Carter and Ceri Connor joined the meeting for this item.

The people strategy had been developed using staff insights from a variety of sources. It was structured around three themes: Thrive, Excel and Belong. Growing the workforce and recruitment was proving more challenging in a very competitive environment so retention of staff remained equally important. Providing a better environment for staff with good development opportunities and ensuring all staff felt that they belonged at the Trust would also help support retention and advocacy. The key would therefore be in ensuring delivery of the strategy.

The final people strategy was considered by the Board. This had been developed with support from the P&ODC and Board members had previously contributed to its development at a more informal strategy session in February 2022.

Decision: The Board approved the people strategy for 2022 to 2026.

6.2 Trust's Green Plan

Paul Chamberlain and Jason Light joined the meeting for this item.

The Trust's green plan set out the framework for the Trust to achieve greater sustainability, reduce its carbon impact and deliver a net zero health service both directly by 2040 and through areas it could influence by 2045. The Board wanted the green plan to be owned by the whole organisation and existing governance structures ensured the involvement of executive management,

clinical staff and all staff through the 'green guardian' network. The Trust would also draw on the experience and knowledge of partners and experts outside the Trust.

The Board also received an update on progress to procure a new energy contract by March 2023 and actions being taken currently to reduce energy costs. These actions had included doubling the use of low temperature hot water from 28% to 56%, de-steaming the Princess Anne Hospital, the addition of solar photovoltaic cells to the roofs of new buildings and increasing the amount of smart metering.

Decision: The Board approved the Trist's green plan.

7 CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

7.1 Register of Seals and Chair's Actions Report

Decision: The Board ratified the application of the Trust seal as set out in the report. DAF had signed the lease guarantee on behalf of UHS Estates Limited in his capacity as a director of that company.

7.2 Schedule of Decisions Reserved to the Board and the Scheme of Delegation

Action: The following changes were requested following review of the schedule of decisions reserved to the Board and the scheme of delegation:

- to clarify that the council of governors was responsible for the appointment of the external auditor;
- to link the definition of significant transaction to that used by NHSE/I as described in the Trust's standing financial instructions.

Decision: Subject to the proposed changes being made, the Board approved the schedule of decisions reserved to the Board and the scheme of delegation.

8 Any other business

Board members thanked PH for his service as a NED and Chair of the Trust and wished him well in his retirement. PH had demonstrated dedication and commitment to staff and patients during this time at the Trust. He had lived the Trust's values as Chair and created a unified Board under his leadership, listening to all voices and achieving a consensus and ensuring Board members worked well as a team. He had also ensured that patients came first on the Board's agenda and had challenged the Board to continue to improve in the same way as the rest of the organisation.

9 To note the date of the next meeting: 26 May 2022

10 Resolution regarding the Press, Public and Others

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

The meeting was adjourned.

University Hospital Southampton
NHS Foundation Trust

List of action items

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 31/03/2022 5.5 Chief Executive Officer's Report				
689.	Diagnostic activity	Teape, Joe	26/05/2022	Completed
	Explanation action item JT agreed to review a breakdown of routine and urgent diagnostic activity split by modality to identify if this highlighted any potential areas of concern. Update: Information circulated 12/4/22.			
Trust Board – Open Session 31/03/2022 7.2 Schedule of Decisions Reserved to the Board and the Scheme of Delegation				
690.	Changes	Flaherty, Karen	26/05/2022	Completed
	Explanation action item The following changes were requested following review of the schedule of decisions reserved to the Board and the scheme of delegation: • to clarify that the council of governors was responsible for the appointment of the external auditor; • to link the definition of significant transaction to that used by NHSE/I as described in the Trust's standing financial instructions.			

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NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Chief Executive Officer's Report**			
Agenda item:	**5.3**			
Sponsor:	**David French, Chief Executive Officer**			
Date:	**26 May 2022**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	My report this month covers updates on the following items: • Operational update • National Paediatric Accelerator • Neonatal funding • COV-BOOST trial • WellFest (an inclusion and wellbeing event for the ICS) • A re-energising appraisal at UHS • Medical bank rates • NHS Providers			
Response to the issue:	The response to each of these issues is covered in the report.			
Implications: (Clinical, Organisational, Governance, Legal?)	Any implications of these issues are covered in the report.			
Summary: Conclusion and/or recommendation	The Board is asked to note the report.			

Operational update

The number of patients with COVID-19 in the hospital has now reduced to 34 at the time of writing and we are using just two wards (G9 and C5) to cohort patients with COVID-19, alongside patients who are in intensive care. We are also moving to a model of caring for patients with COVID-19 within specialty areas where COVID-19 is not the primary reason for their admission. This has commenced within cancer care and will be rolled out to other specialties over the coming weeks. In the period since Easter our elective work has progressed more routinely and we have managed to cap the surgical day unit inpatients at around twelve and have therefore had a better period for elective operating activity.

In relation to emergency and urgent care, we are now seeing another period of significant presentations to the emergency department (**ED**) with attendances reaching 400 a day and an average daily attendance of 385 to date in May 2022. This is some way above capacity and highlights the importance of the patient flow improvement programme, which includes a workstream on patient pathways both through and bypassing ED where possible. We continue to carefully monitor ED occupancy levels and admit patients as soon as we can following a decision to admit. The number of patients no longer meeting the criteria to reside in hospital remains high (199 at the time of writing) and we need to continue to support system-wide action plans to reduce these numbers.

Operationally we are now focussed on our elective backlogs. Our transformation programmes across inpatient flow, outpatients and operating theatres are now establishing clear plans for the year ahead with governance, actions and measurable outputs that will continue to be reported to the Finance and Investment Committee.

National Paediatric Accelerator

In May 2021 NHS England and NHS Improvement (**NHSE/I**) announced a £160 million funding initiative to tackle waiting lists and develop a blueprint for elective recovery. The funding was to trial new ways of working to accelerate recovery as the NHS began to emerge from the earlier waves of the COVID-19 pandemic.

The National Paediatric Accelerator involved ten trusts: Alder Hey Children's NHS Foundation Trust, Birmingham Women's and Children's NHS Foundation Trust, Great Ormond Street Hospital for Children NHS Foundation Trust, Guy's and St Thomas' NHS Foundation Trust, Oxford University Hospitals NHS Foundation Trust, Manchester University NHS Foundation Trust, Sheffield Children's NHS Foundation Trust, The Leeds Teaching Hospitals NHS Trust, University Hospital Southampton NHS Foundation Trust and University Hospitals Bristol NHS Foundation Trust.

The trusts received £20 million of 'accelerator' funding in total and set objectives across six areas: delivery of elective activity, innovation, inequalities, data and benchmarking, shared learning and developing a project management office and governance. The trusts delivered:

- 101.6% of 2019-20 elective activity between May and November 2021;
- the roll-out of an artificial intelligence (AI) tool in all ten trusts that allows the trusts to identify in advance which children are most at risk of not attending appointments (proven to be 80% accurate so far);
- ten pilot programmes across the trusts building on the AI tool to reduce health inequalities in a range of ways including providing free transport, appointments in schools, access for patients with ADHD, clinician-led calls and patient portals;

- ten shared learning sessions sharing ideas and best practice in areas such as theatre productivity, working with the independent sector, international recruitment and tackling inequalities in access;
- two 'super Saturdays' leading to over 2,000 additional appointments, trials of virtual reality as an alternative to general anaesthetic, outreach using a health bus and new multidisciplinary clinics;
- benchmarking on access to patients based on deprivation, ethnicity and learning disability status and outpatient follow-ups; and
- demand modelling for future waiting list growth, future activity requirements and future financial gaps.

For Southampton Children's Hospital, the key achievements were:

- the expansion of the home sleep study service and initiating a home video telemetry service;
- the trial of an 'intelligent triage' model for referrals to paediatric dermatology;
- trialling new models of working by investing in non-medical roles such as pharmacy-led clinics in paediatric neurology and paediatric endocrinology; and
- regular Saturday operating lists resulting in 188 additional elective procedures across paediatric surgery and paediatric orthopaedics.

While the accelerator funding has enabled the trusts involved to control waiting lists better than those that did not receive funding, there were still 91,000 children waiting for care across the trusts involved, with an estimated additional 112,000 children who were not referred as expected during the COVID-19 pandemic. These trusts are continuing to work together as the Children's Hospital Alliance to tackle waiting lists and other challenges and have bid for an additional £30 million of funding from NHSE/I. Aims for the coming year include further roll-out of the proven transformations, developing models for surgical hubs and community diagnostic centres for paediatrics and developing a 'national virtual children's hospital'.

More detailed information about the National Paediatric Accelerator can be made available to Board members on request.

Neonatal funding

Following the Neonatal Critical Care Review 2018 (**NCCR**) and implementation of the neonatal transformation programme, neonatal operational delivery networks (ODNs) are reviewing neonatal services within regions, including activity and capacity, service sustainability, staffing standards and the ability to meet service specifications across all neonatal units within networks. This continues the programme of service designation review within Wessex and the re-designation of smaller services in 2017-2018. (See NHS England » Implementing the Recommendations of the Neonatal Critical Care Transformation Review.)

As part of the NCCR transformation programme, the network is currently undergoing a programme of service review with specialised commissioning, recommending a change from a local neonatal unit (LNU) to a special care unit (SCU) in neonatal services within Wessex, including Salisbury District Hospital, Royal County Hospital, Winchester, Basingstoke and North Hampshire Hospital and St Richard's Hospital in Chichester. This change in designation, the re-designation of local services in Hampshire Hospitals NHS Foundation Trust and Salisbury NHS Foundation Trust, will result in pathway changes leading to neonatal flows into the Trust making further demands on bed capacity.

The Trust has continued to highlight concerns requiring capital investment in its estate, notably:

- the impact on patient safety due to longstanding risk issues related to the neonatal estate, including risks identified within a CQC report relating to size of cot spaces;
- the impact on capacity, with an anticipated additional 440 cot days in the intensive care unit/high dependency unit (**ICU/HDU**); and
- the impact of unplanned growth on being able to provide a full range of specialised children's services.

The Trust submitted a plan to specialised commissioning to expand the unit and address the current environment and patient safety issues. The plan included:

- relocating the special care baby unit (**SCBU**) to E level of the Princess Anne Hospital (**PAH**) to release the space for ICU/HDU expansion and increase SCBU cot spaces by two; and
- reconfiguration of the current neonatal unit on PAH D level to increase cot sizes by moving some existing ICU/HDU cots into the vacated SCBU area and support accommodation, as well as three new ICU/HDU cot spaces to future-proof the service.

The national maternity transformation team wrote to the Trust in early May 2022 to confirm that £5.13 million of capital funding has been allocated to it in 2022/23, as part of a national £45 million investment in neonatal cots across England. This significant new investment will support the NHS to deliver the best quality care for babies in the most appropriate clinical setting.

We are of course delighted with this announcement, as it will make a real difference to the service, our staff and our patients. Work is now underway to finalise the local business case, and complete national business case templates, as well as to ensure we can complete the capital works within 2022/23.

COV-BOOST trial

The results of the latest in a series of studies led by UHS into the effectiveness of booster vaccines has revealed that the fourth doses are both safe and even more effective than third doses at boosting immunity against COVID-19. Fourth doses of COVID-19 vaccines have been offered as a spring booster for those most vulnerable in the UK. This has been a precautionary strategy to maintain high levels of immunity prior to the study data being available. A wider group of people may be offered a fourth dose booster later this year if the Joint Committee on Vaccination and Immunisation considers it needed at that time.

In the fourth dose study, 166 people who had received a third dose of Pfizer, following Pfizer or AstraZeneca initial doses in June 2021, were randomised to receive full dose Pfizer or half dose Moderna as a fourth dose. These were approximately seven months after their third dose. The latest COV-BOOST findings now show that fourth dose mRNA booster vaccines for COVID-19 are well tolerated in people who received Pfizer as a third dose. They are also effective at increasing both antibody and cellular immunity up to and above baseline and peak levels observed following third dose boosters.

This globally significant nationwide study has been led by Professor Saul Faust and the latest findings were published in The Lancet Infectious Diseases in May 2022. COV-BOOST provided the world's first data on the safety, immune responses and side effects of third dose in mix and match schedules. The study was key to shaping the UK's 2021 autumn booster programme and gives vital evidence for global vaccination efforts. Led by UHS, COV-BOOST is being delivered by a network of trial sites across the UK. The study is funded by the Vaccine Taskforce and the National Institute for Health and Care Research (NIHR). It is delivered under the National Immunisation Schedule Evaluation Consortium (NISEC). Delivery partners are Oxford Vaccine

Group (University of Oxford), Imperial College London Clinical Trials Unit, PHARMExcel Ltd and the NIHR Clinical Research Network.

WellFest (an inclusion and wellbeing event for the ICS)

The Hampshire and Isle of Wight (**HIoW**) integrated care system (**ICS**), in partnership with people teams across the ICS, have organised a wellbeing and inclusion event for staff. WellFest will offer 1,500 NHS staff from across HIoW the chance to attend events on one of three days on 4, 5 and 6 July 2022. WellFest has an exciting range of activities, speakers and events focused on the wellbeing and inclusion of our people. The event will be designed to thank and reward the efforts of staff, in addition to coinciding with the NHS's birthday on 5 July 2022. UHS will receive a pro-rata allocation of the 1,500 tickets available. We will ensure a diverse range of our UHS family is provided with the opportunity to attend.

A re-energising appraisal at UHS

People's development and appraisal have been significantly affected by the pandemic. This has been strongly indicated through the voice of our UHS family in our 2021 staff survey and from our insights work. Our people strategy emphasises personal development and growth under the 'Excel' pillar. Working in partnership with a group from across the Trust, including our unions, the organisational development team has refreshed our current appraisal documents and launched new training to help improve the quality of our conversations with managers. We continue to face difficulties balancing operational pressures in UHS with ensuring appropriate time and space for the development of our people. Quality career conversations through appraisal and providing space for development remains a critical part of trying to retain our UHS family in an ever more competitive labour market.

Medical bank rates

The Trust has recently agreed new, consistent pay rates for bank (locum) junior doctor staff across all specialties following detailed discussions involving divisional directors, executives and the finance team. The new rates will take effect from 1 June 2022 and will provide a fairer system for junior doctors, which will result in a pay increase for most. This recognises the significant contribution junior medical staff make in supporting rotas where there are gaps while also reducing pay inflation in this area.

NHS Providers

Chris Hopson, the chief executive of NHS Providers, will be leaving that role on 10 June 2022 to become chief strategy officer at NHS England. Saffron Cordery, the deputy chief executive, will become interim chief executive of NHS Providers. As chief strategy officer at NHS England Chris will oversee strategy and policy, communications and stakeholder activity, including the relationship with government, and delivery of the NHS's environmental sustainability commitments.

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Infection Prevention 2021-22 Annual Report**			
Agenda item:	**5.4**			
Sponsor:	**Gail Byrne, Chief Nursing Officer/Director of Infection Prevention & Control**			
Author:	**Nitin Mahobia, Deputy Director of IP&C/Hospital Infection Control Doctor Julie Brooks, Head of Infection Prevention.**			
Date:	**26th May 2022**			
Purpose	**Assurance or reassurance** √	**Approval**	**Ratification**	**Information** √
Issue to be addressed:	To review progress and performance in relation to reducing the risk of healthcare associated infection (HCAI) in UHS and provide an annual report for 2021/22.			
Response to the issue:	This report provides an overview of performance and progress in relation to reducing the risk of healthcare associated infection including: • Performance against key infection indicators • Assurance of infection prevention standards, practice and processes • Ongoing response in relation to the COVID-19 pandemic. • Identification of learning and actions to further reduce risks of HCAI to patients, staff, the organisation and the public.			
Implications: (Clinical, Organisational, Governance, Legal?)	Legal duty to protect service users and staff from avoidable harm in a healthcare setting: 'Code of Practice on the prevention and control of Infection'/ Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the legal duty to ensure the health and safety of all employees whilst at work and of any persons affected by the Trust's activities, as per the Health and Safety at Work etc. Act 1974.			
Risks: (Top 3) of carrying out the change / or not:	• Risk of harm to staff and patients due to healthcare associated infection. • Risk of reputational and financial penalty from enforcement action. • Increased length of stay of inpatients who acquire healthcare associated infection leading to reduced organisational productivity.			
Summary: Conclusion and/or recommendation	Despite another exceedingly challenging year, UHS continues to perform well overall in relation to HCAI with overall assurance of effective practice, systems and processes in place and an understanding of areas/measures required for improvement. Key areas of focus for 2022/23 include reduction of C.difficile and gram negative bloodstream infections. Members are asked to: 1. Review the report and the identified actions detailed in each section and ensure these are addressed via the Divisional Governance processes, with relevant teams and staff groups. 2. Support the proposed actions/ measures to facilitate improvements.			

1. Introduction

Summary of progress in reducing risk of healthcare acquired infection in UHS

Category		End of year RAG	Action /Comment
National Objectives:	MRSA bacteraemia	R	1 MRSA BSI attributable to UHS 2021/22 in March 2022.
	Clostridium difficile infection	R	74 cases against a threshold of 64 for the year.
	E coli Bacteraemia	G	138 cases in 2021 2022 against a threshold of 151
	Klebsiella Bacteraemia	A	64 cases in 2021 2022 against a threshold of 64
	Pseudomonas Bacteraemia	G	30 cases in 2021 2022 against a threshold of 34
Other	MSSA		43 post-48 cases in 2021 2022
	Hospital onset, healthcare associated COVID19		103 hospital-onset probable healthcare-associated cases in 2021/22. 125 hospital onset -definite healthcare associated cases in 2021 2022.
Antimicrobial Stewardship	Prudent antibiotic prescribing	G	The standard contract requirement for reduction in antibiotic usage for 2021/22 was waived, as in 2020/21. Had it been applied as anticipated, UHS would very likely have met this.
Provide assurance of basic infection prevention practice:	Assurance of Infection Prevention Practice Standards	G	The annual infection prevention audit programme was re-instated in April 2021 for the monitoring and assurance of infection prevention and control practices but subsequently suspended in September 2021.

2. Analysis
2.1 Healthcare Associated Infections

MRSA Bacteraemia

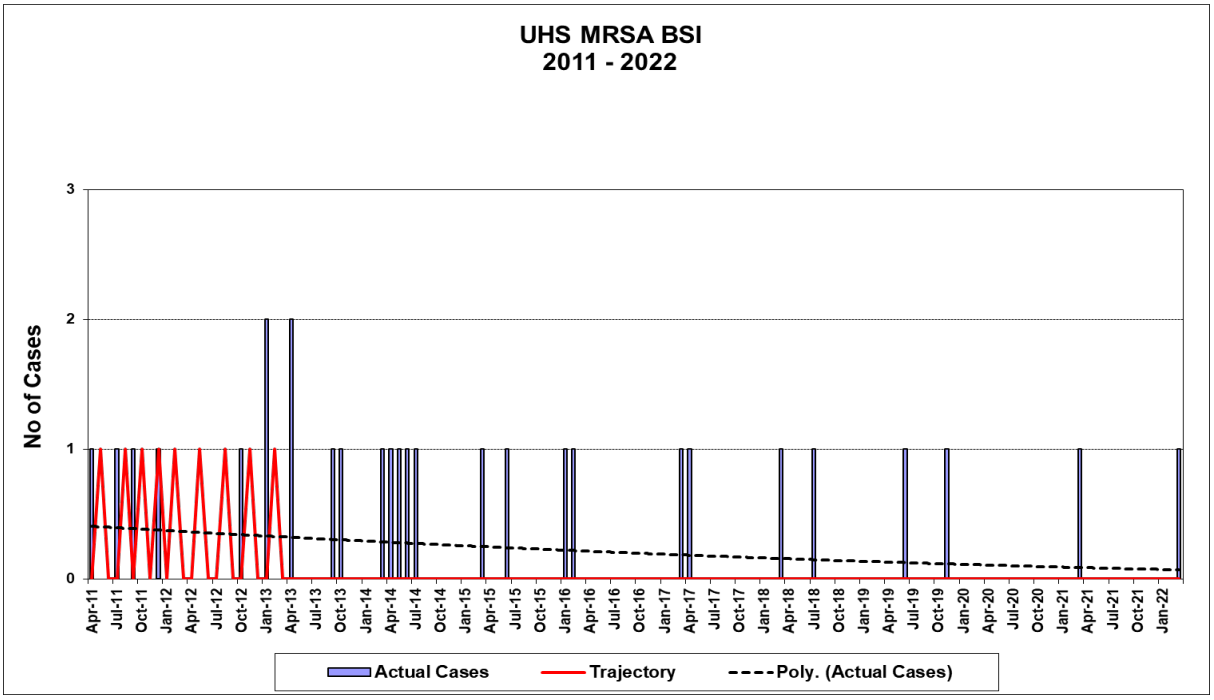
1 UHS acquired MRSA BSI in 2021 22

Summary of case and learning:

1 MRSA BSI Case in 2021/22 which occurred in March 2022 on PICU.

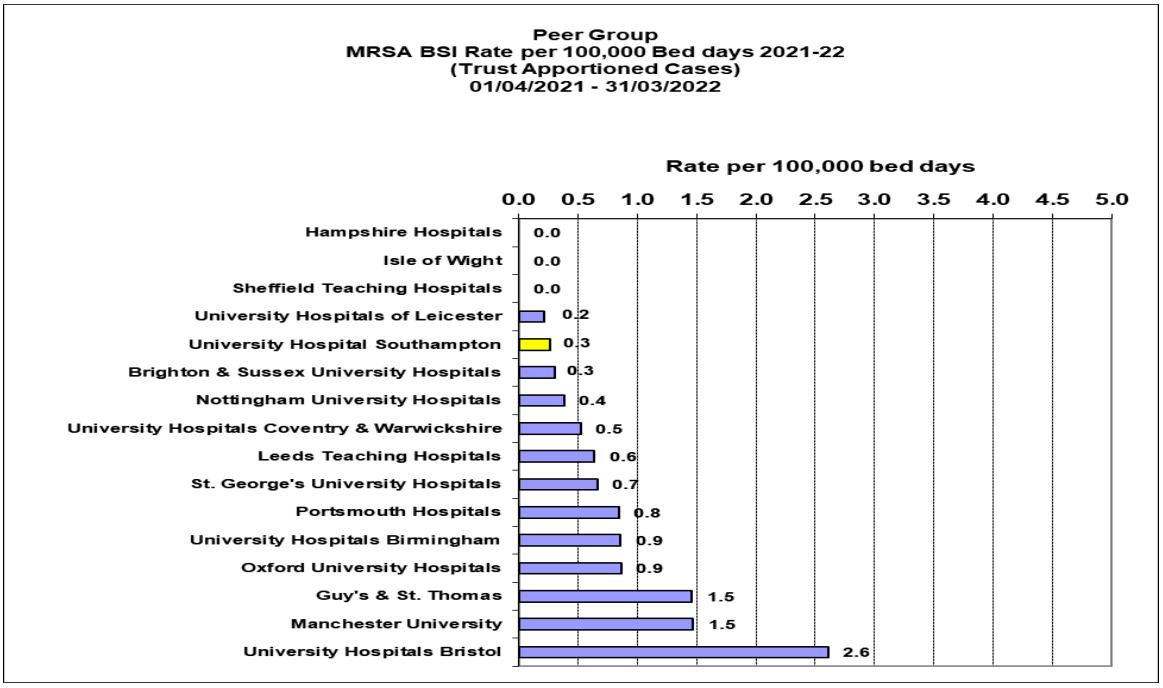
1-year-old girl with a chromosomal abnormality and congenital heart disease, including Ventricular septal defect, coarctation of the aorta, hypoplastic aortic arch, was admitted electively for complex cardiac surgery. Postoperatively while an inpatient in the paediatric intensive care, she acquired MRSA, which was first isolated in respiratory secretions. This finally led to MRSA bacteraemia, which was treated with antibiotics. The initial source of infection was likely to be the chest, but unfortunately, it has become a more deep-seated infection with infective endocarditis. Currently, the patient is being managed with specialist input from Paediatric Infectious disease and specialist Microbiology advice.

This MRSA bacteraemia was reviewed, but no apparent acquisition cause was identified. The typing of these MRSA isolates suggested some similar strain to a case previously identified in Neonatal intensive care. The isolates have been sent for whole-genome sequencing and further ongoing investigation. There is an ongoing review of infection control challenges in PICU, suggesting a general increase in complexity of the patient group and isolation of more resistant bacteria. Based on available information, this case of MRSA bacteraemia is classified as unavoidable.



Comparative data from PHE for 2021/22

UHS has an attributable MRSA BSI rate of 0.3 cases/100,000 bed days and ranks 5 of 16 self-selected peer hospitals. Top quartile, median and lower quartile marker rates are 0.0, 0.0 and 0.6 cases/100,000 bed days.



Acquisition of MRSA colonisation in UHS

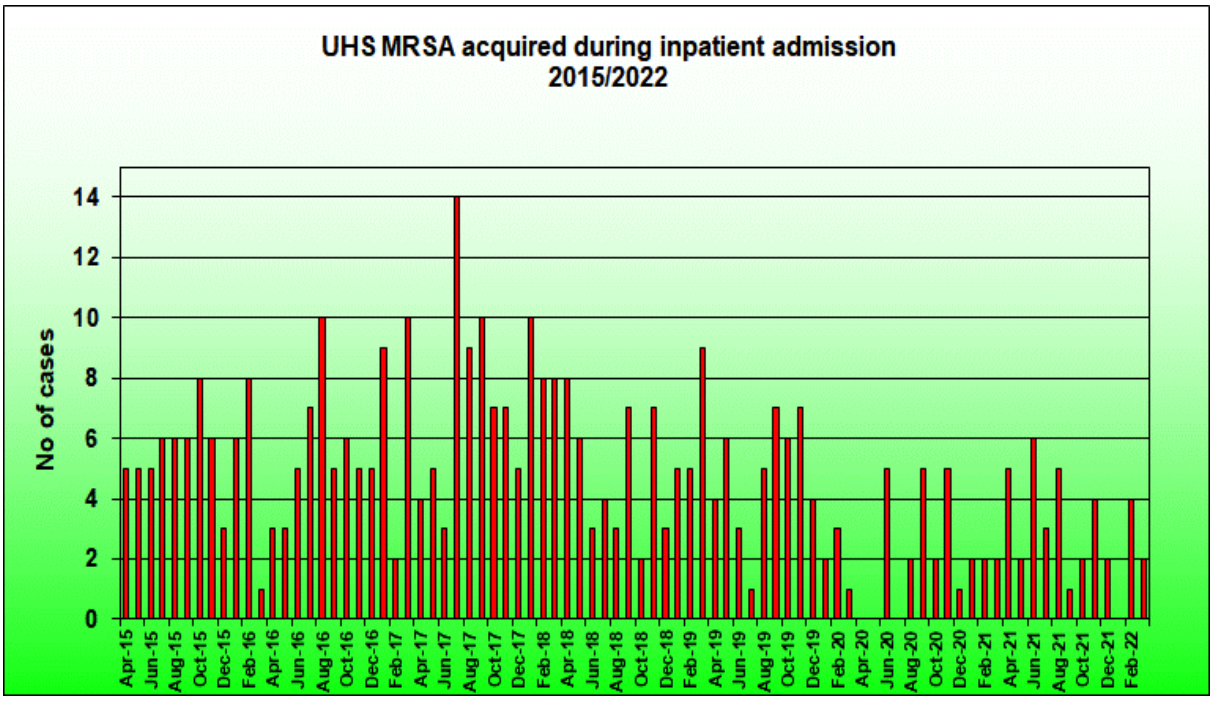
35 patients acquired MRSA (colonisation or infection) in UHS in 2021/22 compared to 26 in 2020/21.

Hospital acquired cases continue to be reviewed by the Infection Prevention Team (IPT) and enhanced surveillance undertaken to review assurance that all elements of the MRSA care bundle were being met (prevention of spread, patient management prior to result, patient management following result).

Absence of documentation, particularly for risk reduction measures and isolation risk assessments continue to be identified as the key theme for failure to meet all elements of the MRSA care bundle. Additional support and training is provided by the IPT to wards with frequent failures in elements of the care bundle.

Summary of actions in to reduce acquisition of MRSA colonisation:

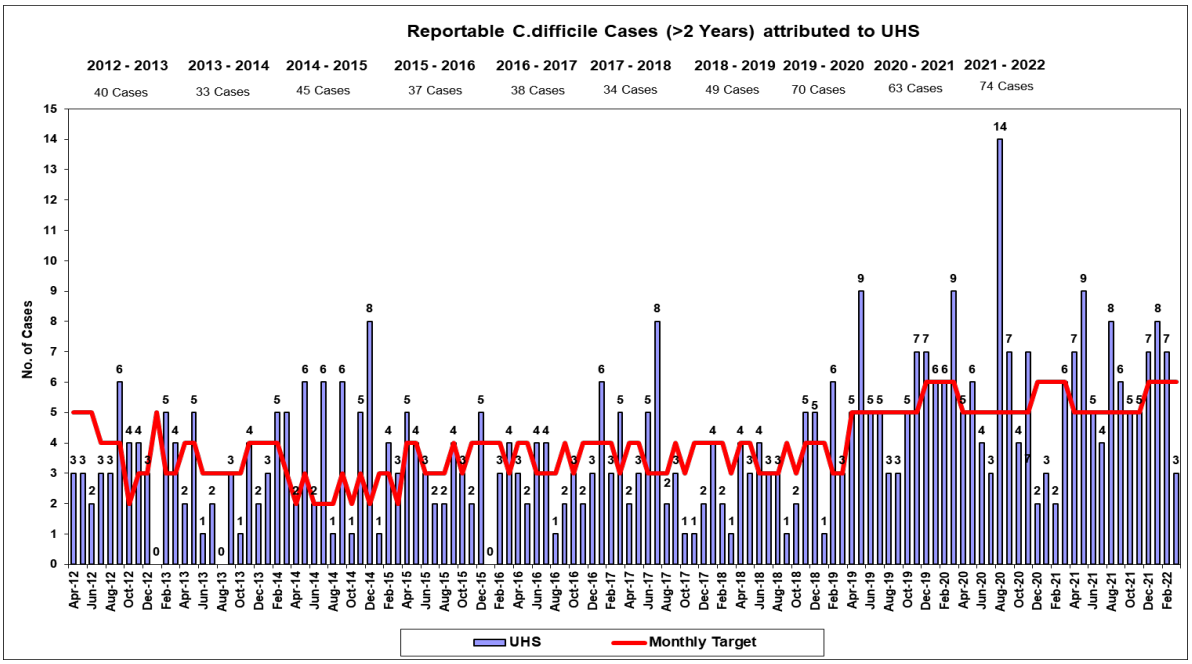
- Continue enhanced surveillance in cases of UHS new acquisition of MRSA and focus on areas for improvement.
- Review of systems and processes to improve documentation of risk reduction measures.
- Review of the practices and standards outlined in the Trust MRSA policy following the publication of new national guidance issued in Autumn 2021.
- Planned review of MRSA screening process, including laboratory processing in 2022 /2023.



Clostridium difficile

From April 2019 NHSE adopted international definitions for attribution of *C. difficile* cases, which attempt to attribute any case to the likely source of acquisition of *C. difficile* and separate this from where the onset of symptoms of *C. difficile* occurred. National performance thresholds for 2021/22 were published in July 2021 with UHS being set a threshold of 64 cases. All thresholds are derived from a 2019 calendar year baseline, to avoid capturing changes related to the pandemic.

End of year outcome:
74 cases in 2021 2022 against a threshold of 64
19 Community Onset – Hospital Attributable (COHA)
55 Hospital Onset – Hospital Attributable (HOHA)



The national performance threshold for C.difficile was exceeded in 2021/22 (74 cases against a threshold of 64) . The increase in C.difficile is a general feature both nationally and locally.

The process to review C.difficile cases in the trust has significantly improved in the last year and learning will inform a C.difficile improvement plan for 2022/23. Toxin positive inpatient cases of C. difficile continue to be reviewed by the Infection Prevention Team and enhanced surveillance undertaken to review assurance that all elements of the C. difficile care bundle were met. All hospital acquired cases are reviewed by a consultant microbiologist/Infection control doctor to identify learning and actions required.

Areas of good practice include hand hygiene; implementation of daily chlorine-based cleaning and clinical cleaning targets being met. Key themes for identified lapses in care relate to completion of isolation risk assessments; isolation with 2 hours of onset of symptoms; completion of the C.difficile integrated care pathway; maintenance of stool charts; monitoring of fluid balance; completion of MUST scores; documented medical review in the patients notes and C.difficile patient information leaflet supplied. In Q1 and Q2 a delay in diagnosis and delay in sampling was identified but learning has been communicated effectively and this is no longer a concern. Feedback of learning is given during surveillance and following investigation. Additional support and training is provided by the IPT to wards with frequent failures in elements of the care bundle.

Detailed case reviews have also been undertaken to identify any learning. All hospital-acquired or hospital-onset C.difficile cases are reviewed by a multidisciplinary panel comprising:

- Infection control Doctor (Deputy Director of Infection Prevention and Control)
- IPC Leads from CCG/ICS
- Specialist Antimicrobial pharmacist
- Infection Control Manager/ Governance lead
- Lead for Antimicrobial Stewardship

The MDT panel review includes review of antimicrobial prescribing, infection prevention & control standards within UHS and any learning for Primary care. Themes/learning from these reviews have identified:

1. Some changes in prescribing may reduce the overall risk of C.difficile.
2. There are a higher number of cases identified in Cancer care, with some cases associated with patients receiving to Chemotherapy in addition to antimicrobial use.
3. A small number of cases are identified as part of outbreaks.
4. Treatment of C.difficile has improved following changes to Trust treatment guidelines . The C.difficile treatment guidelines were updated to include evidence-based treatment guidance based on published evidence and NICE guidance
5. There are still some gaps in practice in managing recurrent C.difficile, and Fidaxomicin is not used when indicated.
6. C.difficile cases in Medicine for older people may have marginally dropped after commencing antimicrobial stewardship ward rounds.
7. Some of the cases were positive within the first week of admission, suggesting a possible role of colonisation before admission.
8. A few high-risk antibiotic use cases are noted in the very immunosuppressed patient for life-threatening infections leading to C.difficile. However, antibiotics are justified for this patient cohort.

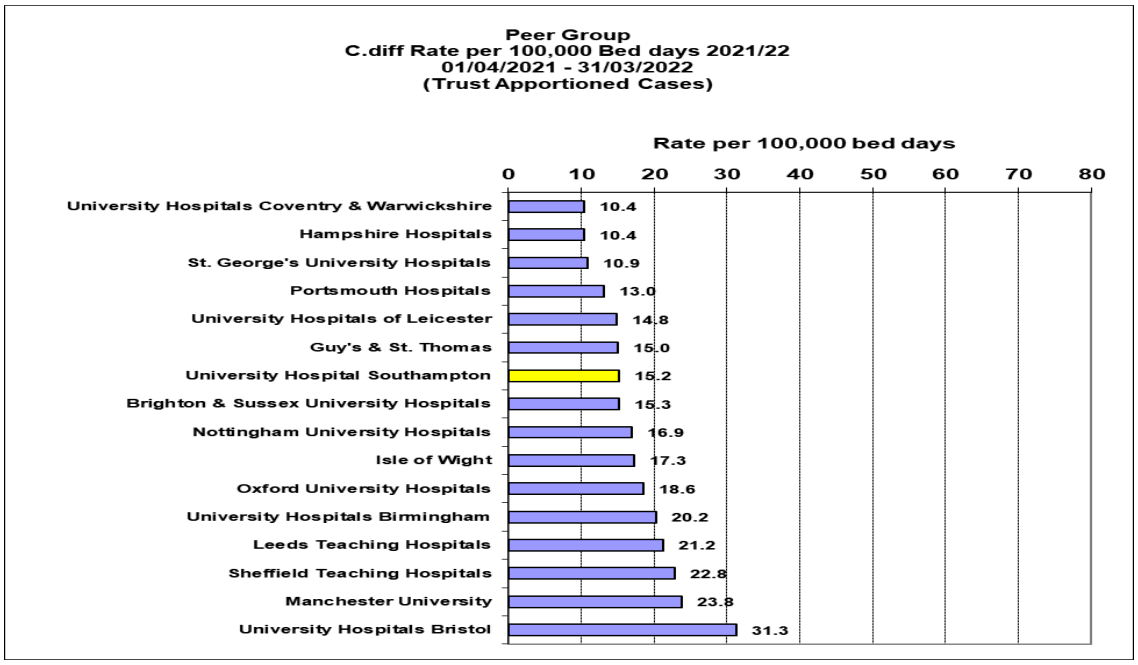
Summary of actions identified to reduce *C. difficile* infection as part of the C.difficile improvement plan for 2022/23:

1. **Antimicrobial Stewardship**
    - Ongoing focus on antimicrobial stewardship via stewardship ward rounds and increasing the number of ward rounds across the trust.
    - Focus on the reduction of the use of high-risk antibiotics as advised in national guidelines for reducing C.difficile.

- Cdifficile MDT ward round pilot ward to support the appropriate management and care of patients with C.difficile. This may also be of benefit in reducing the number of recurrences of C.difficile, improving patient care and reducing length of stay.
- A service review of the trust antimicrobial stewardship team, through benchmarking with other teaching hospitals, to ensure it is adequately resourced to support the trusts antimicrobial stewardship programme/strategy and national AMR agenda.

2. **Isolation**: continued focus on early isolation of patients presenting with symptoms of diarrhoea; optimising the management of isolation facilities and improving standards of isolation care.
3. **Cleaning & Decontamination** - continued focus on consistent cleaning standards by contracted the cleaning service (SERCO) and clinical staff and further work to embed UVC technology within the Trust.
4. **Education & training** – focus on education and training of staff in relation to antimicrobial stewardship; identification, assessment, management and treatment of cases; infection prevention and control practices including isolation and washing hands with soap and water.
5. **Informatics and data analysis –** explore digital options to alert clinicians to a recent diagnosis of C.difficile and the need be judicious in the use of antibiotics in these cohorts to reduce relapse and recurrences. Development of electronic stool charts and indwelling device charts to improve documentation and enable remote review and analysis.
6. **Patient movement –** focus on reducing multiple patient movements across the trust to reduce the risk of transmission of infection, including C.difficile.

UHS ranks seventh out of 16 self-selected peer acute trusts, with a rate of 15.2 cases/ 100,000 bed days. Comparative data needs careful interpretation because of differences in test selection, methodology and reporting criteria between trusts



Post 48 hr Bacteraemia (excluding MRSA)

The NHS Standard Contract 2021/22 included quality requirements for NHS trusts and NHS foundation trusts to minimise rates of a number of additional Gram-negative bloodstream infections to threshold levels set by NHS England and NHS Improvement. This includes Klebsiella Species and Pseudomonas aeruginosa in addition to E-coli. Details of these requirements were issued in July 2021.

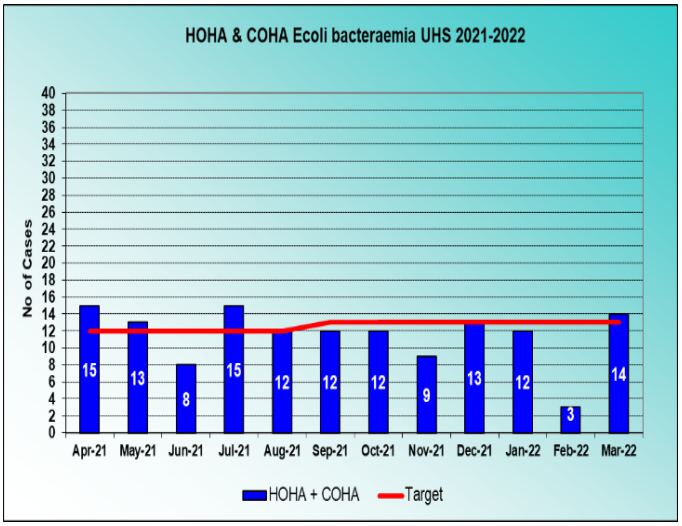
Post-48h BSI	2021-22	2020-21	2019-20	2018-19	2017-18	2016-17
E coli	138	67	67	67	81	51
Klebsiella	64	40	57	42	39	25
Pseudomonas	30	13	24	23	19	15
MSSA	43	36	30	44	36	39
VRE	9	7	12	10	10	9

Following notification in July 2021 of the threshold requirements for minimising gram-negative bloodstream infections caused by Klebsiella Species and Pseudomonas aeruginosa, reviews of post 48hr cases by the IPT commenced in August 2021, alongside the process already in place for E-coli, VRE and MSSA.

Post-48h bacteraemia's are reviewed by IPT and selected cases investigated in detail where there is potential learning to be found. Many patients are complex, often with unavoidable factors such as self-line care at home or extremely young age. Most of the cases are unavoidable but where there is preventable infection for example line infection or catheter related infection this is followed up with appropriate investigation. Investigation by post infection review of cases supports identification of emerging trends/themes, identification of organisational learning and targeted improvement actions.

The rise of gram-negative bacteraemia is a trend that has been seen nationally with pandemic related factors or acuity of the patients. Some of the increases in UHS can be explained through improved sepsis diagnosis, enabling better isolation of bacteria from blood culture in the laboratory. The use of a more sensitive system in the laboratory has enabled better detection of pathogens and a shorter time to positivity, leading to better patient outcomes, early discharge, and ability to undertake antimicrobial resistance surveillance.

E coli Bacteraemia: UHS were set an E. coli threshold of 151 Cases for the Year 2021-2022



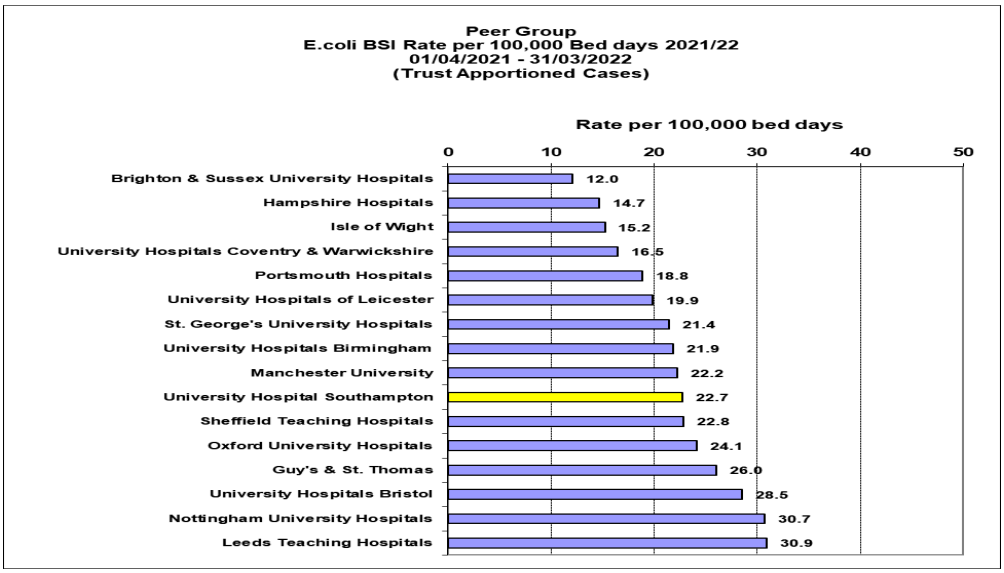
End of year outcome

138 cases in 2021 2022 against a threshold of 151

- 53 Community Onset – Hospital Attributable (COHA)
- 85 Hospital Onset – Hospital Attributable (HOHA)

Of the 138 cases:

- 133 cases were assessed to have been managed appropriately
- 5 cases underwent post infection reviews

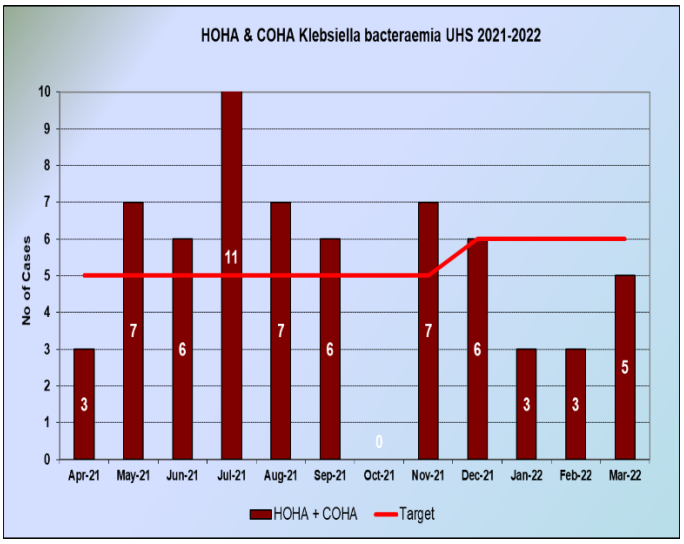


Key themes/leaning from cases

- Management and care of invasive devices (urinary catheter, Intravenous lines) including documentation, ANTT and Hand Hygiene.
- Timely removal of indwelling catheters.
- Care and management of patients admitted with long term indwelling catheters.
- Practice/procedure for balder washouts requires review.
  Review of wound dressings to identify alternatives to reduce the number of times a wound dressing is changed

Actions to reduce E-coli bacteraemia include continued focus on reducing risk of catheter associated UTI (CAUTI) through management of urinary catheters, avoiding unnecessary catheterisation and early removal. The trust Urinary Catheterisation Prevention of Infection Policy was updated in Q2 to include up to date evidence and standards. System wide work is being undertaken and ongoing in relation to the management of patients with long term catheters/those discharged from acute care with a urinary catheter.

Klebsiella Bacteraemia: UHS were set a Klebsiella threshold of 64 Cases for the Year 2021-2022.

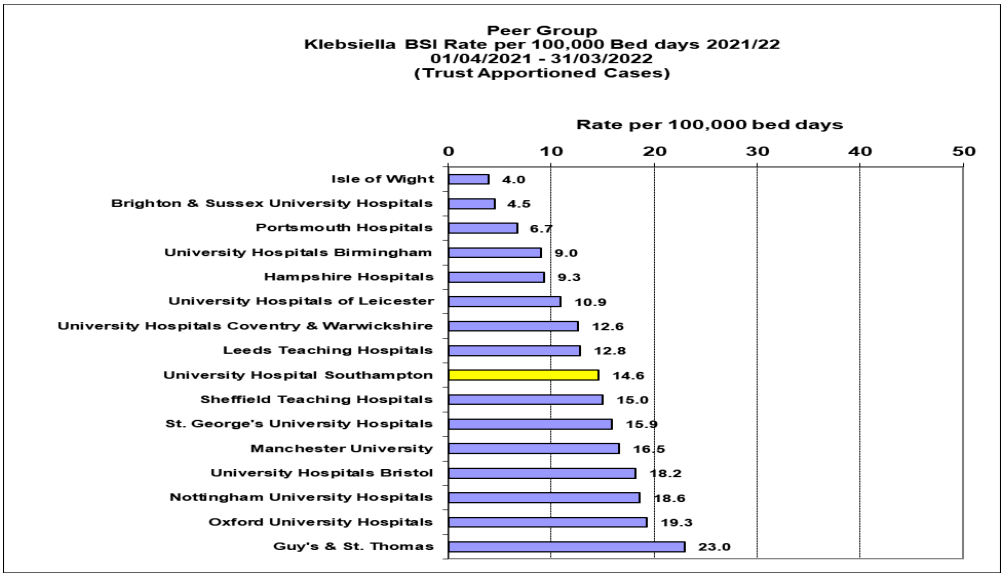


End of year outcome:
64 cases in 2021 2022 against a limit of limit of 64

- 11 Community Onset – Hospital Attributable (COHA)
- 53 Hospital Onset – Hospital Attributable (HOHA)

Of the 64 cases:

- 63 cases were assessed as being managed appropriately
- 1 case underwent post infection review.



Key themes/leaning from cases

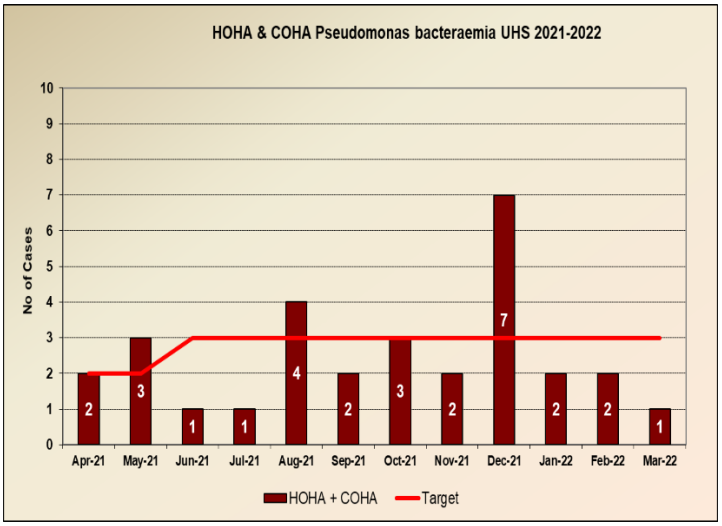
- Care and management of PICC line.

Most of the cases reviewed did not show any pattern to suggest they are avoidable, although a particular area of concern relates to invasive device associated infection.

Data from review of cases will be used to identify the pattern of infections associated with Klebsiella bacteraemia and improvement actions required.

A key area of focus to reduce Klebsiella bacteraemia relates to invasive device care and management.

Pseudomonas Bacteraemia: UHS were set a Pseudomonas bacteraemia threshold of 34 Cases for the Year 2021-2022

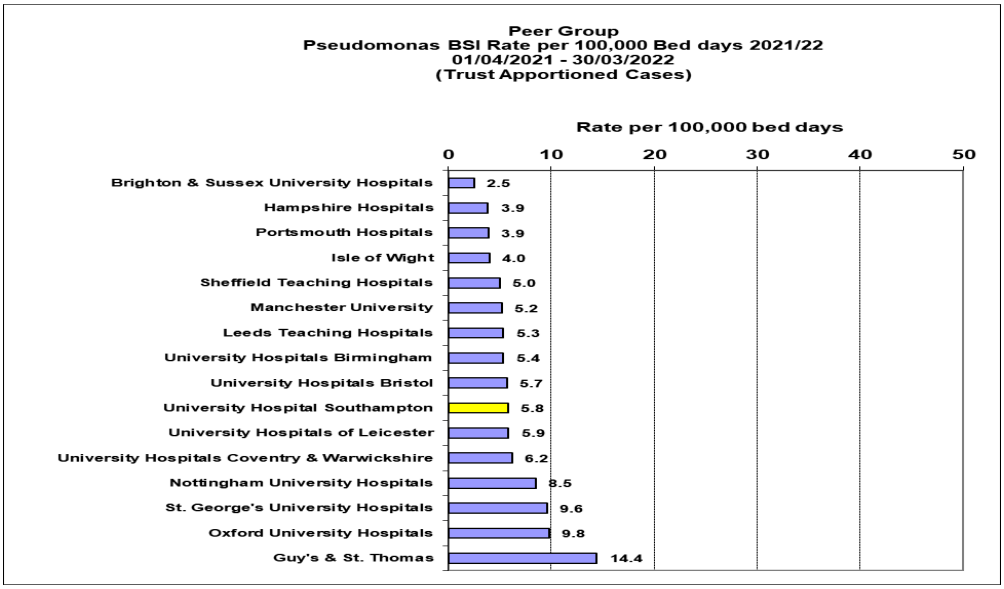


End of year outcome:
30 cases in 2021 2022 against a limit of limit of 34

- 9 Community Onset – Hospital Attributable (COHA)
- 21 Hospital Onset – Hospital Attributable (HOHA)

Of the 30 cases:

- 27 cases were assessed as being managed appropriately
- 3 cases underwent post infection reviews



Key themes/leaning from cases

- Management and care of Intravenous devices including documentation, ANTT, Hand Hygiene and timely removal.
- Process and procedures for incubator and ventilator cleaning requires review.

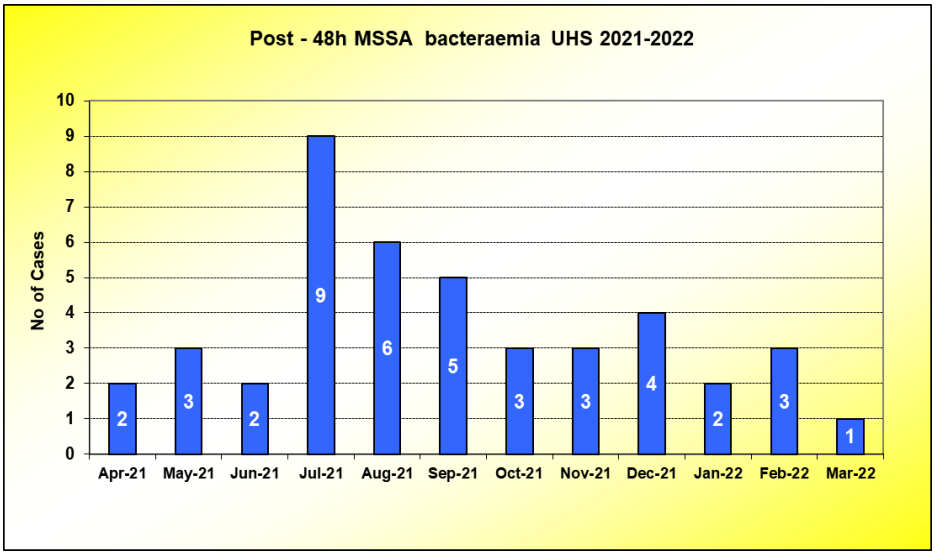
Many patients in UHS are immunocompromised and neutropenic and therefore at particular risk of pseudomonas bacteraemia. Use of invasive devices in augmented care units (level 2 and level 3) increases the risk of bacteraemia making it an important area of focus.

Actions to reduce Pseudomonas bacteraemia include:

- All Pseudomonas bacteraemia is reviewed to identify any lapse in care which may have contributed to bacteraemia. PIR is requested when there are possible areas of improvement.

- Focus on invasive device care and management.
- Increased focus on water safety and correlation with reducing risk to patients:
    - Water safety meetings to include clinically focused discussion of cases of bacteraemia to identify and agree required improvement actions.
    - Posters to be placed at all handwashing sinks which will promote their use for hand washing only thus reducing risk of bacterial contamination of outlets and the water system. These are being installed in phased manner across the trust.
    - Ongoing close monitoring of Pseudomonas infections in augmented care areas with focus on monitoring of water quality for pseudomonas through water testing.
    - See section 2.11 for detail further detail on water safety

MSSA Bacteraemia



Key themes/learning:
Key themes identified from post infection reviews of cases of MSSA bacteraemia undertaken in 2020/21 relate to peripheral intravenous cannula care, management and documentation.

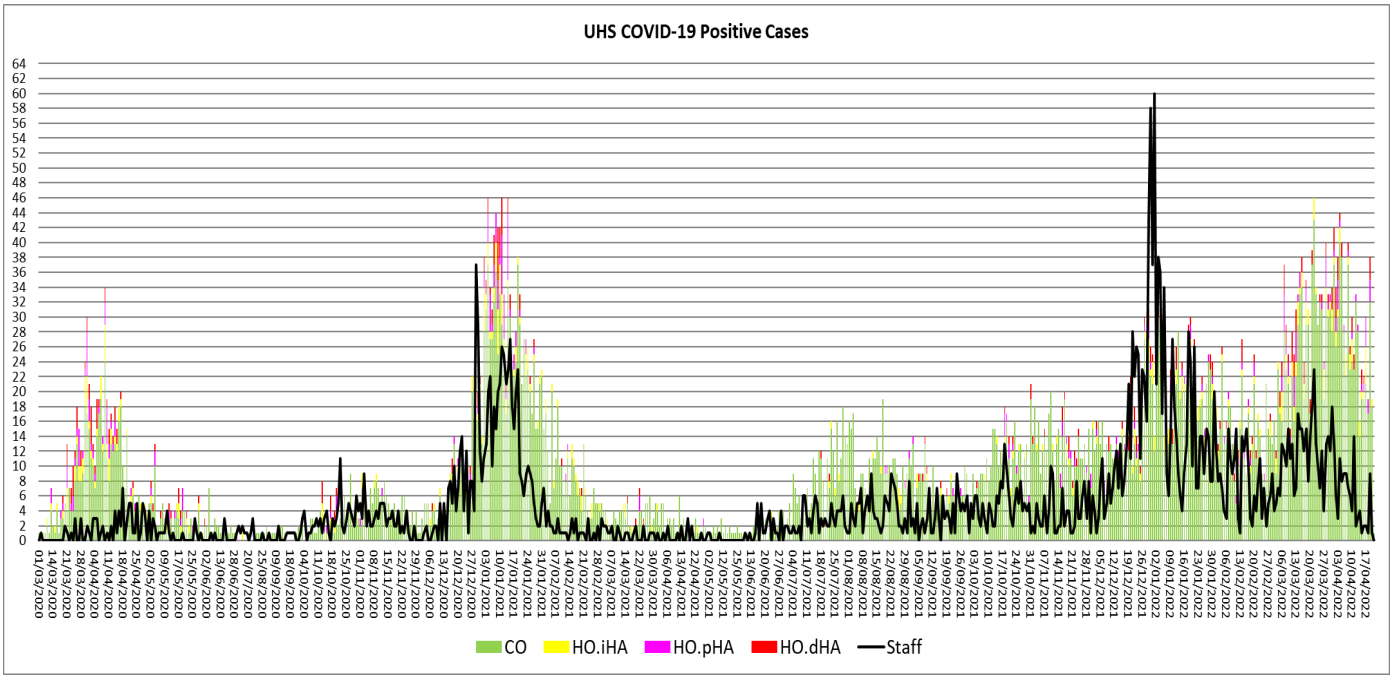
2.2 COVID-19 Pandemic

The global COVID-19 pandemic has remained a key area of focus for UHS in 2021/22. The continued robust focus and attention to infection prevention and control strategies targeted at reducing the risk of hospital transmission of COVID-19 has been central to the Trusts ongoing response to the pandemic, whilst at the same time focusing on restoring operational activity. The health, safety and wellbeing of our patients, communities and staff has remained a priority.

New SARS- CoV2 variants presented challenges for UHS and the Southeast region during the year, firstly with the Delta variant (spring-autumn 2021) and then the Omicron variant over winter. Both variants being more transmissible than the previous resulting in the ability to rapidly spread between individuals creating challenges in controlling transmission within the hospital environment.

The Omicron variant presented significant challenges for the trust alongside existing winter pressures. An exponential increase in case numbers in the community resulted in a significant increase in hospital admissions and this, alongside the increased transmissibility of this new variant, resulted in a significant increase in hospital onset infections and multiple outbreaks within UHS along with significant challenges associated with COVID related staff absence. Nationally, multiple outbreaks were also reported in care homes and other healthcare settings.

Strategies to reduce the risk of in-hospital transmission of COVID-19 have remained in place and have been subject to ongoing review with appropriate and timely actions and improvements taken to reduce the ongoing risk of hospital onset infection and outbreaks. Leadership and oversight has continued to be provided from the Chief Nursing Officer/Director of Infection Prevention & Control. Strategic and operational decisions have continued to be made effectively with discussion in Trust operational huddles and incident meetings and the Infection Control Gold Command Committee.



Cases of Hospital-onset (healthcare associated) COVID-19 Infection

As per national requirements all cases of probable and definite healthcare associated COVID-19 are identified and investigated through the RCA investigation process either as an individual case reviews or part of a wider outbreak investigation.

Cases identified in UHS: April 2021 to March 2022

Community Onset (CO)	Indeterminate (HO.iHA)	Probable (HO.pHA)	Definite (HO.dHA)
3760	155	103	125

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

Outbreaks of COVID-19 infection

The use of local UHS surveillance data facilitates early warnings of increased rates of infection enabling us to identify both outbreaks and clusters (detection of unexpected, potentially linked cases) of infection amongst patients and staff. Close liaison between the Infection Prevention Team, Occupational health and clinical/non-clinical teams is in place to support identification, investigation and management of increased incidence of infection.

Total Number of Outbreaks April 2021-March 2022	**54**
Outbreaks involving Patients and Staff	30
Outbreaks involving Patients Only	15
Outbreaks involving Staff Only	9
Total Number of Positive **Patients**	249
Total Number of Positive **Staff**	166

All outbreaks were managed by the Infection Prevention Team via a formal incident/outbreak management process and reported onto the national outbreak management system, with ongoing monitoring until 28 days following the last confirmed case.

Outbreaks (4) where there have been probable or definite hospital-onset healthcare associated COVID-19 infection deaths* have subsequently been reported as serious incidents as per national requirements. 10 patients were identified as a probable or definite hospital-onset healthcare associated COVID-19 infection death and a detailed RCA investigation has been undertaken.

Incident or Outbreak Date	**Details of Incident**	**Ward**	**No of patient**	**No of patient RIP< 28 days**
19/09/2021	Covid 19 Outbreak	D8	**2**	**2**
20/09/2021	Covid 19 Outbreak	Bassett Ward	**11**	**6**
20/10/2021	Covid 19 Outbreak	MOP	**16**	**1**
18/11/2021	Covid 19 Outbreak	F4 Spinal	**11**	**1**

A probable or definite hospital-onset healthcare associated COVID-19 infection **death is defined as;*

- *the death of a patient who has a positive specimen result where the swab was taken within 28 days of death and/or COVID-19 is cited on either Part 1 or Part 2 of the death certificate (i.e. the death resulted from a COVID-19 clinically compatible illness with no period of complete recovery between the illness and death);*
- ***and** the COVID-19 infection linked to the death meets the definition of 'probable' or 'definite' hospital-onset healthcare associated infection.*

Summary of key themes/ learning from outbreaks and individual hospital onset cases.

- Risks associated with the physical environment, particularly lack of mechanical ventilation and difficultly in achieving good airflow by natural ventilation (due to lack of windows/ inability to open windows in some areas), has been identified as a significant factor in relation to

aerosol transmission in the context of outbreaks. Other risks related to the physical environment include the lack of bathroom/toilet facilities on some wards resulting in a high number of patients sharing facilities or difficulty in allocating dedicated facilities for Covid contacts.

- Patient adherence with mask use and social distancing. This included challenges with confused and wandering patients, complex patients with significant physical or mental health needs and individual inpatients frequently leaving the ward for non-clinical/treatment reasons (e.g.to meet others in retail outlets/outside) increases the risk for COVID-19 transmission.
- Lack of onward care provision in the community resulting in delayed patient discharge.
- Patients and staff testing positive to COVID19 despite being fully vaccinated, indicating apparent waning immunity in those who were vaccinated over six months ago.
- Staff and Patient hand hygiene
- The need to undertake multiple bed/ward moves in order to create capacity for increasing numbers of COVID-19 patients (due the significant increase in COVID admissions and hospital cases) and ensure that clinical care was not compromised, is likely to have resulted in transmission events and subsequent outbreaks.
- Movement of staff between different wards to manage the opening of new areas and to ensure patient safety was maintained in a period of staff absence/sickness.

2.3 Viral Gastroenteritis including Norovirus.

An increase in cases and outbreaks of Norovirus and other gastrointestinal viruses was seen in UHS in 2021/22 following no reported outbreaks in the previous year 2020/21. A rise in community prevalence of Norovirus has also been seen in 2021/22 compared to 2020/21.

Year	Bed days lost due to bay/ward closures
2016-17	232
2017– 8	101
2018-19	946
2019-20	1039
2020-21	0
2021-22	361

In 2021/22 there were 17 outbreaks associated with viral gastroenteritis involving 63 patients and 3 staff. Of the 17 outbreaks 2 resulted in full ward closure, with the remaining resulting in bay closures within wards.

	Number of outbreaks	Cause	No of Bed Days Lost	No of Pts	No of Staff	No of Bays Closed	Wards closed
Q4	8	Norovirus x6 Adenovirus x1 Sapovirus x1	24	26	1	11	0
Q3	0	-	0	0	0	0	0
Q2	7	Norovirus x 5 Unknown Likely Viral D&V x2	278	24	1	7	1
Q1	2	Norovirus x 1 Unknown Likely Viral D&V x 1	59	13	1	1	1
Total	17		**361**	**63**	**3**	**19**	**2**

In 2021/22 modifications were made to faecal diagnostic and sample processing as part of quality improvements in the Microbiology Laboratory. This resulted in an extension of the viral panel and reduction in turnaround times for results. The viral panel now includes Astrovirus, Sapovirus, Adenovirus, and Rotavirus as well as Norovirus. This change resulted in earlier detection of outbreaks of adenovirus and Sapovirus in the children's cardiac ward (E1), with subsequent outbreak control measures implemented to reduce risk of further transmission of infection.

Key themes/learning from outbreaks:

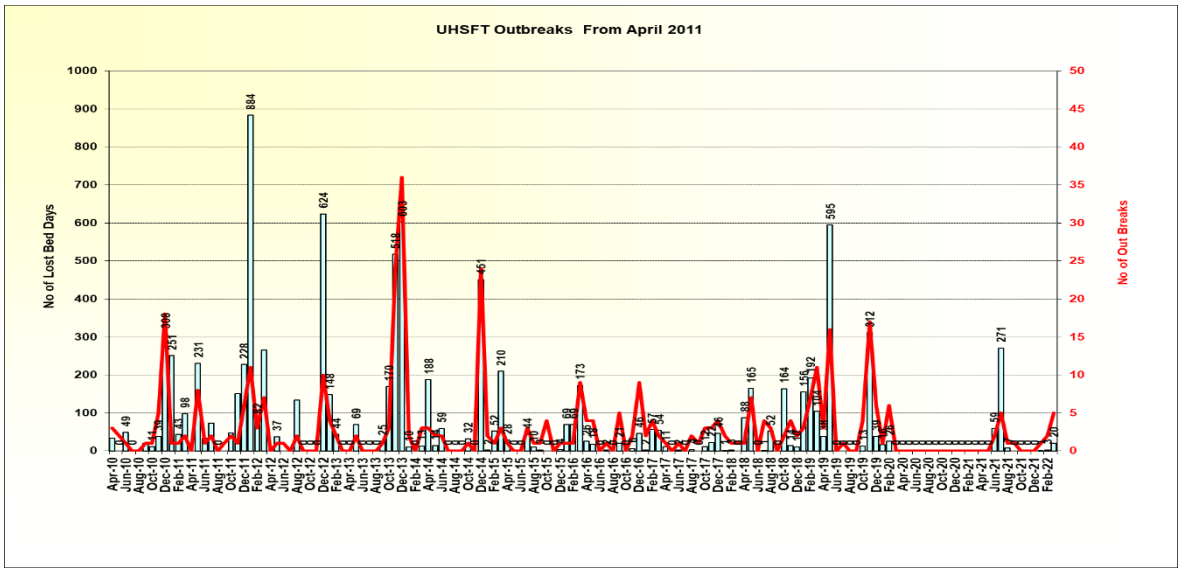
- Early identification, assessment and management of patients with unexpected/unexplained diarrhoea and/or vomiting.
- Management of patients with type 5 stools
- The importance of early isolation of patients with symptoms (e.g. within 2 hours of developing loose stools/D&V).
- Cleaning of equipment.
- Importance of the need to focus on patient and parent hand hygiene
- Cluttered Environment / items located in inappropriate locations.
- Potential risk of transmission associated with parents/families interacting with each other and their children e.g. caring for each other's babies including changing nappies; using shared facilities on the ward.

Key actions for 2022/23 to support prevention and management of outbreaks within UHS include:

- Work with partners and local/national agencies, e.g. CCGs/ICS/ UKHSA/local Health Protection Teams, to improve intelligence and communication relating to community Norovirus activity.
- Work with partners regarding admission avoidance strategies where appropriate e.g. hydration management in care homes/the home.
- Further improve availability and turnaround time for diagnostic tests.
- Ongoing focus on effective management of existing isolation capacity within UHS to ensure optimal use and explore longer term options to increase isolation capacity.
- Enhancing processes/practices to support prevention of outbreaks occurring including rapid assessment, identification and isolation of suspected cases
- Ongoing education and awareness of staff in the assessment and management of

unexplained/unexpected D&V and expected infection prevention practices.

- Ongoing implementation of a robust communication plan/strategy for use prior to/during outbreaks
- Enhancing practices/processes to support management and control of outbreaks when they occur.



2.4 Respiratory virus infections.

In 2021/22 there were 0 outbreaks related to Influenza A/B or RSV.

Despite concerns of the potential for a significant increase in cases of RSV (particularly in children) and influenza, overall activity remained very low in 2021/22.

2.5 Actions to minimise the risk of in-hospital transmission and outbreaks associated with COVID19, other respiratory viruses and Norovirus

Actions and strategies to reduce the risk of in-hospital transmission of respiratory viruses (including COVID 19 and influenza) and Norovirus, along with planning for potential increase in cases have remained in place and under ongoing review. Specific actions to support effective management and control of all infections have included:

- Use of local & national prevalence data to facilitate early warnings of increased rates of infection in the local community/area – COVID-19, Norovirus and respiratory viruses
- The ongoing use of local UHS surveillance data to facilitate early warnings of increased rates of infection enabling us to identify both outbreaks and clusters (detection of unexpected, potentially linked cases) of infection amongst patients and staff.
- Ongoing close liaison between the Infection Prevention Team, Occupational health & clinical/non-clinical teams to support identification, investigation and management of increased incidence of infection.
- Updates/amendments to national/regional guidance have been reviewed and assessed by the Infection Prevention Gold Command Committee and trust guidance revised and implemented according to the outcomes of the review.
- Improved capacity for rapid diagnostic testing (result within 2 hours) for COVID-19 and other respiratory and gastrointestinal pathogens (including Norovirus) to support rapid decision making and management– both point of care testing in admission pathways and rapid in-lab testing
- Screening and triaging of all patients either prior to arrival to a care area, or as soon as possible on arrival, to allow early recognition of patients presenting with symptoms of infection or at high risk of infection.

- Ongoing focus on more effective management and optimal use of single room capacity to facilitate rapid isolation of patients presenting with suspected infections.
- Ongoing review of patient pathways and placement with care groups to support appropriate segregation of patients presenting with/without symptoms of infection or at high risk of infection.
- Working with partners regarding admission avoidance where appropriate e.g. hydration management in care homes/the home.
- Ongoing proactive focus on bed planning and management with collaborative discussions amongst key stakeholders, including the Infection Prevention Team, to manage and reduce overall risk to the organisation.
- Limiting patient movement as far as possible.
- Promotion of the Flu vaccination and COVID booster vaccination.
- Careful review and consideration of the lifting of restrictions in place within the Trust, e.g. visiting, and the re-introduction of restrictions if required, led by DIPC/Infection Prevention Gold Command Committee.
- Refreshed awareness campaign (#Don'tgoviral) focusing on the importance of maintaining the measures of hand hygiene, wearing of masks, social distancing, testing, vaccination and other infection prevention standards.
- Further improving communication cascades and internal alerts/escalation.
- Ongoing monitoring and focus on infection prevention and control practices in clinical and non-clinical spaces
- Ongoing review and work to improve ventilation standards in clinical and non-clinical areas.
- Ongoing emphasis on working from home where possible

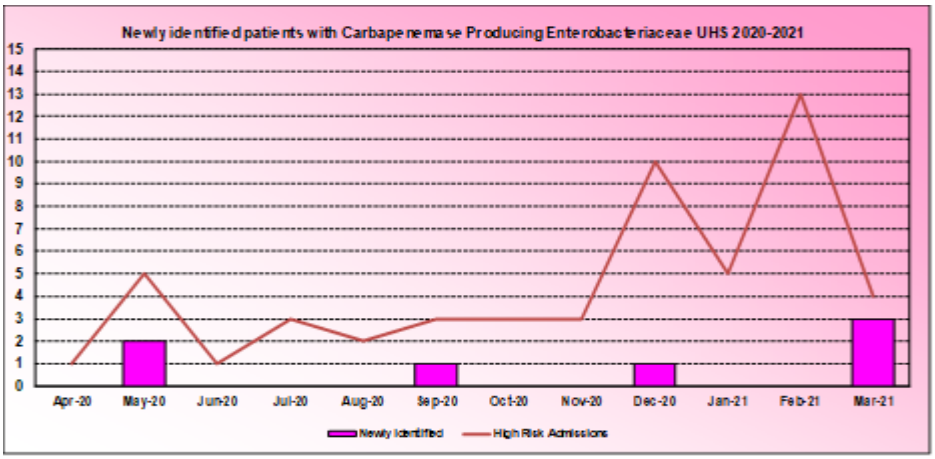
Next steps and future planning in relation to COVID-19

Whilst COVID-19 remains in general circulation and with the virus likely to remain endemic for some time to come, to support the ongoing recovery of elective planned and diagnostic services, the focus for 2022/23 will be a transition to 'Living with COVID' within our hospital settings and services. This will involve a transition back to many pre-pandemic Infection Prevention and Control measures whilst also ensuring that relevant learning and actions to support effective management and control of infections (as outlined in the sections above) are maintained and integrated as standard measures and practices.

The Trust will continue to need to undertake local risk assessments to ensure safe systems of work, balancing risks across the whole patient pathway, ensuring safe care for our patients, the safety of our staff, reducing the risk of nosocomial transmission, and supporting the delivery of elective recovery.

Planning and preparedness for future variants, along with the potential for future pandemics will also need to be a key area of focus for the Trust.

2.6 Carbapenemase-producing Gram negative bacteria



CPE continues to be a key risk for UHS and early identification of patients at risk and appropriate management is the key to reducing risk of transmission. The global and national prediction suggests an increase in antimicrobial resistance including CPE, which continues to be major public health risk as identified by the World Health Organisation and as outlined in the UK's five-year national action plan for tackling antimicrobial resistance (2019-2024).

Detection of CPE is now much improved with the use of improved workflows within the laboratory and use of PCR based method for detection thus improving our ability to detect, isolate and contain the risk posed by CPE.

April 2021 to April 2022:

- 0 UHS Hospital acquired cases
- 53 High Risk patients admitted to UHS
- 22 new patients detected as being colonised with CPE
- 2 new patients detected as being colonised with MBL
- 14 new patients detected as being colonised with MDRO
- 3 new patients detected as being colonised with OXA 48

Key actions to reduce risk and transmission from CPE:

- Education and awareness in relation to the updated Trust CPE policy
- Enhanced focus on antimicrobial stewardship to reduce use of broad-spectrum antibiotics specially carbapenems group of antibiotics.
- Plan to use PCR as first line for diagnostics in 2022-2023.
- To continue undertake extensive screening of CPE in key areas of hospital including patients on carbapenems.

2.7 Surgical Site Infections

Surgical site surveillance (using PHE SSI modules) is undertaken for hip and knee replacement surgery, including use of post discharge patient questionnaires. This is usually carried out on a continuous basis, but participation was reduced during 2021/2022 due to the ongoing pandemic.

Incidence of SSI infection Jan – Dec 2021: 230 hip replacement operations performed. 0.9% infected during this time compared to all hospitals rate of 0.8% over last 5 years.

For the period Oct-Dec 2021: 53 hip replacement operations performed with 1 infection reported but, due to small numbers, the infection rate was 1.9%.

Critical analysis of the healthcare and patient risk factors for infections identified are discussed by a well-represented SSI Group within Orthopaedics which comprises of:

1. Care Group Clinical Lead/Orthopaedic consultant
2. Consultant Microbiologist - Orthopaedics
3. Theatre Matron - Orthopaedics
4. Infection Prevention & Control Specialist Practitioner (SSI Lead)
5. Theatre Education Practitioner – Infection Control Link
6. Recovery Room Education Practitioner – Infection Control Link
7. Surgical Surveillance Nurse – reporting to the Trauma & Orthopaedic Lead Matron

2.8 Assurance of Infection Prevention Practice standards, including environmental cleaning

Infection Prevention Practice standards

The Trust annual infection prevention audit programme was re-instated in April 2021, following, suspension for the majority of 2020/2021, to monitor infection prevention and control practice standards in clinical and non-clinical areas. However, due to operational pressures within the hospital as a result of further increased prevalence of COVID-19, staffing challenges and the need to re-deploy staff to other areas etc. the audit programme was suspended in September 2021 for the remainder of 2021/22.

Audits undertaken in 2021/22:

High Impact Intervention Audits (Care process to prevent infection) - all self-assessed audits

	Element	% Standards met
Prevention of urinary catheter associated infections	Insertion	99%
	Ongoing care	95%
Prevention of infections associated with central venous access devices	Insertion	100%
	Ongoing care	97%
Prevention of infections associated with peripheral vascular access devices	Insertion	97%
	Ongoing care	88%
Prevention of surgical site infection	Pre-operative	98%
	Intra-operative	100%
	Post-operative	99%
Prevention of ventilator associated pneumonia		100%

Hand Hygiene

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

Monitoring and assurance of hand hygiene practice for inpatient areas consisted of:

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

Monitoring and assurance of hand hygiene practice for inpatient areas consisted of

- peer audits only

Audit type	Month	% Standards met	
Inpatient areas (self- assessed)	June 2021	95%	
Outpatient areas (self-assessed)	June 2021	95%	
Inpatient areas (covert audit undertaken by Infection Prevention Nurses	August 2021	69% (trust median score)	Against a performance improvement target of 60% (the trust median score established following February 2019 covert audits).

Miscellaneous Audits (all self-assessed with exception of IPT PPE audit)

Audit	% Standards met
Sharps safety	97%
Standard Precautions	97%
Isolation	98%
Personal Protective equipment (PPE)	99%
Use of PPE (undertaken by IPT)	98%

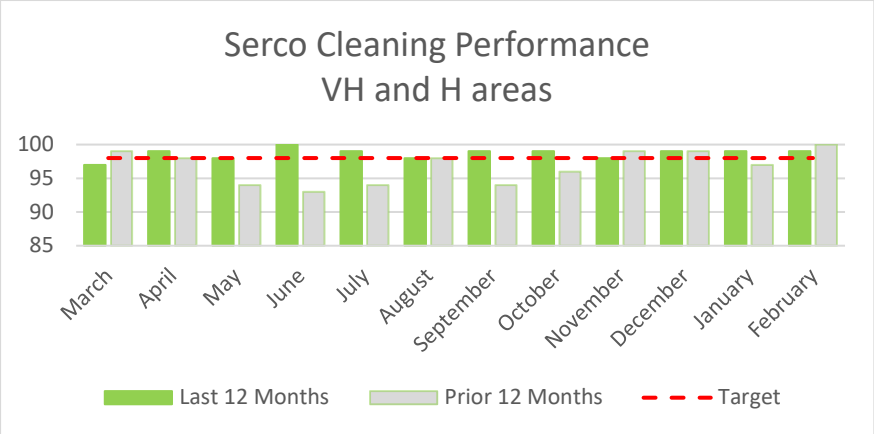
Overall audits identify that there is good assurance related to practice and infection prevention and control standards. Areas who do not achieved the expected audit standards are required to identify actions for improvement and are offered support and input from the Infection Prevention Team.

In addition to the formal audits, ongoing monitoring of infection prevention and control practices in clinical and non-clinical spaces has been undertaken through a range of avenues:

- As part of IPT visits and reviews of clinical areas.
- Ward leader/Matron walkabouts & spot checks
- Infection Prevention Team COVID zero & #Dontgoviral walkabouts /reviews in clinical areas.
- COVID secure walkabouts in non-clinical areas.
- Through the use of local Infection control guardians/local COVID zero champions/infection prevention link staff

Environmental Cleaning

Monitoring of environmental cleaning standards (domestic and clinical) have continued to be undertaken by the environmental monitoring team in 2021/2022. During this period, the volume of audits has increased significantly, ensuring all areas of the hospital are being assured for cleanliness far more frequently.
Serco has consistently delivered high levels of cleaning across the hospital, with all monthly targets achieved in 2021/2022.

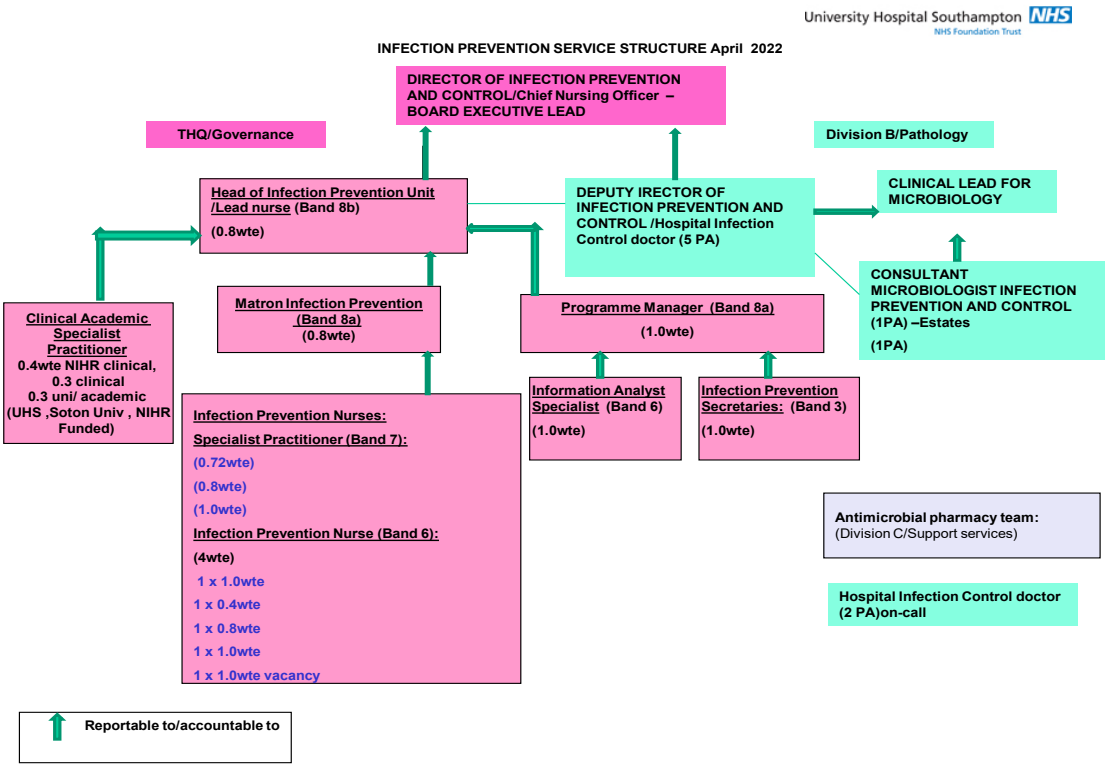


2.9 Antimicrobial Stewardship.

See Appendix 1 for full report.

2.10 Infection Prevention Team/Service

Resource



The Infection Prevention Team (IPT) is a relatively small service with huge impact across the Trust providing a comprehensive Trust-wide specialist Infection Prevention & Control advisory service. The team provides leadership, support and specialist expertise and advice across the organisation and are the key enablers and drivers of infection prevention and control. A business case for additional resource (for specialist infection prevention practitioners) was submitted and approved in 2021/22 with posts successfully recruited to. The Team is made up of a diverse set of people with significant experience in infection control, with leadership and oversight from the Chief Nursing Officer/Director of Infection Prevention & Control.

The ongoing COVID-19 pandemic has remained the key area of focus for the IPT in 2021/22 with activities focused on the prevention, control and management of COVID19 within the UHS. Despite another very challenging year, the IPT have continued to demonstrate extreme resilience and respond to the Trust's service needs, including an extension to the existing winter on-call service.

Research and Innovations

- One of two university hospital NHS Trusts participating in the PRHAPs (Preventing non-ventilator hospital-acquired pneumonia) study- a study aimed at using routinely collected clinical assessment data to inform the development of a prognostic screening tool to identify patients admitted to hospital and at high risk of developing non-ventilator associated hospital acquired pneumonia.

- Ongoing adoption and development of the use of air purifier technology on a large scale to manage and reduce the risk of transmission and outbreaks of COVID19. The IPT have also been involved in the development of guidance for use of air purifiers in primary care.
- Innovative staff & public engagement/communications campaigns led by the UHS Communications team and supported by the IPT – COVID zero/dontgoviral. The COVID zero campaign, promoting safety across the workforce and services throughout the pandemic, has earned award winning recognition for 'best crisis comms' at the PR week Corporate, City & Public Affairs awards.
- Ongoing development of IT systems to support infection management and delivery of an effective service to the Trust.

2.11 Estates

Water Quality

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

Water safety is monitored via the water safety committee which has the overall responsibility of ensuring good standards across the hospital. The focus on water safety has continued function as normal throughout the pandemic, including 2021/22. UHS has its own challenges like any other larger hospital which has older pipework and a high number of augmented care units with vulnerable patients. Infection with pseudomonas can increase the length of stay of inpatients in augmented care units and Pseudomonas bacteraemia is reported and monitored.

There have been improvements in almost all of the processes related to water safety in 2021/22 which continues to improve across the trust. One of the highlights is the use of filters in the water supply to the new GICU build which has significantly reduced the growth of pseudomonas. This is the first instance of the use of this technology in England and has directly benefitted the patient in terms of outcome. The work was supported by an innovation grant. Other key achievements and improvements in 2021/22 include:

- A change in the water hygiene contract with 2 new contractors that cover water sampling, carrying out the water hygiene PPM and completing legionella & other risk assessments.
- A new asset list, identifying key locations, has been installed on Zetasafe ready for use by the new contractors from December 2021.
- Trust's direct labour to manage remedial work.
- Completion of Pseudomonas clinical risk assessments in augmented care units.

The benefits of the new contract are:

- Contracting out of sampling to a specialist contractor: there is now a specialist contractor that can supply a cloud-based recording system that shows trend data and record of remedial actions.
- Contracting out of Legionella Risk Assessments which provides the Trust with accurate nonbiased state of the waters system to a high quality.
- Contracting out water hygiene PPM including TMV servicing, temperature monitoring, showers. An asset led contract which means there is no longer a requirement to have to monitor the times the contractor is on site. There are also measurable KPI`s
- Directly employed team to maintain non-conforming issues, sample failures; reduces the need to rely on contractors to complete remedial tasks.
- PPMs will be managed through the trust planet system and recorded on the trust Zetasafe system
- The zeta app itself will be used on any smart phone and our PDA`s going forward
- A more accurate asset register will be provided ensuring outlets are not being overlooked

Air Quality/Ventilation

Providing a clean environment, including fresh air, is considered essential to the healthcare environment. The focus on the importance of ventilation has been highlighted further during the COVID-19 pandemic, where the apparent association between transmission/outbreaks and poor ventilation in a range of settings (healthcare and non-healthcare) has been established.

Air quality is monitored by Estates Department and reviewed by a multi-disciplinary Ventilation Safety Group. Regular external audit of performance is provided by an Authorised Engineer Air Quality. Historical issues particularly with ageing operating theatre ventilation which requires major engineering work to achieve modern standards are under regular review and are included in medium/long term refurbishment plans. Plans are in place to improve centre block and neurosurgery theatres ventilation.

The COVID-19 pandemic has further highlighted key areas in UHS where mechanical ventilation is lacking or does not meet current standards in clinical areas. General ventilation across UHS wards, outpatient areas and offices is variable, with only a small number of areas having good ventilation (see table below). Many areas where ventilation is poor also experience high temperatures which affects both patient and staff wellbeing.

Block	RAG	Notes
West Wing Wards G5, G6, G7, G8 & G9		
West Wing Wards F5, E5, D5		
West Wing Wards C5, C6, SHDU, RDHU, Endoscopey		
All other West Wing Wards		
East Wing Wards G2 PHDU/Neuro, G4 Heamo-dialysis area & CHDU & CCU		
East Wing Original A&E Footprint		Majors Area & RAU (Old minors) perform well; remaining areas perform poorly
East Wing Ward C3 & Plaster Suite		Performance considerably lower than anticipated
East Wing all other wards (G1, G2 & E1)		No mechanical Ventilation
East Wing all other wards (G3 & G4)		No mechanical Ventilation
East Wing NIC/Infill areas		
East Wing Annex - "New" A&E & D Level Out Patients		
Centre Block PICU		
Centre Block GICU Side A, B & B2		
Centre Block Piam Brown		
Centre Block F10, F11, D10		Extract Ventilation only
Centre Block Pulmonary Function Suite		4 x Rooms suitable for AGPs

Many of our COVID outbreaks within UHS have occurred in areas of poor ventilation. Air purifier units have been temporarily deployed as a control measure into areas affected by outbreaks and have also been deployed into high-risk areas such as admission units. However, use of these units are only a temporary short-term solution and a long-term solution is required.

Actions are in place to explore ways to improve the current state of ventilation in key areas of the hospital. Short-medium term solutions are being explored with the limiting factor in relation to long term solutions being the large scale of work with potential disruption and the significant investment required for rectification work. Currently, the risk is managed by the careful placement of portable air purifiers. These air purifiers are likely to play an essential role in risk mitigation.

Focus on ventilation in the built environment may further reduce the risk from many other healthcare associated infections such as influenza and other respiratory virus, Norovirus and MRSA.

Ventilation is identified as one of estates highest priorities for addressing and is included in the backlog maintenance replacement programme but requires funding.

3.0 Operational and financial impact of Healthcare Associated Infection

Outbreaks of infection e.g. Norovirus, COVID-19 can result in significant impact on operational capability/capacity of the Trust resulting in cancellation of elective procedures and staff absence.

The increased length of stay with healthcare associated infection contributes further to decreased operational productivity.

A recent study has estimated the cost of healthcare associated infection in the UK is approximately 774 million pounds.

Appendix 1

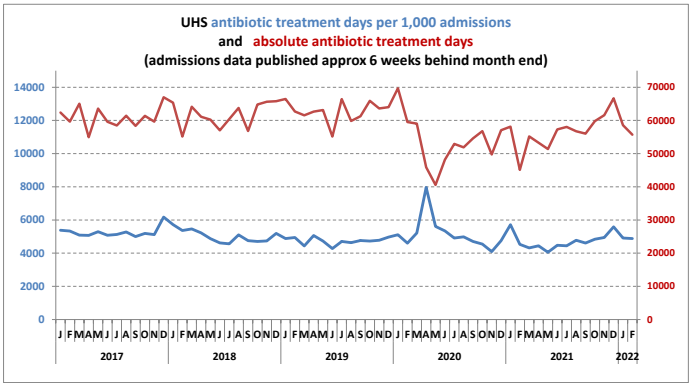
1. UHS Antimicrobial Usage Data

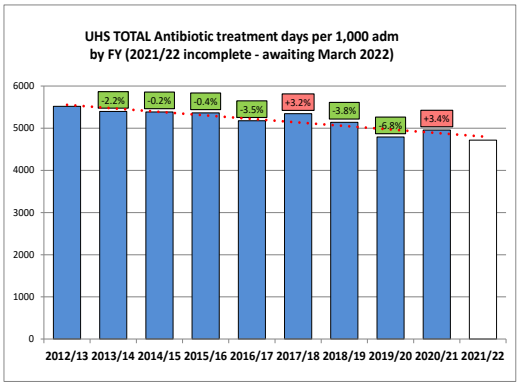
Introduction

Antimicrobial stewardship is, of course, part of the role of many individuals and teams at UHS but formal activity and strategic development at UHS is principally undertaken by a small team, comprising Dr Tom Cusack (averaging 1.4 PA/wk) and the antimicrobials team within pharmacy (4 individuals, 3 WTE). This group meets weekly.
Wider groups comprise the adult and paediatric Antimicrobial Stewardship Teams, which meet approximately quarterly to review progress and discuss strategy.

UHS Stewardship Internal Review

Antimicrobial usage per 1,000 admissions (and admissions numbers) is currently close to pre-COVID levels, as shown below, but in the longer term our trend in usage continues to be downward.





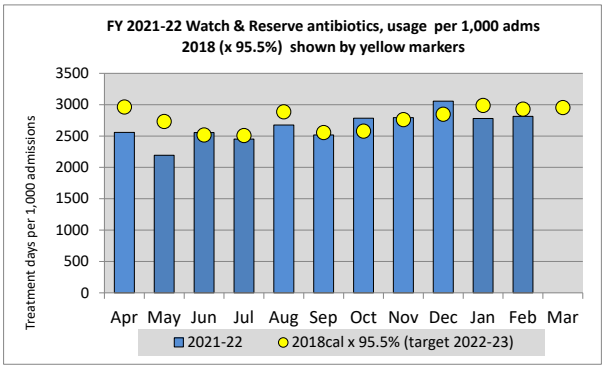
Additional Considerations for Stewardship Activity

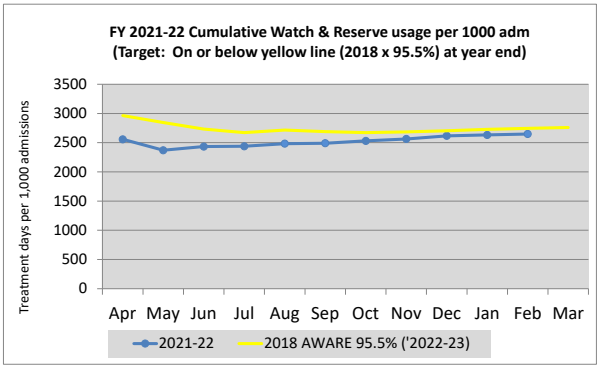
High usage of antibiotics is still seen in the management of highly symptomatic COVID-19 in-patients but these numbers are significantly down in recent months.
Stewardship activities in other patient groups have continued, however pharmacy anti-infectives team resource has been diverted heavily (est. 70% lost) to COVID-19 hospital and community therapeutics and vaccination work streams, leaving limited time for stewardship activities. Dr Cusack's time has also been taken up periodically, such as by requirement for 4 weeks of full-time clinical cover on COVID wards in late 2021.

1. UHS Antimicrobial Usage Data and National/Local Targets

1.1 Overall Antibiotic use

The standard contract requirement for reduction in antibiotic usage for FY2021/22 was waived, as in 2020/21. Had it been applied as anticipated, UHS would very likely have met this.
For 2022/23, a new requirement will be applied: Reduction of 4.5% from calendar year 2018 usage in combined WHO/NHSE AWaRE subgroups for "watch" and "reserve" agents. UHS performance against that baseline for 2021/22 is shown below as an illustration only; delays in NHS data preclude generation of any 2022/23 data thus far. As can be seen, despite March data remaining unavailable it appears that UHS would have met this target had it been in force this year.

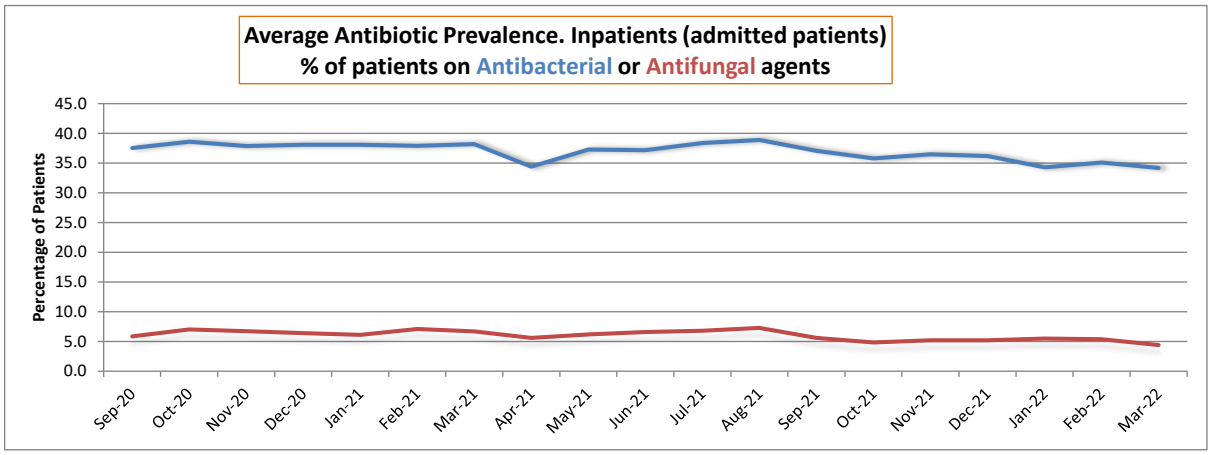




Ref: Internal reporting; source data from https://www.rx-info.co.uk/ Refine

1.2 Proportion of Patients on Antibiotics

The proportion of admitted patients prescribed an antibiotic at any one time has fallen from around 37-38% pre-COVID to 35%. The highest prevalence of patients on antibiotics sits within specialist medicine, which is to be expected due to the in-patient type (infectious diseases and cystic fibrosis).

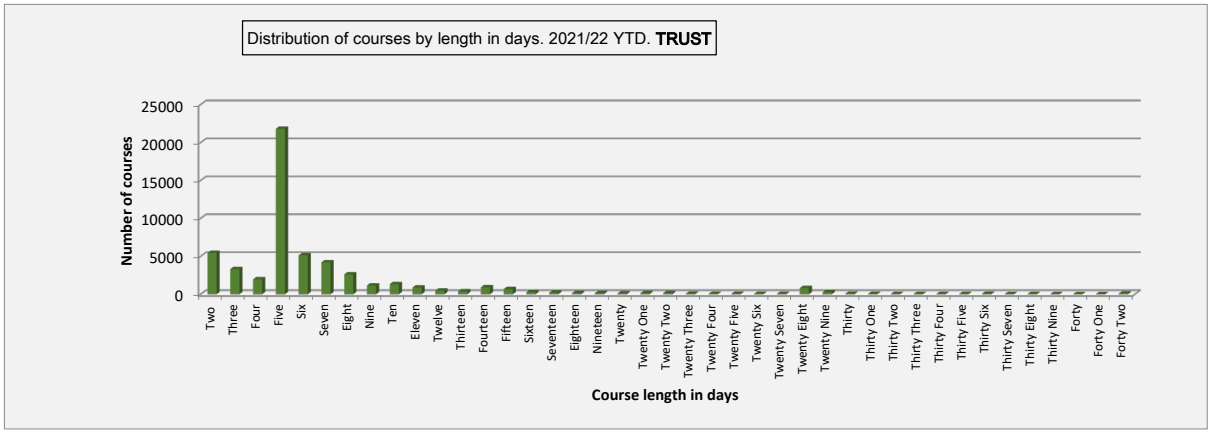


Ref: Reporting data from JAC prescribing system

1.3 Duration of Antibiotic Treatment

Antibiotic durations are monitored following the introduction of automatic 5-day course lengths to many antibiotics on the JAC electronic prescribing system in December 2018.

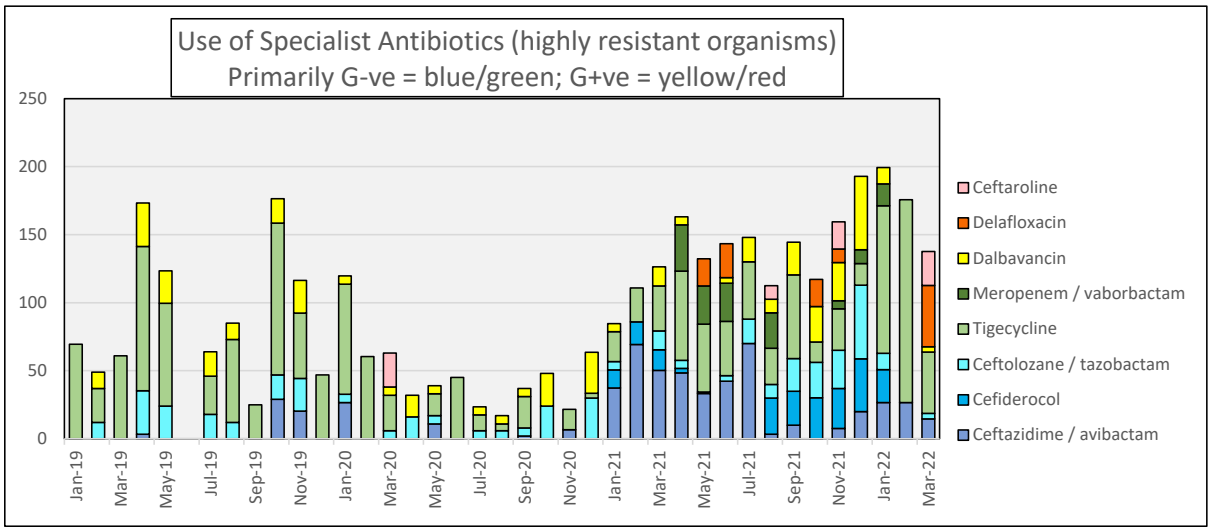
For Q4 2021-22, 63% of prescribed antibiotic courses were for 5 days or shorter; a higher proportion than any earlier recorded quarter.



Ref: Reporting data from JAC prescribing system

1.4 Specialist Antimicrobial Usage

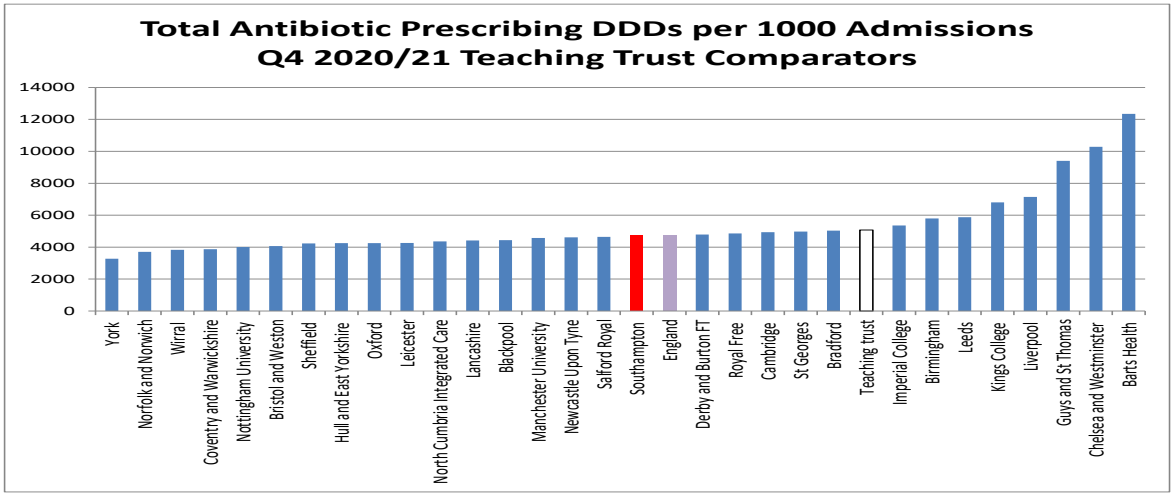
In response to the increase in resistant Gram-negative infections nationally and locally and difficulties in delivering prolonged courses of Gram-positive treatment, our use of expensive last-line restricted antimicrobials is increasing. We are monitoring the use of these antimicrobials to ensure they are used in-line with sensitivities and on expert advice. Availability of laboratory sensitivity testing is ensured when a new restricted antimicrobial is introduced at UHS. Unavailability of ceftolozane-tazobactam continues but return of global supply expected in mid-2022.

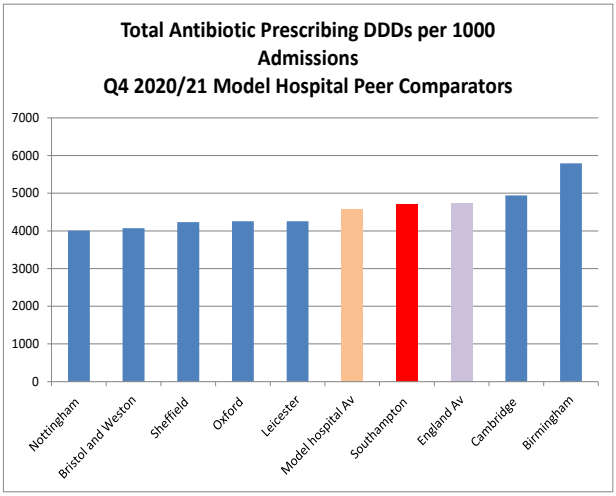


Ref: Internal reporting; source data from https://www.rx-info.co.uk/ Refine

1.5 Comparative Data 2020/21 Q4 (most recent available)

When compared to teaching trust hospitals within England, antibiotic use at UHS is 7.6% less than the teaching trust average within England. When compared to our model hospital comparator sites our usage is 3% higher than the model hospital average. Prior to the COVID-19 pandemic UHS antibiotic use was 3% higher than the model hospital average; our performance has remained steady when compared to others which should be commended given the challenges of the past 18 months.





Ref fingertips.phe.org.uk accessed 15/09/2021

2. AMS Improvement Projects April 21 onwards

2.1 Antimicrobial Stewardship rounds in the Acute Medical Unit

Stewardship rounds have been instated in the acute medical units. This area has been identified for rounds as an admission ward to target antimicrobial prescribing at the point of prescribing. They comprise a consultant microbiologist/infectious diseases and specialist pharmacist once or twice per week. Initial perception is that this clinical area demonstrates good adherence to the principles of antimicrobial stewardship and adherence to trust antimicrobial guidelines despite extremely high workload.

2.2 Guideline review

Four major infection policies (sepsis, pneumonia, *Clostridioides.difficile,* trauma 1st dose) have been reviewed and updated in line with changes to national guidance and local antibiotic resistance patterns. A revised urinary tract guideline is in final drafting and is expected to submit for approval by end June 2022.

2.3 Education

FY1 and FY2 MedEd/MyMedByte sessions
NMP prescribing course half day – Nov and Feb Annually
Southern Patient Safety Week antimicrobials session

2.4 Audit / Research

During the COVID-19 pandemic, the routine "HAPPI" audit process for antimicrobial prescribing was suspended. This is scheduled to recommence in June 2022 (postponed from April/May due to exceptional trustwide workload pressure and reprioritisation of pharmacist activity to support rapid in-patient turnover). The audit is aimed at standards in documentation related to antimicrobial prescribing, at least in part addressing requirements of the Health Act.

For 2022-23, the team has agreed to take on the supervision of two University of Southampton medical students in their third year research/audit project activity. These will be monitoring/supporting stewardship activity within UHS, specifically in relation to the UTI CQUIN and outcomes from our use of specialist antibiotics.

'Antimicrobial Prescribing Report for IPC April 2022. Prepared by Pharmacy Anti-Infectives Team' before further dissemination .

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Ockenden Report - Final Report from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust**			
Agenda item:	**5.5**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Emma Northover, Director of Midwifery** **Marie Cann, Interim Senior Midwifery Manager** **Alison Millman, Safety and Quality Assurance Midwifery Matron**			
Date:	**26 May 2022**			
Purpose	**Assurance or reassurance** ✓	**Approval**	**Ratification**	**Information**
Issue to be addressed:	This report to our Trust Board in an open session is a requirement of the Ockenden report itself but also of NHSI/E. **1.** The report also focused on the Morecambe Bay Review and **2.** Maternity Workforce which is a key component of maternity safety.			
Response to the issue:	**1. Ockenden Report findings (Appendix 1 and 1a)** The final Independent Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust was published on Wednesday 30th March 2022. The review was undertaken by a multi-professional team of midwives and doctors including obstetricians, neonatologists, obstetric anaesthetists, a physician, cardiologist, neurologist and others who examined the maternity care and treatment provided to 1,486 families over two decades. The full report can be read here. The UHS Maternity Service and the Trust acknowledges the findings of the report which makes for difficult reading and empathises with the many families affected. Our Maternity Service takes the findings of this report extremely seriously and after completing the initial review, are taking some time to pause and reflect on the clear messages for us as a maternity provider as well as what this might mean for us in terms of identifying areas and actions for improvement. The service remains committed to working in collaboration with families and other agencies across the Local Maternity and Neonatal System (LMNS) to make these improvements and ensure that we continue to deliver compassionate and safe care.			

The Integrated Care System and Regional NHSI/E scrutinised the evidence we submitted on the recommendations arising from part one of the Ockenden report and received favourable feedback. The result can be seen in Appendix 1a and resulting action plan in 1b. We have also provided:

- Regular reports to Trust Board and other sub-Committees (Quality Committee, Trust Executive Committee and Quality Governance Steering Group) providing an update on the compliance with 7 Immediate and Essential Actions (IEA).
- Updates to the Local Maternity and Neonatal System (LMNS) and shared our reporting information and evidence.

Members of the Board should note that there are two areas that we did not provide enough evidence, and these can be seen in Appendix 1 and 1a improvement plan. Both are related to risk assessment for place of birth. It is true that issues with compliance to date have been directly related to the accurate recording of this risk assessment whilst using the new digital system, Badgernet, that was implemented across the Maternity Service in June last year. Having identified this as a problem, the digital team have been working hard with the supplier to ensure that, going forward, the recording of this risk assessment within the electronic notes will become a mandatory field for all midwives to complete following their discussions with women at every antenatal appointment.

Over the following months the agreed next steps across the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) LMNS are to support the 4 key pillars including safe staffing; a well-trained workforce; learning from incidents and listening to families. The Maternity Service has completed the following:

- Shared the report with staff and offered several opportunities to discuss concerns and provide support where required.
- Listened to family feedback and support families who may raise historic concerns, which will be supported by the Consultant Midwife and Obstetric team.
- Worked with Maternity Voices Partnership (MVP) to ensure families booked with the Maternity Service are reassured and hold listening events.
- Continued strong lines of communication with the Freedom to Speak up Guardian and explored options with them to increase FTSU representation within Maternity. Raise and refresh awareness around support from FTSU champions and direct self-referral to the Guardian and increase communication and visual reminders to ensure awareness of the importance of speaking up and raising concerns in Maternity Services.

In addition, the Maternity Service will look to:

- Review any future findings from the East Kent Maternity Services report which will publish later this year. This is likely to have further implications for maternity services and therefore any future actions will need to be overseen systematically and concomitantly.
- Continually review safe staffing requirements, whilst providing assurance to Trust Board in terms of how safe staffing levels are monitored and maintained.
- Have an identified person within Maternity Services to act as a central point of contact for the complaints department whilst coordinating and facilitating responses from the most appropriate staff.
- Review the process for all governance frameworks, learning from incidents, culture, complaint processes and listening to families.
- Have a collaborative approach to any new direction from the national team and share learning across the SHIP LMNS.
- Undertake a review and benchmark of the final Ockenden report over the next months, although not required at this point.
- Continually monitor the culture of our service as this is intrinsically linked to safety.

A full report of our maternity services against the Ockenden and East Kent recommendations will be submitted to the Quality Committee and Trust Board, as required.

For further assurance an external team from NHSI/E is visiting the Trust in August 2022 to review progress against the recommendations and to undertake listening exercises with Maternity Service staff.

2. **The Kirkup Report - Morecambe Bay (Appendix 2 & 2a)**

The Kirkup Report related to the findings of an independent investigation of the management, delivery and outcomes of care provided by the University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) from January 2004 to June 2013. In 2015 the UHS Maternity Service commissioned a multi-professional Morecambe Bay steering group covering both the Maternity and Neonatal Services to review and consider the findings and recommendations of the report.

Since the Ockenden report the UHS Maternity and Neonatal Services has further reviewed the findings and shared with the Trust and externally Appendix 2, demonstrating that care provided continues to be

safe, effective, and responsive with ongoing monitoring of any improvement plans.

Further recommendations have been developed to strengthen safety improvements and these are in Appendix 2a. The improvement plan will be monitored through the Maternity Risk and Patient Safety Group and at Trust level.

3. Midwifery and Neonatal Workforce

3.1 Midwifery Workforce

Staffing levels across UHS Maternity Services have remained challenged with the reasons for absence being both COVID-19 and non-COVID-19 related. The biggest cause for staff sickness remains anxiety and depression with absence rates across the workforce currently at 6% for registered staff and 13% for unregistered staff. There has however, been a welcome fall in sickness absence amongst registered staff over the last few months that had previously been sitting at around 9%. In respect of the ongoing impact of the pandemic, the lifting of national COVID-19 restrictions at the end of March naturally saw an increase in prevalence rates of infection within the local community. This, in turn, presented additional challenges for the management of the Maternity workforce in terms of maintaining consistent and balanced safe staffing levels. The fluctuations in available workforce have been mainly caused by an increased requirement for COVID-19 screening for staff and thereafter the related isolation periods.

The UHS Maternity Services have escalation directions in place that detail procedures around contingency staffing and therefore safety has always been maintained. The chronic effects of working through the pandemic are evident across the workforce with levels of resilience and staff burnout being obvious. As such, staff wellbeing remains a top priority for the leadership team and support for employees continues with additional helpful areas including Occupational Health, Professional Midwifery Advocates (PMA) and other staff support networks.

The UHS Maternity workforce has been required to adopt a flexible approach to providing care, facilitated by the deployment of staff across the service, to ensure safety for families. Despite this, the service continues to welcome a regular cohort of new starters to the Trust which includes both newly qualified and experienced staff members.

The recent appointment of a recruitment and retention midwife to provide front line support to preceptors and new starters to the Trust is clearly proving to be an invaluable resource after much positive feedback being received to this effect.

Current improvements for the Maternity workforce include:

- Rolling recruitment to ensure an active approach across the Maternity workforce as vacancies arise. This has been set up to work on a quarterly basis in conjunction with the Midwifery Practice Education team, so new staff feel well supported in their roles.
- Project work both locally and across the region in respect of maternity workforce, including ongoing plans for developments for recruitment and retention for the next 5 years.

A review of Maternity staffing is carried out every 6 months unless stimulated by internal or external reasons. This review assesses the retrospective acuity and activity data. This is considered with the use of the BirthRate Plus tool using a ratio of 1 midwife to every 24 users of the service (1:24) to assess the recruitment and training needs. Following a fall in births during the pandemic data has shown that births seem to be returning to pre-pandemic levels however, the Maternity Service has the flexibility to recruit to the 1:24 ratio as and when activity increases.

To support recruitment the UHS Maternity Service received a financial funding opportunity from the Ockenden report team and a bid for 9 whole time equivalent (WTE) midwives was made. The UHS Maternity Service was awarded 2.9 WTE funded midwives. The Division has additionally provided 6.1 WTE midwives funding. The WTE will be used to support 'safety' education and training within the Maternity Service.

Alongside this, UHS Maternity Services were successfully awarded some additional funding from HEE at the end of last year. These monies have been invested in two additional leadership positions to further support workforce development and recruitment pipeline coherence. This has led to the successful appointments of a band 8a Workforce Lead and a band 6 Lead Midwife for the ongoing development of midwifery support workers, with both positions being fixed term contracts in place for the next 12 months.

The maternity workforce is reviewed on a shift-by-shift basis however we, over the coming months, will be reviewing our Maternity workforce not against number of births but also acuity and vulnerability of mothers to ensure that we have the right workforce in the right place.

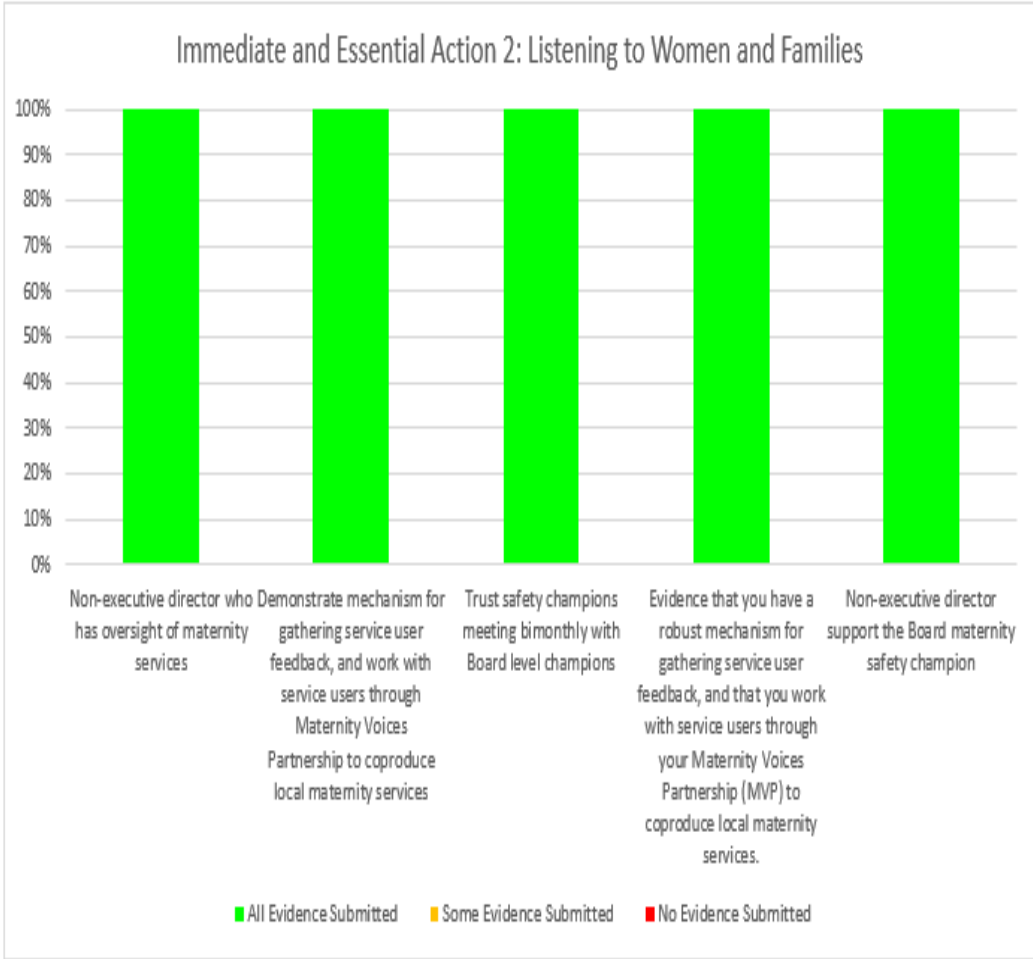
3.2 Obstetric Workforce

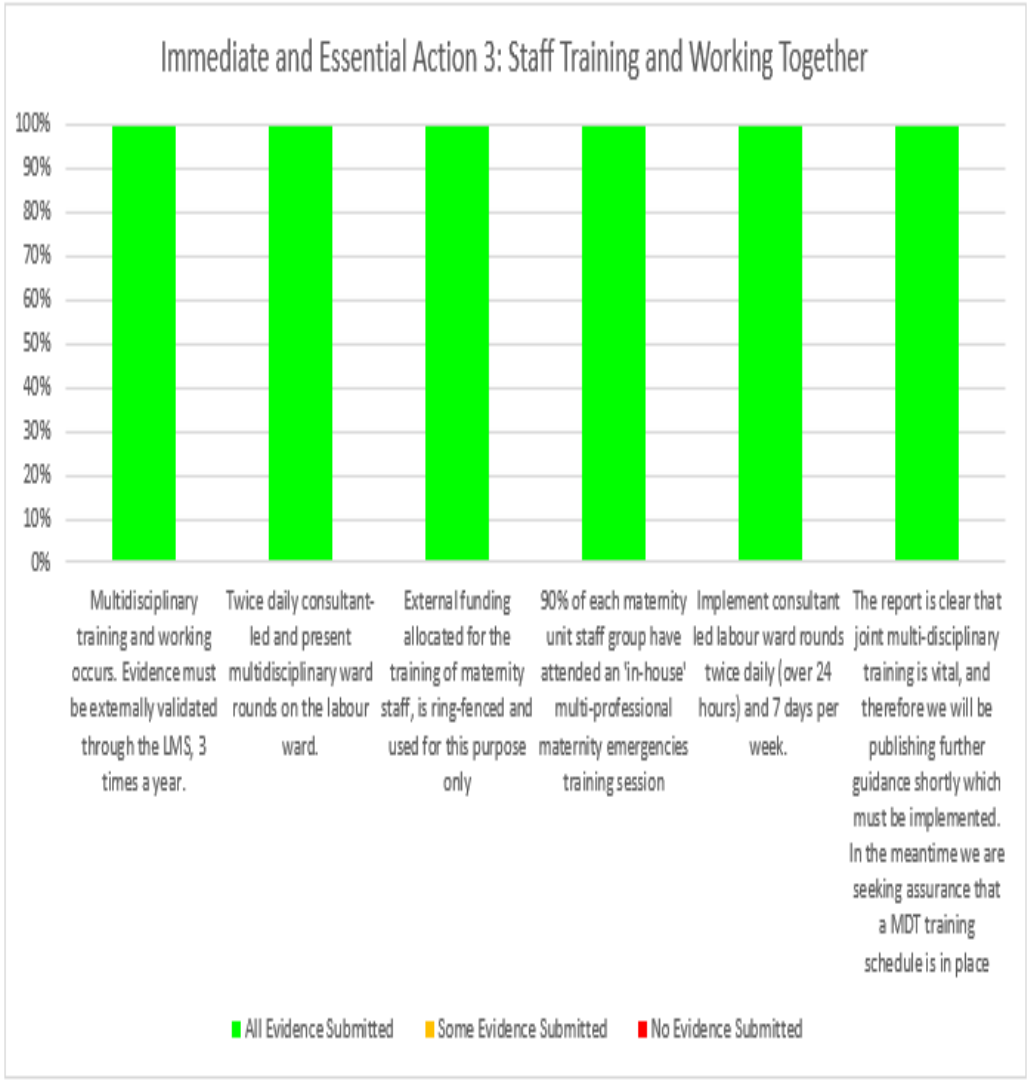
The obstetric consultant leads, and maternity senior leadership team acknowledge and are committed to incorporating the principles outlined in the Royal College of Obstetricians and Gynaecologists (RCOG) workforce document: '*Roles and Responsibilities of the Consultant*

	Providing Acute Care in Obstetrics and Gynaecology'. In addition to the midwifery funding provided by the Ockenden team, the obstetric workforce received 0.8 WTE funding and this has been appointed to within the service. **3.3 Neonatal Nursing** The UHS Neonatal Unit continue to recruit to their workforce in accordance with the recommendations from the British Association of Perinatal Medicine (BAPM) standards and an improvement plan is in place to ensure the standards are met including: • A rolling nurse advert to continually recruit new staff; this is aimed to recruit staff who are newly qualified, new to the neonatal speciality and international nurses with previous neonatal experience. • Continued recruitment of band 5 staff. • There is a targeted band 5 and 6 neonatal qualified in specialty (QIS) staff with education and training commissioned by Health Education England. • A recruitment incentive to attract experienced Neonatal Unit staff at band 6. • The international recruitment team are attempting to attract overseas nurses with neonatal experience to support between non-QIS and QIS trained staff, with a view to putting them all onto the QIS programme. • Seven staff successfully completed the QIS course in 2021. There are 8 staff on the current QIS course and plan to increase this to 10 on the next course at the end of 2022. • Continue to utilise NHS Professional bank staff to supplement current vacancies.
Implications: (Clinical, Organisational, Governance, Legal?)	The National safety focus on all maternity services at all levels continues to drive significant safety improvements. Consequences for not meeting safety recommendations and actions clearly have cultural and leadership implications and less positive impact on outcomes for families. The Maternity Incentive Scheme (MIS) Year 4 was relaunched on 6 May 2022 drives the safety agenda but also creates further significant financial implications for Trusts. There are well established governance frameworks within the Maternity Service, Trust and the Local Maternity and Neonatal System (LMNS). These are vital to maintain safety as gaps in systems and processes make services less safe and affect the experience of the families who use our services.
Risks: (Top 3) of carrying out the change / or not:	The risk implications for the UHS Trust and Maternity Services sit within several frameworks including:

	• **Reputational** – Safety concerns can be raised by the public to both NHS Resolution and the CQC. The CQC can undertake reviews of services who they believe have safety concerns. • **Financial** – Full compliance with the 10 safety actions defined in MIS Year 4 by NHS Resolution is an expectation for full inclusion in the scheme. • **Governance** – Safety concerns can be escalated to the Care Quality Commission for their consideration and to NHS England, the NHS Improvement Regional Director, the Deputy Chief Midwifery Officer, the Regional Chief Midwife and DHSC for information. • **Safety** - Non-compliance with requirements or recommendations would have a detrimental impact on the women and their families leading to increased poor outcomes and staff wellbeing.
Summary: Conclusion and/or recommendation	The Maternity and Neonatal Services can confirm that the information provided in this report on the Ockenden report findings, Kirkup report Morecambe Bay findings and Maternity Workforce provides an overview of the safe practices within this service. Maternity and Neonatal Services have provided information on the recent reviews and, where appropriate, the improvement plans are in place to close the gaps in information or evidence. The Maternity and Neonatal Services continue to drive robust governance processes and frameworks and are prepared to reassess the service and any benchmarking to provide assurance that any gaps in the delivery of safety or quality care are reduced. There will be ongoing monitoring and review of action plans and updates on these reported to the Trust and externally, as required. Oversight will additionally be provided to the Maternity and Neonatal Safety Champions.

Appendix 1 – Ockenden Report Final Assessment Findings Dec 2021




Immediate and Essential Action 3: Staff Training and Working Together
100%
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40%
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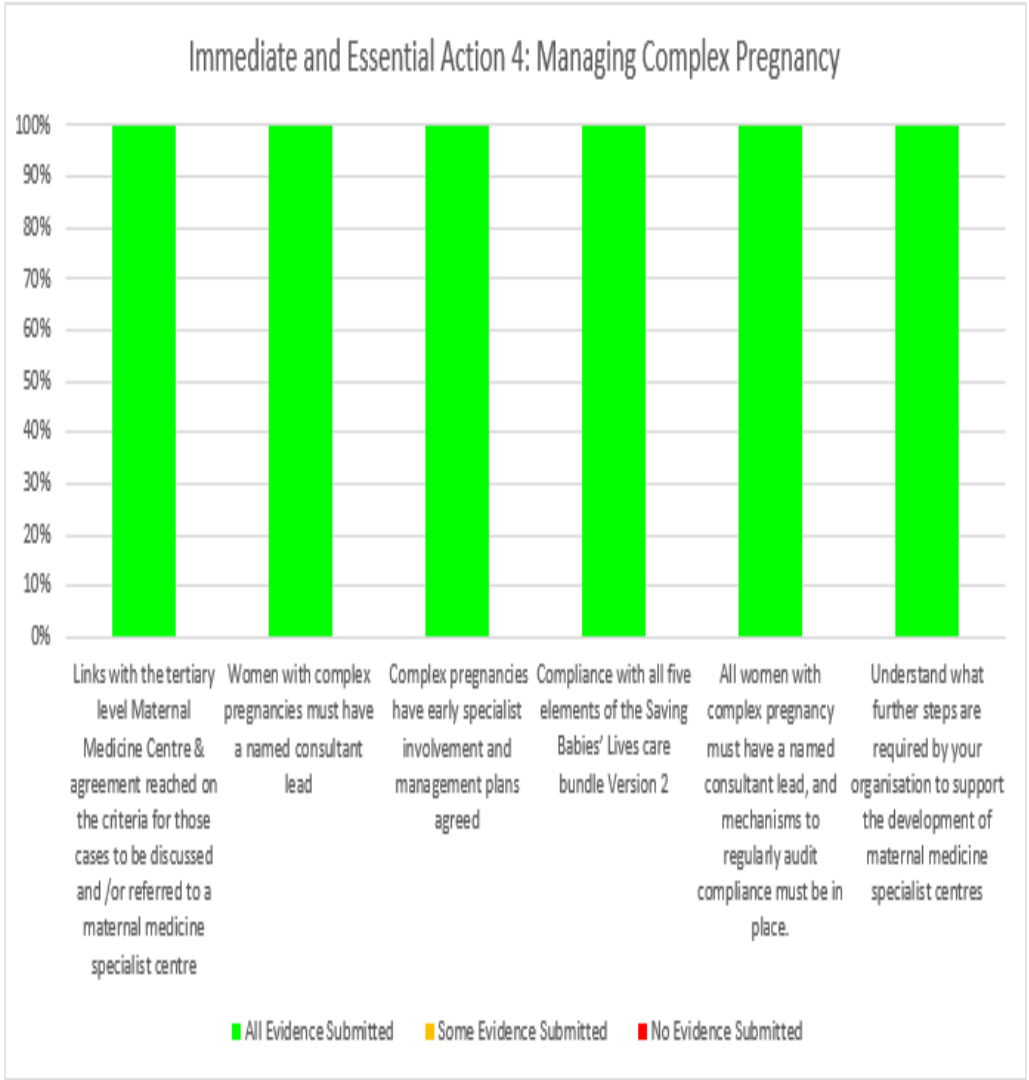
10%
0%
Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.
Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.
External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only
90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session
Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Immediate and Essential Action 4: Managing Complex Pregnancy
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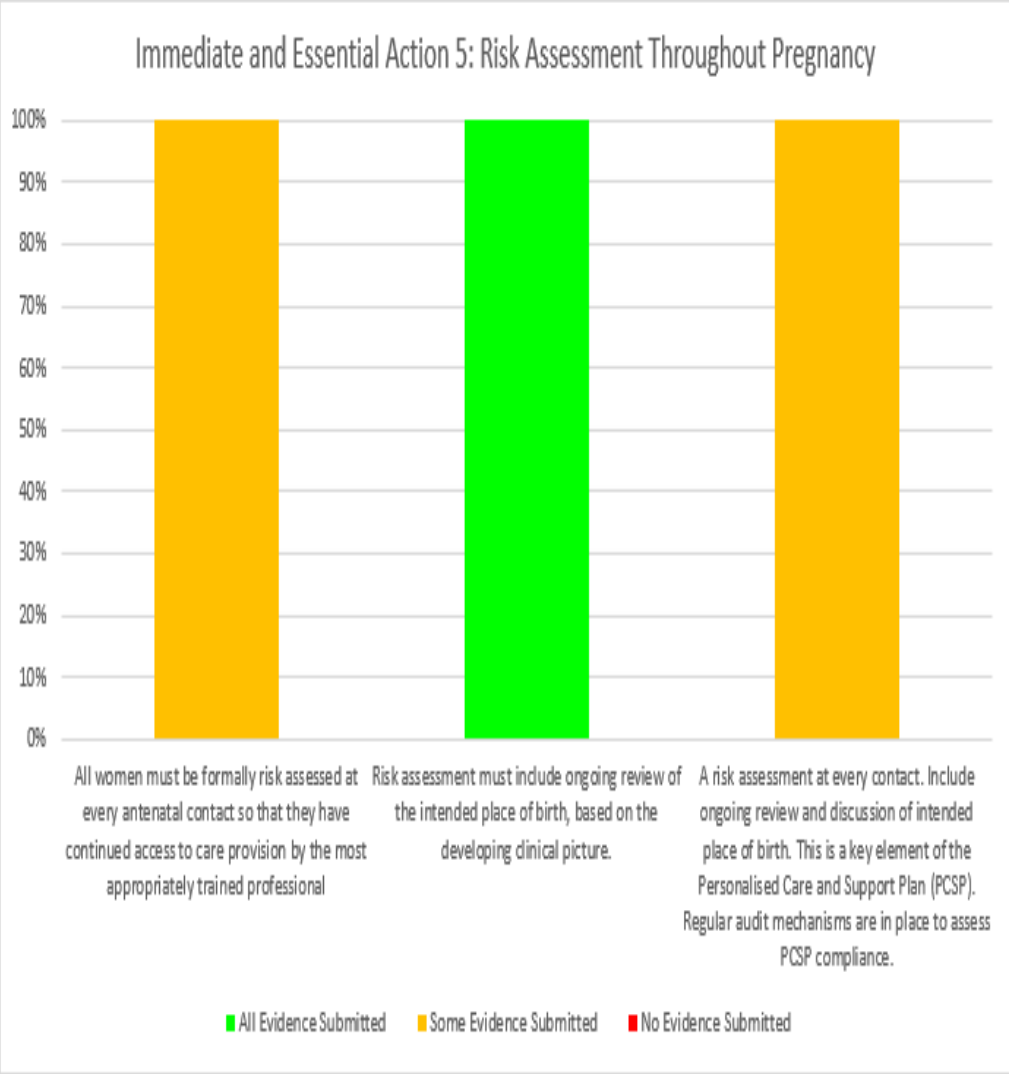
Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre
Women with complex pregnancies must have a named consultant lead
Complex pregnancies have early specialist involvement and management plans agreed
Compliance with all five elements of the Saving Babies' Lives care bundle Version 2
All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Immediate and Essential Action 5: Risk Assessment Throughout Pregnancy
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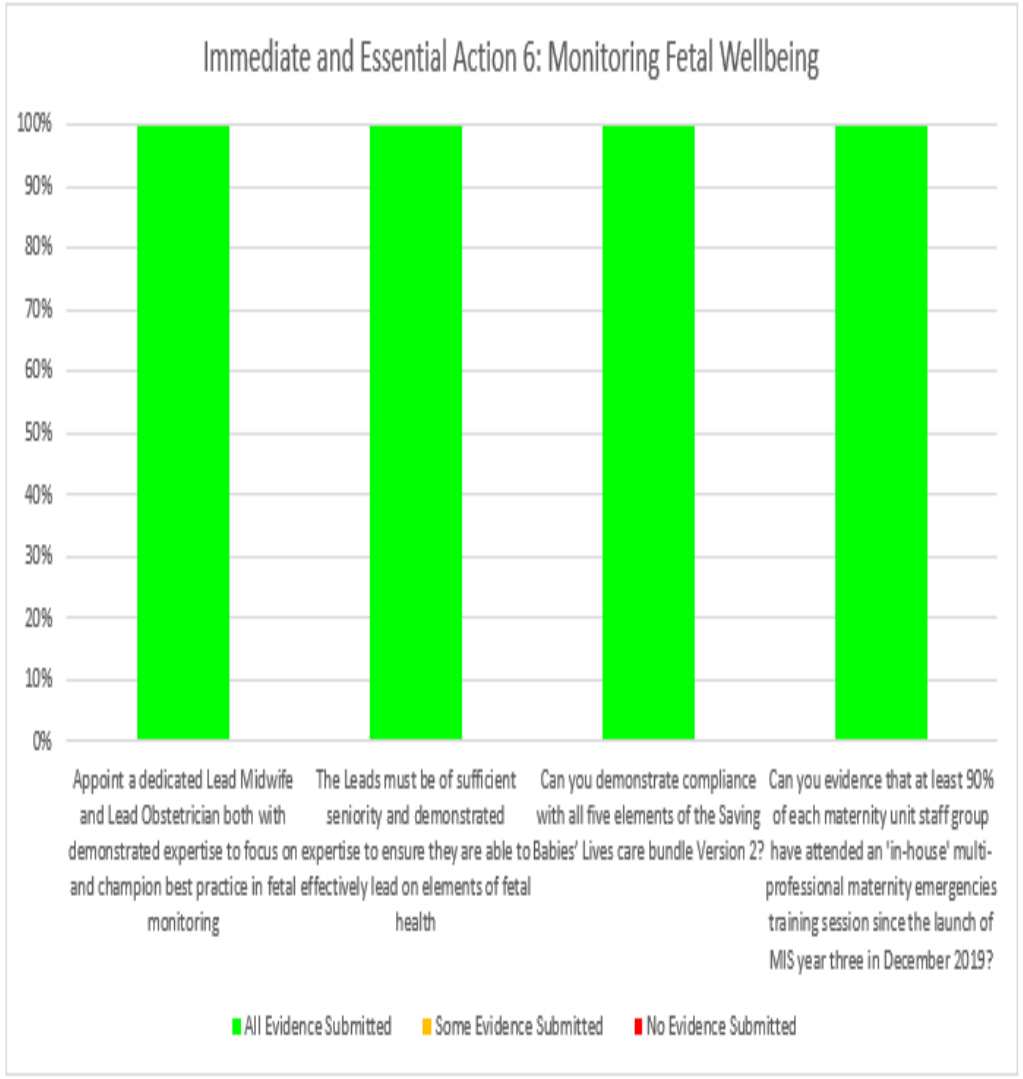
All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional
Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.
A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Immediate and Essential Action 6: Monitoring Fetal Wellbeing
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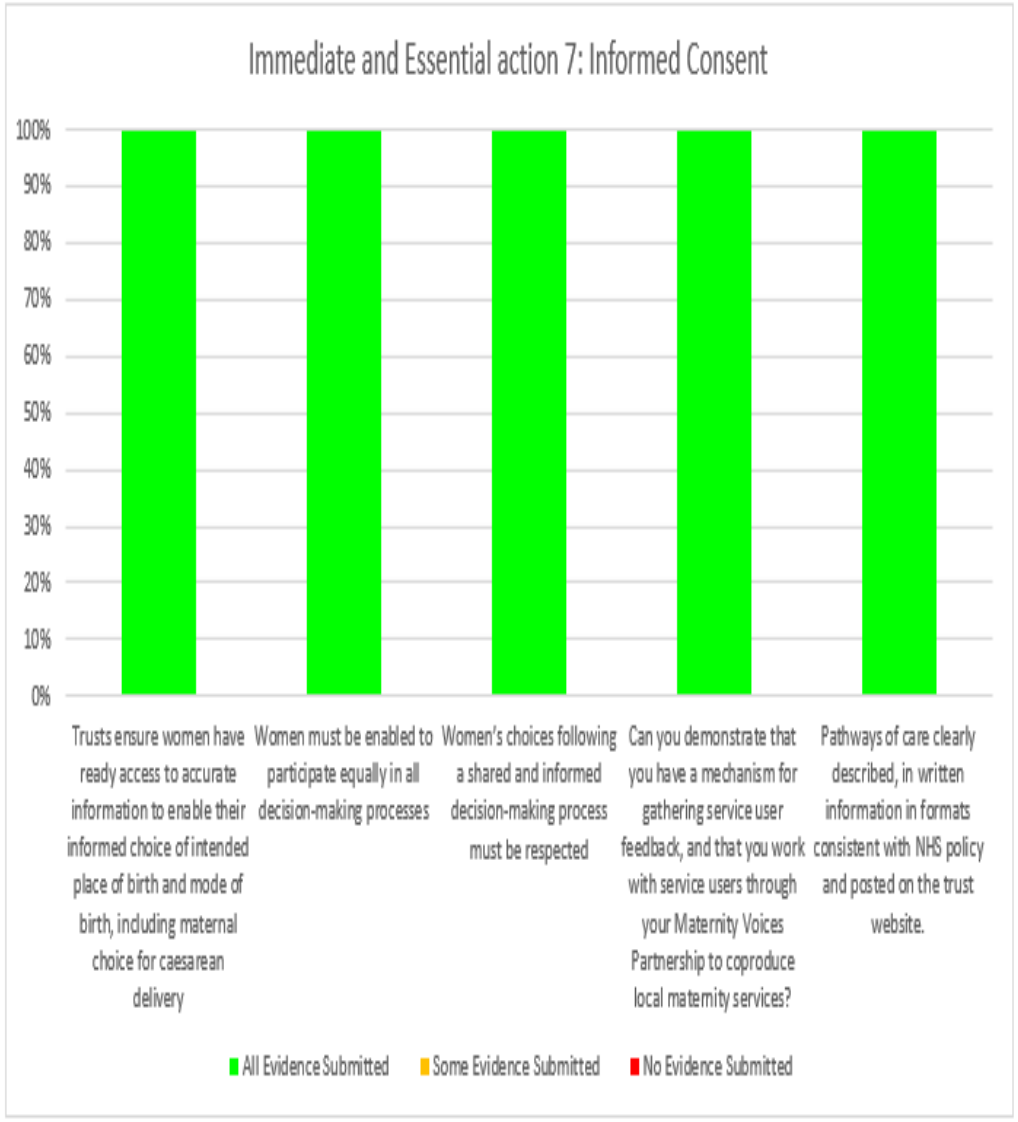
Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring
The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health
Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Immediate and Essential action 7: Informed Consent
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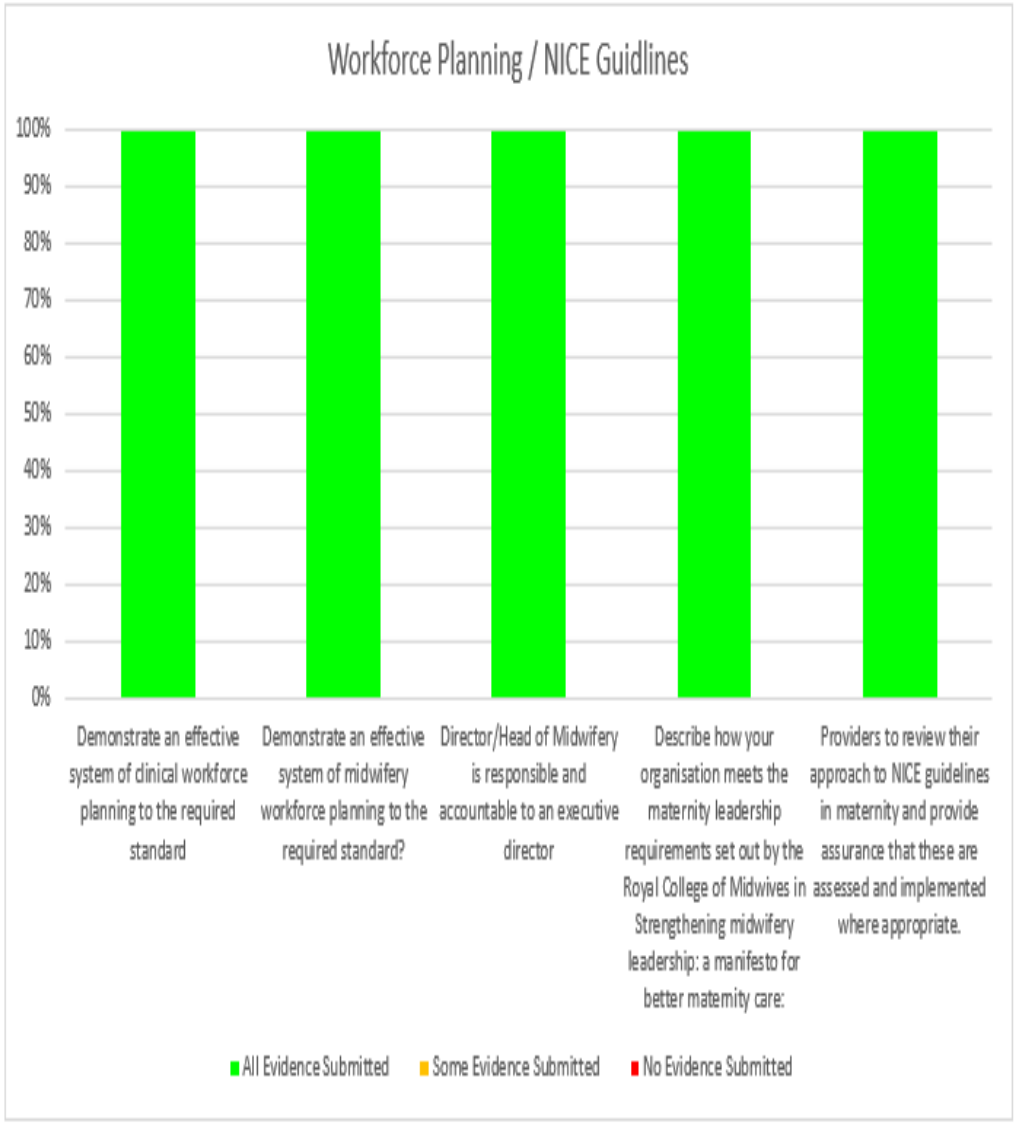
Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery
Women must be enabled to participate equally in all decision-making processes
Women's choices following a shared and informed decision-making process must be respected
Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Workforce Planning / NICE Guidlines
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Demonstrate an effective system of clinical workforce planning to the required standard
Demonstrate an effective system of midwifery workforce planning to the required standard?
Director/Head of Midwifery is responsible and accountable to an executive director
Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:
Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted

Appendix 1a - Action Plan for the Ockenden Report Findings December 2021

Recommendation complete	
Recommendation within timescale	
Recommendation outside of timescales	
Recommendation has additional actions to complete	

Recommendation	Assurance	Action point	Actions to address	Action owner	Review Date	Status
IEA5 (Q30) – All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional.	There are criteria for the birthing environments to ensure women who arrive in labour are birthing in the appropriate place. There are escalation systems and process in place for women who are risk assessment changes once in a birthing environment to ensure good communication between the intrapartum environments.	To ensure that the intended place of birth is risk assessed at every visit to the maternity service.	To discuss options for recording risk assessments within the BadgerNet system.	Consultant midwives and Digital team	30th April 2022	
IEA5 (Q33) – A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	As above	That there are regular audits in place ensure that the intended place of birth is risk assessed at every visit to the maternity service.	Audits to be undertaken regularly by the audit midwife and on the audit plan.	Audit Midwife	30th June 2022	

Appendix 2 – Kirkup Report - Morecambe Bay Review February 2022

Advisory notes:

- The template is to support you to benchmark where maternity services are now regarding the Morecambe Bay recommendations in the Kirkup Report 2015.
- If the evidence is within your Ockenden report 2020 action plans you could choose to embed and reference where it is in the document.
- Please amend the examples of evidence column to meet compliance for UHS maternity services.
- The wording of the recommendations is not the same as in the actual report. This is because the recommendations were extremely lengthy, and we have summarised what the ask was.

Recommendations for the University Hospitals of Morecambe Bay NHS Foundation Trust for other Trusts to benchmark against.	**Linked to further reviews/regulation**	**Examples of evidence (not limited to)**	**Embedded Compliance Red none Amber partially Green fully**	**Actions to be embed compliance fully** **See Appendix 2a for action plan**
1. Is an apology given to those affected, for the avoidable damage caused and any previous failures to act.	Duty of Candour legislation regulation 20 CQC Safe Domain	Duty of Candour Policy Meeting timeframes Exception reports and escalation	G	No further action required
2. Review the skills, knowledge, competencies, and professional duties of care of all obstetric, paediatric, midwifery and neonatal staff, and agency, locums caring for the critically ill in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies.	MIS SA8 Ockenden IEA 3 CQC Effective Domain	Mandatory Training Compliance is 90% for all groups HDU level 2 training Induction guidelines for all staff Role specific Training Needs Analysis for Midwives Trainees have Wessex ARCP or equivalent	G	MIS and Ockenden requirements met. At time of submission all aspects of MIS Safety Action 8 were in place.
3. Identify opportunities to broaden staff experience in other units, including by	MIS SA8 CQC Well Led Domain	Preceptorship Programme Number of staff currently on secondment	G	MIS and Ockenden requirements met.

Recommendations for the University Hospitals of Morecambe Bay NHS Foundation Trust for other Trusts to benchmark against.	Linked to further reviews/regulation	Examples of evidence (not limited to)	Embedded Compliance Red none Amber partially Green fully	Actions to be embed compliance fully See Appendix 2a for action plan
secondment and by supernumerary practice.	Ockenden IEA 3	Induction Programme Individual action plans in line with HR policy Maternity Academy Director of Midwifery /Heads of Midwifery programmes Secondment opportunities		No further action required. .
4. Continuing professional development of staff and link this explicitly with professional requirements including revalidation.	MIS SA 8 Ockenden IEA 3 CQC Safe Domain	All staff met revalidation requirements Appraisals Training Needs Analysis Professional Midwifery Advocate support Revalidation processes and systems Trainees have Wessex ARCP or equivalent	A	MIS and Ockenden requirements met. Further actions - Action plan Appendix 2a
5. Promote effective Multi-Disciplinary Team working, joint training sessions.	MIS SA 8 Ockenden IEA 3 CQC Effective Domain	Multi-Disciplinary Team Mandatory Training CTG training Live Skills & Drills training	G	MIS and Ockenden requirements met. No further action required.
6. Protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of high or low risk care.	Ockenden IEA 5 CQC Safe Domain	Clinical risk assessment guidelines in date Audits Self-Referral system for women Wessex Antenatal Pathways Labour Line Triage The regional MDT faculty for Human factors via maternity academy	G	MIS and Ockenden requirements met. No further action required. See Ockenden Appendix 1 & 1a

Recommendations for the University Hospitals of Morecambe Bay NHS Foundation Trust for other Trusts to benchmark against.	**Linked to further reviews/regulation**	**Examples of evidence (not limited to)**	**Embedded Compliance Red none Amber partially Green fully**	**Actions to be embed compliance fully** **See Appendix 2a for action plan**
7. Audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols.	MIS SA 6 Ockenden IEA 5 CQC Effective Domain	Clinical risk assessment guidelines in date Audit of case notes	G	MIS and Ockenden requirements met. No further action required.
8. Identify a recruitment and retention strategy achieving a balanced and sustainable workforce with the requisite skills and experience.	MIS SA 4 & 5 Ockenden IEA Workforce CQC Safe Domain	Internal policy Regional task and finish groups Birth Rate Plus assessments and evidence to agree funding Board reviews 6 monthly of midwifery and clinical work force Ongoing workforce challenges HR report including return to work policy and procedure	G	MIS and Ockenden requirements met.
9. Joint working between its main hospital sites, including the development and operation of common policies, systems and standards.	MIS SA 9 Ockenden IEA 1 & NICE CQC Effective Domain	Joint Local Maternity & Neonatal System (LMNS) policies/guidelines/projects Perinatal Quality Surveillance Framework embedded June 2021 Evidence of cross site governance processes and procedures where applicable Wessex antenatal pathways Labour Line Governance frameworks BadgerNet IT systems across the Trust	G	MIS and Ockenden requirements met. No further action required. Joint LMNS sharing in place.
10. Forge links with a partner Trust, to	MIS SA 8	Regional Practice Development forum	G	MIS and Ockenden

Recommendations for the University Hospitals of Morecambe Bay NHS Foundation Trust for other Trusts to benchmark against.	Linked to further reviews/regulation	Examples of evidence (not limited to)	Embedded Compliance Red none Amber partially Green fully	Actions to be embed compliance fully See Appendix 2a for action plan
benefit from opportunities for learning, mentoring, secondment, staff development and sharing.	Ockenden IEA 1 & 4 CQC Well Led Domain	Regional PMA forum Lead midwife educator meetings LMNS buddy SOP External review of Serious Incidents' (SI) and Perinatal Mortality Review Tool (PMRT) MatNeoSIP SHIP LMS Perinatal Quality & Safety Forum Wessex Maternal & Neonatal Safety Network Maternity Academy Child Death review group Wessex Practice Education Group Wessex Intrapartum group Labour Line		requirements met. Further actions - Action plan Appendix 2a
11. Staff awareness of incident reporting, review its policy of openness and honesty. Duty of Candour compliance.	MIS SA 8 Ockenden IEA 2 & 9 CQC Safe Domain	Mandatory training, Ward to board round (Non-Executive Director Safety Champion) Safety Champions meetings ward to Board rounds Co-production notice boards MQuEST meetings Newsletters Theme of the week	A	MIS and Ockenden requirements met. Further actions - Action plan Appendix 2a
12. Review the structures, processes and staff involved in investigating incidents, Root Cause Analysis, learning, training.	MIS SA 3 Ockenden IEA 1 CQC Safe Domain	Maternity Risk Management strategy in date Psychological support for staff – debriefs	G	MIS and Ockenden requirements met.

Recommendations for the University Hospitals of Morecambe Bay NHS Foundation Trust for other Trusts to benchmark against.	**Linked to further reviews/regulation**	**Examples of evidence (not limited to)**	**Embedded Compliance Red none Amber partially Green fully**	**Actions to be embed compliance fully** **See Appendix 2a for action plan**
Include arrangements for staff debriefing and support following a serious incident.		sessions PMA support RCA training After Action Reviews Psychological first aid and de-briefs Lessons learnt shared at handovers, newsletter, notice boards, email, closed media forums		No further action required.
13. Review the structures, processes and staff involved in responding to complaints, and learning are the public involved.	MIS SA 1 & 7 Ockenden IEA 2 CQC Effective Domain	Complaint's policy in date PALS Birth reflections service You said we did responses Maternity Voices Partnership (MVP) involvement *All PMRT cases, SI's and Healthcare Safety Investigation Branch (HSIB) reports reflect the family's voice/feedback*	G	MIS and Ockenden requirements met. No further action required.
14. Review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support.	MIS SA 8 Ockenden IEA 3 & Workforce CQC Safe Domain	Mandatory Training compliance 90% Workforce Board Papers midwifery and clinical staff RCM leadership requirements RCOG workforce issues/role-responsibilities guidance Evidence of Leadership development programme and succession planning for Clinicians New starter skills assessment Confirmation of training compliance	G	MIS and Ockenden requirements met. No further action required.

Recommendations for the University Hospitals of Morecambe Bay NHS Foundation Trust for other Trusts to benchmark against.	Linked to further reviews/regulation	Examples of evidence (not limited to)	Embedded Compliance Red none Amber partially Green fully	Actions to be embed compliance fully See Appendix 2a for action plan
		Development opportunities Consultant Midwife training Advanced clinical practice		
15. Review of governance systems clinical governance, so that the Board has adequate assurance of the quality of safe care.	Ockenden IEA 1 CQC Well Led Domain MIS 10 SA	Maternity Risk Management strategy in date Local & National Maternity Dashboard Risk Register in place with reporting Governance structure HoM/DoM presents directly to Board not sub-committees Highlight Reports Training programmes and compliance is validated locally and via the LMNS	G	MIS and Ockenden requirements met. No further action required.
16. Ensure middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and provide appropriate guidance and training.	MISSA 4,5 & 8 Ockenden IEA Workforce CQC Well Led Domain	Training Needs Analysis Appraisals Job Description include roles and responsibilities Non-Executive Director walk rounds engagement Senior Leadership Team visibility Safety Champions walk rounds engagement	G	MIS and Ockenden requirements met. No further action required.
17. Review access to theatres, and ability to observe and respond to all women in labour and ensuite facilities; arrangements for post-operative care of women.	MIS SA 9 Ockenden IEA 4 & 5 CQC Safe Domain	Access to 2nd theatre Recovery staff are trained, and competency assessed in line with national guidance Staff providing level 2 HDU care are	A	MIS and Ockenden requirements met. Further actions - Action plan Appendix 2a

Recommendations for the University Hospitals of Morecambe Bay NHS Foundation Trust for other Trusts to benchmark against.	Linked to further reviews/regulation	Examples of evidence (not limited to)	Embedded Compliance Red none Amber partially Green fully	Actions to be embed compliance fully See Appendix 2a for action plan
		trained, and competency assessed in line with national guidance LW coordinators supernumerary 1-1 care given in established labour Are there en-suite facilities On W&N Risk Register		
18. All above should involve CCG, and where necessary, the CQC and Monitor.	CCG assurance visits CQC regulation visits	Outcomes of visits CQC ratings Action plans Actions plans monitored governance floor to Board Feedback to staff	G	

Appendix 2a Action Plan for the Kirkup Report - Morecambe Bay February 2022 Review

Recommendation complete	
Recommendation within timescale	
Recommendation outside of timescales	
Recommendation has additional actions to complete	

Recommendation	Action point	Actions to address	Action owner	Review Date	2016 Status	2022 Status
4. Continuing professional development of staff and link this explicitly with professional requirements including revalidation.	Workforce strategy to be further developed to ensure individualised education and training programmes.	Further development of the Workforce strategy	Emma Northover and the Practice Education team	30th June 2022	G	
11. Staff awareness of incident reporting, review its policy of openness and honesty. Duty of Candour compliance.	To improve ward level awareness of incidents, claims and complaints and ensure these are addressed and information available to users of the service.	Improve information ward boards in clinical areas.	Maternity and Neonatal Matron team and ward leads	30th June 2022	G	
17. Review access to theatres, and ability to observe and respond to all women in labour and have en-suite facilities; arrangements for post-operative care of women.	Continued review of the availability of a second theatre.	For regular review or audit and continue the action plan as recorded on the Risk Register entry. Review of incidents reported through Adverse Event reporting.	Fiona Lawson Care Group Manager Sarah Walker Care Group Clinical lead Emma Northover	30th June 2022	G	

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Freedom to Speak Up Report**			
Agenda item:	**5.6**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Christine Mbabazi, Freedom to Speak Up Guardian**			
Date:	**26 May 2022**			
Purpose	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** ✓
Issue to be addressed:	To provide an update on the Freedom to Speak Up (FTSU) agenda and report on the number of cases received by the Trust.			
Response to the issue:	Trust Board is asked to: • Note the number of FTSU cases received to date. • Note the actions taken from the concerns raised.			
Implications: (Clinical, Organisational, Governance, Legal?)	1. Mechanism to support for the creation of a culture where staff feel safe and able to speak up about anything that gets in the way of delivering safe, high quality care or affects their experience in the workplace. This includes matters related to patient safety, the quality of care and cultures of bullying and harassment. 2. Compliance with the raising concerns policy for the NHS following the recommendations made by Sir Robert Francis after the enquiry into Mid Staffordshire NHS Foundation Trust. 3. Compliance with the Public Interest Disclosure Act 1998.			
Risks: (Top 3) of carrying out the change / or not:	1. Failure to keep improving services for patients and the working environment for staff. 2. Failure to support a culture based on safety, openness, honesty and learning. 3. Failure to comply with NHS requirements and best practice and commissioning contracts.			
Summary: Conclusion and/or recommendation	Trust Board is asked to note this report.			

1 Executive Summary

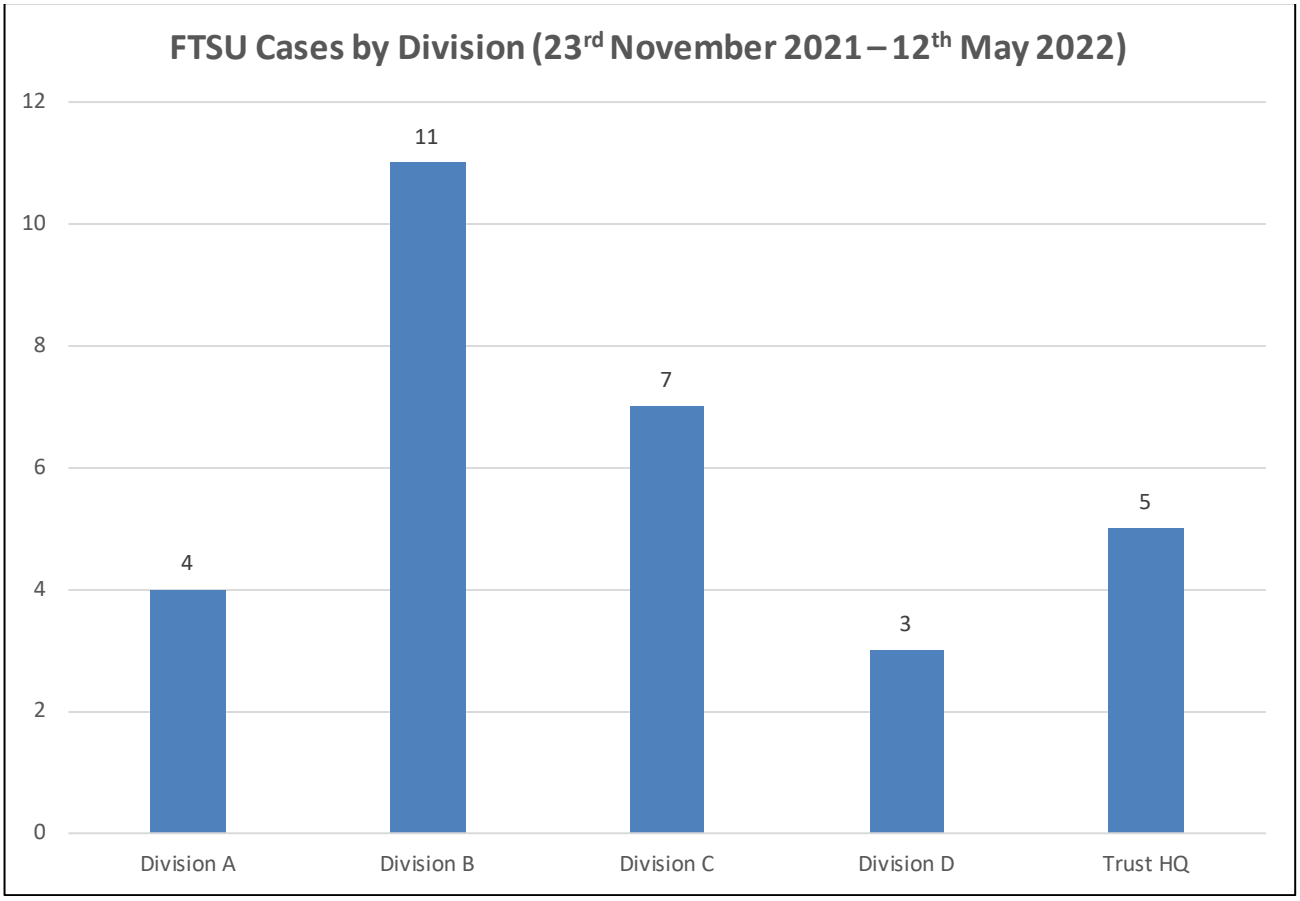
To provide an update following the last report written in November 2021 that presented the themes of concerns raised and the recruitment of FTSU champions. In November's report the Trust had received 87 cases from 27th May to 22nd November 2021 a slight increase on the previous year. The Trust has received 30 FTSU cases from 23rd November 2021 – 12th May 2022. A summary of the cases received in the period are detailed in this paper.

2 Purpose/Context/Introduction

The purpose of this report is to update Trust Board on the FTSU agenda, noting the cases raised to the FTSU champion in the Trust and the actions taken to resolve the concerns.

3. Case Update

The Trust has received 30 FTSU cases from 23rd November 2021 – 12th May 2022. A summary of the cases received in the period are detailed in the table below:



Category	Covid Concerns	Other	Total
Vaccination and redeployment	2	0	02
Bullying and Harassment	0	11	11
Team Dynamics	0	10	10
Patient safety	0	04	04
Other concerns	0	03	03
Total	2	28	30

It should be noted that, following guidance from NHS Improvement and the national FTSU office, a wide definition of what constitutes a 'FTSU case' is used by the Trust. Emphasis is placed on creating a culture of openness where staff feel able to raise any matter that they are concerned about, rather than whether it fits within a defined category of concern.

4. Themes, concerns raised and Actions that have been taken.

- **Vaccinations:** Concerns were raised by staff who had not been vaccinated and were to be redeployed, however in January after the Government's announcement ruling out compulsory covid vaccination, there was a significant decrease to concerns raised regarding vaccination.

  What has the organisation done regarding the above?

  The Trust communicated to all people redeployed due to vaccination status outlining the next steps to return them to their substantive roles, since this no concerns have been raised with the FTSU guardian regarding vaccinations.

- **Bullying and Harassment:** Bullying, harassing and discrimination cases remains the highest number of concerns received in any quarter in most Trusts. It is believed this is because people feel safe to raise concerns knowing that they can do so confidentially with the guardian, giving them the confidence to speak up if they believe they are experiencing bullying. HR is dealing with the concerns regarding bullying and harassing and in some cases culture reviews have been used. It is not clear whether the bullying is related to an exhausted, overworked workforce that is spread thinly with less patience or is it just people being unkind. Human resources review each individual case and using both formal and informal methods including mediation, look to find resolve to the concerns raised.

  What else is the Trust doing about this?

  Belonging is one of the key goals of our UHS people strategy. The Trust has teamed up with an outside consultancy called Steps to develop a programmed to explore how to create an inclusive culture within the Trust and how behaviours can impact the culture in the organisation and what to do about it. The training is called Stop. Start. Continue (Actionable Allyship).

  A number of UHS staff have been trained as facilitators to carry out the training throughout the organisation. The training focuses on bias and micro aggressions based on the following: race, gender, LGBTQ+, neurodiversity and nationality culture.

  Some departments have held listening events, working towards understanding diverse cultures and promoting inclusive and non–discriminatory behaviours.

  Provision of wellbeing support resources like psychological help and counselling is vital in these cases as bullying, harassment, victimisation, and discrimination in most cases affects people's mental wellbeing and day today living.

- **Team Dynamics** – Behavioural relationships between members of the team. This is sometimes due to individuals, teams under a lot of pressure, team alignment and conflict in teams. HR has been working to resolve these on a case-by-case basis. Depending on teams and the dynamics, training and away days have been provided including the above Actionable Allyship training.

5. Freedom to Speak Up Training and raising awareness campaign.

'Speak Up, Listen Up, Follow Up', a new e-learning package is aimed at anyone who works in healthcare. This is the new package from the National Guardian Office is FTSU training for all workers in the NHS/healthcare (Speak Up), all managers (Listen Up) and all Senior managers to(Follow Up)

https://nationalguardian.org.uk/2020/10/27/freedom-to-speak-up-training-for-all-workers-launched/

At UHS, this training is going to be available to all staff as a result of changes occurring in with Learning and Development team and how resources are made available to staff. A FTSU tile on VLE will enable staff to access this training.

We continue to raise awareness regarding Freedom to Speak Up to embed the culture of speaking up. Screen savers have been used across the organisation to promote FTSU, giving staff an alternative route to have their voices heard.

Following the publication of the Ockenden report FTSU have also been working with maternity services to ensure that this is championed and maternity staff have an opportunity to speak up if they have any concerns about the service.

6 Next Steps / Way Forward / Implications / Impact

The FTSU Guardian and Champion network will continue to encourage and support staff to speak up if they are concerned. The importance of doing this throughout the COVID period, to ensure patient and staff safety, has been noted at national level by the National Guardian Office and CQC.

5 Recommendation

Trust Board is asked to:

- Note the number of FTSU cases received to date.
- Note actions taken on specific cases as well as Trust wide work on concerns identified through FTSU.

Appendix A: Freedom to Speak Up Dashboard (November 2021 – May 2022)

Year	Qtr	Date Concern Raised	Department	Contact Method (Internal / External)	Trust Board Summary	Status
2021	Q3	25/11/2021	Division C	Internal	Team dynamics	Closed
2021	Q3	25/11/2021	Division C	Internal	Team dynamics	Closed
2021	Q3	29/11/2021	Division A	Internal	Bullying and harassment - Senior management	Closed
2021	Q3	02/12/2021	Division D	Internal	Team dynamics	Closed
2021	Q3	06/12/2021	Trust HQ	Internal	Team dynamics	In progress
2021	Q3	06/12/2021	Division C	Internal	Vaccination - team dynamics,bullying	Closed
2021	Q3	09/12/2021	Division B	Internal	Bullying, Harassment and discrimination	In progress
2021	Q3	10/12/2021	Division B	Internal	Bullying, harassment, career blocking of manager	In progress
2021	Q3	14/12/2021	Trust HQ	Internal	Conflict of interests	Closed
2022	Q4	06/01/2022	Trust HQ	Internal	Team Dynamics	Closed
2022	Q4	06/01/2022	Division D	Internal	Oncall rota gaps/patient safety issue	Closed
2022	Q4	13/01/2022	Division B	Internal	Team Dynamics	Closed
2022	Q4	18/01/2022	Division C	Internal	Bullying manager, career development blocking	In progress
2022	Q4	20/01/2022	Division B	Internal	Team Dynamics - microaggressions	Closed
2022	Q4	28/01/2022	Division C	Internal	Vaccination - team dynamics,bullying	Closed
2022	Q4	07/02/2022	Division B	Internal	Confidential information breached - Personal	In progress
2022	Q4	09/02/2022	Division A	Internal	Patient safety	Closed
2022	Q4	15/02/2022	Trust HQ	Internal	Bullying environment	Closed
2022	Q4	17/02/2022	Division B	Internal	Patient safety - Doctors and Patients	Closed
2022	Q4	23/02/2022	Division D	Internal	Bullying behaviour of manager	In progress
2022	Q4	18/03/2022	Division C	Internal	Unfair recruitment practices, favouritism, Senior management	Closed
2022	Q4	18/03/2022	Division C	external	Bullying and Harasssment of Serco staff connected to UHS staff	In progress
2022	Q1	04/04/2022	Division A	internal	Team dynamics	In progress
2022	Q1	05/04/2022	Trust HQ	Internal	Patient safety - Linet Eleganza Beds	In progress
2022	Q1	06/04/2022	Division A	Internal	Bullying and harassment	In progress
2022	Q1	11/04/2022	Division B	Internal	Bullying and mistreatment	Closed
2022	Q1	12/04/2022	Division B	Internal	Team Dynamics	In progress
2022	Q1	19/04/2022	Division B	Internal	Unfair recruitment,exclusion, Team dynamics and Discrimination	In progress
2022	Q1	06/05/2022	Division B	external	Bullying and Team dynamics	In progress
2022	Q1	10/05/2022	Division B	Internal	working conditions	In progress

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Integrated Performance Report 2022/23 Month 1**			
Agenda item:	**5.8**			
Sponsor:	**David French, Chief Executive Officer**			
Author	**Jason Teoh, Director of Data and Analytics**			
Date:	**26 May 2022**			
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.			

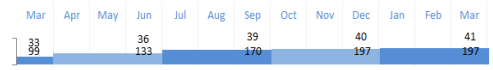
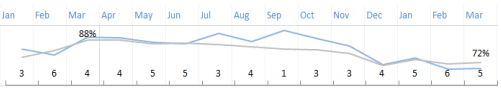
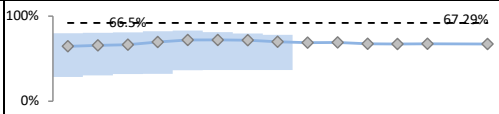
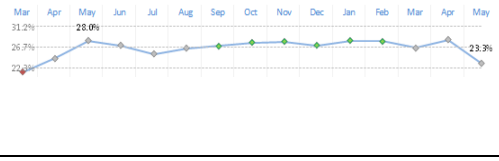
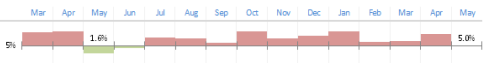
University Hospital Southampton NHS
NHS Foundation Trust

Integrated KPI Board Report

covering up to

April 2022

Author - Jason Teoh, Director of Data and Analytics

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

Introduction

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

The report aims to provide assurance:
• regarding the successful implementation of our strategy; and
• that the care we provide is safe, caring, effective, responsive, and well led.

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

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

This month there have been no material changes in the format of the report.

Minor changes have been made to titles in the People / Workforce sections to align these with the areas of focus set out in our People Strategy 2022-26.
• Workforce Capacity is now labelled as Thrive.
• Enjoy Working Here is now labelled as Excel.
• Compassion and Inclusion is now labelled as Belong.

Summary

This month the 'Spotlight' section features Referral to Treatment (RTT) waiting list and waiting times:
• This is a regular scheduled review of the RTT waiting list and waiting times, with the last Spotlight update having been provided in January 2022.
• The total waiting list size has been growing since the start of the calendar year due to higher referral volumes.
• The number of patients waiting over 52 weeks has been stable at approximately 2,000 patients.
• The number of patients waiting over 104 weeks saw significant reductions, and UHS ended the financial year with 59 patients who had waited over 104 weeks. Of these, 54 were due to patient choice, and there were mitigating factors for each of the remaining five patients.
• NHS England and NHS Improvement planning guidance has changed and requests that by July 2022 no patient should wait longer than two years (except for patient choice). We expect to meet this requirement.
• NHS England and NHS Improvement planning guidance also requests that there are no patient waits of over 78 weeks by March 2023. We aspire to meet this commitment but recognise that it is extremely challenging, and we are reviewing what further action we can take.

Areas of note in the appendix include:
1. A higher number of healthcare acquired (36) and probable hospital associated (35) COVID-19 infections continued into April 2022, aligned with the significantly increased rates of COVID-19 infection in the community, and the increased number of inpatients with COVID-19. There were several internal campaigns in April 2022 to remind staff of the continued importance of infection prevention which has helped to address this issue.
2. There were five severe or moderate medication errors recorded in April 2022 – the highest for several months. All moderate and severe cases are reviewed at the Medications Safety Meeting and no obvious themes were identified other than operational pressure.
3. There has been a spike in the number of Serious Incidents Requiring Investigation (SIRIs) reported in April 2022, with 22 raised. Of these, 20 were linked to reporting of cardiac harm reviews carried out over the last 4-6 months and collectively reported in April 2022 following agreement with commissioners.
4. The number of 'Red flag' staffing incidents recorded (24 in April 2022) has reduced and is back in line with the longer-term trend after the significant increase seen in March 2022.
5. Ongoing high volumes of attendances to the Emergency Department (ED) continue to apply pressure on our ability to meet the ED four-hour standard or to reduce the mean time in department.
6. Staff sickness rates remained high in April 2022 at 5%, of which between 2-3% was due to COVID-19. The twelve-month rolling average staff sickness absence rate is now 4.6% (target of 3.4%).
7. Performance against the 62-day cancer standard continued to improve slightly against the previous month, meaning UHS was ranked second out of 19 equivalent teaching hospitals.
8. The number of patients enrolled on My Medical Record continues to increase and has gone up by 60% over the last year.

Ambulance response time performance
In response to a request from NHS England and Improvement that all acute trust boards see the response time performance for their local ambulance services, we are working with South Central Ambulance Service NHS Foundation Trust (SCAS) to source this information to build into the report. The following information below is the latest information published by SCAS and relating to the Southampton, Hampshire, Isle of Wight, and Portsmouth area as a whole.

It should be noted that UHS does not significantly contribute to ambulance handover delays. In the week commencing 9 May 2022, our average handover time was 17 minutes across 719 emergency handovers, and 19 minutes across 47 urgent handovers.

National indicators

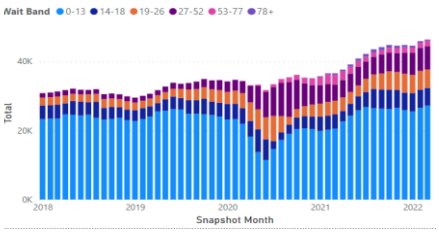
Performance Measure	Feb-22			Year to date			Full year		
	Actual	Plan	RAG	Actual	Plan	RAG	Forecast	Plan	RAG
Cat 1 Mean - 7 Minute Target	00:08:52	00:07:00	R	00:08:02	00:07:00	R	00:08:02	00:07:00	R
Cat 1 90th Percentile - 15 Minute Target	00:16:03	00:15:00	R	00:14:55	00:15:00	G	00:14:55	00:15:00	G
Cat 2 Mean - 18 Minute Target	00:30:42	00:18:00	R	00:25:44	00:18:00	R	00:25:44	00:18:00	R
Cat 2 90th Percentile - 40 Minute Target	01:02:49	00:40:00	R	00:52:20	00:40:00	R	00:52:20	00:40:00	R
Cat 3 90th Percentile - 2 Hours	04:50:46	02:00:00	R	03:50:36	02:00:00	R	03:50:36	02:00:00	R
Cat 4 90th Percentile - 3 Hours	06:03:48	03:00:00	R	04:55:20	03:00:00	R	04:55:20	03:00:00	R

Spotlight Subject - Referral to treatment (RTT) waiting times

The following information is based on the validated March 2022 submission.

Since the start of 2022 the overall RTT waiting list has again started to grow as a result of a recent increase in referrals. Between February and March 2022, the waiting list grew by around 460 patients to approximately 46.3k patients.
The impact of the COVID-19 pandemic in creating a backlog of patients continues; the waiting list is 27% higher compared to the previous year (March 2021), and 35% higher than the position prior to the pandemic (Jan 2020). Although activity has returned to pre-pandemic levels, the size of the waiting list remains sensitive to referral volumes.

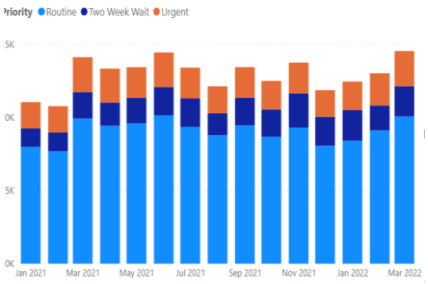
Graph 1: PTL by wait band



Referral volumes are now higher than pre-pandemic levels, with some growth expected through the rest of 2022 due to the "catch up" of delayed referrals from GPs through the pandemic. Referrals have increased by nearly 50% compared to January and February 2021 during the pandemic (graph 2). This has caused a corresponding increase in the volume of 0-18 week waiters (light and dark blue bars in graph 1) compared to 2018/19.

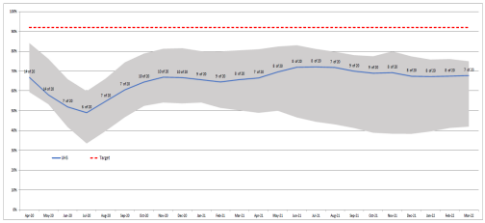
The mix of referrals have changed with a slightly higher proportion of Urgent and 2 Week Wait (2WW) referrals, which perhaps highlights more complex cases due to patients not seeing their GPs during the pandemic.

Graph 2: Referral volumes by priority

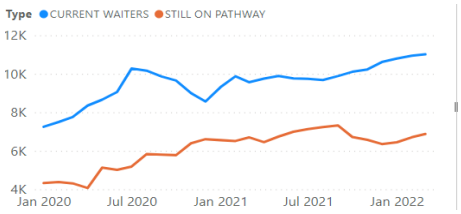


Referral management remains an important aspiration, and we continue to work with the local system, GPs and the wider Hampshire & Isle of Wight Integrated Care System to identify where we can safely reduce the number of patients being referred to UHS.

Graph 3: RTT 18 week performance comparison for Teaching Hospitals



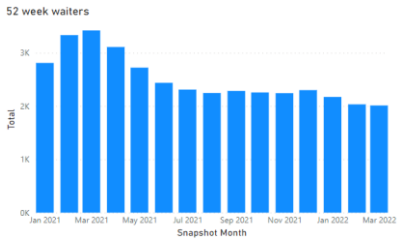
Graph 4: Waiting list for Current Waiters and Still on Pathway



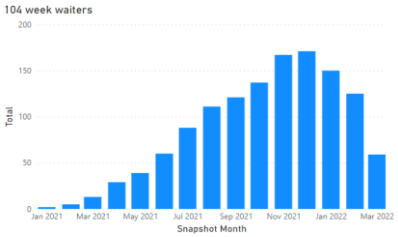
Looking specifically at the patients waiting for admission ('current waiters') in graph 4, this has grown through the pandemic, and stands at around 11k patients (24% of the waiting list). Proportionally, this is similar to pre-pandemic levels (where it was between 20-22%); however, it represents a significantly higher absolute number. We expect our theatre transformation programme to help generate additional capacity from the existing estate and footprint to help address the patients awaiting admission.

At the upper end of the waiting list, the 52+ week patients have stabilised at around 2k patients (graph 5). We are expecting to see some increases in this cohort as it is now one year on from a higher volume of referrals received in April - June 2021. However, through full financial year 2022/23 we expect to maintain this at broadly similar levels in line with the NHS England and Improvement requirement to maintain, or reduce, year long waits. Presently, 12% of the patients waiting 52 weeks or more are waiting for their first appointment, with the remainder on pathway or awaiting admission.

Graph 5: 52+ week waits



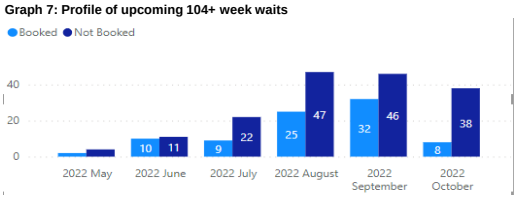
Graph 6: 104+ week waits



Throughout Q3 and Q4 of 2021/22 there were significant reductions in the number of patients waiting 104+ weeks. We ended the year with 59 patients who had waited more than two years (graph 6). However, of those, 54 were due to patient choice, and remaining five patients had mitigating circumstances for their long waits. This was a significant achievement given the risk profile that we had.

We have a clear view of the upcoming risk profile of patients (Graph 7), and are confident that we can achieve no aptients waiting more than two years (besides patient choice) by July 2022 and will work hard to maintain this position going forwards.

Graph 7: Profile of upcoming 104+ week waits



There remains a significant capacity challenge around the NHS England requirement to have no 78+ weeks by the end of March 2023. At the time of writing, there were over 370 patients who had waited more than 78 weeks. As we have now, broadly, addressed the 104 week waits, our operational teams are reviewing the options for this next cohort.

To address the waiting list, we have a number of interventions that we expect to deliver reductions in waiting patients through 2022/23.
(1) We are aiming to deliver 104% of the 2019/20 baseline, in line with the Elective Recovery Fund, and this will clearly help us to reduce the number of patients waiting for care (assuming a static referral rate). We have made a positive start, delivering 100% against baseline in April 2022 despite high levels of COVID-19 and significant operational challenges.
(2) We are running a theatre efficiency project, aiming to improve theatre utilisation, reduce cancellations, and treat more patients. In addition, the four additional theatres built last year (which are now fully running) will provide more capacity.
(3) Particularly during winter, significant numbers of patients are cancelled because of a lack of beds, largely driven by non-elective medical demand. Our patient flow project aims to reduce length of stay, improve earlier discharge and therefore create more beds for the elective surgical programme.
(4) We are texting the entire waiting list to revalidate their referrals - as well as to assess patient risk for the longest waiters. Historic trials of this have delivered a small reduction in the waiting list due to patients who no longer require treatment.
(5) The Outpatient Transformation programme, and in particular the Personalised Outpatient Programme, is expected to reduce follow up appointments, which enables capacity to potentially be used for first outpatient appointments.

In addition, we will continue to maximise use of the independent sector, where cost effective, to treat as many patients as possible. Our Transformation team also continues to use Getting It Right First Time (GIRFT) data to benchmark and to understand where we can drive further efficiencies to allow us to treat more patients.

For awareness, the following tables provide breakdowns of the current waiting list, for the top ten specialties in descending size order, divided between those patients in outpatient care and those waiting for admission. There have been no significant changes to the order of the top specialties over the last few months.

All waiters

Specialty	Referral and Still on Pathway	Waiting for Admission	Grand Total
130 - OPHTHALMOLOGY	4821	741	5562
502 - GYNAECOLOGY	2682	1224	3906
400 - NEUROLOGY	2848	39	2887
110 - TRAUMA AND ORTHOPAEDIC	782	1798	2580
101 - UROLOGY	1515	966	2481
330 - DERMATOLOGY	1559	880	2439
104 - COLORECTAL SURGERY	1386	380	1766
140 - ORAL SURGERY	1336	400	1736
214 - Paediatric Orthopaedics	1297	327	1624
340 - RESPIRATORY MEDICINE	1600	9	1609

78+ week waiters

Specialty	Referral and Still on Pathway	Waiting for Admission	Grand Total
120 - EAR NOSE & THROAT	11	79	90
110 - TRAUMA AND ORTHOPAEDIC	2	73	75
140 - ORAL SURGERY		31	31
104 - COLORECTAL SURGERY	2	27	29
502 - GYNAECOLOGY		21	21
150 - NEUROSURGERY	1	19	20
171 - PAEDIATRIC SURGERY		18	18
100 - GENERAL SURGERY	1	14	15
420 - PAEDIATRICS	10		10
105 - HEPATOBILARY & PANCREATIC SUR		9	9

NHS Constitution - Standards for Access to services within waiting times

The NHS Constitution* and the Handbook to the NHS Constitution** together set out a range of rights to which people are entitled, and pledges that the NHS is committed to achieve, including:

The right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible

- Start your consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions
- Be seen by a cancer specialist within a maximum of 2 weeks from GP referral for urgent referrals where cancer is suspected

The NHS pledges to provide convenient, easy access to services within the waiting times set out in the Handbook to the NHS Constitution

- All patients should receive high-quality care without any unnecessary delay
- Patients can expect to be treated at the right time and according to their clinical priority. Patients with urgent conditions, such as cancer, will be able to be seen and receive treatment more quickly

The handbook lists 11 of the government pledges on waiting times that are relevant to UHS services, such pledges are monitored within the organisation and by NHS commissioners and regulators.

Performance against the NHS rights, and a range of the pledges, is summarised below. Further information is available within the Appendix to this report.

* https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

** https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england

		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD
UT28-N	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	10 9	8 8	66.5% 7 7	8 8	9 8	9 8	9 7	10 9	10 9	10 8	9 8	8 8	6 8	5 8	66.4% 7	≥92%	
CN1-N	% Patients following a GP referral for suspected cancer seen by a specialist within 2 weeks (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	3 2	96.1% 9	12 5	13 13	16 11	15 13	16 14	16 14	17 14	17 9	14 10	16 7	12 5	13 4	13 90.6%	≥93%	
UT34-N	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	7 3	86.0% 1	3 1	11 4	13 6	15 7	16 7	13 2	12 4	15 5	13 3	13 4	11 4	12 72.3% 2		≥85%	-
UT25-N	Patients spending less than 4hrs in ED - SGH Main ED (Type 1 and UCH) Major Trauma Centres (Type 1) Rank of 8->	2	3	87.2% 3	3	3	3	3	1	3	2	2	3	3	3	67.5% 3	≥95%	-
UT33-N	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching Hospital average (& rank of 20) South East Average (& rank of 18)	12 17	9 16	27.2% 10 16	10 17	10 16	9 15	7 14	6 12	7 13	7 14	7 14	7 13	6 12	7 13	24.1%	≤1%	-

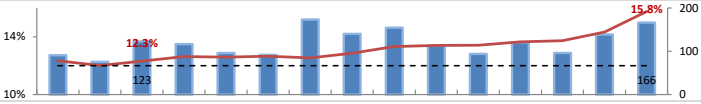
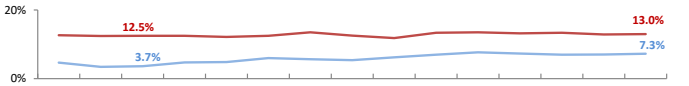
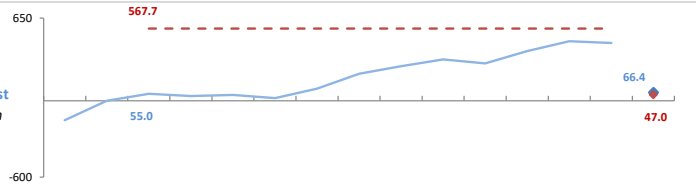
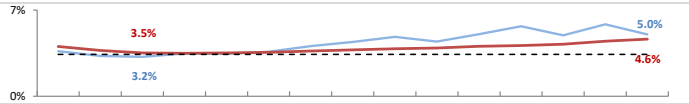
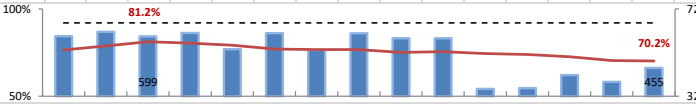
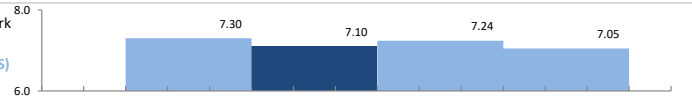
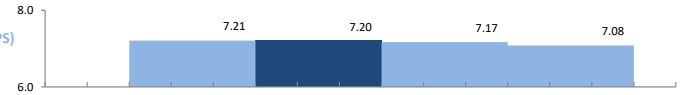
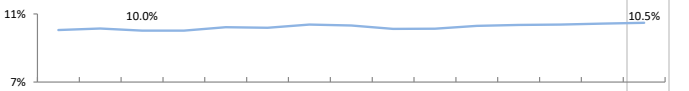
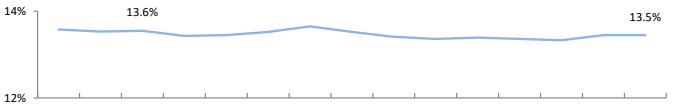
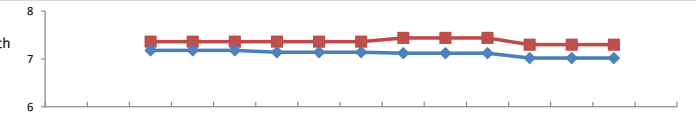
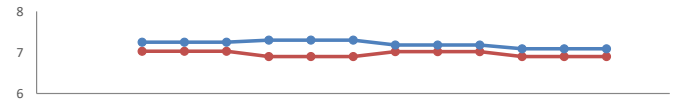
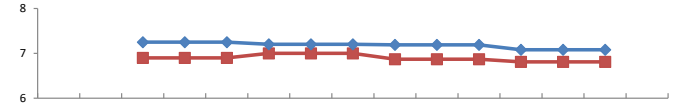
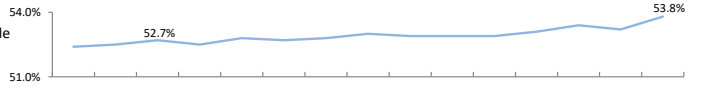
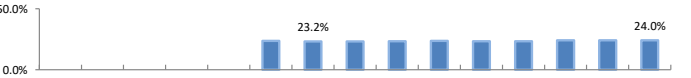
Outcomes		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
UT1-N	HSMR - **UHS** HSMR - **SGH**	81.7											81.1				≤100		
		81.1											79.8						
UT2	HSMR - Crude Mortality Rate	3.0%											2.7%				-		
UT3	Percentage non-elective readmissions within 28 days of discharge from hospital	12.9%											11.6%						
UT4-L	**Cumulative Specialties** with Outcome Measures Developed	57				61			63			63			63		+1		
		332				396			406			383			393				
UT5	Developed Outcomes RAG ratings	76%				80%			78%			77%			76%		-		

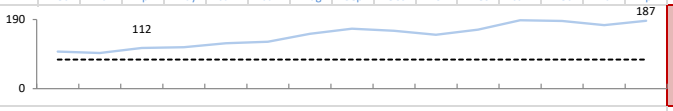
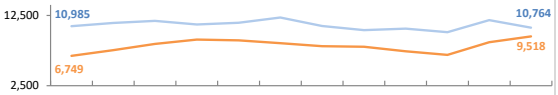
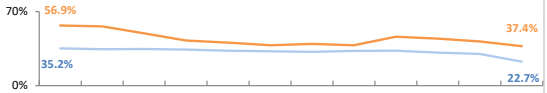
Safety		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
UT6-N	Cumulative Clostridium difficile Most recent 12 Months vs. Previous 12 Months	5	7	11	16	15	21	18	25	32	33	39	39	43	44	50	49	52	56	55	64	57	71	63	74	7	9	5	9	≤5
UT7	**Healthcare-acquired COVID infection**: COVID-positive sample taken >14days after admission (validated)	2	5	0	0	0	3	0	7	6	11	22	20	14	42	36	-	36	-
UT8	**Probable hospital-associated COVID infection**: COVID-positive sample taken >7 days and <=14 days after admission (validated)	2	2	1	0	0	0	4	3	9	11	14	18	11	32	35	-	35	-
UT9	Pressure ulcers category 2 per 1000 bed days	0.21														0.33	-	-	-
UT10	Pressure ulcers category 3 and above per 1000 bed days	0.35														0.33	-	-	-
UT11-N	Medication Errors (severe/oderate)	1														5	≤3	5	≤3
UT12	Antibiotic usage per 1000 admissions This year vs. last year	3,782														4,604	-	-	-
UT13	Serious Incidents Requiring Investigation (SIRI) (based upon month reported as SIRI, excluding Maternity)	5														22	-	22	-
UT14	Serious Incidents Requiring Investigation - Maternity															1	-	1	-
UT15	Number of high harm falls per 1000 bed days	0.09														0.16	-	-	-
UT16	% patients with a nutrition plan in place	94.9%															-	-	-
UT16 - monthly audit has been paused due to pressure on all ward areas, a re-start date is currently being considered (still on hold at 16/05/2022).																			
UT17	Red Flag staffing incidents	15														24	-	24	-

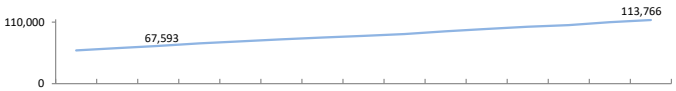
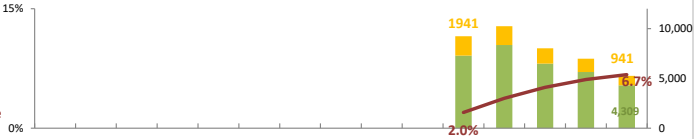
Patient Experience		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
UT18-N	FFT Negative Score - Inpatients			0.6%												0.5%	≤5%	-	-
UT19-N	FFT Negative Score - Maternity (postnatal ward)			6.6%												3.0%	≤5%	-	-
UT20	Total UHS women booked onto a continuity of carer pathway			41.5%												44.3%	-	-	-
UT21	Total BAME women booked onto a continuity of carer pathway			65.6%												83.3%	-	-	-
UT22	% Patients reporting being involved in decisions about care and treatment			85%												87%	≥90%	-	-
UT23	% Patients with a disability/ additional needs reporting those needs/adjustments were met (total number questioned included at chart base)			90.0%												91.0%	≥90%	-	-
				65	111	292	254	280	341	197	153	163	155	131	95	143	117			
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)			66												18	-	-	-

Access Standards		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
UT25-N	Patients spending less than 4hrs in ED - SGH Main ED (Type 1 and UCH) Major Trauma Centres (Type 1) Rank of 8->	87.2%														67.5%	≥95%	-	-
		2	3	3	3	3	3	3	1	3	2	2	3	3	3	3			
UT26	Average (Mean) time in Dept - non-admitted patients	02:38														03:31	-	-	-
UT27	Average (Mean) time in Dept - admitted patients	03:42														05:15	-	-	-
UT28-N	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	64.3%														66.4%	≥92%		
		10	8	7	8	9	9	9	10	10	10	9	8	6	5				
		9	8	7	8	8	8	7	9	9	8	8	8	8	7				
UT29	Total number of patients on a waiting list (18 week referral to treatment pathway)	37,613														48,458	-	-	-
UT30	Patients on an open 18 week pathway (waiting 52 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	3,108														2,171	-	-	-
		5	4	4	4	6	7	7	7	7	7	7	7	7	7				
		13	13	13	13	13	14	14	14	14	14	13	13	13	13				
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
UT31	Patients on an open 18 week pathway (waiting 104 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)															54	-	-	-
		12	9	8	8	8	8	8	6										
		16	16	16	17	16	16	16	16	16	16								
UT32	Patients waiting for diagnostics	9,561														10,916	-	-	-
UT33-N	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	27.2%														24.1%	≤1%	-	-
		12	9	10	10	9	7	6	7	7	7	7	6	7					
		17	10	16	17	16	15	14	12	13	14	14	13	12	13				
UT34-N	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	86.0%														72.3%	≥85%	-	-
		7	5	3	11	13	15	16	13	12	15	13	13	11	12				
		3	1	1	4	6	7	7	2	4	5	3	4	4	2				
UT35-N	31 day cancer wait performance - decision to treat to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	98.0%														88.7%	≥96%	-	-
		7	7	11	9	17	13	16	18	9	9	11	12	14	16				
		2	2	4	4	8	6	12	14	3	3	2	5	6	13				
UT36-N	31 day cancer wait performance - Subsequent Treatments of Cancer (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	97.1%														92.4%	≥95.3%		
		14	11	16	14	15	17	13	18	14	16	15	11	14	15				
		8	8	11	12	12	13	9	16	12	14	15	7	10	7				

R&D Performance		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
PN1-L	Comparative CRN Recruitment Performance - non-weighted		10	12	10	10	9	10	9	9	9	8	9	8	9	1	Top 10		
PN2-L	Comparative CRN Recruitment Performance - weighted		8	10	10	5	3	4	3	3	3	3	4	4	3	6	Top 5		
PN3-L	Comparative CRN Recruitment - contract commercial		2	14	8	12	11	4	4	3	7	7	8	9	10	2	Top 10		
PN4-L	Achievement compared to R+D Income Baseline Monthly income increase % YTD income increase %		46.0%	46.0%	-22.0%	152.0%	45.0%	143.0%	-5.0%	334.0%	0.0%	29.0%	-234.0%	143.0%	359.0%	63.0%	≥5%		
PN4-L	Note – Monthly and YTD Income are affected by a permanent change in accounting treatment implemented in M10 (Jan) 2021/22 in order to improve accuracy. Prior to M10, R+D open and ongoing studies/ grants in credit had anticipated future costs accrued. From M10 onwards, income received is deferred where costs have not yet been incurred/ invoiced. This change results in an adjustment of -£5m to monthly and YTD income which has been applied in M10. (An equivalent adjustment to the costs accounted for means that the balance of income and expenditure is not affected).																		

Thrive		Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr	Monthly target	YTD	YTD target
WR1-L	Substantive Staff - Turnover **-R12M turnover %** **-Leavers in month (FTE)**		R12M <= 12.0%		
WR2-L	Staff Vacancies **-Nursing vacancies** (registered nurses only in clinical wards) **-All Staff vacancies**				
WR3-L	Workforce Numbers (FTE) - Variation compared to end March 2022 **-Planned monthly growth in Staff in post** **-Actual monthly growth in Staff in post** *-new financial year and workforce plan* *-Including - Doctors in training.* -Excluding - Chilworth laboratory, Additional hours (medical staff), Bank and agency				
WR4-L	Staff - Sickness absence **-R12M sickness %** **-Sickness in month %**		R12M <= 3.4%		
Excel		Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr	Monthly target	YTD	YTD target
WR5-L	Non-medical appraisals completed **-R12M appraisal %** **-Appraisals in month**		R12M >= 92.0%		
WR6-L	Medical staff appraisals completed - Rolling 12-months				
WR7-L	Staff recommend UHS as a place to work score: National Quarterly Pulse Survey (NQPS) **National NHS Staff Survey**				
WR7-L - Metric has changed from The Friends and Family Test (%, Q4 2020) to the Pulse Survey (out of 10).					
WR8-L	Staff survey engagement score National Quarterly Pulse Survey (NQPS) **National NHS Staff Survey**				
WR8-L - Maximum score = 10, Average of "Acute and Acute&Community", group is 7					
Belong		Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr	Monthly target	YTD	YTD target
WR9-L	% of Band 7+ staff who are Black and Minority Ethnic		15% by 2023		
WR10	% of Band 7+ Staff who have declared a disability or long term health condition		-		
WR11	Staff recommending UHS as a place to work: White British staff compared with all other ethnic groups combined **-White British** **-All other ethnic groups combined**				
WR12	Staff recommending UHS as a place to work: Non disabled /prefer not to answer compared with Disabled **-Non disabled /prefer not to answer** **-Disabled**				
WR13	Staff recommending UHS as a place to work: Sexuality = Heterosexual compared with all other groups combined **-Sexuality = Heterosexual** **-all other groups combined**				
WR11, WR12,WR13: Average recommendation score of 10 = Highly recommend to 0 = Strongly not recommended, results from National Quarterly Pulse Survey					
FN6	Percentage of staff living locally (inside the Southampton City boundaries)				
FN7	Percentage of staff residing in deprived areas (lowest 30% - national Index of Multiple Deprivation)		-		

Local Integration		Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr	Monthly target	YTD	YTD target
NT1	Number of inpatients that were medically optimised for discharge (monthly average)		≤80	-	-
NT2	Emergency Department activity - type 1 This year vs. last year		-	10,764	-
NT3	Percentage of virtual appointments as a proportion of all outpatient consultations This year vs. last year		-	-	-

Digital		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
FN1	My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month)																-		
FN2	My Medical Record - UHS patient logins (number of logins made within each month)																-	23,015	
FN3	Patients choosing digital correspondence - Total choosing paperless in the month - Total offered but not yet choosing paperless in the month - % of total My Medical Record service users who have chosen paperless (cumulative)																-		
FN4	Reduction in transcription through implementation of voice recognition software	In development															-		

Report notes - Nursing and midwifery staffing hours - April 2022

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.

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. We now include both mothers and babies in our occupancy levels which will impact the care hours per patient day.

Throughout COVID-19, a growing number of our clinical areas started to move and change specialty and size to respond to the changing situation (e.g. G5-G9, Critical Care and C5). With the evolving COVID-19 position since April 2021 these wards had in the main returned to their normal size and purpose. Over the last few months COVID-19 numbers remained high so wards and departments have again been required to change focus and form to respond to changing circumstances - in April this included changing the focus of our Surgical Day Unit to support inpatient care. These decisions are sometimes swift in nature and the data in some cases therefore 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
CC Neuro Intensive Care Unit	Day	6168	3780	845	644	61.3%	76.3%	31.5	5.0	36.5	Beds flexed to match staffing; Safe staffing levels maintained by sharing staff resource.
CC Neuro Intensive Care Unit	Night	4948	3721	688	552	75.2%	80.2%				Beds flexed to match staffing; Safe staffing levels maintained by sharing staff resource.
CC - Surgical HDU	Day	2586	1784	831	531	69.0%	63.9%	15.3	4.4	19.7	Beds flexed to match staffing; Safe staffing levels maintained by sharing staff resource.
CC - Surgical HDU	Night	2068	1648	674	468	79.7%	69.4%				Beds flexed to match staffing; Safe staffing levels maintained by sharing staff resource.
CC General Intensive Care	Day	13059	9683	2083	1407	74.2%	67.5%	29.7	4.6	34.3	Beds flexed to match staffing; Safe staffing levels maintained by sharing staff resource.
CC General Intensive Care	Night	10248	8767	1704	1458	85.5%	85.5%				Beds flexed to match staffing; Safe staffing levels maintained by sharing staff resource.
CC Cardiac Intensive Care	Day	6838	5618	1588	901	82.1%	56.7%	27.7	3.9	31.6	Beds flexed to match staffing; Safe staffing levels maintained by sharing staff resource.
CC Cardiac Intensive Care	Night	5772	5670	850	692	98.2%	81.4%				Beds flexed to match staffing; Safe staffing levels maintained by sharing staff resource.
SUR E5 Lower GI	Day	1451	1114	653	1041	76.8%	159.3%	3.6	3.9	7.5	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
SUR E5 Lower GI	Night	690	678	345	875	98.3%	253.6%				Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
SUR E5 Upper GI	Day	1447	1256	980	812	86.8%	82.9%	3.7	2.4	6.2	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
SUR E5 Upper GI	Night	679	684	345	462	100.7%	133.7%				Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
SUR E8 Ward	Day	2560	2071	1399	1192	80.9%	85.2%	4.5	3.0	7.5	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
SUR E8 Ward	Night	1657	1187	1193	1013	71.6%	84.9%				Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
SUR F11 IF	Day	1920	1452	735	755	75.6%	102.7%	4.3	2.7	7.0	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
SUR F11 IF	Night	689	691	690	621	100.3%	90.0%				Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
SUR Acute Surgical Unit	Day	1430	1029	709	707	72.0%	99.7%	7.7	4.6	12.4	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
SUR Acute Surgical Unit	Night	690	703	679	333	101.8%	49.1%				Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
SUR Acute Surgical Admissions	Day	2093	1926	873	784	92.0%	89.8%	3.8	2.3	6.1	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.

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SUR Acute Surgical Admissions	Night	989	966	1029	1009	97.7%	98.1%				Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
SUR F5 Ward	Day	1824	1711	1025	921	93.8%	89.8%	3.8	2.2	5.9	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
SUR F5 Ward	Night	1130	1071	671	671	94.8%	100.0%				Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
OPH Eye Short Stay Unit	Day	984	1096	830	575	111.4%	69.3%	14.1	9.0	23.1	Safe staffing levels maintained.
OPH Eye Short Stay Unit	Night	330	330	330	331	100.0%	100.3%				Safe staffing levels maintained.
THR F10 Surgical Day Unit	Day	3255	1223	4378	1879	37.6%	42.9%	3.7	4.6	8.3	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Non-ward based staff supporting areas; day unit being used for inpatients of varying numbers between 6 and 24 throughout the month.
THR F10 Surgical Day Unit	Night	1036	568	1067	363	54.8%	34.0%				Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Non-ward based staff supporting areas.
CAN Acute Onc Services	Day	1000	1039	613	668	103.9%	108.9%	11.9	8.2	20.1	Increase in acuity/dependency of patients in the month.
CAN Acute Onc Services	Night	345	638	345	483	184.9%	140.0%				Increased night staffing to support raised acuity.
CAN C4 Solent Ward Clinical Oncology	Day	1309	1567	1008	1172	119.7%	116.3%	4.5	3.8	8.4	Increase in acuity/dependency of patients in the month.
CAN C4 Solent Ward Clinical Oncology	Night	1024	974	690	980	95.2%	142.0%				Additional staff used for enhanced care - Support workers.
CAN C6 Leukaemia/BMT Unit	Day	2739	2480	349	427	90.5%	122.4%	7.6	1.2	8.9	Increase in acuity/dependency of patients in the month.
CAN C6 Leukaemia/BMT Unit	Night	1984	1898	0	289	95.7%	Shift N/A				Safe staffing levels maintained.
CAN C6 TYA Unit	Day	1169	992	448	98	84.9%	21.8%	11.0	0.7	11.6	Safe staffing levels maintained.
CAN C6 TYA Unit	Night	639	642	0	0	100.5%	Shift N/A				Safe staffing levels maintained.
CAN C2 Haematology	Day	2245	2392	1099	938	106.6%	85.4%	5.9	2.7	8.7	Increase in acuity/dependency of patients in the month.
CAN C2 Haematology	Night	1725	1955	1034	1064	113.3%	102.9%				Increase in acuity/dependency of patients in the month.
CAN D3 Ward	Day	1735	1736	800	1095	100.0%	137.0%	4.7	3.4	8.1	Additional staff used for enhanced care - Support workers.
CAN D3 Ward	Night	1028	1138	690	935	110.7%	135.5%				Additional staff used for enhanced care - Support workers.
ECM Acute Medical Unit	Day	3874	4148	3902	3484	107.1%	89.3%	6.2	5.1	11.3	Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource; Figures still contain additional point-of-care activity and Clinical Coordination.
ECM Acute Medical Unit	Night	3945	4357	3414	3599	110.4%	105.4%				Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource; Figures still contain additional point-of-care activity and Clinical Coordination.
MED D5 Ward	Day	1227	1468	1692	1081	119.7%	63.9%	3.2	2.4	5.6	Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource.
MED D5 Ward	Night	1035	985	903	803	95.2%	89.0%				Safe staffing levels maintained by sharing staff resource.
MED D6 Ward	Day	1070	1140	1450	1361	106.5%	93.9%	3.4	4.0	7.5	Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
MED D6 Ward	Night	1018	1034	923	1176	101.6%	127.5%				Safe staffing levels maintained by sharing staff resource.
MED D7 Ward	Day	691	671	1156	955	97.1%	82.6%	2.9	2.8	5.7	Safe staffing levels maintained; Supervisory Ward Leader working clinically to support RN deficit.
MED D7 Ward	Night	690	656	345	300	95.0%	86.9%				Safe staffing levels maintained; Supervisory Ward Leader working clinically to support RN deficit.
MED D8 Ward	Day	1072	1021	1414	1328	95.2%	94.0%	3.1	3.4	6.5	Safe staffing levels maintained; Supervisory Ward Leader working clinically to support RN deficit.
MED D8 Ward	Night	1035	955	923	837	92.2%	90.7%				Safe staffing levels maintained; Supervisory Ward Leader working clinically to support RN deficit.
MED D9 Ward	Day	1242	1321	1670	1393	106.3%	83.4%	2.8	2.8	5.6	Increase in acuity/dependency of patients in the month; Safe staffing levels maintained; Supervisory Ward Leader working clinically to support RN deficit.

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MED D9 Ward	Night	1036	890	918	833	85.9%	90.8%				Safe staffing levels maintained; Supervisory Ward Leader working clinically to support RN deficit.
MED E7 Ward	Day	1021	1187	1253	1523	116.3%	121.6%	3.1	3.8	6.9	Increase in acuity/dependency of patients in the month; Safe staffing levels maintained; Supervisory Ward Leader working clinically to support RN deficit; Increase in beds from 20 to 26.
MED E7 Ward	Night	621	978	759	1174	157.4%	154.6%				Increase in acuity/dependency of patients in the month; Safe staffing levels maintained; Supervisory Ward Leader working clinically to support RN deficit; Increase in beds from 20 to 26.
MED F7 Ward	Day	812	864	1375	1441	106.4%	104.8%	2.9	3.8	6.7	Safe staffing levels maintained; Supervisory Ward Leader working clinically to support RN deficit.
MED F7 Ward	Night	690	701	679	571	101.6%	84.1%				Safe staffing levels maintained; Supervisory Ward Leader working clinically to support RN deficit.
MED Respiratory HDU	Day	2260	1363	521	207	60.3%	39.7%	14.5	2.3	16.8	Beds flexed to match staffing; Safe staffing levels maintained by sharing staff resource; Staffed to acuity levels.
MED Respiratory HDU	Night	2071	1404	345	231	67.8%	66.8%				Beds flexed to match staffing; Safe staffing levels maintained by sharing staff resource; Staffed to acuity levels.
MED C5 Isolation Ward	Day	1128	1011	1069	424	89.7%	39.6%	6.2	2.4	8.6	Safe staffing levels maintained; Staffed to acuity levels.
MED C5 Isolation Ward	Night	1039	987	334	346	94.9%	103.7%				Safe staffing levels maintained; Staffed to acuity levels.
MED D10 Isolation Unit	Day	1059	999	1258	1156	94.3%	91.9%	3.9	3.6	7.5	Safe staffing levels maintained; Supervisory Ward Leader working clinically to support RN deficit.
MED D10 Isolation Unit	Night	689	1032	690	704	149.9%	102.0%				Safe staffing levels maintained; Supervisory Ward Leader working clinically to support RN deficit.
MED G5 Ward	Day	1404	1158	1651	1478	82.5%	89.5%	3.0	3.0	6.0	Band 4 staff working to support registered nurse numbers; Increase in acuity/dependency of patients in the month; Supervisory Ward Leader working clinically to support RN deficit.
MED G5 Ward	Night	1002	967	667	677	96.6%	101.5%				Safe staffing levels maintained; Increase in acuity/dependency of patients in the month.
MED G6 Ward	Day	1472	1138	1699	1259	77.3%	74.1%	3.0	3.2	6.2	Band 4 staff working to support registered nurse numbers; Increase in acuity/dependency of patients in the month; Supervisory Ward Leader working clinically to support RN deficit.
MED G6 Ward	Night	1035	805	679	759	77.8%	111.9%				Safe staffing levels maintained; Increase in acuity/dependency of patients in the month.
MED G7 Ward	Day	679	690	810	862	101.6%	106.5%	3.7	3.4	7.1	Safe staffing levels maintained by sharing staff resource; Additional beds open in the month; Supervisory Ward Leader working clinically to support RN deficit.
MED G7 Ward	Night	690	690	461	415	100.0%	89.9%				Safe staffing levels maintained by sharing staff resource; Additional beds open in the month.
MED G8 Ward	Day	1429	1236	1716	1300	86.5%	75.8%	3.3	3.2	6.6	Band 4 staff working to support registered nurse numbers; Increase in acuity/dependency of patients in the month; Supervisory Ward Leader working clinically to support RN deficit.
MED G8 Ward	Night	1035	920	690	793	88.9%	114.9%				Safe staffing levels maintained; Increase in acuity/dependency of patients in the month.
MED G9 Ward	Day	1445	1354	1372	1342	93.7%	97.8%	3.8	3.1	6.9	Beds flexed to match staffing; Band 4 staff working to support registered nurse numbers; Increase in acuity/dependency of patients in the month; Supervisory Ward Leader working clinically to support RN deficit.
MED G9 Ward	Night	1024	1091	690	644	106.5%	93.3%				Beds flexed to match staffing; Increase in acuity/dependency of patients in the month; Safe staffing levels maintained.
MED Bassett Ward	Day	1281	934	2419	1824	72.9%	75.4%	2.7	3.9	6.5	Patient requiring 24 hour 1:1 nursing in the month; Additional staff used for enhanced care - Support workers; Supervisory Ward Leader working clinically to support RN deficit.
MED Bassett Ward	Night	1035	977	1035	966	94.4%	93.3%				Patient requiring 24 hour 1:1 nursing in the month; Additional staff used for enhanced care - Support workers.
CHI High Dependency Unit	Day	1536	1182	0	19	76.9%	Shift N/A	13.9	0.2	14.1	Non-ward based staff supporting areas.
CHI High Dependency Unit	Night	1035	1023	0	11	98.8%	Shift N/A				Safe staffing levels maintained.
CHI Paed Medical Unit	Day	1857	1528	720	822	82.3%	114.1%	7.9	3.9	11.8	Band 4 staff working to support registered nurse numbers; Non-ward based staff supporting areas; Safe staffing levels maintained.
CHI Paed Medical Unit	Night	1650	1393	638	636	84.4%	99.7%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
CHI Paediatric Intensive Care	Day	6071	5393	1336	471	88.8%	35.2%	27.2	3.1	30.3	Non-ward based staff supporting areas; Beds flexed to match staffing; Safe staffing levels maintained.
CHI Paediatric Intensive Care	Night	5522	4931	874	706	89.3%	80.8%				Beds flexed to match staffing; Safe staffing levels maintained.
CHI Piam Brown Unit	Day	3711	2407	1008	387	64.8%	38.4%	13.5	2.7	16.2	Beds flexed to match staffing; Safe staffing levels maintained.
CHI Piam Brown Unit	Night	1381	938	667	290	67.9%	43.4%				Beds flexed to match staffing; Safe staffing levels maintained.

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
CHI Ward E1 Paed Cardiac	Day	2082	1407	615	556	67.6%	90.4%	6.9	2.6	9.5	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
CHI Ward E1 Paed Cardiac	Night	1380	1203	357	438	87.2%	122.8%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
CHI Bursledon House	Day	803	522	498	464	65.0%	93.2%	4.4	4.0	8.4	Band 4 staff working to support registered nurse numbers; Non-ward based staff supporting areas; Safe staffing levels maintained.
CHI Bursledon House	Night	176	155	176	154	88.1%	87.5%				Band 4 staff working to support registered nurse numbers; Non-ward based staff supporting areas; Safe staffing levels maintained.
CHI Ward G2 Neuro	Day	752	675	858	288	89.7%	33.6%	7.6	2.0	9.6	Non-ward based staff supporting areas; Safe staffing levels maintained.
CHI Ward G2 Neuro	Night	718	658	720	58	91.6%	8.0%				Safe staffing levels maintained.
CHI Ward G3	Day	2330	2122	1820	817	91.1%	44.9%	8.6	3.1	11.7	Safe staffing levels maintained.
CHI Ward G3	Night	1606	1819	990	594	113.2%	59.9%				Safe staffing levels maintained.
CHI Ward G4 Surgery	Day	2419	2343	1226	872	96.9%	71.2%	8.7	3.0	11.7	Safe staffing levels maintained.
CHI Ward G4 Surgery	Night	1650	1761	660	556	106.7%	84.2%				Safe staffing levels maintained.
W&N Bramshaw Womens Unit	Day	1098	899	715	467	81.9%	65.4%	6.1	3.0	9.2	Non-ward based staff supporting areas; Beds flexed to match staffing; Safe staffing levels maintained.
W&N Bramshaw Womens Unit	Night	667	702	644	322	105.2%	50.0%				Beds flexed to match staffing; Safe staffing levels maintained.
W&N Neonatal Unit	Day	6638	4576	1602	1115	68.9%	69.6%	10.4	2.3	12.7	Safe staffing levels maintained.
W&N Neonatal Unit	Night	5183	3968	1320	772	76.6%	58.4%				Safe staffing levels maintained.
W&N PAH Maternity Service combined	Day	10268	8541	4249	3337	83.2%	78.5%	9.2	3.2	12.4	Safe staffing levels maintained.
W&N PAH Maternity Service combined	Night	6530	5260	1969	1490	80.5%	75.7%				Safe staffing levels maintained.
CAR CHDU	Day	4972	4010	1616	1458	80.6%	90.2%	14.3	4.5	18.8	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource; beds flexed to 18 due to distancing.
CAR CHDU	Night	3799	3531	994	923	92.9%	92.8%				Safe staffing levels maintained; Safe staffing levels maintained by sharing staff resource; beds flexed to 18 due to distancing.
CAR Coronary Care Unit	Day	2606	2583	927	915	99.1%	98.7%	9.4	3.5	12.9	Safe staffing levels maintained by sharing staff resource; Safe staffing levels maintained by sharing staff resource; beds flexed to 21 due to distancing, Staffing covid ptson c5.
CAR Coronary Care Unit	Night	2235	2332	814	906	104.3%	111.3%				Increased night staffing to support raised acuity; Additional staff used for enhanced care - Support workers; beds flexed to 21 for distancing, staffing covid pts on C5.
CAR Ward D4 Vascular	Day	1940	1672	1073	940	86.2%	87.5%	4.4	3.0	7.4	Safe staffing levels maintained by sharing staff resource; Safe staffing levels maintained by sharing staff resource.
CAR Ward D4 Vascular	Night	1118	1040	991	904	93.0%	91.2%				Safe staffing levels maintained; Safe staffing levels maintained; Twilight RN supplementing .
CAR Ward E2 YACU	Day	1522	1369	863	822	89.9%	95.2%	4.4	3.4	7.8	Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
CAR Ward E2 YACU	Night	695	714	660	788	102.7%	119.4%				Increased night staffing to support raised acuity; Increased night staffing to support raised acuity
CAR Ward E3 Green	Day	1551	1429	1471	1067	92.1%	72.6%	3.2	2.9	6.2	Safe staffing levels maintained; Skill mix swaps undertaken to support safe staffing across the Unit.
CAR Ward E3 Green	Night	682	630	747	789	92.4%	105.6%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAR Ward E3 Blue	Day	1560	1348	1082	1042	86.4%	96.3%	4.1	4.0	8.0	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
CAR Ward E3 Blue	Night	683	676	660	935	99.0%	141.7%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAR Ward E4 Thoracics	Day	1631	1404	1300	1072	86.1%	82.4%	4.3	3.4	7.7	Band 4 staff working to support registered nurse numbers; Band 4 staff working to support registered nurse numbers.
CAR Ward E4 Thoracics	Night	1026	989	572	813	96.3%	142.0%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAR Ward D2 Cardiology	Day	1320	971	709	976	73.6%	137.7%	3.8	4.2	8.0	Band 4 staff working to support registered nurse numbers; 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
CAR Ward D2 Cardiology	Night	683	640	638	824	93.7%	129.2%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
NEU Acute Stroke Unit	Day	1428	1528	2589	2425	106.9%	93.7%	3.1	5.0	8.1	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
NEU Acute Stroke Unit	Night	990	970	1650	1538	97.9%	93.2%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
NEU Regional Transfer Unit	Day	1103	966	388	298	87.6%	76.8%	8.2	4.7	12.9	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
NEU Regional Transfer Unit	Night	660	463	660	528	70.1%	80.0%				Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
NEU ward E Neuro	Day	1789	1753	1099	1245	98.0%	113.3%	4.3	3.6	7.9	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
NEU ward E Neuro	Night	1320	1157	990	1188	87.6%	119.9%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
NEU HASU	Day	1491	1295	394	454	86.8%	115.2%	8.5	2.6	11.1	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
NEU HASU	Night	1321	1148	330	309	86.9%	93.6%				Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
NEU Ward D Neuro	Day	1845	1821	1846	1549	98.7%	83.9%	4.2	3.8	8.0	Band 4 staff working to support registered nurse numbers.
NEU Ward D Neuro	Night	1298	1364	1639	1353	105.1%	82.6%				Band 4 staff working to support registered nurse numbers.
SPI Ward F4 Spinal	Day	1489	1633	1152	975	109.7%	84.6%	4.2	3.0	7.1	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
SPI Ward F4 Spinal	Night	990	1012	1001	902	102.2%	90.1%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
T&O Ward Brooke	Day	1040	1047	966	882	100.6%	91.3%	3.8	3.6	7.4	Patient requiring 24 hour 1:1 nursing in the month; Increase in acuity/dependency of patients in the month; Additional staff used for enhanced care - Support workers.
T&O Ward Brooke	Night	690	690	1035	743	100.0%	71.8%				Additional staff used for enhanced care - Support workers; Patient requiring 24 hour 1:1 nursing in the month; Increase in acuity/dependency of patients in the month.
T&O Trauma Admissions Unit	Day	886	735	735	638	83.0%	86.8%	11.4	10.6	22.0	Increase in acuity/dependency of patients in the month; Staff moved to support other wards; Skill mix swaps undertaken to support safe staffing across the Unit.
T&O Trauma Admissions Unit	Night	649	451	660	463	69.5%	70.1%				Increase in acuity/dependency of patients in the month; Staff moved to support other wards; Skill mix swaps undertaken to support safe staffing across the Unit.
T&O Ward F1 Major Trauma Unit	Day	2269	2256	1828	1757	99.4%	96.1%	4.6	4.1	8.6	Increase in acuity/dependency of patients in the month; Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit.
T&O Ward F1 Major Trauma Unit	Night	1725	1556	1725	1643	90.2%	95.3%				Increase in acuity/dependency of patients in the month; Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit.
T&O Ward F2 Trauma	Day	1608	1267	1866	2052	78.8%	110.0%	2.9	5.1	8.1	Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit; Staff moved to support other wards.
T&O Ward F2 Trauma	Night	990	771	1320	1503	77.9%	113.9%				Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit; Skill mix swaps undertaken to support safe staffing across the Unit.
T&O Ward F3 Trauma	Day	1492	1760	1932	1523	117.9%	78.8%	4.0	4.4	8.4	Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource.
T&O Ward F3 Trauma	Night	979	927	1331	1485	94.6%	111.6%				Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource.
T&O Ward F4 Elective	Day	1355	1213	722	957	89.5%	132.6%	3.6	3.6	7.2	Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource.
T&O Ward F4 Elective	Night	671.3	627.5	660.5	902.5	93.5%	136.6%				Patient requiring 24 hour 1:1 nursing in the month; 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 2022-23 Month 1**			
Agenda item:	**5.9**			
Sponsor:	**Ian Howard, Chief Financial Officer**			
Author:	**Philip Bunting, Interim Deputy Director of Finance**			
Date:	**26 May 2022**			
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:	**Financial Planning / National Context** In April, as approved by Trust Board, UHS submitted an Operating Plan for 22/23, notably: • UHS submitted a deficit plan of £19.5m for 2022/23 (circa 1.8% of revenue). • This included inflationary pressure above funded levels of £23m which mainly related to energy, non-pay inflation and drugs. • Analysis for Trust Board indicated a range of financial scenarios from £19.5m deficit to £64.3m deficit, with risk drivers associated with: o CIP delivery o Activity below 104% linked to Covid levels impacting bed capacity o Inflationary pressures beyond assumed levels o Covid staff absence / backfill costs National Context: • This was part of a wider system deficit plan submission of £106m for HIOW ICS (circa 3% of revenue). This was broadly consistent with the average regional and national deficit (3%). • The national picture is 13% real-terms cost increase since 19/20, with a 6% reduction in cost-weighted activity, leading to a 17% reduction in productivity since 19/20 (based on M10). • There is a view that plans contain “excess inflation” that was unforeseen at planning guidance stage, for which additional funding may be made available. • However, excess inflation and other pressures are above reasonably explained values and unlikely to be funded. Planning Resubmission: • HIOW ICS has been informed of the need to resubmit its plan due to the scale of deficit in excess of understandable inflationary pressure. This is required for the end of June 2022. Additional capital and revenue funding may be at risk if the			

deficit is not reduced nationally.
- We may take the opportunity to review the phasing of the plan to reflect a more realistic CIP profile.

M1 Financial Position

UHS reported a deficit of £3.7m in April 2022. This is £2.3m adverse when compared to the plan of £1.4m deficit in month. There were three key drivers behind this:

- Covid costs – Covid related absence remained high in early April peaking at 420 WTE. Although this reduced towards the end of the April the plan was predicated on a ceiling level of 200 WTE. The excess cost related to backfill is estimated at £0.7m.
- Operational Pressures / Emergency Demand – ED continues to experience volumes in excess of planned levels driving up expenditure especially on premium rate staffing.
- Cost Improvement Plans – due to the considerable operational pressures the development of plans from Q4 21/22 have been delayed. Only £0.3m has been recognised, although this is likely to rise to >£0.5m on review. Some schemes are likely to have a different savings profile than the 1/12^{ths} assumed in the plan; however, it must be recognised we are significantly behind schedule.

Elective Recovery Framework (ERF):

- Despite operational pressures, ED demand and Covid related staff absence, UHS has delivered against the planned activity trajectory submitted as part of the 2022/23 plan.
- Delivery of 100% of 19/20 activity levels compared to a plan of 98%, noting the plan incorporated a phased delivery of 104% for the full year.
- No financial upside or downside has been accrued / provided for as a result of this performance with all calculations currently based on draft activity data. National calculations for April are not expected until July.

Implications:

A run rate continuing at this level of deficit would generate a £44.5m deficit across 2022/23 which would be £25m adverse to plan of £19.5m deficit. This is at the midpoint between the plan and the worst-case scenario presented to the Finance and Investment Committee in April. This would lead to a reduced cash balance, a reduced ability to invest in capital and revenue improvements, and increased local, regional and national scrutiny. It is therefore not sustainable to continue at this rate of deficit.

Response to the financial challenge

Recovery Plan:

Whilst we seek additional funding to cover inflationary pressures and specialised commissioning service growth, we also need to address our

	overall operating costs. Due to the scale of financial risk, a recovery plan is being developed to drive an improvement trajectory. This will be presented to F&IC in June and will focus on a variety of measures, for example: • Driving transformation / productivity at greater pace • Elective Recovery Framework acceleration, including review of activity restrictions linked to Infection Prevention & Control • Cost control measures including use of temporary staffing – bank, agency and WLIs • Benchmarking and historic cost analysis to support areas for investigation • Reduction in Covid costs • Review of Independent Sector usage • Review of cost and activity movements since 19/20 to highlight the movement in productivity and identify areas of potential opportunity to be investigated. This analysis has been started within a finance spotlight section presented below, with draft further detail by Care Group presented to Finance & Investment Committee. • Investments are likely to be withheld from budgets until a fully developed CIP programme can be assured • Progress on central savings schemes e.g., procurement savings targets and benefits from UEL theatres business case **Capital** • Internal capital expenditure totalled £1.5m in April which was £1m behind plan. The trust has an internal capital plan of £49m for 2022/23. Many of the major projects have yet to commence and are in the planning phases hence an acceleration in spend is expected in future months. Spend, and any emerging risks and opportunities, will be monitored closely in year via Trust Investment Group. • External CDEL business cases are being worked up for wards (£10m) and Neonates (£5.1m). There is also potential funding for an additional CT scanner, expansion of community diagnostics and expansion of the targeted lung programme all being progressed which have potential access to capital funding.
Implications:	• 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 relating to the month 1 run rate and projected potential deficit if the run rate continues. • Investment risk related to the above • Cash risk linked to volatility above • Inability to maximise CDEL (which cannot be carried forward)
Summary: Conclusion and/or recommendation	Trust Board is asked to note this report.

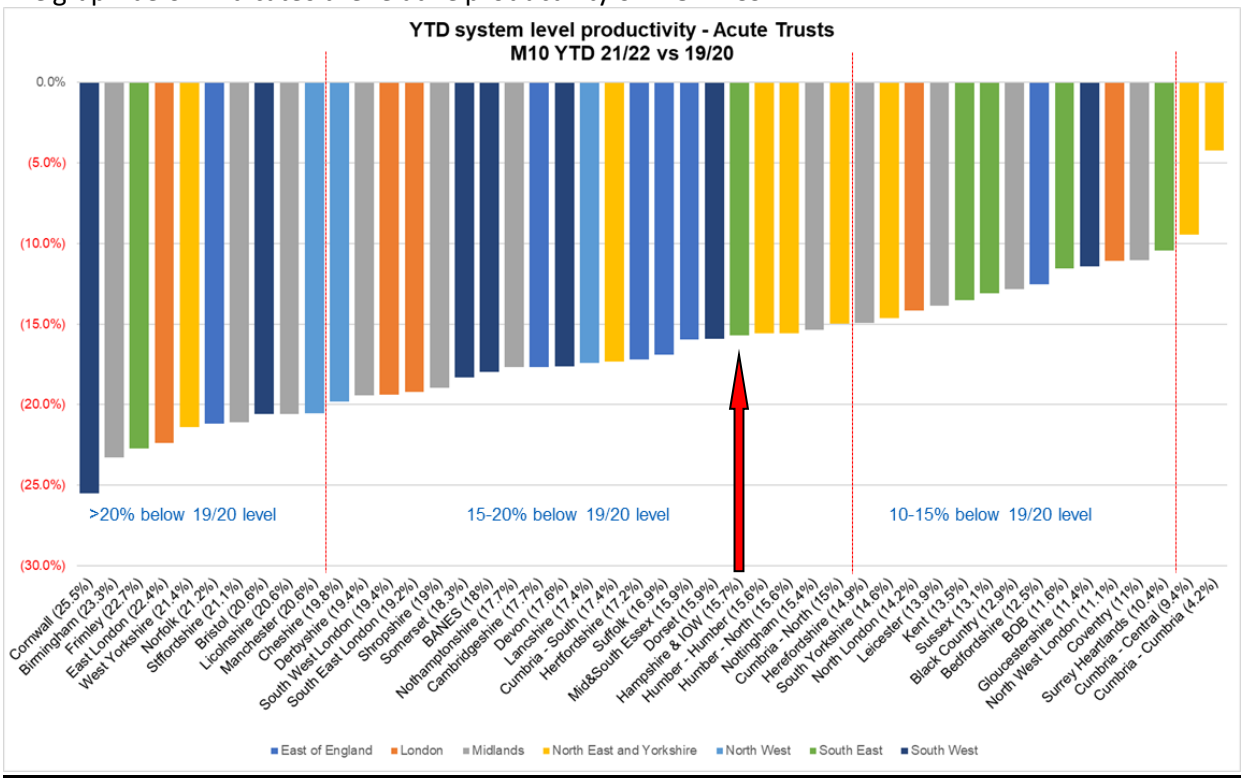
Finance Spotlight

National Analysis – Cost / Weighted Activity Analysis 19/20 v 21/22

The national team have undertaken productivity analysis as at M10 in 21/22. This highlights national cost growth of 13% since 19/20, with a reduction in Cost-Weighted Activity of 6.3%.

Using the formula below outlines a national productivity reduction of 17.1%.
productivity growth = [(1 + CWA growth) / (1 + RT cost growth)] -1

The graph below indicates the relative productivity of HIOW ICS:



The table below reflects HIOW providers. Once specific cost growth around R&D and Covid (e.g., Saliva Testing) are removed, the UHS productivity reduction equates to 11.5%. Whilst that is better than national average, it does imply UHS costs have increased by more than other Trusts locally.

							% Impact (+ Improvement/- Deterioration) on Implied Productivity If following costs are removed from cost base - YTD M"&C4				
Region Name	System	Org Name	Trust Type	YTD Real Terms Cost Growth at M10	YTD CWA Growth at M10	YTD Implied Productivity Growth at M10	HCD	R&D Cost	Education and Training Cost	Total COVID Costs as reported in PFR	YTD Implied Productivity Growth at M10
ENGLAND		**ENGLAND (Acute and Specialis**	**Acute & Spec**	**13.0%**	**(6.3%)**	**(17.1%)**	**0.6%**	**(0.0%)**	**0.1%**	**2.4%**	**(14.0%)**
East of England		East of England Implied Prod	Acute & Spec	13.4%	(6.2%)	**(17.3%)**	0.7%	0.0%	0.3%	2.8%	**(13.5%)**
London		London Implied Prod	Acute & Spec	11.4%	(7.8%)	**(17.2%)**	1.1%	(0.1%)	0.0%	2.6%	**(13.6%)**
Midlands		Midlands Implied Prod	Acute & Spec	12.3%	(7.0%)	**(17.2%)**	(0.2%)	(0.1%)	0.1%	2.3%	**(15.1%)**
North East and Yorkshire		North East and Yorkshire Implied	Acute & Spec	11.7%	(6.3%)	**(16.1%)**	1.2%	0.0%	0.1%	2.3%	**(12.4%)**
North West		North West Implied Prod	Acute & Spec	15.2%	(7.5%)	**(19.7%)**	0.9%	0.0%	0.0%	1.7%	**(17.0%)**
South East		South East Implied Prod	Acute & Spec	15.1%	(1.4%)	**(14.3%)**	(0.0%)	0.1%	0.1%	2.7%	**(11.5%)**
South West		South West Implied Prod	Acute & Spec	13.4%	(7.3%)	**(18.3%)**	0.6%	0.0%	0.1%	2.4%	**(15.2%)**
South East	HIOW	Hampshire Hospitals NHS Founda	Acute	15.1%	3.8%	**(9.9%)**	(0.4%)	0.0%	0.1%	3.3%	**(6.9%)**
South East	HIOW	Isle of Wight NHS Trust	Acute	24.0%	5.2%	**(15.1%)**	(0.1%)	0.0%	(0.1%)	2.3%	**(13.1%)**
South East	HIOW	Portsmouth Hospitals University NH	Acute	14.5%	0.4%	**(12.4%)**	(0.0%)	(0.0%)	0.1%	3.5%	**(8.9%)**
South East	HIOW	University Hospital Southampton N	Acute	24.5%	(1.7%)	**(21.0%)**	1.6%	1.6%	(0.0%)	6.3%	**(11.5%)**
South East	HIOW	Southern Health NHS Foundation T	Mental Health	9.7%	-	-	-	-	-	-	-
South East	HIOW	Solent NHS Trust	Community	17.7%	-	-	-	-	-	-	-
South East	HIOW	South Central Ambulance Service I	Ambulance	25.7%	-	-	-	-	-	-	-

A local analysis of productivity movements by Care Group is underway and a first draft has been presented to the Finance & Investment Committee.

2022/23 Finance Report - Month 1

Report to:	**Board of Directors and Finance & Investment Committee** **April 2022**
Title:	**Finance Report for Period ending 30/04/2022**
Author:	**Philip Bunting, Interim Deputy Director of Finance**
Sponsoring Director:	**Ian Howard, Chief Financial Officer**
Purpose:	**Standing Item**
	The Board is asked to note the report

Executive Summary:

In Month and Year to date Highlights:

1. UHS reported a deficit of £3.7m in April 2022. This is £2.3m adverse when compared to the plan of £1.4m deficit in month. The key driver for this was continued covid costs, especially relating to staff covid absence and the required backfill, in addition to limited traction with CIPs.

2. A run rate continuing at this level of deficit would generate a £44.5m deficit across 2022/23 which would be £25m adverse to the annual plan of £19.5m deficit. Recovery plan actions are being explored to mitigate this risk.

3. The main income and activity themes seen in M1 were:
   - UHS is in receipt of £29m of upfront funding for 2022/23 to deliver the required Elective Recovery Fund target of 104% of elective, day case and outpatient activity (excluding follow ups).
   - Despite operational pressures, ED demand and Covid related staff absence, UHS has delivered against the planned activity trajectory submitted as part of the 2022/23 plan. This targeted 98% of 19/20 activity levels in month 1 which has been marginally overachieved against. The national target of 104% has therefore not been achieved in month.
   - No financial upside or downside has been accrued / provided for as a result of this performance with all calculations currently based on draft activity data. National calculations for April are not expected until July

Finance: I&E Summary

A deficit of £3.7m position was reported in April 2022; £2.5m adverse to plan. There are three main drivers for this position:

Covid related absence remained high in early April peaking at 420 WTE. Although this reduced towards the end of the April the plan was predicated on a ceiling level of 200 WTE. The excess cost related to backfill is estimated at £0.7m.

ED continues to experience volumes in excess of planned levels driving up expenditure especially on premium rate staffing.

Just £0.3m of CIP was delivered against a plan of £2.7m. This was not unexpected due to the considerable operational pressures experienced in April that have constrained CIP progress.

Existing cost pressures from 2021/22 also continue to drive the underlying deficit related to energy costs and drugs.

		Current Month			Cumulative			Plan		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
NHS Income:	Clinical	69.2	69.1	0.1	69.2	69.1	0.1	830.3	830.3	0.0
	Pass-through Drugs & Devices	11.2	10.5	0.7	11.2	10.5	0.7	134.6	134.6	0.0
Other income	Other Income excl. PSF	10.6	14.2	(3.7)	10.6	14.2	(3.7)	126.6	126.6	0.0
	Top Up Income	0.9	0.6	0.3	0.9	0.6	0.3	8.3	8.3	0.0
Total income		**91.8**	**94.4**	**(2.6)**	**91.8**	**94.4**	**(2.6)**	**1,099.8**	**1,099.8**	**0.0**
Costs	Pay-Substantive	48.5	50.2	1.7	48.5	50.2	1.7	581.5	581.5	0.0
	Pay-Bank	3.1	4.1	1.1	3.1	4.1	1.1	35.2	35.2	0.0
	Pay-Agency	1.1	1.6	0.5	1.1	1.6	0.5	12.0	12.0	0.0
	Drugs	5.3	4.9	(0.4)	5.3	4.9	(0.4)	63.2	63.2	0.0
	Pass-through Drugs & Devices	11.2	10.5	(0.7)	11.2	10.5	(0.7)	134.6	134.6	0.0
	Clinical supplies	6.9	6.5	(0.4)	6.9	6.5	(0.4)	83.9	83.9	0.0
	Other non pay	16.3	19.8	3.5	16.3	19.8	3.5	197.7	197.7	0.0
Total expenditure		**92.3**	**97.5**	**5.2**	**92.3**	**97.5**	**5.2**	**1,108.1**	**1,108.1**	**0.0**
EBITDA		**(0.5)**	**(3.1)**	2.7	**(0.5)**	**(3.1)**	2.7	**(8.2)**	**(8.2)**	0.0
EBITDA %		-0.5%	-3.3%	2.8%	-0.5%	-3.3%	2.8%	-0.7%	-0.7%	0.0%
	Non Operating Expenditure	0.9	0.8	(0.2)	0.9	0.8	(0.2)	11.2	11.2	0.0
Surplus / (Deficit)		**(1.4)**	**(3.9)**	2.5	**(1.4)**	**(3.9)**	2.5	**(19.4)**	**(19.4)**	**0.0**
Less	Donated income	0.1	0.0	0.1	0.1	0.0	0.1	1.4	1.4	0.0
Add Back	Donated depreciation	0.1	0.2	0.1	0.1	0.2	0.1	1.3	1.3	0.0
Net Surplus / (Deficit)		**(1.4)**	**(3.7)**	**2.3**	**(1.4)**	**(3.7)**	**2.3**	**(19.5)**	**(19.5)**	**0.0**

University Hospital Southampton NHS
NHS Foundation Trust

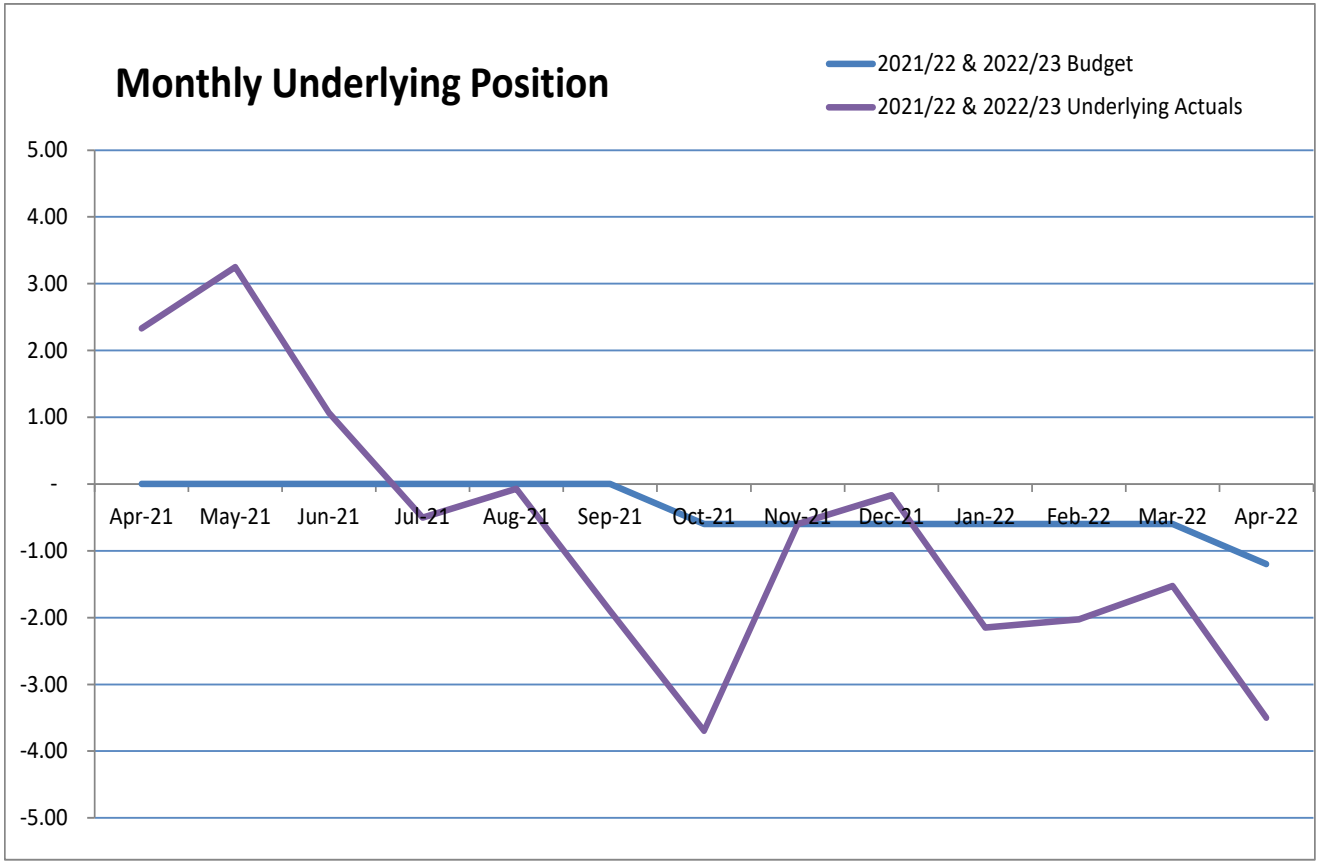
Monthly Underlying Position

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

All values for 2021/22 were restated to include ERF income which following the release of guidance for 22/23 is now confirmed as continuing albeit subject to marginal adjustments for over/under performance. For this reason it has been included as a recurrent funding source for the purposes of this analysis. In month only £0.2m of non recurrent costs has been removed therefore an underlying deficit of £3.5m in month is reported.

The step change from c£2m per month in H2 2021/22 to £3.5m in April 2022 closely maps to pay inflation for which changes in national insurance rates and the accrued costs of the 2022/23 pay award totalled £1.5m. All other areas of income and expenditure remained broadly flat with minimal CIP achievement in month offsetting inflationary pressures.

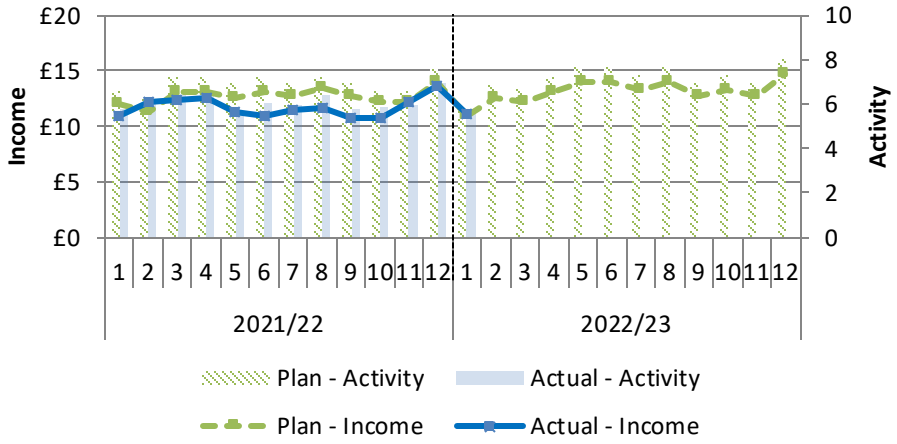
Clinical income has also remained flat with growth and inflation funding offset by efficiency and Covid reductions.



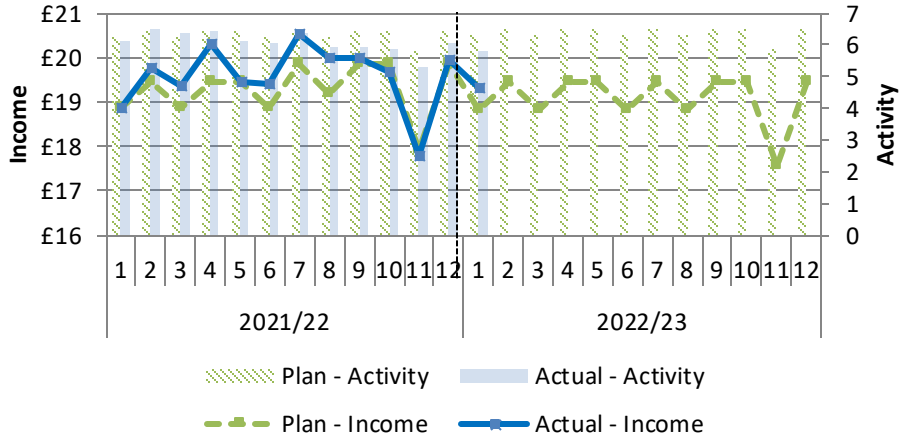
University Hospital Southampton NHS
NHS Foundation Trust

Clinical Income

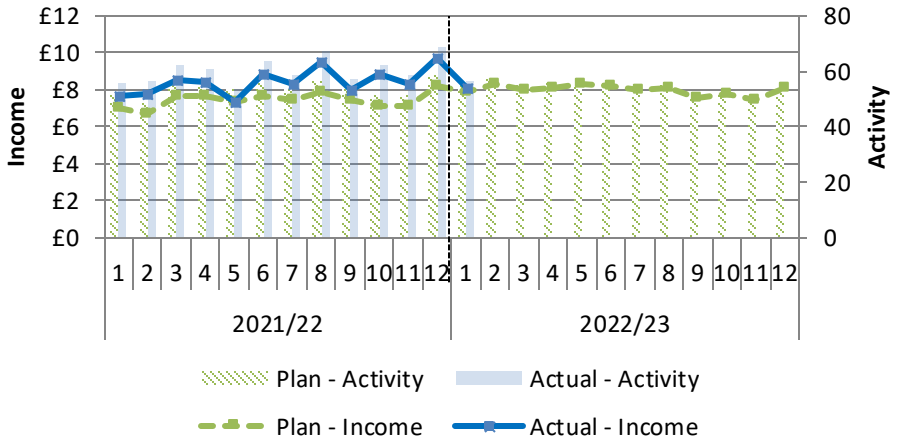
Elective spells



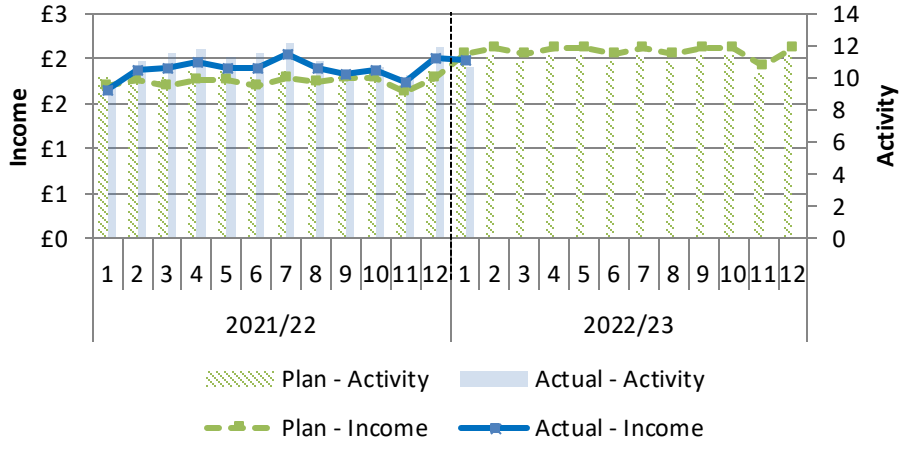
Non elective spells



Outpatients



A&E - Emergency Medicine



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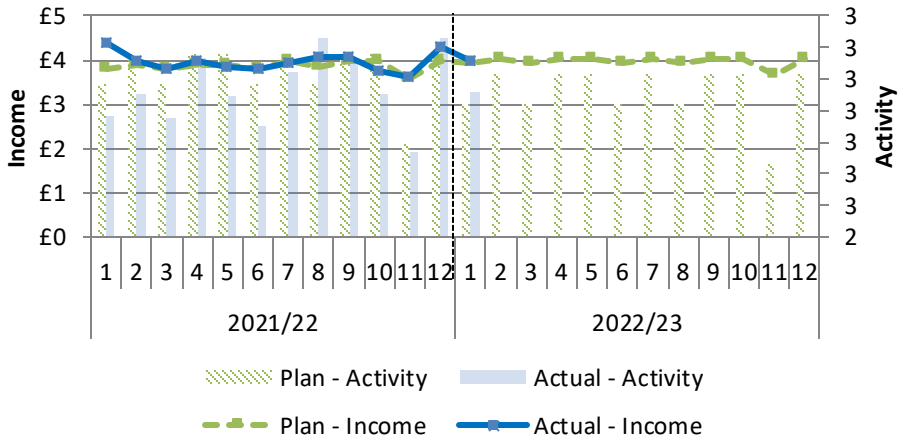
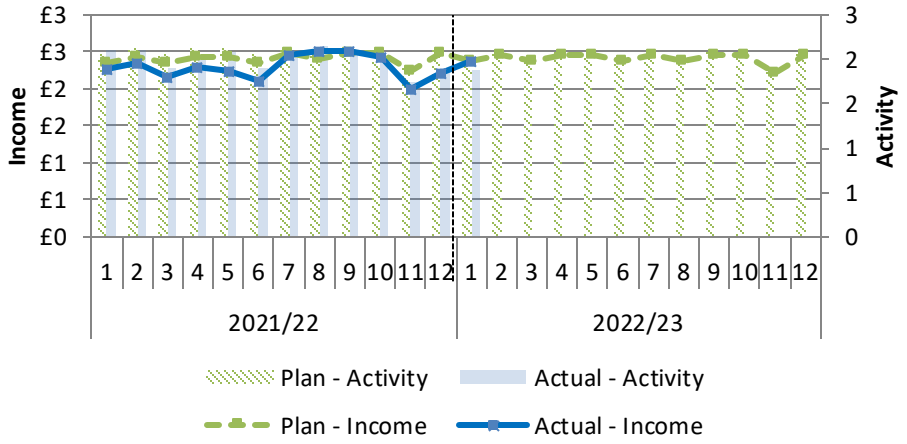
Clinical Income

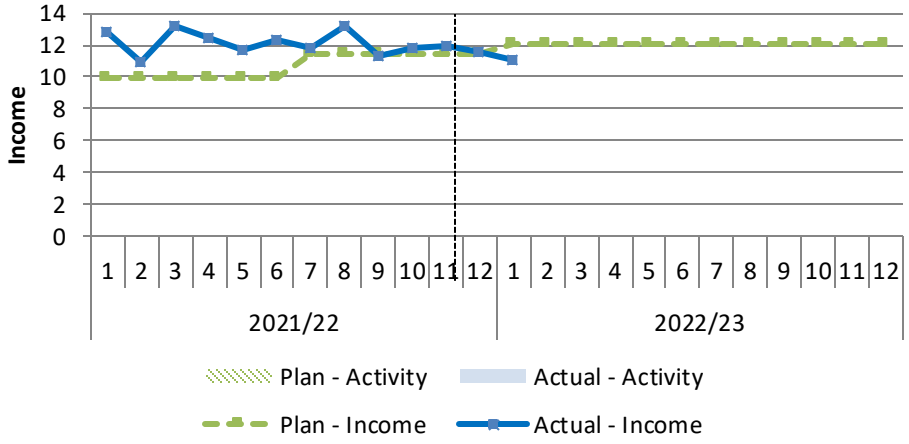
Adult critical care



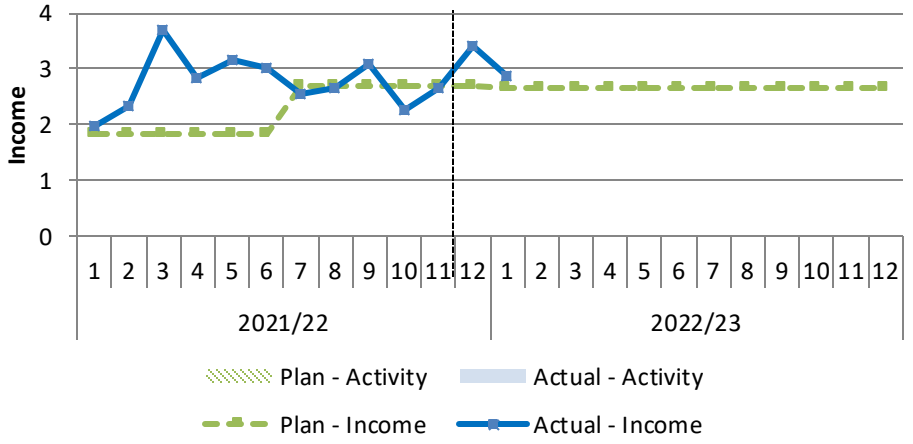
Neonatal & paediatric critical care



Tariff excluded drugs



Tariff excluded devices



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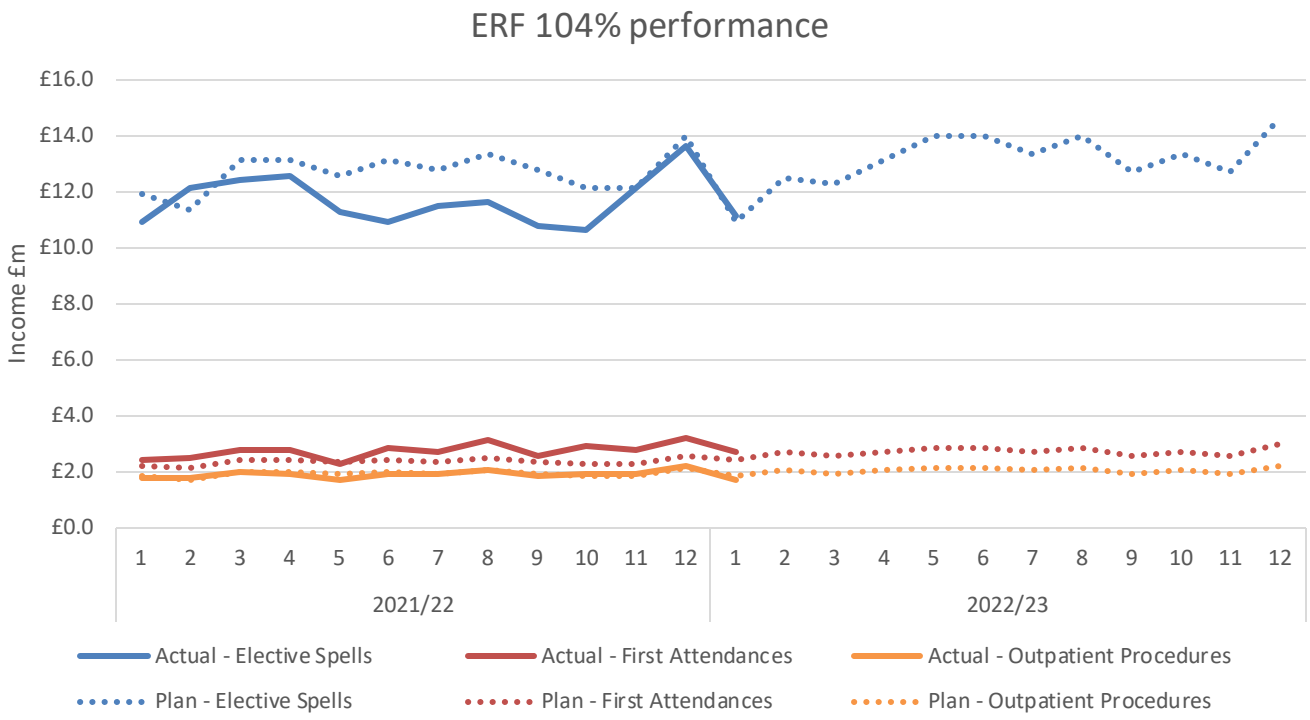
Elective Recovery Fund 22/23

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

In 22/23 the Trust has a target to achieve 104% of 19/20 activity for elective inpatients, outpatient first attendances and outpatient procedures.

The graph and table show measurement against internal plan is set at the 104% target for the year but includes an improvement trajectory so is lower in earlier months. Against this improvement plan April performance would suggest an ERF payment of £218k. However, April activity does not represent achievement against the 104% of 19/20 target and when compared to a plan without improvement built in would represent a loss of -£591k.

Further work will be undertaken ahead of month 2 reporting to compare the UHS plan and phasing with the nationally set baseline as well as report performance at a Care Group level.

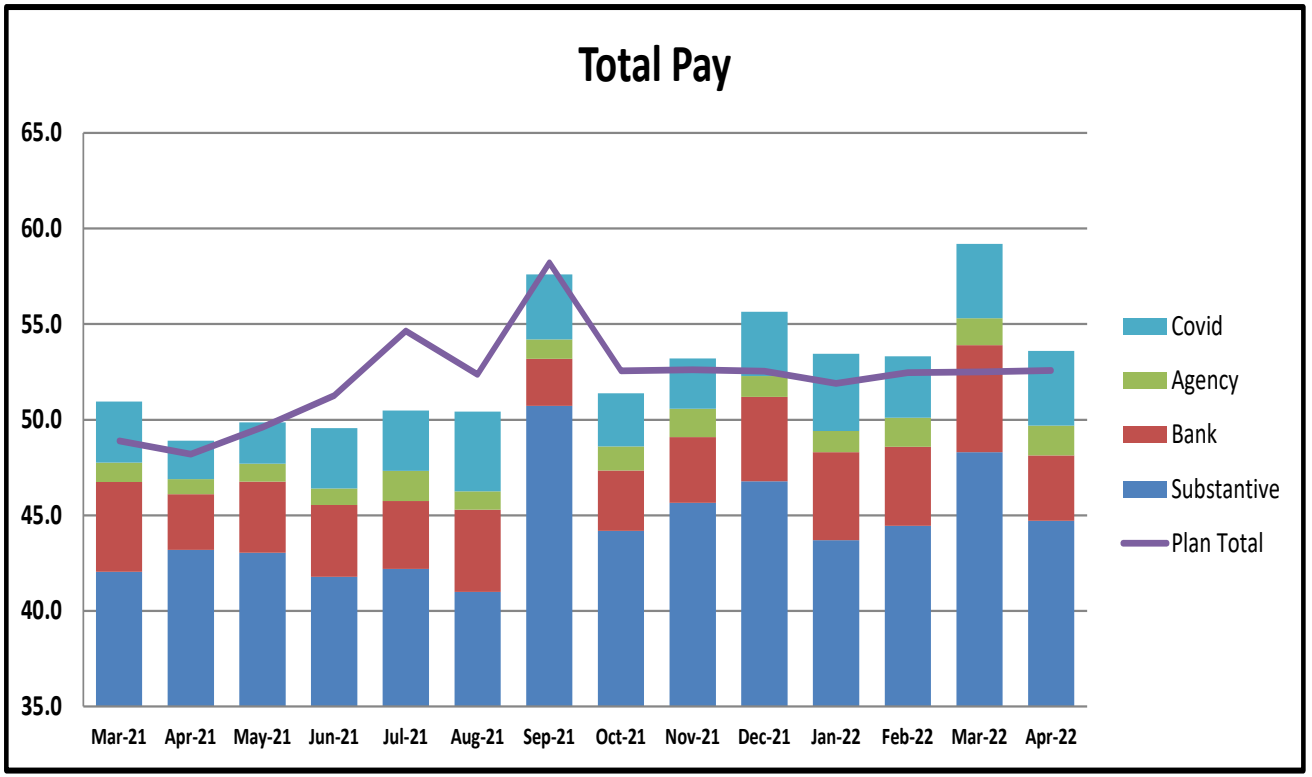


Internal Baselines - Phased Trajectory				
£'000	Total baseline	Total income	Total performance	ERF adjustment @75%
Apr-22	£15,277	£15,567	£291	£218
May-22	£17,263	£0	£0	£0
Jun-22	£16,801	£0	£0	£0
Jul-22	£17,894	£0	£0	£0
Aug-22	£18,975	£0	£0	£0
Sep-22	£18,975	£0	£0	£0
Oct-22	£18,113	£0	£0	£0
Nov-22	£18,975	£0	£0	£0
Dec-22	£17,251	£0	£0	£0
Jan-23	£18,113	£0	£0	£0
Feb-23	£17,251	£0	£0	£0
Mar-23	£19,837	£0	£0	£0

Substantive Pay Costs

Total pay expenditure in April was £53.6m, down £5.6m from March. However £4.4m of this decrease relates to the year end accrual for untaken annual leave that was included in March. Excluding this costs decreased by £1.2m. This was driven by lower bank spend (down £1.4m from March) offset slightly by higher Agency spend (up £0.2m from March). Covid staff costs are estimated at £3.9m in month remaining flat from M12.

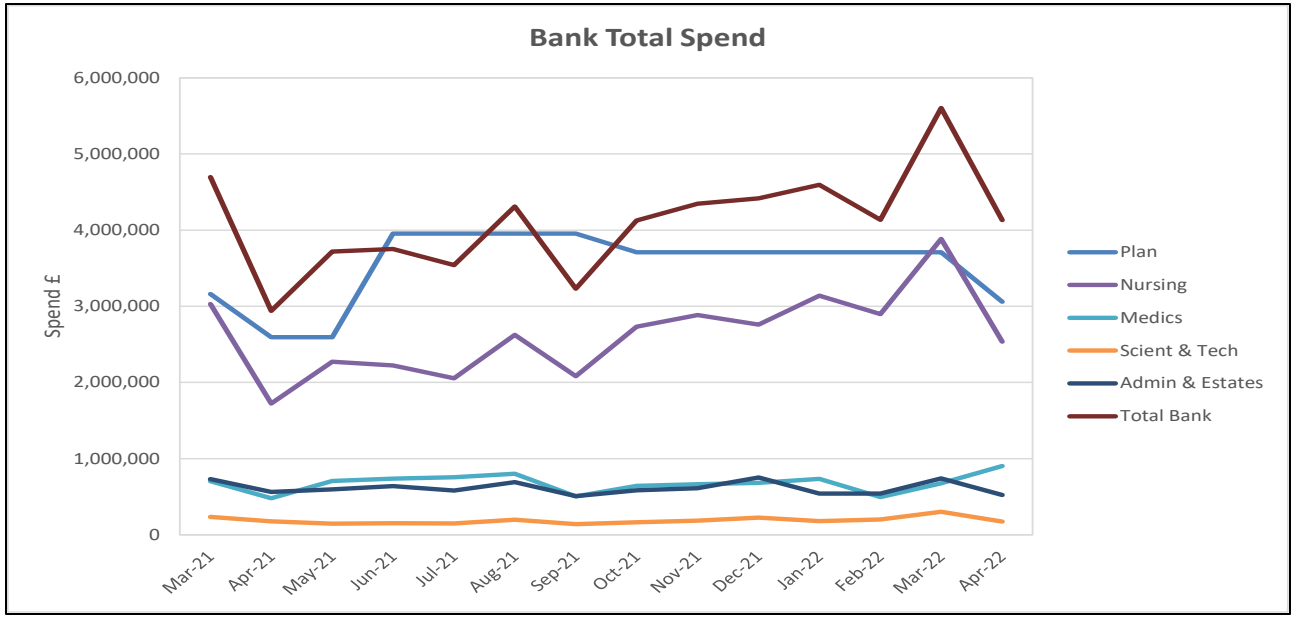
Increases in pay costs over the last 24 months are under review as part of challenging where costs can be targeted for reduction in a post pandemic environment.

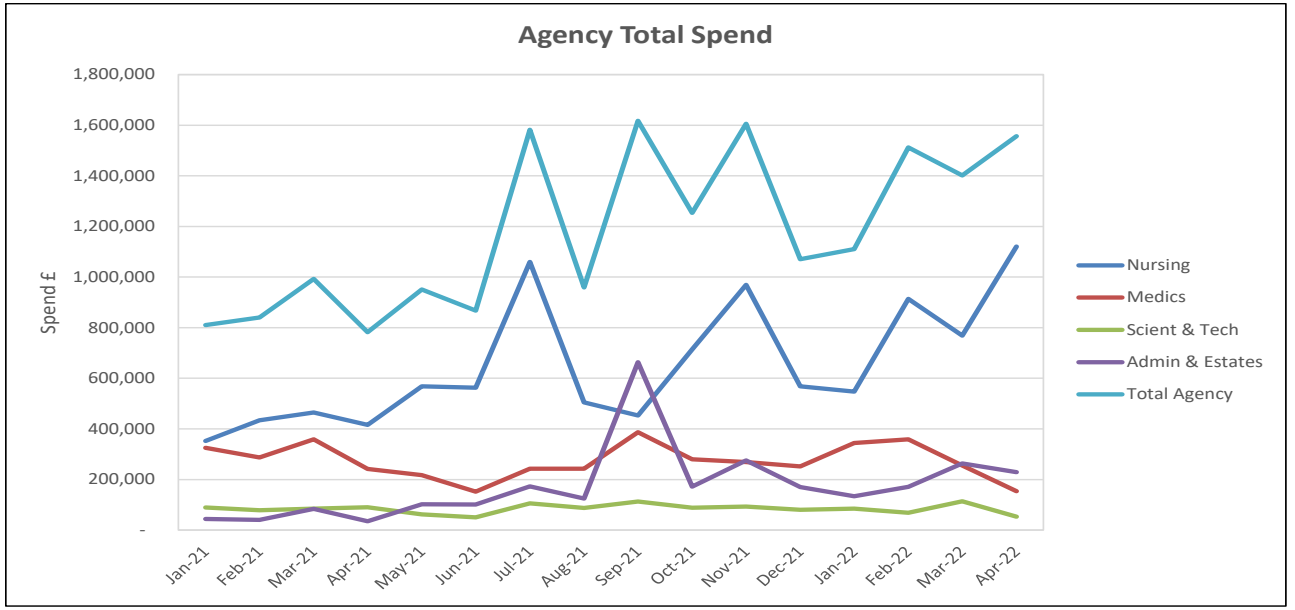


Temporary Staff Costs

Expenditure on bank staff has decreased month on month by £1.5m. This was predominantly in nursing (£1.4m down) and admin (£0.3m) offset by an increase in medic spend (£0.2m). The main decreases in bank nursing staff were due to a one off cost of £0.6m in M12 however there were also smaller reductions in Critical Care (£0.3m), Theatres (£0.1m) and Cardiac (£0.1m).

Agency spend increased from March to April by £0.2m mainly in nursing due to ED operational pressures. Although volatile month to month spend remains at c£1.4m per month and has done since July 2021.



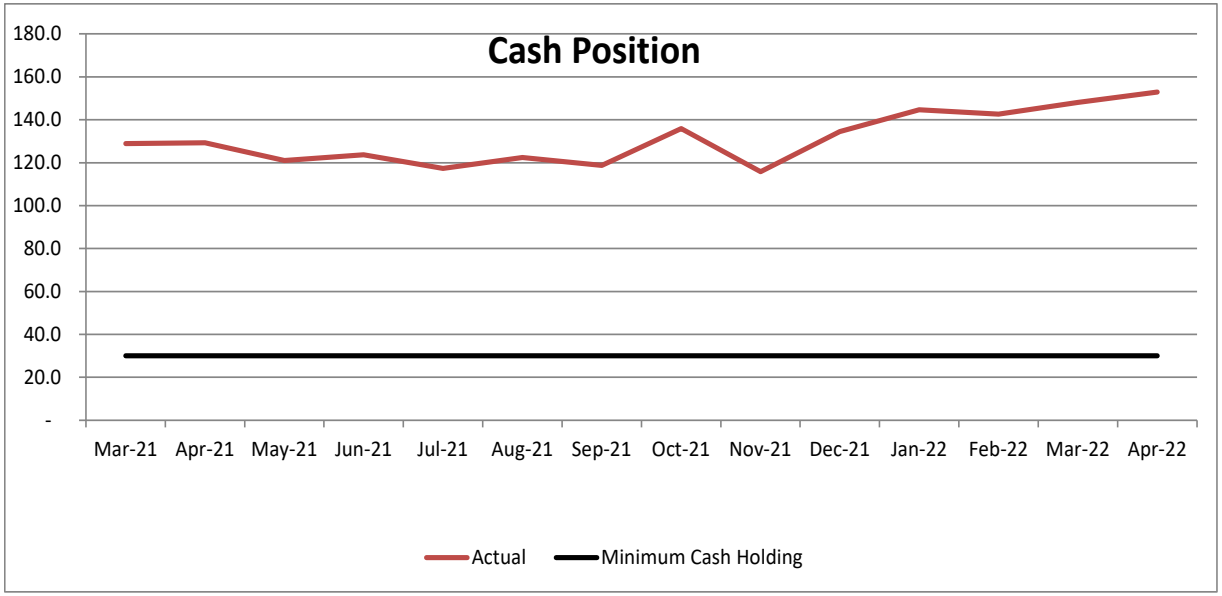


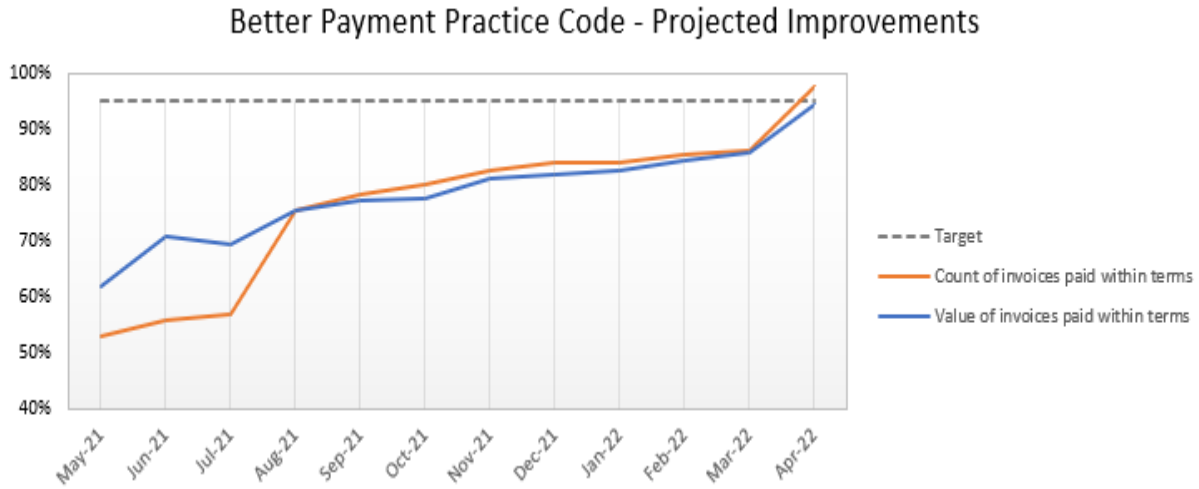
Cash

The cash balance increased slightly in April to £153m and is analysed in the movements on the Statement of Financial Position.

A gradual reduction in cash is expected over the next two years as capital expenditure plans exceed depreciation. A slow downward trajectory is therefore forecast.

The latest position on our Better Payment Practice Code road map to compliance project is also on this slide. These statistics are measured on a YTD basis. BPPC is now reaching the expected percentage of 95% compliance on count of invoices paid and very close to reaching 95% on value of invoices paid. The performance for April are an improvement against March 2022 highlighting performance on dealing with disputes more effectively.





Capital Expenditure

(Fav Variance) / Adv Variance

Expenditure on capital schemes in Month 1 was £1.5m against a budget of £2.5m. The main areas of expenditure were strategic maintenance (£0.7m), design fees and initial costs on the wards and theatres schemes (£0.25m in total), IT (£0.2m) and purchased equipment (£0.1m). All the larger estates projects planned for 2022/23 have yet to fully commence their high cost phases.

The Trust have planned and are forecasting to spend the full £49m capital allocation plus any additional awards for externally funded schemes. External funding of £0.7m for the Digital Maternity and Digital Outpatients schemes is shown in the month 1 forecast. Additional external funding will be shown when agreed.

	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
Internally Funded Schemes									
Strategic Maintenance	680	621	59	680	621	59	8,255	8,255	0
Rolling Estates Budgets	79	5	74	79	5	74	950	950	0
NICU Pendants	44	0	44	44	0	44	528	528	0
Refurbish of neuro theatres 2 & 3	150	0	150	150	0	150	1,800	1,800	0
General Refurbishment Fund	92	0	92	92	0	92	1,097	1,097	0
Fit Out of F Level VE (Theatres)	100	187	(87)	100	187	(87)	5,000	5,000	0
Oncology Centre Ward Expansion Levels D&E	200	58	142	200	58	142	8,000	8,000	0
Fit out of C Level VE (MRI) Capacity	0	0	0	0	0	0	6,592	6,592	0
IMRI	0	66	(66)	0	66	(66)	1,300	1,300	0
PICU Side Rooms	100	0	100	100	0	100	1,203	1,203	0
Donated Estates Schemes	0	21	(21)	0	21	(21)	0	0	0
Information Technology Programme	317	151	166	317	151	166	5,000	5,000	0
Pathology Digitisation	37	0	37	37	0	37	448	448	0
Medical Equipment panel (MEP)	83	2	81	83	2	81	1,000	1,000	0
Purchased Equipment / Lease Buyouts	41	123	(82)	41	123	(82)	500	500	0
Divisonal Equipment	41	39	2	41	39	2	500	500	0
Donated Equipment	29	0	29	29	0	29	350	350	0
Subsidiaries Equipment	17	0	17	17	0	17	200	200	0
Other	58	232	(174)	58	232	(174)	691	691	0
Slippage	0	0	0	0	0	0	(7,450)	(7,450)	0
Donated Income	(91)	(21)	(70)	(91)	(21)	(70)	(1,398)	(1,398)	0
Total Trust Funded Capital excl Finance Leases	**1,977**	**1,484**	**493**	**1,977**	**1,484**	**493**	**34,566**	**34,566**	**0**
Medical Equipment Panel (MEP) - Leases	41	0	41	41	0	41	2,200	2,200	0
Equipment leases	183	0	183	183	0	183	500	500	0
IISS	260	0	260	260	0	260	3,115	3,115	0
Fit out of C Level VE (MRI) Capacity	0	0	0	0	0	0	5,619	5,619	0
Adanac Park Car Park	0	0	0	0	0	0	3,000	3,000	0
Total Trust Funded Capital Expenditure	**2,461**	**1,484**	**977**	**2,461**	**1,484**	**977**	**49,000**	**49,000**	**0**
Disposals	0	0	0	0	0	0	0	0	0
Total Including Technical Adjustments	**2,461**	**1,484**	**977**	**2,461**	**1,484**	**977**	**49,000**	**49,000**	**0**
Externally Funded Schemes									
Maternity Care System (Wave 3 STP)	30	0	30	30	0	30	89	89	0
Digital Outpatients (Wave 3 STP)	49	19	30	49	19	30	592	592	0
Total CDEL Expenditure	**2,540**	**1,503**	**1,037**	**2,540**	**1,503**	**1,037**	**49,681**	**49,681**	**0**

2022/23 Finance Report - Month 1

Statement of Financial Position

(Fav Variance) / Adv Variance

The April statement of financial position illustrates net assets of £510.9m, with the main movements in the position explained below.

Receivables and payables both moved by significant amounts as a result of reclassifying several items on the balance sheet. These therefore contra off.

Cash increased by £4.9m from M12 to M1 due to final payments made by UKHSA related to mass saliva testing. All invoices have now been paid in full.

Statement of Financial Position	2020/21 YE Actuals £m	2022/23 M12 Act £m	2022/23 M1 Act £m	2022/23 MoM Movement £m
Fixed Assets	514.2	514.2	512.8	(1.4)
Inventories	17.0	17.0	17.4	0.3
Receivables	56.3	56.3	93.9	37.6
Cash	148.1	148.1	153.0	4.9
Payables	(208.8)	(208.8)	(254.4)	(45.6)
Current Loan	(2.5)	(2.5)	(2.5)	0.0
Current PFI and Leases	(9.1)	(9.1)	(9.1)	0.1
Net Assets	**515.1**	**515.1**	**510.9**	**(4.2)**
Non Current Liabilities	(20.9)	(20.9)	(21.3)	(0.4)
Non Current Loan	(49.1)	(49.1)	(49.0)	0.1
Non Current PFI and Leases	(33.6)	(33.6)	(33.0)	0.6
Total Assets Employed	**411.6**	**411.6**	**407.7**	**(3.9)**
Public Dividend Capital	261.9	261.9	261.9	0.0
Retained Earnings	109.2	109.2	105.3	(3.9)
Revaluation Reserve	40.5	40.5	40.5	0.0
Total Taxpayers' Equity	**411.6**	**411.6**	**407.7**	**(3.9)**

Please note that the 2021/22 balances are still subject to audit and therefore could potemtially change

University Hospital Southampton NHS
NHS Foundation Trust

Efficiency and Cost Improvement Programme 22/23 – M1

Cost Improvement Programme (CIP) Delivery in Month 1

The reported savings were:

- Significantly lower than plan; £0.26m compared to our plan of £1.67m (£20m phased equally across 12 months). And also,
- Significantly lower than would have been expected based upon a typical profile of delivery over 12 months; £0.98m in month 1.

One of the causes has been delayed reporting of CIP achievement, it is likely that at least £0.23m of further savings have been achieved in the month, which will now be transacted as part of M2 reporting.

In addition, real difficulties are also being experienced with the identification and delivery of CIP schemes. Divisional review meetings recommenced in March (following suspension due to COVID) to support this, yet COVID related absence, operational impacts, and year end procedures all impacted upon CIP management work in April.

CIP Identified for 2022/23, as at the end of Month 1

The table (see right) totals those divisional / directorate schemes on the CIP schedule which have planned start dates and financial values identified.

In addition, there are a number of further schemes for which estimated financial values are available, including those related to medicines optimisation and procurement, which are collectively valued at £5m increasing the total value identified to approximately £10.40m.

Schemes in THQ and informatics have not yet been documented for 2022/23 , and time will be allocated in M2 and M3 to address this.

Actions

- Divisional and Directorate CIP targets have now been confirmed, together with guidance on the valuation and delivery of relevant schemes
- The CIP delivery reporting process and monthly timetable and will be reviewed
- Targets have been set for CIP identification, to achieve at least 75% by the end of Q1 and 100% by the end of Q2
- A focus on converting estimated financial benefits into planned start dates and financial values (M2), in addition to supporting further scheme identification through the review of expenditure changes and enabling trust projects (M2 and M3)
- Meetings will take place with THQ Directorates in M2 and M3 to review their documented CIP plans and financial values

Efficiency improvement through central schemes

- £13m of efficiency improvement is expected to be delivered and accounted for centrally.
- Savings have not been achieved in month 1 as a result of central schemes, though those schemes identified are anticipated to transact in later months.
- Schemes identified include benefits of the theatre supply chain business case, income recovery in relation to prior private patient activity, and the opportunity for financial contribution should NHS elective activity exceed the 104% target level through productivity.

Division	CIP Target 22/23	Total Valued on Schedule 22/23	Total Delivered M1
Division A	£ 4,259,720	£ 1,867,000	£ 164,000
Division B	£ 5,535,422	£ 1,007,000	£ -
Division C	£ 3,937,671	£ 1,091,100	£ 38,000
Division D	£ 3,572,456	£ 660,000	£ 15,000
EFCD	£ 1,301,859	£ 504,000	£ 41,000
Informatics	£ 334,375	£ -	£ -
THQ	£ 1,058,496	£ -	£ -
Total	**£ 20,000,000**	**£ 5,129,100**	**£ 258,000**

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**CRN: Wessex 2021/22 Annual Report and 2022/23 Annual Plan (attached slide-set)**			
Agenda item:	**6.1**			
Sponsor:	**Paul Grundy, Chief Medical Officer** **Christine McGrath, Director of Strategy and Partnerships**			
Author:	**Graham Halls, Business Intelligence Manager, CRN Wessex** **Clare Rook, Chief Operating Officer, CRN Wessex**			
Date:	**26 May 2022**			
Purpose	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **x**
Issue to be addressed:	Unless otherwise stated, this report covers Clinical Research Network (CRN) Wessex's performance in the 2021/22 financial year (April 2021 to March 2022). **Key achievements/issues:** ● The National Institute of Health and Care Research (NIHR) and CRN Wessex's priorities for UK clinical research were COVID-19, the managed recovery of the existing research portfolio, other published strategic improvement initiatives and the CRN's high level objectives. ● Over one hundred and fourteen thousand participants were recruited in the 2021/22 financial year. This was the highest recruitment per million population for the second year compared to the fourteen other CRN regions in England. ● Since March 2020, over two hundred and two thousand participants have supported one hundred and one pandemic studies at over three hundred sites in Wessex. More than ten per cent of these studies have been developed in and led by the region. Three Wessex sites are in the top ten of over six thousand NHS sites for COVID-19 research recruitment. Over three thousand volunteers have been recruited on to COVID-19 vaccine trials. ● Only six per cent of study research sites remain paused for reasons related to the pandemic. The number of recruiting studies has increased in Wessex, on average, each quarter during 2021/22. ● Eight hundred and thirty-three thousand pounds of new funding has been used to establish a direct delivery team (DDT) based at three research hubs in Bournemouth, Southampton & Portsmouth and recruiting primarily outside the hospital care setting. ● The highest percentage of GP practices in Wessex ever have participated in clinical research during 2021/22, with almost one hundred and fifty recruiting.			
Response to the issue:	**1 Purpose/Context/Introduction** This report informs the UHS Board of Directors of the clinical research activities within the Wessex region. The report covers pandemic research (including vaccine trials), the restart and managed recovery of other studies and performance against the NIHR's high level objectives. Although the report focuses on the 2021/22 financial year research activity, it was necessary to expand this period when discussing the response to the COVID-19 pandemic.			

2 Key issues

National priorities for health research

The National CRN Coordinating Centre and the Department of Health and Social Care (DHSC) Science, Research and Evidence Directorate agree on a set of national priorities for the CRN on an annual basis. These priorities are set in the pursuance of the vision, goals, and aims of the CRN. These priorities are reflected in the annual plan for CRN Wessex.
The priority activities for the NIHR CRN in 2021/22 are listed in chart one.

COVID-19 research	• COVID-19 Vaccine studies • COVID-19 non-Vaccine studies.
Recovery, Resilience and Growth (RRG) of Clinical Research (including Managed Recovery)	• Deliver the UK-wide programme of work to drive the managed recovery of multi-site studies • Deliver existing commitments to make UK clinical research delivery easier, more efficient, and more effective • Begin to deliver ambitious new initiatives that will set us on the path towards realising our vision for the future of UK clinical research.
NIHR CRN Strategic Improvement Priorities	• Primary Care Research Engagement • Review and Refresh CRN Research Delivery • CRN Governance Improvement • Evidence the impact and value of the activity of the CRN on the health and care sector.
NIHR CRN High Level Objectives (HLOs)	• The purpose of the NIHR CRN is to provide efficient and effective support for the initiation and delivery of funded research in the NHS and other health and care settings. The performance of the NIHR CRN in meeting this purpose is measured against the CRN High Level Objectives (HLOs). The priority for the NIHR CRN is to meet and, if possible, exceed the HLO ambitions set on an annual basis by the DHSC.

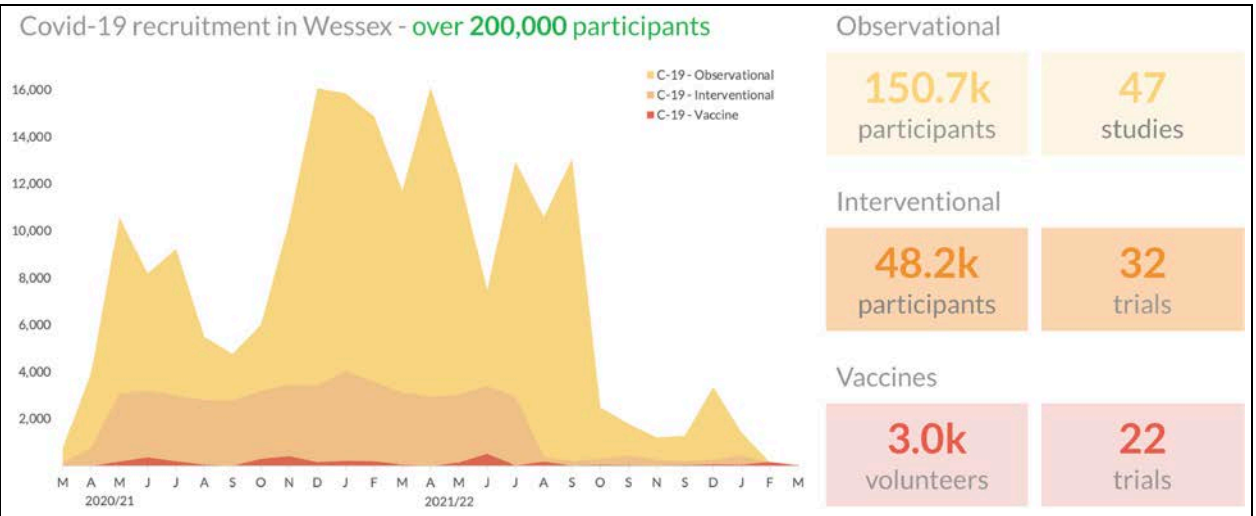
Chart 1 – NIHR priorities for the 2021/22 financial year: 1 April 2021 – 31 March 2022.

COVID-19 research

The NIHR's goal through research into COVID-19 is to gather the necessary clinical and epidemiological evidence to inform national policy and enable new diagnostics, treatments, and vaccines to be developed and tested.

CRN Wessex's activities to support COVID-19 research studies are summarised in charts 2a-c. Wessex research sites have recruited over two hundred thousand participants. The Wessex region has been the lead for over thirty studies, or 10.5 per cent of the English COVID-19 portfolio. Acting as the lead usually involves supporting a sponsor in the development and site selection for a project led by a local chief investigator and their team. For comparison, Wessex has only five per cent of the English population.

Three Wessex sites, Moorgreen Hospital (Southern Health), Queen Alexandra Hospital in Portsmouth and Southampton General Hospital, were within the top ten of 6,193 recruiting United Kingdom NHS sites (chart 2b). They surpassed some of the largest hospitals in the country.



Participants recruited	Recruiting studies	Recruiting studies – lead network	Recruiting sites
2,691,775 UK	297 UK	294 England	6,193 UK
202,321 (7.5%) Wessex	101 (34.0%) Wessex	31 (10.5%) Wessex	302 (4.9%) Wessex

Chart 2a – Key COVID-19 research deliverables in Wessex with UK or England figures provided for reference: 1 March 2019 – 31 March 2022.

Site name	Region	Participants
Yorkshire Ambulance Service Trust HQ	Yorkshire and Humber	66,512
Moorgreen Hospital	Wessex	64,243
University Hospitals of Leicester NHS Trust	East Midlands	18,662
Bristol Royal Infirmary	West of England	15,770
Queen Alexandra Hospital	Wessex	13,614
Southmead Hospital	West of England	13,484
Queen Elizabeth Hospital	West Midlands	12,233
Southampton General Hospital	Wessex	9,067
Royal Blackburn Hospital	Greater Manchester	8,053
St Thomas' Hospital	South London	7,952

Chart 2b – Top ten highest recruiting NHS trust or primary care sites for COVID-19 research: 1 March 2019 – 31 March 2022.

Wessex recruitment per million population on to the interventional COVID-19 studies has been benchmarked against the fourteen other clinical research network regions in chart 2c. The Wessex region has demonstrated their commitment to patients through their support of lifesaving COVID-19 clinical trials.

Chart 2c – Interventional recruitment on COVID-19 studies per million population by clinical research network region: 1 March 2019 – 31 March 2022.

COVID-19 vaccine trials

Three Wessex vaccine research hubs were set up in Hampshire (Southampton & Portsmouth) and Dorset (Bournemouth) in the 2020/21 financial year, with £1m of pump prime funding from the UK government's Vaccine Taskforce.

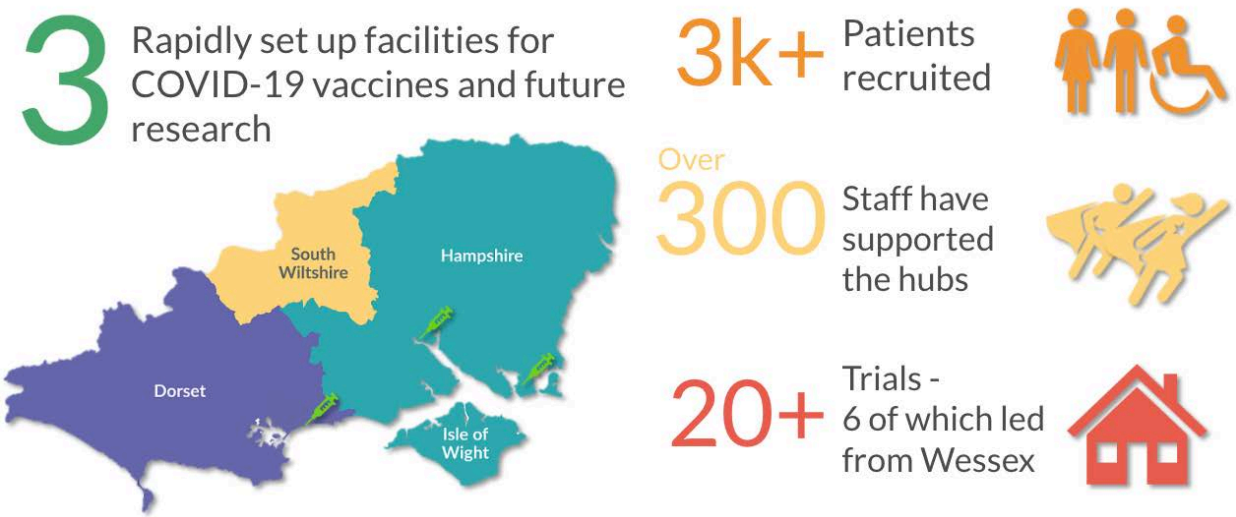


Chart 3a – Location and key performance indicators about the Wessex research hubs: 1 March 2019 – 31 March 2022.

Three thousand one healthy volunteers have been recruited to twenty-one COVID-19 vaccine trials since May 2020 (charts 3a-b). As recruitment increases, so does the ongoing burden of follow up visits, with eight active trials at the end of 2021/22. Over three hundred staff supported the vaccine hubs, either already working for NHS organisations or newly appointed. Six national vaccine trials have been led from Wessex, providing almost ten thousand volunteers in England, Wales and Scotland access to new vaccines or combinations.

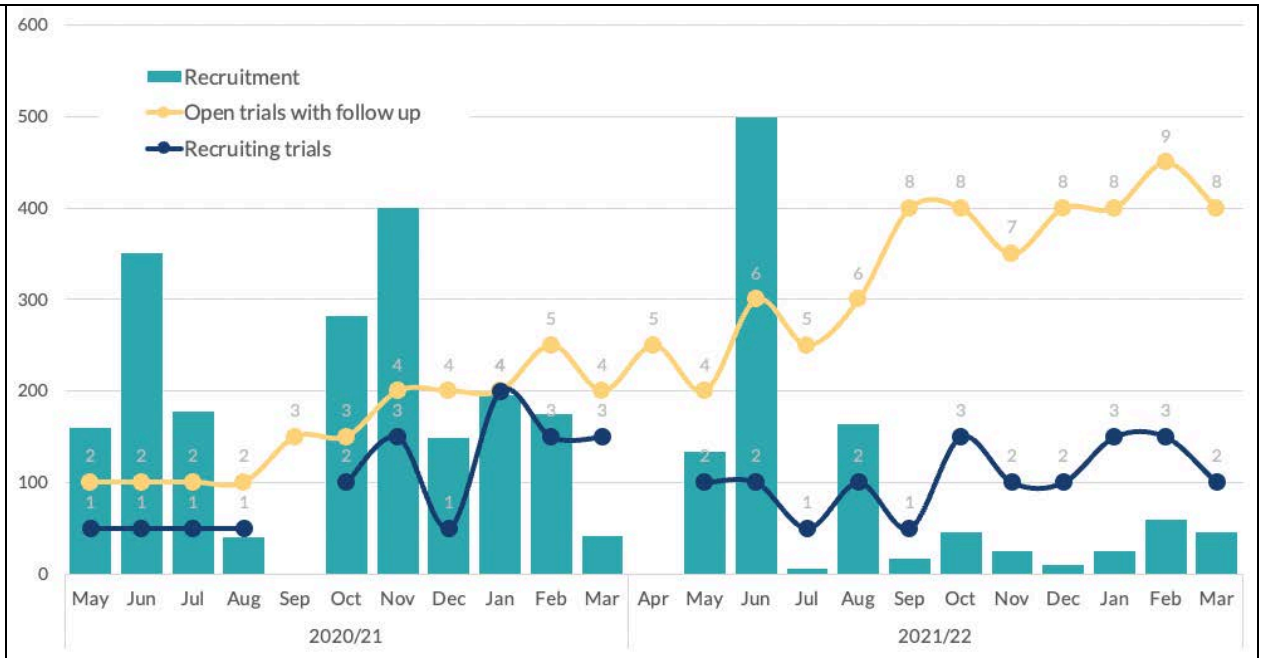


Chart 3b – Number of active COVID-19 vaccine trials and their recruitment in Wessex: 1 May 2020 – 31 March 2022. The first trial opened in May 2020.

DHSC & NIHR Research Recovery, Resilience and Growth Programme (RRG)

The RRG programme has the following key objectives:

- Ensure the restoration of clinical research activity that was underway pre-COVID-19
- Maximise opportunities to build back better
- Deliver on the commitment to make the UK the leading global hub for life sciences.

The DHSC ringfenced over £15 million to support the managed recovery of the UK research portfolio. Wessex received £1.5m over three rounds of funding applications. This investment primarily supports commercial 'managed recovery' badged studies (see the next section for further details) but has also impacted other research.

The restart of research sites across the region has been tracked since the beginning of the 2021/22 financial year (chart four). Most Wessex research sites have now reopened to recruitment or closed, with only six per cent paused due to the pandemic.

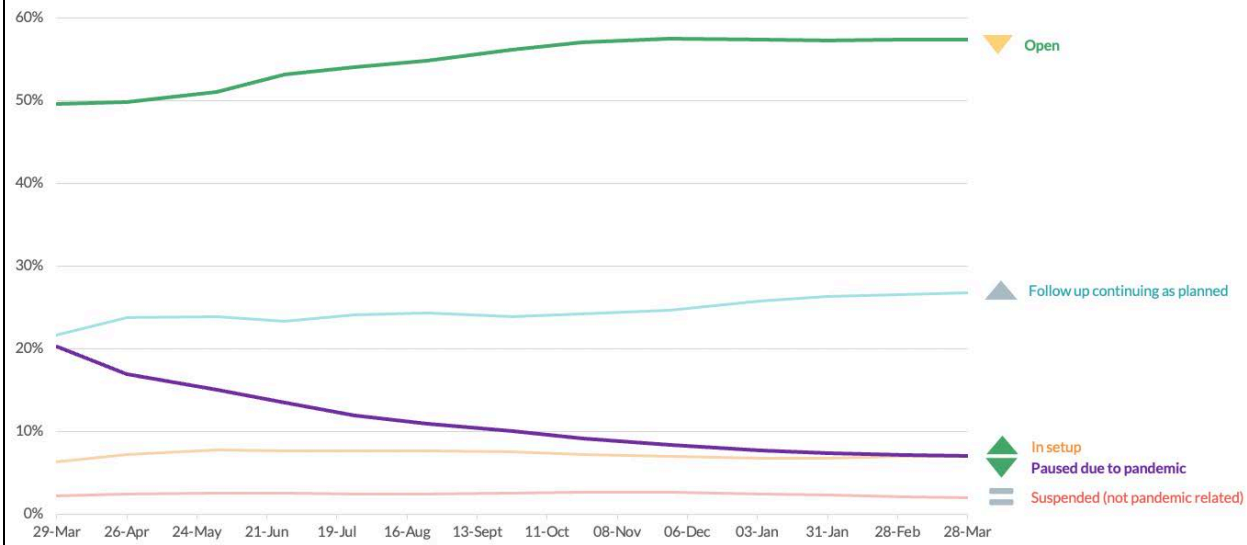


Chart 4 – Wessex recruiting site statuses: 29 March 2021 – 28 March 2022.

Managed recovery

The NIHR CRN has worked with life sciences, non-commercial funders, NHS R&D, research partners across the UK and patients and the public on a process to manage the recovery of multi-site studies. Further details can be found on the NIHR Managing Research Recovery website (https://www.nihr.ac.uk/researchers/managing-research-recovery.htm). The scope was interventional, multi-site clinical research studies that were urgent and required the support of NIHR CRN. Funders identified their most urgent studies.

Research delivery teams worked with local clinical research networks and R&D leadership to assess site, regional and national delivery capacity and capability. National specialty leads reviewed their portfolio to identify other studies that fell into the scope of this approach.

Chart five shows the proportion of interventional research activity on studies that have been identified through this process compared to other research. Twenty-three per cent of Wessex interventional recruitment was on managed recovery identified studies, compared to nineteen per cent across the United Kingdom.

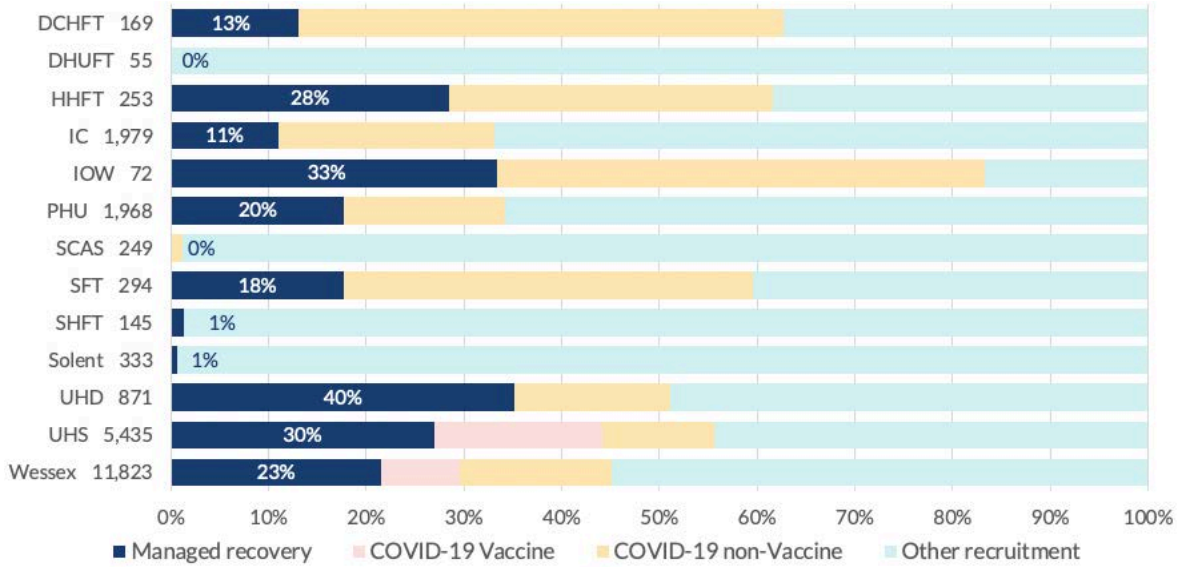


Chart 5 – Proportion of interventional research recruitment by type at each Wessex organisation and for Wessex overall: 1 April 2021 – 31 March 2022. Recruitment is provided alongside the organisation's acronym (see appendix two for full names).

NIHR CRN High level objectives for 2021/22 (HLOs)

The purpose of the NIHR CRN is to provide efficient and effective support for the initiation and delivery of funded research in the NHS and other health and care settings. The performance of the NIHR CRN in meeting this purpose is measured against the CRN High Level Objectives (HLOs). These are outlined in chart six, with current Wessex and English (all LCRNs) performance indicated relating to ambitions agreed with the DHSC.

During 2021/22, the Wessex region achieved five of the seven HLOs. Of note were the primary care activity and the participant in research experience survey, both of which were the highest ever, thanks to the support of staff from across the region. All NHS trusts in Wessex were research active, and over half (one hundred and forty-eight) of primary care practices had some involvement in NIHR CRN portfolio studies during the financial year. Wessex's commercial performance was below the DHSC and NIHR's ambition, which was reflected in England's average performance. In comparison, Wessex performed significantly better on commercial trials identified for additional support through managed recovery.

Objective		Measure	Ambition	Wessex	All LCRNs
Efficient Study Delivery	Deliver NIHR CRN Portfolio studies to recruitment target within the planned recruitment period	(1) Proportion of **new commercial contract studies** achieving or surpassing their recruitment target during their planned recruitment period, at confirmed CRN sites	80%	67%	63%
		(2) Proportion of **commercial contract studies in the managed recovery process** achieving or surpassing their recruitment target during their planned recruitment period	80%	71%	50%
		(3) Proportion of **non-commercial studies in the managed recovery process** achieving or surpassing their recruitment target during their planned recruitment period	70%	100%	87%
Provider Participation	Widen participation in research by enabling the involvement of a range of health and social care providers	(1) Proportion of **NHS Trusts recruiting into NIHR CRN Portfolio studies**	99%	100%	100%
		(2) Proportion of NHS Trusts recruiting into NIHR CRN Portfolio **commercial contract studies**	70%	73%	71%
		(3) Proportion of **General Medical Practices** recruiting into NIHR CRN Portfolio studies	45%	57%	51%
Participant Experience	Demonstrate to people taking part in health and social care research studies that their contribution is valued	Number of NIHR CRN Portfolio study participants responding to the **Participant in Research Experience Survey**, each year	1,113	1,216	- Not reported yet

Chart 6 – Local and national performance for the NIHR CRN High Level Objectives for 2021/22: 1 April 2021 – 31 March 2022.

All research activity in Wessex

The recruitment to NIHR CRN portfolio studies over time in Wessex and UK-wide is shown in chart 7a. The monthly total participants enrolled more than doubled from levels in 2019/20 (April 2019 - March 2020) in Wessex and the rest of the UK. Over fifty per cent of UK recruitment was on only four exceptionally large studies that required no change to the participant's care, one of which was designed and led by Southern Health NHS Foundation Trust. The closure of three of these studies in the second half of 2021 resulted in a fall in average recruitment to 4,800. For comparison, the Wessex average monthly recruitment in the year before the pandemic was 3,200.

Chart 7a – NIHR CRN portfolio research recruitment by month over the last two financial years (1 April 2020 – 31 March 2022) in Wessex and the UK, for comparison.

Charts 7b to 7d compare year on year Wessex recruitment by the lead medical specialty, local clinical research network region and NHS organisation. Around one hundred fourteen thousand five hundred participants were recruited in Wessex during the 2021/22 financial year, the third-highest among LCRN regions.

During this year, the mental health, infection, primary care and children specialties were dominant, primarily because pandemic research has been led from these areas. At the end of 2020, CRN Wessex appointed its first delivery manager for public health and social care research. The highest proportional growth was seen in ageing, hepatology, surgery and public health – each with over three hundred per cent increases in recruitment compared to the 2020/21 financial year. In general, most Wessex specialties appear to have begun to recover in total recruitment, but not necessarily in the breadth of studies available to patients in the region. Seven of the eleven NHS trusts increased their recruitment compared to the 2020/21 financial year (chart 7d).

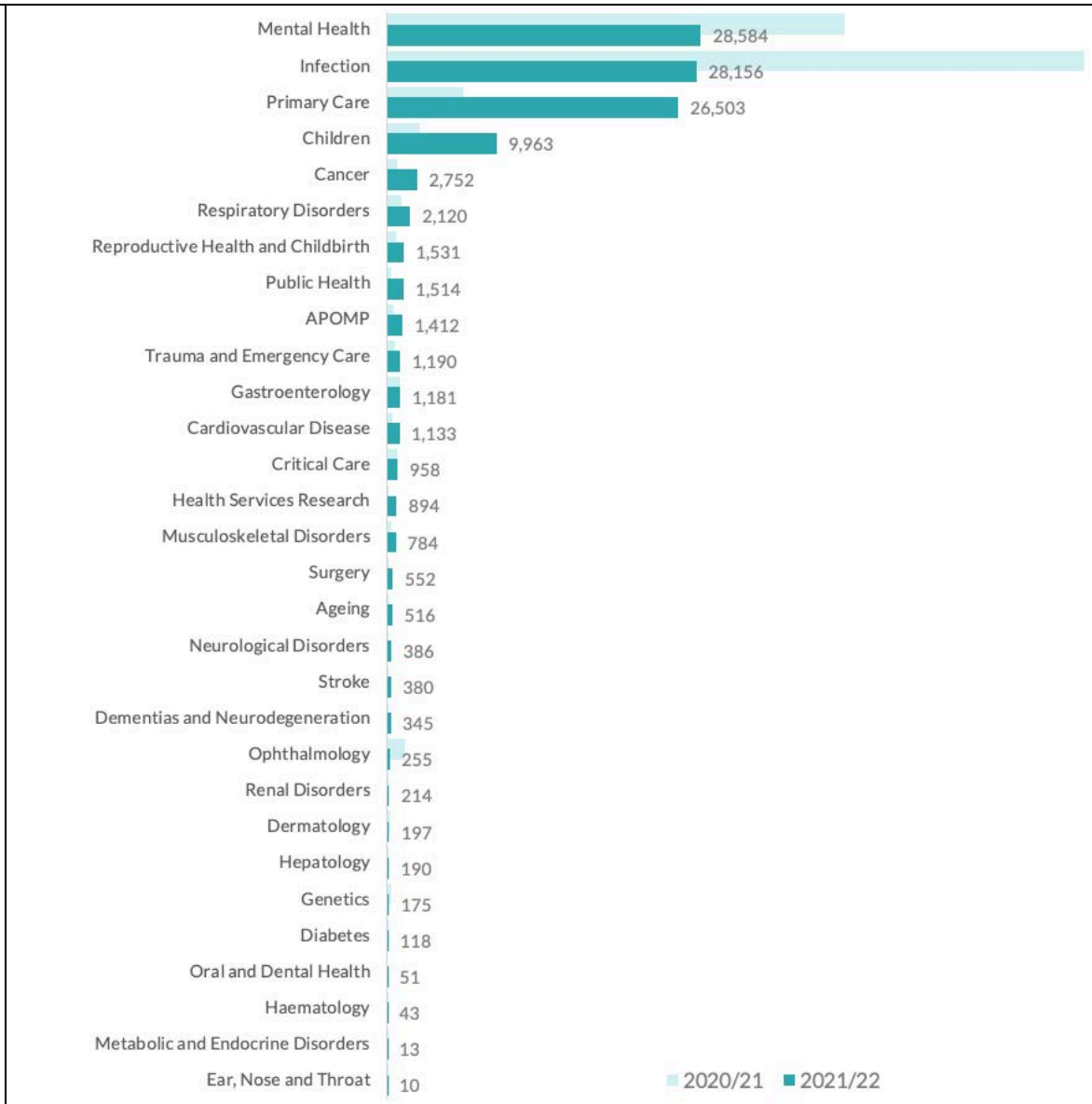


Chart 7b – NIHR CRN portfolio research recruitment by managing specialty over the last two financial years (1 April 2020 – 31 March 2022) in Wessex.

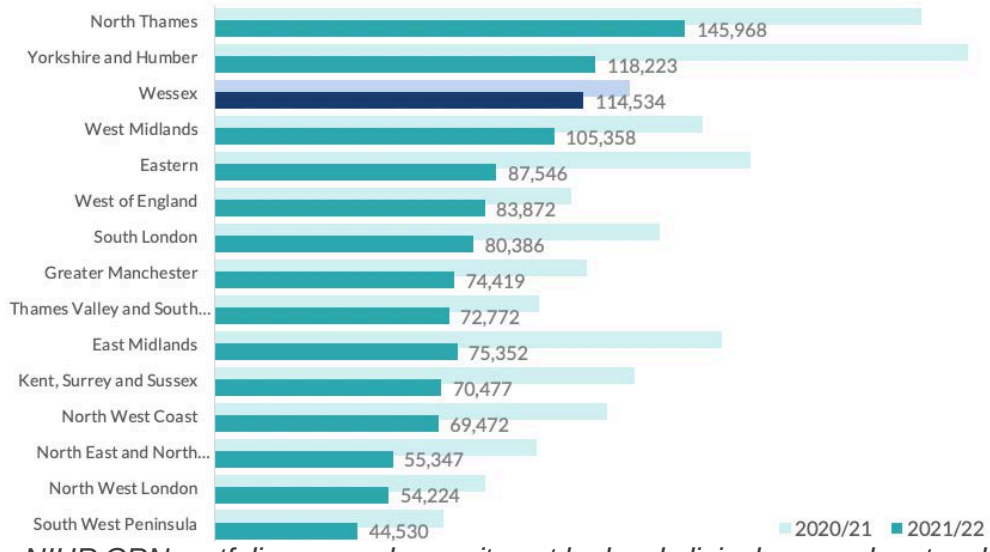


Chart 7c – NIHR CRN portfolio research recruitment by local clinical research network over the last two financial years: 1 April 2020 – 31 March 2022.

Chart 7d – NIHR CRN portfolio research recruitment by Wessex partner organisation over the last two financial years: 1 April 2020 – 31 March 2022.

The pandemic has disrupted research in the region, but signs show that it is beginning to recover. The number of studies that have recruited each quarter since April 2017 is shown in chart eight. This was relatively consistent until resources were re-prioritised to the pandemic response in quarter one of the 2020/21 financial year. The one-year rolling average shows that the number of recruiting studies has increased since, with a slight drop in the final quarter.

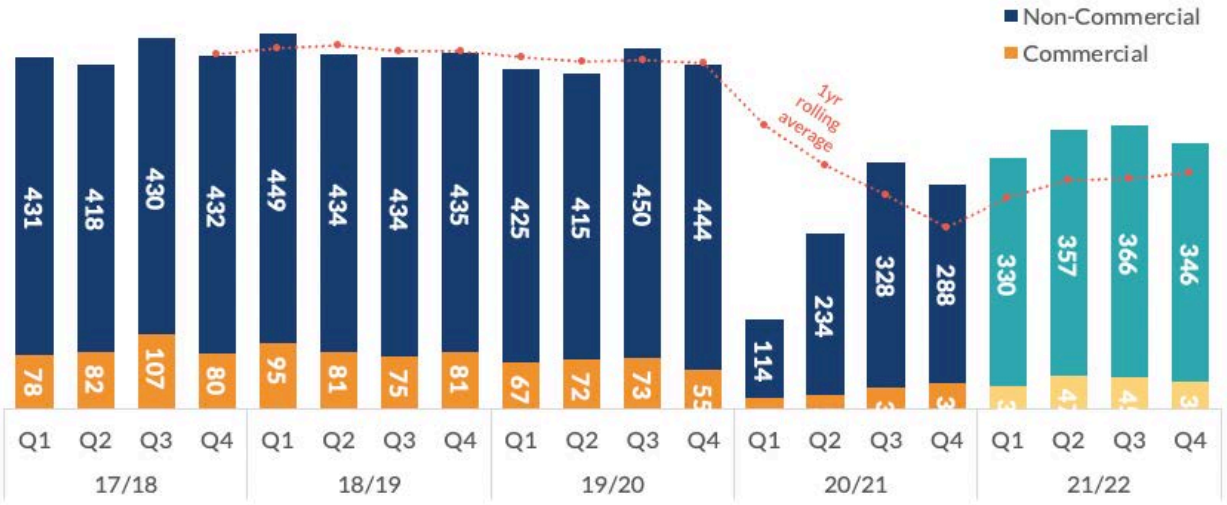


Chart 8 – Total NIHR CRN portfolio studies that have recruited within Wessex by quarter in the last five financial years (1 April 2017 – 31 March 2022).

Direct delivery teams

In 2021/22, an additional £30m funding was provided across the fifteen local CRNs. £17.5m was for cost pressure and staff retention (CRN Wessex received £1.1m) and £12.5m of this was to be used to build a new workforce, a 'CRN Direct Delivery Team' (DDT). These were established in each local CRN with the flexibility to deliver priority research studies across broader settings, particularly outside of hospitals. Wessex received £833,000 to fund the direct delivery team, and in total, received just under £2m of the £30m allocations (6.7%). Wessex's DDTs are based at the three hubs established within Wessex at Bournemouth, Southampton, and Portsmouth in 2020/21. The team supports trial delivery in the hubs and elsewhere across Wessex, including in primary care.

Implications: (Clinical, Organisational, Governance, Legal?)	All NHS organisations have a duty to their local population to participate in and support health and care research. The NIHR provides service support funding to facilitate research activity within Wessex. It is, therefore, necessary for CRN Wessex and its partner organisations to ensure that this is used effectively during the pandemic response and subsequent recovery, resilience, and growth of other studies.
Risks: (Top 3) of carrying out the change / or not:	CRN Wessex maintains a risk register which can be found in appendix one. The main identified risks relating to the subjects covered in this paper are: 1. Staff burnout. 2. Fuel prices/fuel shortage. 3. Supply chain issues. Please review the risk register for details of the already underway or planned responses.
Summary: Conclusion and/or recommendation	The 2021/22 financial year was the second-largest ever in terms of research activity. This was a direct result of the disproportionate and considerable development and support for COVID-19 research provided by the general practices, care homes, hospitals and other sites in the Wessex region. The region demonstrated that it was a leader in vaccine research. These organisations' clinical and administrative staff can be proud of their contribution to lifesaving pandemic trials and the substantial work completed in 2021/22 to recover the non-Covid 19 portfolio. The establishment of research hubs and a direct delivery team and plans in 2022/23 for new methods of mobile and decentralised research delivery should lead to the targeting of under-served communities and further improvements in the clinical research service for the Wessex population. The UHS Board of Directors will continue to be updated on performance quarterly.

Appendix
Appendix 1 – CRN Wessex Risk Register

Page one of two:

PRE-RESPONSE (INHERENT)									POST RESPONSE (RESIDUAL)							
Risk ID	**Primary category**	**Date raised**	**Risk Owner**	**Risk Description (to include cause/event, and effect)**	**Probability**	**Impact**	**Value (PxI)**	**Proximity**	**Response Actions**	**Action owner(s)**	**Action status**	**Probability**	**Impact**	**Value (PxI)**	**Risk status (open or closed date)**	**Trend** (since last reviewed)
CRN 02	Performance	Apr-17	CDs/COO	**Cause: Reduction in commercial contract research**. Exacerbated by national pandemic declared in March 2020. **Event:** Leading to a reduction in the treatment options for patients from commercial research studies and reduced commercial income. **Effect:** Meaning that there will be less funding for research infrastructure and treatment opportunities for patients. In addition diminished infrastructure to support new initiatives with commercial sponsors.	4	4	16	Now	1. Dedicated Industry Manager post to promote commercial research in the network. 2. Close monitoring and support for partners with EOI process 3. Support for partners to recruit to time and target to maximise the performance metrics for delivery of commercial research 4. Reporting and discussion through executive group and partnership group 5. Allocation of contingency funding as appropriate to support infrastructure 6. Maximise commercial vaccine activity 7. Engage with RRG prrogramme and managed national recovery workstreams 8. Applications submitted for all rounds of MR funding 9. Develop research hub operating model to provide opportunities for all trusts to support commercial trials	Commercial Lead	All - ongoing	4	3	12	Open	Static
CRN 03	Reputational	Apr-17	CDs/COO	**Cause: Contract renewal** due 31 March 2024 **Event:** Leading to **uncertainty** in Wessex research system **Effect:** Meaning that **staff seek suitable alternative employment**	3	3	9	Mar-24	1. Participate in national consultations and shape of future local networks 2. Continued communication to keep staff informed as more information becomes available 3. Contract extension by DHSC to 31 March 2024 4. CRN team ready to support re-application process	CD(s)	Ongoing Ongoing Complete Ongoing	2	2	4	Open	Static
CRN 04	Performance	Nov-18	CDs/COO	**Cause: Service pressures from restart of clinical services post acute clinical pressures of further waves of pandemic in NHS and social care** **Event:** Leading to **partner disengagement and reduction in research capacity** with research agenda due to clinical and service pressures **Effect:** Meaning a **decrease in activity.** Portfolio activity may be affected due to large amount of resources needed to support clinical services and exacerbated with the response to the pandemic. (see CRN 06).	5	3	15	Now	1. WFD strategy to provide optimal support. Weekly stand-up meeting with senior research nurses and weekly update call with all partners 2. Support partners with managed recovery programme through study support service to sequence studies appropriately aligned with the restart of clinical services in their organisations 3. Capture legacy of pandemic and maintain pace of research and risk based management of research to support agile research delivery. 4. Deployment of DDT in 21/22 to provide additional research capacty in community and non NHS settings with teams dispersed across Wessex in the vaccine hub locations	WFD Lead	All - ongoing	5	3	15	Open	Increased
CRN 06	Performance	Jun-20	CDs/COO	**Cause: Future waves of Covid-19 pandemic** **Event:** Leading to a **reduction in research capacity** in NHS and social care **Effect:** Meaning **recruitment** to all studies, including priority studies, may be **detrimentally affected** by future waves of Covid infections. In *extremis* CRN funded staff may be redeployed to clinical duties and shortages in staffing will be exacerbated by staff sickness, sheilding and isolating.	5	4	20	Now	1. Agile staff deployment supported by contractual arrangements between partners and the host. 2. Strong clinical leadership to motivate staff and provide first-hand intelligence to the partners 3. Wessex workforce campaign to recruit additional staff to DDT 4. Active support for POs to restart non UPH studies e.g weekly calls with POs 5. Core team returning to 40/60 split of office/home January 2022	WFD Lead / COO / SSS Lead	All - ongoing	5	2	10	Open	Decreased

Page two of two:

PRE-RESPONSE (INHERENT)									POST RESPONSE (RESIDUAL)							
Risk ID	**Primary category**	**Date raised**	**Risk Owner**	**Risk Description (to include cause/event, and effect)**	**Probability**	**Impact**	**Value (PxI)**	**Proximity**	**Response Actions**	**Action owner(s)**	**Action status**	**Probability**	**Impact**	**Value (PxI)**	**Risk status (open or closed date)**	**Trend** (since last reviewed)
CRN 7	Workforce	Aug-21	CDs/COO	**Cause: Staff burnout** **Event: Lack of registered staff to deliver clinical trials** **Effect: Meaning that fewer clinical trials are delivered**	4	4	16	Now	1. Ongoing recruitment to the direct delivery team 2. Reinvestment of hub income to increase head count 3. Use MR additional funding to recruit to data management and CTA posts to relieve research nurses of non-clinical tasks	WFD/COO	All - ongoing	4	4	16	Open	Increased
CRN 8	Performance	Mar-22	CDs/COO	**Cause: Fuel prices/fuel shortage** **Event: Cost of fuel becomes prohibitively expensive/fuel shortages prevent core delivery team travel across the region to deliver trials** **Effect: Meaning that fewer clinical trials are delivered**	3	4	12	Now	1. DDT based nearer hub locations could pick up some work 2. Look for opportunities for remote trial delivery	COO/DCOO	All - ongoing	4	4	16	Open	Increased
CRN 9	Performance	Mar-22	CDs/COO	**Cause: Supply chain issues** **Event: Cost of fuel becomes prohibitively expensive/fuel shortages impact on supply chain for drugs and consumables required for trial delivery** **Effect: Meaning that fewer clinical trials are delivered**	3	4	12	Now	1. Raise locally and nationally for advice on prioritisation of key activities/studies	COO/DCOO	All - ongoing	4	4	16	Open	Increased

Appendix 2 - Glossary

Partner organisation abbreviations used by CRN Wessex:

- DCHFT – Dorset County Hospital NHS Foundation Trust
- DHUFT/DHC - Dorset Healthcare University NHS Foundation Trust
- HHFT - Hampshire Hospitals NHS Foundation Trust
- IOW - Isle of Wight NHS Trust
- IC – Independent contractors, including primary care practices
- Non-NHS – Organisations linked to the NHS such as universities, care homes etc.
- PHU - Portsmouth Hospitals University NHS Trust
- SFT - Salisbury NHS Foundation Trust
- Solent – Solent NHS Trust
- SCAS - South Central Ambulance Service NHS Foundation Trust
- SHFT - Southern Health NHS Foundation Trust
- UHD – University Hospitals Dorset NHS Foundation Trust
- UHS - University Hospital Southampton NHS Foundation Trust

Local clinical research network or devolved nation abbreviations and their 2021/22 financial year population:

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

NIHR | National Institute for Health Research

CRN Wessex Annual plan 2022/23

Areas of Strategic Focus

- Build on learnings from the **research response to COVID-19** and support the **recovery of the health and social care system**
- Build **capacity and capability** in **preventative, public health and social care** research
- Improve the lives of people with **multiple long-term conditions** through research
- Bring clinical and applied research to **under-served regions** and communities with **major health needs**
- **Strengthen careers** for research delivery staff and under-represented disciplines and specialisms
- Expand our work with the **life sciences industry** to improve health and economic prosperity
- Driving research through **digital developments**
- Communication of **research strengths and opportunities** more broadly

Build on learnings from the research response to COVID-19 and support the recovery of the health and social care system

- Delivery of the **PANORAMIC platform study** utilising successful collaboration between general practices with delivery support from LCRN core research nurse and direct delivery teams
- **HARMONIE study** - taking a Wessex wide approach and a mixed model for contracting to deliver this RSV immunisation trial in infants
- Develop a **future research hub** model

Build capacity and capability in preventative, public health and social care research

- New Primary Care Network (PCN) **funding model** to enable population level research activity and contribute to **national primary care strategy by increasing number of GP practices** in Wessex recruiting to research studies
- Funding of **Local authority** based researchers/research leads
- Pan network project to develop community based **participant identification centres**

Bring clinical and applied research to under-served regions and communities with major health needs

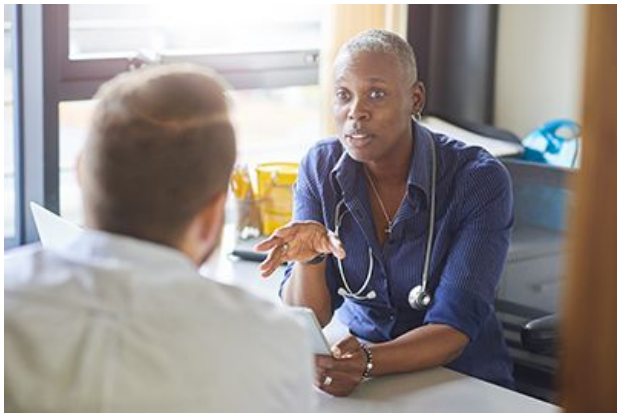
- **Roving PI** for diabetes on the Isle of Wight
- Developing **research ready communities**
- Take research out to community locations on **research buses**
- Establish a **steering group** to oversee a number of projects related to meeting the research needs of under-served populations

Improve the lives of people with multiple long-term conditions through research

- Embedding research within **Dorset ICS** wellbeing & diagnostic hubs
- Scoping of **social prescribing services** across the supra-region

Strengthen careers for research delivery staff and under-represented disciplines and specialisms

- Development of **GP research fellow posts**
- Post acute stroke research group - supporting ECRs working in the community, facilitating **under-represented post acute stroke research** in a non-acute setting to meet local need
- **Mental health research** extended into **primary care and community** settings e.g. IAPT

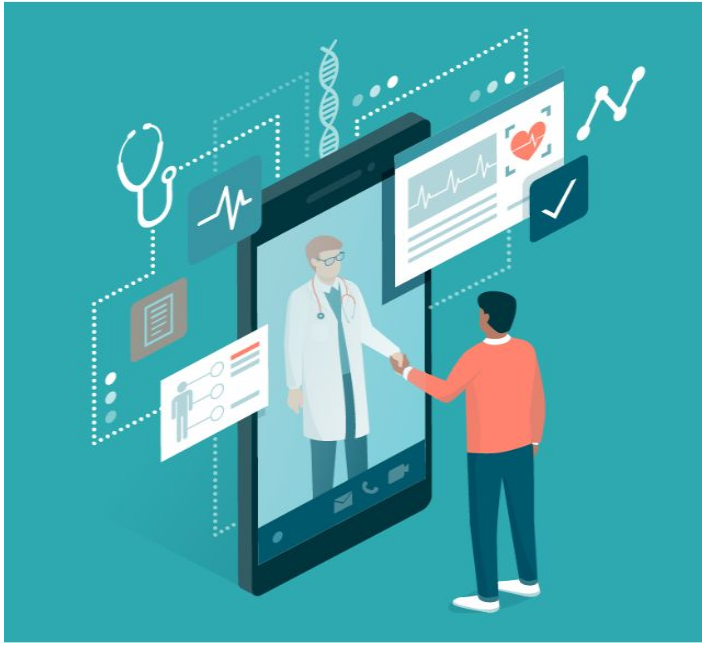


Expand our work with the life sciences industry to improve health and economic prosperity

- **Dementia Rater** - local **supra regional lead rater post** working with national rater programme
- Local implementation of **national costing validation** for commercial research (National Contract Value Review)

Driving research through digital developments

- Find, Recruit and Follow-Up
  - Analysis of large data-sets
  - Approach individuals about participation
  - Collect outcome data using existing data
- Piloting of **UMed** - digital tool to support general practices to become research active
- Demographics project to identify reach of research within Wessex



Communications

- **Regional workforce campaign** to showcase the benefits of a career in health and social care research delivery.
- **Thank you event** and activities to acknowledge the contributions of research delivery staff across Wessex
- **Social media marketing** to reach new audiences and support recruitment to trials.
- Launch of a **new e-newsletter** to promote research opportunities to patients and the public.
- **Increased storytelling** and PR activities to communicate the value of the NIHR and its partners.

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Register of Seals and Chair's Actions**			
Agenda item:	**7.1**			
Sponsor:	**Jane Bailey, Interim Chair**			
Date:	**26 May 2022**			
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. There have been no Chair's actions since the last report.			
Implications: (Clinical, Organisational, Governance, Legal?)	Compliance with The NHS Foundation Trust Code of Governance (probity, internal control) and UHS Standing Financial Instructions and Scheme of 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 **Deed of Amendment** made by University Hospital Southampton NHS Foundation Trust in its capacity as trustee of Southampton Hospital Charity to change the charity's registered name to Southampton Hospitals Charity to reflect the charity's branding. Seal number 244 on 3 May 2022.

2 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:	**Remuneration and Appointment Committee Terms of Reference**			
Agenda item:	**7.2**			
Sponsor:	**Jane Bailey, Interim Chair**			
Author:	**Karen Flaherty, Associate Director of Corporate Affairs and Company Secretary**			
Date:	**26 May 2022**			
Purpose	**Assurance or reassurance**	**Approval** X	**Ratification**	**Information**
Issue to be addressed:	At its meeting in March 2022, the Remuneration and Appointment Committee (the **Committee**) considered its role in recommending and monitoring the level and structure of remuneration for 'senior management'. The Committee agreed that: • the definition of senior management for these purposes should be non-clinical senior leadership roles remunerated at levels above those specified in the NHS agenda for change terms and conditions, all of which are in the first layer of management below board level; and • it would monitor the remuneration for these roles annually and approve the level of remuneration or any proposed change to remuneration where the proposed remuneration for the role would exceed that of any executive director.			
Response to the issue:	The terms of reference for the Committee have been amended to reflect the Committee's decision. The proposed changes are highlighted in the attached draft of the terms of reference, which have been reviewed and are recommended for approval by the Committee.			
Implications: (Clinical, Organisational, Governance, Legal?)	The terms of reference ensure that the purpose and activities of the 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 NHS Foundation Trust Code of Governance. 2. Non-compliance with the Trust's constitution relating to the composition of Board committees. 3. The Board of Directors and the Committee may not function as effectively without terms of reference in place.			
Summary: Conclusion and/or recommendation	The Board of Directors is asked to: • agree the definition of senior management for these purposes as non-clinical senior leadership roles remunerated at levels above those specified in the NHS agenda for change terms and conditions, all of which are in the first level of management below board level; and • approve the revised terms of reference for the Committee.			

Remuneration and Appointment Committee Terms of Reference

Version: ~~3~~4

Date Issued:	~~30 November 2021~~26 May 2022
Review Date:	November 2022
Document Type:	Committee Terms of Reference

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1. Role and Purpose

1.1 The Remuneration and Appointment Committee (the **Committee**) is responsible for identifying and appointing candidates to fill all the executive director positions on the board of directors (the **Board**) of University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**) and for determining their remuneration and other conditions of service.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of independent and objective review of remuneration and executive director appointments in accordance with relevant laws, regulations and Trust policies.

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

2. Constitution

2.1 The Committee has been established by the Board. The Committee has no executive powers other than those set out in these terms of reference.

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 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 the non-executive directors of the Trust except as provided in paragraph 3.2 below.

3.2 For any decisions relating to the appointment or removal of the executive directors, membership of the Committee will include the Chief Executive Officer, as required under Schedule 7 of the National Health Service Act 2006, who will count in the quorum for the meeting. The Chief Executive Officer will not be present when the Committee is dealing with matters concerning their appointment or removal, remuneration or terms of service.

3.3 The chair of the Board will chair the Committee (the **Committee Chair**). In the absence of the Committee Chair and/or an appointed deputy, the remaining non-executive directors present will elect one of themselves to chair the meeting.

3.4 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 Chief People Officer; and

3.4.2 Associate Director of Corporate Affairs/Company Secretary.

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 that are the responsibility of a particular executive director or manager. Any attendee will be

asked to leave the meeting when the Committee is dealing with matters concerning their appointment or removal, remuneration or terms of service.

4. Attendance and Quorum

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

4.2 The quorum for a meeting will be four members, including the chair of the Board (or the Deputy Chair in their absence). 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.

5. Frequency of Meetings

5.1 The Committee will meet as required, which will usually be four times each year.

5.2 The Committee may establish a sub-committee for a specific purpose where it would be impractical for the Committee to be involved, for example the appointment of an executive director following agreement by the Committee of the process, job description and person specification.

6. Conduct and Administration of Meetings

6.1 Meetings of the Committee will be convened by the Company Secretary 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 People Officer and the Company Secretary. The agenda and supporting papers will be distributed to each member of the Committee and the regular attendees no later than 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 Company Secretary 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

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

Remuneration Role

7.2 The Committee will:

7.2.1 establish and keep under review a remuneration policy in respect of executive directors (as set out in Appendix A);

7.2.2 consult the Chief Executive Officer about proposals relating to the remuneration of the other executive directors;

7.2.3 in accordance with relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of the Trust's executive directors, including salary, any performance-related pay or bonus, provisions for other benefits,

including pensions and cars, allowances, payable expenses and compensation payments;

7.2.4 adhering to all relevant laws, regulations and Trust policies:

7.2.4.1 establish levels of remuneration that are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose, and at a level that is affordable to the Trust;

7.2.4.2 decide whether a proportion of executive director remuneration should be structured so as to link reward to corporate and individual performance;

7.2.4.3 make sure that any performance-related elements of executive remuneration are stretching and promote the long-term sustainability of the Trust, and take as a baseline for performance any competencies required and specified in the job description for the post;

7.2.4.4 consider all relevant and current directors relating to contractual benefits such as pay and redundancy entitlements;

7.2.4.5 use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors while ensuring that increases are not made where Trust or individual performance do not justify them;

7.2.4.6 be sensitive to pay and employment conditions elsewhere in the Trust;

7.2.5 monitor and assess the output of the evaluation of the performance of individual executive directors, and consider this output when reviewing changes to remuneration levels;

7.2.6 on an annual basis monitor the remuneration of non-clinical senior leadership roles remunerated at levels above those specified in the NHS agenda for change terms and conditions;

~~7.2.5~~7.2.7 approve the level of remuneration or any proposed change to remuneration for a senior leadership role referred to in 7.2.6 where the proposed remuneration for the role would exceed that of any executive director; and

~~7.2.6~~7.2.8 consider issues of equality and diversity when evaluating and setting remuneration.

Appointment Role

7.3 The Committee will:

7.3.1 regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the Board evaluation process as appropriate, and make recommendations to the Board and the Governors' Nomination Committee, as applicable, with regard to any changes;

7.3.2 give full consideration to and make plans for succession planning for the executive directors, taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future;

7.3.3 keep the leadership needs of the Trust under review at executive director level to ensure the continued ability of the Trust to operate effectively in the health economy;

7.3.4 be responsible for identifying the and appointing candidates to fill posts within its remit as and when they arise;

7.3.5 when a vacancy is identified, evaluate the balance of skills, knowledge and experience of the Board, and its diversity, and in the light of this evaluation, prepare a

description of the role and capabilities required for the particular appointment. In identifying suitable candidates the Committee will use open advertising or the services of external advisers to facilitate the search, consider candidates from a wide range of backgrounds and consider candidates on merit against objective criteria;

7.3.6 ensure that a proposed executive director is a 'fit and proper' person as defined in law and regulation and monitor procedures to ensure that executive directors remain 'fit and proper' persons;

7.3.7 ensure that a proposed executive director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise;

7.3.8 ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported;

7.3.9 carefully consider what compensation commitments (including pension contributions) the executive directors' terms of office would give rise to in the event of early termination to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing executive director's obligation to mitigate loss. Appropriate clawback provisions should be considered in the case of an executive director returning to the NHS within the period of putative notice; and

7.3.10 consider any matter relating to the continuation in office of any executive director, including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract.

8. Accountability and Reporting

8.1 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 Trust's annual report will include sections describing the work of the Committee including its remuneration policies, details of the remuneration paid to executive directors and the process it has used in relation to the appointment of executive directors.

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 Improvement Guidance on pay for very senior managers in NHS trusts and foundation trusts

Appendix A
Executive Director Pay Principles

1. **The importance of executive director pay**
   The delivery of the forward vision and our annual Trust objectives is predicated on ensuring talent is available at all levels of the Trust. Good senior leadership is vital, and therefore a key strategy for UHS must be to recruit and retain the best executive director talent into the Trust. This will be from a combination of both good internal succession planning, bringing top talent from the NHS and also seeking high calibre individuals from other sectors.

2. **Determination of pay levels of posts**
   Pay for executive director posts will be determined by:
   - Use of NHS Improvement (**NHSI**) data on pay for executive director positions in comparable trusts (Figure 1).
   - Use of other salary benchmarking exercises.
   - Job evaluation as required.
   - The conditions required to attract suitably qualified individuals, particularly where commercial, financial or other niche business skills are required.

   Pay levels will be reviewed not less frequently than annually by the Committee in accordance with the Trust's pay review cycle to ensure that salary levels are both appropriate and provide value for money.

3. **Setting salary of executive directors**
   The following principles will apply:
   - UHS will aim to pay at around mid-point of NHSI levels for trusts of a comparable nature and scale.
   - UHS will review pay based on performance, changes in the NHSI framework levels and, in particular, the need to retain key individuals likely to be of interest to other trusts.
   - UHS will not recognise relevant changes of NHSI framework levels in respect of individuals where this is not justified by individual performance.
   - UHS will be mindful of equality, particularly in relation to gender and ethnicity in pay levels.
   - UHS will ensure all cost of living increases nationally awarded are reflected in executive director pay each year, as decided by the Committee, unless performance of an individual is unsatisfactory.
   - Any decision to introduce performance-related pay, or bonuses, will be subject to decision by the Committee based on a sound business case and adherence to NHSI guidance on executive pay.

4. **Approval process**
   All decisions on pay for executive directors will be managed in line with the terms of reference for the Committee.

   The Committee, supported by the Chief People Officer, will also ensure that the NHSI prevailing guidance on setting executive director pay, including any required approval process, will be followed as appropriate.

Figure 1 – NHS Improvement Pay Thresholds

Very large acute NHS trusts and foundation trusts (£500m+)	Lower quartile	Median	Upper quartile
Chief executives	£195,000	£225,000	£267,500
Deputy CEO	£143,500	£165,000	£200,000
Director of finance	£148,500	£157,500	£190,000
HR/Workforce directors	£120,000	£130,000	£145,000
Medical directors	£189,000	£215,000	£230,000
Nursing directors	£130,000	£142,500	£157,500
Chief operating officer	£141,000	£190,000	£198,000
Corporate affairs/Governance directors	£88,000	£105,000	£117,500
Strategy and planning directors	£112,000	£137,500	£162,000
Director of facilities/Estates	£120,000	£135,000	£145,000

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