University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	28/07/2022
Time	9:00 - 12:45
Location	Microsoft Teams
Chair	Jenni Douglas-Todd

1	9:00	**Chair's Welcome, Apologies and Declarations of Interest** Note apologies for absence, and to hear any declarations of interest relating to any item on the Agenda.
2		**Patient Story** The patient 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 26 May 2022** Approve the minutes of the previous meeting held on 26 May 2022
4	9:20	**Matters Arising and Summary of Agreed Actions** Discuss any matters arising from the minutes, and to agree on the status of any actions assigned at the previous meeting.
5		**QUALITY, PERFORMANCE and FINANCE** Quality includes: clinical effectiveness, patient safety, and patient experience
5.1	9:25	**Briefing from the Chair of the Charitable Funds Committee (Oral)** Dave Bennett, Chair
5.2	9:30	**Briefing from the Chair of the Finance and Investment Committee (Oral)** Jane Bailey, Chair
5.3	9:35	**Briefing from the Chair of the Quality Committee (Oral)** Tim Peachey, Chair
5.4	9:40	**Chief Executive Officer's Report** Receive and note the report Sponsor: David French, Chief Executive Officer
5.5	9:50	**Integrated Performance Report for Month 3** Review and discuss the Trust's performance as reported in the Integrated Performance Report. Sponsor: David French, Chief Executive Officer

5.6 **Finance Report for Month 3**

10:30 Review and discuss the finance report
Sponsor: Ian Howard, Chief Financial Officer

5.7 **Complaints Annual Report 2021-22**

10:40 Receive and discuss the report
Sponsor: Gail Byrne, Chief Nursing Officer
Attendee: Ellis Banfield, Associate Director of Patient Experience

5.8 **Learning from Deaths 2022/23 Quarter 1 Report**

10:55 Review and discuss the report
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Ellis Banfield, Associate Director of Patient Experience

5.9 **Maternity Safety 2022-23 Quarter 1 Report**

11:05 Review and discuss the report
Sponsor: Gail Byrne, Chief Nursing Officer
Attendees: Emma Northover, Director of Midwifery/Marie Cann, Senior Midwifery Manager/Alison Millman, Interim Safety & Quality Assurance Matron

5.10 **Break**

11:15

5.11 **Violence and Aggression against Staff Progress Update**

11:30 Review and discuss the update
Sponsor: Steve Harris, Chief People Officer
Attendee: Sarah Herbert, Deputy Chief Nursing Officer

6 **STRATEGY and BUSINESS PLANNING**

6.1 **Corporate Objectives 2022/23 Quarter 1 Review**

11:40 Review and feedback on the corporate objectives
Sponsor: David French, Chief Executive Officer
Attendee: Christine McGrath, Director of Strategy and Partnerships

6.2 **Board Assurance Framework (BAF) Update**

11:50 Review and discuss the update
Sponsor: Gail Byrne, Chief Nursing Officer
Attendee: Helen Potton, Associate Director of Corporate Affairs (Interim)

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

7.1 **Feedback from the Council of Governors' (CoG) meeting on 20 July 2022 (Oral)**

12:00 Sponsor: Jenni Douglas-Todd, Trust Chair

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

12:05 Receive and ratify the Chair's action
In compliance with the Trust Standing Orders, Financial Instructions, and the Scheme of Reservation and Delegation.
Sponsor: Jenni Douglas-Todd, Trust Chair
Attendee: Helen Potton, Associate Director of Corporate Affairs (Interim)

7.3 **Trust Constitution**

12:10 Approve the proposed amendments to the Trust's constitution
Sponsor: David French, Chief Executive Officer
Attendee: Helen Potton, Associate Director of Corporate Affairs (Interim)

7.4 **Trust Executive Committee Terms of Reference**

12:15 Approve the proposed amendments to the Terms of Reference
Sponsor: David French, Chief Executive Officer
Attendee: Helen Potton, Associate Director of Corporate Affairs (Interim)

7.5 **Re-appointment of Directors at UHS Pharmacy Limited (UPL)**

12:20 Approve the recommendation
Sponsor: David French, Chief Executive Officer
Attendee: Helen Potton, Associate Director of Corporate Affairs (Interim)

8 **Any other business**

12:25 To raise any relevant or urgent matters that are not on the agenda

9 **To note the date of the next meeting: 29 September 2022**

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

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

11 **Follow-up discussion with governors**

12:30

University Hospital Southampton
NHS Foundation Trust

Minutes Trust Board – Open Session

Date	26/05/2022
Time	9:00 - 11:55
Location	Dean's Committee Room, C Level, South Academic Block, Southampton General Hospital (and by Microsoft Teams for attendees other than KF, FM and CMcG)
Chair	Jane Bailey (JB), Interim Chair
Present	Jane Bailey (JB), Interim Chair Dave Bennett (DB), Non-Executive Director (**NED**) Gail Byrne (GB), Chief Nursing Officer 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 Ian Howard (IH), Chief Financial Officer Tim Peachey (TP), NED and Interim Deputy Chair/Senior Independent Director Joe Teape (JT), Chief Operating Officer
In attendance	Julie Brooks (JBr), Head of Infection Prevention Unit (for item 5.4) Karen Flaherty (KF), Associate Director or Corporate Affairs and Company Secretary Femi Macaulay (FM), Associate NED Nitin Mahobia (NM), Deputy Director of Infection Prevention and Control (for item 5.4) Christine Mbabazi (CM), Equality & Inclusion Adviser/Freedom to Speak Up Guardian (for items 5.5 and 5.6) Christine McGrath (CMcG), Director of Strategy and Partnerships Emma Northover (EN), Director of Midwifery (for item 5.5) Clare Rook (CR), Chief Operating Officer, CRN: Wessex (for item 6.1) One member of the public (for item 2) Five governors (observing) Four members of staff (observing) Two members of the public (observing)
Apologies	Cyrus Cooper (CC), NED

1 Chair's Welcome, Apologies and Declarations of Interest

JB welcomed all those attending the meeting in person or by Microsoft Teams. This was the first time that the board of directors (the **Board**) had met in person since the COVID-19 pandemic and it was hoped that this would be the first step to returning to meetings that staff, governors and members of the public would be able to attend in person.

DAF introduced Dr Ramkumar Shanmugasundaram, a consultant in clinical oncology and clinical lead for the Wessex and Thames Valley radiotherapy network, who was participating in the NHS Leadership Academy's Nye Bevan programme.

2 Patient Story

The patient story was shared by a carer who had recently had some negative experiences relating to outpatient appointments. Although the Trust's experience of care team was still in the process of responding to the issues that the individual had raised, the carer was keen to share their experiences with the Board to ensure that action was taken as soon as possible to improve the experience for other patients and carers.

While on many occasions both the carer and their brother had experienced great care, the concerns they had raised were:

- the lack of available toilets, including accessible toilets, in proximity to a mobile scanning unit open for appointments on a Sunday morning when patients were asked to attend with a full bladder and were required to drink more water immediately prior to the scan;
- the speed at which contact details were provided on a recorded message, which made it impossible to write these down when listening to the message, and this message had now been changed as a result of the carer's feedback;
- conflicting information provided in appointment letters sent at different times but arriving on the same date;
- the failure to call patients within the appointment time provided for telephone and virtual appointments, with colleagues not being alerted to potential delays thereby enabling them to respond to patients' queries or make alternative arrangements in a timely way; and
- ensuring that a carer's details were clearly recorded in the patient's records to avoid delays when communicating with carers.

The way in which their brother's last outpatient appointment had taken place, with the doctor making the telephone call being given little time to prepare, had left them feeling abandoned as they had been told that no further treatment was available and discharged with minimal explanation or warning. They felt that it would be much kinder for this type of appointment to take place in person. Another appointment had now been scheduled to address this.

The individual requested that toilet facilities were made available near the mobile scanning unit at weekends, staff were asked to write down telephone numbers and email addresses at the same time as recording these messages to ensure that these were read at an appropriate speed and appointment letters were drafted to make clear when a change to a previous appointment was being made.

Board members thanked the individual for sharing their story and for highlighting actions that could be taken to address the issues identified. While the Board acknowledged that staff had been under great pressure recently, it was important to remember that greater consideration and kindness and good communication could make such a difference to the experience of care for both patients and carers. The patient story shared at the meeting in April 2022 had demonstrated how the kindness and compassion of staff had made all the difference for that patient during their time in hospital and to their recovery.

3 Minutes of Previous Meeting held on 31 March 2022

The minutes of the meeting held on 31 March 2022 were approved as an accurate record of that meeting subject to the following changes:

- to change the last line of the second paragraph of the patient story (item 2) to 'Her daughter was now doing well at home having left hospital.'; and
- to correct the initials in the briefing from the chair of the People and Organisational Development Committee (item 5.3) to refer to 'JH' and not 'JB'.

4 Matters Arising and Summary of Agreed Actions

Both actions (689 and 690) from the previous meeting had been completed and could be closed.

5 QUALITY, PERFORMANCE and FINANCE

5.1 Briefing from the Chair of the Audit and Risk Committee

KE summarised the areas considered at the meeting of the Audit and Risk Committee (**ARC**) held earlier that week. These included:

- waivers of competitive tendering processes, which were principally attributable to the need to maintain continuity with an earlier project, although the ARC was keen to receive confirmation that there were no associated budget overruns;
- data protection compliance and the need for ongoing monitoring of the number of subject access and freedom of information requests to ensure that resources were in place to continue to respond in a timely manner;
- the good progress of the external audit of the 2021/22 annual report and accounts, with no significant issues identified to date;
- the draft head of internal audit opinion, which provided significant assurance on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control with minor improvements required;
- the report of the internal audit review of financial controls, which included a medium priority recommendation relating to authority levels not having been followed, albeit that the decisions taken were appropriate;
- the internal audit plan for 2022/23, following which the scope of the internal audit relating to workforce would be reconsidered to perhaps cover staff retention rather than wellbeing to ensure that there was learning that the Trust could put into action;
- the latest updates from the Trust's local counter fraud specialist, including the successful response to cyber-enabled fraud, which had prevented potential losses of just over £200,000 and resulted in no losses to the Trust; and
- the annual self-assessment of the Trust's counter fraud arrangements, with the Trust rating itself as fully compliant in twelve areas and partially compliant in one area relating to the management of conflicts of interest following recent improvements to the process, however this was an improvement on the previous year where the Trust had assessed itself as fully compliant in ten areas.

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. This had included consideration of the following areas:

- the risks to the delivery of the operational plan for 2022/23, including the identification of schemes for the cost improvement programme (**CIP**) and the complexity of the external environment in which the Trust was operating;
- the quarterly update in relation to estates and facilities, including the number of vacancies in this area due to difficulties in recruiting skilled tradespersons in the current labour market, the impact of inflation on costs and the significant progress in addressing backlog maintenance;
- the bi-annual update from the Trust's subsidiary, UHS Estates Limited, which included the integration of theatres management in order to maximise efficiency gains;
- the implications of the delivery of the Trust's capital plan and ongoing investment on capacity and its ability to deliver elective recovery in future years in excess of the current target of 104% of the levels of elective activity in 2019/20; and
- the cost benchmarking and opportunities for efficiency for the trauma and orthopaedics service, which had prompted a wide-ranging discussion, with further reviews planned in other areas.

5.3 Chief Executive Officer's Report

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

- the national paediatric accelerator;
- funding to increase neonatal space and capacity, including the need to spend this by the end of March 2023 while taking account of the impact of implementation on capacity in other areas;
- the results of the latest study in the COV-BOOST trial led by the Trust;
- proposed changes to medical bank rates to address inconsistencies and the resulting imbalance in the fill rates for junior doctor rotas on a Trust-wide basis, which may result in some disruption to rotas in early June 2022; and
- Chris Hopson's appointment as chief strategy officer at NHS England with effect from 10 June 2022 following his successful leadership of NHS Providers representing NHS trusts.

It was noted that the proposal to deliver additional neonatal space and capacity would be presented to the F&IC and the Board at a later date. The proposed changes in designation and the re-designation of neonatal services within Wessex would also have an impact on maternity services provided by the Trust as the two services were closely linked and both mothers and babies would be transferred to maternity and neonatal services at the Trust. While the changes would take effect from 2028, these transfers were likely to begin before then in anticipation of the proposed changes.

The Board discussed the perception among junior doctors of the changes to medical bank rates and how this had been communicated. This had resulted from a balanced review of the quality, efficiency and financial implications of the current approach and the proposed changes, which had been led by clinicians. There was a risk that junior doctors could choose to work additional shifts at other trusts without the adoption of a similarly equitable and consistent approach across the Hampshire and Isle of Wight (**HIoW**) integrated care system (**ICS**). The rates being offered to junior doctors under the new approach were equitable.

The Board also congratulated CC on being recognised as the top research scientist for medicine in the UK and ranking sixteenth worldwide in the list published by research.com, one of the major websites for medicine research. This recognised the extent and contribution of CC's research, including its influence on public health policy. Unfortunately, CC was unable to attend the Board meeting as he was visiting a research centre elsewhere in the UK, however, Board members wished to recognise this achievement and their appreciation for his contribution to medical research and the Board.

5.4 Infection Prevention 2021/22 Annual Report

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

It had been another challenging year for infection prevention, responding to the changing nature of the COVID-19 pandemic and new guidance. The following areas of performance were highlighted, where the Trust had not achieved levels below the national thresholds that had been set in 2021/22:

- one case of MRSA (Methicillin-resistant Staphylococcus aureus) bacteraemia attributable to the Trust that had occurred in March 2022, which had been investigated and classified as unavoidable with the patient currently recovering well in hospital;
- 74 cases of Clostridium difficile, against a threshold of 64 cases; and
- 64 cases of Klebsiella bacteraemia, against a threshold of 64.

The Board reviewed the report and the proposed actions and measures to facilitate the improvements identified, which it considered to be an appropriate response. This was considered to be a good performance overall in very challenging circumstances and reflected the Trust's strong commitment to infection prevention. The Trust expected to see a continuing improvement in performance as processes and learning continued to be embedded.

The Trust continued to adopt a cautious approach to relaxing COVID-19 restrictions within the hospitals in line with national guidance. This evidence-based phased approach allowed the Trust to assess the impact of each change once implemented. New national guidance was expected to be issued within the next week and was likely to focus on managing patients with incidental COVID-19 infections within the relevant specialty, in a similar way to patients with other respiratory infections. This was made more difficult for the Trust due to its older estate and the shortage of side rooms for patients. The Trust would seek to achieve an appropriate and pragmatic balance between elective recovery and infection prevention.

The Board congratulated the infection prevention team on the report and its work and performance. NM thanked the Trust for its support, including the ongoing investment in the physical estate and water safety.

5.5 Ockenden Report - Final Report from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust

Emma Northover joined the meeting for this item.

The report was noted and it was recognised that the learning from the final report following the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust (the **Ockenden review**) could be applied in all clinical areas. The maternity service was compliant with all but

two of the seven immediate and essential actions from the first report 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.

The focus for the maternity service following the publication of the final report from the Ockenden review would be to support the four key pillars of safe staffing, a well-trained workforce, learning from incidents and listening to families as part of the agreed next steps for the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) local maternity and neonatal system (LMNS). The culture within the maternity service was supported by good working relationships between midwives and obstetricians. Further reports were expected later in the year following the independent investigation into the maternity and neonatal services provided by East Kent University NHS Foundation Trust led by Dr Bill Kirkup and an independent review into maternity services at Nottingham University Hospitals NHS Trust.

TP and GB, the Board's maternity safety champions, had visited the maternity service the previous week. They had been impressed by the way in which safe staffing levels were monitored and managed, with four hourly reviews during the day and overnight. They were satisfied that the Trust had done all it could to implement the immediate and essential actions from the Ockenden review and had seen how well midwives, obstetricians and anaesthetists worked together, which was fundamental to maintaining a positive safety culture.

The Board discussed the recent report from Birthrights following an inquiry into systematic racism in maternity care. Maternity continuity of carer had been rolled out to the most vulnerable groups who could have poor outcomes, including black and minority ethnic (**BAME**) mothers, and had been demonstrated to improve outcomes. There were three well-established community teams, whose staff were outside the contingency framework for staffing. While the recommendations in the final report of the Ockenden review had allowed trusts to suspend continuity of carer, the Trust had decided to continue to provide the service to these vulnerable groups.

Christine Mbabazi, the Trust's freedom to speak up (**FTSU**) guardian, who had joined the meeting to present the next item on the agenda, the FTSU report, spoke about the work she was doing with the maternity service to maintain an open and transparent culture where the views of staff were heard. CM and EN were seeking to increase the number of FTSU champions across the Princess Anne Hospital site as this had been proven to have a positive impact on enabling staff to speak up by promoting an understanding that it was safe to do so. It was noted that 50% of the cases investigated as part of the Ockenden review had not been reported as incidents. The Trust continued to triangulate information relating to FTSU concerns, staffing and the reporting culture to identify potential patient safety issues. There was also a BAME reference group associated with the maternity service, which was reviewing the Birthrights report.

EN welcomed any feedback on the reporting to the Board to ensure that this remained as concise and informative as possible.

5.6 Freedom to Speak Up Report

Christine Mbabazi joined the meeting for this item and had also been present for item 5.5.

The Board noted the report. CM highlighted:

- the potential impact of the Trust's actionable allyship training on the number of bullying, harassment and discrimination concerns, which continued to be the main reason for concerns raised with the FTSU guardian; and
- the new e-learning FTSU training packages from the National Guardian's Office aimed at all NHS/healthcare staff (Speak Up), managers (Listen Up) and senior managers (Follow Up), which would be available on the Trust's virtual learning environment (VLE).

The Board considered the number of longer standing cases shown in Appendix A that had not yet been closed. These were relatively few in number and were principally due to awaiting a final outcome following the implementation of plans to address concerns. This sometimes involved employee relations processes running concurrently with the FTSU concern. Cases were only closed where the person who had raised the concern was satisfied that the concern had been addressed or, if they were not satisfied, following review by the FTSU steering group.

FTSU concerns were correlated with other data, including staff surveys and employee relations activity, to highlight particular areas of concern within the Trust. This triangulation had led to specific interventions such as training about discrimination in the emergency department.

The Board discussed the need for a continual process of awareness to ensure good understanding of the role of the FTSU guardian and process among all staff groups. Staff tended to become aware of FTSU when they needed it and also had access to the FTSU guardian for two years after they left the Trust in order to raise concerns to be investigated. While the number of concerns had decreased, this was following a peak in concerns due to staff vaccinations for COVID-19 and the resulting redeployment of staff. January and February were consistently months during which comparatively fewer concerns were raised, possibly due to seasonal operational pressures over winter.

Action: It was requested that future FTSU reports included comparative information from previous years in order to identify trends and also identified cases from previous reporting periods that had not yet been closed.

5.7 Break

The meeting was adjourned for a short break.

5.8 Integrated Performance Report for Month 1

The integrated performance report (**IPR**) was noted. The Board reviewed the detailed information regarding referral to treatment (RTT) waiting times and the waiting list. The number of patients waiting over 104 weeks had significantly reduced and there were currently 16 patients requiring a treatment plan, which presented a low risk of a small number of patients who would have been

waiting more than 104 weeks for treatment by 1 July 2022. Since Easter 2022 there had been no theatre lists cancelled and good levels of activity had continued into May 2022, although there was a risk that some activity would need to be cancelled during the current week. The Trust continued to work to increase capacity, including the development of an elective hub at Winchester Hospital with partners in the HIoW ICS and new theatres and new wards at Southampton General Hospital.

The Trust was also looking at ways in which it could work differently, including learning from other trusts through the national GIRFT (Getting It Right First Time) programme, which was supported by a dedicated team. The Trust was also sharing learning in areas where the Trust was recognised as an exemplar, such as clinical prioritisation. While the Trust performed well comparatively in other areas including length of stay, there were a small number of areas in a few specialties where the Trust had identified scope for improvement such as same day treatment. This was often made difficult due to the complex cohort of patients referred to the Trust. It was important for the Trust to implement improvements where it could as this would enable it to clearly highlight locally and nationally where physical capacity or workforce remained the limiting factor in terms of efficiency and capacity.

The Trust was keeping in touch with patients on the waiting list and encouraging them to contact the Trust if they had any concerns or if their condition was deteriorating. This had proven successful and was being extended to those waiting for their first outpatient appointment. It was recognised that communication with patients was not always good enough, as had been illustrated by the patient story earlier in the meeting. The Trust had also commissioned software that would enable it to analyse the waiting list in more detail, including identifying patients awaiting follow-up and when the recommended date for follow-up had passed.

Waiting list performance would continue to be reported to the Board at each meeting, providing insight into individual specialities experiencing more significant delays, such as gynaecology, as well as aggregate performance data. This would ensure that the Board had a good understanding of current and anticipated performance in 2022/23 and the factors contributing to this. This would continue to be a dynamic situation as the Trust responded to referral patterns and changes in capacity. The Trust would continue to use its resources effectively and increase capacity, including reducing the number of patients medically optimised for discharge (MOFD) remaining in hospital. The Board considered how to strike an appropriate balance between prioritising patients with the most urgent clinical need and treating those patients who had waited longest.

The Board also discussed diagnostic waiting times and recovery, which was due to be considered in detail at the next meeting of the Quality Committee in June 2022. Following a visit to Lymington New Forest Hospital earlier that week, it was clear that not all endoscopy capacity there was being fully utilised. Capacity at community diagnostic centres (**CDCs**) was being reviewed following the first phase of investment as it had been identified that the additional capacity in CDCs was not being fully used in many areas nationally. Southern Health NHS Foundation Trust had experienced difficulties in recruiting staff at Lymington New Forest Hospital and had approached the Trust to see if it could recruit staff to some roles. The Board was keen to ensure that the capacity at CDCs locally was maximised in order to reduce

waiting times and that network and other arrangements were used to facilitate this.

The Trust had also had difficulty in operating its endoscopy service fully in April 2022 due to nurse staffing gaps, however, capacity had returned to normal levels in May 2022. There were other areas of challenge in diagnostics, including non-obstetric ultrasound and radiology capacity.

Actions: (1) The Board requested that the report to the Quality Committee relating to diagnostic waiting times and recovery incorporated some analysis of the drivers for activity and capacity in the different diagnostic modalities. (2) The Board requested more information on the timeline for the Trust's decision relating to the recruitment of staff for Lymington New Forest Hospital.

It was clarified that there were only two severe or moderate medication errors recorded in April 2022, rather than five reported in the IPR. Two of these had been downgraded following review and one related to a capacitous patient refusing medication.

The Board also discussed the reviews of potential harm to patients waiting for cardiac surgery. The Trust continued to monitor this closely and had taken action previously to refer patients requiring urgent treatment to other units and increase capacity through the recruitment of staff and use of theatres in the independent sector. The waiting list was now at the same level as prior to the COVID-19 pandemic and the Trust continued to maintain oversight and manage the waiting list proactively through its clinical prioritisation processes and ongoing reviews despite there being no national targets for urgent cardiac activity as there were for cancer.

While COVID-19 related staff absence remained high, albeit reducing, stress and anxiety among staff was also driving sickness absence. This was symptomatic of the pressures and tension staff had been working under for the past two years. The focus on supporting staff wellbeing would continue to be monitored by the People and Organisational Development and reported to the Board.

5.9 Finance Report for Month 1

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

- the block contract and elective recovery fund arrangements in place in 2022/23, which resulted in a fixed funding envelope for the Trust;
- the submission of a deficit plan of £19.5 million for 2022/23, which was principally attributable to inflationary pressures relating to energy, non-pay inflation and drugs costs;
- due to the scale of the deficit, which was approximately 3% in the HIoW ICS and nationally, the HIoW ICs would need to resubmit its operational plan for 2022/23 by the end of June 2022 with a view to reducing the deficit, and additional funding of £1.5 billion would potentially be available to fund inflation, ambulance services and continuing healthcare costs;
- the risks to the delivery of the plan to achieve 104% of the levels of elective activity in 2019/20, including the impact of the COVID-19 pandemic on staff absence and capacity, further inflationary pressures, the scale of the CIP and the Trust's ability to deliver this, despite the

Trust delivering activity 2% above its target in the first month of 2022/23; and

- the national drive for the NHS to increase productivity given the 13% cost increase in real terms since 2019/20, coupled with a 6% reduction in cost-weighted activity, leading to an overall 17% reduction in productivity since 2019/20.

The Board considered the challenges relating to achieving a breakeven position as an ICS, achieving the CIP, improving productivity and reducing the Trust's current run rate, including the impact on staff and their wellbeing.

6 STRATEGY and BUSINESS PLANNING

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

This item was considered after item 7.2. Clare Rook joined the meeting for this item.

The report covered Clinical Research Network (**CRN**) Wessex's performance in 2021/22 and its plans for 2022/23. Over 114,000 participants had been recruited in 2021/22. This was the highest recruitment per million of population for the second year compared to the 14 other CRN regions in England. Since March 2020, over 202,000 participants had supported 101 pandemic studies at over 300 sites in Wessex. More than ten per cent of these studies had been developed in and led by the region. Three Wessex sites were in the top ten of over 6,000 NHS sites for COVID-19 research recruitment. Over 3,000 volunteers had been recruited on to COVID-19 vaccine trials.

The Board discussed the plans to increase commercial funding for research, building on the current portfolio and links with the life sciences industry. Decentralised care and digital were identified as the key areas for growth and there was already great strength in these areas in Wessex, particularly its development of a trusted research environment (TRE) and its ability to deliver research efficiently using the three established research hubs and through its approach to contracting. Given the current funding settlement from the National Institute for Health and Care Research and the uncertainty relating to how CRN Wessex would benefit from the levelling up agenda, it would be important to generate additional income in order to build capacity.

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.

7.2 Remuneration and Appointment Committee Terms of Reference

SH noted that the pay threshold information for supra-large NHS trusts and foundation trusts was now in the public domain and that the table included at appendix A of the terms of reference should be updated to reflect this.

Action: KF would update appendix A to the terms of reference.

Decision: Subject to this change being made, the Board approved the amendments to the terms of reference for the Remuneration and Appointment Committee.

8 Any other business

There was no other business.

9 To note the date of the next meeting: 28 July 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 26/05/2022 5.6 Freedom to Speak Up Report				
704.	Comparative information	Byrne, Gail Mbabazi, Christine	29/11/2022	Pending
	Explanation action item It was requested that future FTSU reports included comparative information from previous years in order to identify trends and also identified cases from previous reporting periods that had not yet been closed.			
Trust Board – Open Session 26/05/2022 5.8 Integrated Performance Report for Month 1				
705.	Diagnostic waiting times and recovery	Teape, Joe	13/06/2022	Completed
	Explanation action item The Board requested that the report to the Quality Committee relating to diagnostic waiting times and recovery incorporated some analysis of the drivers for activity and capacity in the different diagnostic modalities.			
706.	Lymington New Forest Hospital	Teape, Joe	28/07/2022	Pending
	Explanation action item The Board requested more information on the timeline for the Trust's decision relating to the recruitment of staff for Lymington New Forest Hospital.			
Trust Board – Open Session 26/05/2022 7.2 Remuneration and Appointment Committee Terms of Reference				
707.	Appendix A	Flaherty, Karen	30/06/2022	Completed
	Explanation action item KF would update appendix A to the terms of reference.			

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Chief Executive Officer's Report**			
Agenda item:	**5.4**			
Sponsor:	**David French, Chief Executive Officer**			
Date:	**28 July 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 • NHS Confederation • Update on ambulance handovers in light of current heatwave • Royal College of Nursing • NHS Pay Award • Care Quality Commission (CQC) • Modernising our Hospital and Health Services Programme • New National Safeguarding Guidance for under 18s accessing early medical abortion services			
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

Operationally we continue to face severe pressures and during July a number of NHS organisations announced they were working under a critical incident. We have also faced severe pressures and although we did not formally declare a critical incident, we did establish an emergency planning response with hospital wide meetings being held to address the most pressing problems. To respond to these issues, which at times were some of the most challenging we have ever faced, we took a number of actions including:

- redeploying more medical staff to ED;
- activating our heatwave plans;
- asking matrons to take personal charge of overseeing discharges;
- standing down a number of non-urgent surgeries;
- opening discharge lounges to improve patient flow;
- opening up all available capacity across the site;
- working to bank holiday protocols over the weekend;
- deploying colleagues from Trust Headquarters departments to support the effort;
- strengthening the on-call teams; and
- holding a number of emergency system meetings to ensure we had an urgent and coordinated response

In addition to the operational response, I also wanted to highlight our communications team who undertook a blanket and regionally coordinated media campaign to inform our community of the pressures we are facing and getting their support with regards to making the right choice at the right time to get the care they need from the NHS. This included a number of honest messages about the situation we faced and resulted in significant and widespread media interest. Although it is hard to connect cause and effect, we have seen reduced attendances to our Emergency Department since the campaign was launched.

Lastly, I wanted to record my personal thanks to all of our colleagues across the Trust. Over this period, we have seen the best of what teamwork is at UHS.

NHS Confederation

On 12 July, we hosted Matthew Taylor, CEO of NHS Confederation for a visit to UHS. His visit included tours of child health and the General Intensive Care Unit (GICU) to demonstrate the extremes of our estate's environment, as well as discussions with the Chair and Executive Directors. In addition to constructive conversations about the Integrated Care System (ICS) and the hospital's role in it, we had the opportunity to deliver messages about:

- UHS is a great hospital with great people;
- our capacity shortfall and the need for investment, and
- the constraints caused by the Capital Department Expenditure Limit (CDEL) on our ability to utilise our cash reserves to address our capacity challenge.

The visit was extremely positive and Matthew was very complimentary about what he saw here.

Update on ambulance handovers in light of current heatwave

On 15 July NHSE wrote to all trusts in relation to the increased pressure on ambulance services. The letter highlighted the importance of working together as integrated care systems to reduce the delays that patients experience by creating capacity within acute hospitals to allow for quicker handover and therefore a faster response to the public.

It highlighted the level of risk that ambulance services were carrying on behalf of systems that had increased due to the heatwave as well as increased staff absence due to Covid-19. The letter asked for steps to be taken to move patients who had completed their emergency medical care, and were awaiting an inpatient bed out of the Emergency Department (ED), to create space for new patients. To facilitate this the letter noted that this may involve the creation of observation areas, and exploring further ways to add additional beds elsewhere in the hospital.

At UHS we are proud that we have some of the best handover performance figures in the region. As a consequence of this, although we do have a queue in ED, this is managed with effective protocols. In further response to the letter the Trust is looking at:

- discharge lounge project to improve flow and support reduced queuing in ED; and
- some limited boarding in the Acute Medical Unit (AMU) at times of extremity in ED.

Royal College of Nursing

Following the letter from NHSE requesting that providers look to opening additional observation areas, the Royal College of Nursing (RCN) has written to all trusts on 15 July raising concerns, on behalf of their members, that patient care would be compromised or that there would be a lack of dignity, when care is given in inappropriate locations.

The letter reminds trusts that with every 'bed' that is created, the nurse staffing level must rise too, and that with the existing nurse staffing challenges, there is a risk that this will further dilute nurse-to-patient ratios. It also reminds trusts about their legal duty under The Health and Safety at Work Act 1974 towards all employees.

UHS takes it's responsibilities for our staff and patients seriously, especially in relation to their health, safety and wellbeing and is working to provide solutions to the challenges faced primarily through our staffing hub.

NHS Pay Award

On Tuesday 19 July the Government announced its pay settlement for 2022/23 for NHS staff. This is applicable to all NHS-employed staff except Junior Doctors. For those on Agenda for Change Contracts, all staff will receive a £1400 uplift representing between 9.3% and 1.3% pay uplift. This will be backdated to 1 April 2022. The pay award has attempted to cushion the effect of cost of living on those lowest paid roles in the NHS but has further presented a challenge to those in mid to senior management positions. For consultants and other senior non-training medics, the government is awarding a 4.5% rise. Junior doctors, who are already on a multi-year pay will receive 2%.

The treasury has not provided additional funding to cover the increase, thought to be worth around £2bn. Instead, NHSE will re-divert funds from other key projects in digital transformation, and will also slow down the roll-out of community diagnostic hubs.

The pay award has been greeted with hostility by major national unions. The British Medical Association (BMA) (Medical Staff) and RCN (Nursing) are expected to ballot members on industrial action shortly. Other key unions are likely to follow representing a similar pattern of industrial unrest mirrored in many other sectors of the economy.

With the Office of National Statistics (ONS) recently published data to show a widening gap between public and private sector pay growth of around 6%, and inflation continuing to rise, the recruitment, retention and industrial relations challenge is only set to continue. UHS will continue to deliver its objectives set out in the People Strategy with the aim of furthering improving the employment experience, opportunity from growth, and inclusion agenda. The Board will be further briefed once any industrial action becomes clear including mitigating actions UHS will take.

Care Quality Commission (CQC)

The CQC are developing their approach to regulation and have published guidance for the five key questions and quality statements on 18th July. The questions on the quality statements set out how the CQC will assess quality against the previous domains of safe, effective, caring, responsive and well led. Quality statements are the commitments that providers, commissioners and system leaders should live up to. Expressed as 'we statements', they show what is needed to deliver high-quality, person-centred care.

They also have developed six evidence categories to bring structure and consistency to their assessments. These show the types of evidence the CQC will use to understand the quality of care being delivered against a quality assessment. This includes:

- people's experience of health care services;
- feedback from staff and leaders;
- observation;
- processes; and
- outcomes

The aim is to roll out the changes by 23rd April 2023. We will provide an awareness training on the new CQC regulation regime and expectations of the Board to a future Trust Board Study Session. The link to the CQC website is:

https://www.cqc.org.uk/guidance-providers/five-key-questions-and-quality-statements

Modernising our Hospital and Health Services Programme

NHS England / Improvement (NHSEI) has been engaging with UHS in relation to the proposals to deliver a new hospital to serve the people of North and Mid Hampshire as part of the Government's New Hospital Programme.

NHSEI have articulated a clear and compelling case for change and it is important that UHS, together with other partners organisations in and around the Hampshire and Isle of Wight (HIOW) system, work together to redesign health services, so that they meet the changing needs and demands of our population over the long-term. We recognise that this is a once in a generation opportunity for investment for HIOW and will work alongside our partners to achieve this.

NHSEI are considering a number of proposals to build a new hospital which will form part of a formal public consultation in due course. We have had the opportunity to provide our input into their plans and have raised our concerns on the potential impact the different options may have. We have highlighted the importance of being able to continue to deliver our services to both our local population and our wider regional population of 4 million people.

We will continue to engage with NHSEI and our partners and will participate in the formal consultation once published.

New National Safeguarding Guidance for under 18s accessing early medical abortion services

In April 2022, Parliament made the decision to legislate to permanently allow the remote delivery of early medical abortion (EMA) services in England and Wales, in line with the temporary arrangements introduced at the start of the Covid-19 pandemic.

The Royal College of Paediatrics and Child Health (RCPCH) have been commissioned, by the Government, to lead on the development of new national safeguarding guidance for under 18s accessing EMA services (at gestations up to 10 weeks) provided through telemedicine services. This guidance will be in place by the 30 August 2022.

All providers have been asked to provide information to support the development of the guidance in relation to policies and practice already in place by 25 July to facilitate this and the Trust will respond to their request appropriately.

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Integrated Performance Report 2022/23 Month 3**			
Agenda item:	**5.5**			
Sponsor:	**David French, Chief Executive Officer**			
Author	**Jason Teoh, Director of Data and Analytics**			
Date:	**28 July 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.			

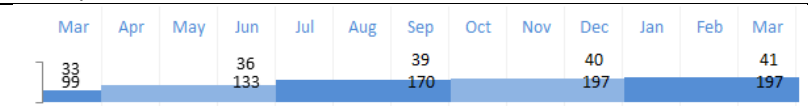
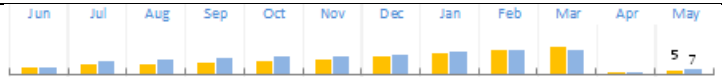
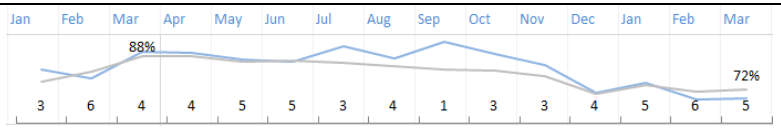
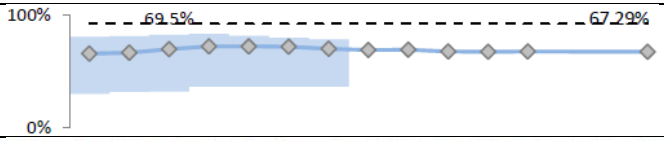
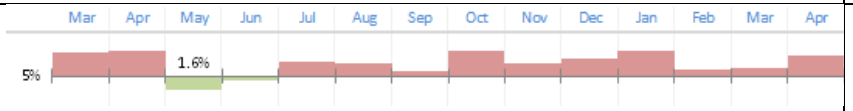
University Hospital Southampton NHS
NHS Foundation Trust

Integrated KPI Board Report

Covering up to
June 2022

Sponsor – David French, Chief Executive Officer
Author – Jason Teoh, Director of Data and Analytics

Report guide

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

Some minor changes have been made to the report this month:

- The Watch & Reserve antibiotics measure (UT12) baseline has been changed to be 95.5% of 2018 usage in line with the NHSE requirement for a 4.5% reduction in usage for "watch" and "reserve" agents.
- Nutrition plan auditing restarted in June 2022, and the corresponding nutrition plan measure (UT16) has now been updated with the latest available information.

Summary

This month the 'Spotlight' section contains a report on Diabetes medication errors and an update on Referral To Treatment (RTT) Waiting List performance.

The Diabetes medication errors spotlight highlights that:

- UHS remains at the forefront of inpatient diabetes care, and has a lower rate of diabetes medication errors when compared with other Trusts of similar size and complexity.
- However, as we recognise that the consequences of errors relating to insulin can be catastrophic, we review each case seriously, taking learning from every near miss, to prevent moderate and high harm incidents occurring.
- We outline the learning taken from recorded incidents over the last 12 months and outline our approach for our service at UHS.

The Referral To Treatment Waiting List spotlight highlights:

- An ongoing growth in the waiting list, linked to higher referrals, with the waiting list (in June 2022) now standing at over 50,000 patients. This is despite UHS recording 113% activity in June against the Elective Recovery Framework baseline on 2019/20 for Outpatient first and procedures performance.
- The actions in place to address the overall waiting list, in particular those waiting for elective surgery.
- There has been a good reduction in the patients waiting the longest for elective surgery – with only 5 patients waiting over two years (all due to patient choice).
- In some of our analysis looking at potential health inequalities, there is no obvious bias within our waiting list towards women.

Areas of note in the appendix include:

1. June 2022 saw an increase in the number of COVID-19 inpatients, and a corresponding increase in the number of healthcare acquired (44) and probable hospital associated (30) COVID-19 infections.
2. Ongoing high volumes of attendances to Emergency Department (ED) continue to apply downward pressure to the ED four-hour standard, which was reported at 64.7%. However, UHS remains in the upper quartile of teaching hospitals for Emergency Department performance, demonstrating that this remains a wider national problem, rather than being localised to UHS.
3. There has been a reduction in pressure ulcers this month – in line with the work conducted by the patient safety teams to address these. Although category 2 ulcers are still above target (0.36 per 1000 bed days), we expect further improvements in this measure in coming months.
4. There has been an increase in Serious Incidents Requiring Investigations (SIRIs) this month, with 12 recorded. Of these six were related to pressure ulcers, and this was an artificial increase as case reviews for pressure ulcers have only just been restarted and so this is an accumulation of reported

incidents. Of the other 6, a common theme is a delay in the pathway of the patient. We are confident that we have taken the appropriate learning from these incidents.

5. The Friends & Family Test (FFT) score for maternity has breached the 5% target this month. The themes for this were around communication, staffing, and capacity. We have traditionally had very low response rates for this metric (c12%), and we have been working hard to increase our response rate from families (28% in Q1 2022/23), while ensuring that we also deliver improvements for our patients.
6. Cancer standards remain under pressure due to high referral volumes, with pressures seen within the skin, head & neck, and urology tumour sites. On the 62 day referral to treatment standard we continue our upper quartile performance when compared against teaching hospitals. Challenged areas continue to be the urology and skin modalities. We are working with the Wessex Cancer Alliance to review potential improvements to the urology pathway, and in skin are looking to ensure that we have the right clinic capacity in line with the recent referral volumes, with the 2 week standard starting to see some corresponding improvements.
7. Patients without a Criteria to Reside in hospital remain extremely high, with an average of 203 patients not meeting the Criteria to Reside standard through June.

Ambulance response time performance

The following is the latest Category 1 to 4 information published by South Coast Ambulance Service (SCAS) published within its May 2022 board papers, relating to the Southampton, Hampshire, Isle of Wight, and Portsmouth area. This is the same information as was available for UHS's June Board report.

Southampton, Hampshire, Isle of Wight, and Portsmouth SCAS response time by category

Performance measure	April 22 Actual	April 22 Plan
Category 1 Mean	00:09:21	00:07:00
Category 1 90th percentile	00:17:04	00:15:00
Category 2 Mean	00:38:25	00:18:00
Category 2 90th percentile	01:23:53	00:40:00
Category 3 90th percentile	04:37:16	02:00:00
Category 4 90th percentile	05:29:57	03:00:00

UHS continues to ensure that it does not significantly contribute to ambulance handover delays. In the week commencing 11 July 2022, our average handover time was approximately 19 minutes across 719 emergency handovers, and just under 20 minutes across 32 urgent handovers. Although this represents slightly worsened performance compared to June, the total number of Emergency Department attendances were higher.

Spotlight: Diabetes medication errors

Background

Diabetes affects around 7% of the UK population, with the prevalence in UHS inpatients around 18-20%, with around 7% of these being specifically for diabetes. Diabetes is one of the areas of clinical practice which rapidly changes, with a great deal of clinical inertia through lack of understanding, clinical experience, and fear of doing the wrong thing amongst healthcare professionals. The speed of clinical change around the management of type 2 diabetes and the fear around the management of insulin in all types of diabetes means that diabetes medications remain one of the leading causes of medication errors and avoidable harm in hospital settings. The most recent, and unfortunately final, National Diabetes Inpatient Audit (NaDIA) was in 2019 and showed the following error rates in comparison with national rates.

Error / Harm (2019 NaDIA)	University Hospitals Southampton NHSFT	England Average
Prescription Errors	10.6%	16.8%
Medication Errors	16.9%	30.4%
Insulin Errors	13.4%	18.2%
Glucose Management Errors	9.2%	18.4%
Severe Hypoglycaemia episodes (blood glucose <3mmol/L)	2.2%	6.8%

NHS Digital ceased funding the National Diabetes Inpatient Audit in 2019[1] and replaced this with the NaDIA-HARMS[2] mandatory year round collection of four harms that can occur to people with diabetes in acute hospitals in England. The harms that we report to NHS Digital are as follows in patients who:

- Require injectable rescue treatment (IM glucagon or IV glucose) to treat hypoglycaemia >6hours post admission. *(Inpatient Severe Hypo)*
- Are Diagnosed with new onset Diabetic Ketoacidosis (DKA) >24hours post admission. *(Inpatient DKA)*
- Are Diagnosed with new onset Hyperosmolar Hyperglycaemic State (HHS) >24hours post admission. *(Inpatient HHS)*
- Are Diagnosed with a new onset foot ulcer >72hours post admission. *(Inpatient Diabetic Foot ulcer)*

The academy of Medical Royal Colleges commissioned guidance to be created on the back of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report into the management of patients with diabetes undergoing surgery "Perioperative Diabetes: Highs and Lows[3]." The guidance from the Centre for Perioperative care (CPOC) was released in March 2021 "Guideline for Perioperative Care for People with Diabetes Mellitus Undergoing

[1] https://digital.nhs.uk/data-and-information/publications/statistical/national-diabetes-inpatient-audit/2019
[2] https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-in-patient-audit-nadia-harms
[3] https://www.ncepod.org.uk/2018pd/Highs%20and%20Lows_Full%20Report.pdf

Elective and Emergency Surgery[4]" which has given the most comprehensive, multidisciplinary best practice recommendations for perioperative care to date.

Incidents at UHS

UHS remains at the forefront of inpatient diabetes care, with lower cases of diabetes medication errors when compared with other Trusts of similar size and complexity. Consequences of errors relating to insulin can be catastrophic; we need to continue to develop methods for early identification of errors and intervene quickly, taking learning from every near miss to prevent moderate and high harm incidents occurring.

Between 1 June 2021 and 1 June 2022 there were three noted incidents of **moderate and above *actual* harm**. All three incidents that resulted in harm involved insulin. Two were caused by an omission of insulin in someone with Type 1 Diabetes and the third related to an omission of IV glucose (to be paired with insulin when given in an intravenous infusion.) On review the two insulin omissions were in cases where the person with Type 1 Diabetes was unable to advocate for themselves either due to temporary or permanent incapacity. Further detail can be found in Appendix 1.

For incidents of **moderate and above with *low actual* harm**, there were five incidents noted. All five incidents that were considered moderate to high risk involved insulin. Three were caused by an omission of insulin and two related to an insulin prescribing error. More detail can be found in Appendix 2.

Overall, although the number of incidents remains relatively low, we continue to closely monitor this with our clinical teams. We work with the teams to ensure that each incident is reviewed, and the root cause of the incident identified, and learning taken. The risk of incorrect diabetes medicine remains on the Trust risk register. Details of this, along with the actions in place, can be found in Appendix 3.

Other notable points

- Diabetes is increasing in prevalence, and this has increased since COVID – with COVID itself causing new onset diabetes in around 18 people per 1000 population based on newly released public health data. There is likely to be 2-3% of the Southampton City population with undiagnosed diabetes as the best epidemiological estimate (>5,000 people).
- We are ahead of national projections for growth in prevalence, partly due to increasing age, and more patients with type 2 diabetes at a younger age linked to obesity. Those that develop type 2 diabetes under the age of 40 are considerably more likely to end up with complications related to diabetes and become hospitalised.
- Those with diabetes are much more likely to be hospitalised with Southampton prevalence at 6% and UHS prevalence at 18% any increase in overall prevalence over the next 10 years will be amplified in the acute care setting.

[4] https://www.cpoc.org.uk/sites/cpoc/files/documents/2021-05/CPOC-Diabetes-Guideline2021.pdf

- Referrals to the inpatient diabetes service have increased by 26% over the past two years with referrals in 2019 at 3000 referrals and in 2021 at 3,785 referrals.
- All Health Care Professionals (HCPs) that are involved in a medication error are invited for a reflective conversation with a specialist member of their profession (Doctor / Nurse / Pharmacist) – this includes near miss and low harm incidents.
- The diabetes team continue to drive education amongst junior doctors, nursing staff, pharmacists, dietetics at multiple points through the year.
- Every ward round is considered a teaching ward round and has an attachment from members of the HCPs across the trust.
- All third-year undergraduate medics now spend an introductory ward round with the inpatient diabetes service and all final years must attend three ward rounds in preparation for ward-based practice as an FY1.
- The diabetes service is currently embarking on a gradual transition to joint working with community diabetes partners, and this will be linked in with a new PCN model of diabetes care where advice and expertise can be delivered closer to GPs and patients.
- Multiple members of the UHS diabetes service are leading on national change and guideline development including new models of care which have been implemented and adapted in multiple other acute trusts nationally.
- Diabetes Link nurses re-instated and relaunched trust-wide to provide champions at ward level to enact change.

Future needs of the series

- The diabetes service will need to continue to expand to continue to deliver high quality care to patients admitted under UHS, with referrals increasing at the current rate workload will be
- There is still a discussion to be had as to the optimal specialist cover for acute settings, where the Inpatient Diabetes Outreach Team (iDOT) service is currently only Monday to Friday, we will continue to explore options to increase support to 6 or 7 day working in line with national GIRFT recommendations.
- The use of technology in diabetes is continuing at a rapid pace with many specialists struggling to keep up with changes. This will require the UHS service to continue to drive this change and educate staff members on the use of this technology as it becomes far more commonplace.
- We will need to continue to work with anaesthetic and surgical pathways to streamline patients with diabetes through elective and emergency surgery which includes work at referral stage, setting the “To Come In” Date, and perioperative management. The aim to reduce length of stay to the same as someone without diabetes and reduce harm whilst in the acute setting.
- We will need to continue to work with acute admission areas to strive to support admission avoidance in appropriate settings such as Same Day Emergency Care (SDEC) wards, or specialist medicine clinical review areas.
- There is a challenge in recruitment of substantive Consultant Physicians, therefore we will continue to review expanded scopes of practice within safe remits of expert non-medical staff which recently has included novel development of a Health Care Assistant to undertake some of the administrative and educational roles of our diabetes specialist nurses releasing time to care clinically for patients.

Appendix 1: Summary of incidents moderate and above *actual* harm

All three incidents that resulted in harm involved insulin. Two were caused by an omission of insulin in someone with Type 1 Diabetes and the third related to an omission of IV glucose (to be paired with insulin when given in an intravenous infusion.) On review the two insulin omissions were in cases where the person with Type 1 Diabetes was unable to advocate for themselves either due to temporary or permanent incapacity.

Issues arising

- Lack of understanding of technology and diabetes
- Safe conversion of VRIII to s/c insulin remains a concern
- Insulin withheld inappropriately, then transferred to other provider for dialysis without insulin on board
- Failure to prescribe glucose substrate alongside Variable Rate Intravenous Insulin Infusion (VRIII)

Learning

- We are developing a joint pathway for diabetes patients undergoing dialysis at Portsmouth with the Portsmouth Diabetes and renal services which will cover aspects of dosing, transfer, and responsibility
- We will continue to work with pre-assessment teams and ward-based teams to educate and provided guidance on the management of insulin pumps should patients be unable to self-manage whilst in hospital.
- A lot of work has gone into education at ward level around ensuring glucose substrate is given alongside VRIII. A new VRIII guideline was written aligning all areas of the trust (aside from CICU) which gives options for fluids or NG feed or TPN to be given alongside intravenous insulin.

Appendix 2: Summary of incidents moderate and above but *low actual* harm

All five incidents that were considered moderate to high risk involved insulin. Three were caused by an omission of insulin and two related to an insulin prescribing error.

Issues arising

- Safe conversion of VRIII to s/c insulin remains a concern and consistently features in both the high harm and high-risk incidents.
- Lack of familiarity with insulin where a doctor new to the NHS had prescribed 20,000 units of insulin for a patient.
- Insulin is often missed from clerking information, where a previous audit recognised that <20% of medical clerking contained all information required for a safe insulin prescription leading to insulin prescribing omission

- Confusion amongst prescribing staff of the different sorts of insulin with similar names (NovoRapid / NovoMix 30) or (Humalog / Humalog Mix 25 / Humalog Mix 50) leading to incorrect prescribing
- Small doses of insulin can sometimes not appear easily on GP prescribing records as being recently dispensed therefore can be missed from medication histories where patients are unable to confirm their own medications.

Learning

- Ideally all new junior medical staff starting at UHS should have to undertake mandatory insulin safety module – Dr Mayank Patel working with statutory and mandatory training team and listed as an action in Risk 43
- We will continue to work with our ward diabetes link nurses to champion variable rate insulin infusion safety at ward level prompting the medical and non-medial prescribers to ensure glucose substrate is prescribed alongside insulin infusions and ensure safe conversion to s/c insulin.
- Need to continue to work with the pharmacy department to support the early review of high-risk patients on diabetes medications. Competing priorities sometimes limits the ability for this to be done in a timely way and should be considered essential ward activity at weekdays and weekends.
- An update to the insulin module within the JAC prescribing system is due to occur in the next 12 months which will support safer prescribing of insulin and help to reduce mis-selection errors.

Appendix 3: Risk register entry, and overall snapshot of diabetes reported errors

Risk Description: There are numerous opportunities for medication errors in relation to prescribing, administering, and screening of insulin. This could lead to life-threatening consequences for diabetic patients (20% of the hospital patient population) including hypoglycaemia, increased risk of CV events or hyperglycaemia leading to diabetic ketoacidosis or hyperosmolar hyperglycaemic state. Patients at risk in the longer term from infection, poor wound healing, cognitive decline in the elderly and poor management due to fear. This could also lead to increased length of stay and re-admission.

Control: Ward based pharmacist workload is prioritised to identify high risk patients/medicines which includes insulin therapy to facilitate urgent review.

Gaps in Control: Competing priorities with trust flow, and discharge process and large number of high-risk patients mean not all patients on insulin are reviewed by pharmacy staff within 24 hours.

Actions

- **Action 1**: Roll out insulin self-administration adults Trust-wide
- **Action 2:** Review of NCEPOD peri-operative diabetes recommendations with clinical effectiveness and surgical/anaesthetic leadership team

- **Action 3**: Implement recommendations of NCEPOD peri-operative review. (We await CPOC (Centre for Post-Operative Care) guidance before finalisation.)
- **Action 4**: Re-review of statutory and mandatory training for safe use of insulin for medical staff, nursing staff, pharmacists and AHP's.
- **Action 5:** Update and alignment of IV insulin protocols trust-wide and peri-operative diabetes guidelines.
- **Action 6:** To review and update the peri-operative diabetes guidelines.

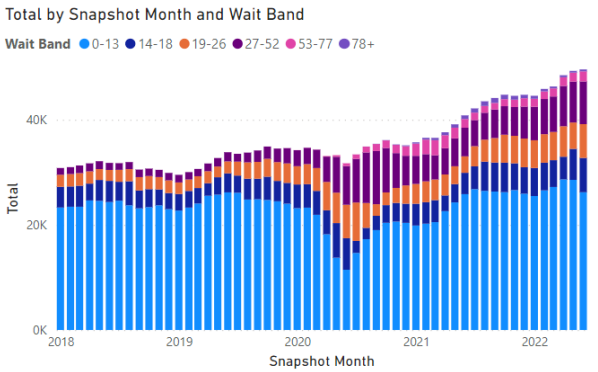
Spotlight: Referral to Treatment Waiting Lists

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

In recent months we have seen a growth in the waiting list because of a recent increase in referrals. Between May and June 2022, the waiting list grew by 908 patients to approximately 50.2k patients.

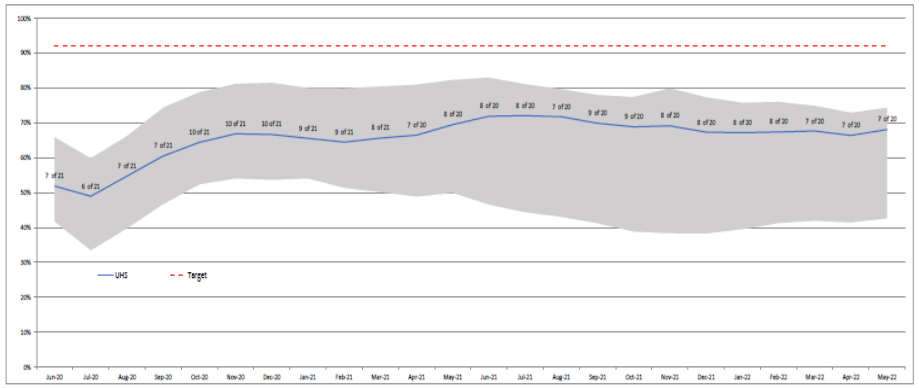
Despite conducting 109% more outpatient first and procedure activity in April, 120% more in May, and 113% more in June, the waiting list is 26% higher compared to the previous year (May 2021), and 44% higher than the position prior to the pandemic (Jan 2020), with the size of the waiting list being sensitive to higher referral volumes.

Graph 1: PTL by wait band

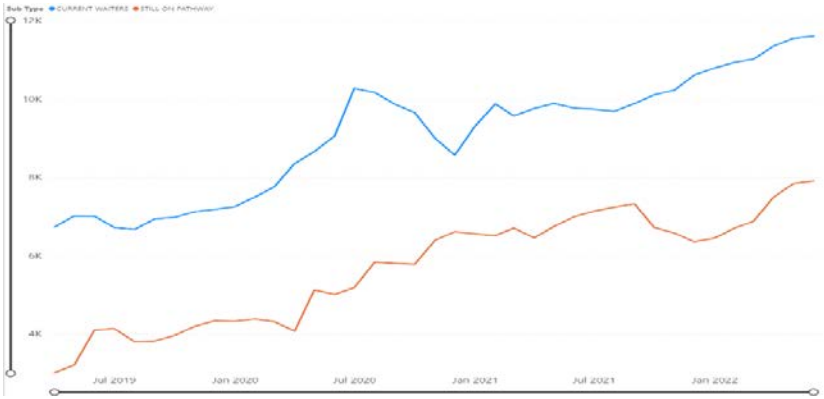


Higher referrals continue to make the achievement of the 18 week wait constitutional standard significantly more challenging, and 66.4% of patients are currently waiting 18 weeks or less. While this is below the national target of 92%, we remain in line with other comparator teaching hospitals (7 of 20 benchmark hospitals in graph 2), reflecting that this continues to be a national challenge throughout the NHS.

Graph 2: RTT 18-week performance comparison for Teaching Hospitals



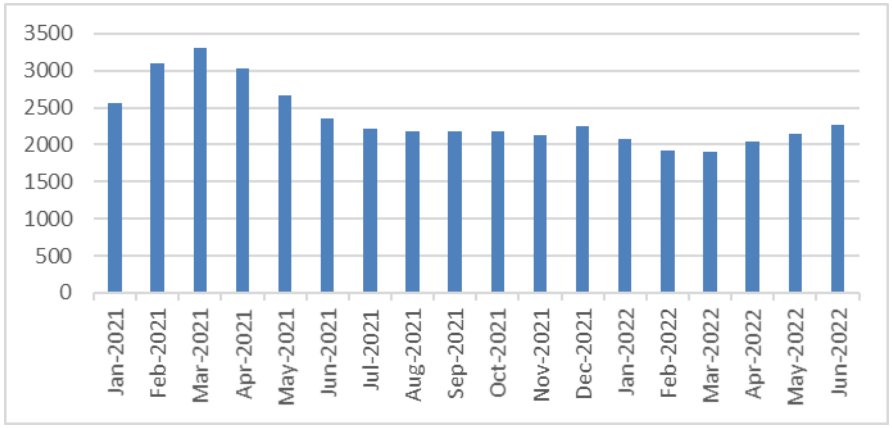
Graph 3: Waiting list for Current Waiters and Still on Pathway



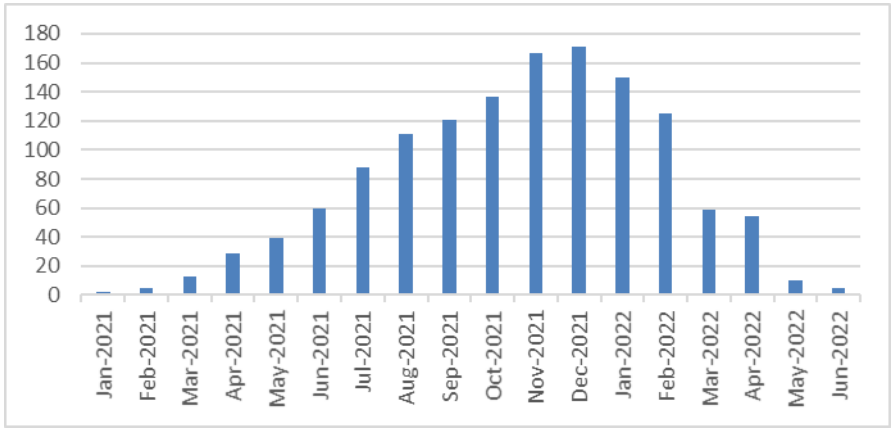
Looking specifically at the patients waiting for admission ('current waiters') in graph 3, this has grown through the pandemic, and stands at 11.6k patients (22.7% of the waiting list). This remains proportionally similar to pre-pandemic levels (where it was between 20-22%). However, it is important to note that the Trust continues to deliver significantly more elective activity than pre-pandemic, including exceeding the targets we committed to as part of the planning round. The fact that, despite this, the waiting list continues to rise highlights the scale of the challenge faced. No further theatres are due to come on-line until 2023, and in the intervening period two will be closed for refurbishment. Therefore, there will not be a step change in capacity to mitigate this growth in the short to medium term. The Trust continues to review how we can further optimise our operating services to generate additional capacity from the existing estate, effective list use and the use of the independent sector where safe and cost effective.

At the upper end of the waiting list, we are seeing a slight growth in the number of patients who have waited more than 52+ weeks (graph 4). This is linked to the increase in referrals after the release of lockdown. We expect to see a few more months of slight growth within the 52+ week waiting list, but expect this to be back around 2,000 patients by March 2023, in line with NHS England and Improvement requirements.

Graph 4: 52+ week waits



Graph 5: 104+ week waits



There remains a significant capacity challenge around the NHS England and Improvement requirement to have no patients waiting 78+ weeks by the end of March 2023. At the time of writing, there were 335 patients who had waited more than 78 weeks. However, the number of 104-week waits have dramatically reduced (graph 5), and there were only five remaining at the end of June, in line with NHSE's requirements to have no patients waiting over two years for treatment, except for patient requested delay.

The interventions we have put in place to deliver reductions in waiting patients through 2022/23 continue.

(1) We are aiming to deliver 106% of the 2019/20 baseline, in line with the Elective Recovery Fund, and this will help us to reduce the number of patients waiting for care (assuming a static referral rate). We have made a positive start, delivering 99% against baseline in April 2022 and 107% of baseline in May 2022 and in June 2022 for Elective operations.

(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 is continuing, and aims to reduce length of stay, improve earlier discharge and therefore create more beds for the elective surgical programme. This project continues to be challenged by the availability of care capacity within the health and social care sector.

(4) We are texting relevant long waiting patients to revalidate their referrals - as well as to assess patient risk for the longest waiters. In line with previous trials, this project has delivered approximately 3% of patients who no longer wish to have their surgery.

(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, Table 1 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. Table 2 does the same, but for the 78+ week waiters. There have been no significant changes to the order of the top specialties over the last few months.

Table 1: All Waiters

Specialty	Referral and Still on Pathway	Waiting for Admission	Grand Total
130 - OPHTHALMOLOGY	4618	756	5374
502 - GYNAECOLOGY	2794	1432	4226
400 - NEUROLOGY	3091	57	3148
330 - DERMATOLOGY	1846	1226	3072
110 - TRAUMA AND ORTHOPAEDIC	877	1912	2789
101 - UROLOGY	1597	1106	2703
104 - COLORECTAL SURGERY	1747	428	2175
214 - Paediatric Orthopaedics	1425	397	1822
140 - ORAL SURGERY	1395	402	1797
320 - CARDIOLOGY	1135	596	1731

Table 2: 78+ week waiters

Specialty	Referral and Still on Pathway	Waiting for Admission	Grand Total
120 - EAR NOSE & THROAT	7	54	61
110 - TRAUMA AND ORTHOPAEDIC		44	44
100 - GENERAL SURGERY	1	40	41
502 - GYNAECOLOGY	1	31	32
104 - COLORECTAL SURGERY	3	27	30
150 - NEUROSURGERY	2	21	23
171 - PAEDIATRIC SURGERY	1	21	22
420 - PAEDIATRICS	20		20
140 - ORAL SURGERY		15	15
108 - SPINAL SURGERY SERVICE	2	12	14

Health inequalities

In addition to our regular review of the size of the waiting list, we have more recently started to review whether there is any inequality within the care that we offer to our patients. We have conducted some foundational univariate correlation analysis (some details below), as well as working with the University of Southampton Lifecourse Epidemiology Centre to develop more detailed multivariate analysis. We will provide a report on this to the Trust Executive Committee shortly.

Overall, our analysis indicates that there is no bias between different inequality factors. An area which has recently been in the press has been longer waiting times for female patients. When comparing the latest waiting list to the same period last year, we have seen a 19.4% increase with the waiting list. The gender split has remained the same with patients identifying as female accounting for 56% of the waiting list and those identifying as male being approximately 44% (Table 3).

Table 3: Growth in Waiting List by gender

RTT PTL Timestamp	TOTAL RTT & NHS Reportable	Female	F%	Male	M%	Unknown	U%
14/07/2021	44,223	24,769	56.01%	19,447	43.97%	7	0.02%
13/07/2022	52,815	29,636	56.11%	23,174	43.88%	5	0.01%

On this basis, we do not believe that there is a bias within our processes which significantly disadvantage females but will continue to develop our analysis, and maintain a close level of monitoring of gender, and other potential inequality factors.

However, when looking specifically at our Gynaecology specialty, the waiting list has grown approximately 32%, and now accounts for a larger proportion of the overall waiting list increasing from 7.45% to 8.23% (Table 4).

We do not believe that this means that females are being disadvantaged – as otherwise this would show throughout the waiting list. Instead, we believe that this indicates that the Gynaecology specialty has a higher proportion of lower clinical priority procedures compared to other specialties.

Table 4: Growth in Gynaecology Specialty Waiting List

RTT PTL Timestamp	GYNAECOLOGY	% of Total RTT PTL
14/07/2021	3,296	7.45%
13/07/2022	4,346	8.23%

Our internal reviews of our application of clinical priority indicates that our surgeons accurately apply clinical priority at UHS as defined by the Royal College of Gynaecologists; therefore, the growth in the waiting list is not down to a specific issue of gender health inequality. We are however working with the team to identify options for additional capacity.

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

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	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)	7	8	9	9	9	10	10	10	9	8	6	5	5	3	66.4%	≥92%	67.3%
		7	8	8	8	7	9	9	8	8	8	8	7	7	7			
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)	13	16	15	16	16	17	17	14	16	12	13	13	13	15	86.9%	≥93%	86.9%
		5	13	11	13	14	14	14	9	10	7	5	4	4	5			
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)	3	11	13	15	16	13	12	15	13	13	11	12	7	11	69.5%	≥85%	74.4%
		1	4	6	7	7	2	4	5	3	4	4	2	3	5			
UT25-N	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 16) South East average (& rank of 16)	6	8	4	5	4	4	6	4	5	8	10	6	4	8	7	≥95%	65.6%
		4	4	4	4	4	2	4	3	3	4	4	4	4	4	3		
UT33-N	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching Hospital average (& rank of 20) South East Average (& rank of 18)	12	9	10	10	10	9	7	6	7	7	7	7	6	7	24.1%	≤1%	23.7%
		17	16	16	17	16	15	14	12	13	14	14	13	12	13			

Outcomes		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Monthly target	YTD	YTD target
UT1-N	HSMR - UHS HSMR - SGH	76.8											85				≤100		
		76.9											85.9						
UT2	HSMR - Crude Mortality Rate	2.8%											2.8%				<3%		<3%
UT3	Percentage non-elective readmissions within 28 days of discharge from hospital	12.5%											10.7%				-	11.3%	
		Q1 21-22			Q2 21-22			Q3 21-22			Q4 21-22			Q1 22-23			Quarterly target		
UT4-L	Cumulative Specialties with Outcome Measures Developed (Quarterly)	61			63			63			63			64			+1 Specialty per quarter		
		396			406			383			393			419					
UT5	Developed Outcomes RAG ratings (Quarterly) Red Amber Green	80%			78%			77%			76%			74%					
UT5 -	Red : below the national standard or 10% lower than the local target Amber : below the national standard or 5% lower than the local target Green : within the national standard or local target																		

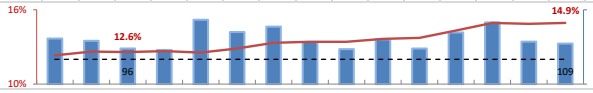
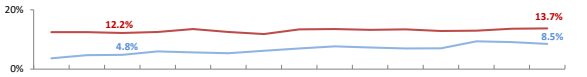
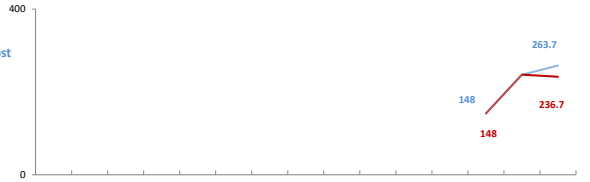
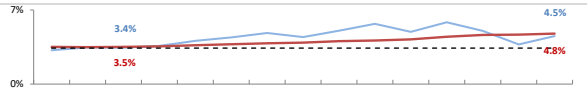
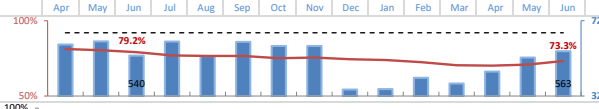
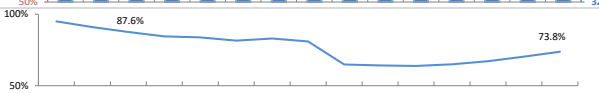
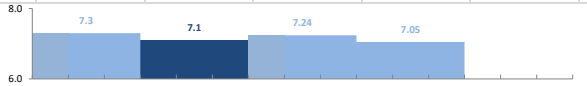
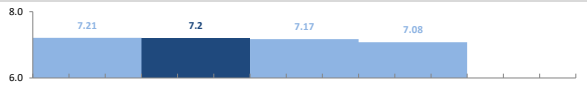
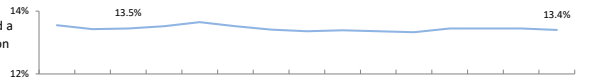
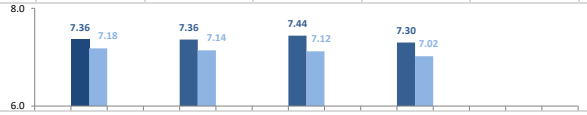
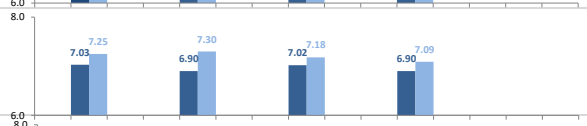
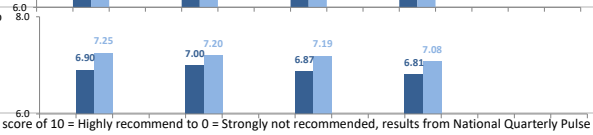
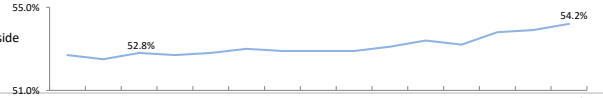
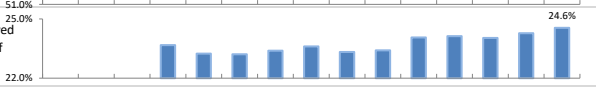
Safety		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Monthly target	YTD	YTD target
UT6-N	Cumulative Clostridium difficile Most recent 12 Months vs. Previous 12 Months	15	21	18	25	3233	3939	4344	5049	52	56	55	64	57	71	63	74	7	9	16	11	21	18	≤5	18	≤15
UT7	**Healthcare-acquired COVID infection**: COVID-positive sample taken >14days after admission (validated)	0	0	0	3	0	7	6	11	21	20	14	42	36	23	37	-	96	-
UT8	**Probable hospital-associated COVID infection**: COVID-positive sample taken >7 days and <=14 days after admission (validated)	1	0	0	0	4	3	9	11	14	17	10	32	35	12	27	-	74	-
UT9	Pressure ulcers category 2 per 1000 bed days	0.31														0.36	<0.3	0.38	<0.3
UT10	Pressure ulcers category 3 and above per 1000 bed days	0.23														0.25	<0.3	0.39	<0.3
UT11-N	Medication Errors (severe/moderate)		1													2	≤3	6	≤9
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Monthly target	YTD	YTD target
UT12	Watch & Reserve antibiotics, usage per 1,000 adms Most recent months vs. 2018*95.5%	2,961	2,555											2,961	2,871		2,961	2,871	2,871
UT12 - For 2022/23, a new requirement is applied: Reduction of 4.5% from calendar year 2018 usage in combined WHO/NHSE AWaRE subgroups for "watch" and "reserve" agents. The performance data relate to successive FINANCIAL years, however the comparator denominator remains CALENDAR year 2018 (we are not using 2020 or 2021 due to the disruptive effect of COVID on both usage and admissions). Data is reported 3 months in arrears.																			
UT13	Serious Incidents Requiring Investigation (SIRI) (based upon month reported as SIRI, excluding Maternity)			7												12	-	44	-
UT14	Serious Incidents Requiring Investigation - Maternity			1												3	-	4	-
UT15	Number of high harm falls per 1000 bed days			0.14												0.23	-	0.16	-
UT16	% patients with a nutrition plan in place (total number wards included at chart base)	97.0%												98.0%	94.0%		≥90%	96.0%	≥90%
		332	304	782	606	691	755	787	444	397				53	742				
UT16 - monthly audit was paused due to pressure on all ward areas between Dec 2021 and May 2022. It has been agreed to restart the audit in June 2022 with some ward areas started May 2022.																			
UT17	Red Flag staffing incidents		8													31	-	78	-

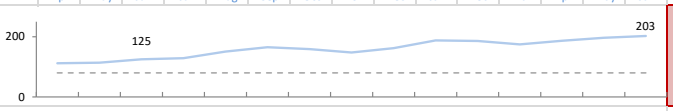
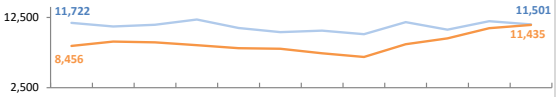
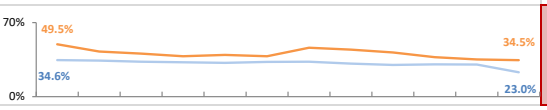
Patient Experience		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Monthly target	YTD	YTD target
UT18-N	FFT Negative Score - Inpatients			0.4%												1.6%	≤5%	1.2%	≤5%
UT19-N	FFT Negative Score - Maternity (postnatal ward)			4.5%												5.3%	≤5%	4.4%	≤5%
UT20	Total UHS women booked onto a continuity of carer pathway			42.5%												46.1%	≥35%	44.1%	≥35%
UT21	Total BAME women booked onto a continuity of carer pathway			57.8%												81.4%	≥51%	78.2%	≥51%
UT22	% Patients reporting being involved in decisions about care and treatment			87.0%												90.0%	≥90%	90.5%	≥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%	91.5%	≥90%
		292	254	280	341	197	153	165	155	131	95	143	117	121	120				
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)			18												51	-	-	-

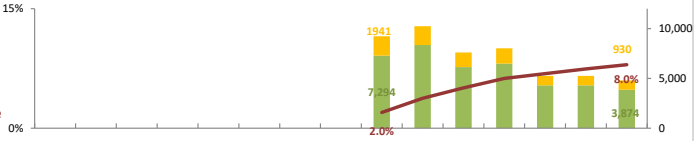
Access Standards

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Monthly target	YTD	YTD target
UT25-N	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 16) South East average (& rank of 16)	6	8	83.3% 4	5	4	4	6	4	5	8	10	6	4	8	64.7% 7	≥95%	65.6%	≥95%
		4	4	4	4	4	2	4	3	3	4	4	4	4	4	3			
UT26	Average (Mean) time in Dept - non-admitted patients			02:45												03:19	≤04:00	03:04	≤04:00
UT27	Average (Mean) time in Dept - admitted patients			03:51												05:37	≤04:00	04:51	≤04:00
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)	7	8	71.9% 9	9	9	10	10	10	9	8	6	5	5	3	66.4%	≥92%	67.3%	≥92%
		7	8	8	8	7	9	9	8	8	8	8	7	7	7				
UT29	Total number of patients on a waiting list (18 week referral to treatment pathway)			40,825												50,191	-	50,191	-
UT30	Patients on an open 18 week pathway (waiting 52 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	4	4	6	7	7	7	7	7	7	7	7	7	7	7		2,011	2,274	2,011
		14	14	2,436 14	15	15	15	15	15	14	14	14	14	14	12	2,274			
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	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)	60	13	13	12	9	8	8	8	8	8	8	6	8	5	5	0	5	0
		17	17	17	18	17	17	17	17	17	17	17	17	17	13				
UT32	Patients waiting for diagnostics			10,005												11,671	-	11,671	-
UT33-N	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	12	9	10	10	10	9	7	6	7	7	7	7	6	7	24.1%	≤1%	23.7%	≤1%
		17	16	18.1% 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)	3	79.0% 11	13	15	16	13	12	15	13	13	11	12	7	11		≥85%	74.4%	≥85%
		1	4	6	7	7	2	4	5	3	4	4	2	3	5	69.5%			
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)	11	9 97.6%	17	13	16	18	9	9	11	12	14	16	14	16		≥96%	92.4%	≥96%
		4	4	8	6	13	15	3	3	2	5	6	14	9	12	87.4%			
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)	16	14	15	17	13	18	14	16	15	11	14	15	13	9		≥95.4%	86.4%	≥95.4%
		12	13	94.1% 13	14	10	17	13	15	16	8	11	8	15	10	92.4%			

R&D Performance		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Monthly target	YTD	YTD target
PN1-L	Comparative CRN Recruitment Performance - non-weighted	12	10	10	9	10	9	9	9	8	9	8	9	1	1	3	Top 10	-	-
PN2-L	Comparative CRN Recruitment Performance - weighted	10	10	5	3	4	3	3	3	3	4	4	3	6	8	11	Top 5	-	-
PN3-L	Comparative CRN Recruitment - contract commercial	14	8	12	11	4	4	3	7	7	8	9	10	2	1	3	Top 10	-	-
PN4-L	Achievement compared to R+D Income Baseline Monthly income increase % YTD income increase %	46.0%	-22.0%	152.0% 59.0%	45.0%	143.0%	-5.0%	334.0%	0.0%	29.0%	-234.0%	143.0%	359.0%	63.0%	37.0%	22.0% 65.0%	≥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).																		

			Monthly target	YTD	YTD target
Thrive		Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun			
WR1-L	Substantive Staff - Turnover **-R12M turnover %** **-Leavers in month (FTE)**		R12M <= 12.0%	14.9%	-
WR2-L	Staff Vacancies **-Nursing vacancies** (registered nurses only in clinical wards) **-All Staff vacancies**		-	-	-
WR3-L	Workforce Numbers (WTE) **-Planned monthly growth in Staff in post** **-Actual monthly growth in Staff in post** *-Including - Doctors in training.* *-Excluding - Chilworth laboratory, Additional hours (medical staff), Bank and agency* *- Substantive SIP only* ** monthly growth is based on a baseline of March 22*		478.1 WTE by March 2023	-	-
WR4-L	Staff - Sickness absence **-R12M sickness %** **-Sickness in month %**		R12M <= 3.4%	4.7%	-
Excel		Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun	Monthly target	YTD	YTD target
WR5-L	Non-medical appraisals completed **-R12M appraisal %** **-Appraisals in month**		R12M >= 92.0%	71.4%	-
WR6-L	Medical staff appraisals completed - Rolling 12-months		-	-	-
		Q1 21-22 Q2 21-22 Q3 21-22 Q4 21-22 Q1 22-23	Quarterly target		
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). Q122-23 data release in second week of Auguest 2022.					
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. Q122-23 data release in second week of Auguest 2022.					
Belong		Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun	Monthly target	YTD	YTD target
WR9-L	% of Band 7+ staff who are Black and Minority Ethnic		19% by 2026	10.5%	-
WR10	% of Band 7+ Staff who have declared a disability or long term health condition		-	-	-
		Q1 21-22 Q2 21-22 Q3 21-22 Q4 21-22 Q1 22-23	Quarterly target		
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.Q122-23 data release in second week of Auguest 2022.					
		Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun	Monthly target	YTD	YTD target
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		Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun	Monthly target	YTD	YTD target
NT1	Number of inpatients that were medically optimised for discharge (monthly average)		≤80	195	-
NT2	Emergency Department activity - type 1 This year vs. last year		-	34,246	-
NT3	Percentage of virtual appointments as a proportion of all outpatient consultations This year vs. last year		≥25%	28.0%	≥25%

Digital		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Monthly target	YTD	YTD target
FN1	My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month)																-	121,474	
FN2	My Medical Record - UHS patient logins (number of logins made within each month)																-	71,629	
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 - June 2022

Our staffing levels are continuously monitored through our staffing hub 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. For the first time we have included both mothers and babies in our occupancy levels which will have impacted the care hours per patient day for comparison in previous months.

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 these wards had in the main returned to their normal size and purpose. Over the last few months COVID-19 numbers again increased so wards and departments have again been required to change focus and form to respond to changing circumstances. 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	6183	4673	816	613	75.6%	75.1%	30.4	3.9	34.3	Safe staffing levels maintained; Staffing appropriate for number of patients.
CC Neuro Intensive Care Unit	Night	4971	4648	664	597	93.5%	89.8%				Safe staffing levels maintained; Staffing appropriate for number of patients.
CC - Surgical HDU	Day	2567	1833	798	414	71.4%	51.9%	17.2	4.2	21.4	Safe staffing levels maintained; Staffing appropriate for number of patients.
CC - Surgical HDU	Night	2055	1822	668	483	88.7%	72.3%				Safe staffing levels maintained; Staffing appropriate for number of patients.
CC General Intensive Care	Day	13049	10020	2125	1478	76.8%	69.5%	27.1	4.1	31.2	Safe staffing levels maintained; Staffing appropriate for number of patients; Staff moved to support other wards.
CC General Intensive Care	Night	10369	9412	1702	1461	90.8%	85.8%				Safe staffing levels maintained; staffing appropriate for number of patients.
CC Cardiac Intensive Care	Day	6988	4925	1637	880	70.5%	53.8%	28.1	4.2	32.3	Safe staffing levels maintained; Staffing appropriate for number of patients; Staff moved to support other wards.
CC Cardiac Intensive Care	Night	5840	5195	838	623	89.0%	74.3%				Safe staffing levels maintained; Staffing appropriate for number of patients.
SUR E5 Lower GI	Day	1473	1098	769	1104	74.5%	143.6%	3.6	3.7	7.3	Safe staffing levels maintained by sharing staff resource; Increase in acuity/dependency of patients in the month.
SUR E5 Lower GI	Night	690	736	345	805	106.7%	233.3%				Increase in acuity/dependency of patients in the month; Patient requiring 24 hour 1:1 nursing in the month.
SUR E5 Upper GI	Day	1455	1226	956	993	84.3%	103.8%	3.9	2.9	6.8	Support workers used to maintain staffing numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
SUR E5 Upper GI	Night	690	695	345	438	100.8%	127.0%				Support workers used to maintain staffing numbers.
SUR E8 Ward	Day	2500	2114	1397	1447	84.5%	103.6%	4.7	3.4	8.1	Skill mix swaps undertaken to support safe staffing across the Unit.
SUR E8 Ward	Night	1665	1227	1205	995	73.7%	82.6%				Staff moved to support other wards.
SUR F11 IF	Day	1906	1531	739	710	80.3%	96.1%	4.5	2.9	7.4	Staff moved to support other wards.
SUR F11 IF	Night	690	713	691	707	103.3%	102.3%				Safe staffing levels maintained.
SUR Acute Surgical Unit	Day	1423	1041	742	744	73.2%	100.4%	7.7	5.1	12.8	Staff moved to support other wards.
SUR Acute Surgical Unit	Night	690	698	697	399	101.2%	57.2%				Staff moved to support other wards; Safe staffing levels maintained.
SUR Acute Surgical Admissions	Day	2094	1935	845	981	92.4%	116.0%	3.9	2.5	6.3	Increased night staffing to support raised acuity.
SUR Acute Surgical Admissions	Night	1035	1027	1035	932	99.3%	90.0%				Safe staffing levels maintained.
SUR F5 Ward	Day	1885	1632	1034	1109	86.6%	107.2%	3.6	2.5	6.1	Skill mix swaps undertaken to support safe staffing across the Unit.
SUR F5 Ward	Night	1141	1068	690	761	93.6%	110.3%				Increased night staffing to support raised acuity.
OPH Eye Short Stay Unit	Day	983	992	837	862	100.9%	102.9%	15.5	14.0	29.6	Safe staffing levels maintained.
OPH Eye Short Stay Unit	Night	330	330	330	330	99.8%	100.0%				Safe staffing levels maintained.
THR F10 Surgical Day Unit	Day	1432	1516	2577	2276	105.9%	88.3%	4.3	6.3	10.6	Additional beds open in the month; has been open to 18 inpatients all month.
THR F10 Surgical Day Unit	Night	287	356	286	480	124.3%	167.8%				Additional beds open in the month; Increased night staffing to support raised acuity;as above.
CAN Acute Onc Services	Day	940	956	644	671	101.7%	104.2%				Safe staffing levels maintained.

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CAN Acute Onc Services	Night	345	596	345	552	172.8%	160.0%	8.0	6.3	14.4	Increased night staffing to support raised acuity; Safe staffing levels maintained; Staffing appropriate for number of patients; Assessment area converted to inpatient facility.
CAN C4 Solent Ward Clinical Oncology	Day	1673	1562	979	1139	93.4%	116.3%	4.2	3.8	8.0	Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month.
CAN C4 Solent Ward Clinical Oncology	Night	1000	944	667	1128	94.4%	169.1%				Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month.
CAN C6 Leukaemia/BMT Unit	Day	2737	2547	126	349	93.1%	275.9%	7.6	1.1	8.7	Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month; Budget increased for HCA support during day and night.
CAN C6 Leukaemia/BMT Unit	Night	1964	1903	0	321	96.9%	Shift N/A				Safe staffing levels maintained.
CAN C6 TYA Unit	Day	1173	944	422	58	80.4%	13.7%	9.5	0.5	10.1	Safe staffing levels maintained.
CAN C6 TYA Unit	Night	662	675	0	33	102.0%	Shift N/A				Safe staffing levels maintained by sharing staff resource.
CAN C2 Haematology	Day	2248	2457	1121	975	109.3%	87.0%	5.5	2.6	8.1	Safe staffing levels maintained.
CAN C2 Haematology	Night	1691	1773	1036	1001	104.9%	96.6%				Safe staffing levels maintained.
CAN D3 Ward	Day	1724	1707	734	1096	99.0%	149.2%	4.5	3.3	7.8	Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month.
CAN D3 Ward	Night	1028	1137	685	994	110.6%	145.1%				Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month.
ECM Acute Medical Unit	Day	3976	4223	3653	4218	106.2%	115.5%	6.1	5.7	11.8	Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource
ECM Acute Medical Unit	Night	3948	4306	3432	3721	109.1%	108.4%				Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource
MED D5 Ward	Day	1190	1586	1665	1506	133.3%	90.4%	3.1	3.3	6.5	Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
MED D5 Ward	Night	1024	979	923	1213	95.6%	131.4%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
MED D6 Ward	Day	1007	1338	1564	1317	132.8%	84.2%	3.4	3.3	6.7	Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
MED D6 Ward	Night	1047	1039	922	967	99.2%	104.8%				Band 4 staff working to support registered nurse numbers; Increased night staffing to support raised acuity.
MED D7 Ward	Day	703	708	1113	952	100.8%	85.5%	2.9	3.0	5.9	Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
MED D7 Ward	Night	686	663	345	472	96.6%	136.7%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers
MED D8 Ward	Day	1051	1053	1416	1416	100.2%	100.0%	2.8	3.2	6.0	Safe staffing levels maintained; Skill mix swaps undertaken to support safe staffing across the Unit.
MED D8 Ward	Night	1035	920	915	815	88.9%	89.0%				Safe staffing levels maintained; Safe staffing levels maintained.
MED D9 Ward	Day	1236	1305	1698	1513	105.6%	89.1%	2.7	3.1	5.8	Additional staff used for enhanced care - RNs; Safe staffing levels maintained.
MED D9 Ward	Night	1035	818	916	981	79.0%	107.1%				Increase in acuity/dependency of patients in the month; Additional staff used for enhanced care - RNs
MED E7 Ward	Day	1053	1057	1241	1621	100.3%	130.5%	2.9	4.2	7.1	Safe staffing levels maintained; Additional staff used for enhanced care - RNs.
MED E7 Ward	Night	690	1013	759	1331	146.8%	175.3%				Safe staffing levels maintained; Additional staff used for enhanced care - RNs; Additional staff used for enhanced care - Support workers.
MED F7 Ward	Day	770	754	1294	1126	97.9%	87.0%	2.4	3.0	5.4	Safe staffing levels maintained.
MED F7 Ward	Night	690	690	690	679	100.0%	98.3%				Safe staffing levels maintained.
MED Respiratory HDU	Day	2289	1508	475	312	65.9%	65.6%	13.6	2.9	16.5	Staffing appropriate for number of patients.
MED Respiratory HDU	Night	2072	1445	334	311	69.7%	93.3%				Staffing appropriate for number of patients.
MED C5 Isolation Ward	Day	1144	1045	1084	457	91.4%	42.1%	6.4	2.5	8.8	Staffing appropriate for number of patients.
MED C5 Isolation Ward	Night	1001	969	345	323	96.8%	93.7%				Staffing appropriate for number of patients.
MED D10 Isolation Unit	Day	1088	878	1282	1120	80.7%	87.4%	3.1	3.6	6.7	Safe staffing levels maintained.
MED D10 Isolation Unit	Night	690	699	690	725	101.2%	105.0%				Safe staffing levels maintained.
MED G5 Ward	Day	1410	1277	1475	1385	90.6%	93.9%	2.8	2.5	5.3	Safe staffing levels maintained.
MED G5 Ward	Night	1024	1051	690	691	102.7%	100.1%				Safe staffing levels maintained.
MED G6 Ward	Day	1405	1349	1428	1206	96.0%	84.5%	3.0	2.7	5.7	Safe staffing levels maintained by sharing staff resource.
MED G6 Ward	Night	1036	921	690	826	88.9%	119.8%				Safe staffing levels maintained.
MED G7 Ward	Day	691	674	826	835	97.6%	101.0%	3.5	3.2	6.7	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
MED G7 Ward	Night	690	645	380	391	93.4%	102.9%				Safe staffing levels maintained.
MED G8 Ward	Day	1394	1154	1509	1309	82.8%	86.8%	2.9	3.2	6.1	Staffing appropriate for number of patients.
MED G8 Ward	Night	1036	841	690	863	81.1%	125.0%				Staffing appropriate for number of patients.
MED G9 Ward	Day	1369	1156	1356	1238	84.4%	91.3%	3.1	3.2	6.3	Staffing appropriate for number of patients.
MED G9 Ward	Night	1035	898	690	840	86.8%	121.7%				Staffing appropriate for number of patients.
MED Bassett Ward	Day	1299	923	2367	1918	71.1%	81.0%	2.4	4.0	6.3	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
MED Bassett Ward	Night	1024	886	1035	1104	86.5%	106.7%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
CHI High Dependency Unit	Day	1555	1164	0	226	74.8%	Shift N/A	15.0	1.5	16.5	Non-ward based staff supporting areas; Beds flexed to match staffing; Safe staffing levels maintained.
CHI High Dependency Unit	Night	1035	1034	0	0	99.9%	Shift N/A				Safe staffing levels maintained.
CHI Paed Medical Unit	Day	1945	1667	701	894	85.7%	127.6%	9.3	4.1	13.4	Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained.
CHI Paed Medical Unit	Night	1650	1689	660	607	102.3%	91.9%				Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
CHI Paediatric Intensive Care	Day	5983	5374	1152	416	89.8%	36.1%	29.5	2.4	31.9	Beds flexed to match staffing; Safe staffing levels maintained.
CHI Paediatric Intensive Care	Night	5524	4923	894	424	89.1%	47.5%				Beds flexed to match staffing; Safe staffing levels maintained.
CHI Piam Brown Unit	Day	3749	2546	998	593	67.9%	59.4%	16.6	3.9	20.5	Beds flexed to match staffing; Safe staffing levels maintained.
CHI Piam Brown Unit	Night	1380	1001	690	242	72.5%	35.0%				Beds flexed to match staffing; Safe staffing levels maintained.
CHI Ward E1 Paed Cardiac	Day	2072	1493	597	563	72.0%	94.3%	6.4	2.2	8.6	Band 4 staff working to support registered nurse numbers; Non-ward based staff supporting areas; Safe staffing levels maintained.
CHI Ward E1 Paed Cardiac	Night	1380	1202	345	382	87.1%	110.8%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
CHI Bursledon House	Day	849	602	518	319	70.9%	61.6%	4.8	3.1	7.9	Band 4 staff working to support registered nurse numbers.
CHI Bursledon House	Night	198	178	198	176	89.9%	88.9%				Band 4 staff working to support registered nurse numbers.
CHI Ward G2 Neuro	Day	757	711	900	132	93.8%	14.7%	8.1	0.8	8.9	Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month; HCA's not normally required.
CHI Ward G2 Neuro	Night	720	710	720	0	98.6%	0.0%				Safe staffing levels maintained.
CHI Ward G3	Day	2327	1926	1730	849	82.7%	49.1%	7.8	3.1	10.9	Beds flexed to match staffing; Safe staffing levels maintained.
CHI Ward G3	Night	1650	1471	992	508	89.2%	51.2%				Beds flexed to match staffing; Safe staffing levels maintained.
CHI Ward G4 Surgery	Day	2425	1994	1204	764	82.3%	63.5%	8.3	2.9	11.1	Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Safe staffing levels maintained.
CHI Ward G4 Surgery	Night	1654	1503	660	442	90.9%	67.0%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained; Beds flexed to match staffing.
W&N Bramshaw Womens Unit	Day	1087	974	634	761	89.6%	120.0%	4.5	3.2	7.7	Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained.
W&N Bramshaw Womens Unit	Night	747	725	633	427	97.0%	67.4%				Safe staffing levels maintained.
W&N Neonatal Unit	Day	6773	4571	1588	1104	67.5%	69.5%	9.9	2.2	12.1	Safe staffing levels maintained.
W&N Neonatal Unit	Night	5273	3885	1331	803	73.7%	60.3%				Safe staffing levels maintained.
W&N PAH Maternity Service combined	Day	10442	8523	4109	3592	81.6%	87.4%	9.4	3.4	12.8	Safe staffing levels maintained.
W&N PAH Maternity Service combined	Night	6598	5449	1972	1502	82.6%	76.2%				Safe staffing levels maintained.
CAR CHDU	Day	4938	3986	1653	1701	80.7%	102.9%	15.0	5.4	20.4	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained;1 bed flexed for social distancing.
CAR CHDU	Night	3784	3596	1001	1001	95.0%	100.0%				Safe staffing levels maintained by sharing staff resource; Safe staffing levels maintained;1 bed flexed for social distancing.
CAR Coronary Care Unit	Day	2590	2629	979	973	101.5%	99.4%	9.2	3.7	12.9	Safe staffing levels maintained by sharing staff resource; Safe staffing levels maintained by sharing staff resource; staffing specialty patients remotely on covid ward regularly.
CAR Coronary Care Unit	Night	2286	2243	924	978	98.1%	105.8%				Safe staffing levels maintained by sharing staff resource; Safe staffing levels maintained;staffing specialty patients remotely on covid ward regularly.
CAR Ward D4 Vascular	Day	1939	1714	1131	1097	88.4%	97.0%	4.5	3.3	7.8	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
CAR Ward D4 Vascular	Night	1023	1154	1001	1029	112.9%	102.8%				Increased night staffing to support raised acuity; Safe staffing levels maintained; 3rd RN on Nights to support rising acuity.
CAR Ward E2 YACU	Day	1554	1301	794	1069	83.7%	134.7%	4.1	3.8	7.9	Staff moved to support other wards; Additional staff used for enhanced care - Support workers.

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 E2 YACU	Night	703	741	627	814	105.5%	129.8%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAR Ward E3 Green	Day	1526	1447	1480	1256	94.9%	84.9%	3.2	3.1	6.3	Safe staffing levels maintained; Staff moved to support other wards.
CAR Ward E3 Green	Night	682	706	770	877	103.5%	113.9%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAR Ward E3 Blue	Day	1574	1358	1112	925	86.3%	83.2%	3.9	3.4	7.2	Band 4 staff working to support registered nurse numbers; Staff moved to support other wards.
CAR Ward E3 Blue	Night	682	662	671	836	97.1%	124.6%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAR Ward E4 Thoracics	Day	1217	1332	1714	1131	109.5%	66.0%	4.1	3.6	7.7	Safe staffing levels maintained; Staff moved to support other wards.
CAR Ward E4 Thoracics	Night	1012	970	453	846	95.8%	187.0%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAR Ward D2 Cardiology	Day	1376	906	660	1081	65.8%	163.8%	3.7	4.2	7.8	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
CAR Ward D2 Cardiology	Night	682	682	649	726	100.0%	111.9%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
NEU Acute Stroke Unit	Day	1483	1415	2569	2502	95.4%	97.4%	2.7	5.1	7.8	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
NEU Acute Stroke Unit	Night	978	870	1650	1725	88.9%	104.5%				Band 4 staff working to support registered nurse numbers.
NEU Regional Transfer Unit	Day	1160	1009	382	381	87.0%	99.6%	7.1	5.1	12.2	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
NEU Regional Transfer Unit	Night	649	463	649	675	71.3%	104.0%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
NEU ward E Neuro	Day	1829	1457	1017	1864	79.7%	183.3%	3.3	4.6	7.9	Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month.
NEU ward E Neuro	Night	1321	1091	990	1617	82.6%	163.3%				Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month.
NEU HASU	Day	1522	1151	386	519	75.7%	134.5%	7.4	3.5	11.0	Band 4 staff working to support registered nurse numbers.
NEU HASU	Night	1331	947	330	484	71.1%	146.7%				Band 4 staff working to support registered nurse numbers.
NEU Ward D Neuro	Day	1813	1844	1874	1840	101.7%	98.2%	4.2	4.5	8.7	Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month.
NEU Ward D Neuro	Night	1320	1421	1672	1713	107.6%	102.5%				Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month.
SPI Ward F4 Spinal	Day	1490	1499	1079	1347	100.6%	124.8%	4.0	3.8	7.7	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
SPI Ward F4 Spinal	Night	979	990	968	1034	101.1%	106.8%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
T&O Ward Brooke	Day	1036	1050	1069	877	101.4%	82.1%	3.5	3.2	6.6	Staffing appropriate for number of patients; Safe staffing levels maintained;Ward on Tipping point staffing levels.
T&O Ward Brooke	Night	667	701	1035	725	105.1%	70.0%				Safe staffing levels maintained by sharing staff resource; Safe staffing levels maintained by sharing staff resource;Ward on Tipping point staffing levels.
T&O Trauma Admissions Unit	Day	889	746	725	593	83.9%	81.7%	8.2	7.7	16.0	Safe staffing levels maintained by sharing staff resource; Safe staffing levels maintained;Bleep holder on TAU & ward on tipping point staffing levels.
T&O Trauma Admissions Unit	Night	660	506	659	583	76.7%	88.4%				Safe staffing levels maintained by sharing staff resource; Safe staffing levels maintained;Bleep holder on TAU & ward on tipping point staffing levels.
T&O Ward F1 Major Trauma Unit	Day	2289	2211	1787	1947	96.6%	108.9%	4.3	4.2	8.4	Staffing appropriate for number of patients; Additional staff used for enhanced care - Support workers.
T&O Ward F1 Major Trauma Unit	Night	1725	1626	1725	1805	94.3%	104.6%				Staffing appropriate for number of patients; Additional staff used for enhanced care - Support workers.
T&O Ward F2 Trauma	Day	1600	1185	1833	2097	74.1%	114.4%	3.1	5.4	8.5	Safe staffing levels maintained by sharing staff resource; Support workers used to maintain staffing numbers;Ward safe on tipping point numbers.
T&O Ward F2 Trauma	Night	979	837	1321	1505	85.5%	114.0%				Safe staffing levels maintained by sharing staff resource; Support workers used to maintain staffing numbers;Ward safe on tipping point numbers.
T&O Ward F3 Trauma	Day	1525	1642	1863	1881	107.6%	101.0%	3.7	4.6	8.4	Safe staffing levels maintained by sharing staff resource; Staffing appropriate for number of patients.
T&O Ward F3 Trauma	Night	990	1002	1321	1364	101.2%	103.3%				Staffing appropriate for number of patients; Additional staff used for enhanced care - Support workers.
T&O Ward F4 Elective	Day	1353	1276	740	803	94.3%	108.6%	3.8	2.9	6.7	Staffing appropriate for number of patients; Additional staff used for enhanced care - Support workers.
T&O Ward F4 Elective	Night	660	660	660	682	100.0%	103.3%				Staffing appropriate for number of patients; Additional staff used for enhanced care - Support workers.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Finance Report 2022-23 Month 3**			
Agenda item:	**5.6**			
Sponsor:	**Ian Howard – Chief Financial Officer**			
Author:	**Philip Bunting – Director of Operational Finance**			
Date:	**28 July 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:	**M3 Financial Position** UHS reported a deficit of £1.2m in July 2022, which is now £6.2m deficit YTD. This is £2.1m adverse to plan in Q1. The favourable movement in month was driven by several items that relate to the previous two months: • £0.9m of backdated drugs and devices income that are now classified as pass through and chargeable to NHS England. • £0.5m of ERF income relating to prior months now more robust data has been coded • £0.4m of Channel Islands income that relates to prior months now more robust data has been coded • A further £0.2m relates to a one-off provision **Underlying Position** The true reported position for M3 is therefore a £2.8m deficit after accounting for the above adjustments. This is consistent with the previous two months that following restatement were an underlying deficit of £2.9m per month. The underlying position can therefore be restated as £8.6m deficit YTD. This is £4.5m adverse to the plan for months 1 to 3 (£4.1m planned deficit). **Key drivers** The key drivers for the underlying deficit to plan are as follows: • Cost Improvement Plans – due to the considerable operational pressures the development of plans from Q4 21/22 have been delayed. Delivery has however significantly improved in M3 with £4.5m now reported against a plan of £6.4m. This shortfall has generated a £1.9m adverse variance to plan. • Covid costs continuing in excess of plan by £2.4m YTD – this mainly relates to staff sickness absence backfill costs which			

improved in May and early June but started to increase in the latter weeks of June following a further covid increase.
- Operational Pressures / Emergency Demand – ED continues to experience volumes in excess of planned levels driving up expenditure especially on premium rate staffing.

As a reminder there are also drivers pre-existing from 2021/22:

- CCG Block Drugs overperformance – £0.6m per month. This continues to be monitored; however, there are no immediate funding solutions for this. Much of the pressure relates to homecare growth for long term conditions that has supported reduced inpatient or outpatient attendances freeing up capacity for priority 1 work.
- Energy costs - £0.8m per month. Although excess inflationary funding has been added to contract envelopes, this doesn't cover exceptional items like energy that had a bigger proportional impact on UHS due to our reliance on gas and end of fixed-rate deals. This pressure has also increased further by c£0.1m per month from original plan assumptions.

Elective Recovery Framework

UHS achieved 109% in June. This included:
- 107% in elective
- 113% in outpatients (including procedures but excluding follow-ups)
- Capped 85% in follow-ups, with actual activity at 133%

April and May activity has also now been coded in more depth and illustrate achievement of 103% and 111% respectively.

This activity level is extremely positive for achievement of the 106% plan (104% target) for the year and is despite continuing operational pressures and ED demand.

Income of £3.7m relating to ERF has been included in the financial position. This increased activity has been delivered at additional cost however, especially with regards to clinical supplies and variable pay costs associated with the additional activity. At 75% payment marginal financial gains are minimal, however the benefit to waiting lists and reduced risk of harm for patients waiting is clearly of significant benefit. It should be noted that some uncertainty remains over national calculations of performance, with data for April expected later in month.

Data for the Southeast illustrates UHS as one of the top (and in many weeks, the top) performers within the region.

Underlying Financial Trajectory

A financial trajectory has been developed illustrating a potential range of scenarios. Due to the level of current uncertainty, particularly with Covid and cost inflation, the range is currently significant between an underlying deficit of £20m and £40m with the intermediate expectation at £29m (assuming CIP delivery at £24m). We would however anticipate CIP delivery to outperform this and financial recovery projects

to improve this position throughout the year to mitigate this risk.

Any shortfall to breakeven 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 underlying deficit.

Response to the financial challenge

Due to the scale of financial risk, a recovery plan has been developed to drive an improvement trajectory. Progress has been made in the last month, with the Trust Savings Group (TSG) holding their first meeting and a programme manager recruitment process commencing.

The purpose of the Trust Savings Group will be to:

- Improve financial performance
- Improve control of income and expenditure
- Oversee the achievement of the financial aspects of the 2022/23 annual plan
- Deliver an improvement to underlying financial performance which provides a foundation for financial sustainability in 23/24 and beyond
- Prepare the organisation for a transition from financial recovery to business as usual whilst continuing to deliver on the trust's financial and non-financial objectives

Updates will continue in future months Finance Reports.

Capital

- The trust has an internal CDEL plan of £49m for 2022/23. Capital expenditure of £4m has been reported YTD against this.
- 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.
- Additionally, £3.5m has been reported against the multi-storey car park at Adanac which has now opened. This is currently reported outside of CDEL on the assumption this asset is capitalised on the basis of IFRS 16 and therefore can be treated outside of scope. Guidance has yet to be issued in detail providing confirmation of this, however.
- Significant progress has been made with External CDEL opportunities:
    - A business case for wards (£10m) has been submitted to NHSE Regional Officer for review as part of Elective Targeted Investment Fund plans.
    - A meeting has been held with Specialised Commissioning regarding confirmed CDEL of £5.1m for Neonates, noting that this does not include cash funding. A business case is expected to be submitted in September. There is added complexity within the case due to the potential loss of bed capacity, with mitigation options currently being explored.
    - A bid for an additional CT scanner for ED has been submitted

	o A bid for an additional CT scanner for the Targeted Lung Programme has been confirmed this week at £1.4m. o Southampton and Southwest Hampshire have submitted a draft bid to NHSE Region for Community Diagnostic Centre expansion at RSH. **Pay Award** An announcement has now been made in regard to the national pay award for 2022/23. The award can be summarised as: • £1,400 set payment for AfC staff, with a top up for B6/B7 to ensure the percentage remains above a floor of 4%. For B5 nurses this equates to between 4.4% and 5.5%, depending on point in the scale. For B1/B2 staff it equates to 9.3%, and for B9 it equates to 1.3%. • Consultants & SAS doctors will receive between 4.3% - 4.5%. • Junior Doctors are part of a long-term pay arrangement and therefore are not part of this arrangement, meaning pay-rises are likely to be circa 2%. Overall, the award will average 4.5%. 2% has already been funded within envelopes and is currently being accrued by organisations. The additional cost will be met in full by NHSE with payment due to be made to providers and then staff in September 2022. To fund this NHSE have however had to pause several areas of national investment with frontline digitisation and Community Diagnostics Centres mentioned as two key areas impacted. This could have an impact on UHS with potential future funding now less probable to flow. No commitments had been made against these programmes. **Independent Sector / Insourcing** The Trust are actively exploring additional capacity in the Independent Sector and through Insourcing companies, subject to IR35 compliance checks. These cases are being considered on a case-by-case basis linked to growth in waiting lists, capacity constraints, length of time on waiting list (104/78/52 week waits), patient safety risk and financial implications. The additional activity is only available at tariff or in some cases above tariff, meaning it is not covered by a 75% marginal rate. This may cause additional in-year cost pressures. Dermatology and ENT are two areas that have been approved for insourcing arrangements with a financial exposure of c£0.3m.
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 2 underlying 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.

2022/23 Finance Report - Month 3

Report to:	**Board of Directors and Finance & Investment Committee** **June 2022**
Title:	**Finance Report for Period ending 30/06/2022**
Author:	**Philip Bunting, Director of Operational 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. In Month 3, UHS reported a deficit position of £1.2m with a £6.2m deficit YTD. This is £2.1m behind plan YTD.

2. The in month position has improved due to several elements of backdated income being recognised relating mainly to drugs and devices income. The underlying position is however £8.6m deficit YTD with one offs helping improve the in year reported position. A run rate continuing at this level would generate a £34m underlying deficit across 2022/23, although that is expected to improve as CIP plans are implemented. Underlying deficit scenarios indicate a range between £20m and £40m.

3. At M3 the CIP YTD achievement is £4.5m, against a planned £6.4m delivery. This is therefore £2.1m behind plan. Identification has however improved to £30m (67%).

4. The main income and activity themes seen in M3 were:
   - Despite operational pressures due to Covid and increasing ED demand, UHS has delivered 109% of Elective Recovery activity in M3, above target and plan levels.
   - Covid related sickness absence increased to c300 WTE at month close
   - ERF income of £3.7m has been estimated within the position, at 75% marginal rate, off-setting the variable costs of additional activity. National calculations on performance are anticipated to be three months in arrears.

5. The underlying deficit of £2.9m per month is driven by:
   1. Drugs & Devices (£0.6m per month) – part of our plan but unable to off-set with CIP
   2. Energy costs – (£0.8m per month) – Inflationary pressure not met with funding
   3. Covid Costs – (£0.8m per month) – continued sickness absence costs and covid not reduced as per planning assumptions
   4. CIP shortfall – (£0.7m per month) - Although progress has been made savings have not been achieved to the level to bridge the gap to breakeven across Q1.
   5. Elective Recovery and ERF – a 75% marginal payment covers costs only and fails to cover IS or insourcing premium costs. For this reason it has not generated additional margins.

Finance: I&E Summary

A deficit of £1.2m position was reported in June 2022 slightly better than planned. The YTD position is however £2.1m adverse to the planned £4.1m deficit target.

In month £0.9m of backdated income was reported relating to pass through drugs and devices that was related to months 1 and 2. There are sometimes delays on data flows meaning capturing this in real time is challenging. Further to this there was £0.9m of other backdated income, mainly relating to ERF, that is shown in M3 and a one off cost of £0.2m. This means the prevailing underlying deficit was £2.8m in month.

Covid-related absences were on downward trend in the early part of the month however increased in the latter part of the month contributing to an overspend on temporary staffing.

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

		Current Month			Cumulative			Forecast		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
NHS Income:	Clinical	69.8	70.8	(1.1)	209.3	209.7	(0.4)	837.0	838.7	(1.7)
	Pass-through Drugs & Devices	11.2	12.8	(1.6)	33.6	34.8	(1.2)	134.6	139.3	(4.7)
Other income	Other Income excl. PSF	10.6	12.5	(2.0)	31.7	40.5	(8.8)	126.6	141.9	(15.3)
	Top Up Income	0.8	0.6	0.2	2.6	2.0	0.6	8.3	8.1	0.3
Total income		**92.4**	**96.8**	**(4.4)**	**277.1**	**287.0**	**(9.9)**	**1,106.6**	**1,128.0**	**(21.5)**
Costs	Pay-Substantive	49.0	49.8	0.8	146.3	148.0	1.8	591.6	592.1	0.6
	Pay-Bank	3.1	3.7	0.6	9.9	11.7	1.8	33.2	40.8	7.7
	Pay-Agency	1.1	0.8	(0.3)	3.6	3.8	0.3	12.0	14.6	2.6
	Drugs	5.2	4.4	(0.8)	15.6	13.1	(2.5)	59.7	52.4	(7.3)
	Pass-through Drugs & Devices	11.2	12.8	1.6	33.6	34.8	1.2	134.6	139.3	4.7
	Clinical supplies	7.3	6.0	(1.3)	21.8	21.2	(0.6)	74.6	74.9	0.2
	Other non pay	15.8	19.7	3.9	47.7	58.2	10.5	189.6	202.6	13.0
Total expenditure		**92.8**	**97.2**	4.4	**278.5**	**290.9**	**12.4**	**1,095.3**	**1,116.8**	**21.5**
EBITDA		**(0.4)**	**(0.4)**	**0.0**	**(1.3)**	**(3.9)**	**2.5**	**11.2**	**11.2**	**0.0**
EBITDA %		-0.4%	-0.5%	0.0%	-0.5%	-1.3%	0.9%	1.0%	1.0%	0.0%
	Non operating expenditure/income	0.9	0.9	(0.0)	2.8	2.7	(0.1)	11.1	11.1	0.0
Surplus / (Deficit)		**(1.3)**	**(1.3)**	**0.0**	**(4.1)**	**(6.5)**	**2.4**	**0.1**	**0.1**	**0.0**
Less	Donated income	0.1	0.1	0.1	0.3	0.2	0.2	1.4	1.4	0.0
Add Back	Donated depreciation	0.1	0.2	0.1	0.3	0.5	0.2	1.3	1.3	0.0
Net Surplus / (Deficit)		**(1.3)**	**(1.2)**	**(0.1)**	**(4.1)**	**(6.2)**	**2.1**	**0.0**	**0.0**	**0.0**

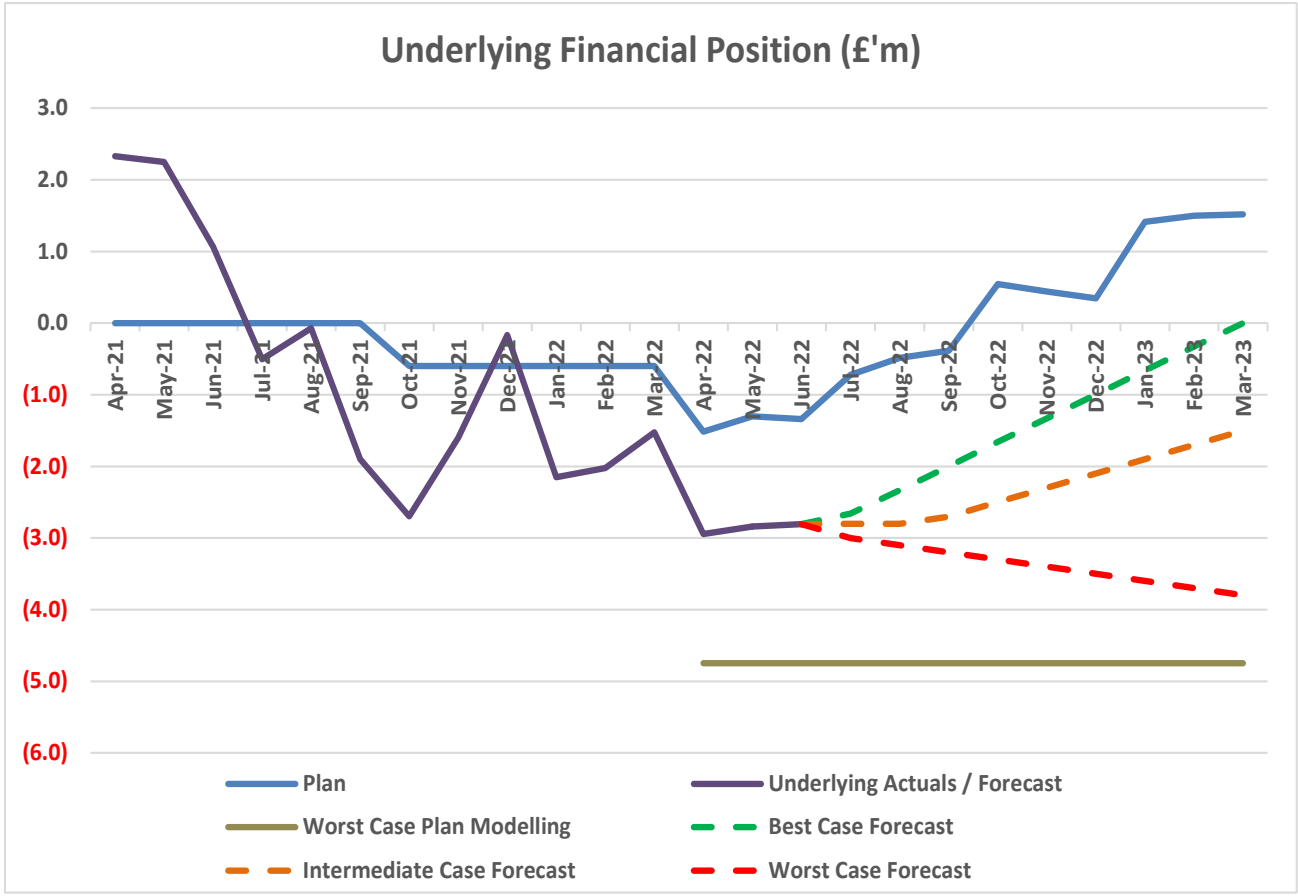
Monthly Underlying Position

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

This differs from the reported financial position as it has been adjusted for non recurrent items (one offs) and also had any necessary costs or income rephased by month to get a true picture of the run rate. The underlying run rate in Q1 is £2.9m deficit per month which is adverse to the planned £1.4m per month due mainly to covid pressures continuing and the delayed delivery of cost improvement plans.

A range of scenarios have been modelled indicating a spread between £20m deficit and £40m deficit. The intermediate scenario stands at £29m deficit with an improvement in CIP forecast consistent with delivering 50% of identified schemes not yet delivering.

There are however continued risks relating to future costs driven by inflationary pressures, growth, non elective pressure in winter and Covid that all mean potential deterioration could occur.



Financial Risks

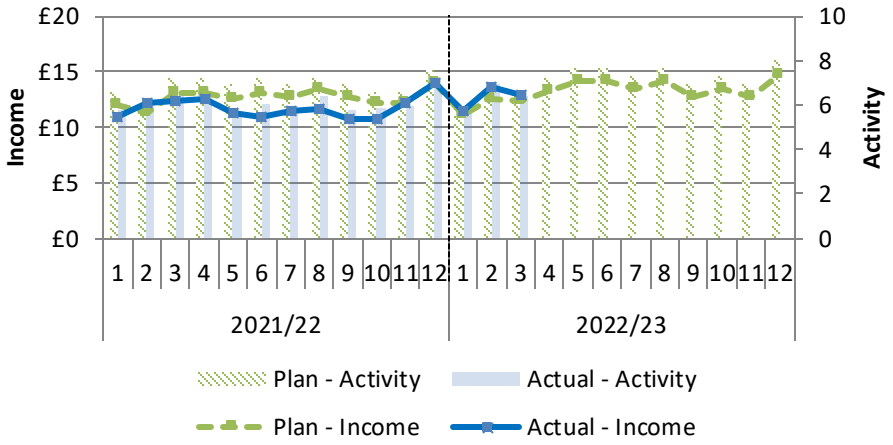
The table illustrates the key variables driving the underlying deficit position. It is intended that these risks will be monitored in year. Some of these are more complex to measure than others so values are estimated at present and more work will be done to refine them over the next month.

It is acknowledged that this generates a wide ranging forecast between £20m deficit and £40m deficit. This is partly due to the scale of volatility related to covid and also inflation. More work will however be done to refine assumptions with a greater degree of accuracy where possible especially with regards to CIP plans.

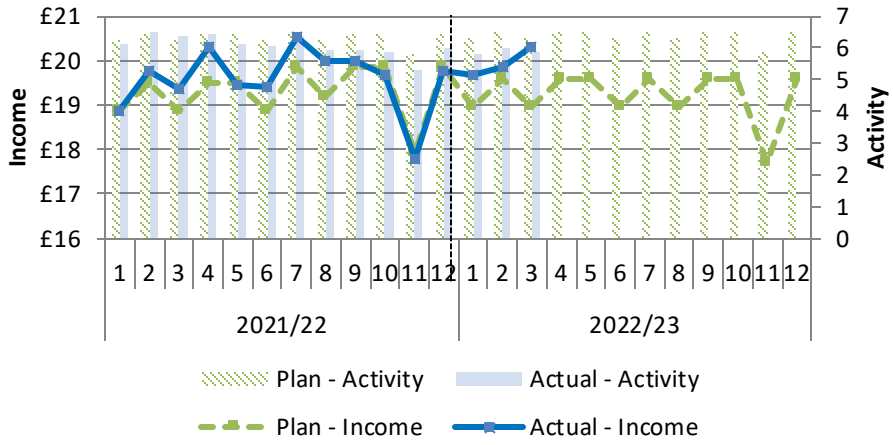
			Q1 Forecast Assessment *(estimates)*		
Risk Variable	**Scenario**	**Original Worst Case Assessment (£m)**	**Best Case (£m)**	**Intermediate Case (£m)**	**Worst Case (£m)**
Cost Improvement Plans not fully delivered	Non delivery of baseline CIP target and central schemes	(28.9)	(14.3)	(20.0)	(26.5)
Covid 19 remains at above 'background' levels dampening elective activity and slowing the release of covid related costs	Activity below plan triggering ERF clawback not offset by marginal cost reductions	(14.0)	(1.3)	(2.0)	(2.7)
Covid 19 remains at above 'background' levels generating higher than planned sickness/absence backfill costs	Staff sickness absence backfill costs beyond planned levels	(3.0)	(1.2)	(2.1)	(4.2)
Inflationary pressures impact the price of goods and services	Non pay inflation above funded levels	(11.3)	(1.0)	(1.5)	(2.0)
Stock outs cause price and/or supply chain risks to materialise	Price increases / lost acivity	n/a	(1.0)	(1.5)	(2.0)
Energy Cost prices continue to rise	Price increase beyond planned pressure	n/a	(1.2)	(1.4)	(1.6)
Block drugs and devices costs continue to overspend	Overspend on planned value	n/a	0.0	(0.5)	(1.0)
Total		**(57.2)**	**(20.0)**	**(29.0)**	**(40.0)**

Clinical Income

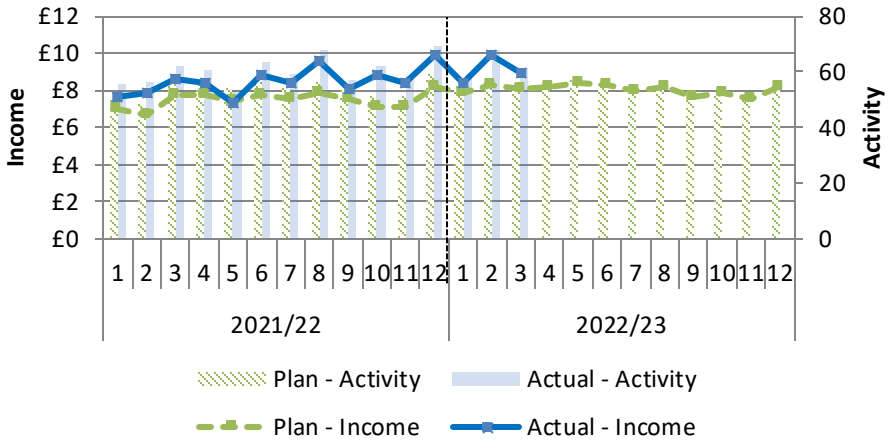
Elective spells



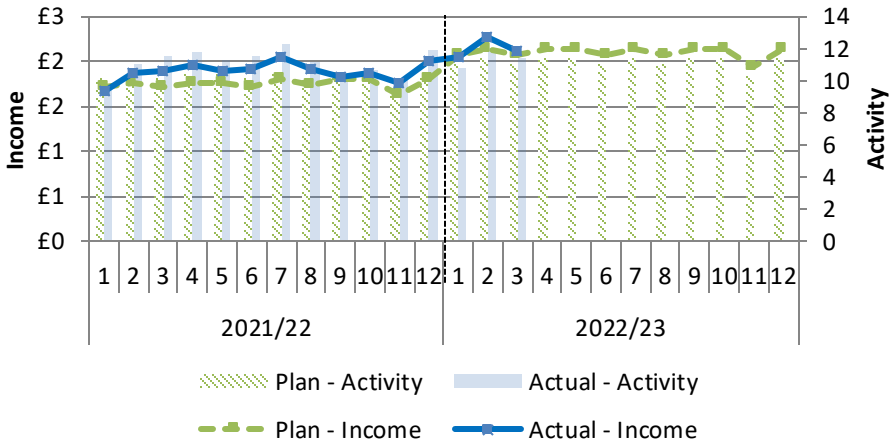
Non elective spells



Outpatients Total

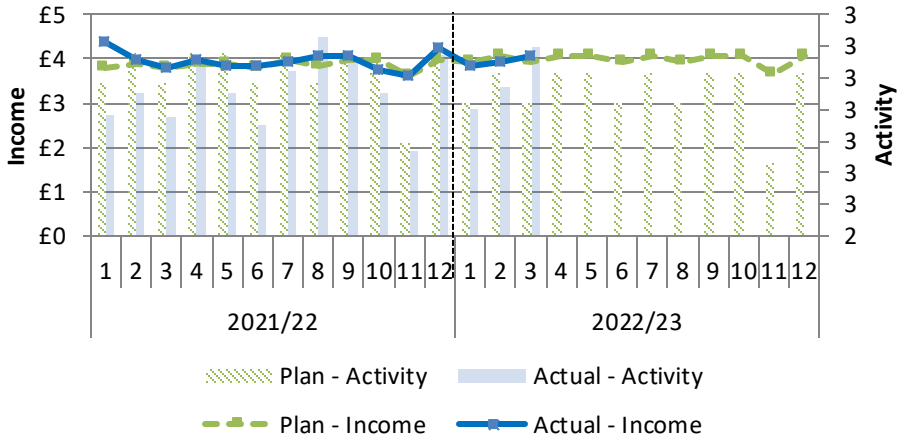


A&E - Emergency Medicine

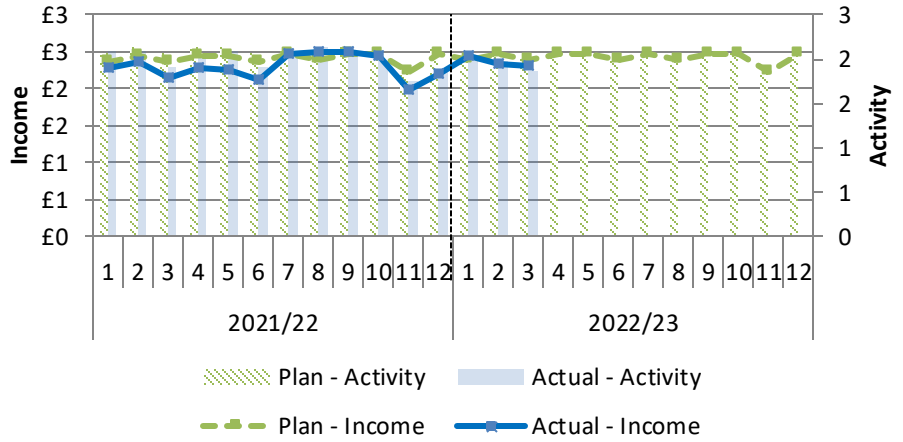


Clinical Income

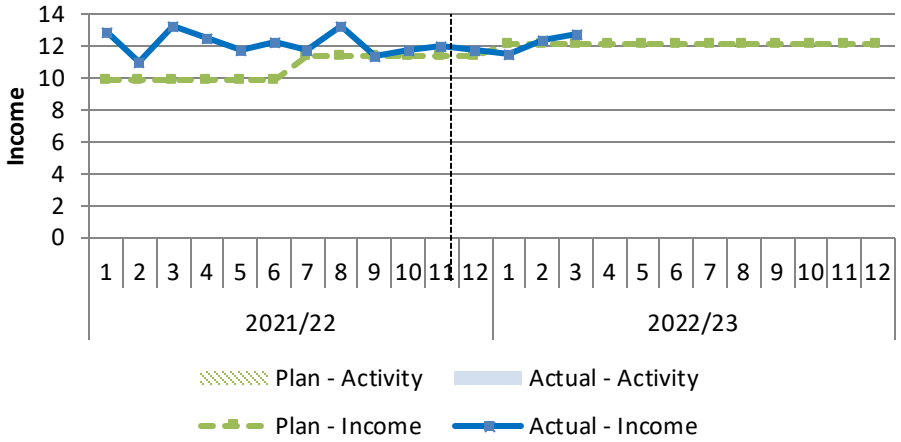
Adult critical care



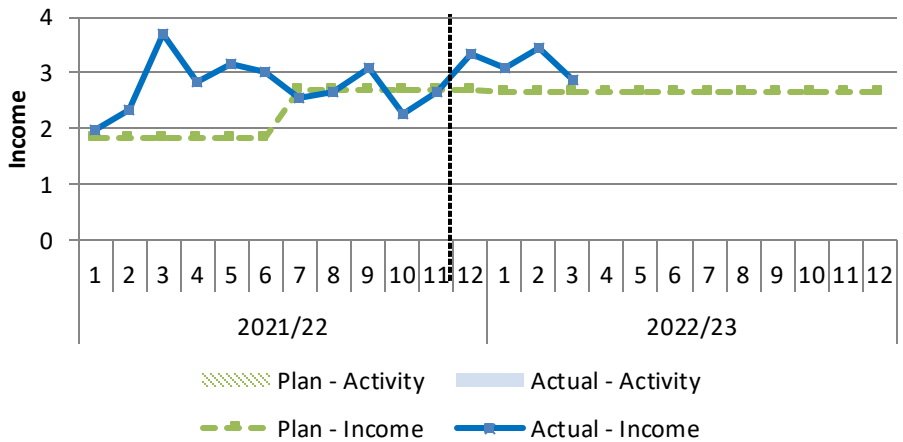
Neonatal & paediatric critical care



Tariff excluded drugs



Tariff excluded devices



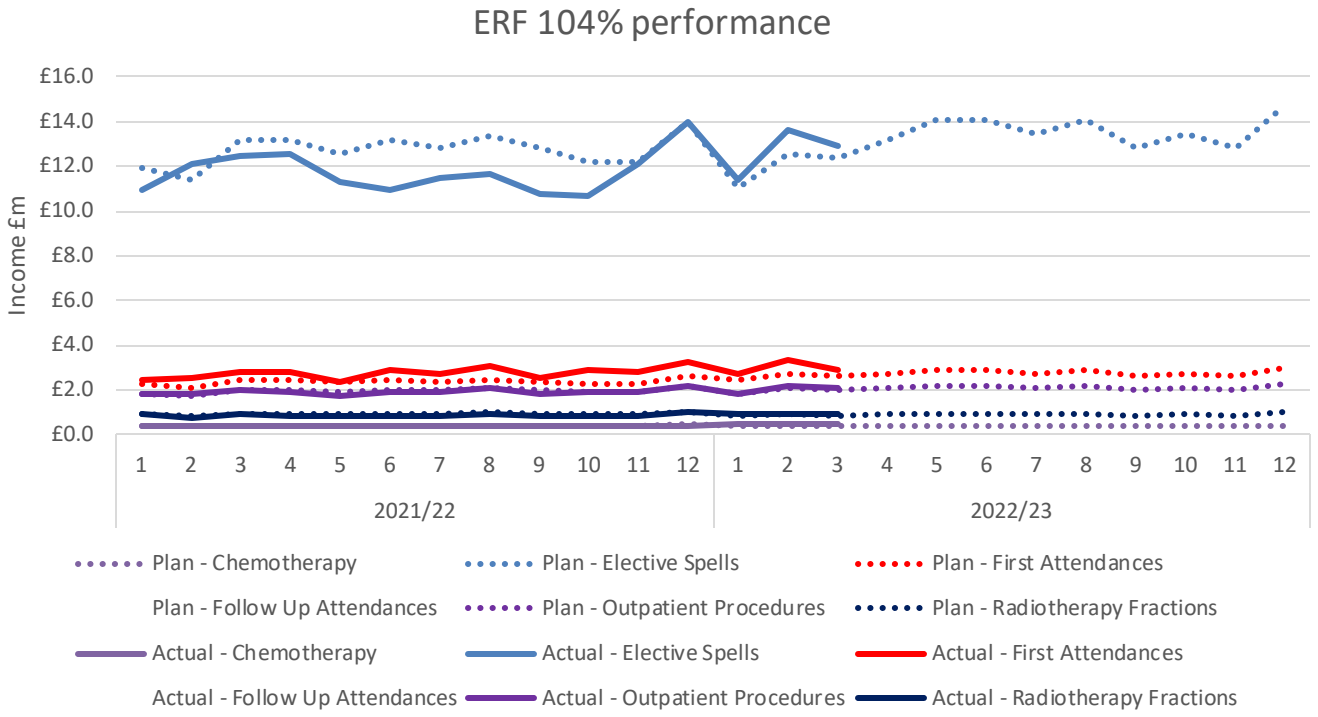
Elective Recovery Fund 22/23

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 plan to achieve 106% of 19/20 activity for elective inpatients, outpatient first attendances and outpatient procedures, above the 104% national target. This stretch was applied as part of the plan resubmission.

The table highlights overall performance against the 19/20 pre-Covid baseline, highlighting M3 performance of 109%.

An ERF payment of £3.7m has been provisionally included within Trust income, off-setting additional variable costs of delivery. However, there remains some uncertainty over the national calculation, with figures expected to be released three months in arrears.



Elective Recovery Framework Performance	M1	M2	M3
Elective performance	99%	107%	107%
Outpatient first and procedures performance	109%	120%	113%
Chemotherapy performance	146%	128%	131%
Radiotherapy performance	119%	111%	116%
Overall ERF performance	**103%**	**111%**	**109%**
Anticipated ERF payment (incl. A&G)	**£815**	**£1,693**	**£1,153**
Outpatient follow up performance	135%	140%	133%

Elective Recovery Fund 22/23

The table illustrates ERF achievement by care group and division for months 1-3.

104% is the nationally required target with 10 out of 15 care groups currently reporting achievement at this level or greater.

Of those specialties not achieving 100% Radiology, Emergency Medicine and Support Services are of a low volume.

Neurosciences is of particular concern and have theatres closures planned but work is being done to make sure activity can be reprovided in other locations.

The trust continues to prioritise on the basis of clinical risk.

Month 3 YTD ERF		Anticipated ERF Payment (incl A&G)	Ind Sector Reimbursement	Total	Recovery % excl IS	Recovery %
DIVISION A	CRITICAL CARE	£90,942	£0	**£90,942**	*196%*	*196%*
	OPHTHALMOLOGY	£521,914	£0	**£521,914**	*120%*	*120%*
	SURGERY	£31,167	£271,005	**£302,172**	*101%*	*104%*
DIVISION A Total		**£644,023**	**£271,005**	**£915,028**	*108%*	*110%*
DIVISION B	ACUTE MEDICINE	£9,679	£0	**£9,679**	*124%*	*124%*
	CANCER CARE	£225,281	£0	**£225,281**	*108%*	*108%*
	EMERGENCY MEDICINE	(£3,950)	£0	**(£3,950)**	*89%*	*89%*
	SPECIALIST MEDICINE	£279,229	£0	**£279,229**	*109%*	*109%*
DIVISION B Total		**£510,239**	**£0**	**£510,239**	*108%*	*108%*
DIVISION C	CHILD HEALTH	£192,897	£0	**£192,897**	*105%*	*105%*
	SUPPORT SERVICES	(£48,186)	£0	**(£48,186)**	*77%*	*77%*
	WOMEN'S HEALTH	£192,224	£36,103	**£228,327**	*110%*	*111%*
DIVISION C Total		**£336,935**	**£36,103**	**£373,038**	*106%*	*106%*
DIVISION D	CARDIOVASCULAR & THORACIC	£606,092	£751,238	**£1,357,330**	*108%*	*116%*
	NEUROSCIENCES	(£26,171)	£0	**(£26,171)**	*100%*	*100%*
	RADIOLOGY	(£12,066)	£0	**(£12,066)**	*98%*	*98%*
	SPINAL SURGERY	£10,628	£116,123	**£126,751**	*101%*	*108%*
	TRAUMA & ORTHOPAEDICS	(£453,968)	£621,291	**£167,322**	*85%*	*100%*
DIVISION D Total		**£124,514**	**£1,488,652**	**£1,613,166**	*101%*	*108%*
MISC	Advice & Guidance	£250,000	£0	**£250,000**		
Grand Total		**£1,865,712**	**£1,795,760**	**£3,661,472**	*105%*	*108%*

University Hospital Southampton NHS
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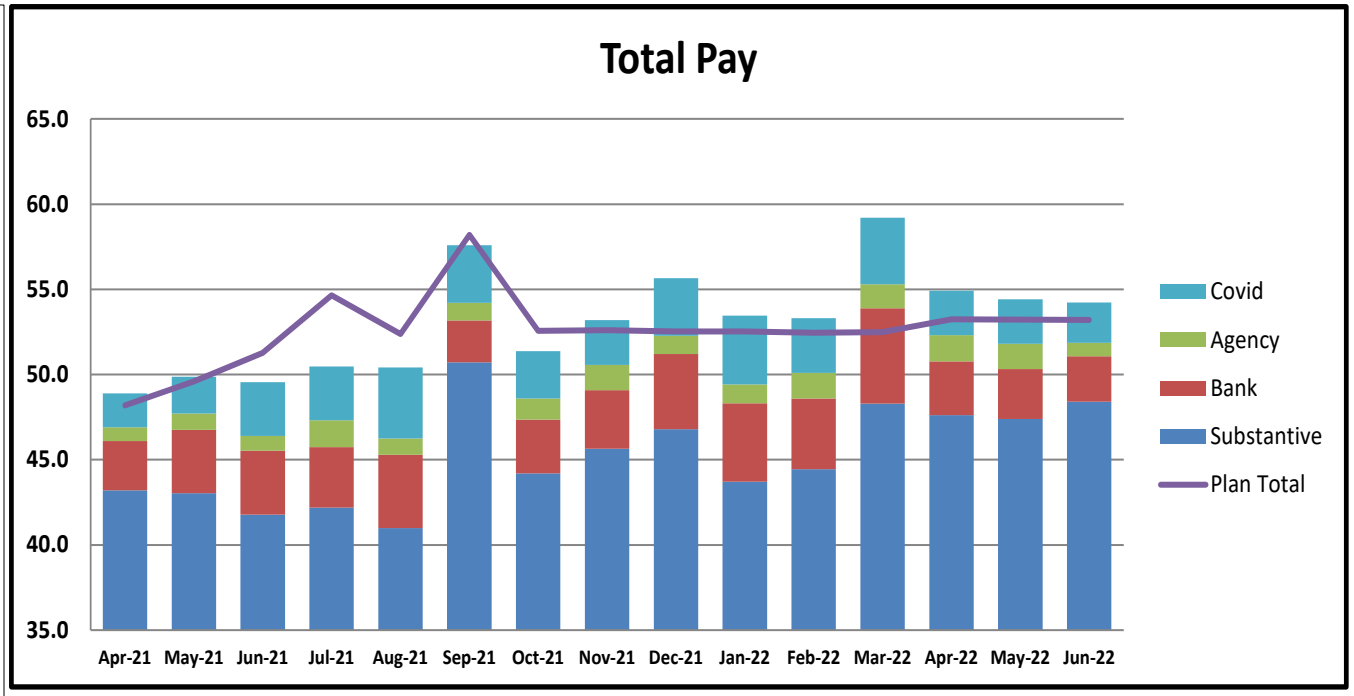
Substantive Pay Costs

Total pay expenditure in June was £54.2m, down slightly on May by £0.2m. The decrease relates to agency staff (£0.7m lower in June), bank staff (£0.2m lower in June) and Covid staffing (£0.2m lower in June) offset by an increase in substantive staff spend (£1m up in June). Covid staff costs are estimated at £2.4m of which £1m was bank staff and £1.4m related to substantive staff.

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.

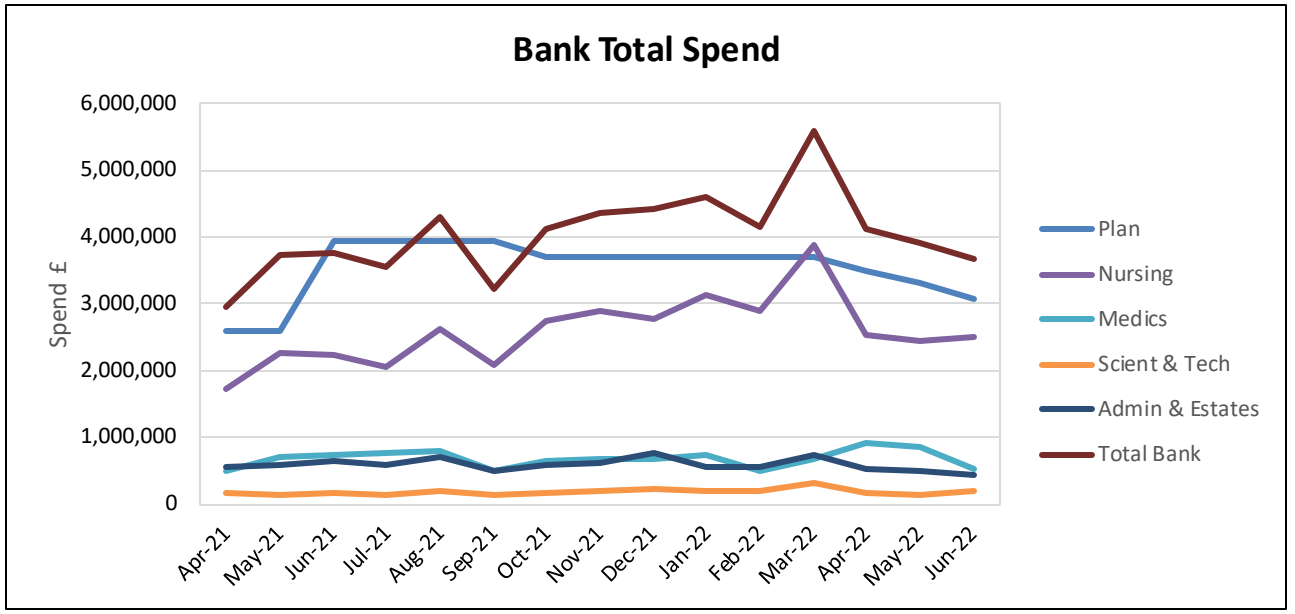


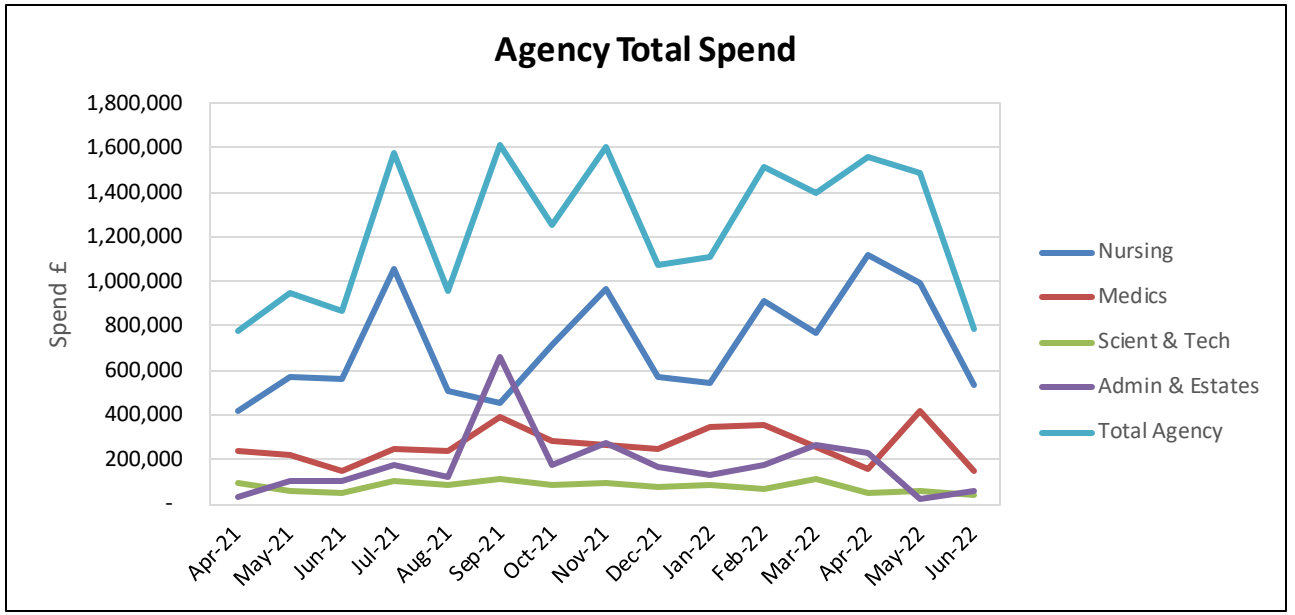
Temporary Staff Costs

Expenditure on bank staff has decreased month on month by £0.25m. All staff groups except medical had steady month on month spend. Bank Medical spend in June decreased by £0.3m.

Agency spend decreased significantly from May to June by £0.7m. The main decreases were in nursing (£0.45m) and medics (£0.26m). The majority of the nursing decrease was related to Bank 5 nurses and the majority of medic spend decrease was related to consultants. This may increase in July however as covid sickness absence was on an upward trend through later weeks of the month.

Although volatile month to month spend remains at c£1.4m per month and has done so since July 2021.





Covid Costs 22/23

The table illustrates Covid costs incurred YTD versus plan with a comparison against spend in 2021/22. The covid block funding was reduced from £40m in 2021/22 to £20m in 2022/23 with significant pressure to remove costs on the assumption a low covid environment was anticipated.

YTD costs are £7.7m which is £2.4m ahead of plan. This is due particularly to staff sickness absence and associated backfill costs being incurred which are £1.1m over plan. Critical Care and ED contribute a further £1.5m of costs in excess of plan.

All areas of spend are under review especially those associated with national guidance changes. Alternatively for some areas where an ongoing need has been identified discussions with commissioners have happened to explore recurrent funding sources. Critical care is the main example of this with NHSE supporting £1.5m in recurrent funding increase from 22/23. ED remains a particular concern as demand remains much higher than pre-Covid levels.

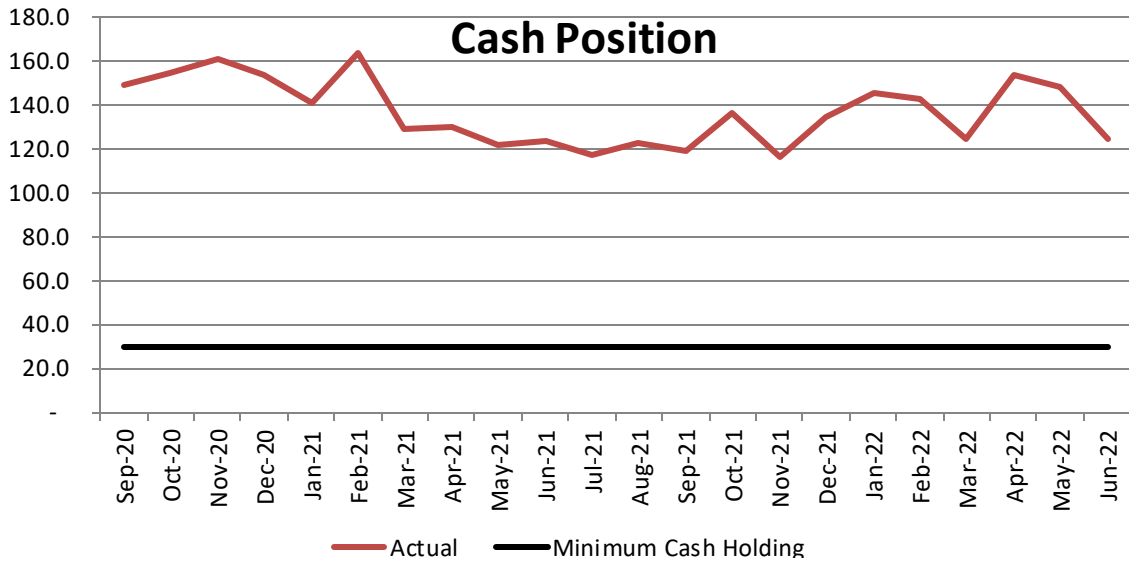
Description	2021/22 Expenditure (£'000)	2022/23 Annual Plan (£'000)	2022/23 YTD Plan (£'000)	2022/23 YTD Actual (£'000)	YTD Variance (£'000)
Covid Related Staff Sickness / Absence	12,164	9,123	2,281	3,364	(1,083)
Critical Care Additional Capacity	4,914	4,914	1,229	2,148	(920)
ED Additional Staff / Segregated Pathways	1,800	1,800	450	1,078	(628)
Car Parking Income - Patients / Visitors	1,776	1,320	330	200	130
Additional Cleaning / Decontamination	812	812	203	222	(19)
C5 uplift to L2 facility for 12 beds for Covid	228	480	120	140	(20)
Staff / High Risk Patient Covid Testing	1,320	500	125	210	(85)
PPE / Perso Hoods and Consumables	1,280	320	80	50	30
Staff Psychology Support	200	200	50	50	0
Car Parking Income - Staff	1,130	183	183	150	33
Clinical Engineering	100	138	35	0	35
Covid Medical Model (Div B)	133	115	29	29	0
PAH Theatres social distancing	108	108	27	0	27
Infection Control Team	107	107	27	27	0
Other (sub £100k plans)	607	613	153	42	111
Door Staffing	804	81	20	17	3
Unvaccinated staff not redeployed	1,020	0	0	0	0
Informatics One Off Costs	337	0	0	0	0
Healthcare at Home increased provision	296	0	0	0	0
Midwifes mat leave cover due to IPC guidance	250	0	0	0	0
Supplier protection for variable cost reductions	192	0	0	0	0
Occupational Health Staffing	176	0	0	0	0
Patient Transport	111	0	0	0	0
TOTAL	**29,865**	**20,813**	**5,341**	**7,726**	**(2,386)**

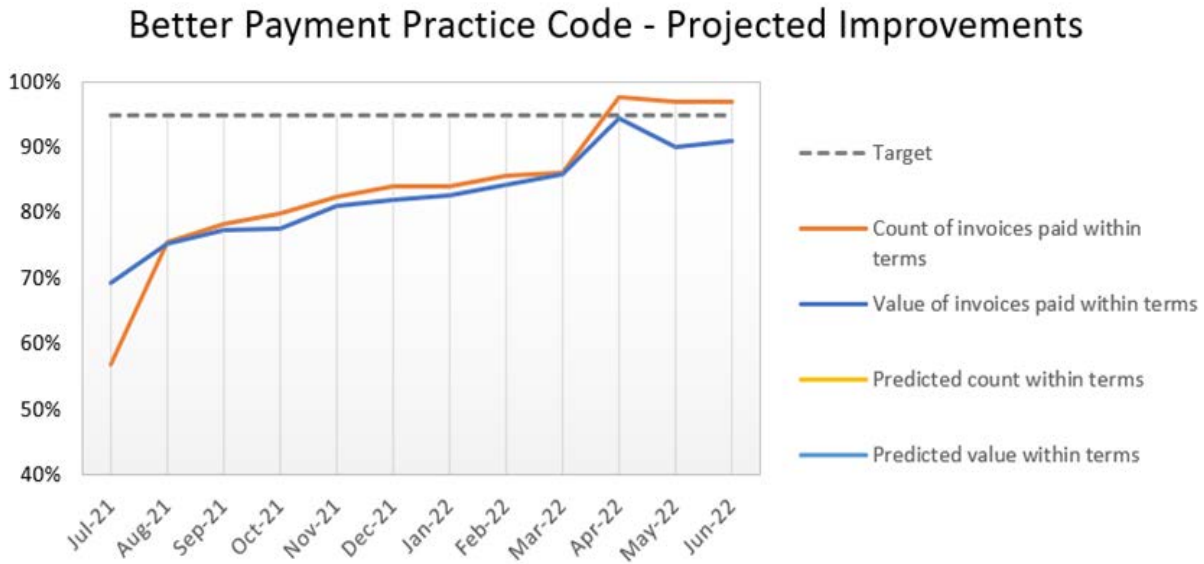
Cash

The cash balance decreased in June to £124m and is analysed in the movements on the Statement of Financial Position. Although reducing significantly this is within normal bounds of volatility when reviewed over the last 12 months.

A gradual reduction in cash is expected over the next two years as capital expenditure plans exceed depreciation. The deficit position will also reduce the cash balance over time unless resolved.

BPPC for June exceeded the target of 95% for number of invoices, and marginally below for value, with continual improvement as part of our recovery plan.





Capital Expenditure

(Fav Variance) / Adv Variance

Expenditure on capital schemes was £7.5m in the year to Month 3 compared to a budget of £4.5m. Total expenditure in June was £4.7m. £3.6m of this expenditure was for the lease of the Adanac Park Multistorey Car Park. Other than this the main areas of expenditure were design fees and initial costs on the wards and theatres schemes (£0.543m in month), IT (£0.223m) and strategic maintenance (£0.218m).

The level of monthly spend is expected to rise significantly from the current low levels as major schemes begin, so the Trust are forecasting to spend our full £49.0m capital allocation plus additional funding awards for wards and the expansion of neonates.

		Month			Year to Date			Full Year Forecast		
Scheme	Org	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 (excl. Neuro Ventilation)	UHS	186	218	(32)	970	1,015	(45)	7,185	6,931	254
Refurbish of neuro theatres 2 & 3 (incl. Ventilation)	UEL	0	4	(4)	0	4	(4)	1,800	2,054	(254)
General Refurbishment Fund	UHS	0	0	0	0	0	0	1,097	1,097	0
GICU Refurb / F level Fit Out / Theatres 10&11	UEL	0	153	(153)	218	371	(153)	5,000	5,000	0
Oncology Centre Ward Expansion Levels D&E	UEL	612	390	222	886	664	222	8,000	8,000	0
Fit out of C Level VE (MRI) Capacity	UEL	0	0	0	0	0	0	6,592	6,592	0
Donated Estates Schemes	UHS	8	23	(15)	142	156	(14)	5,362	5,362	0
Other Estates Schemes	UHS	5	27	(22)	25	38	(13)	2,681	2,705	(24)
Information Technology (incl Pathology Digitiation)	UHS	595	223	372	1,166	796	370	5,448	5,448	0
IMRI	UHS	0	11	(11)	104	115	(11)	1,300	1,300	0
Medical Equipment panel (MEP)	UHS	0	2	(2)	4	6	(2)	2,500	2,500	0
Other Equipment	UHS	1	0	1	227	169	58	1,550	1,550	0
Other	UHS	67	177	(110)	605	678	(73)	691	691	0
Slippage	UHS	0	0	0	0	0	0	(3,380)	(3,404)	24
Donated Income	UHS	(8)	(56)	48	(174)	(190)	16	(6,760)	(6,760)	0
Total Trust Funded Capital excl Finance Leases		**1,466**	**1,173**	**293**	**4,173**	**3,822**	**351**	**39,066**	**39,066**	**(0)**
Leases										
Medical Equipment Panel (MEP) - Leases	UHS	0	0	0	113	0	113	700	700	0
Equipment leases	UHS	0	0	0	0	170	(170)	500	500	0
IISS	UHS	0	0	0	0	0	0	3,115	3,115	0
Fit out of C Level VE (MRI) Capacity	UHS	0	0	0	0	0	0	5,619	5,619	0
Total Trust Funded Capital Expenditure		**1,466**	**1,173**	**293**	**4,286**	**3,993**	**293**	**49,000**	**49,000**	**(0)**
Disposals	UHS	0	0	0	0	0	0	0	0	0
Total Including Technical Adjustments		**1,466**	**1,173**	**293**	**4,286**	**3,993**	**293**	**49,000**	**49,000**	**(0)**
Externally Funded Schemes										
Maternity Care System (Wave 3 STP)	UHS	89	0	89	89	0	89	89	89	0
Digital Outpatients (Wave 3 STP)	UHS	110	18	92	147	54	93	592	592	0
Oncology Centre Ward Expansion Levels D&E	UEL	0	0	0	0	0	0	0	10,000	(10,000)
Neonatal Expansion	UHS	0	0	0	0	0	(0)	0	5,130	(5,130)
Outside CDEL Limit										
Adanac Park Car Park	UHS	0	3,459	(3,459)	0	3,459	(3,459)	0	3,459	(3,459)
Total CDEL Expenditure		**1,665**	**4,650**	**(2,985)**	**4,522**	**7,507**	**(2,985)**	**49,681**	**68,270**	**(18,589)**

Statement of Financial Position

There were a number of large offsetting movements within the Statement of Financial Position this month; the movement within fixed assets of £7.5m was largely offset by a movement within receivables due to a mapping correction capturing UHS Estates Ltd embedded leases, plus an offset with finance leases for the recognition of the lease for the new car park. The movements most affecting the cash position relate to working capital as follows:

- £5m ERF block paid on 1st July by commissioners.
- £2.2m of Cancer and CDC Funding overdue for payment
- Specialist commissioning accruals for variable drugs and devices (£1.8m) due for payment July;
- Guernsey invoices (£1.5m overdue) now confirmed as paid in July.
- Release of £4.3m of deferred income with cash received in advance.

Statement of Financial Position	2021/22 YE Actuals £m	2022/23 M2 Act £m	2022/23 M3 Act £m	2022/23 MoM Movement £m
Fixed Assets	471.9	464.6	471.9	7.2
Inventories	17.0	17.4	17.8	0.3
Receivables	53.1	48.9	59.4	10.5
Cash	148.1	140.9	124.0	(16.8)
Payables	(204.2)	(194.4)	(194.7)	(0.4)
Current Loan	(1.7)	(1.7)	(1.7)	0.0
Current PFI and Leases	(9.1)	(8.5)	(8.5)	0.0
Net Assets	**475.0**	**467.2**	**468.1**	**0.9**
Non Current Liabilities	(23.0)	(21.2)	(21.2)	0.0
Non Current Loan	(6.8)	(6.8)	(6.3)	0.5
Non Current PFI and Leases	(33.6)	(32.8)	(35.5)	(2.8)
Total Assets Employed	**411.6**	**406.4**	**405.0**	**(1.3)**
Public Dividend Capital	261.9	261.9	261.9	0.0
Retained Earnings	115.6	110.4	109.0	(1.3)
Revaluation Reserve	34.1	34.1	34.1	0.0
Other Reserves				
Total Taxpayers' Equity	**411.6**	**406.4**	**405.0**	**(1.3)**

University Hospital Southampton NHS
NHS Foundation Trust

Efficiency and Cost Improvement Programme 22/23 – M3

UHS Total
£30.3m identified, 67% of the total 22/23 requirement which is £45.4m

Divisions and Directorates
£11.0m of CIP schemes identified, an increase from £9.5m at M2. This represents 55% of it's 22/23 target which = £20m

Central Schemes
£19.3m of CIP schemes now identified. This represents 76% of the 22/23 target which = £25.4m

Of the identified UHS total, £4.9m is Pay, £20.2m is Non-Pay, and £5.3m is Income.

Month 3 CIP Identification	Non Recurrent ('000s)	Recurrent ('000s)	Total ('000s)	Target ('000s)	% Identified
Division A	£2,078	£1,827	£3,905	£4,260	92%
Division B	£601	£1,634	£2,235	£5,535	40%
Division C	£1,076	£511	£1,587	£3,938	40%
Division D	£551	£1,381	£1,932	£3,572	54%
THQ	£304	£742	£1,046	£2,695	39%
Other*	£0	£330	£330		
Central Schemes	£7,272	£12,042	£19,314	£25,400	76%
Grand Total	**£11,882**	**£18,467**	**£30,349**	**£45,400**	**67%**

Month 3 CIP Identification	Pay ('000s)	Non Pay ('000s)	Income ('000s)	Total
Division A	£2,197	£1,504	£204	£3,905
Division B	£529	£1,045	£661	£2,235
Division C	£1,361	£226	£0	£1,587
Division D	£234	£1,097	£601	£1,932
THQ	£530	£446	£70	£1,046
Other*	£0	£330	£0	£330
Central Schemes	£0	£15,542	£3,772	£19,314
Grand Total	**£4,851**	**£20,190**	**£5,308**	**£30,349**

**Procurement schemes not yet allocated to care group schedules*

University Hospital Southampton NHS
NHS Foundation Trust

Efficiency and Cost Improvement Programme 22/23 – M3

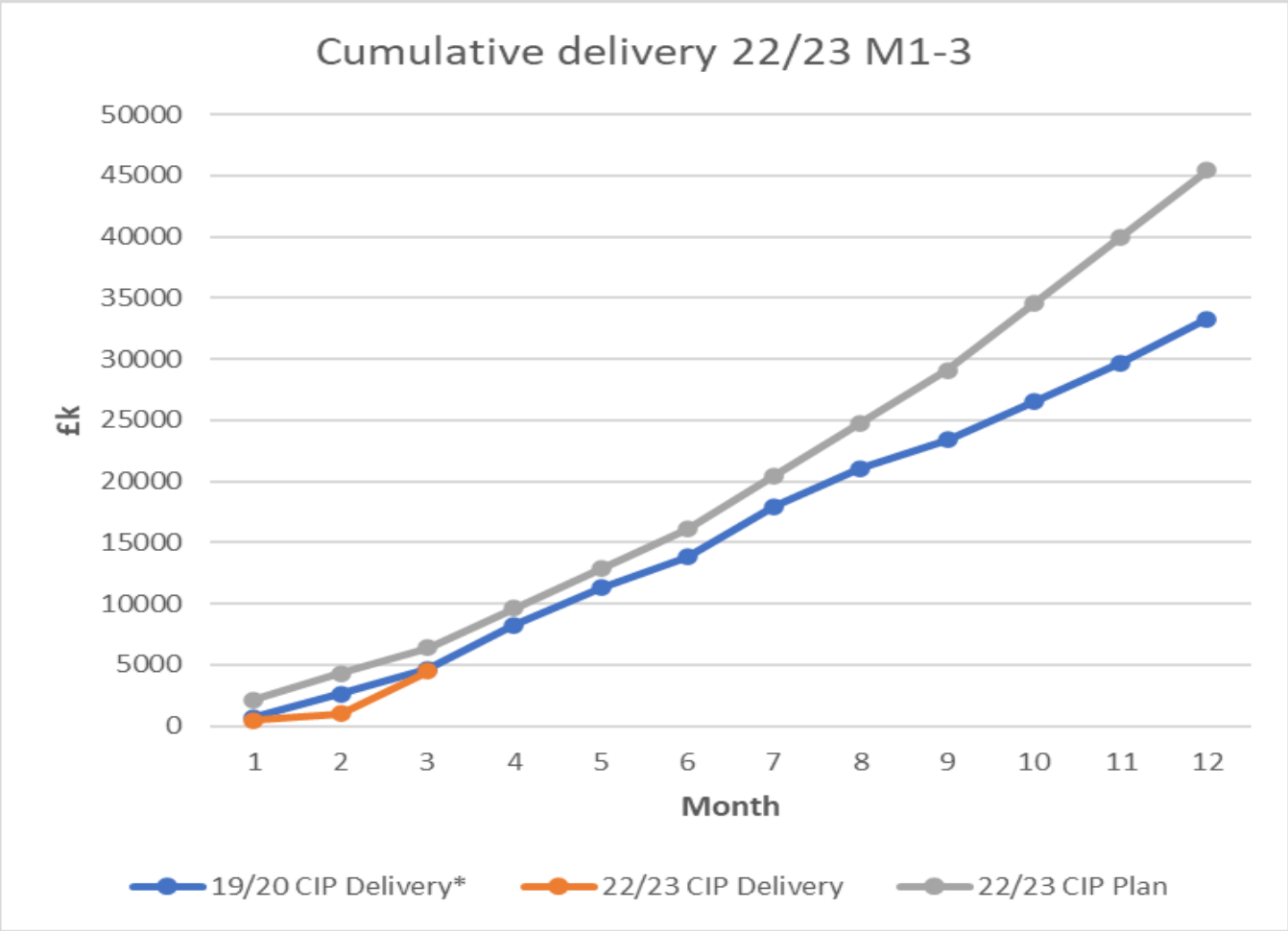
M3 YTD achievement is £4.5m, an increase from the £1.2m achieved at M2.

£0.8m of new divisional and directorate schemes commenced in M3, in addition to those already delivering at M2.

£2.3m of CIP through central schemes was recognised in M3, relating to Q1 delivery.

Of the £4.5m YTD, £3.4m is non-recurrent, £1.2m of which was workforce slippage and vacancies.

Our £4.5m cumulative delivery is against a planned £6.4m delivery at this point (the plan was phased with a reduced delivery target in earlier months). This was the first month THQ CIP schemes began transaction.



**19/20 CIP Delivery included profit generated on NHS commissioner income, and LOS scheme 'buy-out'*

Efficiency and Cost Improvement Programme 22/23 – M3

University Hospital Southampton NHS
NHS Foundation Trust

Risk Assessment

£15m of the 22/23 target value remains unidentified after month three, and identification and delivery of this value should be considered a medium to high risk of non-delivery

The larger identified schemes, which represent £22m / 72% of the total financial value that has been identified, have been risk assessed as follows:

Risk Assessment	Number of schemes >£200k	Value (£k)	Percentage of value	Percentage of schemes
Green	12	11,771	54%	63%
Amber	5	7,858	36%	26%
Red	2	2,232	10%	11%
Total	19	21,861	100%	100%

This assessment suggests that 72% of the currently identified value is likely to be delivered within the financial year

Risk assessment of the smaller identified schemes will be undertaken over the next month, and a risk assessed forecast then reported monthly

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Complaints Annual Report 2021-22**			
Agenda item:	**5.7**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Ellis Banfield, Associate Director of Patient Experience**			
Date:	**28 July 2022**			
Purpose	**Assurance or reassurance X**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	All NHS providers are required to produce an annual complaints report. This duty is set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.			
Response to the issue:	The annual complaints report highlights: • Complaints are returning to pre-pandemic levels both at the Trust and nationally • Concerns raised via PALS have increased over the pandemic • The % of complaints upheld or partially upheld has dropped compared to previous years, and is lower than the national average • PHSO activity was impacted by the pandemic. The completed action plan for 2021/22 is included at the end of the paper • UHS aligns with the national picture around complaint themes, with clinical treatment, communications, patient care, and staff behaviour remaining the top themes locally and nationally.			
Implications: (Clinical, Organisational, Governance, Legal?)	This report is a statutory requirement.			
Risks: (Top 3) of carrying out the change / or not:	Major risk identified in this report is the increasing activity through the PALS service, although note that the scope of PALS sits outside the purpose of this report.			
Summary: Conclusion and/or recommendation	The Board is asked to receive this report as fulfilling the requirements set out within the NHS complaints regulations.			

Annual complaints report 2021/22

Purpose of report

This report provides information about the complaints received to University Hospital Southampton NHS Foundation Trust in the period of April 2021 to March 2022. The report fulfils the requirement of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

Definition of terms

Complaint

A formal complaint made in writing to UHS trust about the care and services provided. These are managed by the complaints team.

Concern

An informal complaint managed outside of the formal process with the aim of a quick resolution. These are managed by the PALS team.

Parliamentary and Health Service Ombudsman

The PHSO will investigate complaints that the complainant feels have not been resolved by the Trust.

Complaints activity

Received:

	19/20	20/21	21/22
Complaints	**448**	**344**	**388**
Concerns	**1016**	**1605**	**2434**
Total	**1464**	**1949**	**2822**

Complaints received were lower during 2020-21 mainly due to there being fewer patients being admitted for elective surgery. In 21/22, complaint numbers have increased although not yet back to pre-Covid levels but there has been an increase in concerns going via the PALS service and being resolved informally. Note that PALS activity overall has been increasing over the pandemic period.

Upheld:

	19/20	20/21	21/22
Complaints received	**448**	**344**	**388**
Complaints upheld	**79**	**41**	**41**
Complaints partially upheld	**158**	**164**	**125**
% of complaints upheld	**53%**	**60%**	**43%**
National comparison	**-**	**-**	**66%**

The % of complaints upheld or partially upheld has dropped to 43% in 21/22. There is no clear reason for this decline but note the volume of resolvable concerns going through the PALS service rather than being made formally as a complaint. Of complaints being upheld, communication was a predominant factor in many of these: even if the core cause of the complaint was not upheld, there were often identified or contributory issues around communication. Nationally at the end of March 22, 65% of complaints were upheld or partially upheld.

Parliamentary and Health Service Ombudsman (PHSO):

	19/20	20/21	21/22
Complaints closed	**13**	**1**	**2**
Complaints upheld	**0**	**0**	**0**
Complaints partially upheld	**5**	**1**	**1**

The PHSO paused its investigations during 20/21 due to Covid, explaining the drop off in numbers. The Trust does not know which complaints have been referred to the ombudsman unless the PHSO decides to investigate. The UHS complaints process is robust, evidenced by no complaints being fully upheld following the PHSO investigation. Where complaints have been partially upheld, the PHSO will issue the Trust with an action plan or remedial action. Action plans for the period are provided at the end of this report.

Complaint themes

Complaints often contain many themes and aspects. The Trust records themes according to the categories required for the K041a data submission to NHSE. These categories are broad but give some idea as to predominant concerns our patients and families raise. The three main themes in complaints received were:

UHS	NHS nationally
Clinical Treatment	Clinical Treatment
Communication	Communication
Values and behaviours	Patient Care

These have been the Trust's top three themes for most of the past 5 years. Data published by NHS Digital places UHS very much within the overall picture of NHS complaints. Patient care, nationally the third main theme, was the fourth main theme for UHS, while values and behaviours was the 4th national theme.

Note on the national picture

National published data for the end of 21/22 highlights formal complaints across the NHS are beginning to approach pre-pandemic levels, something observed at UHS.

PHSO complaint action plans

In 2021/22 2 complaints were partially upheld and the following actions taken:

	Recommendations	Action required	Impact of action	Designated Lead	Date in place
1	The MOP consultant did not prescribe Mr O with the correct dosage of amantadine & The MOP consultant did not fully consider if amantadine was safe to prescribe to Mr O	• Review prioritisation process in pharmacy to ensure amantadine and similar medicines are included so as to inform the ward pharmacist and ensure early review. • Continue to develop prioritisation tool based on learning from incidents a both locally and nationally, and include wider digital information as and when it is possible to improve the prioritisation process and reduce the risk of medication errors • Share case in pharmacy M&M • Lead clinician for Southern PD forum to bring up as a learning point that amantadine should be avoided if eGFR less than 15 (this is the group where neurologists and Geriatricians meet to discuss Parkinson's related problems).	• Identification of patients newly prescribed amantadine prior to provision of stock. • Early pharmacist review of prescriptions for amantadine and alternative Parkinson's medicines to ensure factors highlighted in this case are considered and the correct dose for patients is selected. • To ensure learning from the case and actions above are embedded into ongoing practice.	Consultant Pharmacist medication safety	Completed with review on 21-4-22 Ongoing with quarterly review at medication safety group. Scheduled for next pharmacy M&M

2	Clinical staff did not review Mr O's clinical condition before transferring him to QA for dialysis and a blood transfusion in the morning of 19 September Improve pre-transfer reviews to the dialysis unit in Portsmouth.	• For transfers out of routine hours, the on-site junior doctor covering the ward will assess the patient and complete the safe to transfer form. • Ideally, this should be completed within 2 hours of transfer or as near as possible with the expectation that if the clinical condition changes the nurses flag concerns before the patient leaves the ward. • Completion of transfer form to accompany patient. • Update the transfer form to include time of review • We will support the ongoing development of our own dialysis service to minimise the requirement to transfer patients. This will include inpatient dialysis beds at UHS	All patient's requiring transfer to dialysis unit will be reviewed by a medical practitioner a minimum of 2 hours prior to transfer Improved communication between the teams involved and direct communication with family, outlining issues and giving full explanation of events	Clinical lead for renal services	May 2022 ongoing completed 14/5/22 CL discussion with Medical Director re the renal Service. Dialysis service at UHS insufficient to meet the needs of the local population – expansion plans

Report to the Trust Board of Directors				
Title:	**Learning from Deaths 2022-23 Quarter 1 Report**			
Agenda item:	**5.8**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Authors:	**Ellis Banfield, Associate Director of Patient Experience; Debbie Watson, Head of Patient & Family Relations**			
Date:	**28 July 2022**			
Purpose:	**Assurance or reassurance x**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	This report ensures that mortality reporting in relation to deaths, reviews, investigations, and learning is regularly provided to the board. The report also provides an update on the development and effectiveness of the medical examiner service.			
Response to the issue:	**Summary** • Q1 deaths have increased from previous year's Q1 but sit broadly aligned with previous years • 99% of deaths reviewed by medical examiners were found to be not avoidable • 2 deaths were reviewed and found to be possibly avoidable. These are detailed below • No cases were deemed poor care by the medical examiner review • HMSR still sits within the low range, but there has been an upwards trend in the reporting period. • Medical examiners service has begun to pilot community reviews with Solent ahead of the required expansion by end of March 2023			
Implications:	The National Guidance on Learning from Deaths sets out expectations that: *Boards must ensure robust systems are in place for recognising, reporting, reviewing, or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care. Providers should ensure such activities are adequately resourced.* This paper sets out a plan to meet these requirements more fully.			
Risks:	1. The Trust does not reduce avoidable deaths in our hospitals. 2. The Trust does not promote learning from deaths, including relating to avoidable deaths and good and poor quality of care. 3. The Trust does not promote an open and honest culture and support for the duty of candour.			
Summary:	This paper is provided for assurance and approval.			

1. Introduction

In 2016 the CQC found that Trusts in England were unable to demonstrate best practice across all aspects of identifying, reviewing, and investigating deaths and capturing and actioning learning identified from these reviews. The CQC's report and recommendations was that mortality governance should be a key priority for Trust boards.

At UHS, IMEG was started in the Trust in September 2014 and has scrutinised all inpatient deaths since. Following national developments, the service has transitioned into the Medical Examiner Service, working to national guidelines, requirements, and expectations. Scrutiny starts with the electronic patient record's being reviewed by a Medical Examiners Officer (MEO) who looks at the pre-hospital care, presentation, and case history to be able to flag any potential issues to the Medical Examiner and identify cases for coronial referral. A doctor (of any grade) from a clinical team will come down and discuss the case with a trained Medical Examiner (ME) and offer a cause of death. This is either agreed upon or discussed further. If any further questions arise from the scrutiny or a potential issue is picked up the case will then be sent for an in-depth mortality review. These reviews can come in the form of questions directed to the speciality Morbidity and Mortality meeting, or presentation at Trust Mortality Review Group (TMRG) which is a multi-disciplinary and multi-professional group who follow the Structured Judgement Review (SJR) template, or an Urgent Case Review with the Patient Safety Team.

2. Analysis and Discussion

2.1 Total Deaths

Having seen a lower number of Q1 deaths compared to the previous two years, Q2 deaths have increased year-on-year as the table below illustrates:

Quarter	2022-23	2021-2022	2020-2021	2019-2020
Q1	578	504	564	606
Q2		429*	511	541
Q3		639*	529	589
Q4		531*	634	620
Total		2103	2,234	2,356

*Across Q2-Q4 the medical examiner service reviewed an additional 323 deaths from CMH & Oakhaven hospices

2.2 Mortality Reviews

In addition to medical examiner scrutiny other additional or more detailed levels of scrutiny may be applied. Some review processes are subject to national guidelines and directives such as the reviews for learning disability, paediatric and neonatal deaths. Others such as Morbidity & Mortality (M&M), Trust Mortality Review Group (TMRG) and serious adverse event case review are locally managed governance processes, although they may feed into other national reporting processes.

The table below lists the total number of case referrals from the medical examiner service into the additional and more detailed scrutiny groups:

Quarter	M&M	TMRG	Scoping	Paediatric	Neonates	LeDeR
Q1	15	n/a	2	17	3	1
Q2						
Q3						
Q4						
Total	96	41	23	18	11	14

As the table makes clear, in addition to Medical Examiner scrutiny, Q1 saw:

- 15 deaths sent to sub-speciality Morbidity and Mortality groups (M&M) for further clarification / questions
- 2 cases were sent for a urgent serious adverse event Case review (commonly known as a scoping meeting within the Trust) with the Patient Safety Team because the reviewing medical examiner felt that death probably avoidable with different or better care
- 20 paediatric and neonatal deaths and 1 LeDer referrals were also made

The number of referrals made by the medical examiners service has declined year on year since 2020, possibly due to the influx of new medical examiners.

Most cases get assigned an initial avoidability and quality rating which then gets adjusted accordingly if they are sent for further review:

The table below outlines outcomes from Medical Examiner Service:

Avoidability	Q2	Q3	Q4	Q1
1. Definitely Avoidable			1	
2. Strong Evidence of Avoidability				
3. Probably Avoidable (>50:50)		1	1	
4. Possible Avoidable (<50:50)		4		2
5. Slight Evidence of Avoidability	2	8	2	3
6. Definitely not avoidable	490	743	611	573
Quality of care				
1. Very Poor				
2. Poor care		1	2	
3. Adequate Care	2	4	3	1
4. Good Care	491	743	611	575
5. Excellent Care	2		2	2
Not yet reviewed yet				

Deaths are also reviewed through 53 different subspecialty Morbidity and Mortality (M&M) meetings currently known of at the Trust. An appointment has been made for a new mortality coordinator post who will pull together identified learning from these M&M meetings into a central bulletin.

Avoidable deaths

Above, 2 deaths were reviewed and categorised as 'possibly' avoidable.

Of these, one patient was a known falls risk and had 3 inpatient falls which resulted injury and the patient deteriorated rapidly. This was referred to patient safety team for falls investigation.

The other case involved a patient with mild learning disability, and had DNA'd an earlier endoscopy where the condition could have been detected earlier and may have been treatable.

2.3 Learning disability deaths

Challenges in reviewing LeDeR cases have remained, despite the best efforts of the Head of Patient Safety. Unavoidable delays due to illness of key staff have meant that there remain 6 historic cases outstanding and 4 current cases from Q1. These will be reviewed in due course.

2.4 Paediatric and neonatal mortality review

Paediatric and Neonatal deaths receive established rigorous scrutiny through other nationally mandated mortality review processes.

13 deaths were discussed at CDAD, with 6 child and 7 neonatal. In total there were 15 neonatal deaths, and 1 has gone forward as a SIRI and 1 was reported to HSIB (since rejected due to a congenital cardiac cause). A further 1 death had a decision for planned palliative care from birth.

Of the 6 deaths reviewed at CDAD, all were graded 5 on the six-point Hogan scale:

Neonatal deaths

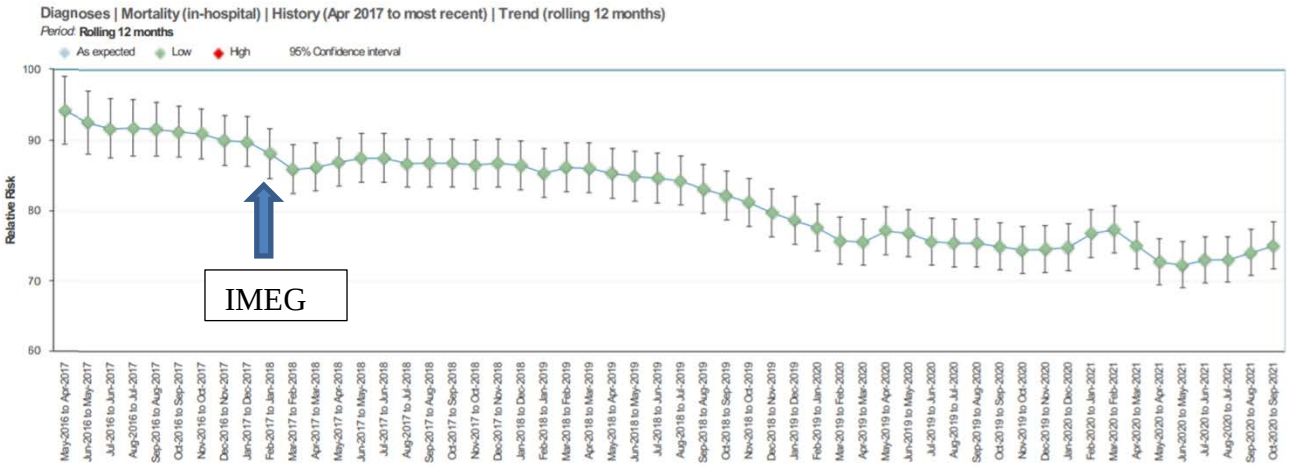
Neonatal deaths are reviewed through the Neonatal Child Death review meeting (CDRM). They are also reported to MBRRACE-UK and reviewed using the standardised perinatal mortality review tool (PMRT), therefore the grading is different to the grading for paediatric and adult deaths. The grading of each case will look at the care of the mother and baby prior to the birth, the care of the baby from birth up to the death of the baby and the care of the mother following the death of her baby. All neonatal deaths which occur at UHS are reviewed using this process. If the mother and/or baby received care at another Trust prior to their death, that Trust will also be involved in the review process and invited to attend our Neonatal CDRM.

The table below shows the gradings for each case in Q1 (15 cases). Note that each case gets three separate gradings and some cases have yet to be graded:

		Q1														
Cases per quarter		C1	C2	C3	C4	C5	C6	C7	C8	C9	C10	C11	C12	C13	C14	C15
Grading of care of the mother and baby up to the point of birth of baby																
A	The review group concluded that there were no issues with care identified up the point that the baby was born		X							x						
B	The review group identified care issues which they considered would have made no difference to the outcome for the baby	X			X	X			x					x		x
C	The review group identified care issues which they considered may have made a difference to the outcome for the baby			X												
D	The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby															
	Not yet graded						x	x			x	x	x		x	
Grading of care of the baby from birth up to the death of the baby																
A	The review group concluded that there were no issues with care identified from birth up the point that the baby died			X		x			x	x	X					X
B	The review group identified care issues which they considered would have made no difference to the outcome for the baby	x	x		x									x	x	
C	The review group identified care issues which they considered may have made a difference to the outcome for the baby															
D	The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby															
	Not yet graded						x	x				x	x			
Grading of care of the mother following the death of her baby																
A	The review group concluded that there were no issues with care identified for the mother following the death of her baby	x	x	x	x	x			x	x	x			x	x	
B	The review group identified care issues which they considered would have made no difference to the outcome for the mother															x
C	The review group identified care issues which they considered may have made a difference to the outcome for the mother															
D	The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother															
							x	x				x	x			

HSMR

UHS previously demonstrated a progressive fall in hospital standardised mortality ratio over the last seven years since our increased scrutiny of death was instituted. The Trust continues to run with a low hospital standardised mortality ratio, suggesting a low level of avoidable deaths but note the slight upwards trend in the current reporting period.



3. Medical Examiner Service Update

3.1 The Medical Examiner Service includes 12 consultant-level medical examiners, covering a 1.9wte time allocation, 5 medical examiner officers, and one administrator. The service is required to prepare for scrutinising all non-coronial deaths in Southampton and the surrounding region. Substantive recruitment for remaining available PA sessions and the lead medical examiner role will happen in August and will reinforce the team's capacity to take on this increased workload.

3.2 Conversations have begun with CCG and primary care colleagues about developing the required processes for service expansion to GPs. We are now live with a service to Solent NHS FT and their GP practices, with PCN north commencing in Sept 2022.

4. Learning from specialties' M&M meetings

4.1 As identified in the previous learning from deaths report, the coordination and integration of the different local mortality review processes within the Trust is challenging and opportunities for wider learning and dissemination have not always been taken.

4.2 A key component of the learning from deaths workstream is to ensure that where appropriate learning is shared, and that the Trust is assured that actions are being identified during mortality reviews. The table below captures some of the actions identified and taken locally across Q1 2022/23

Actions / learning / good practice	**Specialty**
Discussion of unexpected death of an elderly man in ED, with anaemia, frailty, and other background factors. Identified several learning points.	ED
Another elderly patient had abnormal obs not escalated, and learning required around why these were not recognised and lack of communication between clinicians. Currently under patient safety review	ED
Improvement required regarding communication with GP regarding aspirin prescriptions	Neonates
Improve documentation to reflect conversations taking place in the bereavement period (including the use of cold cot, discussions re. taking baby home, and use of cubicles on PICU for end of life care)	Neonates
Community matron to address CO monitoring was not undertaken and ensure that all staff have access to appropriate equipment	Neonates
Importance of asking domestic violence questions and how to manage this if the partner is present	Neonates
Integrate drug interaction training within SACT training programme for SpRs	Haematology
Request to medication safety group that pharmacist use CHIE to help with drug screening to provide a further 'safety net' in the event of prescribing error	Haematology
Importance of palliative care input running alongside CAR-T pathway	Haematology
Importance of assessing for CNS involvement at diagnosis in high-risk lymphoma	Haematology

5. Conclusion

5.1 UHS continues to demonstrate low levels of avoidable mortality and overall good quality of care for most patients who die during their admission. HMSR has increased but is within ‘low’ range.

5.2 Medical examiner service expansion continues to make progress with more medical examiners and medical examiner officers recruited.

5.3 Recruitment of the Trust’s mortality coordinator has been completed and will further progress the Trust’s mortality governance programme.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Maternity Safety 2022-23 Quarter 1 Report**			
Agenda item:	**5.9**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Emma Northover, Director of Midwifery** **Marie Cann, Interim Senior Midwifery Manager** **Hannah Mallon, Divisional Governance Manger**			
Date:	**28 July 2022**			
Purpose	**Assurance or reassurance** ✓	**Approval**	**Ratification**	**Information**
Issue to be addressed:	The purpose of this report is to provide assurance to members of the Trust Board and to ensure appropriate and continued oversight of those important safety indicators related to maternity care provision. The paper constitutes safety information from Quarter 1 and provides updates in relation to the following topics: **1.** Ockenden initial and final report **2.** Perinatal Surveillance Provider Board Measures (Appendix 1) **3.** NHS Resolution Maternity Incentive Scheme (MIS) Year 4 **4.** Maternity Serious Incident (SI) reporting, including HSIB cases (Appendix 2, 3 & 4 and Supporting Encs A-F available in iBabs Documents) **5.** Perinatal Mortality Review Tool (PMRT) (Appendix 5) **6.** Avoiding Term Admissions into Neonatal (ATAIN) **7.** Maternity and Neonatal NHSR Claims Scorecard (Appendix 6) **8.** Medical workforce **9.** CQC provider engagement visit to Maternity **10.** Freedom to Speak Up Champions			
Response to the issue:	**1. Ockenden Initial and Final Report** In response to the initial Ockenden report, UHS Maternity Service provided a significant amount of externally scrutinised evidence to support compliance for the 7 Immediate and Essential Actions (IEA). In December 2021 the service received positive feedback from the Ockenden review team for the evidence collated for all but 2 of the 59 actions, IEAs. These 2 identified actions included: • IEA5 (Q30) – (Amber rated). 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. • IEA5 (Q33) – (Amber rated). 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).			

Following feedback, we acknowledged that whilst there are processes in place to undertake these risk assessments, further improvements could be made through digital reporting using mandatory fields for midwives. Having now made some necessary adaptions to the digital information system (Badgernet), we can confirm an increased level of compliance against the completion of these risk assessments in pregnancy. Planned audits will continue until full compliance is achieved and formally reported to this Board in the next Maternity Safety report.

The final Ockenden report has specified a further 15 Immediate and Essential Actions (IEAs). In terms of preparedness, we have been proactive in the forming of an Ockenden working party. Alongside this, we are completing a gap analysis to ensure appropriate evidence is available to highlight both areas of strong practice and identify any areas for further improvement. We are confident that there is strong evidence to demonstrate robust processes around risk, safety, and governance.

We would like Board members to note that NHSEI Regional Maternity Teams are currently undertaking 'Insight' visits. These visits are an ideal opportunity to showcase our service and provide evidence of progress and compliance against the Ockenden IEAs. Our Insight visit is scheduled for September, and it is anticipated that these visits will then occur annually. Going forward, this responsibility will be delegated to the Local Maternity and Neonatal System (LMNS).

2. Perinatal Surveillance Provider Board Measures

Relevant data to illustrate the Perinatal Surveillance Provider Board Measures for Quarter 1 can be found in Appendix 1. The following key points should be noted:

- Any clinical events occurring within Maternity are reviewed by a panel involving relevant stakeholders and clinical experts. Incidents of a moderate or serious nature receive further investigation both locally and externally to the organisation. Any SI which meets the criteria will be referred to the Healthcare Serious Investigation Branch (HSIB). Following a full investigation on behalf of HSIB, a report is then provided and any lessons for learning shared as appropriate. Further details can be seen in Section 5 of Appendix 1.

- Recent concerns raised to Maternity Safety Champions have been identified within Appendix 1. To date, these escalations have largely been issues relating to workforce and the estates of the building.

- Workforce provision, from both a Midwifery and Obstetric perspective, continues to present an ongoing challenge to Maternity Services. Together with continual senior leadership oversight, regular reviews of staffing across the service are maintained 24/7. Actions for mitigating against any gaps in staffing involve a series of operational actions for escalation.

- Compliance levels around mandatory education and training have been significantly affected by recent operational challenges across the service and staff have been redeployed to provide clinical care. Additional out-of-hours training sessions have been programmed to support key training requirements.

- Opel alert status for both Maternity and Neonatal services continue to be monitored with any significant or prolonged events being appropriately investigated. This process enables us to establish whether any adverse harm has been caused has a result.

3. NHS Resolution Maternity Incentive Scheme (MIS) Year 4

The MIS Year 4 was relaunched on 6 May 2022. Eligibility for the payment requires a completed Trust Board declaration to be submitted to NHS Resolution by midday on Thursday 5 January 2023. The full details around all of the safety actions and the Year 4 MIS are here.

Maternity has provided the Board with an overview of our current compliance levels in Appendix 1, Section 2. This information details all 10 of the safety actions and any actions for improvement. In addition, the Board should note the following:

- Safety Action 6 Saving Babies Lives Care Bundle. Maternity continues to make improvements regarding this safety action and can confirm that compliance should be achieved by December 2022. Maternity has an agreed variance in place which has been shared with the CCGs and Maternal Medicine Network. This agreement involves a variation in both growth scanning for patients with raised BMI and twin pregnancies.

- Safety Action 6 & 8 training compliance. Maternity continues to work towards a 90% compliance target with additional training sessions being programmed to achieve this. An area of focus will include fetal monitoring training.

Board members should note that evidence for the MIS safety actions will be provided in advance of the final declaration. This will ensure appropriate verification and oversight of the evidence collated prior to Executive sign-off.

4. Maternity Serious Incident (SI) Reporting, including HSIB Cases

All Maternity SI reports and a summary of key issues must be received by Committees, Trust Board and the Local Maternity and Neonatal System (LMNS) for scrutiny, oversight, and transparency at least every 3 months (recommended in the Ockenden report). Maternity can provide assurance to the Board that the appropriate reporting is occurring, and the below appendices provide an update on serious

incidents for Quarter 1. The Board are asked to note the robust processes in place for investigation of incidents as well as the sharing of the learning.

- Appendix 2 - Quarter 1 Moderate or above incidents (Supportive Enc A/B/C/D)
- Appendix 3 – Quarter 1 HSIB reported incidents
- Appendix 4 – Quarter 1 Summary of investigations received from HSIB (Supportive Enc E/F).

NB Enclosures A-F are available in iBabs Documents.

5. Perinatal Mortality Review Tool (PMRT)

The Maternity PMRT process is a requirement of NHS Resolution MIS. For Quarter 1 reporting Appendix 5 provides details on the cases. It should be noted that, 17 babies were eligible for notification (including babies that died within the Children's Hospital). Reporting should occur within 7 working days, and we can confirm full compliance. Of the babies eligible for notification and surveillance, 11 babies have received surveillance, 2 babies are still within the timescale and 1 baby is excluded. We can confirm that parents are being informed about the review of their baby's death and are being given every opportunity to express their concerns and have questions answered. Maternity is developing a formal 'tracker' using the Trust Safeguard system to assist in the continual monitoring of actions.

6. Avoiding Term Admissions into Neonatal (ATAIN)

Maternity is required to report quarterly to the Board in respect of the requirements for NHSR Safety Action 3. We can confirm that there are pathways in place and audits undertaken to ensure that these standards are met. This information is then openly shared with the Safety Champions and the LMNS. As it stands, Maternity and the Neonatal Services are on track to deliver the NHSR requirements.

In terms of action planning, the team are currently looking at opportunities for improving reporting processes around term admissions and are addressing the low compliance of ATAIN training within the Neonatal team.

7. Maternity and Neonatal NHSR Claims Scorecard

Maternity has sought information from the Trust Legal team regarding the Maternity and Neonatal Claims NHS Resolution Scorecard.

The scorecard information will be used as a valuable tool in identifying areas for improvement and will be shared across the safety and governance frameworks. It should be noted that, in addition, the Trust Legal team provide reports to Board separately which contain Maternity case information. For the Board members key information is highlighted in Appendix 6.

8. Medical Workforce

Gaps within the medical workforce have been raised as a concern to the Maternity Safety Champions. During peaks of unscheduled birthing activity normal obstetric medical staffing has been stretched to provide emergency care in all clinical areas.

There are a reduced number of obstetric trainees and gaps in the rota due to sickness absence. Many of these staffing gaps have been covered internally by the existing workforce. This in turn has resulted in many of the junior doctors working over their agreed hours and is rapidly becoming a situation that feels unsafe. This was compounded by the recent revision of pay rates across the Trust, which has now been resolved.

Current actions to address this concern includes a full review of the Risk Register entry. Concerns regarding medical staffing have been escalated appropriately through the Maternity Safety Champions and the Divisional team to Board level. A full review of this situation is taking place by the Obstetric Care Group Clinical lead. The Board will be further provided with a more detailed medical workforce report in the next Maternity Safety report for assurance purposes.

9. CQC Provider Engagement Visit to Maternity

Maternity welcomed a visit by the CQC as part of the Trust Engagement Meeting. Maternity welcomes any review or inspection especially considering the current focus nationally on safety and quality in maternity services. The CQC made specific enquiries around the opel 4 alert status which saw a prolonged closure of UHS Maternity Services. Alongside this, the CQC sought some assurances around the Healthcare Safety Investigation Branch (HSIB) investigations and any actions achieved following the final Ockenden report.

Board members should note that Maternity confirmed the following:

- The opel 4 alert status closure of Maternity occurred in March 2022 and is being reviewed by the Trust Serious Incident Scrutiny Group (SISG). On initial review there appears to be no resulting harm overall.

- Feedback from the HSIB report covered the period August 2018 until the end of March 2022. The report confirms 37 referrals, leading to 29 investigations, of which 28 are currently complete. Across the LMNS, UHS Maternity Service are currently the 3rd highest reporter of cases and have the highest total number of completed reports. This demonstrates that the Maternity Service are reporting appropriate cases and managing them in a timely and effective way.

	• Maternity and HSIB work in close collaboration and to support families have co-produced a patient information leaflet. This is available to families and supports them in understanding HSIB and the Trust's approach to investigations. The leaflet will be shared with other Trusts nationally as an example of supporting families. • Maternity provided an update on the improvements being made and the pragmatic approach to undertaking a gap analysis of the initial and final Ockenden report. Overall, the CQC appeared to be satisfied with the visit to Maternity and the briefing information provided to them. We anticipate that the CQC will undertake a full review of the service within the next year. **10. Freedom to Speak Up Champions** Staff feeling enabled and empowered to speak up regarding any issues relating to safety and cultural concerns in Maternity Services remains a priority focus. Following a successful recruitment drive, we are delighted to see another 8 staff across different disciplines come forward to support this role. Christine Mbabazi, FTSU Guardian, will be responsible for training and supporting this group of individuals going forward. Considering Ockenden, Health Education England has also highlighted the need for student midwives in training to have a clear awareness of how to speak up. The lead Midwifery Educator will be working closely with Christina to strengthen our approach to this.
Implications: (Clinical, Organisational, Governance, Legal?)	The national safety focus on all maternity services continues to drive significant safety improvements. Consequences for not meeting safety recommendations and actions clearly have cultural and leadership implications and impact negatively on outcomes for families. Despite well-established governance frameworks within the Maternity Service, Trust and the Local Maternity and Neonatal System (LMNS), any gaps in systems and processes may lead to significant financial ramifications and reputational implications if patient safety recommendations are not maintained.
Risks: (Top 3) of carrying out the change / or not:	The risk implications for UHS Maternity include: • **Reputational** – Safety concerns can be raised by the public to both NHS Resolution and the CQC. The CQC can undertake reviews of services who they believe have safety concerns. • **Financial** – Compliance with NHS Resolution Maternity Safety Actions to meet all ten standards is an expectation for many maternity safety requirements. • **Governance** – Safety concerns can be escalated to the Care Quality Commission for their consideration and to NHS England, the NHS Improvement Regional Director, the Deputy Chief Midwifery Officer, the Regional Chief Midwife and DHSC for information.

	• **Safety** - Non-compliance with requirements or recommendations would have a detrimental impact on the women and their families leading to increased poor outcomes and staff wellbeing.
Summary: Conclusion and/or recommendation	In summary the Maternity Quarter 1 2022 safety and quality report demonstrates a drive in the service to meet the Ockenden findings and put into action any improvements to ensure a safe service for both families and staff. The Perinatal Surveillance Provider Board Measures provides oversight of key information for the Board, including any focus for improvement. Maternity understands the importance of ensuring delivery of the NHS Resolution Maternity Incentive Scheme (MIS) and will endeavour to provide evidence to support a confident submission in January 2023. Maternity will continue to scrutinise serious incidents and undertake Perinatal Mortality reviews to identify learning and opportunities for sharing the learning. To support staff working within the Princess Anne Hospital recruitment of further FTSU Guardians has taken place and it is hoped this will encourage staff to raise concerns and safety issues. Board members should be aware of the concern raised by the medical workforce within the Obstetric team and the associated actions that have been put in place. Maternity would welcome the opportunity to provide assurance and reassurance to the Board for both Obstetric and Midwifery workforce in the next Maternity Safety report. Finally, Maternity welcomed the visit by the CQC and are keen to receive continual reviews and scrutiny. The NHSEI Insight visit planned for later in the year will provide an opportunity for us to celebrate and showcase what we do best.

Appendix 1 - Perinatal Surveillance Provider Board Measures

RAG rated using the below method		
On track to achieve improvements / low risk	Off track/plan in place / medium risk	Off track/no plan in place/high risk

Section 1		April	May	June
Maternity safety support programme?	Yes/No	No	No	No
The number of incidents logged graded as **moderate or above**	In month incidents Number of Moderate Number of Serious/severe	4 x moderate 1 x severe 1 x catastrophic	1 x moderate 2 x catastrophic	2 x moderate 4 x catastrophic
Themes of incidents graded **moderate & above** What actions are being taken?	Incident themes Immediate learning from 72-hour review In month incidents	2 x therapeutic cooling 1 x severe UVC extravasation 1 x neonate fractured arm 1 x birth injury (right forearm fracture) 1 x neonatal death	1 x swallowed colostrum syringe cap (incident occurred in Mar) new provider with a different cap 1 x maternal death indirect death but a review will occur re the VTE assessment for women presenting with hyperemesis gravidarum (HG) 1 x preterm neonatal death	1 x NNU on Opel 4 for greater than 24 hours 1 x thematic review of 3 cases of patients with urinary retention in labour 1 x term neonatal death (HSIB) 1 x maternal death – indirect death (HSIB) 1 x preterm early neonatal death 1 x term late neonatal death
Themes from reviews of perinatal deaths *Findings of review of all perinatal deaths using the real time data monitoring tool*	Themes & key actions In month reviews (please reference month incident happened)	1 x Neonatal CDRM meeting held (no deaths to discuss) 1 x perinatal mortality review meeting held 3 x stillbirths reviewed (from Jan and March). No learning identified.	1 x perinatal mortality review meeting held. No neonatal CDRM this month due to SONeT M&M 1 x stillbirth reviewed (from Mar) No learning identified	Perinatal mortality review meeting held. 1 x stillbirth reviewed (from May) 1 x late neonatal death reviewed (from May) Neonatal CDRM meeting held 3 x neonatal deaths reviewed (from April)

				Learning/actions identified: • Awareness of out of hours pharmacist to get hold of medication not kept on the ward. • Resuscitaire not correctly connected to the oxygen outlet in the wall. • Missed aspirin prescription • CO monitoring for booking • Review the congenital cardiac pathway
Did 100% of perinatal mortality reviews include an external reviewer?	Yes/No	Yes	Yes	Yes
HSIB referrals made in month	How many HSIB referrals made in month	1 referral made 1 final report received	1 referral made 1 referral from May rejected	2 referrals made
HSIB referral criteria met ***Findings of review of all cases eligible for referral to HSIB***	Bullet point- why referrals made	Therapeutic cooling	Maternal Death	Neonatal death Maternal death
Audit findings relating to safety/quality	By exception Audit summary, issue identified, actions taken, outcome	Audits being completed around elements of SBLv2, and continued auditing around the Place of Birth risk assessment as per Ockenden report	Audits completed for Saving babies Lives NHS Resolution Ockenden	Audits being completed for SBLv2 and NHSR safety actions and continue around the Place of Birth and risk assessment as per Ockenden report. Improvements being made on all requirements. However further work required around recording of BMI.
Safeguarding allegations against providers	Any Section 42 investigations reported to LADO Yes/No	None	None	None
Issues affecting wider safeguarding which could affect maternity	Items emerging in safeguarding networks Notifications via	None	None	None

	safeguarding Domestic violence prevalence			
Feedback from safety champions & walkabouts	Only include items relating to safety	Concerns raised in relation to babies within the Transitional Care Unit.	• Concerns raised in relation to midwifery staffing on nights shifts. • Board level walk around as a 'pre CQC' walk around exercise - 27/5/22. No safety concerns raised.	Concerns raised in relation to the following, • Obstetric workforce - **Action** review of workforce and recruitment. Reporting to W&N Risk & Patient safety Group. • Estates of the building - **Action** Estates team have reviewed the PAH environment and will report through the Governance reporting and on the Risk Register. • CTG equipment including keyboards - **Action** Equipment review taken place with additional ordering of CTG machines (delivery not until Sept 22).
Service user voice feedback ***Patient experience outliers***	Active engagement items Themes of feedback Key actions being taken (not limited to MVP feedback)	MVP chair has raised an issue around women undergoing IOL being given full options and alternatives - this does not relate to UHS particularly but across maternity users generally - UHS is going to work with MVP and support a questionnaire via Gather to see what areas would benefit from increased awareness	Planned review with IOL to take place with MVP lead during this month	None
Complaints (Moderate)	Number	None that required a safety	None that required a safety	None that required a safety

Complaints	Themes & key actions In month reviews (please reference month incident happened)	None	The themes remain varied, with communication as a constant.	The themes remain varied, with communication as a constant. The number of the types of concerns remain static apart from patient messages which have declined since the height of Covid-19.
Friends & Family Test	Response rate Score- % likely to recommend overall	Response rate = 26% (target 20%) % Likely to recommend 79% % Likely to NOT recommend 4.2%	Response rate = 30% (target 20%) % Likely to recommend 81% % Likely to NOT recommend = 4%	**For Qtr. 1 Overall** Response rate = 28% (target 20%) Score - % likely to recommend 87% Score - % likely to NOT recommend = 4%
External reviews or actions requested from CQC, RCOG, HSIB, HEE, NHSR,	Yes/No	None	None	CQC walkabout as part of the provider engagement meeting.
Coroner Reg 28		None	None	None
Workforce- concerns regarding staffing levels or skill mix *Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively.*	BR+ levels recommended/ actual Obs cover recommended/ actual % shielding % sick % maternity leave Quarterly issues # posts out to recruitment Recruitment success level	**RM** Sickness - 8.20% Maternity - 5.89% Vacancy - 19.58 WTE Starters - 1.73 WTE Leavers - 1.63 WTE Study Leave - 2.71% **MSW** Sickness - 8.81% Maternity - 3.80% Vacancy - 4.86 WTE Starters - 8.20 WTE Leavers - 2.31 WTE Study Leave - 3.48% **Recruitment** There is ongoing recruitment in place with quarterly intakes into the service Adverts are out currently for Case loading RM. A successful B3 recruitment has started so this has reduced MSW vacancy rates by 6 WTE.	**RM** Sickness - 7.34% Maternity - 6.24% Vacancy - 19.66 WTE Starters - 0.29 WTE Leavers - 1.00 WTE Study Leave - 3.64% **MSW** Sickness - 6.95% Maternity - 3.53% Vacancy - 5.25 WTE Starters - 0.59 WTE Leavers - 0.03 WTE Study Leave - 10.20% **Recruitment** There is ongoing recruitment in place with quarterly intakes into the service We have 2.2 RM recruited but not started yet and a B5 intake planned for SEPT. Adverts are out currently for 2 WTE Case loading RM. A successful B3 recruitment has	**RM** Sickness = 6% Maternity = 6% Vacancy = 19.66 WTE Starters = 1.20 WTE Leavers - 5.13 WTE Study Leave = 10% **MSW** Sickness = 6 % Maternity = 3% Vacancy = 0 WTE Starters = 1 WTE Leavers = 0 WTE Study Leave = 3 % **Recruitment** 14 WTE of RMs have been recruited to start in OCT time. 3 WTE of B6 are being interviewed at the end of this month MSW Vacancy rates are 0 we are fully recruited currently

			started so explains the high Study Leave an decreased sickness.	There is ongoing recruitment in place with quarterly intakes into the service Adverts are out currently for 2 WTE Case loading RM, 1.8 WTE for Self-Referral Team and 1.60 for MDAU Sickness has reduced in month. Obstetric workforce concerns raised to safety Champions additional actions and reporting to occur.
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training (target 90%)	Training compliance % broken down into staff group (MW, MSW, Drs)	Training and education off plan with medium risk - impact of COVID / Omnicom **Maternity Emergency Training:** Obstetric trainees = 38.46% Consultant Obstetricians = 70% Consultant Anaesthetists =12% Anaesthetic trainees = 30% UHS Midwives = 79% MSW & Nursery nurses =75% Theatre staff =30% Maternity elective =67% Day surgery & recovery = 48%	Training and education remain challenged due to impact of Covid and non Covid related sickness, a 30% shortfall in the number of obstetric trainees and some uncertainties around the reach required for anaesthetists at trainee and consultant levels to attend training. This is an issue being considered at Royal College level currently. **Maternity Emergency Training:** Obstetric trainees = 52% Consultant Obstetricians = 70% Consultant Anaesthetists = 29% Anaesthetic Trainees = 37 % Midwives = 84% MSW and Nursery Nurses = 85% Theatre Staff = 33% Maternity Elective = 67% Day Surgery and Recovery = 48%	Training and education remain challenged due to impact of Covid and non Covid related sickness. **Maternity Emergency Training (Up to the 23rd of June):** Obstetric trainees = 62% Consultant Obstetricians = 72% Consultant Anaesthetists = 23% Anaesthetic Trainees = 40% Midwives = 82% MSW and Nursery Nurses = 84% Theatre Staff = 67% Maternity Elective = 67% Day Surgery and Recovery = 57% Fetal Monitoring Midwives = 90% Consultant Obstetricians = 67% Obstetric trainees = 83%
Section 2 - Progress/challenges in meeting NHS R Safety Actions				
1: Are you using the PMRT to review perinatal deaths?		MIS paused for 3 months	MIS paused for 3 months	Maternity can give assurance that, at the current time we meet the evidence requirements for this action.
2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?				The digital team have scored 11 out of 11 for the CQIN for reporting to the MSDS. A SHIP BI analyst has now been appointed and will be creating some additional reporting capability to demonstrate

				compliance. Maternity understands this will lead to full compliance.
3: Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?				Appropriate evidence in place.
4: Can you demonstrate an effective system of medical workforce planning to the required standard?				Obstetric workforce reporting monthly. Neonatal and Anaesthetic workforce reporting is 6 monthly and will follow in subsequent reports
5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?				Midwifery workforce planning report will be shared 6 monthly at this committee and Trust Board meetings. Workforce report planned for August 2022
6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?				Maternity is working towards compliance with all 5 elements of SBL. There is a current agreement with the CCG's and Maternal Medicine Network for a variation for SBLs which is being reviewed and updated. 3 areas require actions, 1. Agree a local variance and audit growth scanning for women with raised BMI 2. Agree a local variance for scanning twin pregnancies 3. Develop a digital stratification of risk assessment for patients at risk of pre-term birth.
7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?				Maternity can confirm that we have a strong and helpful relationship with our MVP, and that the evidence requirements will be meet for this safety action.

8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?				Maternity can confirm that full compliance with this safety action is being actively pursued with a target compliance of 90% (in the 18 months preceding the 5th of January 2023) for all agreed staff groups. The ideal scenario would be to meet the 90% compliance threshold in a 12-month period however, NHSR MIS requirements have granted a longer period this year to mitigate for Covid.
9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?				Maternity can confirm that the required evidence is in place and available in the environments and on StaffNet for all staff to see. Safety Champions are in place and regular reports to Trust Committees and Boards discuss neonatal safety and quality issues and oversight is provided.
10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme?				Maternity can provide assurance that we currently meet the requirement for this safety action and can further assure the committee and Trust Board that the service enjoys a mutually positive relationship with our local HSIB colleagues who have no concerns in the way cases are reported to them.
Section 3 Ockenden Recommendations				
Enhanced Safety				
Listening to women and families				
Staff Training and Working Together				
Managing Complex Pregnancy				
Risk Assessment Throughout Pregnancy				Additional data capture now embedded into the maternity Badgernet system to ensure capture of place of birth risk

				assessments. Regular audits in place to monitor improvements.
Monitoring Fetal Wellbeing				
Informed Consent				
Significant gaps in NHSI maternity self-assessment tool				
Concerns raised in Annual Surveys & progress on actions to address: **Staff** **Maternity**	Issues / actions / outliers			Staff annual survey has been reviewed by the service and improvement plan in place.
Number of times maternity unit has been: **1) Suspended** **2) Had to divert** **3) Reasons for this**	S: Number + reasons D: Number +reasons			**01.06.22** - Escalated at 5.30 pm due to NNU status and de-escalated on 02.06.22 at 2.00 am to Opel 3. One woman diverted to RHCH. **04.06.22** - Escalated at 5.40 pm due to NNU status and de-escalated on 04.06.22 at 8.15 pm to Opel 3. Not aware of any women diverted. **10.06.22** - Escalated at 11.40 am due to NNU status and de-escalated on 10.06.22 at 5.30 pm to Opel 3. Not aware of any women diverted. **14.06.22** - Escalated at 3.00 pm due to capacity, acuity and activity and de-escalated on **14.06.22** at midnight to Opel 3. Not aware of any women diverted. **16.06.22 -** Escalated at 8.30 am due to staffing and acuity and de-escalated on 16.06.22 at 12.00 noon to Opel 3. Not aware of any women diverted. We escalated again on 16.06.22 at 4.00 pm due to staffing and capacity and de-escalated on 17.06.22 at 3.50 pm to Opel 3 (important to note the timings as

				this was just shy of 24 hours, but not over). One woman diverted to RHCH.
Number of times Neonatal unit has been: **1) Suspended** **2) Had to divert** **3) Reasons for this**	S: Number + reasons D: Number +reasons			8 Opel 4 alerts (2 staffing, 6 capacity) 18 Opel 3 alerts (18 capacity) 27 Refusals 19 due to Capacity 8 Labour ward
Section 4 Saving Babies Lives Care Bundle				
Reducing Smoking in Pregnancy	% Compliance	Currently under review within the service		Audits being undertaken to establish current compliance
Risk assessment, prevention, and surveillance of pregnancies at risk of fetal growth restriction	% Compliance			Audits in place with 2 actions, • Agree a local variance and audit growth scanning for women with raised BMI • Agree a local variance for scanning twin pregnancies
Raising awareness of reduced fetal movement	% Compliance			Audits being undertaken to establish current compliance
Effective fetal monitoring during labour	% Compliance			Audits being undertaken to establish current compliance
Reducing preterm birth	% Compliance			Audits being undertaken to establish current compliance and to develop a digital stratification of risk assessment for patients at risk of pre-term birth.
Proportion of midwives with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (annual)		Currently being collated by the UHS Trust	Currently being collated by the UHS Trust	No current change

Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (annual)		There was 91.8% satisfaction with clinical supervision out of hours	There was 91.8% satisfaction with clinical supervision out of hours	No current change
CQC Rating		2019, action plan complete	2019, action plan complete	2019, action plan complete
Overall		Good	Good	Good
Safe		Requires Improvement - improvement plan in place and completed	Requires Improvement - improvement plan in place and completed	Requires Improvement - improvement plan in place and completed
Effective		Good	Good	Good
Caring		Good	Good	Good
Well Led		Good	Good	Good
Responsive		Good	Good	Good

Appendix 2 – Moderate incidents or above

Incident Date	Type of Incident	Summary of Incident	Outcome of Incident	Key Learning and Recommendations	What Actions have been identified?	Action Completion Date
Dec 21	Multiple obstetric emergencies in approx. 40 mins (Enc A)	Multiple obstetric emergencies occurred within a short period of time. Requiring 3 theatres to be open.	No harm to any of the mothers or babies.	Case logged as Near Miss SIRI. **Case closed at SISG 05/05/2022.**		
Feb 22	Neonatal death and 3.5L PPH (Enc B)	Patient in their 3rd pregnancy. Bloods that were taken showed anti-FYa antibodies present, therefore was referred to the Fetal Medicine Department. Regular scans for growth were scheduled. Babies' abdominal circumference began tailing off at growth scan at 33 weeks gestation and there was possible redistribution of placental flow, therefore a plan was made for twice daily CTGs as an inpatient. A CTG in MDAU was performed and the patient, went home for day leave then returned as an inpatient that evening. Concerns were noted on the morning CTG, and the patient was transferred to Labour Ward. It was noted that there had been no fetal movements felt since readmission. The CTG classified as abnormal and variability of the fetal heartrate was reduced. It became difficult to auscultate the fetal heart rate, therefore decision for category 1 caesarean section. Baby girl born in very poor condition requiring resuscitation. She was successfully resuscitated and admitted to the NNU. She had evidence of renal and liver hypoxic damage. At 18hrs of life she developed CAM evidence of seizure activity. MDT discussions involving parents were held and the decision was made to redirect to comfort care. RIP 2 days of age.	Care redirect to comfort care. Baby died 2 days of age	Case logged as SIRI. **Case closed at SISG 09/06/2022**. To note that this case is a Coroner's post-mortem, and the results are pending.		

Incident Date	Type of Incident	Summary of Incident	Outcome of Incident	Key Learning and Recommendations	What Actions have been identified?	Action Completion Date
Feb 22	Neonatal death and PPH (Enc C)	Patient in their 1st pregnancy (IVF). Previous medical history highlighted uterine surgery and uterine fibroids. During the pregnancy there were regular growth scans. It was noted at 26 weeks that there was a grade 4 placenta praevia. At 29 weeks the patient called labour line in suspected labour, with possible spontaneous rupture of members (SROM) and abdominal pain. On admission there was confirmed SROM. Steroids and magnesium sulphate was administered. On Labour Ward the CTG showed variable decelerations which recovered to a stable baseline. The CTG was discussed with SpR who was happy to discontinue the CTG, with plan for CTG to be repeated in the morning. The CTG was repeated as planned but fetal heart was unable to be auscultated, therefore a decision for category 1 caesarean section. Baby boy was born in poor condition and admitted to NNU. His neurology was monitored closely from birth but sadly this remained abnormal. Care was therefore redirected to palliation. RIP 2 days of age.	Care redirect to comfort care. Baby died 2 days of age	Case logged as SIRI. **Case closed at SISG 09/06/2022**. To note that this case is waiting for results from the post-mortem.		
Mar 22	Maternity Service on Opel 4 alert for greater than 24 hours	Maternity Service on Opel 4 alert from 30/03/22 – 03/04/22.	No evidence of any harm as a direct consequence of the Opel 4 alert. There was 1 case which the Opel 4 alert may have been a contributing factor.	For RCA to be completed to ensure correct processes were followed and to ascertain if any harm came to women/babies as a result including and women diverted to other units or delays in treatment. Reported to the CQC as per requirements and as a SIRI. Date of incident – 30/03/2022 Decision made for RCA – 05/04/2022 60-day target for report completion – 07/07/2022 Due date for report completion – 07/07/2022		

Incident Date	Type of Incident	Summary of Incident	Outcome of Incident	Key Learning and Recommendations	What Actions have been identified?	Action Completion Date
Mar 22	Moderate clinical – neonatal admission to ED (Enc D)	2-day old baby discharged home on established breast feeds. Dad went to give baby a syringe of colostrum but did not realise the purple end of the syringe was a cap. Pushed plunger to dispense the colostrum and cap flew off into baby's mouth. The cap swallowed by baby causing oesophageal obstruction. Brought to the Emergency Department, moved immediately into resus, and rapidly transferred to theatre for removal of foreign body with multiple teams present as location of cap unknown.	Cap removed in theatre. Good recovery post-operatively with normal feeding and observations. Discharged home.	The incident occurred in March however not reported until April. Incident was reviewed and immediate learning identified.	Maternity service changed colostrum collecting syringes. Patient information leaflets amended to include caveat about the lids. Incident reported to Trust Clinical Engineering Team who have reported to the MHRA (Medicines and Healthcare products Regulatory Agency) Share learning within SHIP Regional Safety meeting the Perinatal Clinical Safety and Quality Forum.	All actions completed.
Apr 22	Umbilical Venous Catheter (UVC) extravasation	A stable preterm baby on the neonatal unit deteriorated acutely with metabolic acidosis and abdominal distension. Ultrasound Scan of abdomen revealed an extensive intrahepatic extravasation of Total Parental Nutrition (TPN)from the Umbilical Venous Catheter (UVC) and a subcapsular collection with haemorrhage. The baby required intubation and was ventilated and needed an emergency peritoneal tap from which large amounts of TPN was drained.	The infusions through the UVC were immediately stopped and UVC removed. Alternative access established. Baby stabilised by intubation, ventilation, sedation, analgesia, fluid resuscitation and blood products. Surgical and radiology specialist input obtained to establish need for surgical decompression. Parents updated.	Patient safety case review held on the 06/05/2022. It was felt that this was a known complication of line insertion. Appropriate escalation was followed throughout this incident. DoC was completed with the family.	The incident will be discussed at the Neonatal M&M meeting for wider learning and reflection on practices. The policy on UVC lines will be updated with clear guidelines on the aspiration process. Explore options with Meta vision to amend the UVC insertion form for aspiration and make the form a mandatory step prior to form closure	June 2022 August 2022 August 2022

Incident Date	Type of Incident	Summary of Incident	Outcome of Incident	Key Learning and Recommendations	What Actions have been identified?	Action Completion Date
Apr 22	Therapeutic cooling	Patient arrived in labour at 40 weeks gestation, who progressed quickly in labour. An attempt was made to auscultate the fetal heart rate (FHR), but this was found to be bradycardic They were transferred to Labour Ward and scanned by the consultant, however the FHR remained low. A decision was made for a ventouse delivery in the labour room. Baby boy born in poor condition possible concealed abruption. Full neonatal resuscitation carried out.	Admitted to NNU and therapeutically cooled. The baby was diagnosed with grade 2 HIE.	Case referred to HSIB in May 2022, however they have since confirmed that as the MRI is normal and there are no care concerns, that no further investigation will take place by their team. The service has undertaken an internal review at Clinical Events meeting and agreed there is no further investigation required.		
Apr 22	Fractured right arm	Baby boy (twin 2) born at 29+4 weeks gestation. Diagnosis of Di-George syndrome. Around 1 month of age, concerns were raised that he had not been moving his right arm for 3 days with some elbow swelling. X-ray of right arm performed. Shows probable trans-physeal fracture. Noted that the X-rays showed some thinning out of the bones.	Reviewed by paediatric orthopaedic team. Plaster of Paris splint applied for comfort.	Discussed at the NNU risk meeting. Fracture thought to have been caused whilst holding him down for IV access. However, on further investigation no fracture identified on USS but possible cartilage abnormality. Therefore, no review required.		
Apr 22	Birth injury fracture right forearm	Premature pre-labour rupture of membranes around 20 weeks gestation with confirmed anhydramnios. The woman presented with contractions and hand presentation at 26 weeks gestation. Cat 2 section performed. Difficult extraction as babies' hand was low in uterus.	Admitted to NNU due to gestation. X-ray performed of the right forearm showed normal alignment.	Case has been reviewed (12th May) and injury caused through traumatic delivery. Feedback given to team involved and no other identified concerns. Downgraded to low minor incident following review.		

Incident Date	Type of Incident	Summary of Incident	Outcome of Incident	Key Learning and Recommendations	What Actions have been identified?	Action Completion Date
Apr 22	Neonatal death	Woman in her 1st pregnancy with history of type 1 diabetes. Referred to UHS fetal medicine team at 31+4 weeks as fetus had suspected atrial flutter. Admitted to Lyndhurst ward and discharged 31+6 weeks. Fetal rhythm still in atrial flutter. Readmitted to UHS 32+5 weeks and plan made for elective LSCS at 33 weeks. Mother reported an episode of reduced fetal movements. CTG did not meet the criteria. Escalated to consultant and plan made for LSCS. Baby boy born in poor condition.	Admitted to NNU, cooled, and started CFAM monitoring. Abnormal neurology. Care redirected. Baby died at 3 days of age	Reviewed through CER twice on 12/04/2022 and 26/04/2022. Graded as incidental sub-optimal x unanticipated poor. Decision made that no further patient safety investigation was required.		
June 22	Neonatal death	Patient with a history of uterine fibroids and previous myomectomy was referred for Obstetric led Care for a raised BP and possible pre-eclamptic toxaemia. Low placenta had been noted with some intermittent blood loss. At 25 weeks gestation they attended MDAU with abdominal cramping and vaginal bleeding for a period of 4 days and reduced Fetal Movements. They were admitted to the service and administered steroids and counselled by NNU team. They remained an inpatient and at 26 they were transferred to Labour Ward with possible meconium-stained liquor. As they had started to experience contractions they were consented for Caesarean Section. In theatre there was a fetal bradycardia therefore a category 1 section was performed. There was a difficult extraction of the baby due to fibroids. Baby girl born in poor condition. Admitted to NNU.	Baby girl required full resuscitation at birth. She was admitted to NNU. At day 2 of life, the extent of her neurological abnormality became apparent with lack of spontaneous movements and fixed and dilated pupils. Care was redirected to comfort care at 4 days of age.	Clinical Events Review held on 30/06/2022. For investigation via RCA and report as a SIRI.		

Incident Date	Type of Incident	Summary of Incident	Outcome of Incident	Key Learning and Recommendations	What Actions have been identified?	Action Completion Date
June 22	Neonatal Unit (NNU) on Opel 4 alert for greater than 24 hours	NNU on Opel 4 alert from 0730 hours on 19/06/2022 to 1625 hours on 20/06/2022 due to staffing and high acuity. Unable to facilitate 3 admissions and 3 admissions deferred.	To review whether there has been any harm to babies because of the alert.	For RCA to be completed to ensure correct processes were followed and to ascertain if any harm came to babies as a result. Reported to the CQC as per requirements and as a SIRI.		
June 22	Urinary retention in labour	Cohort review of 3 incidents related to patients in urinary retention whilst in labour.	To review whether there has been any harm.	A cluster of cases were noted to have concerns around urinary retention, whilst these would not routinely individually trigger for a higher-level review, due to the sudden prevalence it was felt a thematic review may be beneficial. Review scheduled for Clinical Events Review Meeting.		
June 22	Neonatal death	Patient in her first pregnancy. Planned for elective c section at 39 weeks, otherwise low risk under maternity led care. Attended MDAU with cramping and PV bleeding at 34+6 weeks gestation. Admitted as she started to go into labour. Male infant born in good condition. They were transferred to Transitional Care (TC). Feeding support was given and the relevant observations and protocols were carried out. He required single phototherapy due to jaundice. 2 car seat challenges were attempted and failed; however, he passed the 3rd using a lie flat car seat. Safe sleeping advice was discussed. He was discharged home 8 days old. He represented to ED 21 days old after collapsing at home.	Admitted to PICU however care was redirected, and he died 2 days later.	Reviewed at Clinical Events Review on 28/06/2022. It was felt that in hindsight delivery could have been expedited sooner, however he was born in good condition. There was also no documentation from the paediatrician who attended the birth.	Neonatal team to review the TC policy re. daily specialist/senior reviews for babies who have been in TC for over 5 days. Neonatal team to review the car seat challenge guideline to ascertain the duration between car seat challenges before discharge.	August 2022 August 2022

Appendix 3 – HSIB Reported Incidents

When an incident occurs that meets HSIB criteria, an internal multidisciplinary clinical events review is undertaken. This review ensure that any immediate learning, actions, and feedback is shared with the individuals involved as well as shared within the service as required. The completed investigations are due back from HSIB within 6 months of the date of the event. All cases (since December 2020) which meet HSIB criteria have been reported as SIRIs as requested by HSIB.

Date	HSIB Criteria	Summary of Incident	Summary of Immediate Actions / Learning
May 22	Maternal death	Patient in their 9th pregnancy (7 liveborn, 1 miscarriage). There was a complex social history (all 7 children in care/adopted/special guardianship). patient self-referred to maternity, seen by triage midwife and liaised to the Needing Extra Support Team (NEST). Presented to ED at 8weeks gestation feeling unwell with vomiting and dizziness. They were noted to have had a headache for 2 days previously. They were treated with IV fluids and antiemetics. Discharged home with safety netting and referral to hyperemesis (HG) clinic the following day. Attended HG clinic and prescribed metoclopramide and discharged. The patient presented to ED at 9 weeks gestation with dropped GCS. A CT scan showed extensive cerebral venous sinus thrombosis with cerebral oedema. Transferred to Neuro ITU. Fixed and dilated pupils noted and certified as being brain stem dead. No Fetal Heart found on scan. Underwent organ donation.	Patient safety case review held 31/05/2022. Referred to HSIB for investigation. Immediate actions: • Case to be discussed at Emergency Department M&M meeting • Teaching to commence re. medical red flags in pregnancy in ED • VTE risk assessments within early pregnancy unit (EPU) to be considered appropriate to commence
June 22	Term neonatal death	Patient in their first pregnancy. They were under the Pre-term Birth clinic for previous large loop excision of transformation zone (LLETZ). Regular cervical length screening was undertaken and was non concerning. Patient requesting Caesarean Section which was agreed and booked for 39/40 gestation. Patient presented to MDAU 37 gestation with pre-labour rupture of membranes. The patient was contracting 3:10. CTG was normal. Plan for Caesarean section as agreed (category 3). Baby born at 37 weeks cried at delivery but became floppy and blue. Emergency buzzer pressed for NNU support. Advanced resuscitation required and baby admitted to the NNU with resuscitation continuing. Echo showed impression of antenatally closed ductus arteriosus. Decision made to stop resuscitation at 2 hours of age. Death certificate issued with post-mortem showing 1a. Severely dysplastic Tricuspid valve 1b. Dilated right atrium/Prenatal closure of ductus arteriosus	Referred to HSIB. Clinical events review scheduled for 14/06/2022.

June 22	Maternal death	Patient in their 2nd pregnancy (previous termination). She had a past medical history of mild idiopathic intracranial hypertension and a previous MRI brain scan in keeping with old left transverse sinus and sigmoid sinus thrombosis (i.e., clots in the brain). She self-referred to the UHS Maternity services at 5 weeks gestation and was added to the list for triage. She presented to the Emergency Department (ED) at UHS with vomiting and complaining of a severe headache at 7 weeks gestation. She underwent a CT scan which showed cerebral venous thrombus and was started on treatment dose enoxaparin. She was admitted to the neurology ward for observation. She had stable symptoms and visual function and self-discharged against medical advice 2 days after admission. She returned to ED the following morning after experiencing an episode of visual loss and was admitted to the neurology ward where she underwent a lumbar puncture. She suffered a cardiac arrest later that day with alteplase given on presumptive diagnosis of massive pulmonary embolism. There was no return of spontaneous circulation and resuscitation was stopped. This case has been referred to the coroner for a coroner PM.	Patient safety case review held 30/06/2022. This case has been referred and accepted for investigation by HSIB pending family consent. The governance team were not informed of this death for 2 weeks. The medical examiners team have since added a box on their scrutiny checklist which asks about pregnancy from conception to 12 months post-partum and have added the governance team email address so that there will be more timely notification.

Appendix 4 – Summary of Investigations Received from HSIB

When an investigation has been completed by HSIB, the investigation report is returned to the Trust and an action plan is written internally. This ensures that the safety recommendations and findings have been reviewed and appropriate actions are put in place to learn from the incident. These action plans are reviewed within the Trust following the SI process and approved at SISG. They are shared with the family where possible through tripartite meetings which are held between HSIB, the Trust and the family. They are also shared with the CCGs for cases reported as SIRIs on STEIS.

Date of Event	HSIB Criteria	Safety Recommendations and Findings	Summary of UHS Actions
Oct 21	Therapeutic cooling (Enc E) (Enc F)	**Final report received 07/04/2022.** Safety recommendations: 1. The Trust to ensure staff are encouraged and supported to utilise the emergency call bell system when a bradycardia, or prolonged deceleration, occurs. 2. The Trust to ensure placentas are sent for pathological examination including histology in line with national guidance (RCPath, 2019).	• Clarify expected practice and timescales for calling for help in line with guidance and training. • All placentas for any baby born in poor condition at term who may undergo therapeutic hypothermia are to be sent for histological examination. • Theme of the Week to reiterate the process for sending placentas to histology • Education webinar to be produced to explain the rationale for placental histology and the process for sending them

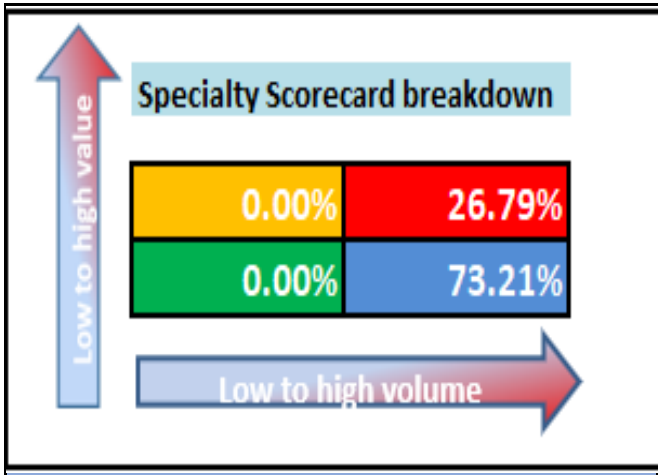
Appendix 5 Quarter 1 – Perinatal Mortality Review Cases

MBRRACE No	Type of Death	Date of Death	Initial Date of Review	Cause of Death	Themes / Actions	Status
80850	IUD	01/04/2022	May 22 PMRG	Awaiting PM findings	Did not receive prescription for aspirin	Published – awaiting PM results
81042	NND	10/04/2022	June 22 NNU CDRM	1a Severe Hypoxic ischemic encephalopathy Stage 3 B Multiorgan dysfunction c Fetal atrial flutter secondary to myocardial dysfunction d Maternal Type 1 Diabetes Mellitus (Infant of diabetic mother)	None	Published – awaiting PM results
81286	IUD	26/04/2022	May 22 PMRG	Awaiting PM findings	None	Published – awaiting PM results
81380	NND	01/05/2022	June 22 NNU CDRM	1a. Respiratory insufficiency associated with extreme preterm birth (23weeks, 750g) 1b. Multiple coronary artery fistulae 1c. Chorioamnionitis 1d. Prolonged rupture of membranes.	Clearer documentation in the bereavement period	Assigned to another Trust for completion
81413	NND	03/05/2022	June 22 NNU CDRM	22 q deletion Truncus Arteriosus Hypocalcemia with dysmorphic features	None for UHS	Assigned to another Trust for completion
81474	NND	07/05/2022	June 22 PMRG	Coroners PM	CO monitoring Asking about DV	In progress
81679	IUD	19/05/2022	June 22 PMRG	Awaiting PM findings	None	In progress
81823	IUD	31/05/2022	June 22 CER	Unknown – declined PM or placenta histology	None	In progress
81853	NND	31/05/2022	Not yet reviewed	Bilateral hypoplastic kidneys Pulmonary hypoplasia Anhydramnios Pulmonary atresia & ventricular septal defect	None at present – to note there was a prenatal decision for palliation post birth	In progress (assigned to another Trust)

81861	NND	03/06/2022	June 22 CER	1a) severely dysplastic tricuspid valve 1b) dilated right atrium / prenatal closure of ductus arteriosus	None – to note referred to HSIB as term neonatal death	In progress
81863	NND	04/06/2022	Not yet reviewed	Severe hypoxic ischemic encephalopathy Extreme prematurity	None at present	In progress
81934	IUD	08/06/2022	Not yet reviewed	Awaiting PM findings	None at present	In progress
Child Health Cases						
MBRRACE No	**Type of Death**	**Date of Death**	**Initial Date of Review**	**Cause of death**	**Themes / Actions**	**Status**
81256	CH	24/04/2022	Jun 2022 PICU CDRM	Coroners PM	Review the congenital cardiac pathway. Multiple transfers in care	In progress
81588	CH	13/05/2022	Not yet reviewed at UHS	Pulmonary hypertension suspected secondary to alveolar capillary dysplasia Malrotation (operated 08/05/22), anal stenosis, undescended testes	None for UHS at present	In progress (assigned to another Trust)
81866	CH	31/05/2022	Not yet reviewed at UHS	Group B streptococcal meningitis	None for UHS at present	In progress
82070	NND	18/06/2022	Not yet reviewed	Unexplained SIDS	None for UHS at present	In progress

Appendix 6 - Maternity Scorecard Claims between 01/04/2011 and 31/03/2021

Specialty - Volume of Claims	Specialty - Value of claims (£)
56	179,836,202
% of Trust Clinical Claims - Volume	**% of Trust Clinical Claims - Value**
9%	49%



Specialty - Ave. Claim Value (£)
3,211,361

% Trust - Ave. Clinical Claim Value
524%

Volume of claims by Incident Year			
Year	**Open**	**Closed**	**Periodical Payments**
2011/12	0	6	0
2012/13	5	6	0
2013/14	2	4	1
2014/15	1	5	0
2015/16	1	2	0
2016/17	6	3	0
2017/18	3	5	0
2018/19	2	0	0
2019/20	1	0	0
2020/21	0	0	0
Total	**21**	**31**	**1**

Top 5 injuries by volume for Obstetrics

	Injury	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Brain Damage	9	76,544,748	8,504,972	16%	43%
2	Adtnl/unnecessary Operation(s)	8	460,602	57,575	14%	0%
3	Cerebral Palsy	5	63,218,567	12,643,713	9%	35%
4	Unnecessary Pain	5	295,168	59,034	9%	0%
5	Fatality	4	1,432,555	358,139	7%	1%
Total Top 5 injuries by Volume for Obstetrics		**31**	**141,951,640**	**4,579,085**	**55%**	**79%**

Top 5 injuries by value for Obstetrics

	Injury	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Brain Damage	9	76,544,748	8,504,972	16%	43%
2	Cerebral Palsy	5	63,218,567	12,643,713	9%	35%
3	Multiple Disabilities	1	12,950,000	12,950,000	2%	7%
4	Not Specified	1	12,487,000	12,487,000	2%	7%
5	Developmental Delay	1	10,550,050	10,550,050	2%	6%
Total Top 5 injuries by Volume for Obstetrics		**17**	**175,750,365**	**10,338,257**	**30%**	**98%**

Top 5 causes by volume for Obstetrics

	Causes	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Fail To Monitor 2nd Stg Labour	11	67,072,652	6,097,514	20%	37%
2	Failure/Delay Diagnosis	8	12,738,529	1,592,316	14%	7%
3	Inappropriate Treatment	5	141,650	28,330	9%	0%
4	Fail To Recog. Complication Of	4	1,263,271	315,818	7%	1%
5	Fail / Delay Treatment	4	12,905,325	3,226,331	7%	7%
Total Top 5 causes by Volume for Obstetrics		**32**	**94,121,426**	**2,941,295**	**57%**	**52%**

Top 5 causes by value for Obstetrics

	Causes	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Fail To Monitor 2nd Stg Labour	11	67,072,652	6,097,514	20%	37%
2	Fail To Make Resp To Abnrm FHR	2	32,534,517	16,267,259	4%	18%
3	Birth Defects	1	12,975,000	12,975,000	2%	7%
4						
5						
Total Top 5 causes by Volume for Obstetrics		**14**	**112,582,169**	**8,041,583**	**25%**	**63%**

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Addressing Violence and Aggression against staff Update**			
Agenda item:	**5.11**			
Sponsor:	**Steve Harris, Chief People Officer**			
Author:	**Sarah Herbert, Deputy Chief Nursing Officer**			
Date:	**28 July 2022**			
Purpose	**Assurance or reassurance Y**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	Violence and aggression towards our people remains a critical challenge at UHS. In March 2021 the Board were asked to endorse a new exclusion policy providing a framework for taking action in addition to supporting additional investment in other mitigating actions. The Board were also provided with an update in December 2021.			
Response to the issue:	The paper provides an update for the Board on the Trust's current position in relation to violence and aggression. It summarises the progress made since the update in December and outlines further work proposed to ensure the Trust maintains a continued focus on the violence and aggression agenda.			
Implications: (Clinical, Organisational, Governance, Legal?)	• Protection of staff health, wellbeing, and safety • Ensuring provision of treatment within legal NHS framework, whilst protecting our people from unreasonable behaviours. • Challenge of determining if patient actions are linked to mental health issues, or just unacceptable behaviours.			
Risks: (Top 3) of carrying out the change / or not:	The top 3 risks are; 1. Inability to reduce violence and aggression towards staff at UHS effecting staff wellbeing 2. Inability to meet the Trust policy and national guidance on violence and aggression 3. Increase in staff absence due to violence and aggression incidences, impacting on services and finances			
Summary: Conclusion and/or recommendation	The Trust Board is asked to: • Note the report and continued progress made to date • Note the improvement in the 2021 staff survey in this area • Note that reported incidents of violence and aggression across the organisation are likely to increase as awareness of the agenda and its management across the Trust grow particularly around the area of hate crime • Note there is still considerable work to be done across the organisation, with external partners and the local community to raise awareness and support action being taken against offenders			

1. Background

1.1 A paper was presented to Board in December 2021 providing an update on progress made around the violence and aggression agenda following the financial investment made by the Trust to support ongoing work in this area. The need for Board support and investment had been highlighted by the increase in prevalence of abuse towards our staff and subsequent impact on staff wellbeing identified in the 20/21 staff survey, compounded by staff accounts presented to Board. Whilst significant progress had been made it was noted that further focused work was required.

1.2 This paper outlines the progress that has been made around the violence and aggression agenda, acknowledging what had been achieved, noting the positive impact this has had on our staff but also highlighting the ongoing work that needs to be done as the problem of violence and aggression towards our staff and within the community continues to grow.

2. Detailed Report

Progress made to date is summarised below:

Policies, procedures, and processes

2.1 The exclusion policy, supported by Trust Board was launched in 2021 and has now been in place for a full year. It has been well received by staff across the organisation, particularly in areas identified as violence and aggression hot spots such as medicine. More recently the emergency department have started using it for repeat attenders who are violent and abusive to staff.

2.2 It is interesting to note that the first part of the process, the warning letter, has been used on a number of occasions yet to date we have only had to escalate to a yellow card once. The decision to issue a yellow card is managed through the complex patient review group. This would indicate that issuing a formal warning is resulting in a change in the behaviour of the individuals involved. The recent yellow card case is due to be reviewed by the steering group in September to ensure organisation-wide learning as we look to constantly improve and streamline our processes to provide proportionate and timely responses to incidents that support both our staff and patients. No red cards have yet been issued.

2.3 Whilst acknowledging the positive impact the introduction of the policy has made there is still significant work to be done in highlighting it more widely across the Trust to ensure uniform application. It is also important to note that whilst the policy is supportive in situations where a patient has capacity, areas that struggle with violence and aggression in patients without capacity have found it has limited application. The V&A group has been focusing on how these teams can be supported through training and education.

Reduction in Restrictive Practice

2.4 This has been an area of focus for the steering group covering two main work streams; education and training for staff and review of current restrictive practices.

De-escalation and Breakaway (disengagement) Training

2.5 Following investment by the Trust we have been able to train 8 staff from a number of clinical areas to become Maybo Facilitators (the nationally recognised method/approach to disengagement training). The VLE site for the training has been set up as a central point for all of the training and 1

day training has commenced with a soft roll out due to the pressures on the hospital. This is open to all staff and the teams have received good feedback not only on the actual training but on the difference it makes in real life situations.

2.6 Area specific days are due to roll out through July and August but speed and intensity of this has been impacted by the current pressures on the organisation, the ability to release clinical staff who are trainers as well as room availability within the Trust. In areas where violence and aggression is of high incidence care groups are supported to offer more training dates specific to their areas over and above what is available to the wider Trust. Acknowledging the volume and urgency for this training we are also looking to train further staff as facilitators in high incident areas such as NICU.

Review of Restrictive Practice

2.7 A working group has met several times and explored the definitions of restrictive practice. The breadth of experience in the group has highlighted that there are many practices within the acute trust that are restrictive and potentially breach national guidance which are not recognised as restrictive practices by clinical staff.

2.8 The need for clear guidance is evident and work has been undertaken to write a comprehensive policy on Reducing Restrictive Practice/ Restraint. The policy is in draft and is anticipated to go to the Mental Health Board and the Violence and Aggression Steering group as a first draft for discussion at the end of July early August respectively.

2.9 Communication is planned alongside the policy work to raise awareness around the definitions and reporting needs and also the importance of the training to learn strategies to de-escalate safely and within national guidance. Publicity on reducing restrictive practice will increase reporting, it is necessary for the Trust to have a true picture of the current situation. However, with the training and adoption of the techniques it is predicted to impact rates of restrictive practice over time.

Stakeholders

2.10 The Trust has continued to strive to strengthen its relationship with Hampshire Constabulary but the ambition of the partnership in relation to Operation Cavell has not been met by the resource currently available in the Force. We hope to work with the wider ICS to drive this agenda and to meet the commitments of Operation Cavell made by both organisations.

2.11 The Trust continues to have a good working relationship with the local Violence Reduction Unit (VRU) and following the successful joint bid to improve road safety around the site we look to work on collaborative projects that promote safety for our staff through work within the community.

Security Management

2.12 Following a thorough recruitment campaign undertaken four months ago, we are pleased to note that Charlie Capp commenced working with the Trust as the new Local Security Management Specialist (LSMS) at the beginning of July. Charlie joins us with extensive security experience from the MOD, having been employed by AWE Aldermaston for the last five years as Warhead Security Ops Lead. Prior to working for the MOD, Charlie has worked in the NHS as Head of Security and as LSMS.

2.13 While only being with the Trust for two weeks, Charlie has dived straight in supporting the management of a number of significant challenges across site. Over the coming couple of months,

the plan will be to work up an annual schedule of security engagement across the Trust, including V&A, theft and crime awareness. One of his initial key priorities will be to build upon existing stakeholder relationships to highlight the growing problems that we face in this area and to support a united response to the approach taken.

Enhanced security

2.14 The funding secured for enhanced security in the Emergency Department (ED) has provided 24/7 presence in the ED, which comprises of: two Security Officers per 12 hrs providing 24hr cover, 7 days a week. This commenced on 1st Sept 2021 and has also freed up security provision for the rest of the organisation.

2.15 It is understood that this provision has been very well received by the Emergency Department Teams but it remains too early to provide substantive evidence to measure the impact of the additional resource. However, with the increased numbers of attendances, we are not seeing an increase in Restraints or Absconding patients within the Emergency Department, these have remained stable, rather than increased and we are providing good responses to the rest of UHS. (see appendix 2)

2.16 This month the ED department is also due to commence a trial providing body worn cameras for clinical staff (already utilised by our security teams) following positive intel from other ED departments nationally that have already taken this step. It is hoped to act as a deterrent to potential offenders, as well as offer additional support to staff should a situation escalate and the police become involved, providing evidence to enable potential convictions. The pilot has been well received by ED staff and will be accompanied by additional media to highlight this step has been taken.

Perimeter Lockdown

2.17 Money was secured following the March paper to support the phased lockdown of the perimeter of the site. The work was sent out to market two months ago, it was anticipated that this work should have been progressed. However, due to significant delays and issues with the supplier, the decision was taken to go back out to the market to find a new supplier to move the project forward. The work package is back out to market and anticipated to start in January 2023.

Staff Support

2.18 Given the significant impact violent and aggressive behaviours can have on our staff, since February 2021, TRIM support has been offered to all staff involved in incidents captured through the Adverse Event Reporting system. The TRiM team will then advise, participate in a TRiM incident briefing (if required) and in all cases will send out support leaflets including a bespoke one around violence and aggression, as well as an invitation to a voluntary 1:1 with a TRiM practitioner. Staff choose whether they want to be supported by a peer in their own area/profession (where available) or someone else. At a 1:1, they receive a supportive conversation, are risk assessed and signposted to further support, where appropriate. Following NICE trauma guidance of 'watching and waiting' for 4 weeks, a follow-up 1:1 is arranged at one month. Feedback forms for service users are being sent out from August 2022 so that we can capture staff feedback on this service. Feedback from our peopleis all positive, with people appreciating the opportunity to talk about the impact of the incident and where necessary, be signposted for further support.

Summary Data of TRiM Support of Staff Involved in V&A Incidents Jan-June 2022:

Total V&A Incident Referrals	Total Invitation Letters/Support leaflets sent	Total 1:1 support facilitated
375	**453**	**25**

See Appendix 2 for a detailed breakdown on incidents reported.

Hate Crime

2.19 In previous papers the increasing incidence of hate crime across the organisation has been noted and the group has worked to raise awareness. This has been supported by the roll out of the allyship training across the Trust, supported by the Violence and Aggression steering group.

2.20 Although prevalent across the whole organisation reporting suggests that the ED department is a particular area for concern. As a result of this some ICS funding was secured to develop a bespoke simulation training with the team that developed the UHS allyship training to support, educate and empower ED staff around this issue. Staff are currently involved in the development of this with a plan to roll out later this year.

Communication - Increasing awareness and reporting

2.21 Communications have been centred around developing a plan to support the long-term priorities of the Violence and Aggression group. Discussions have been had with the wider group to agree what those priorities are and below is a summary of how a communications plan will support those objectives. In addition to that the group is taking every opportunity to reinforce the No Excuse for Abuse messaging externally, particularly at times of high pressure on services.

2.22 Internal focus here is to increase the evidence base of the scale of hate crime around the trust. The group is aware of anecdotal evidence but don't have an accurate picture of incidents so that responses and support can be properly targeted. The aim of the comms campaign will be to increase awareness of what hate crime is, how to report hate crime specifically whether as a victim or witness and the importance of doing so.

2.23 Plans also include repurposing some allyship testimonials for use internally to promote the training. Externally the group is looking to establish better comms links with the city-wide hate crime network and share resources externally particularly about being a reporting centre for hate crime.

2.24 The steering group has identified the need to relaunch the exclusion policy and encourage reporting to improve awareness of the process. The group felt that a year into the policy being launched, a push on reminding people it was there and how to use it was important. Comms will focus on using case studies and real-life experience of where implementation has worked as well as how we can share good practice to de-escalate situations.

General awareness of proactive work/local solutions/support available

2.25 The priority was around spotlighting local solutions to violence and aggression issues, including de-escalating violent behaviours, using breakaway areas and the use of enhanced care plans. Looking to the group to support a comms plan by providing examples and case studies of what could be highlighted through internal platforms.

2.26 From there the group can build up messaging around the support available once the reporting is known and again use real-life examples of how support may have positively impacted and helped colleagues.

3. Next Steps

3.1 The problem of violence and aggression towards our staff continues to be a concern and whilst we have put in place different measures, both locally and nationally incidents continue to increase and as a Trust we need to continue to strive to find more ways to support our staff. The 2021 staff survey results suggested an improvement in staff experience in this area as we move from being a national outlier on violence and aggression to being in line with national averages (see appendix 3).

3.2 Although it is clear that the work of the Violence and Aggression group has made a difference to staff, there is still much to do. As locally and nationally violence to NHS workers increases, we need to look to find further measures to support our staff, whilst working with external stakeholders to influence work within our local community. Our staff and local community need to see that the organisation doesn't tolerate violence and aggression, by putting reduction measures in place but also by providing robust support for those who are affected.

3.3 Whilst we will never be able to fully eliminate violence and aggression from the organisation particularly in cases where our patients lack capacity, we need to find new methods to plan and support the safe management of these patients. Working with and listening to these teams will be how this is achieved.

4. Recommendations

The Board is asked to:

- Note the report and progress made to date
- Note the improvement in the staff survey in this area
- Note that reported incidents of violence and aggression across the organisation are likely to increase as awareness of the agenda and its management across the Trust grow particularly around the area of hate crime
- Note there is still considerable work to be done across the organisation, with external partners and with the local community to raise awareness and support action being taken against offenders

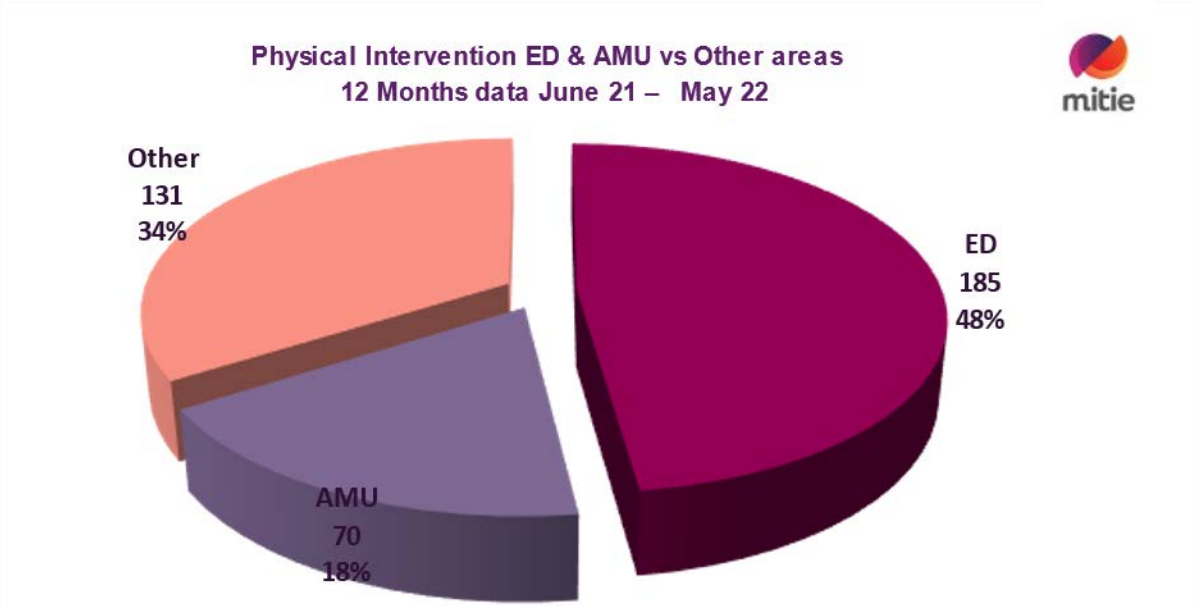
Appendix 1

TRiM referrals by category.

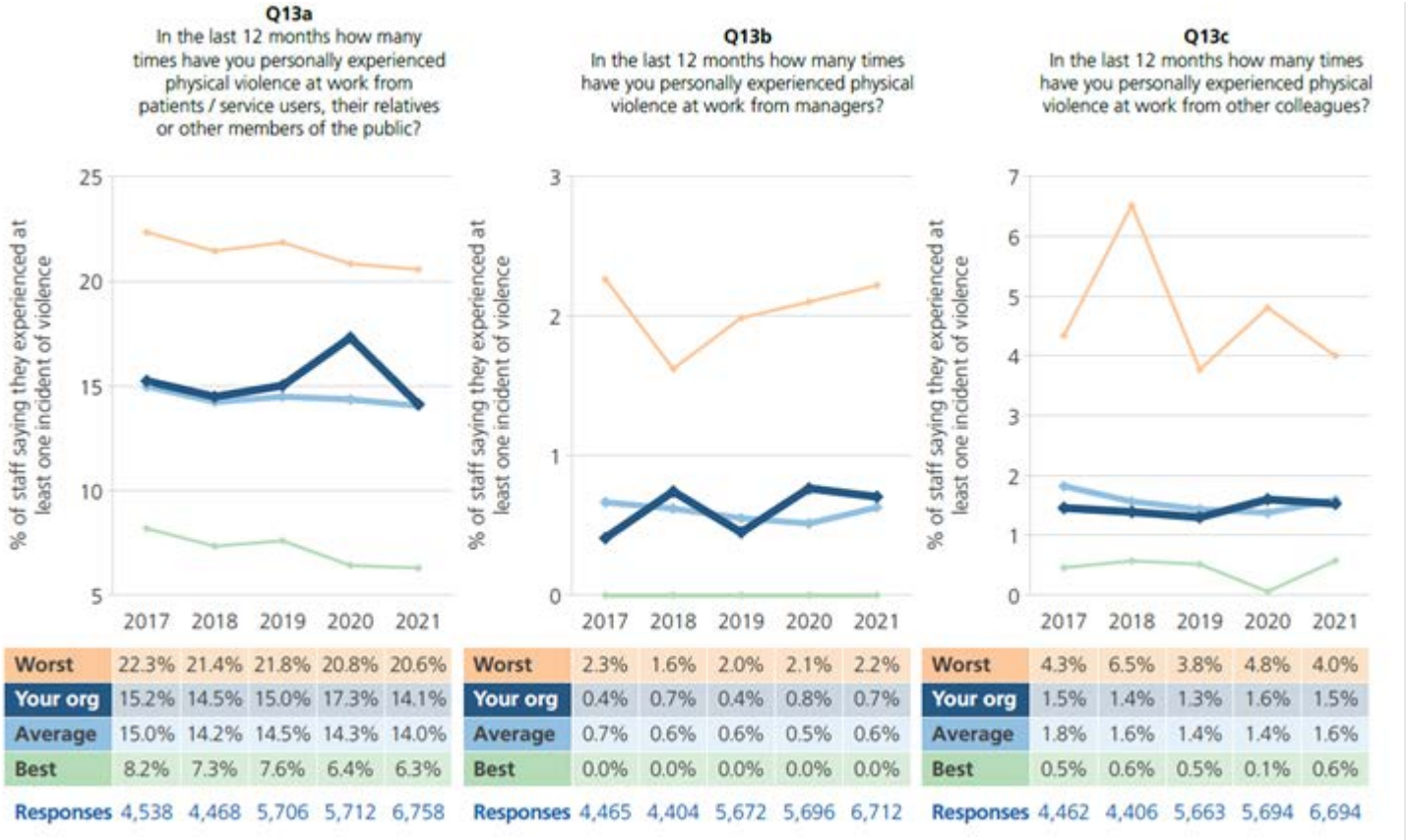
Breakdown by AER Category

AER Category Type	*Total No. of Incidents referred*
Physical aggression – patient to staff	161
Physical aggression – relative to staff	5
Physical aggression – staff to staff	2
Physical aggression – patient to patient (impact on staff)	0
Verbal aggression patient to staff	73
Verbal aggression – relative to staff	12
Verbal aggression staff on staff	2
Verbal aggression – patient to patient (impact on staff)	0
Challenging behaviour generally	30
Challenging behaviour patient to staff	55
Challenging behaviour – relative to staff	0
Challenging behaviour staff to staff	5
Discrimination, race, colour, ethnicity – *unclear who coming from to staff*	
Discrimination – race, colour, ethnicity – patient to staff	20
Discrimination – race, colour, ethnicity – relative to staff	1
Discrimination – race, colour, ethnicity – staff to staff	1
Discrimination – gender	0
Sexual aggression patient to staff	1
Sexual aggression relative on staff	1
Patient Self-Harm (Impact on Staff)	4
Other	2

Appendix 2



Appendix 3



<table>
<tr><td colspan="5">Report to the Trust Board of Directors</td></tr>
<tr><td>Title:</td><td colspan="4">Corporate Objectives 2022/23 – Quarter 1 review</td></tr>
<tr><td>Agenda item:</td><td colspan="4">6.1</td></tr>
<tr><td>Sponsor:</td><td colspan="4">David French, Chief Executive Officer</td></tr>
<tr><td>Author:</td><td colspan="4">Christine McGrath, Director of Strategy and Partnerships</td></tr>
<tr><td>Date:</td><td colspan="4">28 July 2022</td></tr>
<tr><td>Purpose</td><td>Assurance or reassurance</td><td>Approval y</td><td>Ratification</td><td>Information</td></tr>
<tr><td>Issue to be addressed:</td><td colspan="4">The Corporate Objective for 2022/23 were approved by the UHS Board in April 2022.</td></tr>
<tr><td>Response to the issue:</td><td colspan="4">This paper provides an update regarding achievement of the Quarter 1 objectives.

The agreed objectives have been colour coded:
Green = Achieved
Amber = Partially achieved / full achievement delayed
Red = Not achieved / achievement delayed

Additional notes are provided for further information.
Achievement has been good, with the vast majority of Q1 objectives achieved.
A summary of Q1 achievement is as follows:

<table>
<tr><th>Q1 2022/23</th><th>Plan</th><th>Green</th><th>Amber</th><th>Red</th></tr>
<tr><td>Outstanding patient outcomes, safety and experience</td><td>14</td><td>11</td><td>3</td><td>0</td></tr>
<tr><td>Pioneering research and innovation</td><td>12</td><td>11</td><td>1</td><td>0</td></tr>
<tr><td>World Class people</td><td>3</td><td>3</td><td>0</td><td>0</td></tr>
<tr><td>Integrated networks and collaboration</td><td>10</td><td>5</td><td>4</td><td>1</td></tr>
<tr><td>Foundations for the future</td><td>11</td><td>7</td><td>2</td><td>2</td></tr>
<tr><td>Total</td><td>50</td><td>37</td><td>10</td><td>3</td></tr>
</table></td></tr>
<tr><td>Implications: (Clinical, Organisational, Governance, Legal?)</td><td colspan="4">Achieving appropriate corporate objectives which are aligned to our Values, Strategic Ambitions, Legal and Regulatory requirements will have positive impacts.</td></tr>
<tr><td>Risks: (Top 3) of carrying out the change / or not:</td><td colspan="4">In the absence of this process, we would risk:
• failing to take the right steps, over the next year, in order to support achievement our longer-term strategic ambitions
• not being able to appropriately monitor progress and make corrective adjustments when required</td></tr>
<tr><td>Summary: Conclusion and/or recommendation</td><td colspan="4">The attached review against Q1 milestones is provided for assurance.</td></tr>
</table>

Outstanding patient outcomes, safety and experience						
Ref	**Short title**	**Lead**	**Q1**	**Q2**	**Q3**	**Q4**
1(a)	Recovery, restoration and improvement of clinical services	COO/ CMO/ CNO	Recovery, operational & activity plans for H1 and winter 2022/23 Operational plan complete for H1, winter plan will be presented in September Submit business case to Trust Investment Group (TIG) for development of Transcatheter Aortic Valve Implantation (TAVI) lab 6 Case going to TIG July 2022 Sign off Trust Strategy for Advice & Guidance (A&G) and plans to reduce follow-ups and initiate Complete Launch of Theatre pathway improvement programme Complete Sign off Trust road map for patient communications Process commenced to contact a cohort of patients on waiting list on a systematic basis to check their status & offer access to a clinician if needed. Starting with current waiters, exercise will also extend to outpatients & patients still on pathway. Additionally, we have developed a patient communications roadmap for the year setting out our proposed actions with timescales. This is draft and will be signed off in quarter 2.	Based on Urgent Care Village (UCV) pilot agree next steps including options appraisal to Trust Executive Committee (TEC) / Trust Board (TB), whichever is more suitable. Secure TIG/TB agreement for CAR-T plan TIG/TB Phase 2 of the theatre improvement programme initiated and second theatre pathway enabler transformation identified and initiated.	Open 25% of allocated cardiac capacity in new cardiac theatre Genomics – implementation of two site one service model Initiate phased implementation CAR-T plan	Commission new MRI x 3 C level vertical extension Commission Cath Lab 6 (TAVI) Achieve national targets for: -A&G (16 per 100 First Out-Patient Appointment (OPFA)) and -Patient Initiated Follow Up (PIFU) (5% of all Outpatient Appointments (OPAs) discharged with PIFU) Phase 2 of the theatre improvement programme completed and Phase 3 initiated.

Outstanding patient outcomes, safety and experience						
Ref	**Short title**	**Lead**	**Q1**	**Q2**	**Q3**	**Q4**
		CNO/ COO	Sign off detailed project plan for inpatient flow programme. Complete Ensure no patient waits longer than 104 weeks at the end of Q1 and ensure delivery of elective target of 104% of activity baseline. Complete (other than a few patients who chose to wait)	Embed use of electronic bed states, map 7-day services, focus with wards on embedding criteria to reside and discharge planning / time for tomorrow, embed review of length of stay in performance meetings, new Onward care referral (OCR) form live on APEX, agree priorities based on scoping for first 12 hours, first 10 days and 10+ days and have first virtual wards running. Ensure no patient waits longer than 104 weeks throughout Q2 and ensure delivery of elective target of 104% of activity baseline.	Focus on next six priorities and embed pathway changes agreed in Q2 Ensure no patient waits longer than 104 weeks throughout Q3 and ensure delivery of elective target of 104% of activity baseline.	Deliver final six priorities and ensure work is embedded as BAU. Agree either continuation of the project in some form or wind-down plan. Ensure no patient waits longer than 78 weeks at the end of Q4 and ensure delivery of elective target of 104% of activity baseline.
1(b)	Introducing a robust and proactive safety culture	CMO/ CNO	Initiate roll-out of national patient safety syllabus levels 1&2 Levels 1&2 available via VLE or E LFH. Currently over 100 staff have completed. We continue to promote via governance and education teams. Initiate work to develop UHS Human Factors strategy	Initiate roll-out of national patient safety incident response framework	Initiate roll-out of national patient safety syllabus levels 3&4	Initiate roll-out of national patient safety syllabus level 5 Launch Human Factors Strategy

Outstanding patient outcomes, safety and experience						
Ref	**Short title**	**Lead**	**Q1**	**Q2**	**Q3**	**Q4**
			Workstream continues. A framework of behaviours has been developed linked to the trust values. Work ongoing about standardising HF language across Trust.	Recruitment and training of quality and patient safety partners and supporting them to become active members of patient safety steering group and serious incident scrutiny group	Identify quality and patient safety partner (QPSP) to sit as an active member of patient safety steering group and serious Incident Scrutiny Group, which must be completed by September 22 (national objective)	Review progress against national expectation of roll-out of national patient safety incident response framework and plan for 2023/24
1(c)	Empowering and developing staff to improve services for patients	CMO	Plan for further shared decision making (SDM) roll-out and delivery against CQUIN In progress and on target: The SDM CQUIN specialities have been agreed with the ICS and baseline assessments have been undertaken for all target areas.	Deliver SDM CQUIN		
1(d)	Always Improving strategy	CNO/ COO	Launch ward based coaching programme Complete - programme launched Commence co-produced quality and patient safety partners programme Complete - programme commenced	Establish governance structure for organisational change programme established trust-wide Design 3-year plan for organisational change to support Always Improving strategy	Quality and patient safety partners embedded into first workstreams Evidenced benefits delivered through local change projects supported Host Always Improving conference	Comprehensive improvement educational offering available to staff at a level appropriate to their needs/roles. Staff survey indicates increase in ability to make improvement at UHS (questions 3d,e,f)
1(e)	Delivering a high-quality experience of care for all	CNO/ CMO	Recruit to health inequalities posts and establish health inequalities programme focusing on access, experience, and outcomes	New Experience of Care Strategy and associated charity programmes	Initial pilot of medical examiner service into the community with selected primary care networks (PCNs) to develop and test new referral processes	Full-roll out of medical examiner service to cover all non-coronial deaths in Southampton and the surrounding areas

Outstanding patient outcomes, safety and experience						
Ref	**Short title**	**Lead**	**Q1**	**Q2**	**Q3**	**Q4**
			Post appointed to and start date 15th August. Initial areas of focus defined and will commence when postholder starts. Progress Patient Support Hub strategic programme including diabetes support initiative Diabetes support initiative near launch - recruitment to specialist volunteer roles underway and in progress. Goes live 18th July	Constitute new Learning from Deaths committee as part of overall integrated strategy for improved end of life care, learning from deaths and expanded medical examiner service.	Launch of Patient Support Hub 'waiting well' initiative to support patients and carers facing long waits. FFT SMS surveys fully operational and embedded, driving increased response rates across emergency and urgent care departments	Health Inequalities report and provisional Trust strategy / action plan submitted to Trust Board

Pioneering research and innovation						
Ref	**Short title**	**Lead**	**Q1**	**Q2**	**Q3**	**Q4**
2(a)	Deliver year 2 of the research and innovation investment plan including the Southampton Emerging Therapies and Technologies Centre (SETT), Research Leaders programme (RLP) and delivery infrastructure	CMO/Dir. of S&P	Formal launch of SETT Innovation Centre (medtech trials component) SETT launched during UHS/UoS 50th Anniversary research event Establish refreshed Research Leaders Programme (RLP) oversight and operational boards Governance structure established Initiate RLP cohort 1 and launch call for cohort 2 Complete Implement strategy to address oncology pharmacy capacity Complete: monitoring impact Implement National Institute for Health and Care Research (NIHR) portfolio research reset process Complete Consider implications of DHSC Future of Clinical Research Delivery report, agree response and initiate Complete. Immediate actions initiated. Longer term response will form part of strategy.	Review Advanced Therapy Treatment Centre (ATTC) Midland and Wales network portfolio and identify expanded study pipeline for development. Regional NHSx TRE business case submitted in response to call	SETT Board established and governance for workstreams in place Initiate RLP cohort 2 and launch call for cohort 3	Commence delivery (TRE) and ATTC studies Plan evaluation of RLP cohort 1 to be conducted in Q1 2022/23 Pilot new digital solutions for patient identification, patient recruitment and data capture SCREI formal launch

Pioneering research and innovation						
Ref	**Short title**	**Lead**	**Q1**	**Q2**	**Q3**	**Q4**
2(b)	Strategy and Partnership working	CMO/Dir. of S&P	Deliver 50th Anniversary UHS/UoS Partnership celebration event. Delivered Commence review for UHS research strategy 2023-2025 Strategic review for UHS research strategy 2023-2025 commenced Joint University of Southampton (UHS/UoS) external review of cancer sciences research. Review complete. UHS Director of Strategy and Partnerships participated on the external review panel. Submit Cancer Research UK (CRUK)/NIHR Experimental Cancer Medicine Centre (ECMC) renewal Application June 2022 CRUK/NIHR ECMC renewal application submitted Secure NIHR Biomedical Research Centre (BRC) and NIHR Patient Safety Research Collaboration (PSRC) funding BRC awarded & funding confirmed. Awaiting PRSC result Present Wessex Health Partners (WHP) business case to TB. WHP BC finalised and approved. Level of investment does not require TB approval.	Submit CRUK Southampton Clinical Trials Unit (SCTU) full application	Secure CRUK/NIHR Experimental Cancer Medicine Centre (ECMC) award Establish, with system partners, WHP in line with business case Implement regional clinical trial hub model Clinical Research Network ((CRN) Wessex led) Present proposed areas of strategic growth to Senior Operations Group for review and incorporate ambition for growth / development into UHS Research Strategy	Secure TB approval of Research Strategy and launch. Secure CRUK SCTU Award Launch WHP Create strategic research growth plans across UHS/UoS partnership and identify potential funding opportunities as they arise

World Class people						
Ref	**Short title**	**Lead**	**Q1**	**Q2**	**Q3**	**Q4**
3(a)	Thrive: Growing developing, innovating our workforce	CPO	Develop and initiate 2022/23 operational workforce plan Workforce plan for 22/23 signed off as part of operating plan for UHS. Design and initiate plan to reduce reliance on temporary staffing. Action plan created and being implemented for agency control for all staff groups. Continuing with substantive recruitment and retention actions to improve perm staff position.	Refresh Trust volunteer strategy to incorporate all voluntary partners, align objectives, and ensure ambitious plans for UHS volunteering.	Establish a strategic five-year outline workforce and education plan for UHS, including demand and supply opportunities.	Deliver a plan to increase apprenticeships by 20% compared to the number of starters 2021-22. Deliver a reduction in healthcare assistant (HCA) vacancy and turnover. Reduce current vacancy level from 21% to 10% Build a greater sense of belonging in HCAs to improve retention. Hit key milestone of 250 new volunteers recruited into Trust volunteer roles.
3(b)	Excel: A great place to work, develop and achieve		Launch a refreshed appraisal framework, including a focus on our corporate strategy. Refresh complete and new process launched. Increases in uptake in appraisal during April and May.	Refresh and launch our forward wellbeing offer post-COVID. Ensure a range of well-being measures to support physical and mental health.	Agree refreshed approach to talent management and succession planning, including launching the UHS careers conversation. Completion of a new roof garden Increase the participation rate in the national NHS staff survey from 55% to 60% in 2022	Recover our focus on people development post-COVID, increasing appraisal coverage to 90% by 31 March 2023. Completion of a new wellbeing centre Launch the refreshed Hospital Heroes Awards aligned to our values with a new 'We are UHS' Awards. Protect our UHS family through the delivery of the 2022/23 vaccination campaign (flu and COVID TBC) against national targets

World Class people						
Ref	**Short title**	**Lead**	**Q1**	**Q2**	**Q3**	**Q4**
3(c)	Belong : Compassionate and inclusive workplace for all	CPO		Refresh and re-launch equality, diversity and inclusion (EDI) strategy	To support the Chief Nursing Officer in a staff engagement programme, 'We Are UHS' to drive pride across the UHS family Through engagement with our people, refresh the underpinning behaviours of our Trust values and produce a new behaviours framework. This will underpin future leadership development and organisational development (OD) interventions.	Deliver annual EDI objectives showing improvements in WRES, WDES and gender experience

Integrated networks and collaboration						
Ref	**Short title**	**Lead**	**Q1**	**Q2**	**Q3**	**Q4**
4(a)	Work in partnership with ICS and PCNs	CEO/ CMO/ Dir. of S&P	UHS strategic intent for Southampton and SW Local delivery system (LDS) determined and partners engaged. Secure TB steer on MOFD/CTR approach. UHS strategic intent for Southampton and SW Local delivery system (LDS) determined and partners engaged. MOFD/CTR TB paper being presented July 2022. Agree with partners, future role of Acute Provider Collaborative (APC) Board and initiate plans to realise Role agreed with partners and paper submitted to ICB for consideration. Of four themes, two are progressing and ICB resource to support has been requested for remaining themes.	LDS plans agreed and initiated. Scope fully new options to address MOFD/CTR subject to TB steer and agree business cases. Agree approach to Specialised commissioning with Hampshire and Isle of Wight (HIOW)integrated care system (ICS) partners	UHS leadership mapped and connected to ICS new leadership structure ensuring UHS strongly represented, gaps identified and action to remedy initiated.	S&SW LDS governance strengthened, plans for 2022/23 delivered and 2023/24 agreed. APC 2022/23 plans delivered and 2023/24 priorities agreed.

Integrated networks and collaboration						
Ref	**Short title**	**Lead**	**Q1**	**Q2**	**Q3**	**Q4**
4(b)	Integrated Networks and Collaboration	CEO/ CMO/ Dir. of S&P	Complete intelligence gathering for prioritised networks and assess maturity. Agree and initiate 'next steps' for each prioritised network. In progress For urology area network (UAN) , constitute cross-system steering group. Achieved, UAN Steering Group constituted: UHS: HHFT :SDH Clinical Leads & UAN Trust management representation, with Senior ICB Commissioner participant Secure TB, ICS and SE Region support for SSWHS CDC year 2 - 4 business case Sign-off process for CDC's nationally slipped by ~2 months. Final revised version of SSWHS yr 2-4 case to be submitted to ICS 15th July NHSE submission end of July with feedback expected end of Q2. Expected submission of bid to TB for review in September Establish UHS oversight group for system infrastructure (elective hub and community diagnostic centres (CDCs). CDC working group formed. Elective hub in process of being established.	Establish governance arrangements structures for remaining prioritised networks and agree project plans. Constitute UAN workstreams and working groups & agree performance management arrangements Secure TB approval for elective hub outline business case (OBC) and submit to NHSE	Top UAN priorities identified and plans to address commenced including draft pathways guided by GIRFT report Complete HIOW elective hub development of clinical ways of working Submit elective hub full business case (FBC) to TB and NHS England. Genomics – implementation of two site one service model	Review progress and agree 2023/24 plans for networks and system infrastructure.

Integrated networks and collaboration						
Ref	**Short title**	**Lead**	**Q1**	**Q2**	**Q3**	**Q4**
			Move fully to collaborative arrangements with partners for pharmacy procurement and distribution Not achieved - consolidation & move to PUH procurement hub has been extensively delayed & now under review. Since the approval of the case in 2019 several of the strategic drivers have diminished & the necessary IT infrastructure is not yet available. A review of the case is planned for the trust investment group in August 22.			
4(b)	Southern Counties Pathology Network	CEO/ CMO/ Dir. of S&P	Appoint Southern counties pathology network (SCPN) clinical lead and establish a next steps matrix to show how the network will move from current emerging status to mature by 2024 including options for redistribution of pathology work across SCP network. Next steps matrix complete and submitted to NHSE. BC being presented July TB. Interviews for Clinical Lead 8th July.		Submission of SCP network full business case to NHS as approved by the Pathology Network Board.	Go live of LIMS for all trusts in the network

Integrated networks and collaboration						
Ref	**Short title**	**Lead**	**Q1**	**Q2**	**Q3**	**Q4**
			Establish SCPN Digital Pathology (DP) Clinical Group and submit 3-year digital roadmap bid for NHSE funding for laboratory information management system (LIMS) & DP. Digital Pathology Clinical Group established, 1st meeting June and now monthly since. Digital roadmap bid submitted (UHS share - £550k for DP and £300k for LIMS). Result due by end of July. We are reasonably confident we will be successful.			
4(b)	Wessex Imaging Network (WIN)	CEO/ CMO/ Dir. of S&P	Submit business case and secure national funding (£30m) for WIN digital strategy, primarily for HHFT to join SWASH system. Business case submitted and funding requested by network has been confirmed.	Secure NHSE funding for SSWHS CDC years 2-4 business case. Commission yr 1 RSH U/S and Hythe CDC and scope use of CDC with Cancer Alliance Options for WIN network arrangements considered		HHFT join SWASH (might be next year) Option for WIN network arrangements agreed
4(c)	Collaborations	CFO/Dir. of S&P	Approach to develop wider strategic partnerships agreed and initiated Complete - Agreed as part of role of Interim Commercial Director and work initiated.	Agree UHS/UoS priorities to increase joint working in research, estates, education and enterprise.	Agree UHS/UoS joint influencing strategy	Agree list of master plan major capital developments requiring collaborative financial approach Secure TB approval of private patient collaboration strategy

Foundations for the future						
Ref	**Short title**	**Lead**	**Q1**	**Q2**	**Q3**	**Q4**
5(a)	Create a sustainable financial infrastructure	CFO	Finalise 2022/23 operating plan, including financial, activity, workforce and performance. Plan finalised.	Develop a medium-term financial plan for 2023/24 to 2024/25.	Approve a medium-term financial plan for 2023/24 to 2024/25.	Finalise 2023/24 operating plan, including financial, activity, workforce and performance.
			Deliver finances to plan or better than plan in Q1. Support delivery of the ICS financial plan. Not achieved - off-plan to date	Deliver finances to plan or better than plan in Q2, whilst targeting an improvement in the underlying financial position. Support delivery of the ICS financial plan.	Deliver finances to plan or better than plan in Q3, whilst targeting an improvement in the underlying financial position. Support delivery of the ICS financial plan.	Deliver finances to plan or better than plan for 2022/23, whilst targeting an improvement in the underlying financial position. Support delivery of the ICS financial plan.
			Develop a £33m savings programme - with at least 75% identification. Deliver savings to the profiled savings programme (15% by Q1) Not achieved - off-plan to date	Develop a £33m savings programme - with 100% identification. Deliver savings to the profiled savings programme (35% by Q2)	Develop a £33m savings programme - with 100% identification. Deliver savings to the profiled savings programme (65% by Q3)	Develop a savings programme for 2023/24. Deliver savings to the profiled savings programme for 2022/23 (100% by Q4)
			Finalise capital plan for 2022/23. Implementation of investments including an on-track capital programme and successful bids for national funding. Achieved and on-plan to date, with successful national funding bids	Implementation of investments including an on-track capital programme and successful bids for national funding.	Implementation of investments including an on-track capital programme and successful bids for national funding.	Implementation of investments including an on-track capital programme and successful bids for national funding.

Foundations for the future						
Ref	**Short title**	**Lead**	**Q1**	**Q2**	**Q3**	**Q4**
5(b)	Making our corporate infrastructure (estates and digital) fit for the future to support a leading university teaching hospital in the 21st century	COO	Estate masterplan finalised Estates Masterplan Finalised: The estates masterplan went to Trust Board on 30th June, with broad sign off. The next step is to finalise the external comms pack and publish. Adanac Park and Ride opened Completed and handed over to the Trust, scheduled to open 3rd week in July Exit LAMP testing facility, whilst retaining skilled staff and protecting UHS and UoS commercial interests. Complete - whilst continuing to explore future opportunities	Estate masterplan published widely Neuro Intensive Care Unit pendant replacement delivered Construction of aseptics and sterile services facilities commenced Ophthalmology new EPR system "Open Eyes" implemented Progress to HIMSS 5. Clinical noting app ready to/start roll out PowerBI usage increased compared to previous quarter	Complete paediatric intensive care unit (PICU) side rooms Business case for the future of the Chilworth LAMP facility developed 18-month security work plan developed covering all key aspects of security within UHS. Have a generic PROMs standard (equivalent to EQ5D) Register 200k active accounts with My Medical Record (MyMR) ready for digital virtual outpatients roll out Voice recognition. Migrate from Alden OKS service to Fluency Flex 3M service complete	Complete design works and tendering for the retained ICU refurbishment Trust Executive Committee review of draft estates strategy Complete the refurbishment of Theatres 10 and 11 Deliver £9m of critical infrastructure backlog maintenance programme Masterplan for remainder of the Adanac Park site agreed and business cases initiated List of master plan major capital developments requiring collaborative approach to funding agreed.

Foundations for the future						
Ref	**Short title**	**Lead**	**Q1**	**Q2**	**Q3**	**Q4**
			(MS 365) plan for future use of Sharepoint in place The project for office 365 has now been wound up with a proposal to initiate a new project for the Sharepoint element (new membership and terms). The steering group has not yet met but is being scheduled in. New Trust Validation Tool (LUNA) deployed across UHS providing visibility of Follow Up Pathways in the Trust Complete PowerBI usage increased compared to previous quarter Complete		MS 365 shared drive (G: O: V: Z: etc) migrations [to SharePoint] completed for all general use PowerBI usage increased compared to previous quarter	Digital outpatients PIFU for five sites already live with MyMR developed PowerBI usage increased every quarter Reduced the number of aged Follow Up Pathways across UHS delivered Clinical Noting App: 25% rolled out
5(c)	Recognising our responsibility as a major employer in the community of Southampton and our role in delivering a greener NHS	COO/CMO	Agree funding requirements to commence the delivery of the sustainability strategy A paper went to TIG in June to request funds for both hard and soft sustainability projects. Design fees were approved, and further information requested. This will be returned in August TIG.	Tender returns for energy procurement contract with full report to Board on outcomes		

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Board Assurance Framework (BAF)**			
Agenda Item:	**6.2**			
Sponsor	**Gail Byrne, Chief Nursing Officer**			
Date:	**28 July 2022**			
Purpose	**Assurance or reassurance** ✓	**Approval** ✓	**Ratification**	**Information**
Issue to be addressed:	The Board Assurance Framework (BAF) provides assurance against the achievement of our strategic objectives; highlighting those that are at risk of not being delivered. The BAF provides evidence to support the annual governance statement, and is a focus of CQC and audit scrutiny. This report sets out the strategic risks, control framework, sources of assurance and action plans. The BAF is a dynamic document that will reflect the Trust's changing strategic position.			
Response to the issue:	The BAF has been developed with input from responsible executives and relevant stakeholders. It satisfies good governance requirements on information and scoring. This report reflects recent discussion at the Audit & Risk Committee, incorporating gaps in control and assurance, as well as updated actions.			
Risks: (Top 3) of carrying out the change / or not:	The ability of the Board to effectively manage strategic risk is fundamental to the delivery of the Trust's strategic objectives, and is a core element of the CQC's 'well led' inspection process. An organisation that does not monitor its strategic risk through a Board Assurance Framework or similar document may not be aware of key risks, or may not understand failures in the control environment and actions planned to address these failures.			
Summary: Conclusion and/or recommendation	The Board Assurance Framework has been refreshed to reflect the updated corporate action plan for 2022/23, as well as recent increases in risk relating to finance and capacity. Scores and dates have been reviewed and updated with pragmatic targets. Key changes are the increases in score for the financial and capacity strategic risks.			

1. Purpose

The University Hospital Southampton Board Assurance Framework identifies the strategic ambitions and the key risks facing the organisation in achieving these ambitions. This paper provides the full Board Assurance Framework relating to the 2022/2023 strategic objectives.

This document seeks to provide assurance to the Board that the Trust is appropriately sighted on, and working to mitigate, key strategic risks through an appropriate governance structure.

It is acknowledged that several of the critical risks described are not expected to be mitigated for several years. While this might suggest that the organisation will tolerate these critical risks for an extended period, instead it should be understood that mitigations for these risks exist outside of the Trust: National and international drivers are responsible and controls are similarly to be implemented by the wider NHS infrastructure.

Following discussion at Board sub committees the Board Assurance Framework has been updated to reflect key gaps in both controls and assurances, and to reflect the updated corporate action plan. The strategic risk relating to Trust finances increased in score significantly, with enhanced action plan and new timeframe for mitigation. The risk relating to capacity and demand has also increased. The full BAF is provided as ***appendix 1***.

The Board is asked to consider:

- the level of assurance provided by the Board Assurance Framework and those areas or actions around which further assurance may be required, or conversely where excessive assurance is being sought;
- the appropriateness and timeliness of key actions to develop either the control or assurance framework for these strategic risks, and
- any risks to the delivery of our strategic objectives that are not currently included in the Board Assurance Framework.

Appendix 1

Trust Status

Trust status

Executive summary:

The key strategic risks for the Trust are:

- capacity (1a);
- staffing (3a); and
- the condition of the Trust's estate (5b),

all of which are interrelated. As of June 2022 the financial pressures on the Trust have been escalated, as each depends on funding to mitigate. The capacity risk has also increased in score reflecting worsening performance due to COVID.

The recent significant increase in COVID infections within the community has impacted on the number of patients being admitted with COVID symptoms, increasing staff absences, and bays being closed following contact. This adds increased pressure to the capacity and staffing limitations.

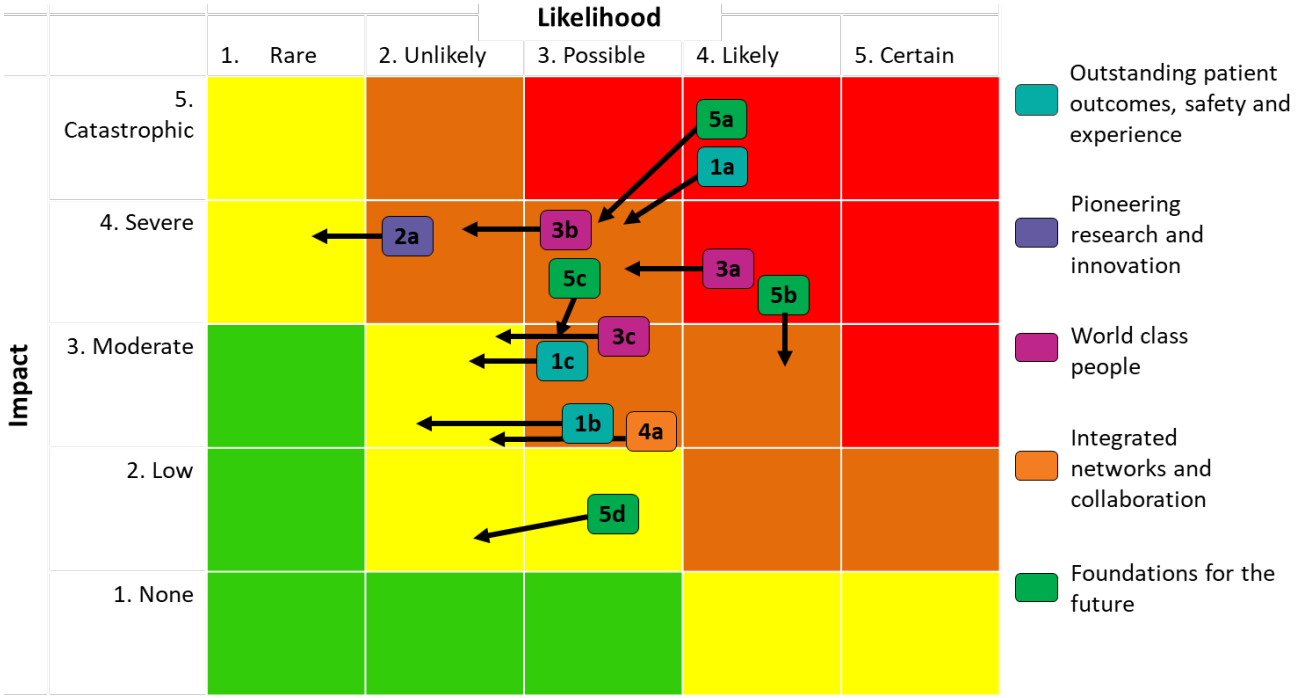
The Emergency Department remains very busy, with daily attendances frequently above 400. Patient flow also remains a challenge, with bed occupancy around 96%.

Increased capacity will not be available until 2023/24. The multi-year estates programme, to match the projected demand, has been agreed, however, there is likely to be significant pressure on capital in 2023/24 and 2024/25.

Trajectory:

The heatmap provided here summarises the current impact and likelihood scoring, along with an arrow illustrating the target score to be achieved through additional actions. The dates by which these scores are to be achieved have been RAG rated in the 'target score' column and the key is below.

*Date RAG:	1-3 months	4-7 months	8-11 months	12+ Months



Outstanding patient outcomes, safety and experience					Monitoring Committee: Quality Committee Executive Leads: COO, CMO, CNO	
1a) Insufficient capacity to respond to emergency demand, reduce wating lists for planned activity and provide diagnostics results in avoidable harm to patients						
Key Controls	**Gaps in Controls**	**Current Risk Score (I x L)**	**Key Assurances**	**Gaps in Assurance**	**Key Actions**	**Target Risk Score* (I x L)**
Use of independent sector to increase capacity Triage of patient lists based on risk of harm Consultant-led flagging of patients of concern Clinical Prioritisation Framework Capacity and demand planning including trajectories, surge capacity and continuity arrangements Specific operational plans for urgent care and cancer care Business continuity arrangements in place to provide continuity of care Outpatient, theatres and inpatient improvement programmes Successful staff and patient vaccination and testing programmes and dispensing of neutralising monoclonal antibody therapies (nMAD) to eligible patients in the community to reduce COVID-19 related hospitalisations	Primary and social care limitations are directly impacting on UHS – excess demand on primary care, impact of Brexit on social care, employment market for domiciliary/home care and care homes Limited funding, workforce and estate to address capacity mismatch in a timely way Lack of integrated care system (ICS) response and local strategy to manage demand in our emergency department as well as to address delays in discharge from the acute sector Staff capacity to engage in quality improvement projects due to focus on managing operational pressures	4 x 5 20	Clinical Assurance Framework, reported monthly to executive Live monitoring of bed occupancy and capacity data Monitoring of urgent care and cancer care pathways Monitoring and reporting of waiting times Harm reviews identifying cases where delays have caused harm.	ICS response to ineffectiveness of plans to reduce emergency demand and number of patients without criteria to reside impacting on flow. Data suggests waiting lists and ED performance are not likely to improve	Outpatient theatres and inpatient flow transformation programmes Review of ED workforce model Trial of urgent care village concept Review of local delivery system plan for reducing delays throughout the hospital. Deliver target of 106% of 19/20 baseline activity to secure additional funding and address waiting lists. Review plans to deliver no 78 week waiters by end of 22/23.	4 x 3 12 Apr-25

Outstanding patient outcomes, safety and experience	Monitoring Committee: Quality Committee
	Executive Leads: CNO, CMO

1b) We do not provide service users with a safe, high quality experience of care and positive patient outcomes.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Trust Patient Safety Strategy Organisational learning embedded into incident management, complaints and claims Learning from deaths and mortality reviews Mandatory, high quality training Health and safety framework Robust safety alert, NICE and faculty guidance processes Integrated Governance Framework Trust policies, procedures, pathways and guidance Recruitment processes and regular bank staff cohort Culture of safety, honesty and candour Clear and supportive clinical leadership Always Improving Programme	Experience of care strategy out of date, needing to be codesigned and codevelop with service users. COVID has caused delays here No agreed funding for the quality of outcomes programme to go forward beyond this year Staff capacity to engage in quality improvement projects due to focus on managing operational pressures	3 x 3 9	Monitoring of patient outcomes CQC inspection reporting: Good overall Feedback from Royal College visits Getting it right first time (GIRFT) reporting to Quality Committee External accreditations: endoscopy, pathology, etc. Kitemarks and agreed information standards Clinical accreditation scheme (with patient involvement) Internal reviews into specialties, based on CQC inspection criteria Current and previous performance against NHS Constitution and other standards Matron walkabouts and executive led back to the floor Quality dashboard, KPIs, quality priorities, clinical audits and involvement in national audits Integrated performance reporting Patient Safety Strategy Oversight Committee	None	**Introducing a robust and proactive safety culture:** Complete actions of gap analysis to enable launch of PSIRF in Q2 2021/22 Embed learning from deaths lead & lead medical examiner roles and develop objectives and strategy Return to full ward team reviews for pressure ulcers that were suspended during COVID. Implement the second round of Ockenden recommendations. **Empowering and developing staff to improve services for patients** Completion of SDM project, data analysis and formulate plan for ongoing roll-out, predominantly focussed on specialist services. To embed as business as usual from April 2023. **Always Improving strategy** Delivery of year 1 outpatients and theatres agreed quality, operational and financial benefits Increase specialties contributing to CAMEO	3 x 2 6 Mar-23

Outstanding patient outcomes, safety and experience					Monitoring Committee: Quality Committee Executive Leads: CNO, COO	
1c) We do not effectively plan for and implement infection prevention and control measures that reduce the number of hospital-acquired infections and limit the number of nosocomial outbreaks of infection.						
Key Controls	**Gaps in Controls**	**Current Risk Score (I x L)**	**Key Assurances**	**Gaps in Assurance**	**Key Actions**	**Target Risk Score* (I x L)**
Annual estates planning, informed by clinical priorities Digital prioritisation programme, informed by clinical priorities Infection prevention agenda Local infection prevention support provided to clinical teams Compliance with NHSIE Infection Assurance Framework COVID ZERO and #Don'tGoViral campaigns Digital clinical observation system Implementation of My Medical Record (MMR) Screening of patients to identify HCAIs Risk assessments in place for individual areas for ventilation, bathroom access, etc. to ensure patient safety.	Transmissibility of Omicron Non-compliant patients Refamiliarisation with response to resurgence of other common infections such as norovirus	3 x 3 9	Gold command infection control Hand hygiene and cleanliness audits Patient-Led Assessment of the Care Environment National Patient Surveys Capital funding monitored by executive NHSE/I infection assurance framework compliance reporting to executive, Quality Committee and Board Clinical audit reporting Internal audit annual plan and reports Finance and Investment Committee oversight of estates and digital capital programme delivery Digital programme delivery group meets each month to review progress of MMR Quarterly executive monitoring of Estates KPIs (maintenance, cleanliness, fire safety, medical devices, etc.)	None	Ongoing COVID ZERO and #Don'tGoViral campaign to expand to include all viruses supported by internal and external communications plan Review infection prevention measures in response to changes in guidance and move to 'living with COVID' Look to decentralise COVID pathways, with COVID positive patients to be cared for in the appropriate specialist areas.	3 x 2 6 Apr-23

Pioneering research and innovation					Monitoring Committee: Finance and Investment Committee Executive Lead: CMO	
2a) We do not secure the required ongoing investment to support our pioneering research and innovation, driving clinical services of the future.						
Key Controls	**Gaps in Controls**	**Current Risk Score (I x L)**	**Key Assurances**	**Gaps in Assurance**	**Key Actions**	**Target Risk Score* (I x L)**
Budget setting and bidding processes, overseen by the executive Research and Development Strategy	*None*	4 x 2 8	Regular reporting to Finance and Investment Committee Annual Research and Development Plan	*None*	Awaiting outcomes from the NIHR Patient Safety Research Collaboration and DHSC regarding funding requests.	4 x 1 4 Jul-22

World class people	Monitoring Committee: People and Organisational Development Committee
	Executive Lead: CPO

3a) We do not increase the UHS substantive workforce by 481 by March 2023 to meet current and planned service requirements through recruitment to vacancies and maintaining annual staff turnover below 12% and to develop a longer-term workforce plan to linked to the delivery of the Trust's corporate strategy.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
New 5 year People Strategy and clear objectives for Year 1 monitored through POD. Recruitment and resourcing processes Workforce plan and overseas recruitment plan General HR policies and practices, supported by appropriately resourced HR team Temporary resourcing team to control agency and bank usage Overseas recruitment Recruitment campaign Apprenticeships New recruitment branding and successful targeted campaigns in critical are, ED, Ophthalmology and theatres. Bank and agency cost project – Joint finance and HR controls	Multi-year workforce and education plan to be developed in cooperation with the wider ICS Implementation of talent management and development programme Appropriate resourcing of people directorate commensurate with ongoing recruitment and retention activity Workforce plan is a risk due to current recruitment market challenges, rising pay in private sector, and buoyancy of job market.	4 x 4 16	Fill rates, vacancies, sickness, turnover and rota compliance NHSI levels of attainment criteria for workforce deployment Annual post-graduate doctors GMC report WRES and WDES annual reports - annual audits on BAME successes Gender pay gap reporting NHS Staff Survey results and pulse surveys	Robust board reporting on wellbeing, belonging and morale	Approval of Year 1 objectives supporting delivery of the Trust's People Strategy Deliver workforce plan for 22/23 including increasing substantive staff and reducing temporary agency spend. Targeted campaigns in key areas. Refresh talent management and succession planning processes Deliver an increase in apprenticeships starters by 20% To deliver improved workforce deployment through continued expansion of the use of e-rostering, including for medical staff To meet the national requirements of the NHS England and NHS Improvement levels of attainment rostering maturity assessment Review of KPIs via IPR in light of new strategy to address identified gaps in assurance Agree long-term workforce education plan, including building relationships across the ICS and with education providers.	4 x 3 12 Mar-25

World class people	Monitoring Committee: People and Organisational Development Committee
	Executive Lead: CPO

3b) We fail to develop a diverse, compassionate and inclusive workforce, providing a more positive staff experience for all staff.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Great place to work including focus on wellbeing 22/23 Workforce planning completed to support COVID recovery Wellbeing and occupational health support for staff Guardian of Safe Working Hours **Building an inclusive and compassionate culture** FTSU guardian and FTSU policies Diversity and Inclusion Strategy/Plans Collaborative working with trade unions	Development of gender equality matrix (GEM) to provide measurements and assurance To recruit to the new network leads for the Trust and re-energise the network capacity and capability EDI strategy Values and behavioural frameworks	4 x 3 12	**Great place to work including focus on wellbeing** Annual NHS staff survey and introduction of quarterly pulse engagement surveys Guardian of Safe Working Hours report to Board Regular communications monitoring report Wellbeing guardian Staff Networks Exit interview process **Building an inclusive and compassionate culture** Freedom to Speak Up reports to Board Qualitative feedback from staff networks data on diversity Annual NHS staff survey and introduction of quarterly pulse engagement Insight monitoring from social media channels Staff listening sessions – 'Talk to David' Allyship Programme	Maturity of staff networks Maturity of datasets around EDI, and ease of interpretation	**Building an inclusive and compassionate culture** To deliver our inclusion plans to improve the experience of diverse staff, collaboratively with our networks and demonstrating improvement in our WRES and WDES scores Refresh and re-launch of the Trust's Wellbeing offer post COVID. Approval of Year 1 objectives supporting delivery of the Trust's People Strategy Improvement of diversity and inclusion insight and intelligence to inform priorities within divisions Creation of divisional steering group for EDI Re-launch a refreshed EDI strategy Deliver a programme on refreshing the underpinning behaviours to the Trusts Values Re-launch appraisal and talent management programme. refresh the underpinning behaviours of our Trust Values and produce a new behaviours framework. This will underpin future leadership development and OD interventions.	4 x 2 8 Mar-25

World class people	Monitoring Committee: People and Organisational Development
	Executive Lead: CPO

3c) We fail to create a sustainable and innovative education and development response to meet the current and future workforce needs identified in the Trust's longer-term workforce plan.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Education Policy Leadership and development opportunities, apprenticeships, secondments In-house, accredited training programmes Provision of high quality clinical supervision and education Access to apprenticeship levy for funding Access to CPD funding from HEE and other sources	Quality of appraisals Limitations of the current estate and access to offsite provision Access to high-quality education technology Estate provision for simulation training Staff providing education being released to deliver education, and undertake own development Releasing staff to attend training, due to capacity and demand	3 x 3 9	Annual Trust training needs analysis reported to executive Trust appraisal process GMC Survey Education review process with Health Education Wessex Utilisation of apprenticeship levy	None	**Great place to work including focus on wellbeing** To have recovered development and education of our people post pandemic (this includes improving appraisals carried out to 92% and appraisal quality as measured through the staff survey) Wellbeing programme Further develop education offer and formal launch of improvement education strategy/ five year education plan Approval of Year 1 objectives supporting delivery of the Trust's People Strategy Relaunch/refresh of the VLE need to be put down as a key action in terms of supporting people to access more self directed learning opportunities?	3 x 2 6 Mar-25

Integrated networks and collaboration					Monitoring Committee: Quality Committee Executive Leads: CEO, CMO, Director of Networks & Strategy	
4a) We do not implement effective models to deliver integrated and networked care, resulting in sub-optimal patient experience and outcomes, increased numbers of admissions and increases in patients' length of stay.						
Key Controls	**Gaps in Controls**	**Current Risk Score (I x L)**	**Key Assurances**	**Gaps in Assurance**	**Key Actions**	**Target Risk Score* (I x L)**
Key leadership role within local ICS Key leadership role within local networked care and wider Wessex partnership UHS strategic goals and vision Establishment and development of Hampshire and Isle of Wight Acute Provider Collaborative (HIoW APC) Establishment of UHS Integrated Networks and Collaboration Board focussing on delivery of the four network types, (Integrated community, Hospital networks, Specialised services and Diagnostic networks)	Potential for diluted influence at key discussions Arrangements for specialised commissioning – delegated from centre to ICS – historically national and regional, rather than local Form and scope of role for HIoW APC in relation to ICS and other acute provider collaboratives	3 x 3 9	CQC and NHSE/I assessments of leadership CQC assessment of patient outcomes and experience National patient surveys Friends and Family Test Outcomes and waiting times reporting	Delay in implementation of new ICS framework and structures until July 2022, and delay in implementation of changes to specialised commissioning to April 2023	**ICS and PCNs** Set priorities for 2022/23 **Integrated Networks and Collaboration** Urology Area Network plan to be agreed Identify appropriate programme management support for networks following appointment for Urology Area Network and approval for HIoW Eye Care Alliance Business case for future working of the Southern Counties Pathology Network due for consideration by Trust Board in early 2022/23 Business case development for aseptic services and elective hub by HIoW APC Further development of HIoW APC to drive improvements in outcomes Development of proposals for next phase for Community Diagnostics Centres Integrated networks and collaboration team set up. Several roles out to advert. Elective hub in Winchester – in final business case review. A two year plan to build, recruit, and open.	3 x 2 6 April-23

Foundations for the future	Monitoring Committee: Finance and Investment Committee
	Executive Lead: CFO

5a) We are unable to deliver a financial breakeven position and support prioritised investment as identified in the Trust's capital plan within locally available limits (CDEL).

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Financial strategy and Board approved break even plan Cost improvement programme (CIP, ~£45mil) and transformation programme (Always Improving) Additional income sources Robust business planning and bidding processes Engagement in ICS financial architecture Robust controls over investment decisions via the Trust Investment Group and associated policies and processes Robust controls over recruitment via the Recruitment Control Panel and associated policies and processes Established counter-fraud specialists and processes 2022/23 Operating Plan	Inflationary pressures, including price of energy Our restricted ability to run full elective programme, impacting on funding Impact of the pandemic on staff sickness levels, requiring high-cost backfill. Efficiency target of 4%.	5 x 4 20	Benchmarking of financial KPIs against other trusts Monitoring of the break even plan contained in regular finance reports to Board. Reporting of level of activity against spend, with executive oversight CQC assessment of use of resources Divisional performance on cost improvement reviewed by senior leaders on a quarterly basis Regular review of counter fraud control effectiveness via LCFS, reporting to Audit and Risk Committee ICS Capital Board overseeing CDEL Executive oversight of control groups	Current short-term nature of operational planning at a national level more generally	Deliver the forecast financial breakeven position for second half of 2022/23, targeting 106% elective activity Finalise and deliver 2022/23 operating plan (£33m of savings) including approach to COVID-19, elective recovery, investment in transformation and CIP and quantify unavoidable cost pressures underpinning deficit position Develop a medium-term financial plan for 23/24 to 24/25 Support the organisation to understand the impact and required cultural change relating to the new financial infrastructure Development of savings plan for 2022/23 Development of capital programme for future years Financial recovery programme and Board to be established, reporting to TEC	4 x 3 12 Mar-23

Foundations for the future	Monitoring Committee: Finance and Investment Committee
	Executive Lead: COO

5b) We do not adequately maintain, improve and develop our estate to deliver our clinical services and increase capacity.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Multi-year estates planning, informed by clinical priorities and risk analysis Up-to-date computer aided facility management (CAFM) system Asset register Maintenance schedules Trained, accredited experts and technicians Replacement programme Construction Standards (e.g. BREEM/Dementia Friendly Wards etc.) Six Facet survey of estate informing funding and development priorities Estates masterplan 22-32 approved.	Missing funding solution to address identified gaps in the critical infrastructure Timescales to address risks, after funding approval Operational constraints and difficulty accessing parts of the site affecting pace of investment including refurbishment	4 x 4 16	Compliance with Health Technical Memoranda monitored by estates and reported for executive oversight Patient-Led Assessments of the Care Environment Statutory compliance audit and risk tool for estates assets Monitoring at Finance and Investment Committee, including progress of capital investment and review of critical infrastructure risk and updates to Six Facet survey Quarterly updates on capital plan and prioritisation to the Board of Directors	Funding streams to be identified to fully deliver capacity and infrastructure improvements	Continue work on the estates strategy following the finalisation and agreement of the estates masterplan, including engagement with all clinical and non-clinical divisions Confirmation of impact of approved funding on critical infrastructure risk Identify future funding options for additional capacity in wards, theatres and diagnostics Delivery of 2022/23 capital plan Develop schemes for additional theatres and beds within UHS, and developing plan for HIOW elective hub. Develop the business case for the future of Chilworth LAMP facility. Deliver £9m of critical infrastructure backlog maintenance Agree plan for remainder of Adanac Park site	3 x 4 12 Apr-25

Foundations for the future					Monitoring Committee: Finance and Investment Committee Executive Lead: COO	
5c) We fail to introduce and implement new technology and expand the use of existing technology to transform our delivery of care through the funding and delivery of the digital strategy.						
Key Controls	**Gaps in Controls**	**Current Risk Score (I x L)**	**Key Assurances**	**Gaps in Assurance**	**Key Actions**	**Target Risk Score* (I x L)**
Digital prioritisation programme, informed by clinical priorities and safeguarded by clinical safety officers Global digital exemplar (GDE) recognition Digital strategy incorporating: • technology programme • clinical digital systems programme • data insight programme	Uncertainty around Hampshire and Isle of Wight ICS digital strategy and our direction of travel, including digital convergence, and alignment with wider expectations. Funding to technically refresh and for digital development, including the impact of proposals for 'levelling up' as part of funding distribution decisions for the funding available. Lack of workforce plan to retain staff needed to underpin strategy Development of a non-clinical/business systems strategy Greater alignment of Always Improving and digital transformation plans	3 x 4 12	Monthly executive-led digital programme delivery group meeting Finance oversight provided by the Finance and Investment Committee Quarterly Digital Board meeting, chaired by the CEO	Revised timetable to achieve paper switch-off target Difficulties in understanding benefits realisation of digital investment.	Achieve 200,000 My Medical Record (MMR) accounts and 30% paper switch-off Plan in place for generic PROM (patient-reported outcome measure) such as QOL (quality of life) 75% migration from outsourced transcription to digital speech recognition completed Digital ophthalmology system project 'open eyes' to be implemented Monitor opportunities for national funding for digital transformation Approve utilisation of funding received from Hampshire and Isle of Wight ICS Identify funding streams to support 2022/23 digital programmes and / or reduce programme in line with available funding. Develop clearer understandings of benefits across whole digital programme Develop digital literacy across trust to support rollout of new products Explore commercial partnership options to mitigate lack of UHS workforce to deliver strategy.	3 x 3 9 Mar-24

Foundations for the future					Monitoring Committee: Trust Executive Committee Executive Lead: CMO	
5d) We fail to prioritise green initiatives to deliver a trajectory that will reduce our direct and indirect carbon footprint by 80% by 2028-2032 (compared with a 1990 baseline) and reach net zero direct carbon emissions by 2040 and net zero indirect carbon emissions by 2045.						
Key Controls	**Gaps in Controls**	**Current Risk Score (I x L)**	**Key Assurances**	**Gaps in Assurance**	**Key Actions**	**Target Risk Score* (I x L)**
Governance structure including Sustainability Board (with patient representation), Sustainability Delivery Group and Clinical Sustainability Group Appointment of Executive Lead for Sustainability Green Plan	Clinical Sustainability Plan/Strategy (CSP) Sustainable Development Management Plan (SDMP) Long-term energy/decarbonisation strategy Communications plan	2 x 3 6	Progress against the NHS direct emission net zero target by 2040, with an ambition to reach an 80% reduction by 2028 to 2032 Progress against the NHS indirect emissions target to be net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039 Quarterly reporting to NHS England and NHS Improvement on sustainability indicators Green Plan and Clinical Sustainability Programme has been approved by Trust Investment Group and Trust Board.	Definition of and reporting against key milestones	Agree funding requirements to commence the delivery of the strategies Progress decarbonisation study and evaluation of potential for an energy performance contract (EPC) as part of the development of a specification ahead of the end of the Trust's energy contract in March 2023. Business case to be presented for approval in September 2022. Review green energy ambitions following extreme rises in electricity costs.	2 x 2 4 Sep-22

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Register of Seals and Chair's Actions**			
Agenda item:	**7.2**			
Sponsor:	**Jenni Douglas-Todd, Chair**			
Date:	**28 July 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. The following action has been undertaken by the Chair. There have been no seals affixed 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 Chair's action.			

1 Signing and Sealing

There have been no seals affixed since the last report.

2 Chair's Actions

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

2.1 **Single Tender Action** for the annual rental of Multi-Storey Car Park 4 at Southampton General Hospital for the period 24 June 2022 to 23 June 2023 to Canada Life Limited at a cost of £1,006,792 excluding VAT. Approved by the Chair on 11 July 2022.

3 Recommendation

The Board is asked to ratify the Chair's action.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Amendments to Constitution**			
Agenda item:	**7.3**			
Sponsor:	**Jenni Douglas-Todd, Trust Chair**			
Author:	**Karen Flaherty, Associate Director of Corporate Affairs and Company Secretary** **Helen Potton, Associate Director of Corporate Affairs and Company Secretary (Interim)**			
Date:	**28 July 2022**			
Purpose	**Assurance or reassurance**	**Approval** **Y**	**Ratification**	**Information**
Issue to be addressed:	Following a review of the composition of the council of governors of the Trust, the council of governors has agreed to alter the number of governors elected by the areas of the public constituency to ensure that these remain representative of those to whom the Trust provides services. Having reviewed the current areas of the public constituencies and the proportion of patients seen by the Trust from those areas, the following proposed changes have been agreed: • to reduce the number of governors representing the Rest of England by one governor; and • to increase the number of governors representing New Forest, Eastleigh and Test Valley by one governor. The council of governors has also agreed to maintain a representative on the council of governors from local commissioners as an appointed governor, following the transfer of functions from NHS Hampshire, Southampton and Isle of Wight Clinical Commissioning Group to NHS Hampshire and Isle of Wight Integrated Care Board taking effect on 1 July 2022. Other minor changes are proposed to be made to the current constitution identified as part of this review and to correct minor typographical and other errors. These changes include: • to reflect the transfer of functions from Monitor/NHS Improvement to NHS England from 1 July 2022; • to update the model election rules attached at annex 4 to the constitution to those published by NHS Providers in August 2014 (these have not yet been updated to reflect the transfer of functions from Monitor to NHS England, however references to Monitor should be read as referring to NHS England); • to remove appendix 4 to annex 8 as it duplicates provisions in paragraph 25 of the constitution, as amended, and the terms of reference for the governors' nomination committee; • to remove references to registers in paragraph 35 that are no longer maintained, or required to be maintained, by the Trust;			

	• to allow written resolutions of the council of governors to be signed electronically or to be approved by email rather than signed, reflecting current practice; • to delete the wording of the form of declaration to be used in the nomination form for elections to the council of governors as set out in the standing orders of the council of governors at annex 5 to the constitution so as to allow that this can be updated as required annually; • to allow the board of directors to determine matters by written resolution if required, reflecting similar provisions already in place in the standing orders of the council of governors; and • to specifically refer to the fit and proper persons checks in appendix 3 to annex 8. • to include reference in Annex 7 to the appointment of the deputy chair at 12.1 and senior independent director at 12.2.
Response to the issue:	The proposed amendments to the constitution, as shown in the attached draft, reflect the changes described above. All changes are intended to effect immediately following approval other than the changes to the elected governors, which are intended to take effect from 1 October 2022, the date on which newly elected and re-elected governors will take office and so will not affect the current terms of office of any serving governor. This is reflected in the proposed changes.
Implications: (Clinical, Organisational, Governance, Legal?)	This will ensure that the composition of the council of governors continues to be representative of the population served by the Trust, a requirement of the National Health Service Act 2006, and the constitution reflects current rules and practice.
Risks: (Top 3) of carrying out the change / or not:	1. The composition of the council of governors remains representative of the public, patients and members and otherwise appropriate. 2. Compliance with the National Health Service Act 2006, as amended. 3. The constitution reflects current practice of the Council of governors and the board of directors.
Summary: Conclusion and/or recommendation	The board of directors is requested to approve the proposed amendments to the Trust's constitution. The proposed amendments have been approved by the council of governors at their meeting on 20 July 2022.

University Hospital Southampton NHS Foundation Trust

(A Public Benefit Corporation)

Constitution

Version control

V1	UHSFT	10 April 2013
V2	UHSFT	2 July 2014
V3	UHSFT	23 May 2016
V4	Hempsons	10 June 2016
V5	DAC Beachcroft	April 2018
V6	UHSFT	January 2020
V7	UHSFT	June 2020
V8	UHSFT	1 April 2021
V9	UHSFT	28 July 2022

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1. **Name**

1.1 The name of the foundation trust is University Hospital Southampton NHS Foundation Trust (the **Trust**).

2. **Principal purpose**

2.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

2.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

2.3 The Trust may provide goods and services for any purposes related to:

2.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

2.3.2 the promotion and protection of public health.

2.4 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

3. **Powers**

3.1 The powers of the Trust are set out in the 2006 Act.

3.2 All the powers of the Trust shall be exercised by the board of directors on behalf of the Trust.

3.3 Any of these powers may be delegated to a committee of directors or to an executive director.

4. **Membership and constituencies**

4.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:

4.1.1 a public constituency; or

4.1.2 a staff constituency.

5. **Application for membership**

5.1 An individual who is eligible to become a member of the Trust may do so on application to the Trust.

6. **Public constituency**

6.1 An individual who lives in an area specified in annex 1 as an area for the public constituency may become or continue as a member of the Trust.

6.2 Those individuals who live in an area specified as an area for any public constituency are referred to collectively as a public constituency.

6.3 The minimum number of members in each public constituency is specified in annex 1.

6.4 An individual who ceases to live in any area specified in ~~Annex~~ annex 1 shall cease to be a member of any public constituency. A member who moves from one area to

another shall become a member of the public constituency for that new area. Members should notify the Trust of any change of address.

6.5 In the case of any doubt the Trust's decision as to whether or not an individual lives in an area shall be final.

7. Staff constituency

7.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:

7.1.1 he/she is employed by the Trust under a contract of employment which has no fixed term; or

7.1.2 he/she is employed by the Trust under a contract of employment which has a fixed term of at least 12 months; or

7.1.3 he/she has been continuously employed by the Trust for at least 12 months under one or more fixed term contracts of employment.

7.2 Individuals who exercise functions for the purposes of the Trust otherwise than under a contract of employment with the Trust may become or continue as members of the staff constituency if they have exercised those functions continuously for a period of at least 12 months. –For the avoidance of doubt, the definition of individuals who exercise functions for the purposes of the Trust includes individuals who are employed by a contractor but excludes any individual who is not employed by the Trust and is a Volunteer or works at the Trust under an honorary contract arrangement.

7.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the staff constituency.

7.4 The staff constituency shall be divided into four descriptions of individuals who are eligible for membership of the staff constituency, each description of individuals being specified within annex 2 and being referred to as a class within the staff constituency.

7.5 The minimum number of members in each class of the staff constituency is specified in annex 2.

7.6 An individual who is:

7.6.1 eligible to become a member of the staff constituency, and

7.6.2 invited by the Trust to become a member of the staff constituency and a member of the appropriate staff class within the staff constituency shall become a member of the Trust as a member of the staff constituency without an application being made, unless he/she informs the Trust that he/she does not wish to do so.

8. Restriction on membership

8.1 An individual who is a member of a constituency or of a class or area within a constituency may not, while membership of that constituency, class or area continues, be a member of any other constituency, class or area.

8.2 An individual who satisfies the criteria for membership of the staff constituency may not become or continue as a member of any constituency other than the staff constituency.

8.3 An individual shall not be eligible for membership of the Trust if he/she:

8.3.1 i~~t~~s under 16 years of age;

8.3.2 has demonstrated aggressive or violent behaviour at any of the Trust's hospitals and following such behaviour he/she has been asked to leave, has been removed or excluded from any hospital in accordance with the relevant Trust policy for withholding treatment from violent/aggressive patients.

8.3.3 has been confirmed as a 'vexatious complainant' in accordance with the relevant Trust policy for handling complaints.

8.3.4 has been removed as a member from another NHS foundation trust.

8.3.5 ~~He~~ is deemed to have acted in a manner contrary to the interests of the Trust.

All members of the Trust shall be under a duty to notify the secretary of any change in their particulars, which may affect their entitlement as a member.

8.4 A member shall cease to be a member on:

8.4.1 death;

8.4.2 resignation by notice in writing to the secretary;

8.4.3 removal under the procedure at paragraph 8.5; or

8.4.4 ceasing to fulfil the requirements of the constitution.

8.5 Where the Trust is on notice that a member may be disqualified from membership, or may no longer be eligible to be a member the secretary shall give the member 14 days' written notice to show cause why his/her name should not be removed from the register of members. ~~-~~On receipt of any such information supplied by the member, the secretary may, if he/she considers it appropriate, remove the member from the register of members.~~-~~ In the event of any dispute the secretary shall refer the matter to the council of governors to determine.

9. Annual ~~**Members' **~~**members' ~~Meeting~~meeting**

9.1 The Trust shall hold an annual meeting of its members (~~'Annual **~~**annual ~~Members' **~~**members' ~~Meeting'~~meeting**). ~~—~~The ~~Annual ~~annual ~~Members' ~~members' ~~Meeting~~ meeting shall be open to members of the public.

10. Council of governors - composition

10.1 The Trust is to have a council of governors, which shall comprise both elected and appointed governors.

10.2 The composition of the council of governors is specified in annex 3.

10.3 The members of the council of governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes or areas within a constituency, by their class or area within that constituency. ~~-~~The number of governors to be elected by each constituency or, where appropriate, by each class or area of each constituency, is specified in annex 3.

10.4 A person may not vote at an election for or stand for election as an Elected Governor unless within the specified period stated in the ~~Model ~~model ~~Election ~~election ~~Rules ~~rules he/she has made a declaration in the specified form setting out the particulars of his/her ~~-~~qualification to vote or stand as a member of the constituency for which the election is being held. It is an offence (other than in relation to the Staff Constituency) to knowingly or recklessly make such a declaration which is false in a material particular.

11. **Council of Governors - election of governors**

11.1 Elections for elected members of the council of governors shall be conducted in accordance with the model election rules.

11.2 The model election rules, form part of this constitution. The model election rules published by NHS Providers in August 2014 are attached at ~~Annex~~ annex 4. A variation of the ~~Model~~ model ~~Election~~ election ~~Rules~~ rules shall not constitute a variation of the terms of this Constitution.

11.3 An election, if contested, shall be by secret ballot.

12. **Council of governors: vacancies**

Where a vacancy arises on the council of governors for any reason other than expiry of term of office, the following provisions will apply. Where the vacancy arises amongst the elected governors, the council of governors shall decide either:

12.1 to call an election to fill the seat for the remainder of that seat's term of office;

12.2 to invite the next highest polling (runner-up) candidate for that seat at the most recent election, who is willing to take office, to fill the seat for any unexpired period of the term of office; or

12.3 to leave the seat vacant until the next scheduled elections are held if the un-expired period of office is less than twelve months.

13. **Voting at council of governors elections**

A member may not for the purpose of Section 60(1) of the 2006 Act, vote at an election for a public governor or staff governor unless within the period specified he/she has made a declaration in the specified form stating the particulars of his/her qualification to vote as a member of a constituency, or class, or area within a constituency for which an election is being held. No member may make a statement of declaration which is false in material particular; this is an offence in respect of Section 60(1) of the 2006 Act for public members and Trust procedures apply for staff members.

14. **Council of governors - tenure**

14.1 An elected governor may hold office for a period of up to three years.

14.2 An elected governor shall cease to hold office if he/she ceases to be a member of the constituency, class or area by which he/she was elected.

14.3 An elected governor shall be eligible for re-election at the end of his/her term.

14.4 An appointed governor may hold office for a period of up to three years.

14.5 An appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him/her.

14.6 An appointed governor shall be eligible for re-appointment at the end of his/her first term.

14.7 The maximum aggregate period of office of any Elected Governor or Appointed Governor is six years.

15. **Council of governors - disqualification and removal**

15.1 A person may not become or continue as a member of the council of governors of the Trust if:

15.1.1 he/she has been ~~adjudged~~ made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

15.1.2 he/she is a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

15.1.3 he/she has made a composition or arrangement with, or granted a trust deed for, his/her creditors and has not been discharged in respect of it;

15.1.4 he/she within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her.

15.1.5 in the case of an individual who is a member of the public constituency, if he/she ceases to live in the area of the public constituency of which he/she is a member;

15.1.6 in the case a member of a staff class, if he/she no longer meets the eligibility requirements of paragraph 7 of the constitution and of annex 2;

15.1.7 in the case of an appointed governor, the sponsoring organisation withdraws their sponsorship of him/her;

15.1.8 he/she has within the preceding two years been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a Health Service Body;

15.1.9 he/she is a person whose tenure of office as the chair or as a member or director of a Health Service Body has been terminated on the grounds that his/her appointment is not in the interests of the health service;

15.1.10 he/she is a director of the Trust, or a governor, executive director, non-executive director, chair, chief executive officer of another Health Service Body, or a body corporate whose business involves the provision of health care services unless he/she is appointed to represent that body as one of the Trust's partner organisations; in such instances regard shall be given to any circumstances which may give rise to potential conflicts of interest to such a degree as to interfere with the person's proper exercise of their duties as a governor of this Trust.~~–~~ Any doubt or question as to what constitutes a material conflict of interest for the purposes of this paragraph should be referred to the chair of the Trust whose decision on the matter will be final;

15.1.11 he/she has had his/her name removed from a list maintained under regulations pursuant to sections 91, 106, 123, or 146 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and he/she has not subsequently had his/her name included in such a list;

15.1.12 he/she lacks capacity within the meaning of the Mental Capacity Act 2005 to carry out all the duties and responsibilities of a governor;

15.1.13 he/she has refused without reasonable cause to undertake any training which the Trust and/or council of governors requires all governors to undertake;

15.1.14 he/she is a member of a local authority “Health Overview and Scrutiny Committee” (this does not apply to appointed governors);

15.1.15 he/she is the subject of a Sex Offenders Order and/or his/her name is included in the Sex Offenders Register;

15.1.16 he/she is an occupant of the same household and/or he/she is an immediate family member of a governor or a director of the Trust;

15.1.17 he/she has failed to repay (without good cause) any amount of monies properly owed to the Trust;

15.1.18 he/she has failed to sign and deliver to the secretary a statement in the form required by the Trust confirming acceptance of the council of governors code of conduct;

15.1.19 he/she is an unfit person within the meaning of the Trust's NHS ~~Provider~~ provider ~~Licence~~licence, save where ~~Monitor~~ NHS England has provided approval in writing to him/~~-~~her becoming or continuing as a governor;

15.1.20 he/~~-~~she has previously been removed from office as a governor of another foundation trust; or

15.1.21 he/~~-~~she has previously been removed from office as a governor by the council of governors of the Trust.

15.2 Where a person has been elected or appointed to be a governor and he/she becomes disqualified from office under the constitution he/she shall notify the secretary in writing of such disqualification.~~-~~ If it comes to the notice of the secretary at the time of the governor taking office or later that the governor is so disqualified, the secretary shall immediately declare that the person in question is disqualified and notify him/her in writing to that effect.~~-~~ A disqualified person's tenure of office shall automatically be terminated and he/~~-~~she shall cease to act as a governor.

15.3 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

16. Council of governors – duties of governors

16.1 The general duties of the council of governors are:

16.1.1 to hold the non-executive directors individually and collectively to account for the performance of the board of directors; and

16.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public.

16.2 The Trust must take steps to ensure that the governors are equipped with the skills and knowledge they require in their capacity as such. ~~-~~An induction programme will be available for each governor at the commencement of his/her term of office.

17. Council of governors – meetings of governors

17.1 The chair of the Trust (i.e. the chair of the board of directors, appointed in accordance with the provisions of paragraph 25.1 below) or, in his/her absence the deputy chair (appointed in accordance with the provisions of paragraph 26 below) shall preside at meetings of the council of governors.

17.2 Meetings of the council of governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

17.3 The validity of any decision or act of the council of governors is not affected by any vacancy among the governors or by any defect in the appointment of any governor.

17.4 For the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the council of governors may require one or more of the directors to attend a meeting.

18. **Council of governors - standing orders**

18.1 The standing orders for the practice and procedure of the council of governors are attached at annex 6.

19. **Council of governors - conflicts of interest of governors**

19.1 Each governor shall comply with standing order 6 of annex 6 which relates to the declaration of interests. –The standing orders for the council of governors make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

20. **Council of governors - expenses**

20.1 The Trust may pay travelling and other expenses to governors at rates determined by the Trust.

21. **Council of governors - further provisions**

21.1 Further provisions with respect to the council of governors are set out in annex 5.

22. **Board of directors - composition**

22.1 The Trust is to have a board of directors, which shall comprise both executive directors and non-executive directors.

22.2 The Trust's board of directors is to comprise:

22.2.1 a non-executive chair who shall not be included in the count of NEDs in 22.2.2 and 22.2.3;

22.2.2 not less than five or no more than seven each of executive and non-executive directors;

22.2.3 the numbers of executives and non-executives shall be equal; and

22.2.4 the chair~~man~~ has a casting vote in the event of a tie.

22.3 One of the executive directors shall be the chief executive.

22.4 The chief executive shall be the accounting officer.

22.5 One of the executive directors shall be the chief financial officer.

22.6 One of the executive directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

22.7 One of the executive directors is to be a registered nurse or a registered midwife.

22.8 The board of directors shall at all times be constituted so that the number of non-executive directors (excluding the chair) equals or exceeds the number of executive directors.

23. **Board of directors – general duty**

23.1 The general duty of the board of directors and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

24. **Board of directors - qualification for appointment as a non-executive director**

24.1 A person may be appointed as a non-executive director only if

24.1.1 he/she is a member of the public constituency, or

24.1.2 where any of the Trust's hospitals includes a medical or dental school provided by a university, he/she exercises functions for the purposes of that university, and

24.1.3 he/she is not disqualified by virtue of paragraph 29 below.

25. **Board of directors - appointment and removal of chair and other non-executive directors**

25.1 The council of governors at a general meeting of the council of governors shall appoint or remove the chair of the Trust and the other non-executive directors. The council of governors will not consider nominations for the chair and other non-executive directors of the Trust other than those made by the appropriate ~~appointment of the chair or any other non-executive directors shall be in accordance with annex 8, appendix 4~~nominations committee.

25.2 At the ~~General~~ general ~~Meeting~~ meeting referred to at paragraph ~~23~~25.1 the council of governors shall decide the:

25.2.1 period of office;

25.2.2 remuneration and allowances; and

25.2.3 the other terms and conditions of office

of the ~~Chairman~~ chair and other ~~Non~~non-~~Executive~~ executive ~~Directors~~directors.

25.3 The non-executive directors, including the chair, shall be appointed by the council of governors for specified terms ~~at intervals~~ of no more than three (3) years. Any term beyond six (6) years (e.g. two three year terms) shall be subject to particularly rigorous review and shall take into account the need for progressive refreshing of the Board. Non-executive directors may in exceptional circumstances serve longer than six (6) years but in such circumstances shall be subject to annual re-appointment.

25.4 Removal of the chair or another non-executive director shall require the approval of three-quarters of the members of the council of governors.

26. **Board of directors - appointment of deputy chair**

26.1 The council of governors at a general meeting of the council of governors shall appoint one of the non-executive directors as a deputy chair.

27. **Board of Directors – appointment of Senior Independent Director**

27.1 The board of directors (in consultation with the council of governors) may appoint any independent non-executive director as the senior independent director, for such period not exceeding the remainder of his/her term as a non-executive director as they may specify on appointing him/her.

27.2 Any non-executive director so appointed may at any time resign from the office of senior independent director by giving notice in writing to the chair. The board of directors (in consultation with the council of governors) may thereupon appoint another independent non-executive director as senior independent director.

27.3 The senior independent director shall perform the role set out in "The NHS Foundation Trust Code of Governance" issued by ~~Monitor~~NHS England.

28. **Board of directors - appointment and removal of the chief executive and other executive directors**

28.1 The non-executive directors shall appoint or remove the chief executive.

28.2 The appointment of the chief executive shall require the approval of the council of governors.

28.3 A committee consisting of the chair, the chief executive and the other non-executive directors shall appoint or remove the other executive directors.

29. **Board of directors - disqualification**

29.1 The following may not become or continue as a member of the board of directors if he/she:

29.1.1 has been ~~adjudged~~ made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

29.1.2 is a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

29.1.3 has made a composition or arrangement with, or granted a trust deed for, his/her creditors and has not been discharged in respect of it;

29.1.4 has within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her.

29.1.5 is a member of the council of governors;

29.1.6 has within the preceding two years been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a Health Service Body;

29.1.7 is a person whose tenure of office as the chair or as a member or director of a Health Service Body has been terminated on the grounds that his/her appointment is not in the interest of the health service;

29.1.8 has had his/her name removed from a list maintained under regulations pursuant to sections 91, 106, 123, or 146 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and he/she has not subsequently had his/her name included in such a list;

29.1.9 is incapable by reason of mental disorder, illness or injury of managing and administering his/her property and affairs;

29.1.10 in the case of a non-executive director, he/she has refused without reasonable cause to undertake any training which the Trust and/or board of directors requires all directors to undertake;

29.1.11 is a member of a local authority “Health Overview and Scrutiny Committee”;

29.1.12 is the subject of a Sex Offenders Order and/or his/her name is included in the Sex Offenders Register;

29.1.13 is an occupant of the same household as, and/or he/she is an immediate family member of, a governor or a director of the Trust;

29.1.14 has failed to repay (without good cause) any amount of monies properly owed to the Trust;

29.1.15 has failed to sign and deliver to the secretary any statement in the form required by the Trust confirming acceptance of any code of conduct for the board of directors;

29.1.16 is an unfit person within the meaning of the Trust's NHS ~~Provider~~ provider ~~Licence~~licence, save where ~~Monitor~~ NHS England has provided approval in writing to him/~~-~~her becoming or continuing as a director;

29.1.17 fails to satisfy the fit and proper persons requirements for directors as detailed in Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as may be amended from time to time; or

29.1.18 fails to provide the required confirmation of his/~~-~~her fitness to continue in post to the secretary, in the form prescribed by the Trust, within 14 days of such confirmation being demanded, without reasonable cause.

29.2 Where a person has been appointed as a director and he/she becomes disqualified from office he/she shall notify the secretary in writing of such disqualification. ~~-~~If it comes to the notice of the secretary at the time of the director taking office or later that the director is so disqualified, the secretary shall immediately declare that the person in question is disqualified and notify him/her in writing to that effect.~~-~~ A disqualified person's tenure of office shall automatically be terminated and he/~~-~~she shall cease to act as a director.

30. Board of directors – meetings

30.1 Meetings of the board of directors shall be open to members of the public. ~~-~~Members of the public may be excluded from a meeting for special reasons.

30.2 Before holding a meeting, the board of directors must send a copy of the agenda of the meeting to the council of governors. ~~-~~As soon as practicable after holding a meeting, the board of directors must send a copy of the minutes of the meeting to the council of governors.

30.3 The validity of any decision of the board of directors or any act of the Trust is not affected by any vacancy among the directors or by any defect in the appointment of any director.

31. Board of directors - standing orders

31.1 The standing orders for the practice and procedure of the board of directors are attached at annex 7.

32. Board of directors - conflicts of interest of directors

32.1 The duties that a director of the Trust has by virtue of being a director include in particular:

32.1.1 a duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust;

32.1.2 a duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

32.2 The duty referred to in paragraph 32.1 is not infringed if:

32.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or

32.2.2 the matter has been authorised in accordance with the constitution.

32.3 The duty referred to in paragraph 32.1 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

32.4 In paragraph 32.1, "third party" means a person other than:

32.4.1 the Trust; or

32.4.2 a person acting on its behalf.

32.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.

32.6 If a declaration under paragraph 32.5 proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

32.7 Any declaration required by paragraph 32.5 must be made before the Trust enters into the transaction or arrangement.

32.8 Paragraph 32.5 does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

32.9 A director need not declare an interest:

32.9.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

32.9.2 If, or to the extent that, the directors are already aware of it.

32.9.3 If, or to the extent that, it concerns terms of the director's appointment that have been, or are to be, considered:

(a) by a meeting of the board of directors; or

(b) by a committee of the directors appointed for the purpose under the constitution.

32.10 A matter shall have been authorised for the purposes of paragraph 32.2 if it has previously been approved by the Board of Directors at a meeting and the minutes of the meeting shall be conclusive evidence of such approval having been given.

33. Board of directors - remuneration and terms of office

33.1 The council of governors at a general meeting of the council of governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the chair and the other non-executive directors.

33.2 The Trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the chief executive and other executive directors.

34. Registers

34.1 The Trust shall have:

34.1.1 a register of members showing, in respect of each member, the constituency to which he/she belongs and, where there are classes or areas within it, the class or area to which he/she belongs;

34.1.2 a register of members of the council of governors;

34.1.3 a register of interests of governors;

34.1.4 a register of directors; and

34.1.5 a register of interests of the directors.

35. Admission to and removal from the registers

35.1 Register of Members

35.1.1 Subject to paragraph 7.6 above, members must complete and sign an application in the form prescribed by the secretary.

35.1.2 The secretary shall maintain the register in two parts. Part one, which shall be the register referred to in the 2006 Act, shall include the name of each Member and the constituency or class to which they belong, and shall be open to inspection by the public in accordance with paragraph ~~34~~ 36 below. Part two shall contain all the information from the application form and shall not be open to inspection by the public nor may copies or extracts from it be made available to any third party. Notwithstanding this provision the Trust shall extract such information as it needs in aggregate to satisfy itself that the actual membership of the Trust is representative of those eligible for membership and for the administration of the provisions of this Constitution.

35.2 Register of Governors

35.2.1 The register shall list the names of governors, their category of membership of the council of governors (public, staff, or appointed) and an address through which they may be contacted which may be the secretary.

35.3 Register of Interests of the Governors

35.3.1 The register shall contain the names of each governor, whether he/she has declared any interests and, if so, the interests declared in accordance with this constitution or the standing orders for governors.

35.4 Register of Directors

35.4.1 The register shall list the names of directors, their capacity on the board of directors and an address through which they may be contacted which may be the ~~Secretary~~secretary.

35.5 Register of interests of Directors

35.5.1 The register shall contain the names of each director, whether he/she has declared any interests and, if so, the interests declared in accordance with this Constitution or the Standing Orders for Directors.

~~35.6 Register of Designated Trust Sub-contractors~~

~~35.6.1 The register shall contain the names of each Trust sub-contractor which is designated by the Trust for the purposes of membership of the Trust.~~

~~35.7 Register of Designated Volunteer Schemes~~

~~35.7.1 The register shall contain the names of each volunteer scheme which is designated by the Trust for the purposes of membership of the Trust.~~

36. **Registers - inspection and copies**

36.1 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Trust, if the member so requests.

36.2 So far as the registers are required to be made available:

36.2.1 they are to be available for inspection free of charge at all reasonable times; and

36.2.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

36.3 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

37. **Documents available for public inspection**

37.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

37.1.1 a copy of the current constitution;

37.1.2 a copy of the latest annual accounts and of any report of the auditor on them; and

37.1.3 a copy of the latest annual report.

37.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

37.2.1 a copy of the order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following secretary of state's rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act;

37.2.2 a copy of the report laid under section 65D (appointment of trust special administrator) of the 2006 Act;

37.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act;

37.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act;

37.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act:

37.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (~~Monitor's~~ NHS England's decision), 65KB (secretary of state's response to ~~Monitor's~~ NHS England's decision), 65KC (action following secretary of state's rejection of final report) or 65KD (secretary of state's response to re-submitted final report) of the 2006 Act;

37.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;

37.2.8 a copy of any final report published under section 65I (administrator's final report) of the 2006 Act;

37.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following secretary of state's rejection of final report) of the 2006 Act;

37.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

37.3 Any person who requests a copy of, or extract from, any of the above documents is to be provided with a copy.

37.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

38. Auditor

38.1 The Trust shall have an auditor.

38.2 The council of governors shall appoint or remove the auditor at a general meeting of the council of governors.

39. Audit committee

39.1 The Trust shall establish a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

40. Accounts

40.1 The Trust must keep proper accounts and proper records in relation to the accounts.

40.2 ~~Monitor~~ NHS England may with the approval of the secretary of state give directions to the Trust as to the content and form of its accounts.

40.3 The accounts are to be audited by the Trust's auditor.

40.4 The Trust shall prepare in respect of each financial year annual accounts in such form as ~~Monitor~~ NHS England may with the approval of the secretary of state direct.

40.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

41. Annual report and forward plans and non-NHS work

41.1 The Trust shall prepare an annual report and send it to ~~Monitor~~NHS England.

41.2 The Trust shall give information as to its forward planning in respect of each financial year to ~~Monitor~~NHS England.

41.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

41.4 In preparing the document, the directors shall have regard to the views of the council of governors.

41.5 Each forward plan must include information about:

41.5.1 the activities other than the provision of goods and services for the purpose of the health service in England that the Trust proposes to carry on, and

41.5.2 the income it expects to receive from doing so.

41.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in paragraph 41~~0~~.5 the council of governors must:

41.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and

41.6.2 notify the directors of the Trust of its determination.

41.7 A trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the council of governors of the Trust present and voting approve its implementation.

42. Presentation of the accounts and reports to the governors and members

42.1 The following documents are to be presented to the council of governors at a general meeting of the council of governors:

42.1.1 the accounts;

42.1.2 any report of the auditor on them;

42.1.3 the annual report.

42.2 The documents shall also be presented to the members of the Trust at the ~~Annual~~ annual ~~Members'~~ members' ~~Meeting~~ meeting by at least one member of the board of directors in attendance.

42.3 The Trust may combine a meeting of the council of governors convened for the purpose of paragraph ~~41~~42.1 with the ~~Annual~~ annual ~~Members'~~ members' ~~Meeting~~meeting.

43. Instruments

43.1 The Trust shall have a seal.

43.2 The seal shall not be affixed except under the authority of the board of directors.

44. Amendment of the constitution

44.1 The Trust may make amendments to its constitution only if:

44.1.1 more than half of the members of the council of governors of the Trust present and voting approve the amendments; and

44.1.2 more than half of the members of the board of directors of the Trust present and voting approve the amendments.

44.2 Amendments made under paragraph ~~43~~44.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

44.3 Where an amendment is made to the constitution in relation to the powers or duties of the council of governors (or otherwise with respect to the role that the council of governors has as part of the Trust):

44.3.1 at least one member of the council of governors must attend the next ~~Annual~~ annual ~~Members'~~ members' ~~Meeting~~ meeting and present the amendment; and

44.3.2 the Trust must give the members an opportunity to vote on whether they approve the amendment.

44.4 If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

44.5 Amendments by the Trust of its constitution are to be notified to ~~Monitor~~NHS England. For the avoidance of doubt, ~~Monitor's~~ NHS England's functions do not include a power or duty to determine whether or not the constitution as a result of the amendments, accords with schedule 7 of the 2006 Act.

45. Significant transactions

45.1 This constitution does not contain any descriptions of the term significant transaction for the purposes of section 51A of the 2006 Act (significant transactions).

45.2 The Trust shall have a policy for the board of directors to consult the council of governors about transactions that are within the description of significant transaction set out in the policy.

46. Mergers, acquisitions, separations and dissolution

46.1 The Trust may make an application under section 56 (Mergers), 56A (Acquisitions), 56B (Separations) or 57A (Dissolution) of the 2006 Act to ~~Monitor~~ NHS England only with the approval of more than half of the members of the council of governors.

47. Interpretation and definitions

47.1 Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

47.2 Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

Accounting officer	is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.
Annual members' meeting	is defined in paragraph 9.1 of the constitution
Appointed governor	means a member of the council of governors appointed by the stakeholder partner in accordance with this constitution.
Area	means an area of the public constituency as specified in annex 1 and "**Areas**" shall be construed accordingly.
Board of Directors or Board	means the board of directors of the Trust as constituted in accordance with this constitution and the 2006 Act.
Chair	means the chairperson of the Trust appointed in accordance with this constitution.
Chief executive	means the chief executive officer of the Trust appointed in accordance with the constitution.
Constitution	means this constitution and all annexes to it.
Deputy chair	means the non-executive director appointed as deputy chair by

	the council of governors to take on the chair's duties if the chair is absent or unavailable for any reason.
Director	means a director on the board of directors.
Executive director	means a member of the board appointed as an executive director in accordance with the constitution.
Finance director	means the chief ~~finance~~ financial officer of the Trust appointed in accordance with the constitution.
Financial year	means each period of twelve months beginning with 1~~st~~ April.
Governor	means a person who is a member of the council of governors.
Health Service Body	shall have the meaning ascribed to it in Section 65~~–~~(1) of the 2006 Act.
Lead governor	means the governor nominated as the lead governor by the council of governors in accordance with annex 6, paragraph 13.
Licence	means the licence issued by ~~Monitor~~ NHS England under Section 87 of the 2012 Act.
Member	means a member of the Trust.
~~**Monitor**~~	~~is the corporate body known as Monitor, as provided by section 61 of the 2012 Act.~~
Motion	means a formal proposition to be discussed and voted on during the course of the meeting.
NHS England	is the corporate body known as NHS England, as provided by section 61 of the 2012 Act.
NHS Foundation Trust Code of Governance	means the Code of Governance published ~~by Monitor~~ in July 2014 or such similar or further guidance as ~~Monitor~~ NHS England may publish from time to time.
Non-executive director	means a member of the Board appointed as a non-executive director in accordance with the constitution.
Officer	means an employee of the Trust or any other person holding a paid appointment or office with the Trust.
Public constituency	means the constituency of the Trust constituted in accordance with paragraph 6 of this constitution and made up of the areas as identified in annex 1.

Public governor	means a member of the council of governors elected by the members of the public constituency in accordance with this constitution.
Regulatory framework	means the 2006 Act, the 2012 Act, the constitution and the Trust's ~~Licence~~ licence as granted by ~~Monitor~~NHS England.
Scheme of reservation and delegation	means the document containing the ~~Reservation~~ reservation of ~~Powers~~ powers to the Board and the ~~Scheme~~ scheme of ~~Delegation~~ delegation for the Trust.
Secretary	means the foundation trust company secretary of the Trust or any other person appointed to perform the duties of the secretary, including a joint, assistant or deputy secretary.
Senior independent director	means the senior independent non-executive director appointed in accordance with the constitution.
Staff classes	means the classes of the staff constituency as specified in annex 2.
Staff constituency	means the constituency of the Trust constituted in accordance with paragraph 7 of this constitution.
Staff governor	means a member of the council of governors elected by the members of the staff constituency in accordance with this constitution.
Trust's Headquarters	Trust Management Office University Hospital Southampton NHS Foundation Trust Tremona Road Southampton SO16 6YD
the 2006 Act	means the National Health Service Act 2006.
the 2012 Act	is the Health and Social Care Act 2012.
Trust	means the University Hospital Southampton NHS Foundation Trust.
Voluntary organisation	is a body, other than a public or local authority, the activities of which are not carried out for profit.

ANNEX 1
The Public Constituency

(Constitution: Paragraph 6)

Name of area (as defined by electoral wards or local authority areas)	Minimum number of members
Southampton City (Southampton City Council)	**100**
New Forest, **Eastleigh and Test Valley** (New Forest District Council, Eastleigh Borough Council and Test Valley Borough Council)	**80**
Isle of Wight (Isle of Wight Council)	**20**
Rest of England and Wales	**100**

ANNEX 2
The Staff Constituency

(Constitution: Paragraph 7)

Staff membership will fall into one of four staff classes:

- Medical practitioners and dental staff
- Nursing and ~~Midwifery~~ midwifery staff
- Health professional and health scientist staff
- Non-clinical and support staff

The minimum number of members for each staff class is 20.

ANNEX 3
Composition of Council of Governors

(Constitution: Paragraph 10)

Public elected governor (13)	**Number**
Southampton City	5
New Forest, Eastleigh and Test Valley	4 (until 30 September 2022) 5 (from 1 October 2022)
~~The~~ Isle of Wight	1
Rest of England and Wales	3 (until 30 September 2022) 2 (from 1 October 2022)

Staff elected governor (4)	**Number**
Medical practitioners and dental staff	1
Nursing and ~~Midwifery~~ midwifery staff	1
Health professional/health scientist staff	1
Non-~~-~~clinical and support staff	1

Appointed governor (5)	**Number**
NHS Hampshire~~, Southampton~~ and Isle of Wight ~~Clinical Commissioning Group (CCG)~~Integrated Care Board (ICB)	1
Southampton City Council	1
University of Southampton	1
Hampshire County Council	1
Solent University	1

ANNEX 4

~~The~~ Model Election Rules

(Paragraph 11)

Part 1 – Interpretation

1. Interpretation

Part 2 – Timetable for election

2. Timetable

3. Computation of time

Part 3 – Returning officer

4. Returning officer
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6. Expenditure
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Part 4 – Stages common to contested and uncontested elections

8. Notice of election
9. Nomination of candidates
10. Candidate's particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination
15. Publication of statement of candidates
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18. Method of election

Part 5 – Contested elections

19. Poll to be taken by ballot
20. The ballot paper
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Action to be taken before the poll

22. List of eligible voters
23. Notice of poll
24. Issue of voting information by returning officer
25. Ballot paper envelope and covering envelope
26. E-voting systems

The poll

27. Eligibility to vote
28. Voting by persons who require assistance
29. Spoilt ballot papers and spoilt text message votes
30. Lost voting information
31. Issue of replacement voting information
32. ID declaration form for replacement ballot papers (public and patient constituencies)

Part 11 – Questioning elections and consequences of irregularities

Part 12 – Miscellaneous

Part 1 – Interpretation

1. Interpretation

(1) In these rules, unless the context otherwise requires:

"2006 Act" means the National Health Service Act 2006;

"**council of governors**" means the council of governors of the corporation;

"corporation" means the public benefit corporation subject to this constitution;

"**declaration of identity**" has the meaning set out in rule 21(1);

"~~Election~~election" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"**e-voting**" means voting using either the internet, telephone or text message;

"**e-voting information**" has the meaning set out in rule 24(2);

"**ID declaration form**" has the meaning set out in rule 21(1);

"**internet voting record**" has the meaning set out in rule 26(4)(d);

~~**"the Regulator"** means the Independent Regulator for NHS foundation trusts;~~

~~**"the 2006 Act**" means the National Health Service Act 2006;~~

~~**"the 2012 Act**"means the Health and Social Care Act 2012;~~

~~**"e-voting"** means voting using either the internet, telephone or text message;~~

"internet voting system" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"**lead governor**" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code;

"**list of eligible voters**" means the list referred to in rule 22(1), containing the information in rule 22(2);

"method of polling" means a method of casting a vote in a poll, which may be~~voting either~~ by post, internet, text message or telephone;

"Monitor" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"**numerical voting code**" has the meaning set out in rule 62(2)(b);

"**polling website**" has the meaning set out in rule 26(1);

"**postal voting information**" has the meaning set out in rule 24(1);

"**telephone short code**" means a short telephone number used for the purposes of submitting a vote by text message;

"**telephone voting facility**" has the meaning set out in rule 26(2);

"**telephone voting record**" has the meaning set out in rule 26(5)(d);

"the telephone voting system" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"**text message voting facility**" has the meaning set out in rule 26(3);

"**text voting record**" has the meaning set out in rule 26(6)(d);

"the text message voting system" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"voter ID number" means a unique, randomly generated numeric identifier allocated to each voter by the rreturning oefficer for the purpose of e-voting;

"**voting information**" means postal voting information and/or e-voting information.

(2) Other expressions used in these rules and in Schedule 7 to the ~~National Health Service~~NHS Act 2006 have the same meaning in these rules as in that Schedule.

Part 2 – Timetable for elections

2. Timetable

(1) The proceedings at an election shall be conducted in accordance with the following timetable.

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll
Final day for delivery of nomination ~~papers~~ forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll
Close of the poll	By 5.00pm on the final day of the election

3. Computation of time

(1) In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

(2) In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

Part 3 – Returning officer

4. Returning officer

(1) Subject to rule ~~67~~69, the returning officer for an election is to be appointed by the corporation.

(2) Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

(1) Subject to rule ~~67~~69, the returning officer may appoint and pay such staff, including such technical advisers, as he or ~~/~~she considers necessary for the purposes of the election.

6. Expenditure

(1) The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or ~~/~~her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

(1) The corporation is to co-operate with the returning officer in the exercise of his or ~~/~~her functions under these rules.

Part 4 - Stages common to contested and uncontested elections

8. Notice of election

(1) The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination ~~papers~~ forms may be obtained,

(e) the address for return of nomination ~~papers~~ forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer,

(g) the contact details of the returning officer, ~~and~~

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

(1) Subject to rule 9.2, e~~E~~ach candidate must nominate themselves on a single nomination form~~paper~~.

(2) The returning officer:

(a) is to supply any member of the corporation with a nomination ~~paper~~form, and

(b) is to prepare a nomination ~~paper~~ form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and ~~it~~ a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

(1) The nomination ~~paper~~ form must state the candidate's:

(a) full name,

(b) contact address in full (which shall be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

(1) The nomination ~~paper~~ form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party,

~~,~~ and if so, which party, and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

(1) The nomination ~~paper~~ form must include a declaration made by the candidate:

(a) that he or ~~/~~she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the ~~Constitution~~constitution; and,

(b) for a member of the ~~Public~~ public ~~Constituency~~or patient constituency, of the particulars of his or ~~/~~her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

(1) The nomination ~~paper~~ form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) ~~–~~ their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

(2) Where the return of nomination forms in an electronic form is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

(1) Where a nomination ~~paper~~ form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination ~~paper~~ form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

(2) The returning officer is entitled to decide that a nomination ~~paper~~ form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination ~~papers~~forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10,

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, ~~as~~ if required by rule 13.

(3) The returning officer is to examine each nomination ~~paper~~ form as soon as is practicable after he or ~~/~~she has received it, and decide whether the candidate has been validly nominated.

(4) Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination ~~paper~~form, stating the reasons for their decision.

(5) The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination ~~paper~~form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

(1) The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

(2) The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination ~~paper~~form.

(3) The statement must list the candidates standing for election in alphabetical order by surname.

(4) The returning officer must send a copy of the statement of candidates and copies of the nomination ~~papers~~ forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination ~~papers~~ forms

(1) The corporation is to make the statement~~s~~ of the candidates and the nomination ~~papers~~ forms supplied by the returning officer under rule 15(4) available for inspection by members of the corporation free of charge at all reasonable times.

(2) If a ~~person~~ member of the corporation requests a copy or extract of the statement~~s~~ of candidates or their nomination form~~paper~~s, the corporation is to provide that ~~person~~ member with the copy or extract free of charge.

17. Withdrawal of candidates

(1) A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

(1) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

(2) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

(3) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to the council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or ~~/~~her in consultation with the corporation.

Part 5 – Contested elections

19. Poll to be taken by ballot

(1) The votes at the poll must be given by secret ballot.

(2) The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

(3) The corporation may decide ~~if~~ that ~~eligible~~ voters, within a constituency~~,~~ or class within a constituency, may, subject to rule 19(4), cast their votes at the poll using such different ~~by any combination of the~~ methods of polling in any combination as the corporation may determine.

(4) The corporation may decide ~~if eligible~~that voters, within a constituency or class within a constituency, for whom an e-mail ~~mailing~~ address is included in the list of eligible voters may only cast their votes ~~by, one or more,~~at the poll using an e-voting methods of polling.

(5) ~~If~~ Before the corporation decides, in accordance with rule 19(3) that one or more, e-voting methods of polling, will be made available for the purposes of the poll, the corporation must satisfy itself ~~to use an e-voting method of polling then they and the returning officer must satisfy themselves~~ that:

(a) if internet voting is ~~being used~~to be a method of polling, the internet voting system to be used for the purpose of the election is configured in accordance with these rules and ~~that it~~ will create an accurate~~ly record the~~ internet voting record in respect of any voter who ~~chooses to~~ casts his or her ~~their~~ vote using the internet voting system.

(b) if telephone voting is ~~being used~~to be a method of polling, the telephone voting system to be used for the purpose of the election is configured in accordance with these rules and ~~that it~~ will create an accurate~~ly record the~~ telephone voting record in respect of any voter who ~~chooses to~~ casts his or her ~~their~~ vote using the telephone voting system.

(c) if text message voting is ~~being used~~to be a method of polling, the text message voting system to be used for the purpose of the election is configured in accordance with these rules and ~~that it~~ will create an accurate~~ly record the~~ text voting record in respect of any voter who ~~chooses to~~ casts ~~their~~ his or her vote using the text message voting system.

20. The ballot paper

(1) The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

(2) Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's ~~and~~ voter ID number if one or more e-voting ~~is a~~ methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

(3) Each ballot paper must have a unique identifier.

(4) Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

(1) ~~In respect of~~The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration ~~of identity must be issued with each ballot paper.~~

~~(2) The declaration of identity is to include a declaration~~:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that ~~the voter~~he or she has not marked or returned any other voting ~~paper~~ information in the election, and

(c) of the particulars of ~~that member's~~his or her qualification to vote as a member of the constituency or class within ~~a~~ the constituency for which the election is being held,

("declaration of identity") and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form (ID declaration form") or the use of an electronic method. ~~.~~

(~~3~~2) ~~The declaration of identity is to include space for:~~

~~(a) the name of the voter,~~

~~(b) the address of the voter,~~

~~(c) the voter's signature, and~~

~~(d) the date that the declaration was made by the voter.~~

~~(4)~~ The voter must be required to return his or her~~the~~ declaration of identity ~~together~~ with his or her ~~the~~ ballot ~~paper~~.

(~~5~~3) The ~~declaration of identity must~~voting information shall caution the voter that if the declaration of identity~~, if it~~ is not duly returned ~~with the ballot paper, or if it~~ is returned without ~~being~~ having

been made correctly ~~completed~~, ~~the voter's ballot paper~~any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

(1) The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule ~~26~~ 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

(2) The list is to include, for each member, a postal ~~mailing~~ address and ~~if available an~~the member's e-mail address, if this has been provided, to which~~where~~ his or ~~/~~her ~~ballot paper~~voting information may, subject to rule 22(3) ~~is to~~ be sent.

(3) The corporation may decide ~~if~~ that the e-voting information is to be sent only by e-mail to those members~~, in a particular constituency or class within a constituency,~~ in the list of eligible voters for whom an e-mail address is included in ~~the~~ that list ~~of eligible voters~~.

23. Notice of poll

(1) The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters un a constituency or class within a constituency, as determined by the corporation in accordance with rule 19(3),

(~~f~~g) the address for return of the ballot papers~~, and the date and time of the close of the poll~~,

(~~g~~h) the uniform resource locator (url) where, if internet voting is ~~being used~~a method of polling, the polling website is located,~~.~~

(~~h~~i) the telephone number where, if telephone voting is ~~being used~~a method of polling, the telephone voting facility is located,

(~~i~~j) the telephone number or telephone short code where, if text message voting is ~~being used~~a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(~~j~~l) the address and final dates for applications for replacement ~~ballot papers~~voting information, and

(~~k~~m) the contact details of the returning officer.

24. Issue of voting information by returning officer

(1) Subject to rule 24(3), a~~A~~s soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following ~~voting~~ information by post to each member of the corporation named in the list of eligible voters:

(a) ~~by post to each member of the corporation named in the list of eligible voters and on the basis of rule 21 able to cast their vote by post:~~

~~(i)~~ a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) ~~(ii)~~ information about each candidate standing for election, pursuant to rule ~~61~~ 64~~of these rules~~, and

(d)~~(iii)~~ a covering envelope;

("postal voting information").

(2) Subject to rules 24(3) and 24(4), as soon as is reasonably practicable on or after the publication of the notice of poll, the returning officer is to send the following information by e-mail and/or post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19(3) and/or rule 19(4) may cast his or her ~~(b) by e-mail or by post, to each member of the corporation named in the list of eligible voters and on the basis of rule 19(4) able to cast their~~ vote by an e-voting method of polling:

(a~~(i~~) instructions on how to vote and how to make a declaration of identity (if required)

(b) ~~(ii)~~ the ~~eligible~~ voter's voter ID number,

(c) ~~(iii)~~ information about each candidate standing for election, pursuant to rule ~~61~~ 64~~of these rules~~, or details of where this information is readily available on the internet or available in such other formats as the returning officer thinks appropriate.~~;~~

(d) contact details of the returning officer,

("e-voting information").

~~(iv) contact details of the returning officer.~~

(~~2~~3) The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

(4) If the corporation determines, in accordance with rule 22(3), that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

(5) The ~~documents are~~voting information is to be sent to the ~~mailing~~ postal address and/or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

(1) The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

(2) The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

(3) There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer:

(a) the completed ID declaration ~~of identity~~form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

(1) If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

(2) If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

(3) If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

(4) The returning officer shall ensure that ~~provision of~~ the polling website and internet voting system provided~~,~~ will:

(a) require a voter, to:

(i) ~~be permitted to vote, to~~ enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

In order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation~~,~~,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of poll,

(vii) the contact details of the returning officer;~~-~~

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("~~the~~ internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of:~~-~~

(i) the voter's voter ID number ~~used by the voter~~;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom ~~he~~ the voter has voted; and

(iii) the date and time of ~~his~~ the voter's vote~~, and~~

(e) if the voter's~~ir~~ vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

(5) The returning officer shall ensure that the ~~provision of a~~ telephone voting facility and telephone voting ~~system~~system provided~~,~~ will:

(a) require a voter to

(i) ~~be permitted to vote, to~~ enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,~~-~~

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("~~the~~ telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:~~-~~

(i) the voter's voter ID number ~~used by the voter~~;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom ~~he~~ the voter has voted; and

(iv~~ii~~) the date and time of ~~his~~ the voter's vote

(e) if ~~their~~ the voter's vote has been cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

(6) The returning officer shall ensure that ~~provision of a~~the text message voting facility and text messaging voting system provided ~~,~~ will:

(a) require a voter to:

(i) ~~be permitted to vote, to~~ provide his or her voter ID number; and

(ii) where the election of for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(c) create a record ("~~the~~ text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number ~~used by the voter~~;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom ~~he~~ the voter has voted; and

(iv~~ii~~) the date and time of ~~his~~ the voter's vote~~vote~~

(d) if the voter's~~ir~~ vote has been duly cast and recorded, provide the voter with confirmation of this;

(e) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

(1) An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in ~~the~~ that election.

28. Voting by persons who require assistance

(1) The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

(2) Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or ~~/~~she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spilt test message votes

(1) If a voter has dealt with his or ~~/~~her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

(2) On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or ~~/~~she can obtain it.

(3) The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or ~~/~~she:

(a) is satisfied as to the voter's identity, and

(b) has ensured that the completed ID declaration ~~of identity~~form, if required, has not been returned.

(4) After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("~~the~~ list of spoilt ballot papers"):

(a) the name of the voter;~~,~~ and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

(5) If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

(6) On receiving the application, the returning officer is to obtain details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

(7) The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

(8) After issuing a replacement voter ID number in respect of a spoilt test message vote, the returning officer shall enter in a list ("list of spoilt text message votes"):

(a) the name of the voter; and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it); and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

(1) Where a voter has not received his or ~~/~~her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

(2) The returning officer may not issue replacement voting information in respect of~~for~~ lost voting information unless he or ~~/~~she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information, ~~and~~

(c) has ensured that ~~the~~ no declaration of identity if required has ~~not~~ been returned.

(3) After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("~~the~~ list of lost ballot documents"):

(a) the name of the voter,

(b) ~~if applicable,~~ the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) ~~if applicable,~~ the voter ID number of the voter.

31. Issue of replacement voting information

(1) If a person applies for ~~a~~ replacement voting information under rule~~s~~ 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by~~in~~ rule 29(3) or 30(2), he or ~~/~~she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

(2) After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) ~~if applicable, the details of~~ the unique identifier of ~~the~~ any replacement ballot paper issued under this rule, and

(c) ~~if applicable,~~ the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

(1) In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

~~32~~33. Procedure for remote voting by internet

(1) To cast ~~their~~ his or vote using the internet ~~the~~, a voter will need to ~~must~~ gain access to the polling website by keying in the url of the polling website provided in the voting information.~~,~~

(2) When prompted to do so, the voter ~~must~~ will need to enter ~~their~~ his or her voter ID number.

(3) If the internet voting system authenticates the voter ID number the system ~~must~~ will give the voter access to the polling website for the election in which the voter is eligible to vote.

(4) To cast ~~their~~ his or her vote the voter ~~may then~~will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she ~~they~~ wish~~es~~ to cast ~~their~~ his or her vote.

(5) The voter ~~must~~ will not be able to access the internet voting ~~facility~~ system for an election once his or her ~~their~~ vote at that election has been cast.

~~33~~34. Voting procedure for remote voting by telephone

(1) To cast ~~their~~ his or her vote by telephone the voter ~~must~~ will need to gain access to the telephone voting facility by calling the designated telephone number provided i~~o~~n the voter information using a telephone with a touch-tone keypad.

(2) When prompted to do so, the voter ~~must~~ will need to enter his or her~~their~~ voter ID number using the keypad.

(3) If the telephone voting facility authenticates the voter ID number, the voter ~~must~~ will be prompted to vote in the election.

(4) When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates ~~, allocated in accordance with rule 62 of these rules,~~ for whom ~~they wish~~he or she wishes to vote.

(5) The voter ~~must~~ will not be able to access the telephone voting facility for an election once his or her ~~their~~ vote at that election has been cast.

~~34~~35. Voting procedure for remote voting by text message

(1) To cast ~~their~~ his or her vote by text message the voter ~~must~~ will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided i~~o~~n the voter information.

(2) The text message sent by the voter must contain ~~their~~ his or her voter ID number and the numerical voting code for the candidate or candidates ~~, allocated in accordance with rule 62 of these rules,~~ for whom ~~they wish~~he or she wishes to vote.

(3) The text message sent by the voter ~~must~~ will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

~~35~~36. Receipt of voting documents

(1) Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration ~~of identity~~form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules ~~36~~ 37 and ~~37~~ 38 are to apply.

(2) The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules ~~36~~ 37 and ~~37~~38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

(3) The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

~~36~~37. Validity of votes

(1) A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration ~~of identity~~form if required that has been correctly completed, signed, and dated.

(2) Where the returning officer is satisfied that rule ~~36~~37(1) has been fulfilled, he or ~~/~~she is to:

(a) put the ID declaration ~~of identity~~form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

(3) Where the returning officer is not satisfied that rule ~~36~~37(1) has been fulfilled, he or ~~/~~she is to:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration ~~of identity~~form accompanying the ballot paper, mark it ~~as~~ "disqualified" and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (~~the~~ "list of disqualified documents"), and

(d) place the document or documents in a separate packet.

(4) An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

(5) Where the returning officer is satisfied that rule 37(4) has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of poll.

(6) Where the returning officer is not satisfied that rule 37(4) has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified";

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

(1) Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration for "disqualified";

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper; and

(c) place the ID declaration form in a separate packet.

~~37~~39. De-duplication of votes

(1) Where different ~~a combination of the~~ methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in ~~an~~ the election.

(2) If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in ~~an~~ the election ~~they~~ he or she shall:

(a) only accept as duly returned the first vote received that ~~contained the duplicated~~was cast using the relevant voter ID number; and

(b) mark as "disqualified" all other votes ~~containing the duplicated~~that were cast using the relevant voter ID number

(3) Where a ballot paper is "disqualified" under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper;

(~~b~~c) record the unique identifier and the voter ~~id~~ ID number on the ballot paper in ~~a list (~~the ~~"~~list of disqualified documents~~");~~ ~~and~~

(~~c~~d) place the ~~ballot paper~~document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

(4) Where an internet voting record, telephone voting record or text voting record is "disqualified" under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable)~~record~~ as "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in ~~a list (~~the ~~"~~list of disqualified documents~~"),~~

(c) place the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

(~~c~~d) disregard the internet voting record, telephone voting record or text voting record (as applicable)~~record~~ when counting the votes in accordance with these ~~Rules~~rules.

~~38~~40. Sealing of packets

[1] It should not be possible, technically, to make a declaration or identity electronically without also submitting a vote.

(1) As soon as is possible after the close of the poll and after the completion of the procedure under rules ~~36~~ 37 and ~~37~~38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms,~~s of identity~~ if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records ~~referred t~~created in accordance with ~~o in~~ rule ~~25~~ 26 are held in a device suitable for the purpose of storage.

Part 6 - Counting the votes

~~39~~41. Interpretation of Part 6

(1) In Part 6 of these rules:

"**ballot documents**" means a ballot paper, internet voting record, telephone voting record or text voting record.

"**continuing candidate**" means any candidate not deemed to be elected, and not excluded,

"**count**" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"**deemed to be elected**" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"**mark**" means a figure, an identifiable written word, or a mark such as "X",

"**non-transferable vote**" means a ballot ~~paper~~document:

(a) on which no second or subsequent preference is recorded for a continuing candidate, or

(b) which is excluded by the returning officer under rule ~~47(4)~~49 ~~below~~,

"**preference**" as used in the following contexts has the meaning assigned below:

(a) "**first preference**" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "**next available preference**" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored), and

(c) in this context, a "**second preference**" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"**quota**" means the number calculated in accordance with rule ~~44 below~~46,

"**surplus**" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"**stage of the count**" means:

(a) the determination of the first preference vote of each candidate,

(b) the transfer of a surplus of a candidate deemed to be elected, or

(c) the exclusion of one or more candidates at any given time,

"**transferable vote**" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"**transferred vote**" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"**transfer value**" means the value of a transferred vote calculated in accordance with rules 4547(4) and 4547(7) below.

4042. Arrangements for counting of the votes

(1) The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

(2) The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant elections, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

4143. The count

(1) The returning officer is to:

(a) count and record the number of:

(i) ~~votes~~ ballot papers that have been returned, and

(ii) the number of internet voting records, telephone voting records and/or text voting records that have been created; and

(b) count the votes according to the provisions in this part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

(2) The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records~~votes~~ and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or ~~a voter's~~the voter ID number on an internet voting record, telephone voting record or text voting record.

(3) The returning officer is to proceed continuously with counting the votes as far as is practicable.

4244. Rejected ballot papers and rejected text voting records

(1) Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted but the ballot paper~~s~~ shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

(2) The returning officer ~~shall~~ is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.

(3) Any text voting record:

(a) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason of only carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

(4) The returning officer is to endorse the word “rejected” on any text voting record which under this rule is not to be counted.

(5) The returning officer ~~shall~~ is to draw up a statement showing the number of ballot papers rejected by him or ~~/~~her under each of the sub-paragraphs (a) to (d) of rule ~~42~~44(1) and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule 44(3).

~~43~~45. First stage

(1) The returning officer is to sort the ballot document~~s~~ into parcels according to the candidates for whom the first preference votes are given.

(2) The returning officer is to then count the number of first preference votes given on ballot document~~s~~ for each candidate, and is to record those numbers.

(3) The returning officer is to also ascertain and record the number of valid ballot document~~s~~.

~~44~~46. The quota

(1) The returning officer is to divide the number of valid ballot document~~s~~ by a number exceeding by one the number of members to be elected.

(2) The result, increased by one, of the division under rule ~~44~~46(1) (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

(3) At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules ~~45~~47(1) to ~~45~~47(3) has been complied with.

~~45~~47. Transfer of votes

(1) Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot document~~s~~ on which first preference votes are given for that candidate into sub-parcels so that they are grouped:

(a) according to next available preference given on those ballot document~~s~~ for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

(2) The returning officer is to count the number of ballot document~~s~~ in each parcel referred to in rule ~~45~~47(1).

(3) The returning officer is, in accordance with this rule and rule ~~46~~ 48~~below~~, to transfer each sub-parcel of ballot document~~s~~ referred to in rule ~~45~~47(1)(a) to the candidate for whom the next available preference is given on those ~~papers~~ballot documents.

(4) The vote on each ballot document transferred under rule ~~45~~47(3) shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot document~~s~~ on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

(5) Where at the end of any stage of the count involving the transfer of ballot document~~s~~, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot document~~s~~ in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot document~~s~~ for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

(6) The returning officer is, in accordance with this rule and rule ~~46~~ 48~~below~~, to transfer each sub-parcel of ballot document~~s~~ referred to in rule ~~45~~47(5)(a) to the candidate for whom the next available preference is given on those ballot document~~s~~.

(7) The vote on each ballot document transferred under rule ~~45~~47(6) shall be at:

(a) a transfer value calculated as set out in rule ~~45~~47(4)(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

(8) Each transfer of a surplus constitutes a stage in the count.

(9) Subject to rule ~~45~~47(10), the returning officer shall proceed to transfer transferable ballot document~~s~~ until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

(10) Transferable ballot document~~s~~ shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

(11) This rule does not apply at an election where there is only one vacancy.

~~46~~48. Supplementary provisions on transfer

(1) If, at any stage of the count, two or more candidates have surpluses, the transferable ballot document~~s~~ of the candidate with the highest surplus shall be transferred first, and if:

(a) ~~The~~ the surpluses determined in respect of two or more candidates are equal, the transferable ballot document~~s~~ of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot document~~s~~ of the candidate on whom the lot falls shall be transferred first.

(2) The returning officer shall, on each transfer of transferable ballot document~~s~~ under rule ~~45~~ 47 above:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

(3) All ballot documents transferred under rule ~~45~~ 47 or ~~46~~ 49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

(4) Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule ~~45~~ 47 or ~~46~~ 49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

~~47~~49. Exclusion of candidates

(1) If:

(a) all transferable ballot documents which under the provisions of rule ~~45~~ 47 above (including that rule as applied by rule ~~47~~49(11)) and this rule are required to be transferred, have been transferred, and

(b) subject to rule ~~48~~50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule ~~47~~49(12) applies, the candidates with the then lowest votes).

(2) ~~-~~The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule ~~47~~49(1) into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

(3) The returning officer shall, in accordance with this rule and rule ~~46~~ 48~~above~~, transfer each sub-parcel of ballot documents referred to in rule ~~47~~49(2)~~(a)~~ to the candidate for whom the next available preference is given on those ballot documents.

(4) The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

(5) If, subject to rule ~~48 below~~50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule ~~47~~49(1) into sub-parcels according to their transfer value.

(6) The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

(7) The vote on each transferable ballot document transferred under rule ~~47~~49(6) shall be at the value at which that vote was received by the candidate excluded under rule ~~47~~49(1).

(8) Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

(9) After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or ~~/~~she shall proceed to transfer in the

same way the sub-parcel of ballot documents with the next highest value and so on until he or ~~/~~she has dealt with each sub-parcel of a candidate excluded under rule ~~47~~49(1).

(10) The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

(11) If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules 47(5) to 47(10) and rule ~~46~~48.

(12) Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

(13) If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be ~~made~~ had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

~~48~~50. Filling of last vacancies

(1) Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

(2) Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

(3) Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

~~49~~51. Order of election of candidates

(1) The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule ~~45~~47(10).

(2) A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he or ~~/~~she obtained the quota.

(3) Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

(4) Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

Part 7 – Final proceedings in contested and uncontested elections

~~50~~52. Declaration of result for contested elections

(1) In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he/she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the University Hospital Southampton NHS Foundation Trust by section 33(4) of the 2006 Act, to the ~~Chair~~ chair of the NHS ~~Trust~~trust, or

(ii) in any other case, to the chair ~~man~~ of the corporation, and

(c) give public notice of the name of each candidate who he or ~~/~~she has declared elected.

(2) The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, ~~and~~

(e) the number of rejected ballot papers under each of the headings in rule ~~42~~44(1), and~~,~~

(f) the number of rejected text voting records under each of the headings in rule 44(6),

available on request.

~~51~~53. Declaration of result for uncontested elections

(1) In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or ~~/~~she has declared elected to the chair~~man~~ of the corporation, and

(c) give public notice of the name of each candidate who he or ~~/~~she has declared elected.

Part 8 – Disposal of documents

~~52~~54. Sealing up of documents relating to the poll

(1) On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with "rejected in part",

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and text voting records, ~~and~~

and ensure that ~~(e) the~~ complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with ~~referred to in~~ rule ~~25~~ 26 are held in a device suitable for the purpose of storage.

(2) The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

~~(b) the declarations of identity,~~

(~~c~~b) the list of spoilt ballot papers and the list of spoilt text messages,

(~~d~~c) the list of lost ballot documents, and

(~~e~~d) the list of eligible voters, ~~and~~

or access ~~(f)~~ the complete electronic copies of the internet voting records, telephone voting records and text voting records ~~referred to in~~created in accordance with rule ~~25~~ 26 held in a device suitable for the purpose of storage. ~~..~~

(3) The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency or class within a constituency, to which the election relates.

~~53~~55. Delivery of documents

(1) Once the documents relating to the poll have been sealed up and endorsed pursuant to rule ~~52~~54, the returning officer is to forward them to the chair of the corporation.

~~54~~56. Forwarding of documents received after close of the poll

(1) Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement ~~ballot papers~~voting information are made too late to enable new ~~ballot papers~~ voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

~~55~~57. Retention and public inspection of documents

(1) The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the ~~Regulator~~board of directors of the corporation, cause them to be destroyed.

(2) With the exception of the documents listed in rule ~~56~~58(1), the documents relating to an election that are ~~-~~held by the corporation shall be available for inspection by members of the public at all reasonable times.

(3) A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

~~56~~58. Application for inspection of certain documents relating to an election

(1) The corporation may not allow:

(a) ~~-~~the inspection of, or the opening of any sealed packet containing:

(i~~a~~) any rejected ballot papers, including ballot papers rejected in part,

(ii~~b~~) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(~~c~~iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or~~,~~

~~(d) any declarations of identity,~~

(~~e~~v) the list of eligible voters, or

(~~f~~b) access to or the inspection of the complete electronic copies of the internet voting records, the telephone voting record and the text voting records ~~referred to in~~created in accordance with rule ~~25~~ 26 held in a device suitable for the purpose of storage

by any person without the consent of the ~~Regulator~~board of directors of the corporation.

(2) A person may apply to the ~~Regulator~~ board of directors of the corporation to inspect any of the documents listed in rule ~~56~~58(1), and the ~~Regulator~~ board of directors if the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

(3) The ~~Regulator's~~ board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to:

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

(4) On an application to inspect any of the documents listed in rule ~~56~~58(1), the board of directors of the corporation must:

(a) in giving its consent~~, the Regulator~~, and

(b) in making the documents available for inspection~~, the corporation~~,

must ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established:

(i) that his or ~~/~~her vote was given, and

(ii) that ~~the Regulator~~Monitor has declared that the vote was invalid.

Part 9 – Death of a candidate during a contested election

~~57~~59. Countermand or abandonment of poll on death of candidate

(1) If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate ~~has~~ had been excluded from the count so that:

(i) ballot documents~~papers~~ which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents~~papers~~ which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

(2) The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot document~~paper~~s pursuant to rule ~~52~~54(1)(a).

Part 10 – Election expenses and publicity

Expenses

~~58~~60. Election expenses

(1) Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application to Monitor ~~the Regulator~~ under Part 11 of these rules.

~~59~~61. Expenses and payments by candidates

(1) A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

~~60~~62. Election expenses incurred by other persons

(1) No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

(2) Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 61 63 and 6264.

Publicity

~~61~~63. Publicity about election by the corporation

(1) The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions, as it considers necessary

(2) Any information provided by the corporation about the candidates, including information compiled by the corporation under rule ~~62~~ 64 must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

(3) Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

~~62~~64. Information about candidates for inclusion with voting ~~documents~~ information

(1) The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

(2) The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling~~ for the election~~~~method~~, the numerical voting code, allocated by the returning officer, to each candidate, for the purpose of recording votes ~~on~~ using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

~~63~~65. Meaning of "for the purposes of an election"

(1) In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

(2) The provision by any individual of his or ~~/~~her own services voluntarily, on his or ~~/~~her own time, and free of charge is not to be considered an expense for the purposes of this Part.

Part 11 – Questioning elections and the consequence of irregularities

~~64~~66. Application to question an election

(1) An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to ~~the Regulator~~Monitor.

(2) An application may only be made once the outcome of the election has been declared by the returning officer.

(3) An application may only be made to ~~the Regulator~~Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

(4) The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as ~~the Regulator~~Monitor may require.

(5) The application must be presented in writing within 21 days of the declaration of the result of the election.

(6) If ~~the Regulator~~Monitor requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

(7) ~~The Regulator~~Monitor shall delegate the determination of an application to a person or panel of persons ~~of the Regulator~~ to be nominated for the purpose ~~of the Regulator~~.

(8) The determination by the person or panel of persons nominated in accordance with rule ~~64~~66(7) shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

(9) ~~The Regulator~~Monitor may prescribe rules of procedure for the determination of an application including costs.

Part 12 – Miscellaneous

~~65~~67. Secrecy

(1) The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information ~~a ballot paper~~ or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter

(iv) the candidate(s) for whom any member has voted ~~for on any particular ballot paper~~.

(2) No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ~~id~~ ID number allocated to a voter.

(3) The returning officer is to make such arrangements as he or ~~/~~she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

~~66~~68. Prohibition of disclosure of vote

(1) No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or ~~/~~she has voted.

~~67~~69. Disqualification

(1) A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

~~68~~70. Delay in postal service through industrial action or unforeseen event

(1) If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24 or

(b) the return of the ballot papers ~~and declarations of identity~~,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate~~, with the agreement of the Regulator~~.

ANNEX 5
Additional Provisions – Council of Governors

1. Process for investigating and resolving complaints made against a governor

1.1 A person wishing to make a complaint concerning the conduct of a governor shall do so in writing to the chair.

1.2 Where a complaint is made under paragraph 1.1 above:

1.2.1 the chair, shall, if in their opinion it is appropriate do so, take fair and reasonable steps to resolve the matter informally within 10 working days from receipt of the written complaint.

1.2.2 the chair, may choose to delegate their responsibility under paragraph 1.2.1 above to another person.

1.3 If the complaint cannot be resolved by informal resolution under paragraph 1.2 above, or the chair decides that informal resolution is not appropriate, the chair may take such action as they consider is appropriate in the circumstances, including, but not limited to:

1.3.1 the suspension of the governor against whom the complaint has been made from the council of governors so that the matter can be investigated. Any suspension of a governor shall be confirmed to them in writing; and

1.3.2 commissioning an investigation into the complaint, to be conducted by individuals with relevant experience from either within or outside of the Trust.

1.4 As soon as reasonably practicable following any decision taken by the chair under clause 1.3 above, the chair shall inform the council of governors that such a decision has been taken, and, to the extent appropriate the reasons for it.

1.5 As soon as reasonably practicable following a decision to commission an investigation, the chair shall provide to the council of governors, to the extent they consider it appropriate, a copy of the terms of reference of such investigation.

1.6 Where an investigation identifies, or, if no investigation is commissioned, the chair believes, a governor has failed to comply with this constitution and/or any code of conduct applying to governors, and/or the Standing Orders, the council of governors shall be asked to decide by a majority of those present and voting, whether to approve a statement of non-compliance or misconduct, which shall set out the reasons for such non-compliance or misconduct.

1.7 The governor concerned shall be notified in writing and provided with a copy of the statement of non-compliance and will be invited to respond within an appropriate and reasonable timescale as determined by the council of governors in the statement of non-compliance. The governor shall be invited to address the Council of Governors in person if the matter cannot be resolved satisfactorily through correspondence.

1.8 Having considered the governor's response, the council of governors shall decide by a majority of those present and voting whether to uphold the statement of non-compliance.

1.9 If the statement of non-compliance is upheld:

1.9.1 subject to paragraph 1.9.2 below, the council of governors may by a majority of those present and voting impose such sanctions as it deems appropriate. This may include a written warning, non-payment of expense suspension from office.

1.9.2 the chair or any other governor may propose a resolution to remove the governor in question from office.

1.10 Where a resolution to remove a governor is proposed and the governor concerned does not believe that the proposal is justified, the chair shall offer the governor in question the opportunity to have the reasonableness of the proposal reviewed by an independent assessor (a "review"). The chair and the governor shall seek to agree on a mutually acceptable independent assessor. If no agreement can be reached within 14 days of the governor requesting a review, then the chair shall decide on the independent assessor.

2. Suspension or termination of office of a governor

2.1 A governor may resign from office by giving notice in writing to the secretary.

2.2 If a governor fails to attend two successive meetings of the council of governors, his/her tenure of office is to be immediately terminated by the council of governors unless the council is satisfied that:

2.2.1 the absences were due to reasonable cause; and

2.2.2 he/she will be able to attend meetings of the council of governors within such a period, as the council of governors considers reasonable.

2.3 Subject to paragraph 1 the council of governors may by a resolution approved by a majority of governors present and entitled to vote at a properly constituted meeting of the council of governors terminate a governor's tenure of office if it considers:

2.3.1 he/she has failed to undertake any training which the council of governors requires all governors to undertake;

2.3.2 he/she has committed a serious breach of the code of conduct for governors, or

2.3.3 he/she has acted in a manner detrimental to the interests of the Trust.

ANNEX 6

Standing Orders for the Practice and Procedure of the Council of Governors

(Paragraph ~~16~~18)

CONTENTS:

1. Introduction

These standing orders for the practice and procedures of the council of governors (and any sub-committees) are the standing orders referred to in paragraph ~~16~~ 18 of the Constitution.

2. Interpretation

2.1 The definition and interpretation of words and expressions contained in these standing orders are as set out at paragraph ~~45~~ 47 of the constitution.

2.2 Save as otherwise permitted by law, at any meeting the ~~Chairman~~ chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he/she should be advised by the ~~Chief~~ chief ~~Executive~~ executive and the ~~Secretary~~secretary).

3. The council of governors

The council of governors may only exercise its powers in formal session.

4. Meetings of the council of governors

4.1 ***Admission of the Public and the Press***

The public and representatives of the press shall be afforded facilities to attend all formal meetings of the council of governors subject to Standing Orders 4.1.1 and 4.1.2 below.

4.1.1 The council of governors may resolve to exclude members of the public and representative of the press from any meeting or part of a meeting on the grounds that:

4.1.1.1 publicity would be prejudicial to the public interest having regard to the confidential nature of the business to be transacted; or

4.1.1.2 there are special reasons stated in the resolution and arising from the nature of the business of the proceedings.

4.1.2 The council of governors may resolve, in the interests of public order, that the meeting shall adjourn for a period to be specified in the resolution to enable the council of governors to complete business without the presence of the public.

4.1.3 Nothing in these standing orders shall require the council of governors to allow members of the public and representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the council of governors.

4.1.4 In the event that the public and press are admitted to all or part of a meeting, the chair (or other person presiding) shall give such directions as he/she thinks fit in regard to the arrangements for meetings and accommodation of the public and press so as to ensure that the council of governors' business shall be conducted without interruption and disruption.

4.1.5 The Trust may make such arrangements from time to time as it sees fit with regards to extending of invitations to observers to attend and address the council of governors.

4.2 ***Calling meetings***

4.2.1 Meetings of the council of governors shall be held at such times and places as the council of governors may determine and there shall be not less than

four meetings in any year.

4.2.2 The chair, or in his/her absence the deputy chair, may call a meeting of the council of governors at any time. If the chair refuses to call a meeting after a requisition for that purpose, signed by at least one third of the whole number of the governors and specifying the business to be transacted at the meeting, has been presented to them, or if, without so refusing, the chair does not call a meeting within seven clear days after such requisition has been presented to them at the Trust's Headquarters, such one third or more of the governors may forthwith call a meeting for the purpose of conducting that business.

4.3 ***Notice of meetings***

4.3.1 Before each meeting of the council of governors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the chair or by an officer of the Trust authorised by the chair to sign on his/her behalf, shall be delivered to, or sent by email, or sent by post to the usual place of residence of every governor, so as to be available to them at least five clear days before the meeting save in the case of emergencies. Subject to Standing Order 4.3.4 below, lack of service of the notice on any governor shall not affect the validity of a meeting.

4.3.2 Notwithstanding the above requirement for notice, the chair may waive notice in writing on written receipt of agreement of at least half of the governors.

4.3.3 In the case of a meeting called by governors in default of the chair, the notice shall be signed by those governors and no business shall be transacted at the meeting other than that specified in the requisition.

4.3.4 Subject to Standing Order 4.3.2, failure to serve notice on more than three-quarters of governors will invalidate any meeting. A notice will be presumed to have been served 48 hours after it was posted.

4.3.5 Save in an emergency, an agenda shall be sent to each governor so as to arrive no later than 5 days in advance of each meeting and supporting papers, whenever possible, shall accompany the agenda. Minutes of the previous meeting will be circulated with the papers for approval and this will be a specific agenda item.

4.3.6 Before any meeting of the council of governors which is to be held in public, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Trust's website and at the Trust's premises at least three clear days before the meeting.

4.4 ***Setting the agenda***

4.4.1 The council of governors may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

4.4.2 A governor desiring a matter to be included on an agenda shall make his/her request in writing to the chair at least ten clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than ten clear days before a meeting may be included on the agenda at the discretion of the chair.

4.5 ***Chair of meeting***

4.5.1 The chair is appointed in accordance with the constitution ~~(annex 9 appendix 4)~~.

4.5.2 At any council of governors meeting, the chair, if present, shall preside.

4.5.3 If the chair is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest the deputy chair shall preside.

4.5.4 If the deputy chair is also absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest, another non-executive director shall preside.

4.5.5 If no non-executive director is available such governor as the governors that are present shall appoint, shall preside.

4.6 ***Motions***

4.6.1 A governor wishing to move or amend a motion shall send written notice of it to the chair at least ten clear days before the meeting. ~~-~~Requests made less than ten days before a meeting may be included on the agenda at the discretion of the chair.~~-~~ This paragraph shall not prevent any motion being moved during the meeting, without notice, on any business mentioned on the agenda subject to Standing Order 4.3.3.

4.6.2 A motion or amendment once moved and seconded, may be withdrawn by the proposer with the concurrence of the seconder and the consent of the chair.

4.6.3 Notice of a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months, shall bear the signature of the governors who gave it and also the signature of four other governors.~~–~~ When the council of governors has disposed of any such motion it shall not be competent for any governor to propose a motion to the same effect within six months; however the chair may do so if he/she considers it appropriate.

4.6.4 The mover of a motion shall have the right of reply at the close of any discussion on the motion or any amendment thereto.

4.6.5 When a motion is under discussion or immediately prior to discussion it shall be open to a governor to move:

4.6.5.1 an amendment to the motion;

4.6.5.2 the adjournment of the discussion or the meeting;

4.6.5.3 that the meeting proceed to the next business;

4.6.5.4 the appointment of an ad hoc committee to deal with a specific item of business;

4.6.5.5 that the motion be now put.

No amendment to the motion shall be admitted if, in the opinion of the chair of the meeting, the amendment negates the substance of the motion.

4.6.6 Emergency motion

Subject to the agreement of the chair and this Standing Order 4.7.6, a governor may give written notice of an emergency motion after the issue of the notice of meeting and agenda up to one hour before the time fixed for

the meeting. The notice shall state the grounds of urgency. At the chair's discretion, the emergency motion shall be declared to the council of governors at the commencement of the business of the meeting as an additional item included on the agenda. The chair's decision to include the item shall be final.

4.7 ***Chair's ruling***

Statements of governors made at meetings of the council of governors shall be relevant to the matter under discussion at the material time and the decision of the chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

4.8 ***Voting***

4.8.1 A governor may not vote at a meeting of the council of governors unless he/she has made a declaration in the form specified within these Standing Orders, that he/she is a member of the constituency which elected him/her and is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 to the 2006 Act or under the Constitution. Such declaration must be dated at least 7 Clear Days prior to the commencement of the meeting.

4.8.2 Except as stated otherwise in the constitution or these standing orders, every question at a meeting shall be determined by a majority of the votes of the governors present and voting on the question.

4.8.3 All questions put to the vote shall, at the discretion of the chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the governors present so request.

4.8.4 Whoever is chair of the meeting of the council of governors shall in the case of an equality of votes on any question or proposal have a casting vote.

4.8.5 If at least one-third of the governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each governor present voted or abstained.

4.8.6 If a governor so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

4.8.7 A governor may only vote if present at the time of the vote on which the question is to be decided; no governor may vote by proxy.

4.8.8 Any matter which could be decided by the council of governors in a meeting may be determined by written resolution. A written resolution shall, with any accompanying papers which are relevant, describe the matter to be decided and provide for governors to sign the resolution to confirm their agreement. A written resolution may comprise identical documents sent to all governors, each to be signed by a governor, or one document to be signed by all governors. A written resolution shall be passed only when at least three-quarters of the governors, including a majority of governors who are members of the public constituency of the Trust, approve the resolution in writing within the timescale imposed in such a notice. A written resolution may be circulated in electronic form (including by email) and signed and returned electronically or approval indicated in writing by email from the email address to which the written resolution was sent in order to meet the requirements of this provision. The secretary shall keep records of all written resolutions.

4.9 ***Meetings: Electronic Communication***

4.9.1 In this Standing Order "communication" and "electronic communication" shall have the meanings set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof.

4.9.2 A governor in electronic communication with the chair and all other parties to a meeting of the council of governors or of a committee or sub-committee of the governors shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting he/she has the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

4.9.3 A meeting at which one or more of the governors attends by way of electronic communication is deemed to be held at such a place as the governors shall at the said meeting resolve. –In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the governors attending the meeting are physically present, or in default of such a majority, the place at which the chair of the meeting is physically present.

4.9.4 Meetings held in accordance with this standing order are subject to requirements in respect of quorum. –For such a meeting to be valid, a quorum must be present and maintained throughout the meeting.

4.9.5 The minutes of a meeting held in this way must state that it was held by electronic communication and that the governors were all able to hear each other and were present throughout the meeting.

4.10 ***Minutes***

4.10.1 The minutes of the proceedings of a meeting shall be drawn up by the secretary and submitted for agreement at the next ensuing meeting where the chair presiding at it will sign them.

4.10.2 No discussion shall take place upon the minutes except upon their accuracy or where the chair considers discussion appropriate. –Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.11 ***Attendance***

Governors who are unable to attend a meeting shall notify the secretary in advance of the meeting so that their apologies may be submitted.

4.12 ***Suspension of Standing Orders***

4.12.1 Except where this would contravene any statutory provision or any direction made by ~~Monitor~~NHS England, any one or more of the standing orders may be suspended at any meeting, provided that at least two-thirds of the governors are present, there is a majority of governors who are members of the public constituency of the Trust, and that a majority of those present vote in favour of suspension.

4.12.2 A decision to suspend the standing orders shall be recorded in the minutes of the meeting.

4.12.3 A separate record of matters discussed during the suspension of standing orders shall be made and shall be available to the chair and governors.

4.12.4 No formal business may be transacted while standing orders are

suspended.

4.13 ***Variation and amendment of Standing Orders***

These standing orders may only be amended in accordance with paragraph ~~43~~ 44 of the constitution.

4.14 ***Record of attendance***

The names of the chair and governors present at the meeting shall be recorded in the minutes.

4.15 ***Quorum***

4.15.1 No business shall be transacted at a meeting unless at least one third of the total number of governors entitled to vote are present at the meeting with the majority of those governors present being from the public constituency.

4.15.2 If at any meeting there is no quorum present within 30 minutes of the time fixed for the start of the meeting, the meeting shall stand adjourned for five clear days and upon reconvening, those present shall constitute a quorum.

4.15.3 If a governor has been disqualified from participating in the discussion on any matter and/or from other voting on any resolution by reason of the declaration of a conflict of interest then he/she shall no longer count towards the quorum. ~~-~~If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. ~~-~~Such a position shall be recorded in the minutes of the meeting. ~~-~~The meeting must then proceed to the next business.

5. Committees

5.1 Subject to any direction and/or guidance of ~~Monitor~~NHS England, the council of governors may and, if directed by ~~Monitor~~NHS England, shall appoint committees of the council of governors from time to time to assist it in the proper performance of its functions under the constitution and the regulatory framework, consisting wholly or partly of members of the council of governors and the board of directors.

5.2 A committee appointed under Standing Order 5.1 may, subject to such directions as may be given by ~~Monitor~~ NHS England or the council of governors, appoint sub-committees consisting wholly or partly of members of the council of governors and the board of directors.

5.3 These standing orders, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the council of governors with the term "chair" to be read as a reference to the chair of the committee and the term "member" to be read as a reference to a member of the committee as the context permits.

5.4 Each committee of the council of governors shall have such terms of reference and remit and shall be subject to such conditions as the council of governors shall decide and shall be in accordance with the regulatory framework and any direction or guidance issued by ~~Monitor~~ NHS England but, for the avoidance of doubt, the council of governors may not delegate to any such committee any of its powers or responsibilities.

5.5 Where committees are authorised to establish sub-committees they may not require such sub-committees to carry out any of their responsibilities unless expressly authorised by the council of governors.

5.6 Where the council of governors determines that persons who are neither governors, nor members of the board of directors nor officers of the Trust, shall be appointed to a committee, the terms of such appointment shall be determined by the council of governors subject to the payment of travelling expenses and other allowances being in accordance with such sum as may be determined by the board of directors or ~~Monitor~~NHS England.

5.7 If the Board of Directors agrees, the Council of Governors may appoint Governors to serve on joint committees with the Board of Directors or committees of the Board of Directors. Where Governors are appointed to committees of the Board of Directors they shall have observer status only.

6. Declarations of interests and register of interests

6.1 *Declaration of interests*

6.1.1 The regulatory framework and the constitution require each governor to declare to the secretary :

6.1.1.1 any actual or potential, direct or indirect, financial interest which is material to any discussion or decision they are involved, or likely to be involved, in making, as described in Standing Orders 6.2.2 and 6.2.6 (subject to Standing Order 6.2.3); and

6.1.1.2 any actual or potential, direct or indirect, non-financial professional interest, which is material to any discussion or decision they are involved, or likely to be involved, in making, as described in Standing Orders 6.2.4 and 6.2.6; and

6.1.1.3 any actual or potential, direct or indirect, non-financial personal interest, which is material to any discussion or decision they are involved, or likely to be involved, in making, as described in Standing Orders 6.2.5 and 6.2.6 .

6.1.2 Such a declaration shall be made either at the time of the governor's election or appointment or as soon thereafter as the interest arises, but within five clear days of becoming aware of the existence of that interest, and in such manner as the secretary may prescribe from time to time.

6.1.3 In addition, if a governor is present at a meeting of the council of governors and has an interest of any sort in any matter which is the subject of consideration, he/she shall, at the meeting and as soon as practicable after its commencement, disclose the fact and the chair shall then decide what action to take. This may include excluding the governor from discussion on the matter and/or prohibiting the governor from voting on any question with respect to the matter.

6.1.4 Subject to Standing Order 6.2.3, if a governor has declared a pecuniary interest (as described in Standing Order 6.2.2) he/she shall not take part in the consideration or discussion of the matter.

6.1.5 Any interest declared at a meeting of the council of governors and subsequent action taken should be recorded in the council of governors' meeting minutes. Any changes in interests should be officially declared at the next relevant meeting following the change occurring.

6.1.6 This Standing Order 6 applies to any committee, sub-committee or joint committee of the council of governors and applies to any member of any such committee, sub-committee, or joint committee (whether or not he/she is also a governor).

6.1.7 The interests of governors in companies likely or possibly seeking to do business with the NHS should be published in the Trust's Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

6.2 ***Nature of Interests***

6.2.1 Interests which should be regarded as "material" are ones which a reasonable person would take into account when making a decision regarding the use of taxpayers' money because the interest has relevance to that decision. Material interests are to be interpreted in accordance with guidance issued by ~~Monitor~~NHS England.

6.2.2 A financial interest is where a governor may receive direct financial benefits (by either making a gain or avoiding a loss) from the consequences of a decision of the council of governors. This could include:

6.2.2.1 directorships, including non-executive directorships held in any other organisation which is doing, or is likely to be doing business with an organisation in receipt of NHS funding;

6.2.2.2 employment in an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding; or

6.2.2.3 a shareholding, partnerships, ownership or part ownership of an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding.

6.2.3 A governor shall not be treated as having a financial interest in any a matter by reason only:

6.2.3.1 of his/her membership of a company or other body, if he/she has no beneficial interest in any securities of that company or other body; or

6.2.3.2 of shares or securities held in collective investment or pensions funds or units of authorised unit trusts; or

6.2.3.3 of an interest in any company, body or person with which he/she is connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter; or

6.2.3.4 of any travelling or other expenses or allowances payable to a governor in accordance with the constitution.

6.2.4 A non-financial professional interest is where a governor may obtain a non-financial professional benefit from the consequence of a decision that the council of governors makes, such as increasing their professional reputation or status or promoting their professional career. This could include situations where a governor is:

6.2.4.1 an advocate for a particular group of patients; or

6.2.4.2 a clinician with a special interest; or

6.2.4.3 an active member of a particular specialist body; or

6.2.4.4 an advisor for the Care Quality Commission or National Institute of Health and Care Excellence.

6.2.5 A non-financial personal interest is where a governor may benefit personally f~~o~~rom a decision that the council of governors makes in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include where the governor is:

6.2.5.1 a member of a voluntary sector board or has a position of authority within a voluntary sector organisation with an interest in health and/or social care; or

6.2.5.2 a member of a lobbying or pressure group with an interest in health and/or social care.

6.2.6 A governor will be treated as having an indirect financial interest, non-financial professional interest or non-financial personal interest where he/she has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision in which the governor is involved in making. This includes material interests of:

6.2.6.1 close family members and relatives, including a spouse or partner or any parent, child, brother or sister of a governor;

6.2.6.2 close friends and associates; and

6.2.6.3 business partners.

6.2.7 If governors have any doubt about the relevance or materiality of an interest, this should be discussed with the chair. ~~–~~Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. ~~–~~The interests of partners in professional partnerships including General Practitioners should also be considered.

6.3 ***Register of interests***

6.3.1 The secretary shall keep a register of interests of governors, which shall contain the names of each governor, whether he/she has declared any interest, and if so, the interest declared.

6.3.2 These details will be kept up to date by means of an annual review of the register of interests in which any changes to interests declared during the preceding twelve months will be incorporated.

6.3.3 The register of interests will be available to the public in accordance with the constitution and the chief executive will take reasonable steps to bring the existence of the register of interests to the attention of the local population.

6.3.4 In establishing, maintaining and publicising the register of interests, the Trust shall comply with all guidance issued from time to time by ~~Monitor~~NHS England.

7. Standards of business conduct

Each governor shall comply with the Trust's code of conduct and any guidance and directions issued by ~~Monitor~~NHS England, in particular the NHS Foundation Trust Code of Governance.

8. Appointments and recommendations

8.1 A governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment but this paragraph of this standing order

shall not preclude members from giving written testimonial of a candidate's ability, experience or character for submission to the Trust in relation to any appointment.

8.2 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.3 Candidates for any staff appointment under the Trust shall, when making such an application, disclose in writing to the Trust whether they are related to any governors or the holder of any office within the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

8.4 The chair and every governor shall disclose to the chief executive or his/her delegated officer any relationship between themselves and a candidate of whose candidature that governor or officer is aware. It shall be the duty of the chief executive or his/her delegated officer to report to the council of governors any such disclosure made.

8.5 On appointment, each governor should disclose to the council of governors whether they are related to any other governor or holder of any office in the Trust.

8.6 Where the relationship to another governor is disclosed, Standing Order 6 shall apply.

9. Confidentiality

9.1 All governors shall abide by the Trust's policies on confidentiality and code of conduct.

9.2 A member of the council of governors or an attendee on a committee of the council of governors shall not disclose a matter dealt with by, or brought before, the council of governors without its permission, or until the committee shall have reported to the council of governors or shall otherwise have concluded on that matter.

9.3 A governor or other attendee at a committee shall not disclose any matter dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the council of governors or committee resolves that it is confidential.

10. Interface between the council of governors and the board of directors

The council of governors will cooperate with the board of directors as far as possible in order to comply with the regulatory framework in all respects and in particular in relation to matters set out in the constitution. In the event of a dispute arrangements are set out in annex ~~9~~8, appendix 2, paragraph 2.

11. Miscellaneous

11.1 The secretary shall provide a copy of these standing orders to each governor and endeavour to ensure that each governor understands his/her responsibilities within these standing orders.

11.2 If for any reason these standing orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the council of governors for action or ratification. All governors have a duty to disclose any non-compliance with these standing orders to the chair as soon as possible.

12. Council of governors: declarations

12.1 A member of a public constituency standing for election as governor must make a declaration for the purposes of Section 60(2) of the 2006 Act in the form specified ~~below~~ stating the particulars of his/her qualification to vote as a member and that he/she is not prevented from being a governor by virtue of paragraph 8 of Schedule 7 of the 2006 Act. It is an offence to knowingly or recklessly make a statement or declaration in respect of Section 60(2) of the 2006 Act which is false in material

particular.

12.2 The specified form of declaration shall be set out on the nomination form referred to in the ~~Model~~ model ~~Election~~ election ~~Rules~~ rules at annex 4. ~~and shall state as follows:~~

~~*"I, the above named candidate, consent to my nomination and agree to stand for election to the council of governors in the constituency indicated in Section 1 of this form. I also declare that I am a member in that constituency.*~~

~~*I, the above named candidate, hereby declare that I am not:*~~

~~*(a) a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;*~~

~~*(b) a person who has made a composition or arrangement with, or granted a trust deed for, his/her creditors and has not been discharged in respect of it;*~~

~~*(c) a person who within the preceding 5 years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than 3 months (without the option of a fine) was imposed on him/her.*~~

~~*I confirm that to the best of my knowledge, the information provided on (or in connection with) this form is accurate".*~~

12.3 A governor elected to the council of governors by the public constituency or staff constituency may not for the purposes of Section 60(3) of the 2006 Act vote at a meeting of the council of governors unless within the period since his/her election, he/she has made a declaration in the form specified below stating which constituency he/she is a member of, and is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 to the 2006 Act:

"*I declare that I am a member of the public constituency or staff constituency and am eligible to vote at a meeting of the council of governors, and that I am not debarred from voting by any of the provisions in paragraph 8 of Schedule 7 to the 2006 Act* ".

13. Lead governor and deputy lead governor

13.1 The council of governors shall appoint or elect a governor as the lead governor.

13.2 A ~~Governor~~ governor seeking election as ~~Lead~~ lead ~~Governor~~ governor will be required to submit a written statement to the ~~Company S~~secretary or equivalent in support of their candidature by a specific deadline. The statement must not be in excess of 300 words. Statements will be circulated to all ~~Governors~~ governors by the ~~Company S~~secretary by email following the expiry of the deadline for submission. Governors shall be provided with a deadline to register an electronic vote by email. The ~~Company s~~Secretary shall act as the ~~Returning~~ returning ~~Officer~~ officer in respect of the election.

13.3 The lead governor shall provide his/her contact details to NHS Improvement (NHSI) and continue to update NHSI and the council of governors with his/her contact details as and when they change.

13.4 The role of the lead governor is to facilitate direct communication between NHSI and the council of governors in the limited circumstances where it may not be appropriate to communicate through the normal channels. ~~–~~The council of governors may agree that the lead governor should undertake other specified duties.

13.5 The lead governor shall take steps to understand NHSI's role, the available guidance and the basis on which ~~Monitor~~ NHS England may take regulatory action.

13.6 In the event that an individual governor wishes to make contact with NHSI, this contact will be through the lead governor.

13.7 The council of governors may appoint or elect a deputy lead governor to undertake such responsibilities as the council of governors may specify.

13.8 The same process set out at 13.1~~.1~~ used for the appointment of the ~~Lead~~ lead ~~Governor~~ governor ~~to~~ will be used for the appointment of the ~~Deputy~~ deputy ~~Lead~~ lead ~~Governor~~governor.

ANNEX 7

Standing Orders for the Practice and Procedure of the Board of Directors

(Paragraph ~~26~~31)

Contents:

22. Sealing of documents
23. Signature of documents
24. Suspension of standing orders
25. Confidentiality
26. Interface between the board of directors and the council of governors
27. Standing orders to be given to members of the Board and officers

Introduction

These standing orders for the practice and procedures of the board of directors (and any sub-committees) are the standing orders referred to in paragraph 31 of the constitution.

1. Interpretation

The definition and interpretation of words and expressions contained in these standing orders are as set out at paragraph ~~45~~ 47 of the constitution.

Save as otherwise permitted by law, at any meeting the ~~Chairman~~ chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he/she should be advised by the ~~Chief~~ chief ~~Executive~~ executive and ~~Secretary~~secretary).

2. Not Used

3. Not Used

4. Meetings

4.1 ***Calling of meetings***

4.1.1 Ordinary meetings of the board of directors shall be held at regular intervals at such times and in such places as the board of directors may determine. Board meetings shall be held in public but the whole or any part of a meeting may be held in private if the Board so resolves.

4.1.2 The chair may call a meeting of the Board at any time.

4.1.3 One third or more directors of the Board may requisition a meeting in writing. If the chair refuses, or fails, to call a meeting within seven clear days of a requisition being presented, the directors signing the requisition may forthwith call a meeting.

4.2 ***Notice of meetings***

4.2.1 Before each meeting of the Board, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the chair or by an officer of the Trust authorised by the chair to sign on his/her behalf, shall be delivered to, or sent by email, or sent by post to the usual place of residence of every director, so as to be available to them at least five clear days before the meeting save in the case of emergencies.

4.2.2 In the case of a meeting called by directors in default of the chair calling the meeting, the notice shall be signed by those directors.

4.2.3 Failure to serve notice on more than three directors will invalidate any meeting. A notice will be deemed to have been served 48 hours after it was posted.

4.2.4 Before any meeting of the Board which is to be held in public, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Trust's website and at the Trust's premises at least three clear days before the meeting.

5. Agendas and supporting papers

Save in an emergency, an agenda shall be sent to each director so as to arrive with each director no later than 5 days in advance of each meeting and supporting papers, whenever possible, shall accompany the agenda. Minutes of the previous meeting will be circulated with the papers for approval and this will be a specific agenda item.

6. Motions

6.1 A member of the Board wishing to move or amend a motion shall send written notice of it to the chair at least ten clear days before the meeting. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the chair. This paragraph shall not prevent any motion being moved during the meeting, without notice, on any business mentioned on the agenda subject to standing order 7.5.

6.2 A motion or amendment once moved and seconded, may be withdrawn by the proposer with the concurrence of the seconder and the consent of the chair.

6.3 Notice of a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months, shall bear the signature of the director who gave it and also the signature of four other members of the Board. When the Board has disposed of any such motion it shall not be competent for any member of the Board, other than the chair, to propose a motion to the same effect within six months; however the chair may do so if he/she considers it appropriate.

6.4 The mover of a motion shall have the right of reply at the close of any discussion on the motion or any amendment thereto.

6.5 When a motion is under discussion or immediately prior to discussion it shall be open to a director to move:

6.5.1 an amendment to the motion;

6.5.2 the adjournment of the discussion or the meeting;

6.5.3 that the meeting proceed to the next business;

6.5.4 the appointment of an ad hoc committee to deal with a specific item of business;

6.5.5 that the motion be now put.

No amendment to the motion shall be admitted if, in the opinion of the chair of the meeting, the amendment negates the substance of the motion.

6.6 ***Emergency Motion***

Subject to the agreement of the chair and this standing order 7, a director may give written notice of an emergency motion after the issue of the notice of meeting and agenda up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. At the chair's discretion, the emergency motion shall be declared to the Board at the commencement of the business of the meeting as an additional item included on the agenda. The chair's decision to include the item shall be final.

7. Voting

7.1 All questions put to the vote shall, at the discretion of the chair, be decided by a show of hands. A paper ballot may be used if a majority of the board of directors present so request.

7.2 Save as provided in the constitution, every question put to a vote at a meeting shall be determined by a majority of the votes of the directors present and voting on the question.

7.3 In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

7.4 In the case of an equal vote, the chair or such other person presiding at the meeting shall have a second, and casting vote.

7.5 If at least one-third of the Directors present so request, the voting (other than by paper ballot), on any question may be recorded to show how each Director present voted or abstained.

7.6 If a Director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

7.7 An Officer who has been appointed formally by the board of directors to act up for an executive director during a period of incapacity or temporarily to fill an executive director vacancy, shall be entitled to exercise the voting rights of the executive director. An Officer attending the board of directors to represent an executive director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive director. An Officer's status when attending a meeting shall be recorded in the minutes.

~~7.7~~7.8 Any matter which could be decided by the board of directors in a meeting may be determined by written resolution. A written resolution shall, with any accompanying papers which are relevant, describe the matter to be decided and provide for directors to sign the resolution to confirm their agreement. A written resolution may comprise identical documents sent to all directors, each to be signed by a director. or one document to be signed by all directors. A written resolution shall be passed only when at least three-quarters of the directors approve the resolution in writing within the timescale imposed when sent. A written resolution may be circulated in electronic form (including by email) and signed and returned electronically or approval indicated in writing by email from the email address to which the written resolution was sent in order to meet the requirements of this provision. The secretary shall keep records of all written resolutions.

8. Meetings: Electronic Communication

8.1 In this Standing Order "communication" and "electronic communication" shall have the meanings set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof.

8.2 A director in electronic communication with the chair and all other parties to a meeting of the board of directors or of a committee or sub-committee of the directors shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting he/she has the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

8.3 A meeting at which one or more of the directors attends by way of electronic communication is deemed to be held at such a place as the directors shall at the said meeting resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the directors attending the meeting are physically present, or in default of such a majority, the place at which the chair~~man~~ of the meeting is physically present.

8.4 The minutes of a meeting held in this way must state that it was held by electronic communication and that the directors were all able to hear each other and were present throughout the meeting.

9. Attendance

Directors who are unable to attend a meeting shall notify the secretary in advance of the meeting in question so that their apologies may be submitted.

10. Quorum

10.1 The quorum of a meeting will be at least half of the whole number of members of the Board (including at least one non-executive director and one executive director).

10.2 An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

10.3 If a member of the Board has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

10.4 The requirement in standing order 10.1 above for a least one executive director to form part of the quorum shall not apply where the executive directors are excluded from a meeting.

11. Chair

The chair is appointed in accordance with the constitution ~~(annex 9 appendix 4)~~ and shall be responsible for the operation of the board of directors (and council of governors), and chair all board of directors (and council of governors) meetings when present.

12. 12.1 Deputy Chair

The deputy chair is appointed in accordance with the constitution.

12.2 Senior Independent Director

The senior independent director is appointed in accordance with the constitution.

~~Not used~~

~~12~~13 **Executive directors**

Executive directors are appointed in accordance with the constitution ~~(annex 9 appendix 4)~~ and shall exercise their authority within the terms of these standing orders, the standing financial instructions and the scheme of reservation and delegation.

~~13~~14 **Chief executive**

The chief executive shall be responsible for the overall performance of the executive functions of the Trust and is the accountable officer for the Trust.

~~14~~15 **Finance director**

The finance director shall be responsible for the provision of financial advice to the Trust and for the supervision of financial control and accounting systems.

~~15~~16 **Non-executive directors**

The non-executive directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust.

~~16~~17 **Not used**

~~17~~18 **Arrangements for the exercise of Trust functions by delegation**

~~17.2~~18.2 ***Scheme of reservation and delegation***

The chief executive shall prepare a scheme of reservation and delegation identifying matters that shall be reserved and those to be delegated which shall be considered and approved by the Board.

17.318.3 ***Delegation of function to committees, officers or other bodies***

Subject to the regulatory framework and such guidance, if any, as may be given by ~~Monitor~~NHS England, the board of directors may make arrangements on behalf of the Trust for the exercise of any of its functions by a formally constituted committee, sub-committee, or an officer of the Trust; in each case subject to such restrictions and conditions as the board of directors think fit.

17.418.4 ***Delegation to committees***

The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, or sub-committees, which it has formally constituted in accordance with the constitution, the terms of authorisation, binding guidance issued by ~~Monitor~~ NHS England and the 2006 Act. ~~-~~The constitution and terms of reference of these committees, or sub-committees and their specific executive powers shall be approved by the Board in respect of its sub-committees.

17.518.5 ***Not used***

17.618.6 ***Delegation to officers***

Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee shall be exercised on behalf of the Trust by the chief executive. ~~–~~The chief executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

17.718.7 ***Discharge of the direct accountability***

Nothing in the scheme of reservation and delegation shall impair the discharge of the direct accountability to the Board of the finance director to provide information and advise the Board in accordance with statutory requirements or any requirements of ~~Monitor~~NHS England.

17.818.8 ***Duty to report non-compliance with standing orders and standing financial instructions***

If for any reason these standing orders are not complied with, full details of the non-compliance, and the circumstance around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. ~~–~~All members of the Board and officers have a duty to disclose any non-compliance with these standing orders to the secretary as soon as possible.

~~18~~19 **Appointment of committees and sub-committees**

~~18.2~~19.2 ***Appointment of committees and sub-committees***

Subject to the paragraph 3.3 of the constitution and such directions and guidance as may be issued by ~~Monitor~~ NHS England from time to time, the Board may appoint committees of the Board consisting of one or more members of the Board.

A committee appointed under this standing order may, subject to such directions and guidance as may be issued by NHS England~~Monitor~~ or the Board, appoint sub-committees.

~~18.3~~19.3 ***Applicability of standing orders and standing financial instructions to committees and sub-committees***

The standing orders and standing financial instructions of the Trust, as far as applicable, shall, as appropriate, apply to meetings and any committees and sub-committees established by the Board. In which case the term "chair" is to be read as a reference to the chair of the committee or sub-committee as the context permits, and the term "member of the Board" is to be read as a reference to a member of the committee or sub-committee also as the context permits.

~~18.4~~19.4 ***Delegation of powers by committees to sub-committees***

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committees unless expressly authorised by the Board.

~~18.5~~19.5 ***Terms of reference of committees***

Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions as the Board shall decide. ~~–~~Such terms of reference shall be in accordance with the regulatory framework and any directions and guidance issued by ~~Monitor~~NHS England.

~~18.6~~19.6 ***Approval of appointments to committees***

Subject to standing order 19.6, the Board shall approve the appointments to each of the committees which it has formally constituted.

~~18.7~~19.7 ***Appointments for statutory functions***

Where the Board is required by the constitution, by any applicable statute or regulations or by any directions or guidance issued by ~~Monitor~~ NHS England to appoint persons to a committee to undertake statutory functions, and where such appointments are to operate independently of the Board, such appointments shall be made in accordance with the constitution or such applicable statute or regulations or such directions or guidance issued by ~~Monitor~~NHS England.

~~18.8~~19.8 ***Committees established by the Board***

The committees established by the Board are:

19.8.1 Audit ~~& Assurance~~and Risk Committee;

19.8.2 Finance and Investment Committee;

19.8.3 People and Organisational Development Committee;

~~18.8.1~~19.8.4 Quality Committee;

~~18.8.2~~19.8.5 Remuneration and Appointment~~Nominations~~ Committee;

~~18.8.3~~19.8.6 Charitable Funds Committee; and

~~18.8.4~~19.8.7 where so required, a committee to act as a joint special committee with a committee of the council of governors for the purpose of resolving disputes between the council of governors and the Board in accordance with the dispute resolution procedure.

~~18.9~~19.9 ***Other committees and sub-committees***

The Board may also establish such other committees and sub-committees as required to discharge the Board's responsibilities.

~~19~~20 **Declarations of interest and register of interests**

~~19.2~~20.2 **Declarations of interests**

~~19.2.1~~20.2.1 Each director shall comply with paragraph 32 of the constitution regarding conflicts of interest.

~~19.2.2~~20.2.2 Interests that need to be declared by a director in accordance with paragraph 32 of the constitution (a Declarable Interest) are:

~~19.2.2.1~~20.2.2.1 any actual or potential, direct or indirect, financial interest which is material to any discussion or decision they are involved, or

likely to be involved, in making, as described in Standing Orders 20.2.2 and 20.2.7 (subject to Standing Orders 20.2.3 and 20.2.4); and

~~19.2.2.2~~20.2.2.2 any actual or potential, direct or indirect, non-financial professional interest, which is material to any discussion or decision they are involved or likely to be involved in making, as described in Standing Orders 20.2.5 and 20.2.7; and

~~19.2.2.3~~20.2.2.3 any actual or potential, direct or indirect, non-financial personal interest, which is material to any discussion or decision they are involved or likely to be involved in making, as described in Standing Orders 20.2.6 and 20.2.7.

~~19.2.3~~20.2.3 If a director has a Declarable Interest, he/she shall make the declaration at the time of his/her appointment or as soon thereafter as the interest arises, and in any event within five clear days of becoming aware of the existence of that interest. The interest shall be declared in such manner as the secretary may prescribe from time to time.

~~19.2.4~~20.2.4 If a director is present at a meeting of the board of directors and has a Declarable Interest, he/she shall, as soon as practicable after the commencement of the meeting, or after the conflict of interest is established, disclose that fact and the chair shall decide what action to take. This may include excluding the director from discussions on the matter and/or prohibiting the director from voting. ~~–~~Subject to Standing Orders 20.2.3 and 20.2.4, if a Director has declared financial interest (as described in Standing Order 20.2.2) he/she shall not take part in the consideration or discussion of the matter.

~~19.2.5~~20.2.5 At the time the interest is declared, it shall be recorded in the minutes of the meeting. ~~–~~Any change in interests should be officially declared at the next relevant meeting following the change occurring.

~~19.2.6~~20.2.6 The interests of directors in companies likely or possibly seeking to do business with the NHS should be published in the Trust's Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

~~19.3~~20.3 **Nature of interests**

~~19.3.1~~20.3.1 A Declarable Interest is one which a reasonable person would take into account when making a decision regarding the use of taxpayers' money because the interest has relevance to that decision. Declarable Interests are to be interpreted in accordance with guidance issued by ~~Monitor~~NHS England.

~~19.3.2~~20.3.2 A financial interest is where a director may receive direct financial benefits (by either making a gain or avoiding a loss) from the consequences of a decision of the Trust. This could include:

~~19.3.2.1~~20.3.2.1 directorships, including non-executive directorships held in another organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding; or

~~19.3.2.2~~20.3.2.2 employment in an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding; or

~~19.3.2.3~~20.3.2.3 a shareholding, partnerships, ownership or part ownership of an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding.

~~19.3.3~~20.3.3 A Director shall not be treated as having a financial interest in any matter by reason only:

~~19.3.3.1~~20.3.3.1 of his/her membership of a company or other body, if he/she has no beneficial interest in any securities of that company or other body; or

~~19.3.3.2~~20.3.3.2 of his/her ownership of shares or securities held in collective investment or pensions funds or units of authorised unit trusts; or

~~19.3.3.3~~20.3.3.3 of an interest in any company, body or person with which he/she is connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that matter.

~~19.3.4~~20.3.4 Any remuneration, compensation or allowances payable to a Director by virtue of paragraph 18 of Schedule 7 of the 2006 Act shall not be treated as a financial interest for the purpose of this Standing Order.

~~19.3.5~~20.3.5 A non-financial professional interest is where a Director may obtain a non-financial professional benefit from the consequence of a decision that the Trust makes, such as increasing their professional reputation or status or promoting their professional career. This could include situations where a Director is:

~~19.3.5.1~~20.3.5.1 an advocate for a particular group of patients; or

~~19.3.5.2~~20.3.5.2 a clinician with a special interest; or

~~19.3.5.3~~20.3.5.3 an active member of a particular specialist body; or

~~19.3.5.4~~ an advisor for the Care Quality Commission or National

~~19.3.5.5~~20.3.5.4 Institute of Health and Care Excellence.

~~19.3.6~~20.3.6 A non-financial personal interest is where a Director may benefit personally f~~o~~rom a decision that the Trust makes in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include where the Director is:

~~19.3.6.1~~20.3.6.1 a member of a voluntary sector board or has a position of authority within a voluntary sector organisation with an interest in health and/or social care; or

~~19.3.6.2~~20.3.6.2 a member of a lobbying or pressure group with an interest in health and/or social care.

~~19.3.7~~20.3.7 A Director will be treated as having an indirect financial interest, non-financial professional interest or non-financial personal interest where he/she has a close association with another individual who has a financial interest, a non-financial professional interest, or a non-financial personal interest who would stand to benefit from a decision of the Trust. This includes material interests of:

~~19.3.7.1~~20.3.7.1 close family members and relatives, including a spouse, partner, parent, child or sibling;

~~19.3.7.2~~20.3.7.2 close friends and associates; and

~~19.3.7.3~~20.3.7.3 business partners.

~~19.4~~20.4 Register of interests

~~19.4.1~~20.4.1 The secretary shall keep a register of interests of directors, which shall contain the names of each director, whether he/she has declared any interest, and if so, the interest declared.

~~19.4.2~~20.4.2 These details will be kept up to date by means of an annual review of the register of interests in which any changes to interests declared during the preceding twelve months will be incorporated.

~~19.4.3~~20.4.3 The register of interests will be available to the public in accordance with the constitution and the chief executive will take reasonable steps to bring the existence of the register of interests to the attention of the local population.

~~19.4.4~~20.4.4 In establishing, maintaining and publicising the register of interests, the Trust shall comply with all guidance issued from time to time by ~~Monitor~~NHS England.

~~20~~21 **Custody of seal**

The common seal of the Trust shall be kept by the secretary in a secure place.

~~21~~22 **Register of sealing**

An entry of every sealing shall be made and numbered consecutively in a register provided for that purpose recording the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealings shall be made to the Board at least quarterly. (The report shall contain details of the seal number, a description of the document and the date of sealing).

~~22~~23 **Sealing of documents**

The common seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board which expression includes, by virtue of the resolution of the Board adopting these standing orders, documents approved for sealing by the chair and either the chief executive or another executive director.

~~23~~24 **Signature of documents**

The chief executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board or any committee or sub-committee with delegated authority.

~~24~~25 **Suspension of standing orders**

Except where this would contravene any statutory provision, or guidance issued by ~~Monitor~~ NHS England any one or more of the standing orders may be suspended at any meeting, provided the meeting is quorate.

~~25~~26 **Confidentiality**

All members of the board of directors shall abide by the Trust's policies on confidentiality and code of conduct.

~~26~~27 **Interface between the board of directors and the council of governors**

The Board will cooperate with the council of governors as far as possible in order to comply with the regulatory framework in all respects and in particular in relation to matters set out in the constitution. In the event of a dispute arrangements are set out in annex ~~9~~8, appendix 2, paragraph 2.

~~27~~28 **Standing orders to be given to members of the Board and officers**

It is the duty of the chief executive to ensure that existing members of the Board and officers and all new appointees are notified of and understand their responsibilities within standing orders and standing financial instructions. Updated copies shall be issued to staff designated by the chief executive.

ANNEX 8
Further Provisions

Appendix 1 - Membership

1. Membership

Representative membership

1.1 The Trust shall at all times strive to ensure that, taken as a whole, its actual membership is representative of those eligible for membership. To this end the Trust shall at all times have in place and pursue a membership strategy which shall be approved by the council of governors and shall be reviewed by them from time to time and at least every three years.

1.2 The council of governors shall present to each annual members' meeting:

1.1.1 a report on steps taken to secure that, taken as a whole, the actual membership of its constituencies and the classes of constituencies is representative of those eligible for such membership;

1.1.2 the progress of the membership strategy; and

1.1.3 any changes to the membership strategy.

Annex 8: Appendix 2

Dispute resolution procedures

1. Dispute: general

In the event of any dispute about the entitlement to membership the dispute shall be referred to the ~~Secretary~~ secretary who shall make a determination on the point in issue. If the member is aggrieved at the decision of the secretary he/she may appeal in writing within 14 days of the secretary's decision to the council of governors whose decision shall be final.

2. Dispute: council of governors and the board of directors

In the event of dispute between the council of governors and the board of directors:

2.1 In the first instance the chair on the advice of the secretary, and such other advice as the chair may see fit to obtain, shall seek to resolve the dispute;

2.2 If the chair is unable to resolve the dispute he/she shall refer the dispute to the secretary who shall appoint a joint special committee constituted as a committee of the board of directors and a committee of the council of governors, both comprising equal numbers, to consider the circumstances and to make recommendations to the council of governors and the board of directors with a view to resolving the dispute;

2.3 If the recommendations (if any) of the joint special committee are unsuccessful in resolving the dispute, the chair may refer the dispute back to the board of directors who shall make the final decision.

Annex 8: Appendix 3

Legal issues

1. Indemnity insurance

The Trust will purchase indemnity insurance cover for governors, directors and the secretary, who have acted honestly and in good faith. They will not be required to meet out of their personal resources, any personal civil liability incurred in the execution or purported execution of their functions save where they have acted recklessly.

2. Checking process: governors and non-executive directors

Governors and non-executive directors will be subject to a checking process at the time of election/appointment to ensure that they meet the fit and proper persons requirements set out in the Trust's NHS provider licence and, in the case of non-executive directors, in regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; this may involve Disclosure and Barring Service (DBS) checks and a health assessment undertaken by the Trust's occupational health department. NB: executive directors undergo these checks as part of the Trust's recruitment process.

3. Review of Trust documents

As part of its commitment to good governance, the Trust will undertake regular reviews of all documentation associated with governance. Any change/amendment will be considered by the appropriate board or committee, or the council of governors if appropriate, and will be submitted to ~~Monitor~~ NHS England where this is required.

4. Interpretation

In the event of a question arising about any ambiguity, meaning or internal inconsistency within this constitution or about any matter not provided for by the constitution the Board shall have jurisdiction to determine that question and its decision shall be binding.

Annex 8: Appendix 4

Appointment of chair and non-executive directors

Not used

Arrangements for the appointment of new non-executive directors and chair

The process for appointing new non-executive directors and chair will be as follows:

subject to paragraph 1.2.2, the chair and other non-executive directors are to be appointed by the council of governors following a process of open competition. Subject to paragraph 23.3 of the constitution, the current chair or a non-executive director may stand for reappointment;

on the first renewal of the appointment of a non-executive director, the council of governors will appoint a nominations committee to determine whether the retiring non-executive director may be reappointed without a process of open competition. If the nominations committee does not consider the reappointment appropriate, then a suitable replacement will be identified in accordance with paragraphs 1.2.3 and 1.2.4 below;

six months before the end of the term of office of the chair or a non-executive director (as the case may be), the council of governors will appoint a nominations committee to seek a suitable replacement. The nominations committee will be constituted in accordance with paragraphs 1.2.5 and 1.2.6 below;

1.2.4 notwithstanding the provisions of paragraph 1.2.3 above, the nominations committee shall seek, by way of open advertisement and other means, candidates for office and assess and select for interview such candidates as are considered appropriate and in doing so the committee shall consult and shall have regard to the views of the board of directors and shall be at liberty to seek advice and assistance from persons other than members of the committee;

1.2.5 the nominations committee will make recommendations to the council of governors, including recommendations about pay (consulting external professional advisers to market-test the remuneration levels of the chair and other non-executive directors at least once every three years and when they intend to make a material change to the remuneration of a non-executive director), and it is the council of governors who shall resolve in a general meeting to appoint such candidate or candidates (as the case may be) as it considers appropriate and in reaching its decision it shall have regard to the views of the board of directors and of the nominations committee as to the suitability of the available candidates and the remuneration and allowances and other terms and conditions of office;

1.2.6 the nominations committee for the chair will consist of the deputy chair or another non-executive director and four governors, including at least one public governor. If the number of governors prepared to serve on the nominations committee is greater than the number of places available, the committee members will be selected by election by their peer governors. In the case of the nomination and selection of the chair, the nominations committee shall be chaired by the deputy chair unless he/she is a candidate, in which case the nominations committee will seek another non-executive director as chair. Each member of the nominations committee will have one vote in respect of any recommendation to the council of governors as to potential candidates for appointment;

1.2.7 the nominations committee for the non-executive directors will consist of the chair and three governors, two of which should be elected. The chief executive will attend in an advisory capacity only. If the number of governors prepared to serve on the nominations committee is greater than the number of places available, the committee members will be selected by election by their peer governors. The chair will chair the nominations committee. Each member of the nominations committee will have one vote in respect of any recommendation to the council of governors as to potential candidates for appointment;

1.2.8 the nominations committees constituted under paragraphs 1.2.5 and 1.2.6 above will be supported by appropriate advice from the secretary and the Trust's director for human resources;

1.2.9 all appointments will be made in accordance with the constitution and the human resources policies of the Trust.

1.3 The council of governors will not consider nominations for membership of the board of directors other than those made by the appropriate nominations committee.

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Trust Executive Committee Terms of Reference**			
Agenda item:	**7.4**			
Sponsor:	**David French, Chief Executive Officer**			
Author:	**Karen Flaherty, Associate Director of Corporate Affairs and Company Secretary** **Helen Potton, Associate Director of Corporate Affairs (Interim)**			
Date:	**28 July 2022**			
Purpose	**Assurance or reassurance**	**Approval** **X**	**Ratification**	**Information**
Issue to be addressed:	It is proposed to amend the terms of reference for the Trust Executive Committee (**TEC**) to add the recently created Financial Recovery Programme Board, Transformation Oversight Group and Trust Savings Group as groups reporting to TEC in the structure diagram in Appendix A.			
Response to the issue:	The proposed draft terms of reference are attached, marked up with the proposed changes, which have been reviewed and approved by the TEC. These are subject to final approval by the Trust's board of directors to provide additional assurance on the constitution of the TEC given the committee's responsibility for developing and implementing the strategy adopted by the board and the operational management of the Trust.			
Implications: (Clinical, Organisational, Governance, Legal?)	The terms of reference ensure that the purpose and activities of the TEC are clear and support transparency and accountability in the performance of its role.			
Risks: (Top 3) of carrying out the change / or not:	1. Executive, divisional and broader clinical leadership are involved in decision-making in areas of strategic and operational significance at UHS. 2. Non-compliance with the Trust's standing financial instructions and policies relating to the specific responsibilities of TEC. 3. The Trust and TEC may not function as effectively without terms of reference in place.			
Summary: Conclusion and/or recommendation	The board of directors is asked to approve the terms of reference following review and approval by the TEC on 20 July 2022.			

University Hospital Southampton NHS
NHS Foundation Trust

Trust Executive Committee Terms of Reference

Version: 8.~~12~~

Date Issued:	~~15 June~~28 July 2022
Review Date:	December 2022
Document Type:	Terms of Reference

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1. Role and Purpose

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

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

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

2. Constitution

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

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

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

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

3. Membership

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

3.1.1 the Chief Executive Officer;

3.1.2 all other Executive Directors;

3.1.3 the Deputy Medical Directors;

3.1.4 the Director of Strategy and Partnerships;

3.1.5 all Divisional Clinical Directors;

3.1.6 all Divisional Directors of Operations;

3.1.7 all Divisional Heads of Nursing and Professions;

3.1.8 the Director of Midwifery;

3.1.9 the Director of Research and Development;

3.1.10 the Director of Education;

3.1.11 the Deputy Director of Nursing for Quality;

3.1.12 the Director of Informatics;

3.1.13 the Director of Estates, Facilities & Capital Development;

3.1.14 the Director of Communications;

3.1.15 the Director of Planning and Productivity;

3.1.16 the Director of Data and Analytics;

3.1.17 the Director of Commercial Development;

3.1.18 the Director of Contracting;

3.1.19 the Deputy Chief Operating Officer;

3.1.20 the Chief Pharmacist;

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

3.1.22 the Dean of Medicine, University of Southampton.

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

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

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

4. Attendance and Quorum

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

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

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

5. Frequency of Meetings

5.1 The Committee will meet monthly and otherwise as required.

6. Conduct and Administration of Meetings

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

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

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

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

7. Duties and Responsibilities

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

7.1 ***Objectives and strategy***

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

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

7.2 ***Performance and operations***

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

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

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

7.2.4 The Committee will optimise the allocation of resources.

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

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

7.3 ***Resources***

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

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

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

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

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

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

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

7.4 ***Governance and risk management***

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

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

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

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

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

7.5 ***Innovation***

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

7.6 ***Policies***

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

8. Accountability and Reporting

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

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

9. Review of Terms of Reference and Performance and Effectiveness

9.1 At least once a year the Committee will review its collective performance and its terms of reference. Any proposed changes to the terms of reference will be recommended to the Board for approval, other than changes to the membership and attendees, which will require approval by the Committee alone.

10. References

10.1 National Health Service Act 2006

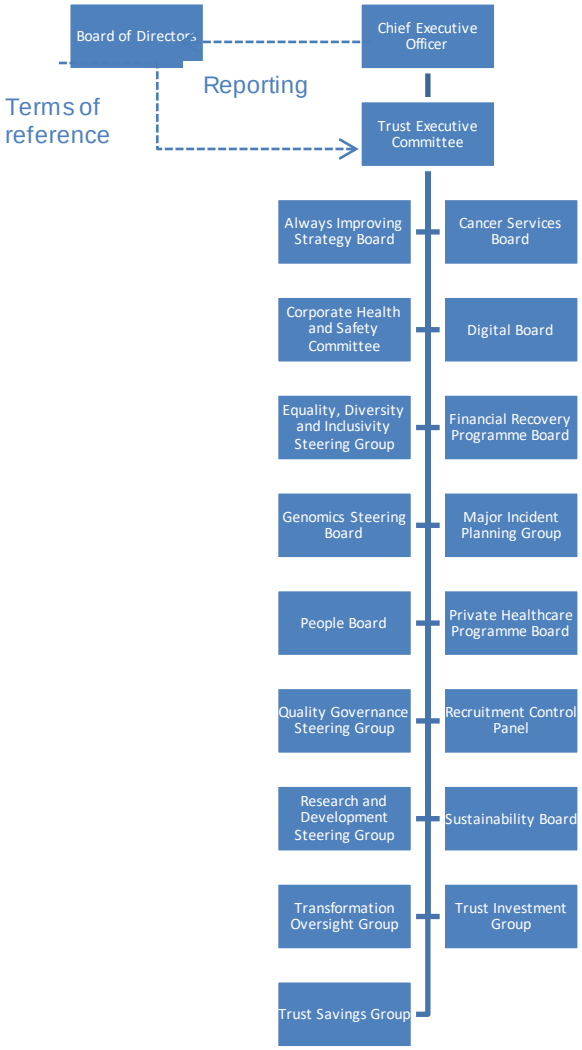
10.2 NHS Foundation Trust Code of Governance

10.3 NHS foundation trust accounting officer memorandum (August 2015)

10.4 NHS Oversight Framework

10.5 Standing Financial Instructions

Appendix A


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

Document Monitoring Information	
Approval Committee:	Board of Directors
Date of Approval:	~~28 April 2022 (changes to membership approved by TEC on 15 June 2022 for which Board approval is not required)~~28 July 2022
Responsible Committee:	Trust Executive Committee
Monitoring (Section 9) for Completion and Presentation to Approval Committee:	December 2022
Target audience:	Board of Directors, Trust Executive Committee, NHS Regulators and Staff
Key words:	TEC, Executive, Committee, Terms of Reference
Main areas affected:	Trust-wide
Summary of most recent changes if applicable:	Changes to ~~membership following internal reorganisation~~Appendix A to include the Financial Recovery Programme Board, Transformation Oversight Group and Trust Savings Group in the groups reporting to TEC.
Consultation:	Executive Directors
Number of pages:	7
Type of document:	Terms of Reference
Does this document replace or revise an existing document?	Yes
Should this document be made available on the public website?	No
Is this document to be published in any other format?	No

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Re-appointment of Directors at UHS Pharmacy Limited**			
Agenda item:	**7.5**			
Sponsor:	**David French, Chief Executive Officer**			
Author:	**Helen Potton, Associate Director of Corporate Affairs and Company Secretary (Interim)**			
Date:	**28 July 2022**			
Purpose	**Assurance or reassurance**	**Approval** **Y**	**Ratification**	**Information**
Issue to be addressed:	In line with the articles of association for UHS Pharmacy Limited (UPL), the Trust's outpatient pharmacy wholly owned subsidiary, the Trust as shareholder has received a recommendation from the UPL Board of Directors for the re-appointment of two directors. The re-appointments relate to: 1. Gary Anderson as director of the company in the capacity as Chair for a second term (from 01 December 2022 – 30 November 2025). 2. Felicity Greene as director of the company in the capacity as Non-Executive Director Pharmacist for a second term (from 21 July 2022 – 30 November 2025). Both re-appointments have been discussed by the UPL Remuneration Committee - composed of 3 independent Directors and 2 UHS Executive Directors (Ian Howard and Paul Grundy). Gary and Felicity recused themselves from the relevant part of the meeting and discussion. Members were unanimous in their support of the recommendation to seek shareholder approval for both re-appointments. It is the view of the UPL Remuneration Committee that each of the directors proposed for re-appointment make a highly effective, insightful and valuable contribution. Both demonstrate the utmost commitment to their responsibilities. This is supported by the UPL Board annual performance evaluation that was undertaken recently. Both re-appointments provide consistency to the clinical and commercial stewardship of the business.			
Response to the issue:	Under the Trust Board's Schedule of Decisions Reserved to the Board and the Scheme of Delegation, the appointment and removal of Directors is a decision reserved to the Trust Board. The Trust Board is asked to approve the recommendation and authorise David French, CEO to sign the Shareholder Resolution as attached at Appendix A.			

Implications: (Clinical, Organisational, Governance, Legal?)	The re-appointment of the two directors will enable UPL Board to remain robust and effective and provide good continuity of service.
Risks: (Top 3) of carrying out the change / or not:	It is important that the Board of UPL remains as constituted and retains corporate memory. Failure to appoint to the two roles could reduce the effectiveness of decisions made.
Summary: Conclusion and/or recommendation	The Board of Directors is asked to approve the recommendation and authorise David French, CEO, to sign the Shareholder Resolution as attached at Appendix A.

Appendix A

SHAREHOLDER RESOLUTION OF UHS PHARMACY LIMITED

Pursuant to the articles of association of UHS Pharmacy Limited (the Company) (Company no: 08206912), University Hospital Southampton NHS Foundation Trust, in its capacity as shareholder, hereby signs the following written resolution:

RESOLVED THAT:

1. Gary Anderson is continued as director of the company in the capacity as Chair for a second term (from 01 December 2022 – 30 November 2025).

2. Felicity Greene is continued as director of the company in the capacity as Non-Executive Director Pharmacist for a second term (from 21 July 2022 – 30 November 2025).

Both directors have previously provided their consent to act as a director of the Company.

DATED:

_____

Director
For an on behalf of
University Hospital Southampton NHS Foundation Trust

EXPLANATION OF RESOLUTION

The Articles of Association state that the shareholder may at any time and from time to time by notice in writing to the Company appoint one or more persons to be a director or directors of the Company and to remove any director or directors from office (article 18.1).

The annual general meeting between UPL and the shareholder is not scheduled until November/ December 2022 and therefore the shareholder is approached to provide approval in writing to the re-appointment of two Directors of the UPL Board.

Individual and collective Board performance, appointments and succession planning are routine business items on the UPL Remuneration Committee agenda. Both re-appointments have been discussed by UPL Remuneration Committee - composed of 3 independent Directors and 2 UHS Executive Directors (Ian Howard and Paul Grundy). Members were unanimous in their support of the recommendation to seek shareholder approval of both re-appointments.

UPL Remuneration Committee (therefore confirms that each of the directors proposed for re-appointment continues to make an effective and valuable contribution and demonstrates commitment to their responsibilities. This is supported by the annual performance evaluation that was undertaken recently.

Terms and conditions of service for both of the UPL Board positions of Chair and NED Pharmacist, as agreed with the support and professional guidance of UHS HR department in 2021, will remain active and unchanged.