University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	25/05/2023
Time	9:00 - 13:00
Location	Conference Room, Heartbeat/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 30 March 2023** Approve the minutes of the previous meeting held on 30 March 2023
4		**Matters Arising and Summary of Agreed Actions** To discuss any matters arising from the minutes, and to agree on the status of any actions assigned at the previous meeting.
5		**QUALITY, PERFORMANCE and FINANCE** Quality includes: clinical effectiveness, patient safety, and patient experience
5.1	9:20	**Briefing from the Chair of the Charitable Funds Committee (Oral)** Dave Bennett, Chair
5.2	9:25	**Briefing from the Chair of the Audit and Risk Committee (Oral)** Keith Evans, Chair
5.3	9:30	**Briefing from the Chair of the Finance and Investment Committee (Oral)** Jane Bailey, Chair
5.4	9:35	**Briefing from the Chair of the People and Organisational Development Committee (Oral)** Jane Harwood, Chair
5.5	9:40	**Briefing from the Chair of the Quality Committee (Oral)** Tim Peachey, Chair
5.6	9:45	**Chief Executive Officer's Report** Receive and note the report Sponsor: David French, Chief Executive Officer

5.7 **Infection Prevention and Control Annual Report 2022-23**

10:00 Receive and discuss
Sponsor: Gail Byrne, Chief Nursing Officer
Attendees: Julian Sutton, Interim Lead Infection Control Director/Julie Brooks, Head of Infection Prevention Unit

5.8 **Learning from Deaths 2022-23 Quarter 4 Report**

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

5.9 **Freedom to Speak Up Report**

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

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

10:30 Review and discuss the update
Sponsor: Steve Harris, Chief People Officer
Attendee: Sarah Herbert, Deputy Chief Nursing Officer

5.11 **Break**

10:40

5.12 **Performance KPI Report for Month 1**

10:50 Review and discuss the Trust's performance as reported in the Integrated Performance Report.
Sponsor: David French, Chief Executive Officer

5.13 **Finance Report for Month 1**

11:15 Review and discuss the report
Sponsor: Ian Howard, Chief Financial Officer

5.14 **People Report for Month 1**

11:30 Review and discuss the report
Sponsor: Steve Harris, Chief People Officer

6 **STRATEGY and BUSINESS PLANNING**

6.1 **Corporate Objectives 2023-24**

11:45 Review and approve
Sponsor: David French, Chief Executive Officer
Attendees: Martin De Sousa, Director of Strategy and Partnerships/Kelly Kent, Head of Strategy and Partnerships

6.2 **CRN Wessex 2022-23 Annual Report and 2023-24 Plan**

11:55 Receive and note the annual report and receive an update on the plan (verbal)
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Clare Rook, Chief Operating Officer, CRN: Wessex

6.3 **Research and Development Plan 2023-24**

12:05 Discuss and approve the plan
Sponsor: Paul Grundy, Chief Medical Officer
Attendees: Christopher Kipps, Clinical Director of R&D/Karen Underwood, Director of R&D/Marie Nelson, R&D Head of Nursing and Health Professions

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

12:15 Review and discuss the update
Sponsor: Gail Byrne, Chief Nursing Officer
Attendees: Craig Machell, Associate Director of Corporate Affairs and Company Secretary/Kyle Lacoste, Trust Documents Manager

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

7.1 **Feedback from the Council of Governors' (CoG) meeting 26 April 2023 (Oral)**

12:25 Sponsor: Jenni Douglas-Todd, Trust Chair

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

12:30 Receive and ratify
In compliance with the Trust Standing Orders, Financial Instructions, and the Scheme of Reservation and Delegation.
Sponsor: Jenni Douglas-Todd, Trust Chair

7.3 **Charitable Funds Committee Terms of Reference**

12:35 Sponsor: Steve Harris, Chief People Officer
Attendee: Craig Machell, Associate Director of Corporate Affairs and Company Secretary

8 **Any other business**

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

9 **Note the date of the next meeting: 27 July 2023**

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**

12:45

University Hospital Southampton
NHS Foundation Trust

Minutes Trust Board – Open Session

Date	30/03/2023
Time	9:00 – 12:30
Location	Heartbeat Education Centre/Microsoft Teams
Chair	Jenni Douglas-Todd (JD-T)
Present	Jane Bailey, Non-Executive Director (NED) (JB) Dave Bennett, NED (DB) Gail Byrne, Chief Nursing Officer (GB) Jenni Douglas-Todd, Chair (JD-T) Keith Evans, Deputy Chair and NED (KE) David French, Chief Executive Officer (DAF) Paul Grundy, Chief Medical Officer (PG) Steve Harris, Chief People Officer (SH) Jane Harwood, NED/Senior Independent Director (JH) Ian Howard, Chief Financial Officer (IH) Tim Peachey, NED (TP) Joe Teape, Chief Operating Officer (JT)
In attendance	Femi Macaulay, Associate NED (FM) Craig Machell, Associate Director of Corporate Affairs and Company Secretary (CM) Christine McGrath, Director of Strategy and Partnerships (CMcG) Ceri Connor, Director of OD and Inclusion (CC) (item 4.12) Sophie Limb, HR Project Manager (SL) (item 4.12) Diana Hulbert, Guardian of Safe Working Hours and Emergency Department Consultant (DH) (item 4.13) Ellis Banfield, Associate Director of Patient Experience (EB) (item 4.14) Lucinda Hood, Head of Medical Directorate (LH) (item 5.1) Kyle Lacoste, Trust Documents Manager (KL) (item 5.2) Chris Lake, Integrated Development Ltd (observing) 4 governors (observing) 10 members of staff (observing) 2 members of the public (observing)
Apologies	Diana Eccles, NED (DE)

1. Chair's Welcome, Apologies and Declarations of Interest

The Chair welcomed attendees to the meeting. It was noted that there were no interests to declare in the business to be transacted at the meeting.

It was noted that Chris Lake from Integrated Development Ltd would be observing the meeting as part of the Board development programme.

The Chair provided an overview of her activities since February 2023, including visits to hospital departments, meetings with peers and other key stakeholders.

2. Minutes of the Previous Meeting held on 31 January 2023

The draft minutes tabled to the meeting were agreed to be an accurate record of the meeting held on 31 January 2023.

3. Matters Arising and Summary of Agreed Actions

It was noted that all actions due had been completed or would be addressed through the business of the meeting.

4. QUALITY, PERFORMANCE and FINANCE

4.1 Briefing from the Chair of the Audit and Risk Committee

The chair of the Audit and Risk Committee was invited to provide an overview of the meeting held on 20 March 2023. It was noted that:

- The committee had discussed whether the Trust's annual report and accounts should be prepared on a going concern basis and agreed that it would be appropriate based on the guidance that NHS Trusts should prepare accounts on a going concern basis unless notified otherwise.
- The committee reviewed salary overpayments and the need to review controls in this area.
- A number of minor amendments to the Trust's Treasury Management Policy were agreed. In addition, the Committee agreed that an appropriate minimum cash balance would be £30m rather than the previous figure of £55m.

4.2 Briefing from the Chair of the Finance and Investment Committee

The chair of the Finance and Investment Committee was invited to provide an overview of the meeting held on 27 March 2023. It was noted that:

- All Board members had been invited to attend the meeting in order to provide an opportunity to discuss the draft annual operating plan due to be submitted to the Integrated Care Board (ICB).
- Following its discussion of the draft annual operating plan, the committee agreed that the plan should be submitted.
- The committee also reviewed the Trust's financial position and its capital expenditure.

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

The chair of the People and Organisational Development Committee was invited to provide an overview of the meeting held on 27 March 2023. It was noted that:

- The committee reviewed the proposed workforce plan and, in particular, the risks and governance associated with the plan.
- At year-end, the Trust was forecast to have c.800 members of staff above the number envisaged in its plan for 2022/23.
- The committee reviewed the staff survey results (item 4.10).

4.4 Briefing from the Chair of the Quality Committee

The chair of the Quality Committee was invited to provide an overview of the meeting held on 20 March 2023. It was noted that:

- The committee had reviewed the quality improvement priorities for 2022/23 and discussed and agreed those for 2023/24.
- Incidence of methicillin-resistant staphylococcus aureus (MRSA) transmission in neonatal was likely due to overcrowding.
- The committee reviewed a report into radiation safety incidents and noted that the spike in incidents was due to the return to a normal level of operation following Covid-19; the long-term data, however, indicated a downward trend.
- Concerns reported to Patient And Liaison Services (PALS) and not resolved within 24 hours would be treated as a complaint by the Ombudsman.
- The Trust was experiencing difficulties in transferring patients to a more appropriate mental health setting where this was required.

4.5 Chief Executive Officer's Report

David French was invited to present the Chief Executive Officer's Report. It was noted that:

- There had been industrial action by junior doctors between 13 and 16 March 2023 and a further four-day strike had been announced to take place in April 2023. It was anticipated that the strike due to take place in April 2023 would be significantly more impactful due to factors including its proximity to the Easter weekend and staff who might be less willing to provide cover a second time.
- An offer had been made by the Government to the Royal College of Nursing (RCN) in an attempt to resolve the ongoing industrial action by nurses. The RCN was consulting its membership, but its leadership had recommended that the offer be accepted.
- There had been a number of changes to pensions in the Budget, including scraping of the lifetime allowance.
- Professor Saul Faust, a consultant paediatrician at the Trust, had received an OBE from the Prince of Wales.
- David French had accepted a place on the Southampton Renaissance Board.

4.6 Integrated Performance Report for Month 11

Joe Teape was invited to present the Integrated Performance Report for Month 11, the content of which was noted. It was further noted that:

- The spotlights included in the report were based on the core four constitutional standards.
- The Trust was experiencing significant operational challenges with around 200 delayed patients per day.
- Work had been undertaken to review cancer patients in the 62 days and above category, and to reduce the backlog. A significant proportion of the backlog was for prostate cancer patients owing to the high number requiring treatment.
- It was acknowledged that it was difficult to apply a single target to all types of cancer, as the risk factors and concerns were significantly different.
- The Trust had been escalated to tier 2 in respect of its long-waiting patients.
- The Trust was working with Southampton City Council in respect of increasing public health involvement in improving the health of the local population.
- There were concerns in terms of health inequalities in respect of the long-waiting patients, as many of those patients were unable to afford private alternatives, which coupled with a tendency for those in less affluent areas to be diagnosed later, posed a significant risk of worse outcomes.
- The Trust expected to end the year with fewer than 20 patients waiting longer than 18 months, all of whom were complicated cases.
- The situation in the Emergency Department had improved compared with prior months.
- The metrics for research and innovation were to be revised following the launch of the Trust's research and development strategy.

Action:

JT and Jane Bailey agreed to discuss the metrics used in respect of My Medical Record.

4.7 Finance Report for Month 11

Ian Howard was invited to present the Finance Report for Month 11, the content of which was noted. It was further noted that:

- The Trust's forecast deficit at year-end had reduced to £11m due to the receipt of additional funding of £5m for previously unpaid elective work.
- The Trust had achieved £39m of its cost improvement programme (CIP) and was on track to achieve the full £45m target.
- £24m remained to be spent on the Trust's capital programme for 2022/23.
- Additional energy costs of £3m were expected to be incurred in 2023/24.

4.8 People Report for Month 11

Steve Harris was invited to present the People Report for Month 11, the content of which was noted. It was further noted that:

- The Trust had experienced growth in its substantive workforce in 2022/23, but had not seen the expected reduction in bank and agency staff. Additional controls had been implemented to manage recruitment, including extending the remit of the Recruitment Control Panel.
- It was considered necessary to have tighter controls on recruitment of substantive roles as well as being clearer in terms of when to engage temporary staff, as agency staffing in particular was a significant financial concern.
- Twenty-four individuals had been recruited to the Trust's senior leadership programme.
- The discount offered to staff at the hospital canteen had been extended by three months using charitable funding.
- In terms of the Trust's gender pay gap, the mean pay gap remained at ~23% with the differential being most significant at the senior medical levels.
- Within the region, staffing numbers had increased significantly since 2019/20 and NHS England was unlikely to accept a workforce plan that led to an increase in staffing numbers.

4.9 Break

4.10 UHS Staff Survey Results 2022 Report

Ceri Connor and Sophie Limb were invited to present the 2022 UHS Staff Survey Results. It was noted that:

- The staff survey was an important method of obtaining staff feedback.
- Despite the circumstances, the Trust had scored seventh in England in terms of staff satisfaction, with the Trust rated above-average in the people-related themes in particular.
- Areas which required additional focus included physical violence, discrimination, pay and wellbeing.
- Violence against staff was recognised as an increasing problem, noting in particular the increasing number of patients presenting with mental health, drug and/or alcohol issues.

4.11 Guardian of Safe Working Hours Quarterly Report

Diana Hulbert was invited to present the Guardian of Safe Working Hours Quarterly Report, the contents of which were noted. It was further noted that:

- Junior doctors had felt supported by the Trust during the period of industrial action.
- Work was being carried out in terms of improving junior doctor pastoral care and wellbeing, including improvements to the mess using the hospital charity.

4.12 Learning from Deaths 2022-23 Quarter 3 Report

Ellis Banfield was invited to present the Learning from Deaths 2022/23 Quarter 3 Report, the content of which was noted. It was further noted that:

- The number of deaths being reviewed by a medical examiner was increasing.
- The Quarter 4 report would include a review of the year as well as lessons learned as appropriate.

5. STRATEGY and BUSINESS PLANNING

5.1 UHS Smoke Free Site Model

Paul Grundy and Lucinda Hood were invited to present the Trust's Smoke-Free Site Model. It was noted that:

- The proposal had been discussed at the Trust Executive Committee at its meeting held on 22 March 2023.
- A consultation had been carried out in respect of the proposal to go 'smoke-free' and the significant challenges associated with this were recognised. These challenges included the impact on the local residents of smokers having to exit the site and the need to support staff in challenging those who smoke on site despite the prohibition.
- However, the basis for going 'smoke-free' was sound, as smoking accounted for 1/6 deaths in Southampton and cost the Trust c.£10.8m per year in terms of admissions.
- There were to be two core elements to the proposal: no smoking on site and smoking cessation support for staff and patients. The model was to be implemented in phases over the course of a year and the Trust would sign up to the NHS smoke-free pledge.
- The nicotine replacement treatment included as part of the smoking cessation support was to be funded jointly for the coming year with the support of the local council and ICB.

Decision:

Having reviewed and discussed the proposed UHS Smoke-Free Site Model, it was agreed to support the proposal and to sign the NHS smoke-free pledge, committing to taking actions to go smoke-free.

5.2 Board Assurance Framework (BAF) Update

The Board Assurance Framework (BAF) was presented to the meeting, the content of which was noted. It was further noted that:

- The BAF had been presented to the Audit & Risk Committee and feedback was to be incorporated.
- The BAF presented represented the year-end position and was to be updated once the 2023/24 operating and workforce plans had been agreed.
- A new strategic risk in respect of innovation was to be incorporated for 2023/24.

6. CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

6.1 Register of Seals and Chair's Actions Report

The paper 'Register of Seals and Chair's Actions Report' was presented to the meeting, the content of which was noted.

Decision:
The Board agreed to ratify the application of the Trust Seal to the documents listed in the 'Register of Seals and Chair's Actions Report'.

7. Any other business
There was no other business.

8. Note the date of the next meeting: 25 May 2023

9. Resolution regarding the Press, Public and Others
Decision: The Board resolved that, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders 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.

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	25/05/2023	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. Update: This will be included in the May 2023 report.			
Trust Board – Open Session 29/09/2022 5.4 Integrated Performance Report for Month 5				
826.	My Medical Record	Teape, Joe	25/05/2023	Completed
	Explanation action item JT noted that there was a business case that was overdue for my medical record around how we industrialised it across the Trust which should provide some huge benefits and would bring a timeline back as to when this would happen. Update: Business case is in late stages of development for approval via Trust Investment Group (Board approval not required).			
Trust Board – Open Session 29/09/2022 5.4 Integrated Performance Report for Month 5				
827.	Digital change and indicators	Teape, Joe	25/05/2023	Completed
	Explanation action item JT noted that there was some big digital change happening with the rolling out of speech recognition and some E tools. In addition it would be helpful to look at the indicators to understand whether they were the right ones and review them as part of the digital updates which could be discussed at F&IC. Update: New indicators included in performance report for April from May 2023.			

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 30/03/2023 4.6 Integrated Performance Report for Month 11				
948.	My Medical Record metrics	• Bailey, Jane • Teape, Joe	25/05/2023	Completed
	Explanation action item JT and Jane Bailey agreed to discuss the metrics used in respect of My Medical Record. Update: New indicators included in performance report for April from May 2023, a further review of this can be undertaken once the strategy for MMR is agreed.			

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Chief Executive Officer's Report**			
Agenda item:	**5.6**			
Sponsor:	**David French, Chief Executive Officer**			
Date:	**25 May 2023**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	My report this month covers updates on the following items: • Pay Agreement – Agenda for Change • BMA Pay Dispute • CQC Maternity Inspection • Over One Thousand TAVIs			
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.			

Pay Agreement – Agenda for Change
Notwithstanding its rejection by the Royal College of Nursing (RCN) and Unite on 2 May 2023, the NHS Staff Council, comprised of 14 NHS employer and trade union representatives, agreed to accept the Government's offer in respect of pay for Agenda for Change staff in England. The additional 2022/23 one off payment (totalling between 3.5% and 8%) and 2023/24 pay rates (a consolidated uplift of 5%) will be received by eligible staff on 29 June 2023. This will also include back pay from 1 April 2023.

The RCN has issued notice of its intention to ballot its members formally on further industrial action. This will be an aggregated ballot (nationwide as opposed to employer by employer) starting on 23 May and concluding on 23 June 2023. The RCN will need to achieve a turnout of at least 50% of its members, with a majority of those voting agreeing to take industrial action. If a mandate is achieved, this will provide the legal basis of a further six months of strike action.

BMA Pay Dispute
The British Medical Association (BMA) is balloting consultants in respect of industrial action. The ballot is on an aggregated basis and will run until 27 June 2023. The focus is on improving pay value for the 2023/24 deal, which is yet to be announced. The proposed form of industrial action by consultants would be to deliver only 'Christmas Day' levels of care in a series of one- or two-day strikes, ie emergency care would continue to be provided, but elective or non-emergency work would be cancelled.

Whilst there has been little formal communication on progress, it is understood that the BMA junior doctor committee is in continued discussion with the Department of Health and Social Care regarding their ongoing pay dispute.

CQC Maternity Inspection
On 15 May 2023, the Care Quality Commission (CQC) carried out an inspection of maternity services at the Princess Anne Hospital.

The initial feedback provided included some suggestions for improvements in terms of the security on Lyndhurst, Burley, Broadlands and MDAU/Triage. In addition, the CQC noted that there was variable cleanliness in relation to baby checks and equipment and that towels on equipment were not always changed between baby checks. The CQC also noted a risk in relation to deterioration of breast milk in the milk fridge, as temperature checks had not been fully completed on Burley. The inspection also picked up that some checks on emergency equipment had not been carried out as per the servicing policy. Furthermore, it was suggested that the Trust should consider whether its interpreter service is used well enough.

In terms of positive findings, the CQC noted that the SHIP safety huddle provided clear information on all areas and that the SHIP maternity triage telephone system provides a valuable service to those using it. In addition, the CQC noted a strong commitment to the IT digital programme and that staff spoken to all enjoyed working at the Trust.

The draft report from the CQC is expected in the next few weeks for factual accuracy checking.

Over One Thousand TAVIs
At the beginning of May 2023, the Transcatheter Aortic Valve Implantation (TAVI) service announced that the Trust had completed over 1,000 successful cases. A celebratory presentation is to be held on 26 May 2023 for all those who have been involved with the service since 2009.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Infection Prevention and Control Annual Report 2022-23**			
Agenda item:	**5.7**			
Sponsor:	**Gail Byrne, Chief Nursing Officer/Director of Infection Prevention & Control**			
Author:	**Julie Brooks, Consultant Nurse Infection Prevention & Control and Deputy Director of Infection Prevention & Control** **Dr Julian Sutton, Lead Hospital Infection Control Doctor**			
Date:	**25 May 2023**			
Purpose:	**Assurance or reassurance** √	**Approval**	**Ratification**	**Information** √
Issue to be addressed:	To review progress and performance in relation to reducing the risk of healthcare associated infection (HCAI) in UHS and provide a 2022/23 report.			
Response to the issue:	This report provides an overview of performance and progress in relation to reducing the risk of healthcare associated infection including: • Performance against key infection indicators. • Assurance of infection prevention standards, practice and processes. • Identification of learning and actions to further reduce risks of HCAI to patients, staff, the organisation and the public.			
Implications: (Clinical, Organisational, Governance, Legal?)	Legal duty to protect service users and staff from avoidable harm in a healthcare setting: 'Code of Practice on the prevention and control of Infection'/ Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the legal duty to ensure the health and safety of all employees whilst at work and of any persons affected by the Trust's activities, as per the Health and Safety at Work etc. Act 1974.			
Risks: (Top 3) of carrying out the change / or not:	• Risk of harm to staff and patients due to healthcare associated infection. • Risk of reputational and financial penalty from enforcement action. • Increased length of stay of inpatients who acquire healthcare associated infection leading to reduced organisational productivity.			
Summary: Conclusion and/or recommendation	The Trust has experienced challenges in 2023/23 in relation to HCAIs along with respiratory virus and norovirus activity and other infections, with a number of national contractual standards not met for the year. Improvements are required in a number of indicators where performance has exceeded expected thresholds. Members of TEC/Quality Committee/Trust Board are asked to: 1. Review the report and the identified actions detailed in each section and ensure these are addressed via the Divisional Governance processes, with relevant teams and staff groups. 2. Note the performance and actions required in relation to antibiotic stewardship and ensure that these are supported and addressed at Divisional, Care Group and Clinical Team level. 3. Support the proposed actions/ measures to facilitate improvements in practice relating to reduction of C.difficile and Gram negative bacteraemia. 4. Note the ongoing concerns in relation to the environment and the impact on preventing & controlling infection.			

1.Introduction

Category		Annual Limit	Action /Comment
National Objectives:	MRSA bacteraemia (Threshold = 0)	R	4 MRSA BSI attributable to UHS
	Clostridioides difficile infection (Threshold = 61)	R	84 cases in 2022/23
	E coli Bacteraemia (Threshold = 127)	R	154 cases in 2022/23
	Klebsiella Bacteraemia (Threshold = 73)	G	51 cases in 2022/23
	Pseudomonas Bacteraemia (Threshold = 36)	G	35 cases in 2022/23
Other	MSSA		45 post 48hr cases in 2022/23
Antimicrobial Stewardship	Prudent antibiotic prescribing	R	NHS standard contract requires a reduction in the use of broad-spectrum antibiotic usage of 4.5% for 2022/23 (against a 2018 baseline)
Provide assurance of basic infection prevention practice:	Assurance of Infection Prevention Practice Standards	G	The annual infection prevention audit programme recommenced in May 2022 for the monitoring and assurance of infection prevention and control practices.

2. Analysis

2.1 Healthcare Associated Infection

Summary of progress in reducing risk of healthcare associated infection in UHS.

MRSA Bacteraemia (MRSA BSI)

4 Healthcare Associated MRSA BSI attributed to UHS in 2022/23.

April 2022 Hospital Onset / Healthcare Associated (PICU)	Repeat of a case previously reported in March 2022 considered as ongoing infection. Receiving specialist input from Paediatric Infectious disease and specialist Microbiology teams. A complex infant on PICU with congenital heart disease and chromosomal abnormality. A full post infection review investigation was undertaken in March 2022 with the Infection Prevention Team & clinical team. No clear cause of acquisition was identified. Continued ongoing review and focus of infection prevention and control practices and challenges in PICU.
October 2022 Community Onset / Healthcare Associated	MRSA positive blood culture taken in emergency department on 12/10/2022. Previous admission to UHS in previous 28 days (Vascular surgery). MRSA in Nose, Groin, ischaemic leg ulcers (tested positive prior to previous admission). Diabetic, critical leg ischaemia, peripheral vascular disease.
November 2022 Hospital Onset / Healthcare Associated (Neonatal Unit)	Extremely preterm infant born at UHS by emergency caesarean section. Unable to tolerate enteral nutrition meant reliance on a neonatal longline for prolonged parenteral nutrition. Longline difficult insertion after multiple attempts by senior team At the time of the MRSA BSI, the NNU unit was being monitored by the Infection Prevention Team due to an increased incidence of MRSA cases on the unit. The IPT were visiting on a weekly basis to review IP&C practice and observations and practice was found to be very satisfactory.
December 2022 Community Onset / Healthcare Associated	MRSA positive blood culture taken on 03/12/2022 following admission to E4 with sepsis and sternal wound infection. Cardiac surgery in September in Manchester. Previous admission to UHS in previous 28 days (CV&T) -transfer from a local hospital for wound management due to a deep sternal wound infection. History of previous MRSA BSI: UHS IPT informed by Dorset IPT that patient had MRSA positive blood culture in a sample from 02/10/2022.

NOTE: Reporting trusts are now asked to provide information relating to prior healthcare exposure -whether patients had been admitted to the reporting trust within one month prior to the onset of the current case. This allows a greater granulation of the healthcare association of cases. Cases are split into one of five groups:

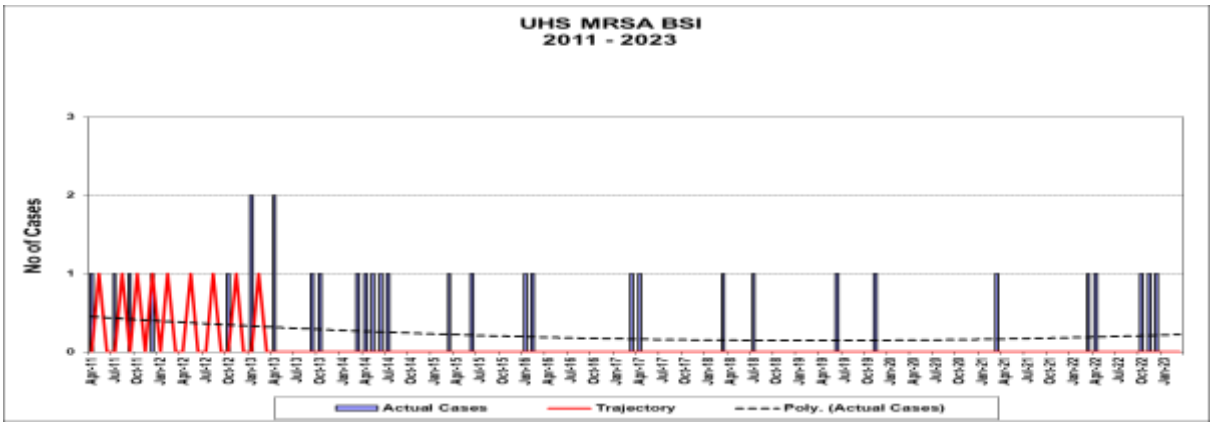
**Hospital-onset, healthcare associated (HOHA) - Specimen date is ≥3 days after the current admission date (where day of admission is day 1)*

**Community-onset healthcare-associated (COHA) - Is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)*

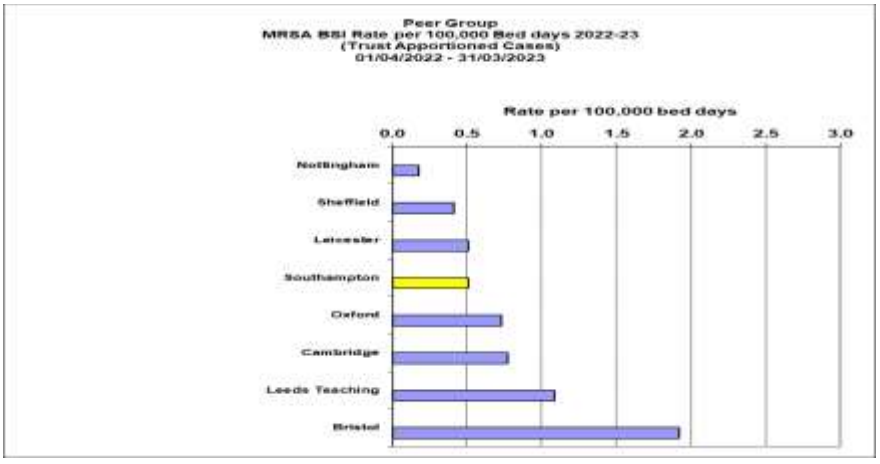
**Community-onset, community associated (COCA) - Is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 28 days prior to the specimen date (where day 1 is the specimen date)*

** Unknown - The reporting trust answered "Don't know" to the question regarding previous discharge in the month prior to the MRSA case.*

** No information - The reporting trust did not provide any answer for questions on prior admission.*



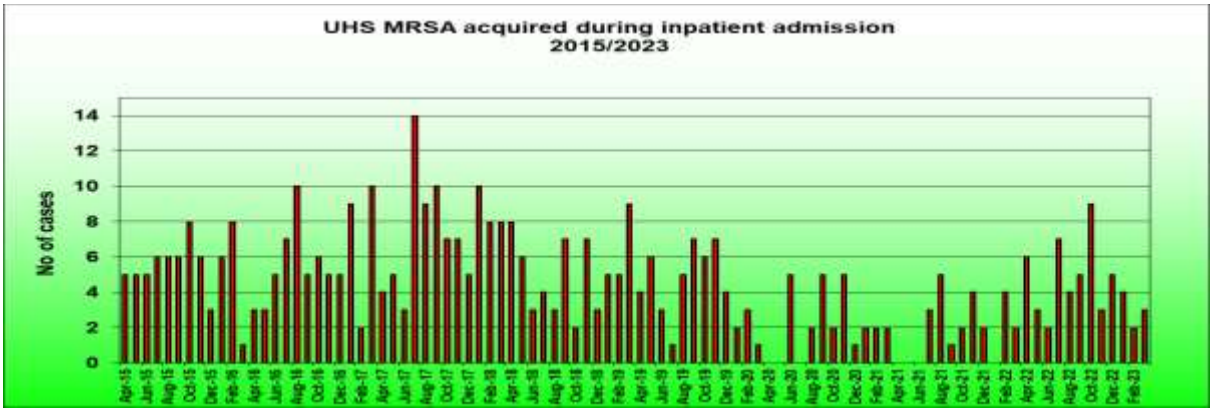
UHS has an attributable MRSA BSI rate of 0.5 cases/100,000 bed days and ranks 4 of 8 self-selected peer hospitals. Top quartile, median and lower quartile marker rates are 0.0, 0.0 and 0.8 cases/100,000 bed days.



Acquisition of MRSA colonisation in UHS

54 patients acquired MRSA (colonisation or infection) in UHS in 2022/23.

A range of MRSA prevention and reduction strategies remain in place within UHS including MRSA screening on admission (& additional screening as per policy), risk reduction washes using chlorhexidine following admission to hospital and ongoing focus and awareness on key elements of IP&C practice. Further review of the Trust MRSA policy for adults and paediatrics is underway, following publication of updated national guidance.



Clostridioides difficile (C.difficile)

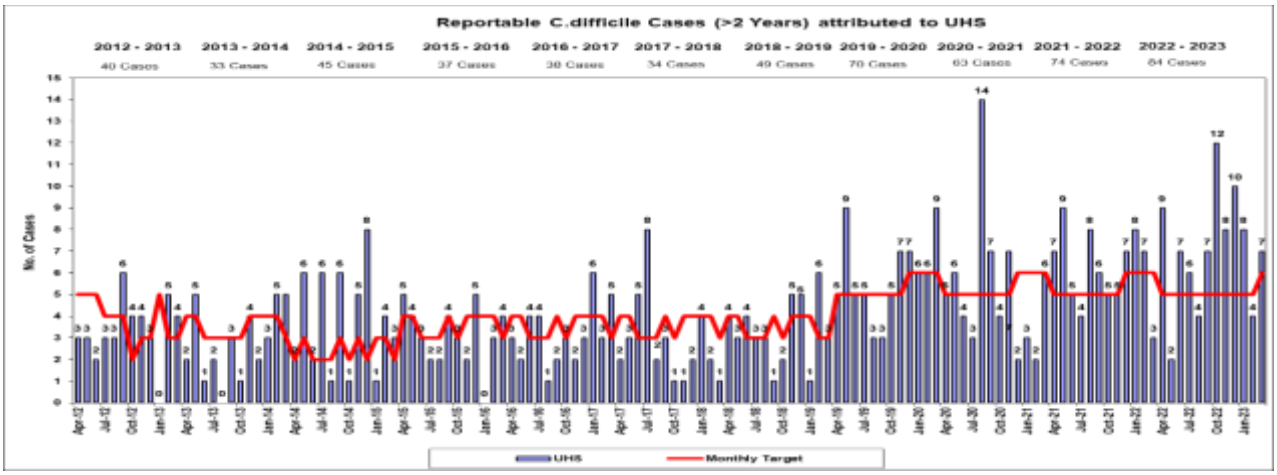
Trusts are required under the NHS Standard Contract 2022/23 to minimise rates of C. difficile so that they are no higher than the threshold levels set by NHS England and Improvement. Thresholds for 2022/23 were derived from a baseline of the 12 months ending November 2021 (the most recent available data at the time of calculating the figures). Trust-level thresholds comprise total healthcare-associated cases i.e. Hospital-onset healthcare associated (HOHA) and Community-onset healthcare associated ((COHA). UHS were set a national performance threshold of 61 cases for 2022/23.

2022/23 progress:

84 cases in 2022/23 against a nationally set threshold of 61.

- 16 Community Onset – Healthcare associated (COHA)
- 68 Hospital Onset – Healthcare associated (HOHA)

2022/23	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
HOHA	6	2	6	4	4	7	11	7	7	6	3	5	**68**
COHA	3	0	1	2	0	0	1	1	3	2	1	2	**16**



An increase in C. difficile cases in 2022/23 has been reported both across the Hampshire and Isle of Wight integrated care system (HIOW ICS) and nationally. Reasons for this ongoing national trend are not fully understood but are undoubtedly multifactorial, including increased complexity of patients and associated use of necessary antimicrobials to treat these patients.

Healthcare associated cases of C.difficile (toxin positive) continued to be reviewed throughout the year by the Infection Prevention Team and Infection Control Doctor to identify any learning or actions for improvement. As part of this process the IPT undertook reviews of IP&C practice for assurance that elements of the C. difficile care bundle were met. A weekly C.difficile MDT virtual ward round continued to support the appropriate management and care of patients with C. difficile infection. In addition a new post infection review (PIR) process for cases of healthcare associated C.difficile was introduced in Q3, which included a requirement for clinical teams, with the support of the IPT, to undertake a post infection review of cases in order to identify risk factors, antimicrobial prescribing patterns, IPC practice gaps/areas of good practice. Unfortunately due to the added workload that this placed on clinical teams, the PIR investigation process was paused, with a view to implementing a revised process for 2023/24.

On case review, a large majority of UHS healthcare associated cases were considered as likely unavoidable. These included elderly patients with complex medical needs, multiple co-mobilities, with or without immunosuppression, and/or cancer who have infections that require treatment and usually antibiotic choice

was appropriate. A small minority of the cases related to use of broad spectrum antibiotics that were potentially inappropriate, failure to recover or relapse from an episode of C.difficile.

Detailed case reviews continued to be undertaken for community cases by the ICS IP&C team, including review of antimicrobial prescribing. These again identify that cases are occurring in complex patients requiring multiple courses of antibiotics which are being appropriately prescribed. In addition, the use of PPIs (proton pump inhibitors) is identified as a theme, which is associated with an increased risk of C. difficile infection

During 2022/23 outbreaks of C.difficile were declared on 3 wards within UHS with an additional 7 wards having periods of increased incidence (PII) declared (due to having two or more new cases of C. difficile on the ward in a 28 day period). As per the agreed PII process actions were implemented in response which included enhanced cleaning of the whole ward with Sochlor/Actichlor plus; increased activity on the ward by the IPT (including a formal weekly review of the ward/observations of practice) review of isolation procedures; request for review of antibiotic usage; enhanced communications with all parties and staff.

Key themes/learning from IPT reviews of IPC practice & the environment (individual cases), PII reviews & outbreak investigations identified:

- Concerns with cleanliness of equipment & assurance/evidence that equipment has been cleaned. e.g. commodes, commodes that required replacement due to rust, wear & tear or damage.
- Inappropriate/overuse of gloves – not changing when required, use of gloves when not required and not undertaking hand hygiene following removal.
- Patients not isolated within 2 hours of onset of symptoms of diarrhoea.
- The need to encourage the use of Fidaxomicin to prevent relapse.

Actions undertaken in 2022/3 to facilitate improvements in practice included:

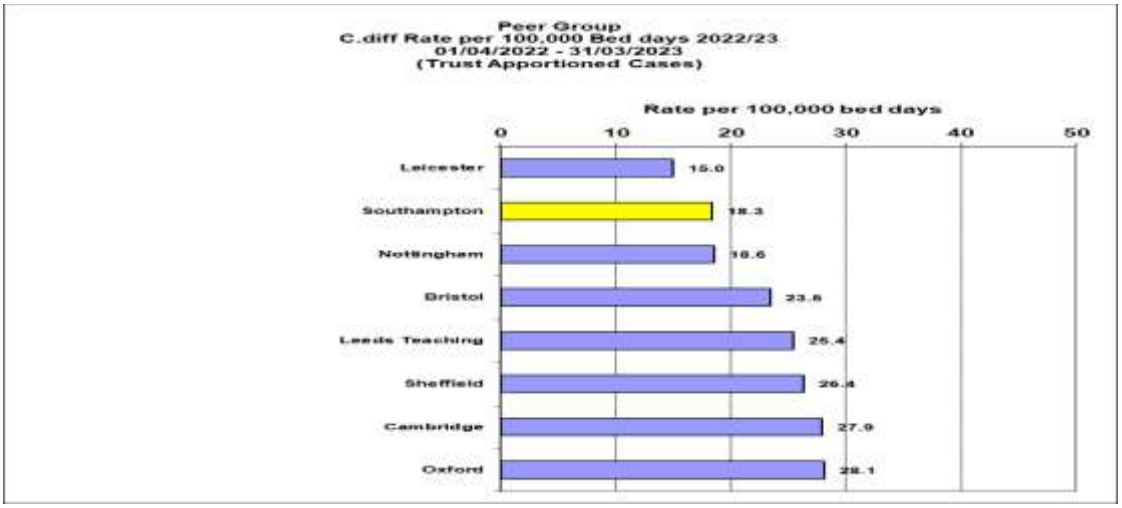
- Antimicrobial stewardship activities via stewardship ward rounds, activities relating to antimicrobial use during World Antibiotic Awareness Week in November 2022 and continued focus on updating antimicrobial prescribing/treatment guidelines.
- Training/awareness for clinical staff on clinical equipment cleaning, including commodes, and on the assessment and management of patients with unexplained/unexpected diarrhoea as part of D&V/winter virus awareness campaign.
- Ongoing use of rapid in-lab testing for gastrointestinal pathogens in AMU patients to support rapid diagnosis, patient management and optimization of isolation capacity. In addition a pilot using rapid GI testing (led by the IPT) commenced in Q3 and continued in Q4 with the aim of facilitating rapid decision-making in relation to bay closures across all Divisions due unexplained/unexpected diarrhea and/or vomiting.

A multifaceted C.difficile improvement plan has been developed for 2023/24:

Learning & improving through investigation of *C.difficile* cases.	**IP&C practices to prevent the risk of transmission of *C.difficile*.**
• Introduction of a concise After-Action Review process for HOHA to review risk factors, antimicrobial prescribing practices, IP&C practice gaps/areas of good practice. • IP&C practice reviews of wards where HOHA/COHA cases have occurred. • C.difficile MDT review panel (including ICS IP&C leads) to review cases & identify themes, learning and actions to improve practice and patient management for UHS, primary care and community/social care providers. • Sharing of learning with clinical/ward teams and across the healthcare system.	**IP&C practices to prevent the risk of transmission of C.difficile** Assessment & isolation: • Continued focus on the early assessment and isolation of patients presenting with symptoms of diarrhoea. • Optimising the management of isolation facilities and improving standards of isolation care. Improving fundamental standards of IP&C practice: • Hand hygiene improvement framework. • 'Give up the gloves' campaign.

• Collaborative working across HIOW ICS – shared investigation/learning of COHA cases, sharing learning & good practice with other acute providers.	• Re-introduction of the UHS IP&C ward accreditation framework. Cleaning & decontamination of the environment : • Relaunch cleaning roles & responsibilities framework • Further education & training on expected cleaning standards, products and process. • Introduction of environmental walkabouts to review practice & the condition of the environment (Estates/IP&C/Cleaning services/Ward). Re-introduction of IP&C spotlight reviews & introduction of additional IPT ward rounds to review & support practice.
Management & treatment of *C.difficile* to reduce risk of relapse/recurrence	**Reducing risk factors for *C.difficile* - antimicrobial prescribing & stewardship.**
Management & treatment of C.difficile to reduce risk of relapse/recurrence • Weekly Clinical C. difficile virtual ward round to review new cases of C. difficile to ensure appropriate treatment & management. • Targeted education to medical staff to increase awareness of C. difficile treatment and management guidelines. • Finalise faecal microbial transplant protocol	**Reducing risk factors for C.difficile - antimicrobial prescribing & stewardship** • Increased antimicrobial stewardship activity targeted to areas not currently covered by microbiologist AMS ward rounds/ areas of concern – pilot of a combined pharmacy AMS/IP&C ward round in respiratory medicine/adult oncology. • Ongoing programme of updates to antimicrobial prescribing guidelines. • Rolling programme of education & awareness to clinical staff . • Focus on prompt switching of intravenous to oral antibiotics (2023/24 CQUIN)

UHS ranks second out of 8 self-selected peer acute trusts, with a rate of 18.3 cases/ 100,000 bed days. Comparative data needs careful interpretation because of differences in test selection, methodology and reporting criteria between trusts.



Post 48 hr Bacteraemia (excluding MRSA)

Trusts were required under the NHS Standard Contract 2022/23 to minimise rates of Gram-negative bloodstream infections so that they are no higher than the threshold levels set by NHS England and Improvement. Thresholds for 2022/23 were derived from a baseline of the 12 months ending November 2021 (the most recent available data at the time of calculating the figures). Trust-level thresholds comprise total healthcare-associated cases i.e., Hospital-onset healthcare associated (HOHA) and Community-onset healthcare associated (COHA).

Post-48h BSI	2022-23	2021-22	2020-21	2019-20
E coli	154 (127)	138 (151)	67	67
Klebsiella	51 (73)	64 (64)	40	57
Pseudomonas	35 (36)	30 (34)	13	24
MSSA	45	43	36	30
VRE	4	9	7	12

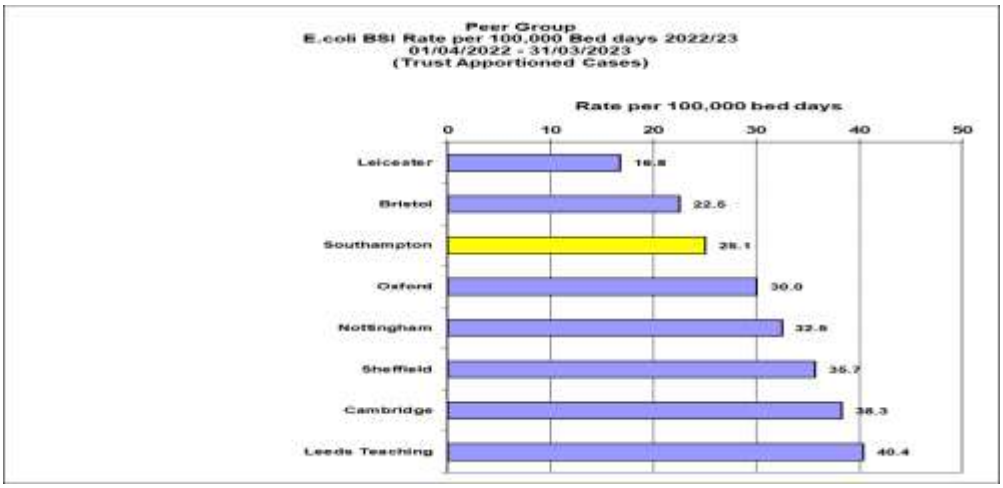
(National thresholds in brackets)

During 2022/23 cases of healthcare associated bacteraemia were reviewed by the Infection Control Doctor/IPT and selected cases investigated in detail where there was potential learning to be found. Many patients are complex, often with unavoidable factors. Investigation by post infection review of cases supported identification of emerging trends/themes, identification of organisational learning and targeted improvement actions.

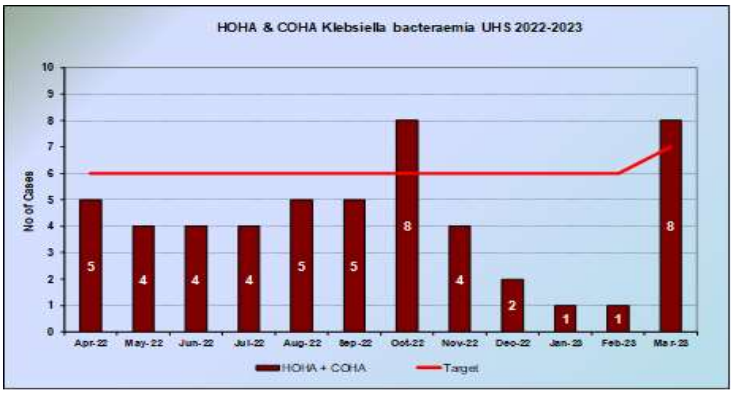
E coli Bacteraemia: UHS were set a threshold of 127 Cases for the Year 2022/23.

End of year outcome
154 cases in 2022/23 against a threshold of 127

- 60 Community Onset – Healthcare Associated (COHA)
- 94 Hospital Onset – Healthcare Associated (HOHA)



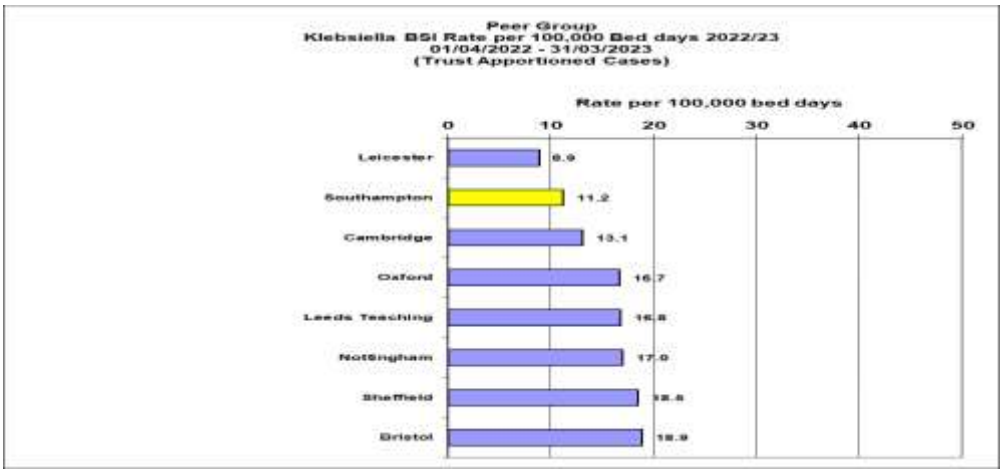
Klebsiella Bacteraemia: UHS were set a threshold of 73 Cases for the Year 2022/23.



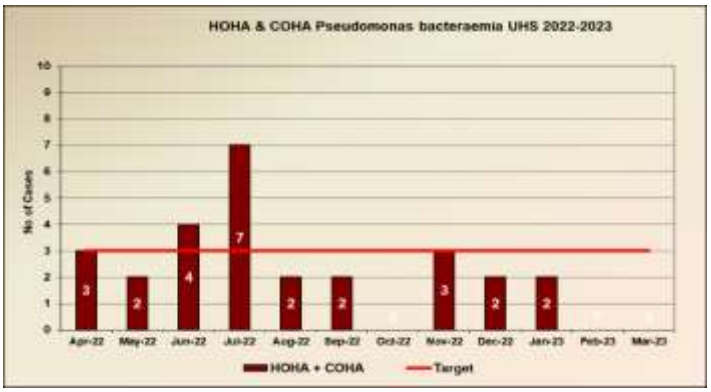
End of year outcome

51 cases in 2022/23 against a threshold of 73

- 15 Community Onset – Healthcare Associated (COHA)
- 36 Hospital Onset – Healthcare Associated (HOHA)



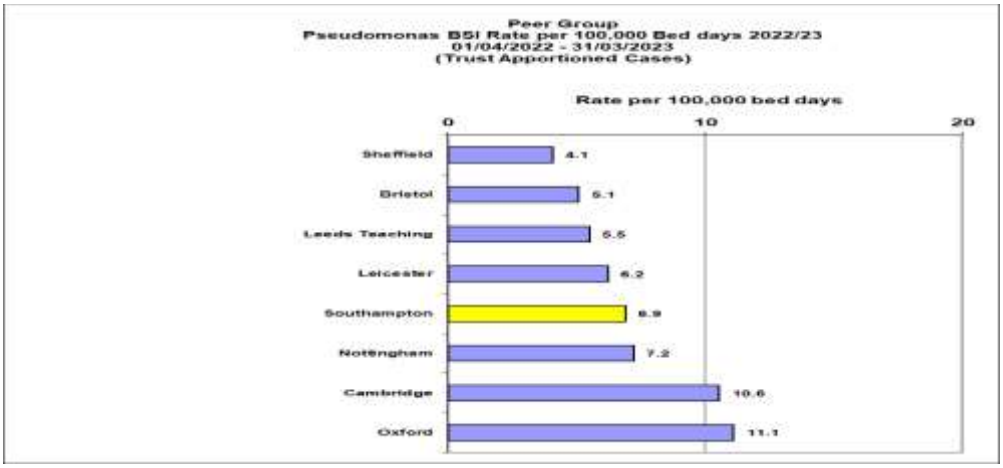
Pseudomonas Bacteraemia: UHS were set a threshold of 36 Cases for the Year 2022/23.



End of year outcome

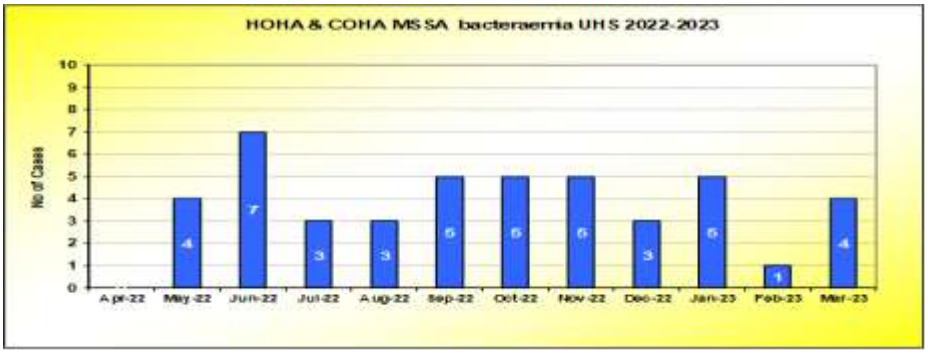
35 cases in 2022/3 against a threshold of 36

- 9 Community Onset – Healthcare Associated (COHA)
- 26 Hospital Onset – Healthcare Associated (HOHA)



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

MSSA Bacteraemia



Key learning from cases of Gram-Negative and MSSA Bacteraemia Infections

Key themes and learning from post infection reviews undertaken in 2022/23 relate to the insertion and management of invasive devices:

1. Indwelling Urinary catheters :
   - consideration of the use of intermittent (in-out) catheterisation as an alternative to fully catheterising the patient.

- the need to facilitate earlier removal of catheters by early trial without catheter (TWOC)
- the need to promote the use of bladder scanner
- the need to promote use of catheter securement devices
- Improvements required in documentation of the review and ongoing need for the catheter.

2. Intravascular (IV) devices:
   - focus on ensuring that IV devices are removed using aseptic non-touch technique.
   - improvements required in the completion of Visual Infusion Phlebitis (VIPS) scores, IV device care documentation and removal of IV devices.
   - ensuring that there is a documented rationale when IV devices remain in-situ longer than the recommended standard.
   - the need for renewed focus on Hand Hygiene & ANTT Training and practice related to IV devices.
   - the need to ensure that patients with IV devices are educated about the devices, including in relation to hand hygiene, personal hygiene/care.

Actions undertaken in 2022/23 to facilitate improvements in practice have included:

1. Continued focus on reducing risk of catheter associated UTI (CAUTI) through management of urinary catheters, avoiding unnecessary catheterisation and appropriate early catheter removal
   - Ongoing project work in T&O to reduce the duration of catheterisation & development of a flowchart for the early removal of catheters to be piloted within the care group The digital indwelling urinary catheter record is now in use as part of Inpatient Noting. Data relating to catheter insertion and use will subsequently be available that will provide the basis for development of a specification for future audit and measurement for improvement.
   - Scoping work commenced on a nurse-led project in GICU to develop a protocol for timely review and removal of urinary catheters.
2. Improving invasive device care and management
   - Commencement of a quality improvement project in Q3 to reduce the length of time that IV devices are in place.
   - Continued focus on water safety and correlation with reducing risk to patients, specifically related to reducing the risk of pseudomonas BSI.
3. Ongoing education and awareness activities related to hand hygiene, principles of aseptic non-touch technique and the insertion and management of invasive devices:

An improvement plan to reduce healthcare associated Gram negative and MSSA bacteraemia has been developed for 2023/24:

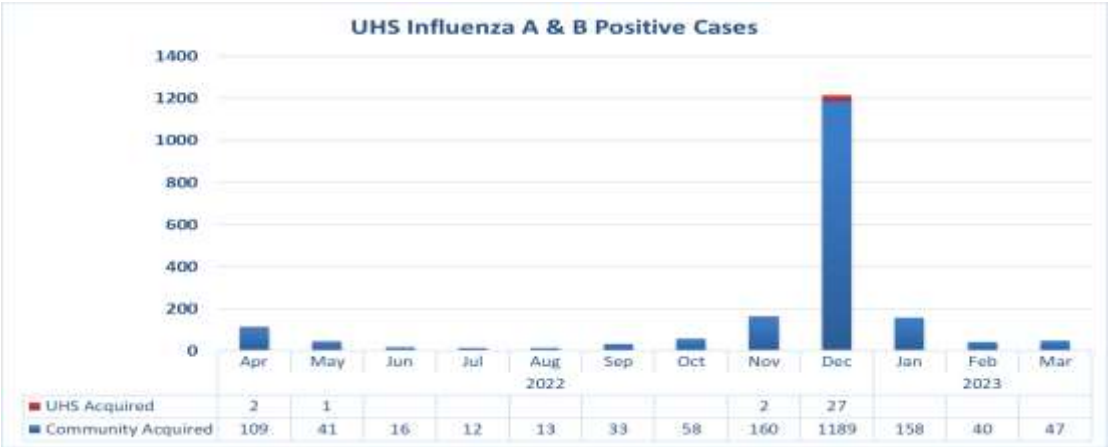
Learning & improving through investigation of cases	Improving standards of IP&C practice to reduce risk of infection
• Introduction of a concise After-Action Review process to review risk factors and practice to identify learning and actions for improvement. • Timely IP&C practice reviews for cases that are related to IV devices, indwelling urinary catheters, surgical site infection or ventilator associated to identify learning, good practice. • Fortnightly BSI review panel to review cases & identify themes, learning and actions to improve practice and patient management. • Sharing of learning with clinical/ward teams and across the healthcare system. • Collaborative working across HIOW ICS – shared investigation/learning of COHA cases, sharing learning & good practice with other acute providers.	• Quality improvement project - reducing risk of catheter associated UTI (CAUTI) through management of urinary catheters, avoiding unnecessary catheterisation and appropriate early catheter removal. • Quality improvement project to improve the care and management of IV devices & reduce the length of time that these devices are in place. • Introduction of focused IPT ward rounds to review & support practice related to IV devices and urinary catheters. • Pilot of combined IP&C invasive device & pharmacy antimicrobial stewardship ward rounds to review and support practice. • Improving standards of hand hygiene-hand hygiene improvement framework, education & awareness activities.

	• Re-focus on standards of aseptic technique - review, update and re-launch of ANTT practice guidelines, education & awareness activities. • Re-introduction of the UHS IP&C ward accreditation framework.
Focus on reducing risk factors that pre-dispose patients to infection	
• Development and implementation of UHS Fundamental Care standards e.g. nutrition & hydration, mouth care, promoting mobility, maintaining skin integrity, bladder and bowel care, personal hygiene. • Focus on health prevention and self-care measures on a wider community and system level in collaboration with HIOW ICS, Southampton City Health Protection Board and via the Southeast Regional IP&C network e.g. such as promoting hydration, good personal hygiene.	

2.2 Respiratory Viruses, including COVID-19

Covid-19 and other respiratory viruses posed challenges for UHS throughout 2022/23. Waves of increased cases of COVID-19 associated with the Omicron variants were seen during the year. In addition, a significant increase in other respiratory virus activity was seen in Q3 both locally and nationally which presented challenges for the Trust in both Adult and Children's services. A sharp increase in cases of influenza in December 2022, alongside increasing cases of RSV and a further increase in cases COVID-19, plus challenges associated with respiratory virus-related staff absence, had a significant impact on the operational capability of the Trust, with the need to create and then further expand cohort capacity (bays and wards to care for patients with COVID-19, symptomatic Influenza A and RSV) in both Adult and Children's services.

Influenza

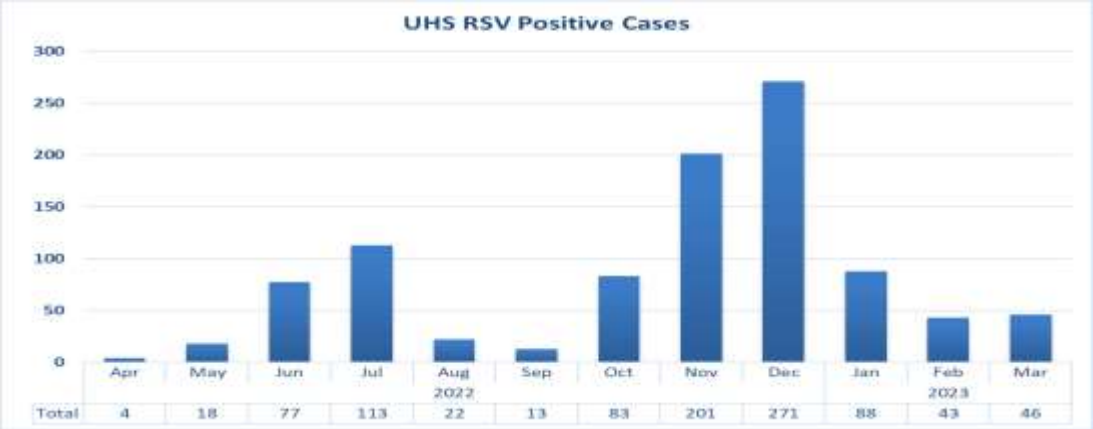


Cases of influenza A rose significantly in December 2022. A very large majority of positive cases were identified in patients attending the Emergency department or being admitted to the AMU or other areas of the Trust via POCT (Point of care testing) or rapid in-lab testing with rapid identification of cases and appropriate patient placement resulting in minimal in-hospital transmission and no identified outbreaks.

The ability to rapidly test patients in ED/AMU using the AMU POCT service resulted in earlier diagnosis of influenza (result within 1 hour, compared to laboratory routine in-lab turnaround time of 8-24hours) enabling more timely clinical decision making. Of the 960 patients tested via the AMU POCT service, 682 (71%) were discharged home and 281 (29%) were admitted to the hospital. This along with the rapid in-lab respiratory service (result within 2 hours) undoubtedly supported the trust in managing the unprecedented ED activity without admitting large numbers of Influenza patients, protecting other services and reducing in-hospital transmission of influenza.

Due to the high number of positive patients who were admitted with influenza, influenza cohort wards were established within the Emergency Medicine/medicine care group (3 wards required at the peak point) along with additional cohort bays/areas where needed, including within admission areas such as AMU. Within the Children's hospital influenza cohort bays were established as needed.

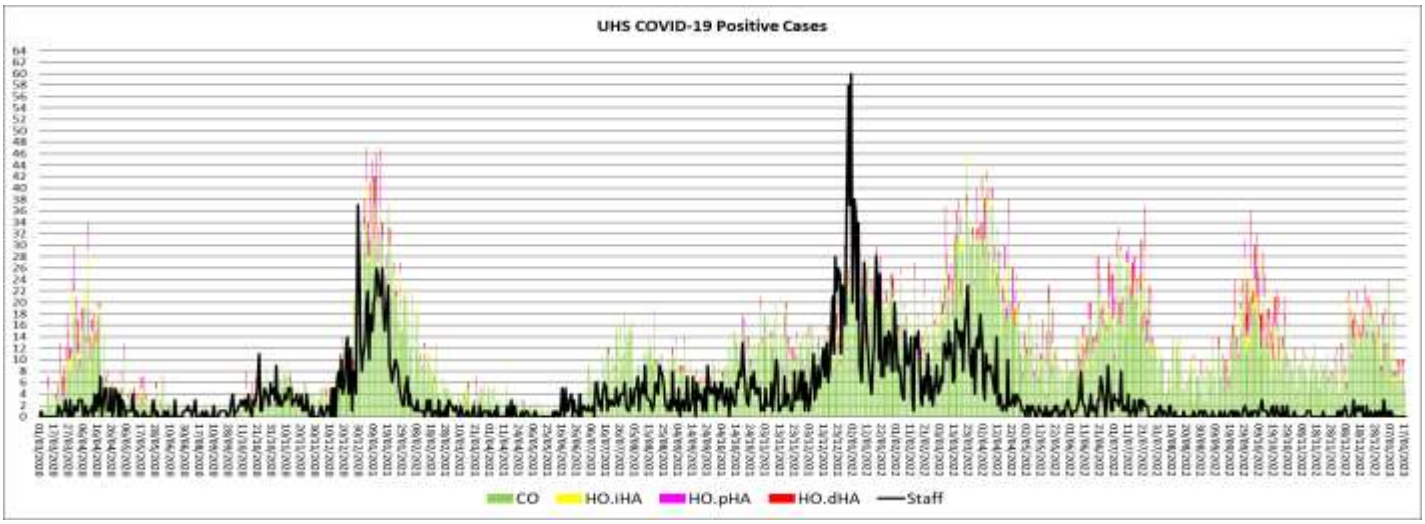
RSV



Increases in RSV impacted particularly on the Children's Hospital and this, alongside increases in cases of children presenting with influenza and suspected Group A streptococcus, resulted in significant operational pressures over the winter period, including in the Children's emergency department and PSSU. Within the Children's hospital RSV cohort bays were expanded as needed. Most positive cases were rapidly identified in patients being admitted to the Trust with minimal in-hospital transmission and no identified outbreaks.

COVID-19

The global COVID-19 pandemic remained a key area of attention for UHS during 2022/23 with continued focus on preventing transmission of infection, whilst supporting the recovery and restoration of services and operational activity, alongside transitioning to 'Living with Covid' in our hospital settings. Throughout the year a number of 'waves' of increased case numbers were seen in the community which resulted in an increase in hospital admissions and this, alongside the very high transmissibility of the Omicron variants of SARS-CoV-2, resulted in an increase in hospital onset infections and outbreaks within our hospitals.



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

In June 2020, as part of the oversight of the response to transmission/outbreaks in hospital, NHS England requested 'all organisations to identify and investigate, through the RCA investigation process, every probable and definite hospital onset-healthcare associated COVID-19 inpatient infection, either as an individual case reviews or part of a wider outbreak investigation. This was in the context of the high prevalence of COVID-19 which was then still a novel virus and at a time of widespread testing both in the community and healthcare settings.

Changes/updates to this national directive are still awaited and in Q3 a revised process was introduced within UHS (aligned with processes used other Trusts within HIOW) for the management and investigation of periods of increased incidence (PIIs), outbreaks and single hospital onset cases. For single hospital onset cases this involved an initial review to determine learning/contributory factors as part of the IPT follow up of a new case, with RCA investigation only to be undertaken by exception or if patient had died and met criteria for healthcare associated death.

Cases identified in UHS: April 2022 to March 2023

	Community Onset (CO)	**Indeterminate (HO.iHA)**	**Probable (HO.pHA)**	**Definite (HO.dHA)**
Q1 (April – June)	1378	83	79	103
Q2 (July-Sept)	1087	86	55	76
Q3 (Oct-Dec)	1035	104	69	122
Q4 (Jan – Mar)	922	53	71	131
Total	**4422**	**326**	**274**	**432**

Definitions of apportionment of COVID-19 in respect of patients diagnosed within hospitals

Definite (HO.dHA): *hospital-onset definite healthcare-associated first positive specimen date 15 or more days after admission to Trust (RCA required)*

Probable (HO.pHA)*: hospital-onset probable healthcare-associated – first positive specimen date 8–14 days after admission to Trust (RCA required)*

Indeterminate (HO.iHA): *hospital-onset indeterminate healthcare-associated – first positive specimen date 3–7 days after admission to Trust*

Community Onset (CO*) - positive specimen date <=2days after hospital admission or hospital attendance.*

Outbreaks & Periods of Increased incidence (PII) of COVID-19 infection

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

	Number of Covid Outbreaks	Outbreaks involving Patients and Staff	Outbreaks involving Patients Only	Outbreaks involving only staff	Total Number of Positive Patients	Total Number of Positive Staff
Q1	45	13	30	2	197	65
Q2	26	4	22	0	162	7
Q3	26	0	26	0	197	0
Q4	22	5	17	0	163	23
Total	**119**	**22**	**95**	**2**	**719**	**95**

	Total Number of Covid Periods of Increase Incidents	Total Number of Positive Patients
Q1	N/A	N/A
Q2	N/A	N/A
Q3	14	40
Q4	14	37
Total	**28**	**77**

All outbreaks (comprising two or more patients) and PIIs have been managed by the Infection Prevention Team and reported onto the national outbreak management system where required, with ongoing monitoring until 28 days following the last confirmed case.

Probable/Definite healthcare associated COVID-19 infection deaths.

During 2022/23, 14 patients were identified as a probable or definite hospital-onset healthcare associated COVID-19 infection with Covid 19 recorded on part one of death certificate. Of these, 10 cases were reported as serious incidents as per national reporting requirements and an RCA investigation undertaken.

A proposal has been developed in Q4 by HIOW ICB to align the reporting and investigation of COVID-19 infection in line with the current Serious Incident Framework (2015) with a view to adopting the underlying principles of PSIRF in the future. On this basis, it has been agreed that UHS pilot this proposal where an initial scoping of the case will be undertaken around acquisition and post diagnosis treatment. Where acts or omissions in care are identified a Serious Incident should be reported and investigated as per normal process. Where no acts or omissions are identified, the scoping and findings should be clearly recorded and any incidental learning captured. 4 cases are currently be reviewed as part of this pilot.

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

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

Key themes/ learning from outbreaks, PIIs, individual hospital onset cases and RCA investigations have remained largely unchanged throughout the year and remain similar to those seen in 2021/22:

- Risks associated with the physical environment, particularly lack of mechanical ventilation and difficultly in achieving good airflow by natural ventilation (due to lack of windows/ inability to open windows in some areas), has been identified as a significant factor in relation to airborne (aerosol) transmission in the context of outbreaks. Other risks related to the physical environment include the lack of bathroom/toilet facilities on some wards resulting in a high number of patients sharing facilities or difficulty in allocating dedicated facilities for Covid contacts.
- Patient adherence with mask use. This included challenges with confused and wandering patients, complex patients with significant physical or mental health needs and individual inpatients frequently leaving the ward for non-clinical/treatment reasons (e.g.to meet others in retail outlets/outside) increasing the risk for COVID-19 transmission.
- Visitors attending the hospital/visiting wards with respiratory virus symptoms or reporting symptoms/positives tests a short period after visiting indicating that they may have been incubating the virus at the point of visiting. Adherence with mask use by visitors has been variable.
- Lack of onward care provision in the community resulting in delayed patient discharge.
- The need to undertake multiple bed/ward moves in order to create capacity for increasing numbers of COVID-19 patients (due the significant increase in COVID admissions and hospital cases) and other infections and ensure that clinical care was not compromised, is likely to have resulted in transmission events and subsequent outbreaks.

Living with COVID-19.

Whilst COVID-19 remains in general circulation and with the virus likely to remain endemic for some time to come, the focus for 2022/23 has been a transition to 'Living with COVID-19' within our hospital settings and services in order to support the ongoing recovery of elective planned and diagnostic services. This has involved a transition back to many pre-pandemic infection prevention and control measures whilst also ensuring that relevant learning and actions to support effective management and control of infections are maintained and integrated as standard measures and practices. Key actions/changes undertaken have included:

- Full decentralisation of the management of adult COVID-19 positive patients from G-level West wing back into their own specialities.
- Gradual lifting of restrictions such as removal of physical distancing requirements, returning to pre-pandemic cleaning protocols, changes to visiting guidance.
- Reintroduction of activities as part of the ongoing review of the UHS roadmap e.g. face to face teaching, face to face meetings.
- Changes to testing requirements for COVID-19 (staff & patients), with the removal of the routine requirement for asymptomatic testing of staff (August 2022) and patients (November 2022 & March 2023), with some exceptions.

Strategies to reduce the risk of in-hospital transmission of COVID-19 and other respiratory viruses have continued to be subject to ongoing review with appropriate and timely actions and improvements taken to reduce the ongoing risk of hospital onset infection and outbreaks. Careful review and consideration of IP&C measures and restrictions has remained in place with the re-introduction of restrictions if required, led by DIPC and the Infection Prevention Gold Command Committee and subsequently the IP&C Senior Oversight Group (which replaced the IP&C Gold Command Committee in Q2).

The Trust has continued to review and respond to updated national guidance when issued and has undertaken local risk assessments where required to ensure safe systems of work, balancing risks across the whole patient pathway, ensuring safe care for our patients, the safety of our staff, reducing the risk of nosocomial transmission, and supporting the delivery of elective recovery. As a result of these risk assessments a number of IP&C measures have been maintained for longer periods or still remain in place within the trust despite the recommendations in national guidance. Examples include continuing to

quarantine patients who have been in contact with a COVID-19 positive case, maintaining universal wearing of masks across our hospital sites.

Planning and preparedness for future variants, along with the potential for future pandemics remains a key area of focus for the Trust.

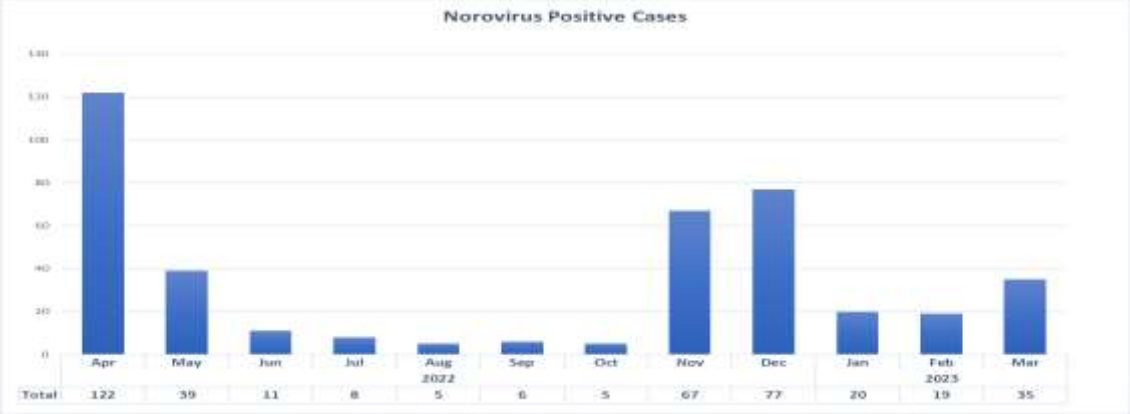
Key actions taken in 2022/23 to support prevention and control of respiratory viruses (including COVID-19) and associated outbreaks included:

- Use of local & national prevalence data to facilitate early warnings of increased rates of infection in the local community/area.
- Screening and triaging of all patients either prior to arrival to a care area, or as soon as possible on arrival, to allow early recognition of patients presenting with symptoms of infection or at high risk of infection.
- Promotion of the Flu vaccination and COVID-19 booster vaccination for staff and patients.
- Continued use of Point of Care (POCT)/rapid in-lab testing for respiratory viruses (SARS-CoV-2, Influenza and RSV) in admission pathways to facilitate early identification and placement of positive cases.
- Education & training activities throughout the year including a winter virus awareness campaign led by the IPT.
- Updates/amendments to national/regional guidance have been reviewed and assessed and trust guidance revised and implemented according to the outcomes of the review.
- Review and update to IP&C guidance for the care of patients with respiratory viruses, including personal protective equipment (PPE) requirements. The requirement for use of FFP3 masks for care of patients with COVID-19 has been retained and the requirement for the use FFP3 for other respiratory viruses introduced.
- Ongoing communications to staff regarding rising levels of infection, expected IP&C practices, situational updates.
- Communications to visitors and the public via Trust website, social media platforms and Southampton City council communication channels.
- Proactive focus on bed planning and management with collaborative discussions amongst key stakeholders, including the Infection Prevention Team, to manage and reduce overall risk to the organisation.
- Careful review and consideration of the lifting of restrictions in place within the Trust, e.g. visiting, and the re-introduction of restrictions if required.
- Further improving communication cascades and internal alerts/escalation.
- Ongoing review and work to improve ventilation standards in clinical and non-clinical areas. This has included the pro-active deployment of air purifiers in high-risk areas.

2.3 Viral Gastroenteritis including Norovirus.

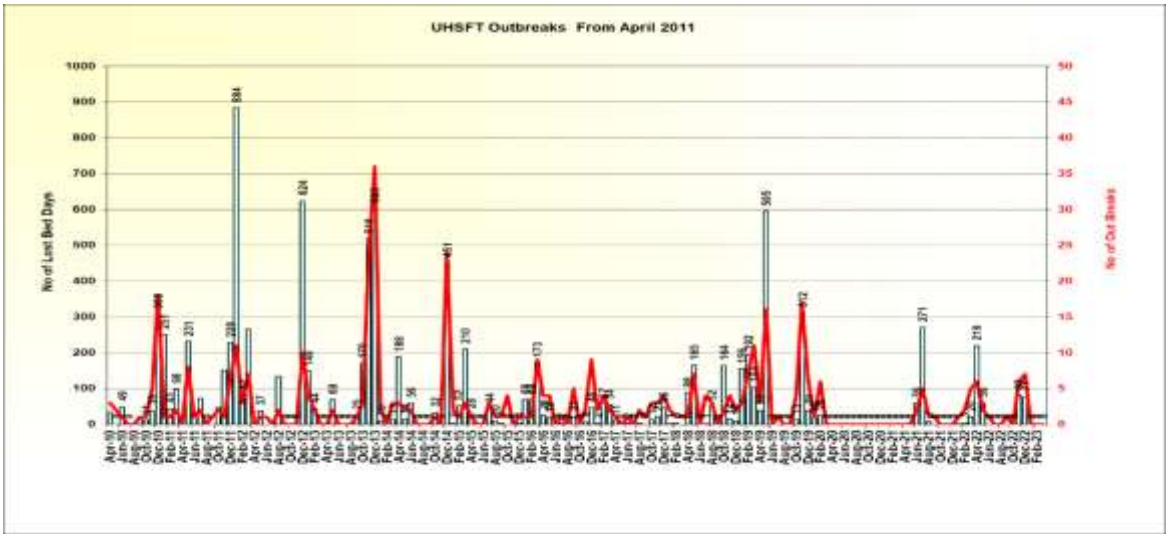
The Trust experienced a significant increase in Norovirus activity in both April 2022 and again in November/early December 2022 with outbreaks resulting in ward/bay closures. Increase in cases and

outbreaks of Norovirus, alongside high numbers of cases of Covid-19/other respiratory viruses within the hospital resulted in significant operational pressures.



Norovirus Outbreaks

	No. of outbreaks	Cause	No of Bed Days Lost	No of Pts	No of Staff	No of Bays Closed	Wards closed
Q1	15	12 x Norovirus 3 x Likely Viral D&V	344	98	7	10	5
Q2	1	Norovirus	0	2	0	1	0
Q3	13	Norovirus	159	70	4	9	4
Q4	0	-	-	-	-	-	-
Total	**29**		**503**	**170**	**11**	**20**	**9**



Year	Bed days lost due to bay/ward closures
2019-20	1039
2020-21	0
2021-22	361
2022-2023	503

Summary of key themes/learning from Norovirus outbreaks included:

- Ensuring early identification, assessment, and management of patients with unexpected/unexplained diarrhoea and/or vomiting, including the management of patients with type 5 stools and sending samples in a timely manner.
- The importance of early isolation of patients with symptoms (e.g., within 2 hours of developing loose stools/D&V).
- The importance of the need to focus on patient hand hygiene
- Ensuring staff are aware of and undertaking correct hand hygiene practices, e.g., hand washing using soap and water.
- The importance of ensuring that patients with symptoms/patients exposed to confirmed cases have dedicated toilet/bathroom facilities. - the lack of bathroom/toilet facilities on some wards results in a high number of patients sharing facilities or difficulty in allocating dedicated facilities for patients with suspected/known infection
- Cleaning of equipment.
- Focus on ensuring a decluttered environment and that items are stored/located in appropriate locations.
- Potential risk of transmission associated with parents/families interacting with each other and their children e.g. caring for each other's babies including changing nappies; using shared facilities on the ward.

UHS continues to be at risk of Norovirus outbreaks due to the limited single room capacity and limited toilet/bathroom facilities in some of the wards.

Key actions taken to support prevention and control of norovirus and associated outbreaks within UHS in 2022/23 has included:

- Education & training activities: training/awareness for clinical staff on clinical equipment cleaning, including commodes; training/awareness on the assessment and management of patients with unexplained/unexpected diarrhoea as part of D&V/winter virus awareness campaign.
- Screening and triaging of all patients either prior to arrival to a care area, or as soon as possible on arrival, to allow early recognition of patients presenting with symptoms of infection or at high risk of infection.
- Implementation of rapid in-lab testing for gastrointestinal pathogens for patients in AMU to support rapid diagnosis, patient management and optimization of isolation capacity. This has demonstrated significant benefits in relation to diagnosis, patient management and optimization of isolation capacity. In addition, a pilot using rapid in-lab GI testing (led by the IPT) commenced in Q3 with the aim of facilitating rapid decision-making in relation to bay closures across all 4 Divisions, due

unexplained/unexpected diarrhea and/or vomiting.

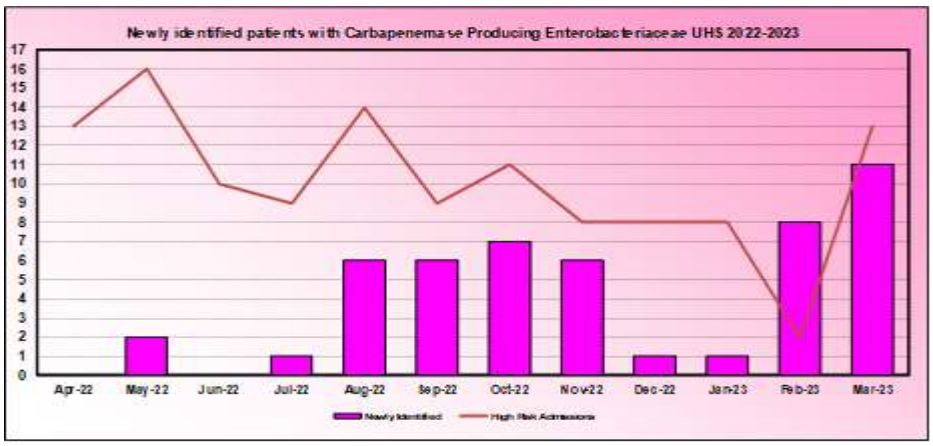
- Ongoing focus on effective management of existing isolation capacity within UHS to ensure optimal use and explore longer term options to increase isolation capacity.
- Use of trust wide communications prior to and during outbreaks – communication cascades/alerts relating to rising levels of infection, expected IP&C practices, situational updates.

2.4 Key actions required to improve future performance and minimise the risk of in-hospital transmission and outbreaks associated with respiratory viruses and Norovirus

Actions and strategies to reduce the risk of in-hospital transmission of respiratory viruses (including COVID-19 and influenza) and Norovirus, along with planning for further potential increases in cases, remains in place and under ongoing review. Key actions required to support future performance include:

- The development of a centralized informatics system to provide accurate real-time infection data (inpatients and admissions) and to support operational planning in relation to placement and management of cases.
- Increasing & expanding the capacity for rapid diagnostic testing (result within 2 hours) for gastrointestinal pathogens (including Norovirus) for symptomatic patients (those with potentially infective diarrhoea) to all admission pathways and expansion of its use for bay closures (currently in-hours Monday-Friday). Implementation of rapid testing for gastrointestinal pathogens for patients in AMU has demonstrated significant benefits in relation to diagnosis, patient management and optimization of isolation capacity. In addition, the pilot of the use of rapid GI testing by the IPT is resulting in significantly earlier bay opening if the test result is negative (bay opened within 2 hours of sample being taken rather than 24-48hrs if waiting for a standard laboratory test result) and supporting optimal use of isolation capacity.
- Ongoing proactive focus on bed planning and management with collaborative discussions amongst key stakeholders, including the Infection Prevention Team, to manage and reduce overall risk to the organisation.
- Ongoing focus on more effective management and optimal use of single room capacity to facilitate rapid isolation of patients presenting with suspected infections and increasing isolation/single room capacity as part of new builds/ward refurbishment.
- Ongoing review and work to improve ventilation standards in clinical and non-clinical areas.
- Development of a programme of work to ensure that there are sufficient patient bathroom/toilet facilities in wards.
- Limiting patient movement (bay and ward moves) as far as possible.
- Further improving communication cascades and internal alerts/escalation.
- Ongoing monitoring and focus on infection prevention and control practices in clinical and non-clinical spaces
- Working with partners regarding admission avoidance where appropriate e.g. hydration management in care homes/the home.
- Further enhancing processes/practices to support prevention of outbreaks occurring including rapid assessment, identification, and isolation of suspected cases.
- Enhancing practices/processes to support management and control of outbreaks when they occur.
- Work with partners and local/national agencies, e.g., ICS/UKHSA/local Health Protection Teams, to improve intelligence and communication relating to community Norovirus activity.

2.5 Carbapenemase-producing Gram negative bacteria



111 High Risk patients admitted to UHS in 2022/23

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

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

Key actions to reduce risk and transmission from CPE:

- Enhanced focus on antimicrobial stewardship to reduce use of broad-spectrum antibiotics especially carbapenem group of antibiotics (e.g. Meropenem).
- To continue to undertake extensive screening of CPE in key areas of hospital including patients on carbapenems.

2.6 Other infections

During the year a wide range of infections (single cases, clusters and outbreaks), outside of those already detailed in the report, have been seen within UHS. These have been identified through laboratory reporting, UHS surveillance systems, national notifications, notifications from clinical teams. All have required a combination of investigation, implementation of infection prevention and control measures, ongoing monitoring and assurance.

Examples include:

- Monkey pox – In May 2022 the Trust were required to respond to the national alert relating to increased cases of Monkeypox within the UK. This involved ensuring safe pathways were in place for assessment, management and testing of patients in the event that cases presented to the hospital, along with setting up a vaccination service to support the monkeypox vaccination programme.
- Candida Auris – In March 2023, 4 cases of Candida Auris were identified in patients who had an inpatient stay on ward D4 (vascular). Investigations and implementation of control measures were undertaken and remain ongoing.

2.7 Surgical Site Infections

Continuous surgical site infection (SSI) surveillance (using UKHSA SSI modules) continues to be undertaken for elective hip and knee replacement surgery. The UHS surveillance system process includes the monitoring of SSIs before discharge, use of 30-day post discharge patient questionnaires and on readmission.

	UHS Incidence of SSI Hip Replacement	UHS Incidence of SSI Knee replacement
Q1	0 (51)	0 (35)
Q2	0 (70) = 0.0% (All other hospitals rate= 0.8 %)	1 (36) = 2.8 % (All other hospitals rate = 1.1%)
Q3	1 (59) = 1.7% (All other hospitals rate=0.8%)	0 infected (47) = 0% (All other hospitals rate = 1.0%)
Q4	Data not yet available	Data not yet available

(as reported by UKHSA)

Summary of cases:

Q2 SSI following total knee replacement – RCA undertaken. Patient with multiple complex comorbidities. Complex surgical procedure: revision periprosthetic fracture, and the risks are more different from a straightforward knee replacement. The patient developed new incontinence before discharge. Patient re-admitted with the SSI and taken to theatre the intra-operative tissue samples grew multiple micro-organisms of which indicated likely contamination of the surgical wound from the patient's incontinence, All the pathway for the prevention of SSI according to the NICE & High impact intervention care bundles were followed. SSI was deemed as likely unavoidable
Q3 SSI following total hip replacement – RCA in progress. Superficial wound infection.

2.8 Assurance of Infection Prevention Practice standards, including environmental cleaning

Infection Prevention Practice standards

The Trust annual infection prevention audit programme was re-instated in May 2022, following, suspension for the majority of 2021/2022, to monitor infection prevention and control practice standards in clinical and non-clinical areas.

High Impact Intervention Audits (Care processes to prevent infection) - self-assessed audits.

	Month	Element	% Standards met
Urinary Catheter Care	May 2022	Insertion	100%
		Ongoing Care	92%
	Nov 2022	Insertion	99%
		Ongoing Care	95%
Central Venous Catheter Care	June 2022	Insertion	100%
		Ongoing Care	92%

	Dec 2022	Insertion	100%
		Ongoing Care	96%
Peripheral Intravenous Cannula Care	June 2022	Insertion	96%
		Ongoing Care	83%
	Dec 2022	Insertion	97%
		Ongoing Care	95%
Surgical Site Infections	Aug 2022	Pre-Operative	96%
		Intra-Operative	100%
		Post-Operative	95%
	Feb 2023	Pre-Operative	100%
		Intra-Operative	100%
		Post-Operative	97%
Cleaning and Decontamination	Sept 2022	Non-Infected	97%
		Infected	94%
	March 2023	Non-Infected	95%
		Infected	96%
Ventilated Patients Audit	Aug 2022		93%
	Feb 2023		82%

Hand Hygiene

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

Monitoring and assurance of hand hygiene practice for inpatient areas in 2022/23 consisted of:

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

Monitoring and assurance of hand hygiene practice for outpatient areas consists of:

- peer audits only

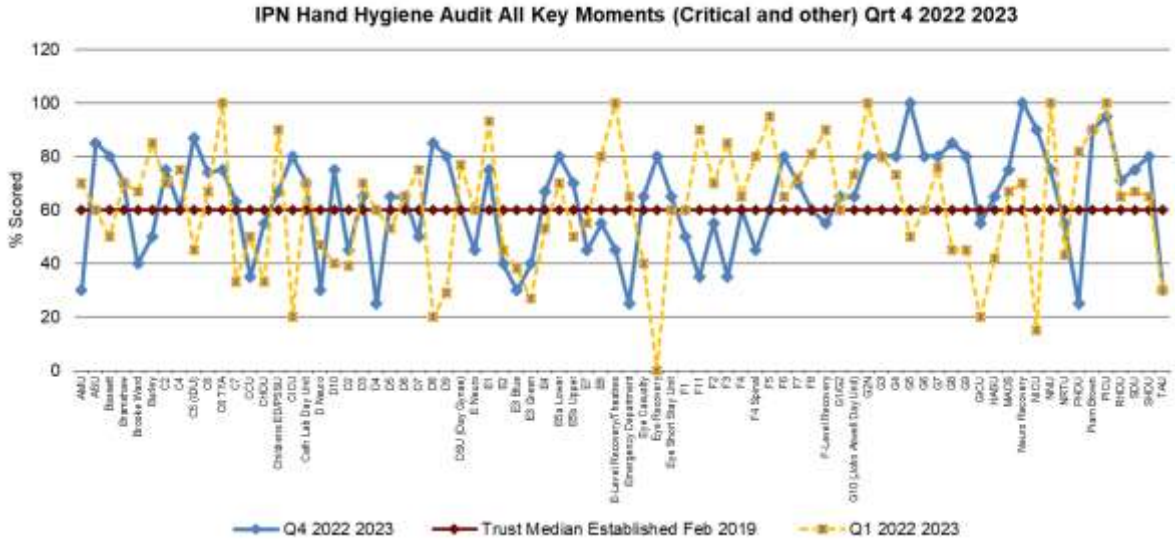
Audit type	Month	% Standards met	
Inpatient areas (self-assessed)	July 2022	94%	
	January 2023	94%	
Outpatient areas (self-assessed)	July 2022	97%	
	January 2023	97%	
Inpatient areas (covert audit undertaken by Infection Prevention Nurses)	Q1 -All inpatient areas Q2 - reaudit of areas who did not achieve the trust median score in Q1 audits.	Q1 overall trust median score = 62%. Overall trust median score following re-audits = 74%	Against a performance improvement target of 60% (the trust median score established following February 2019 covert audits).
	Q4 2022/23 all inpatient areas	Q4 overall trust median score = 63%.	

Within the hand hygiene performance improvement framework (non-self-assessed audits) inpatient areas are measured against a performance improvement target of 60% (the trust median score established following the first covert audits undertaken in February 2019). All areas are expected to improve performance to score above the trust median score.

Those scoring 30-59% will require action plans to improve to the median score. Those scoring below 30% will have improvement plans supported by IPT.

Of the 78 areas audited within Q4, 51 areas achieved on or above the Trust median score of 60%. 27 areas achieved below the expected standards, 3 of which scored below 30%. These areas continue to be supported by the Infection Prevention Team who are working with ward leaders and matrons to improve hand hygiene practice.

In Q1 of the 75 areas audited , 48 achieved on or above the Trust median score of 60%. 27 areas fell below the expected standard, 7 of which scored below 30%. Re-audits in Q2 demonstrated improvements in practice following feedback of results, education and awareness activities.



Improving standards of hand hygiene practice will continue to be an ongoing area of focus in 2023/24 with the need to have a rolling programme of education and awareness to achieve consistent practice.

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

Audit	Month	% Standards met
Standard Precautions	October 2022	98%
Isolation Audit	October 2022	96%
Sharps Safety	May 2022	98%
	November 2022	98%
PPE (IPT audit)	Q1 2022 2023	90%
	Q3 2022 2023	95%
PPE	Sept 2022	98%
	March 2023	98%

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

Processes are in place for regular review of areas not achieving expected standards. Performance in relation to audit standards has been reviewed monthly by the Infection Prevention Team in order to identify areas of concern/those requiring additional support to improve practice standards. 5 areas were contacted in relation to their performance and requested to implement actions for improvement and offered support and education from the IPT.

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

- As part of IPT visits and reviews of clinical areas.
- Ward leader/Matron walkabouts & spot checks

A range of actions/activities throughout the year to facilitate improvements in practice:

- The Infection Prevention Team (IPT) have continued to review practice, visiting areas, undertaking spot checks and arranging education/awareness sessions as required.
- IPT have provided support to areas not achieving expected standards.
- Focused education/awareness activities and campaigns.
- Communications/reminders via Infection Prevention Newsletters, emails, social media platforms, staff briefings.

Environmental Cleaning

Monitoring of environmental cleaning standards (domestic and clinical) continued to be undertaken by the environmental monitoring team and Serco in 2022/2023. During this period, the EMT have had a high turnover in staff, however, have maintained the required level of audits, ensuring all areas of the hospital are being assured for cleanliness. Serco has consistently delivered high levels of cleaning across the hospital for 3 consecutive years.

Audits did however identified concerns in some areas with cleaning of patient care equipment by clinical staff. This

Over the last 12 months a total of 22598 terminal cleans have been completed at an average of 1883 per month.

Following a delay in the implementation of the New National Standards for Healthcare Cleanliness (2021) due to late contractual negotiations between the Trust and Serco (with an agreed derogation from NHSE), full implementation will occur in May 2023. The delay carried no significant risk as the Trust/Serco were working to higher standards of cleaning in may elements during this period.

Infection Prevention and Control Board Assurance Framework.

NHSE/I developed a Board Assurance framework in 2021 with a number of subsequent updates to enable a self- assessment of compliance with UKHSA COVID-19 related infection prevention and control guidance, to identify risks, to act as an improvement tool and to assure trust boards.

This was further updated in September 2022 to enable a self-assessment of compliance with the new National Infection Prevention and Control Manual (NIPCM) and other related infection prevention and control guidance to identify risks associated with infectious agents, gaps in assurance and actions to mitigate/control risks. The UHS self-assessment against the framework noted good evidence and overall assurance of compliance with national IP&C guidance.

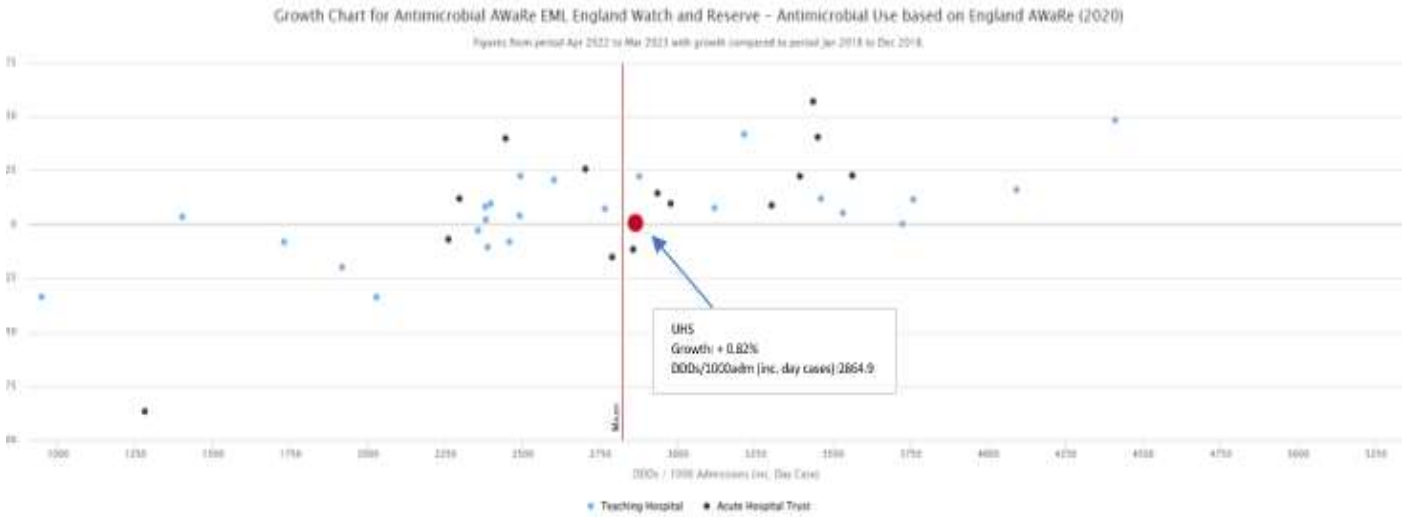
2.9 Antimicrobial Stewardship.

Antimicrobial stewardship, along with the focus on infection prevention and control, is a key component in reducing antimicrobial resistance.

The NHS standard contract 2022-23 required a reduction in the use of broad-spectrum antibiotic usage of 4.5% for 2022-23 when compared to Calendar year 2018 as baseline. UHS has not met this target. For 2023/24 the target changes to a total 10% reduction when compared to a baseline of calendar year 2017 which is going to be even more challenging.

The use of broad-spectrum antibiotic usage has remained fairly static compared to 5 years ago but there has been no reduction. This is also reflected in other hospitals across the country.

The chart below shows comparison to other trusts.



HAPPI audits (antimicrobial monitoring audits) recommenced in 2022/23 with 41% completed of the target number. 80% of audited patients had antibiotics prescribed according to guidelines or justified non-guideline use. 86% of audited patients had an indication documented at initiation. There is bias introduced into the data as patients are not selected randomly. Pharmacy needs to work on increasing audit numbers and randomly selecting patients. There is a potential role for other staff groups to undertake audit.

CQUINS

- AMR CQUIN 22/23: CCG2 Appropriate antibiotic prescribing for UTI in adults aged 16+. CQUIN target met for all 3 quarters and so full payment achieved. This was a resourced CQUIN with funding provided for data collection via the trust finance team.
- AMR CQUIN for 23/24 is more challenging with a focus on switching from IV to oral antibiotics. It carries a financial risk of £800k. This will require engagement from all clinicians in UHS to provide prompt review of IV therapy and switch to oral as soon as is appropriate if we are to meet the requirements of the CQUIN. A switch of 1 dose from IV to oral for every course has been estimated to provide savings of £150k. There are numerous benefits associated with prompt switch which have provided these cost estimates including reduced nursing time spent on administering medicines, reduced patient length of stay and reduction in use of consumables.

A re-focus and increased emphasis is required within UHS on the appropriate prescribing of antimicrobials highlighting the serious consequences of antimicrobial misuse and reminding clinical staff that prescribing antimicrobials carries risks as well as benefits. This requires support and engagement from Divisional, care Group and Clinical Teams, and also additional Medical Microbiology and Pharmacy staffing resource.

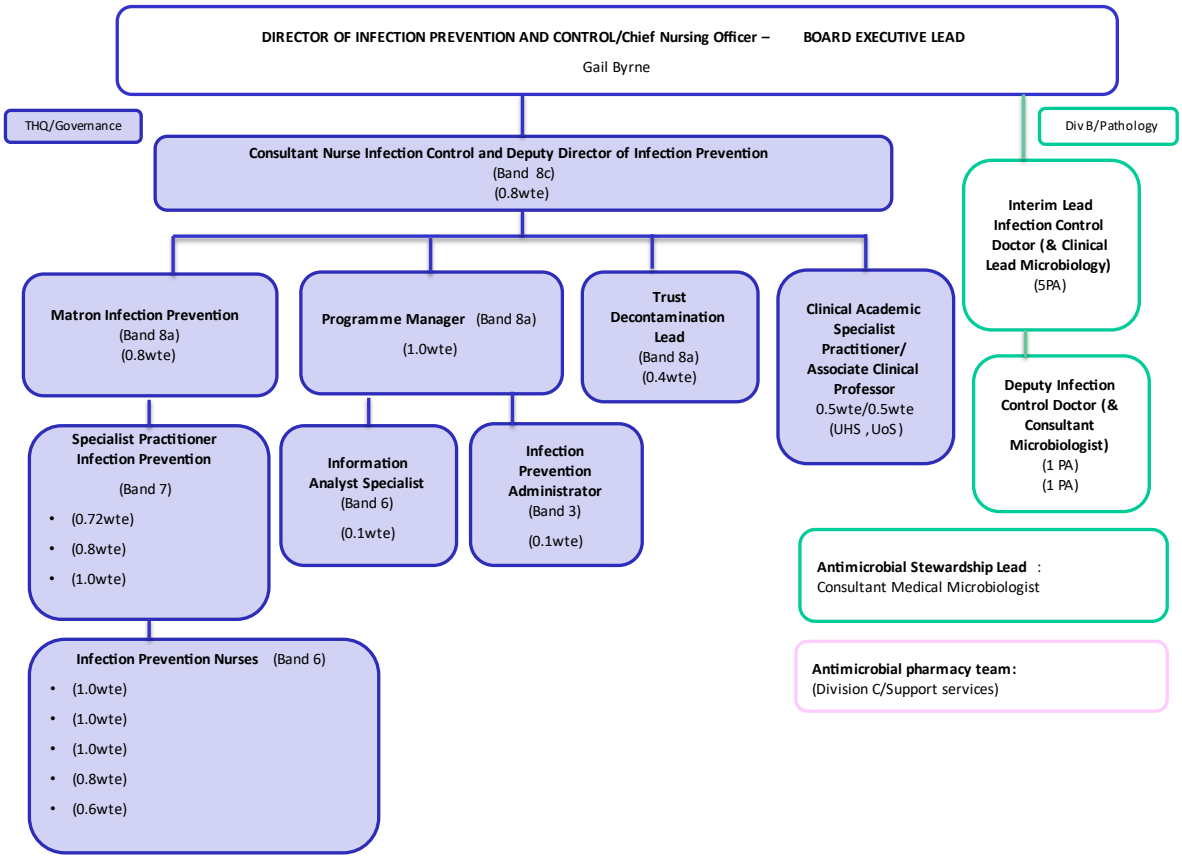
Formal antimicrobial stewardship (AMS) activity and strategic development at UHS is led by a small team comprising a consultant medical microbiologist (only 1.4PAs per week allocated to AMS activity) and pharmacy anti-infectives team (3 WTE). Activity of this team in relation antimicrobial stewardship activities has been hugely reduced over the last 3 years during the pandemic due to their diversion to support COVID-19 related programmes of work (e.g. vaccination for staff, members of the community and inpatients, and therapeutic COVID treatments for patients in the community and for UHS inpatients). A service review, through benchmarking with other teaching hospitals and against nationally recommended staffing levels is being undertaken. The ultimate aim is to ensure the UHS AMS team is adequately resourced to support the Trust's antimicrobial stewardship programme/strategy and national AMR agenda moving forward. Without adequate resource the Trust will remain at high risk of continuing to fail to meet nationally set AMS targets.

Further resourcing (both medical and pharmacy) staffing of the AMS team will allow for increased educational activity and targeted stewardship rounds.

See Appendix 1 for full report. (Note – full data for Q4 not yet available)

2.10 Infection Prevention Team/Service

Resource



The Infection Prevention Team (IPT) is a relatively small service with huge impact across the Trust providing a comprehensive Trust-wide specialist Infection Prevention & Control advisory service. The team provides leadership, support and specialist expertise and advice across the organisation and are the key enablers and drivers of infection prevention and control. The Team is made up of a diverse set of people with significant experience in infection control, with leadership and oversight from the Chief Nursing Officer/Director of Infection Prevention & Control.

The ongoing COVID-19 pandemic has remained an area of focus for the IPT in 2023/22 with significant increase in workload throughout the year as new waves of infection have occurred alongside the need to respond to increased cases, incidents and outbreaks of other infections.

A range of activities have been undertaken throughout the year focused on preventing and controlling infection and an extensive programme of IP&C policy reviews has commenced to ensure that UHS policies are aligned with the new National Infection Prevention & Control Manual that was published in 2022. The

team have continued to support Divisions in the prevention and control of infection as well as providing expert advice/input into other services such as estates, cleaning, waste.

Despite another very challenging year, the IPT have continued to demonstrate extreme resilience and respond to the Trust's service needs, remaining motivated to improve patient outcomes by supporting reductions in HCAI.

Research, Innovations & Achievements

- One of two university hospital NHS Trusts participating in the PRHAPs (Preventing non-ventilator hospital-acquired pneumonia) study- a study aimed at using routinely collected clinical assessment data to inform the development of a prognostic screening tool to identify patients admitted to hospital and at high risk of developing non-ventilator associated hospital acquired pneumonia. Final phase of data collection completed in Q2 2022/23. As a result a future interventional study is being planned.
- Ongoing adoption and development of the use of air purifier technology on a large scale to manage and reduce the risk of transmission and outbreaks of COVID19 and other respiratory viruses.
- Ongoing development of IT systems to support infection management and delivery of an effective service to the Trust. This has included the development of a dashboard for use by the IPT, Site Operations Team and others. The dashboard provides information on new cases of respiratory viruses (admitted and inpatients) and patients with infection by ward location.
- A pilot using rapid in-lab GI testing (led by the IPT in collaboration with the laboratory) commenced in Q3 with the aim of facilitating rapid decision-making in relation to bay closures across due unexplained/unexpected diarrhea and/or vomiting. This pilot has demonstrated significant benefits to date.
- Publications – members of the IPT have contributed to a number of publications in national journals
- Members of the IPT have presented at national, regional and local conferences.
- Our clinical academic nurse specialist is leading work at national level to reduce risk of invasive device associated infection.
- Members of the IPT have been/are members of national working groups and advisory groups for guideline development and research.

2.11 Estates & the Built Environment

The design, planning, construction, refurbishment and on-going maintenance of the healthcare facility has an important role to play in the prevention and control of infection. The physical environment has to assist, not hinder, good practice. It is important that healthcare buildings are designed with appropriate consultation, and the design facilitates good infection prevention and control (IPC) practices and has the quality and design of finishes and fittings that enable thorough access, cleaning and maintenance to take place. Good standards of basic hygiene, cleaning and regular planned maintenance will assist in preventing healthcare-associated infection (HCAI).

Within UHS, the EFCD team overall have effective processes in place to ensure that consideration of IPC practices occurs throughout the planning, design, construction and refurbishment phases of a project. Effective working relationships have developed with the IPT, involving regular consultation.

During 2022/23 ongoing concerns have been highlighted in relation to the existing environment in some areas of our hospital sites (e.g. ventilation, lack of toilet/bathroom facilities, lack of isolation facilities, general repair of ward/outpatient environments) and the impact on preventing & controlling infection. This has included high risk areas for infection such as the Neonatal Unit (NNU), for which refurbishment has been long planned, and PICU, along with other general ward areas.

Progress has been made during the year in addressing concerns in some areas e.g. PICU refurbishment with the creation of addition single rooms and improvements to ventilation; work commenced on D4 vascular ward to improve the support spaces; work commenced in the maxillo-facial outpatient department to improve the environment; refurbishment of dirty utility (Sluice) rooms in the Children's Hospital. In addition, refurbishment of neuro theatres has been completed and centre block theatres 10 and 11 are nearing completion. Work on the NNU is anticipated to commence in early 2023-24.

Water Quality

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

The Trust Water Safety Group has continued to meet on alternate months with a remit to:

- Provide clear direction and oversee the strategic and operational implementation of water safety and hygiene management throughout the Trust.
- Support and steer action on water safety and hygiene in order to meet Trust objectives and local and national targets and statutory compliance.
- Ensure action is taken across the Trust to minimise the risk of infection emanating from water and 'wet' systems supporting the improvement in patient safety and the patient experience.

Water safety meetings include the review of the programme and outcomes of monitoring of sampling for Legionella and Pseudomonas; review of risks and actions required/taken; review of water safety risk assessments for Legionella/pseudomonas.

Good progress continues to be made including:

- Following completion of Pseudomonas risk assessments, formation of Water safety Action Groups established for key areas of concern (clinical, domestic, IPT and engineering team meeting together) to implement solutions to eradicating Pseudomonas in augmented care areas.
- Identification of risks identified with the UHS water systems (e.g. insufficient water pressures, temperatures, condition of water tanks, overuse of point of use filters) and actions/plans required to resolve these – both remedial and long term actions. Significant progress has been made with the replacement of Saunders valves (a key risk) across the site that will improve water circulation.

Air Quality/Ventilation

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

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

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

Many of the COVID-19 outbreaks within UHS have continued to occur in areas of poor ventilation. Of particular concern within UHS are wards within East wing, particularly F level, who have experienced a higher number of outbreaks compared to other areas. Outbreaks of COVID-19 have resulted in bay/ward closures impacting significantly on bed capacity and overall operational capability. The ongoing concerns regarding ventilation were escalated to the Infection Prevention Committee and Quality Governance Steering Group by both the infection Prevention Team and Division D.

Currently, the risk is managed by the careful placement of portable air purifiers which are likely to play an essential role in risk mitigation. Air purifier units have been deployed as a control measure into areas affected by outbreaks/at high risk of outbreaks and have also been deployed into high-risk areas such as admission units. However, use of these units is only a temporary short-term solution.

Actions are in place to explore ways to improve the current state of ventilation in key areas of the hospital. with the limiting factor in relation to long term solutions being the large scale of work with potential disruption and the significant investment required for rectification work. Long term solutions to install ductwork will be scheduled in line with future ward refurbishment programmes.

Options for a medium term solution to improve the ventilation on some of the highest risk wards on F Level East Wing (Orthopaedics) have been identified by the Estates team in collaboration with the Infection Prevention Team. Installation of ceiling/wall mounted units into 8 bays within the T&O wards that have been assessed by the IPT/DHN/Matrons as highest risk for outbreaks (F2 &F1 trauma bays) is due commence in April/May 2023.

Focus on ventilation in the built environment may further reduce the risk from many other healthcare associated infections such as influenza and other respiratory virus, Norovirus and MRSA. Ventilation is identified as one of estates highest priorities for addressing and is included in the backlog maintenance replacement programme but requires funding.

3.0 Operational and financial impact of Healthcare Associated Infection

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

The increased length of stay and treatment costs associated with healthcare associated infection e.g. C.difficile, contributes further to decreased operational productivity. A recent study has estimated the total annual cost of healthcare associated infection in the UK to be 774 million pounds.

4.0 Appendices

Appendix 1 : Pharmacy Anti-infectives Team Report to IPC Q3 (Oct– Dec 2022)
Appendix 2 : Q4 Division A Matron and CGCL Report
Appendix 3: Q4 Division B Matron and CGCL Report
Appendix 4: Q4 Division C Matron and CGCL Report
Appendix 5: Q4 Division D Matron and CGCL Report

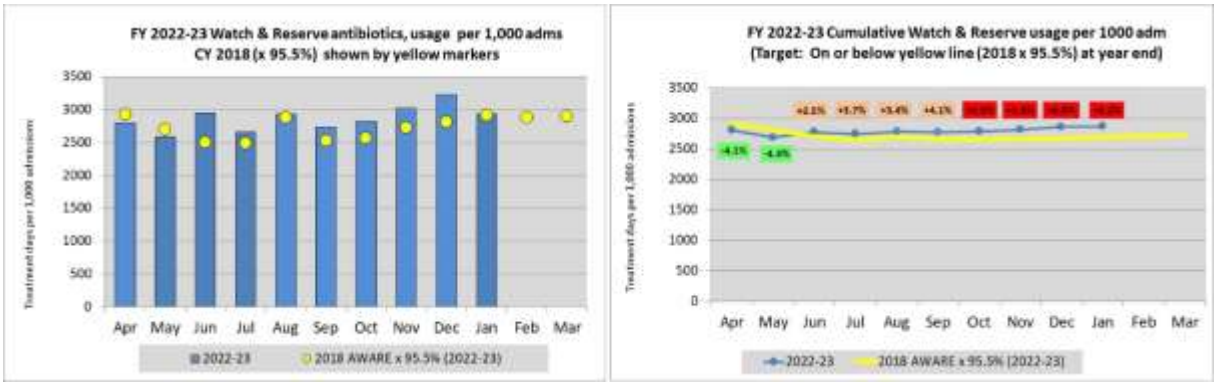
Appendix 1

Pharmacy Anti-infectives Team Report to Infection Prevention Committee
March 2023

1. Total Antibiotic Consumption

a. Internal performance

The NHS standard contract 2022-23 requires a reduction in the use of broad-spectrum antibiotic usage of 4.5% for Financial Year (FY) 2022-23 when compared to Calendar year (CY) 2018 as baseline. Practically this means increasing the proportional usage of WHO AWaRe programme Access category antibiotics and reducing our usage of the Watch and Reserve antibiotics: https://www.who.int/publications/i/item/2021-aware-classification. Current performance can be found in the chart below, February figures not yet available. The blue columns (actual usage) need to be below the yellow dots (target) to meet our contractual obligations. UHS has not been meeting the required reductions in antibiotic consumption since June 2022 and it is unlikely that this will reverse before the end of the FY. The target then changes to a total 10% reduction when compared to 2017 calendar baseline which is going to be even more challenging.



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

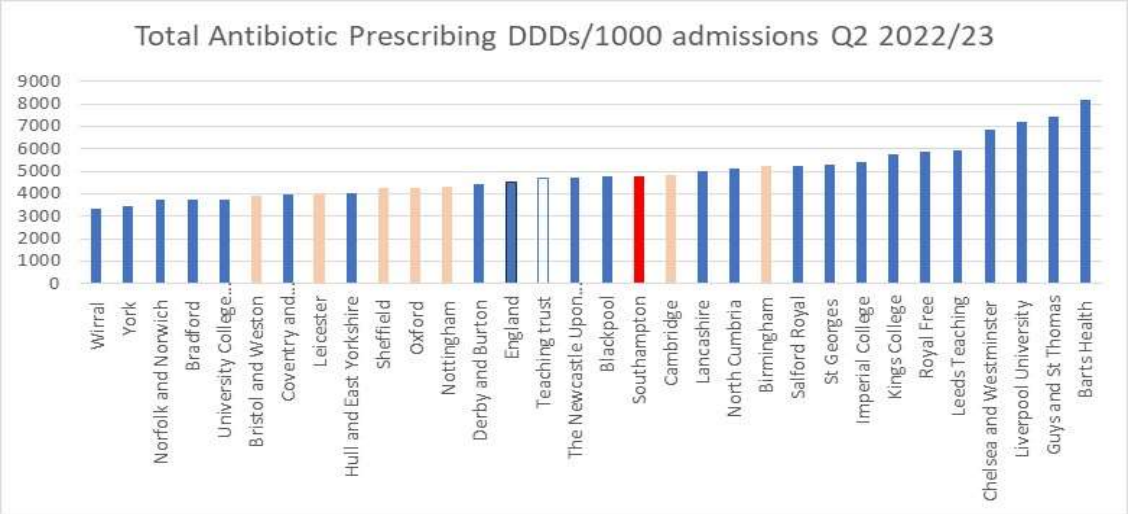
This has been discussed in the UHS adult AST (antimicrobial stewardship team) meeting and potential reasons for this include:

- A higher patient complexity being seen, possibly resulting in a higher proportion of admitted patients being prescribed multiple antibiotics
- Increase in COVID patients, who are routinely prescribed antibiotics
- Limited formal antimicrobial stewardship (AMS) activity taking place
- Lack of AMS being practiced by clinical teams across the trust.

Antimicrobials are prescribed everywhere by everyone; there is a need for high level trust leadership and innovative IT solutions and engagement from all clinical leads to improve the quality of care delivered and encouragement to follow the principles of start smart then focus.

b. National comparators for total Antibiotic Consumption

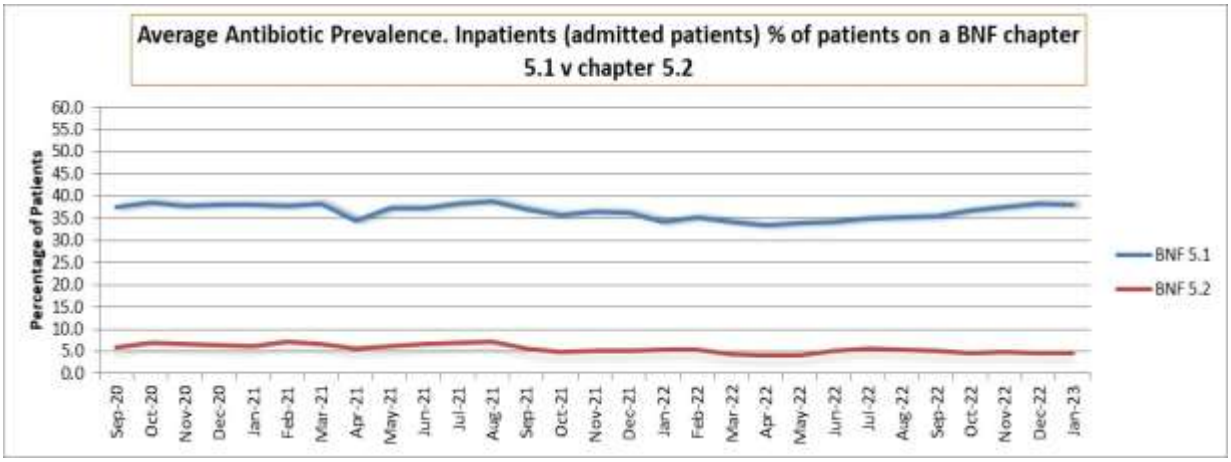
Benchmarking with peer teaching trusts for Q2 2022/23 (most recently available data) can be found below. UHS total antibiotic consumption is 6% above the average for England and 2% above the teaching trust average (as DDDs/1000 admissions).



Ref: fingertips.phe.org.uk

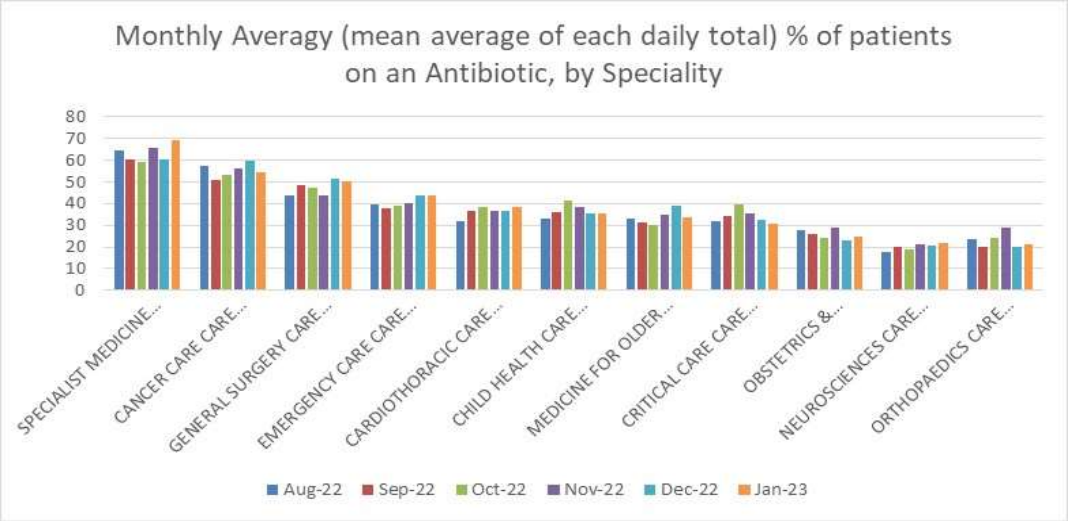
c. Proportion of Patients on Antibiotics

Almost 40% of inpatients at UHS are on an antibiotic, if all antimicrobials are included then 42.6% of patients at any time are prescribed one.



Ref: Reporting data from JAC prescribing system

This can be broken down by speciality with a mean average of each daily total for the month. Specialist medicine consists of D10 and C5 for this report, moving forwards for Q4 these will be included with the emergency care group, encompassing all medical wards.



Ref: Reporting data from JAC prescribing system

d. HAPPI Audits

Hospital Antibiotic Prudent Prescribing Indicators (HAPPI) audits have been re-introduced (September 2022) to gain information on antimicrobial prescribing. The aim is for 5 audits to be completed each month for each ward by the ward pharmacists. In total 834 audits have been completed to end Feb 2023 out of a possible 2040 (41%).

Documentation of Indication at time of Initiating Antibiotic

Month	Number of patients audited	% Indication documented on day of initiation
Sep-22	150	81%
Oct-22	152	84%
Nov-22	140	86%
Dec-22	85	88%
Jan-23	148	90%
Feb-23	158	86%
Target	340 per month	>90%

Use within guideline

Month	N/A-No Guideline	N/A-No indication documented	Off guideline-Justified	Off guideline-Not justified	On guideline
Sep 2022	11%	3%	23%	7%	57%
Oct 2022	5%	4%	22%	9%	60%
Nov 2022	10%	8%	23%	10%	49%
Dec 2022	7%	1%	22%	8%	61%
Jan 2023	9%	3%	17%	4%	67%
Feb 2023	10%	6%	27%	9%	49%

When the detailed data of which indications are referred to in the 'N/A -no guideline' column this will aid prioritisation for guideline development.

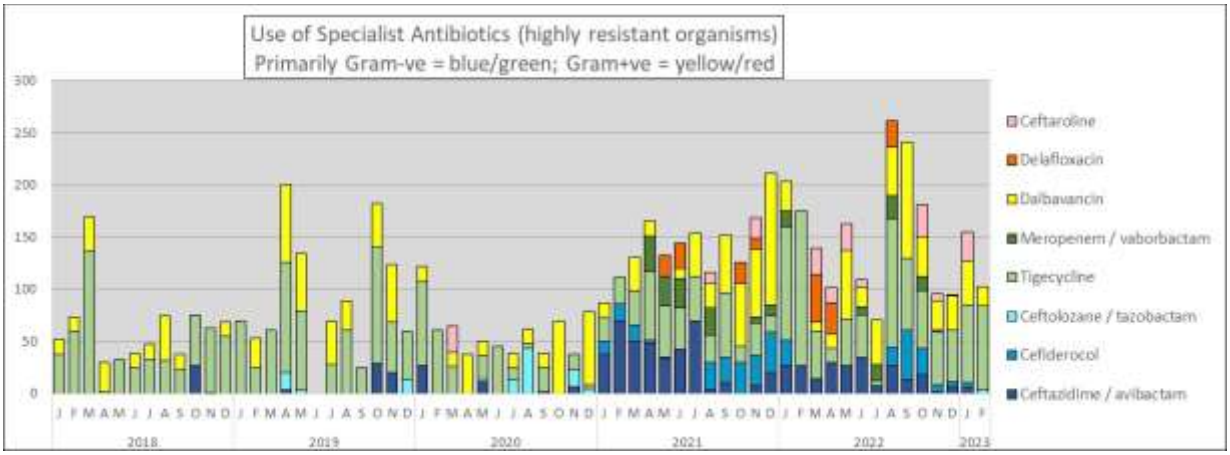
Review done within 72 hours of initiation of antibiotic

Month	Audited within 72hrs	Change drug to broader spectrum	Change drug to narrower spectrum	Continue unchanged	IV-Oral switch	OPAT	Stop
Sep 2022	51%	3%	3%	32%	9%	0%	1%
Oct 2022	43%	1%	2%	43%	7%	0%	3%
Nov 2022	47%	3%	2%	38%	8%	0%	2%
Dec 2022	49%	6%	4%	31%	7%	0%	4%
Jan 2023	53%	1%	3%	36%	5%	1%	1%
Feb 2023	52%	3%	3%	32%	8%	1%	3%
Grand Total	**49%**	**3%**	**3%**	**36%**	**7%**	**0%**	**2%**

There is further work to be done on collecting sufficient data for each care group to meaningfully compare them. Work is being done to adjust the process to encourage audit submissions. This will help inform if there are particular care groups of concern in order to target antibiotic quality prescribing initiatives. This data may also help target resources with the IVOS (intravenous to oral switch) CQUIN being undertaken in FY 23/24.

e. Specialist Antimicrobial Usage

In response to the increase in gram negative resistant infections nationally and being seen at UHS our use of expensive last-line restricted antimicrobials is increasing. We are monitoring the use of these antimicrobials to ensure they are used in-line with sensitivities and on expert advice only. Nationally, Blueteq reporting forms have been introduced from the 1st of July 2022 for two of these antibiotics, which require clinical detail and completion by a specialist. The use of the restricted antimicrobials was reviewed recently and >90% of prescriptions were deemed to be appropriate.



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

2. CQUIN: CCG2 Appropriate antibiotic prescribing for UTI in adults aged 16+

Description: CQUIN target is to achieve 60% of all parameters outlined in the table below for patients aged 16+ years treated for UTI; thus meeting NICE guidance for diagnosis and treatment.

Full payment is expected for Q3. Full achievement of the CQUIN for the year equates to £800k. Funding was provided for an audit data collector and improvement work, although the post holder did not start until October 22.

Parameter	% Achievement Q2		% Achievement Q3	
	Non-CAUTI	CAUTI	Non-CAUTI	CAUTI
Documented diagnosis of specific UTI based on clinical signs and symptoms	90	100	97	86
Diagnosis excludes use of urine dipstick* in people aged 65+ years and in all CAUTI **as sole diagnostic method*	90	56	92	64
Empirical antibiotic regimen prescribed following NICE/local guidelines	87	94	92	79
Urine sample sent to microbiology as per NICE requirement	86	94	84	100
For diagnosis of CAUTI, documented review of urinary catheter use is made in clinical record.	88		71	
Proportion satisfying ALL relevant parameters (i.e. CQUIN achievement) (Minimum threshold for any payment, 40%; maximal payment ≥ 60%)	**61%**		**64%**	

3. Other Stewardship Activities in Q3

- Antimicrobial stewardship rounds have continued, conducted by microbiologists and pharmacists in many clinical areas. Gaps noted in provision to general medicine, cancer care (excl. BMT) and pharmacy/microbiology support to paediatric stewardship.
- Monthly retrospective review of *C. difficile* cases and weekly review of active C.*difficile* infection patients has continued throughout Q3 with consultant support diverted from PAs allocated to stewardship.
- Antimicrobial awareness week marked with a stand in the front entrance and highlighted by communications across social media and trust communications.
- Teaching:
    - FY1 and FY2 Medical education sessions have been run by the stewardship team.
    - University of Southampton non-medical prescribing course.
    - Pharmacy education. Weekly sessions run by the infection pharmacists.

Appendix 2
Division A Q4 Matron and CGCL Report

Care Groups: Surgery, Critical Care , Ophthalmology and Theatres and Anaesthetics

Matrons: Kerry Rayner, Jo Rigby, Kathy Bowen Jake Smokcum, Charlie Morris, Lisa Turnbull, Linda Monk, Michaela Jones. Ryan Bird, Leah Marriott, Tracy Richards, Mitzi Garcia, Raquel Domene Luque and Fretzie Condevillamar

Clinical Lead: John Knight, Lucy White, Aris Konstantopoulos and Aby Jacob

Date of Report: April 2023

Author: Colette Perdrisat

Performance Quarter 4 – 1st January to 31st March 2023

Key Indicator	Number	Limit	Status
MRSA Bacteraemia	**0**	**0**	**Green**
***Clostridium difficile* diarrhoea**	**2**	**4**	**Green**
E. coli (HOHA)	**7**	**Trust Limit of 33**	**Trust Total 43** (HOHA + COHA)
Pseudomonas (HOHA)	**2**	**Trust Limit of 9**	**Trust Total 10** (HOHA + COHA)
Klebsiella (HOHA)	**1**	**Trust Limit of 19**	**Trust Total 10** (HOHA + COHA)
MSSA Bacteraemia	**2**	**No Limit**	
GRE	**2**	**No Limit**	

	No	Cause	Comments
HCAI-Related Deaths	**1**	Covid 19	Patient Covid 19 positive day 8 HO.pHA and died 8 days post positive result. Clinical Review of case underway by Infection Prevention Doctor.
		Leak in Theatre J	Water leak into anaesthetic room from toilet water cistern. Leak has been for a while (?4 weeks) mould seen above the ceiling. theatre staff not aware of the leak's policy / protocol Previously leak - estates team denied access. Theatre staff stopped using the anaesthetic room to anaesthetise the patient due to the leak but continued to access the room via the theatre, disrupting the air flow and risking contamination within the theatre. IV drugs continued to be drawn up and left out in the anaesthetic room. Key parts were covered.

			Due to 2 other theatres being out of use due to refurbishment difficulty moving theatre J list to another theatre.

Performance Year to Date

Key Indicator	Number	Limit	Status
MRSA Bacteraemia	**0**	**0**	**Green**
***Clostridium difficile* diarrhoea**	**9**	**13**	**Green**
E. coli (HOHA)	**21**	**Trust Limit of 94**	**Trust Total 154** (HOHA + COHA)
Pseudomonas (HOHA)	**9**	**Trust Limit of 27**	**Trust Total 35** (HOHA + COHA)
Klebsiella (HOHA)	**13**	**Trust Limit of 73**	**Trust Total 51** (HOHA + COHA)
MSSA Bacteraemia	**8**	**No Limit**	
GRE	**3**	**No Limit**	

Key Learning from Investigation of Infections and Deaths:

Ophthalmology- nil to report

Surgery – nil to report

Critical Care - GICU – CDiff March '23, GICU – One commode was noted to have some debris on it, possibly bodily fluids. Action plan written advising staff to ensure commodes are thoroughly cleaned after use. Spot-checks and ongoing surveillance are in place. After completion of surveillance, the IPT were contacted to note that couple of porters were wearing the same gown and gloves they had transferred the patient to the ward with, when returning the clean bed into the unit. Porters were spoken with at the time.

GICU – Ecoli BSI Jan '23. Missing line insertion, removal and CADI documentation. Patient had type 7 stool with a femoral vas cath insitu. Advocated to medical staff to document in the medical notes reasons for insertions site of choice, particularly if the femoral region is chosen and encourage invasive lines to be inserted away from femoral region where possible especially if the patient is experiencing diarrhoea. Liaising with CIS team to provide a prompt on the CVAD insertion record. Evidence of multitasking wearing same pair of gloves for several tasks during IP audits. Ongoing education and audits to advocate more frequent hand hygiene and glove changing were required.

GICU – TB March '23. Patient on GICU without suspicion of TB, but when transferred to RHDU the patient was tested and has confirmed positive. A list of contacts of staff and patients has been compiled and sent to OH, H&S and IPT. Staff did not wear FFP3 masks whilst caring for the patient whilst on GICU as there was no indication (i.e. no AGPs).

Progress and Success:

Ophthalmology - 5 Star cleaning audits across all areas in Ophthalmology

Hand hygiene compliance achieved at above 60% for all areas within ophthalmology, Eye Casualty currently at 58% and has had some intensive support from IPT

Surgery – nil to report

Critical Care - GICU Bedpan racks put up in sluices as per recommendation by IPT following CDiff outbreak in last quarter.
No infections or deaths that require investigation in **CICU, SHDU or NICU**.
SHDU – reaudits of peripheral cannula ongoing care 100% (Jan) and hand hygiene 100% (Jan)
Amendments to metavision documents to encourage recording of G-straps, hygiene needs in relation to catheter care – improvements in documentation seen.
GICU VAP audit 100% (Feb)
GICU, CICU & SHDU cleaning and decontamination audits 100% (March)
NICU and SHDU PPE audit 100% (March)

Ongoing Challenges:

Critical Care:

Urinary catheter ongoing care reaudits in Jan – 80-90% in ICU focus on applying securement devices (or documenting reason for unsuitability) and documenting hygiene needs have been met.

VAP – audits 80-87% in CICU and NICU; focus on documenting teeth brushing and nursing head up (or documenting reason for not)

SSI – post op care 92% CICU (Feb); focus on ensuring hand hygiene is carried out before patient contact

Cleaning and decontamination 60% NICU (March) – reaudit planned for April.

PPE – 91% ICUs (March) – focus on reminding staff to wear visors within 2m of covid patients, not wearing a single pair of gloves for multiple tasks and encouraging hand hygiene.

Summary of Action since Last Report, Current Focus and Action Plan:

Ophthalmology - Some non-submissions on IPT audits. Addressing these with our area leads

Surgery - small increase in COVID positive patients seen prior to new guidance on testing. All patients cohorted on E8 and managed well.

Critical Care - Reminders to all staff to ensure visors are worn for all patients with Covid patients (all pathways)
Focus on hand hygiene specifically wearing gloves for one intended task not multiple tasks across.
Continue to audit as per IP programme and step up where non-compliance needs addressing.

Surgery –

Key area	Responsible	Updates
ANTT Procedural cards not displayed	TR / FC	In progress
Glove Usage	FC	In progress
Computer Dust	Each Matron	In progress
Safe Storage of Antichlor	Each Matron	In progress
Rusty Pieces of equipment	Each Matron	In progress
Staff Bags on floor in anaesthetic room	RD	In progress
Linen storage	Each Matron	In progress

Sharps bin not signed	Each Matron	In progress
Recovery Sluice Management_	MG	Actioned
Patient Bedside equipment 'I am clean'	MG	Actioned
Intubation Trolley equipment	RD	In progress
Ventilation and air flow seals	Each Matron	In progress
Used coffee mugs in the anaesthetic room on work surfaces	RD	In progress
Hydration station boxes placement no correct.	Each Matron	In progress
Phones and laptops found in the theatre not stored correctly	Each Matron	In progress
No Plastic boxes or boxes not being used for bags in the anaesthetic room	RD	In progress
Equipment in theatres found dusty	Each Matron	In progress
Rusty trolleys -found in theatre	Each Matron	In progress
Equipment found outside the theatres a large percentage of the equipment is dusty	Each Matron	In progress

Any Other Issues to Bring to the Attention of TEC and Trust Board:

None

Date this report will be an agenda item at Care Group Governance Meeting	**Date this report will be an agenda item at Divisional Governance Meeting**
April 2023	**April 2023**

Appendix 3

Division B Q4 Matron and CGCL Report

Care Groups: Cancer Care, Emergency Medicine, Helicopter Emergency Medical Services, Medicine and Medicine for Older People, Pathology and Specialist Medicine

Matrons: Jenny Milner, Steph Churchill, Julia Tonks, Abigail Fail, Emma Chalmers, Susie Clarke, Erica Wallbridge, Steve Hicks, Gillian Lambert, Emma Lavelle, Sandra Souto, Nat Kinnaird, Samantha Brownsea and Kat Black.

Clinical Lead: Matthew Jenner, David Land, Gayle Strike and Michelle Oakford

Date of Report: April 2023

Author: Suzy Pike

Performance Quarter 4 – 1st January to 31st March 2023

Key Indicator	Number	Limit	Status
MRSA Bacteraemia	**0**	**0**	**Green**
***Clostridium difficile* diarrhoea**	**4**	**6**	**Green**
E. coli (HOHA)	**12**	**Trust Limit of 33**	**Trust Total 43** (HOHA + COHA)
Pseudomonas (HOHA)	**3**	**Trust Limit of 9**	**Trust Total 10** (HOHA + COHA)
Klebsiella (HOHA)	**1**	**Trust Limit of 19**	**Trust Total 10** (HOHA + COHA)
MSSA Bacteraemia	**1**	**No Limit**	
GRE	**0**	**No Limit**	

	Number	Cause	Comments
HCAI-Related Deaths	**2**	Covid 19	Patient 1 – Covid 19 positive day 10 of admission HO.pHA and died 11 days post positive result. Patient 2 – Covid 19 positive day 29 of admission HO.dHA and died 10 days post positive result. Clinical review underway by Infection Prevention Control Doctor
Incidents/ Outbreaks of Infection	**4**	TB patient on D5, ED GICU, RHDU	COPD patient with a productive cough. Staff and Patient contacts identified. Letter being sent to patients by clinical teams.
		C.diff PII on G6	2 Healthcare associated cases of cdiff within 28 days Daily assessment and evaluation of care not completed/signed for at end of each shift for some patients.

		?VHF Case on D10	Risk factors not picked up in ED and VHF pathway not followed. Once identified as a query patient should have been moved to C5 negative pressure room as per policy but remained on D10 initially as deemed a very low risk. D10 not familiar with PPE requirements and donning and doffing instructions for VHF or the additional precautions required. Waste were not aware of the need to have a supply of yellow rigid waste bins. C5 had 3 available. C5 did not keep a log of staff entering the room after the patient was transferred to them.
		C.diff PII on C2	On the three out of five visits, faecal matter on commodes and bedpans were found. commodes with dried faecal matter under the seater, Bedpan had a dried faecal matter The base of the beds and notes trolley were dusty Weighing scale not cleaned for 4 days Sharps bins and boxes were in the floor which inhibits cleaning. Shower curtain in side room 10 was not changed in between patients. Sluice Hopper was left unflushed.

Performance Year to Date

Key Indicator	Number	Limit	Status
MRSA Bacteraemia	**0**	**0**	**Green**
***Clostridium difficile* diarrhoea**	**30**	**24**	**Red**
E. coli (HOHA)	**46**	**Trust Limit of 94**	**Trust Total 154** (HOHA + COHA)
Pseudomonas (HOHA)	**10**	**Trust Limit of 27**	**Trust Total 35** (HOHA + COHA)
Klebsiella (HOHA)	**13**	**Trust Limit of 73**	**Trust Total 51** (HOHA + COHA)
MSSA Bacteraemia	**8**	**No Limit**	
GRE	**1**	**No Limit**	

Key Learning from Investigation of Infections and Deaths:

Cancer Care:

- Enhanced surveillance on C2 following C Diff cases. No links between cases found.
- Reduced number of sharps containers on ward so not stored on the floor, inhibiting cleaning.
-

Medicine – Respiratory:

- Confirmed patient with Pulmonary TB identified on RHDU – had been moved from D5 and GICU. Staff high risk contacts identified on RHDU and D5 and offered screening with occupational Health.
- Case has been reported to Health and Safety. Patient contacts identified and letters shared.
- Next meeting 02/06/23.

Medicine – MOP:

- Need to refocus and re- educate staff in regard to use of CDIFF pathway.
- Delay in sending stool samples being sent

Progress and Success:

Cancer Care:

- Staff Covid testing requirements, testing reduced in high risk areas and stopped in low risk areas.
- Ongoing review with infection prevention regarding screening for infections in outpatient areas

Emergency Medicine – AMU:

- POCT testing now for symptomatic only patients has reduced the volume of testing and significant reduction in positive results.
- Through the admission process all patients come into a side room and side room capacity has been a challenge but with current volume manageable.
- GI testing reducing time in side rooms and implementing correct antibiotic regimes. There would be a benefit to roll out across the division.

Emergency Medicine – ED:

- Ongoing pathway for suspected respiratory viruses via RAU.
- Ongoing close working with inpatient areas to isolate pts.
- Continued appropriate identification of pts requiring side rooms.
- Improved compliance with hand hygiene, now > 80% - following an audit of only 25% compliance. Peer audits, Light box, DHN meeting with matrons and clinical leads.

Medicine:

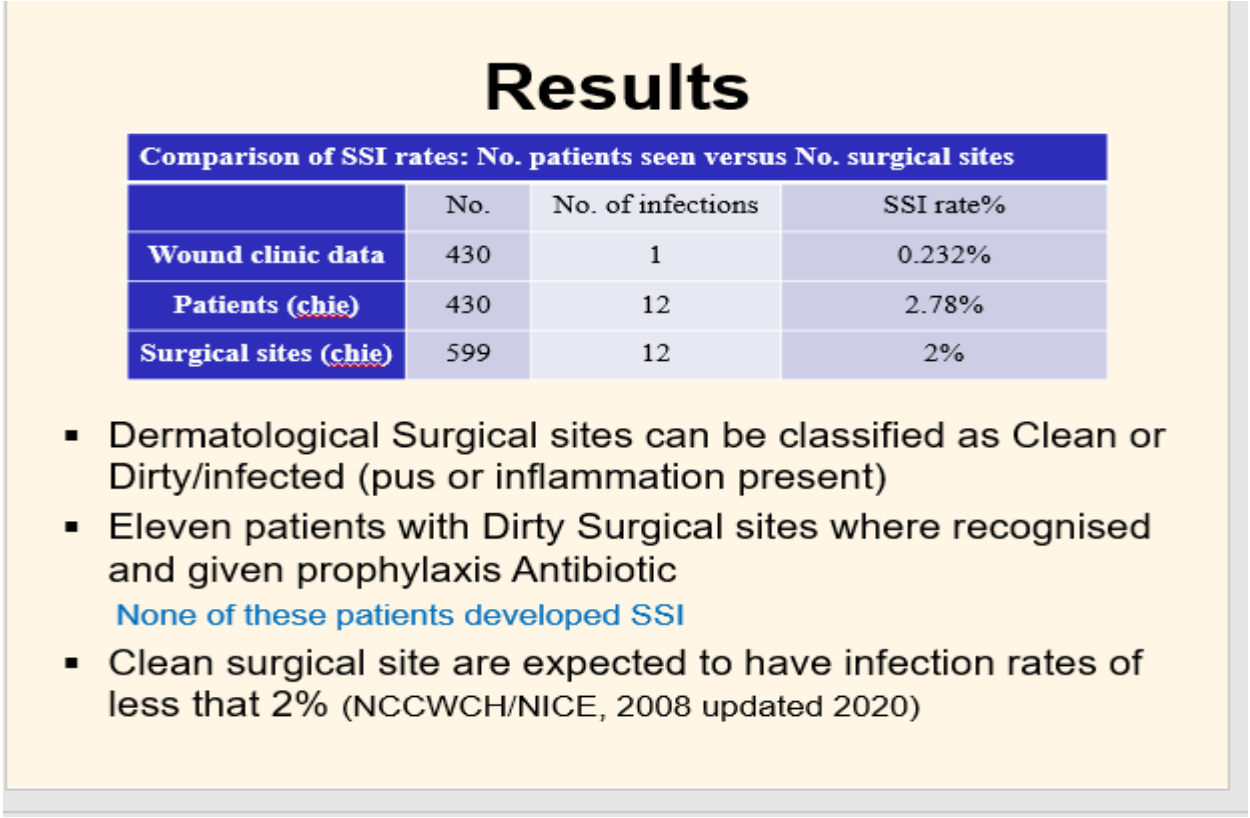
- Cleaning standards remain high in GHU/GIM wards.
- Hand hygiene compliance has increased.
- Peer hand hygiene audits continue across the wards.
- Good engagement between IPT and ward staff.
- Correct PPE and signage in use.
- Improved compliance with commode cleaning
- Improved documentation on stool charts.
- C-Diff teaching sessions commenced in safety briefing.

Specialist Medicine:

- All areas compliant with COVID swabbing guidance changes within the past quarter. COVID positive pathways in place in all areas and patients have attended successfully through this pathway.
- One incident within Endoscopy where un-swabbed patient became unwell during Bronchoscopy and required admission. Patient was swabbed as per pathway at the time of

incident and was found to be COVID +ve. Correct actions taken and due to correct PPE wearing and case management, this was an isolated positive event.

- Endoscopy environmental audits shows significant improvements with action plans from SERCO following areas for improvement which had been identified within their audits.
- Derm self-audit of SSI rates:



Results

Comparison of SSI rates: No. patients seen versus No. surgical sites			
	No.	No. of infections	SSI rate%
Wound clinic data	430	1	0.232%
Patients (chie)	430	12	2.78%
Surgical sites (chie)	599	12	2%

- Dermatological Surgical sites can be classified as Clean or Dirty/infected (pus or inflammation present)
- Eleven patients with Dirty Surgical sites where recognised and given prophylaxis Antibiotic

  None of these patients developed SSI
- Clean surgical site are expected to have infection rates of less that 2% (NCCWCH/NICE, 2008 updated 2020)

Ongoing Challenges:

Cancer Care:

- Side room capacity -linked to impact from current testing strategy
- Hot and cold pathways in AOS impacting allocation of patient based on acuity – currently reviewing with AOS ops team and infection prevention
- Patient swabbing on C7. PCR testing required for specific group of patients to determine if can be treated – awaiting outcome from Trust meeting

Emergency Medicine – AMU:

- additional capacity opened and multiple teams in the unit especially in the mornings creating noise and vigilance with hand hygiene.

Emergency Medicine – ED:

- Volume of pts requiring RAU or SR at times exceeds capacity.
- Waiting for pts to be post taked by specialities before transfer.
- Initial hand hygiene failed in adult ED, repeat audit passed. Significant work has been done to improve hand hygiene and appropriate glove wearing including hand washing demonstrations, poster campaign and general raised awareness in the dept. Ongoing volume of pts in dept.
- Hand wash basins, recurrent blockages resulting in being out of order for periods of time. – Working with estates to resolve.

Medicine :

- D8 has had many outbreaks over the past 2 years of COVID. Following outbreak review meetings the concerns and contributory factors include lack of toilet facilities on the ward and clientele who often leave the ward.
- Staffing vacancy and reliability on agency workers for Nurses and HCA's.
- Vacancy in housekeepers.
- Education to wider MDT to ensure they are compliant with infection prevention practices, particularly hand hygiene.
- Agency staff not fit mask tested- escalated to Temporary resourcing team and ward teams putting in CIM's.
- Crowding on wards due to multiple team attendance secondary to locality model in MOP

Specialist Medicine:

- Ongoing focus for IPT audits as high numbers of non-submission within the care group. Link and timetable recirculated, added to agenda for Band 7 meetings and 1:1s.

Summary of Action since Last Report, Current Focus and Action Plan:

Cancer Care:

- GI panel swabbing agreed in principle for AOS. Data collection underway so able to compare impact of rapid GI swabbing.
- Swabbing in outpatients for covid and other infections
- Covid swabbing for patients and visitors currently under review

Emergency Medicine – AMU:

Current focus on hand hygiene with recurrent teaching updates in place.

Emergency Medicine – ED:

- Current focus is on effective hand hygiene and glove wearing in dept.

Medicine:

- Continued delivery of decentralised approach for covid – across G7/C5
- Hand hygiene focus
- C.Diff pathway refocus and education

Any Other Issues to Bring to the Attention of TEC and Trust Board:

Cancer Care:

- Side Room pressures continue in cancer care as an impact of our current testing strategy.

Emergency Medicine – ED:

- Some inpatient areas still requesting covid swabs prior to transfer in particular Critical care. Discussions being supported by matrons and clinical leads across both areas.
- Ongoing challenges related to hand wash basins

Date this report will be an agenda item at Care Group Governance Meeting	Date this report will be an agenda item at Divisional Governance Meeting
May 2023	May 2023

Appendix 4

Division C Q4 Matron and CGCL Report

Care Groups: Women and Newborn, Maternity, Child Health, and Clinical Support

Matrons: Karen Elkins, Ronilo Ramos, Alison Millman, Kim Allsop, Kirsteen Dick, Rachel Harris, Ann Hood, Lisa Ingram, Carol Purcell, Nikki Medhurst, Victor Taylor, Lucia Lazzeri-Ford and Catherine Roberts

Clinical Lead: Balamurugan Thyagarajan and Charlie Keys

Date of Report: April 2023

Author: Louisa Green, Emma Northover

Performance Quarter 4 – 1st January to 31st March 2023

Key Indicator	Number	Limit	Status
MRSA Bacteraemia	**0**	**0**	**Red**
***Clostridium difficile* diarrhoea**	**2**	**3**	
E. coli (HOHA)	**1**	**Trust Limit of 33**	**Trust Total 34** (HOHA + COHA)
Pseudomonas (HOHA)	**4**	**Trust Limit of 9**	**Trust Total 5** (HOHA + COHA)
Klebsiella (HOHA)	**1**	**Trust Limit of 18**	**Trust Total 14** (HOHA + COHA)
MSSA Bacteraemia	**0**	**No Limit**	
GRE	**0**	**No Limit**	

	Number	Cause	Comments
HCAI-Related Deaths	**0**		
Incidents/ Outbreaks of Infection	**10**	MRSA PII on NNU	3 Patients UHS MRSA acquired cases identified on NNU. Sample typing unrelated with any other previous isolates. Umbilicus site missed swab on admission. Currently having spot checks from IPC because of a 4x positive MRSA cases admitted from Maternity with positive umbilical result.
		Bacterial colony counts of breast milk on NNU	IPC Review found items stored in splash zone of sink. Bottles, wrappers etc evident under sink unit - indicating not cleaned regularly. Air con unit used when pasteurisation machine is on - unsure if serviced/cleaned regularly.

			Leak occurred in November 1 tile replaced, the other remains in situ due to sensor being in place - ? if completely dried. This ceiling tile is not flush at one end. One of the vents is not set into the ceiling as much as the other. The tap on the hand washing sink in the pasteurisation room is stiff to push and creates a very strong flow which is directly into the plug hole.
		Salmonella on G3	7-month-old child acquired healthcare associated salmonella – baby having FMA milk, pre-packed pureed food and fromage frais. Therefore, further investigated - parents/nursing staff washing NIV mask in hand washing sink. Ongoing actions regarding how best to clean these within the ward environment.
		Stenotrophomonas on PICU	IPC reviewed 3 cases of hospital acquired Stenotrophomonas on PICU. All of these had positive ET secretions /aspirates. IPC meeting held to explore practise, use of equipment related to respiratory care and any environmental concerns. Actions to include environmental sampling and additional cleaning of McGrath laryngoscope handle. Also identified, 1 incubator trolley had a reminder sign stuck on with micropore tape on to the top of the trolley, advised for this to be removed to aid cleaning. Observed no other sinks being cleaned on the unit between 10.30- 14.00. SLA states sinks should be cleaned 3 times a day on PICU with second clean taking place between 12.00-13.00 McGrath MAC Video Laryngoscope are being reportedly cleaned using the Tristel Trio wipe system however no record of cleaning is being kept. Purified water being used for chest drains due to sterile water shortage, memo from pharmacy advises that sterile water should be used for chest drains rather than the purified water. Double gloving practices for NP, OP suctioning. 4 patients on PICU all with Pseudomonas, isolates were all unrelated.
		SCH	2x pseudomonas PB isolates unrelated. 1x pseudomonas E1. 1 x Klebsiella E1 C diff infection identifies on patient in PICU previously on PHDU and G1 – practise review undertaken. 1 x C diff infection G3 G3 patient was culture positive to salmonella.

			E1 several patients symptomatic with D&V. one patient and parent identify with Norovirus isolated.

Key Learning from Investigation of Infections and Deaths:

SCH

PICU
McGrath laryngoscope handle (although unlikely cause Stenotrophomonas infections) is currently cleaned using 3 step Tristel wipes. Improvements to be made to record keeping identifying which handle was used for the patient and who it was decontaminated by. Risk assessment currently being reviewed by IPT as out of date and potential change of practice to follow. Plan to move to using Clinell wipes which is the current cleaning practice for these handles on GICU.
Practice review follow C diff case, actions:
Reminder to staff that long sleeve gowns are for single use only.
Linen bins to be ordered for cubicles to ensure prompt disposable of soiled linen.
Yellow cloths not to be stored by handwashing sinks due to risk of contamination from splash back.
Serco concerns raised following IP observation of cleaning standards:
Cleaning solution poured down handwashing sink, bottom of the sink then wiped with yellow cloth, same cloth used to wipe the bins.
Sinks not cleaned during 3 separate occasions throughout the day.
Domestic not adhering to BBE

G3
Patients CPAP masked cleaned in handwashing sink risk of contamination from splash back. Shared reminder to staff and parent's handwashing sinks are to be used for handwashing only.

E1
Patients promptly isolated following D & V symptoms. One patient and one parent confirmed with norovirus. Parent remained on the unit in isolation as breast feeding. Symptomatic patients in high care risk assessed with adherence to IP measures, no patients in high care positive to norovirus.

All wards
Long sleeve gowns and gloves to be worn for any patient with Multidrug Resistant Organisms (MDRO). Gowns are for single use only

Neonates:
Swabbing for admissions from maternity will need to be re-visited as we have had 4 positive cases for MRSA all of which were admissions from UHS Maternity Services.

Maternity:
Maternity continues to promote and ensure compliance with recommended Trust Infection Control processes.

Jan 2023 Hand Hygiene Audit
Labour ward – 100% compliance
G level wards – 85%-90% compliance. Feedback to individual clinicians and planned re audit in April 2023.

Progress and Success:

SCH
Renovation of the sluices on PMU and G4 to ensure they meet with IP standards are very near to completion. Other ward sluices within the Children's hospital to follow.
Reduction in winter viruses.

Low incidence of covid within the Children's hospital has led to surgical masks no longer being worn in clinical areas. Exceptions to include E1, PICU, when carrying out AGP's or when caring for severely immunocompromised children. Adherence to current PPE guidance for Covid positive Children or contacts continues.

Neonates

- Incubator cleaning SOP final draft currently going through governance.
- Expressing room- Leaking taps causing cupboard to become unserviceable with possible Pseudomonas in this room. Leak resolved and all cupboards in room replaced to make room safe. Room now back in use.
- NICU had 100% compliance in the last trust hand hygiene audit in January 2023.
- NICU had 100% compliance in the last preventing surgical site infections audit in February 2023

W&N

PAH Outpatients:

- Outpatient Saving Lives Audits: All audits submitted; no major concerns identified. Formal results for Hand Hygiene 100% overall compliance. Formal results not yet published for March audits, Use of PPE, and Cleaning & Decontamination.
- Staff maintain effective infection prevention standards and compliant with practice

In-Patient Services:

- Environmental Cleaning Monitoring: Bramshaw and Gynae Day Unit and Recovery have maintained their high audit scores, Theatres have failed on 2 occasions but have already passed their last audit. No significant issue to escalate.

Maternity:

Good compliance with COVID and Infection Prevention management in Maternity.
Consistently Good Environmental and Cleaning Audit scores.
0 Clinical Cleaning Audit failures
0 Serco Cleaning Audit failures

Ongoing Challenges:

SCH

Lack of isolation facilities across the children's hospital. Not all cubicles used for infection prevention due to high level of CAMHS patients that require isolation for safety reasons.

PHDU lack of isolation facilities highlighted again in recent CAS review, this remains on the risk register.

Fluctuations in staffing level across the Children's Hospital continues to make caring for isolated patients more challenging.

Neonates

- Sluice- sluice has had an update since a case of Klebsiella on the unit. A new extended work surface for the housekeepers to use has been fitted so they have more surface space when cleaning. NNU fluid waste disposal point is currently out of action in the sluice, we have therefore isolated a toilet at the far end of the unit to dispose of contaminated water/ liquid waste on the unit. There is ongoing work to re-locate incubator de-contamination to re-commission the fluid disposal unit in the Sluice.
- Insufficient space on NNU has been highlighted as an ongoing issue on the register since July 2015. This is compromising patient safety due to inadequate spacing between patient bedspaces

in the clinical areas. The recommendation is 2 meters between incubators. NNU expansion plan to commence in the summer of 2023 which will address this issue.

- Water safety is a concern, especially as the coffee room tap is growing pseudomonas. We are looking at refurbishment for the staffroom but have currently put 'not drinking water' signs up in coffee room, milk kitchen and expressing room.

Summary of Action since Last Report, Current Focus and Action Plan:

SCH

Patients in the cubicles are now regularly reviewed to ensure patients are de-flagged from isolation as soon as appropriate.
Post infection review documentation being revisited. More support for ward staff to complete this with IPN's.

Neonates

Several estate projects have been completed to improve infection prevention and further estate work as part of the expansion will continue to improve the situation.
Key actions to take forward

- Re-location of incubator de-contamination
- Staff room estate to be improved
- Swabbing for patients admitted from post-natal wards.

Maternity:

No longer COVID screening any maternity admissions or partners unless symptomatic of viral infection with respiratory symptoms.

Maternity appendix on MRSA guideline updated in Jan 2023.
Theme of the Week reminder to staff of updated guideline highlighting MRSA risk reduction measures, management, and treatment.
Antenatal screening for MRSA more robust with specific question around MRSA and other multi drug resistant organisms included at booking and added to badgernet booking document.

Estates work and decoration completed on Labour Ward with white rock protection applied.
Estate maintenance and repairs ongoing.

Hand wash only sink signage in place.

Any Other Issues to Bring to the Attention of TEC and Trust Board:

Nothing further to add.

Date this report will be an agenda item at Care Group Governance Meeting	Date this report will be an agenda item at Divisional Governance Meeting
April 2023	April 2023

Appendix 5

Division D Q4 Matron and CGCL Report

Care Groups: Cardiovascular and Thoracic, Neurosciences, Trauma and Orthopaedics and Radiology

Matrons: Jenny Dove, Sonia Webb, Jean-Paul Evangelista, Sarah Halcrow, Beverley Harris, Rebecca Tagg, Claire Liddell, Tracy Mahon, and Rebecca Tagg.

Clinical Lead: Edwin Woo, Boyd Ghosh, Jonathan Hempenstall, Nick Hancock, and Charles Peebles

Date of Report: April 2023

Author: Natasha Watts

Performance Quarter 4 – 1st January to 31st April 2023

Key Indicator	Number	Limit	Status
MRSA Bacteraemia	**0**	**0**	**Green**
***Clostridium difficile* diarrhoea**	**6**	**3**	**Red**
E. coli (HOHA)	**5**	**Trust Limit of 33**	**Trust Total 43** (HOHA + COHA)
Pseudomonas (HOHA)	**0**	**Trust Limit of 9**	**Trust Total 10** (HOHA + COHA)
Klebsiella (HOHA)	**2**	**Trust Limit of 19**	**Trust Total 10** (HOHA + COHA)
MSSA Bacteraemia	**4**	**No Limit**	
GRE	**0**	**No Limit**	

	No	Cause	Comments
HCAI-Related Deaths	**1**	Covid 19	Patient 1 Covid 19 positive day 21 of admission HO.dHA and died 2 days post positive result. Clinical review underway by Infection Prevention Control Doctor
Incidents/ Outbreaks of Infection	**6**	Candida auris on D4	6 patients identified with Candida Auris on D4 Query environmental transmission. Concerns on ward re Hand Hygiene. Review of antibiotic data - Abx use on diabetic and vascular patients on broad spectrums for long periods of time which exerts a high selection pressure on the local eco system.

	12 patients 7 staff	Covid - 19	The outbreak occurred on Ward F2; a ward that has had recurrent Covid-19 outbreaks due to lack of ventilation across the ward. Air purifiers have been put in all the bays and windows are kept open to improve ventilation. There was onward transmission with 12 positive patients and 7 positive patients. The positive staff had looked after the positive patients. The ward was closed and one of the patients was started on Dexamethasone. Ventilation issues that should have been addressed by Estates by mid-March had not yet been actioned by the time of the outbreak. An action was made for the Head of Infection Prevention to escalate the issue to the Director of Estates, the Associate Director of Estates, and the Senior Project Manager. At the time of the outbreak the signage at the front entrance stated that masks were no longer required which caused confusion when visitors arrived at the wards where they had to wear masks. This was a possible cause of visitor non-compliance to the wearing of masks in the bays. An action was made to raise the issue with Comms and make masks more visible.
	3	*Clostridium difficile*	2 patients who were nursed in the same bay and 1 patient who was nursed in the next bay, and all were nursed by the same team on the night before the acquisition, had C. diff on Ward F1 - MTU. Ribotyping confirmed that all the 3 patients had Ribotype CE 014. The Infection Control Team found dirty commodes on their visits. Though commodes were found to be dirty, none of the patients were using commodes prior to having C. diff infection. There were no issues with environmental cleaning identified. In January the IPN hand hygiene audit score was 50% which was lower than the 2022 score which was 60%

Performance Year to Date

Key Indicator	Number	Limit	Status
MRSA Bacteraemia	**0**	**0**	**Green**
***Clostridium difficile* diarrhoea**	**22**	**12**	**Red**
E. coli (HOHA)	**18**	**Trust Limit of 94**	**Trust Total 154** (HOHA + COHA)
Pseudomonas (HOHA)	**3**	**Trust Limit of 27**	**Trust Total 35** (HOHA + COHA)
Klebsiella (HOHA)	**7**	**Trust Limit of 73**	**Trust Total 51** (HOHA + COHA)
MSSA Bacteraemia	**9**	**No Limit**	

GRE	**0**	**No Limit**	

Key Learning from Investigation of Infections and Deaths:

T&O:
A root cause analysis was carried for a patient who developed E. coli bacteraemia on Ward F2. The patient was discharged to RSH for rehabilitation with a catheter in situ. A plan was made with the ward and the discharge officer that the catheter should be taken out in RSH whilst on rehab. The nurse discharging the patient documented that the catheter should be taken out in RSH. However the medical team did not document this in the discharge summary, which is a learning for the team. The patient was re-admitted with E. coli bacteraemia 11 days after discharge.

CVT:
Swabbing patients was not timely, there was no surveillance swabbing after first positive candida then 11 positives. This was mainly due to Candida Auris being a new infection and needed to be assessed and plans put in place by the Trust. Quick identification that the infection is a MDRO infection is essential for planning and screening.
Hand hygiene audit score for D4 was below trust requirement but has now vastly improved during the outbreak with extra spot checks and education

Progress and Success:

T&O:
Continued vigilance for Noro virus protection and actions.
Ventilation to support air flow in T&O is planned for May 2023 for F1 and F2 bays. It is hoped this reduces the frequency of covid outbreaks.

Neuro:
There was a decline in the pass mark of hand hygiene audits done by the IPC team. This has been discussed regularly with ward teams. Focus on ward areas have been reiterated. Spot checks, refresher teaching, re-education and regular meetings have been set up to ensure that the MDT (Medical, Nursing, AHP and other clinical staff) have been reminded of good hand hygiene and resolve the poor standards.

Amidst with all these challenges, Hyper Acute Stroke unit have been commended with their good practice in tackling a mini outbreak of C. Difficile. The review highlights some excellent practice regarding documentation, hand hygiene and PPE use. The IPC team thanked the staff in working hard to adhere to all best practice standards relating to prevention and management of C.difficile which makes a huge impact on the safety of our patients.

CVT:
There was an increased number of Covid-19 positive cases in patients across a number of cardiac wards particularly CHDU and E3. All CHDU staff was required to wear FFP3 masks while outbreak is ongoing and visiting hours reduced.

Ongoing Challenges:

T&O:
Surgical site infection (SSI) surveillance reports by Public Health and Safety Agency for the ongoing mandatory SSI surveillance in T & O, intended to benchmark with other Trusts and root cause analysis of infected cases shows that generally patient risk factors contribute to SSIs.

Neuro:
Whilst the majority of staff are good at wearing PPE. Hand hygiene audit showed a significant reduction of good standards.

Continuous staff engagement for education, training and refreshing of Hand Hygiene.
Spot checks are being made.
Glowbox is used to further refresh Good hand hygiene technique.
Posters, social media interactive apps have been set up for Neuro staff as part of the re-education and refresher.

CVT:
Issues with promptness of estates requests, the replacement of room tiles on D4 requested delayed due to availability of resources.

Summary of Action since Last Report, Current Focus and Action Plan:

Current Focus on hand hygiene in all clinical area and audits have been reiterated.
Spot checks, refresher education and posters have been set up.

Any Other Issues to Bring to the Attention of TEC and Trust Board:

Poor ventilation in east wing. Temperatures starting to rise on wards, still awaiting confirmation from estates that ward areas can order air con units .

Date this report will be an agenda item at Care Group Governance Meeting	**Date this report will be an agenda item at Divisional Governance Meeting**
April 2023	April 2023

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Learning from Deaths 2022-23 Quarter 4 Report**			
Agenda item:	**5.8**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Authors:	**Ellis Banfield, Associate Director of Patient Experience; Alex Woodhead, Mortality data and insight coordinator**			
Date:	**25 May 2023**			
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** Q4 deaths falling under medical examiner review have increased slightly from previous year. 97% of deaths reviewed found no evidence of avoidability 1 death was reviewed and found to be possibly avoidable. 98% of cases were deemed good care or better by the medical examiner review.			
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.			

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. Currently the service is moving towards physical notes being available for UHS deaths, in these cases a Medical Examiner will review the patient's notes prior to discussion with a doctor (of any grade) from the clinical team caring for the patient during their admission. The case is discussed, and a cause of death offered by the doctor; this is either agreed upon or discussed further, with the medical examiner suggesting an appropriate cause of death where necessary or referring to the coroner. 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 an Urgent Case Review with the Patient Safety Team.

2. Analysis and Discussion

2.1 Total Deaths

Quarter	2022-23	2021-2022	2020-2021	2019-2020
Q1	578	504	564	606
Q2	653	429	511	541
Q3	651	639	529	589
Q4	699	531	634	620
Total	2581	2103	2238	2356

Q4 deaths have increased from the previous year, this is in large part due to the steadily increasing number of community deaths being reviewed by the medical examiners service. 493 of Q4 deaths reviewed occurred at a UHS site, 206 occurred in the community inc. 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) and serious adverse event case review (Scoping) 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	Scoping	Paediatric	Neonates	LeDeR
Q1	15	2	17	3	1
Q2	19	7	-	-	2
Q3	13	8	-	-	4
Q4	10	6	-	-	3
Total	57	23	17	3	10

As the table illustrates, in addition to Medical Examiner scrutiny, Q4 saw:

- 10 deaths sent to sub-speciality Morbidity and Mortality groups (M&M) for further clarification / questions
- 6 cases were sent for an 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 may have been avoidable with different or better care
- 3 LeDeR referrals were also made
- Information on paediatric and neonate reviews not available at time of writing

Most cases get assigned an initial avoidability and quality rating which then gets adjusted accordingly if they are sent for further review. 11 cases had no avoidability score at the time of this report, 10 had no quality-of-care score.

The table below outlines outcomes from Medical Examiner Service:

Avoidability	Q1	Q2	Q3	Q4
1. Definitely Avoidable				
2. Strong Evidence of Avoidability				
3. Probably Avoidable (>50:50)		2	1	
4. Possibly Avoidable (<50:50)	2	2	2	1
5. Slight Evidence of Avoidability	3	6	6	6
6. Definitely not avoidable	573	638	633	681
Quality of care				
1. Very Poor				
2. Poor care		2	1	
3. Adequate Care	1	7	7	1
4. Good Care	575	617	589	674
5. Excellent Care	2	18	43	14

Avoidable deaths

Above, 1 death was reviewed and categorised as 'possibly' avoidable. In this case anticoagulation was ceased due to intracerebral bleed concerns, pending a head CT. Following the CT report showing no bleed anticoagulation was not restarted for 2 weeks. The case was referred to the appropriate M&M for discussion.

HSMR

2.2.1 Our contract with Dr Foster recently finished and the BI are in the process of swapping over to HED (run by UH Birmingham), who have HSMR, albeit ever so slightly different.

2.2.2 The HSMR in the most recent 12 months of data (Dec21-Nov22) from Dr Foster has reduced compared to the previous update and was 88.1.

3. Medical Examiner Service Update

3.1 The statutory status of Medical Examiner has been postponed until April 2024

3.2 The wider roll out to community GP practices is progressing steadily (although they can now of course push back as expected statutory requirement has slipped)

3.3 Trust trial of health records tracking patient to mortuary has commenced to ensure information for proportionate scrutiny of last illness

4. Conclusion

4.1 UHS continues to demonstrate low levels of avoidable mortality and overall good quality of care for most patients who die during their admission.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Freedom to Speak Up Report**			
Agenda item:	**5.9**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Christine Mbabazi, Freedom to Speak Up Guardian**			
Date:	**25 May 2023**			
Purpose	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** ✓
Issue to be addressed:	To provide an update on the Freedom to Speak Up (FTSU) agenda, cases, and report on the reflection and planning tool advised by the National Guardian Office. This will also show comparative information from previous reports to identify trends as well available cases to the Guardian.			
Response to the issue:	Trust Board is asked to: • Note the outcome of the National Guardian Office's self-reflection and planning assessment tool. • Note the comparative information of cases in the past 5 years.			
Implications: (Clinical, Organisational, Governance, Legal?)	1. Mechanism to support a culture where staff feel safe and can speak up about concerns. 2. Compliance with the raising concerns policy for the NHS following the recommendations made by Sir Robert Francis after the enquiry into Mid Staffordshire NHS Foundation Trust. 3. Compliance with the Public Interest Disclosure Act 1998.			
Risks: (Top 3) of carrying out the change / or not:	1. Failure to keep improving services for patients and the working environment for staff. 2. Failure to support a culture based on safety, openness, honesty and learning. 3. Failure to comply with NHS requirements and best practice and commissioning contracts.			
Summary: Conclusion and/or recommendation	Trust Board is asked to note this report.			

1. Executive Summary

To provide an update following the last report written in November 2022. The Trust received 35 cases from 15th November 2022 to 12th May 2023.

The key themes remain bullying and harassment, discrimination as well as team dynamics. The solutions/interventions required to manage these cases remain unchanged and continue to be implemented as described in the previous Trust board report.

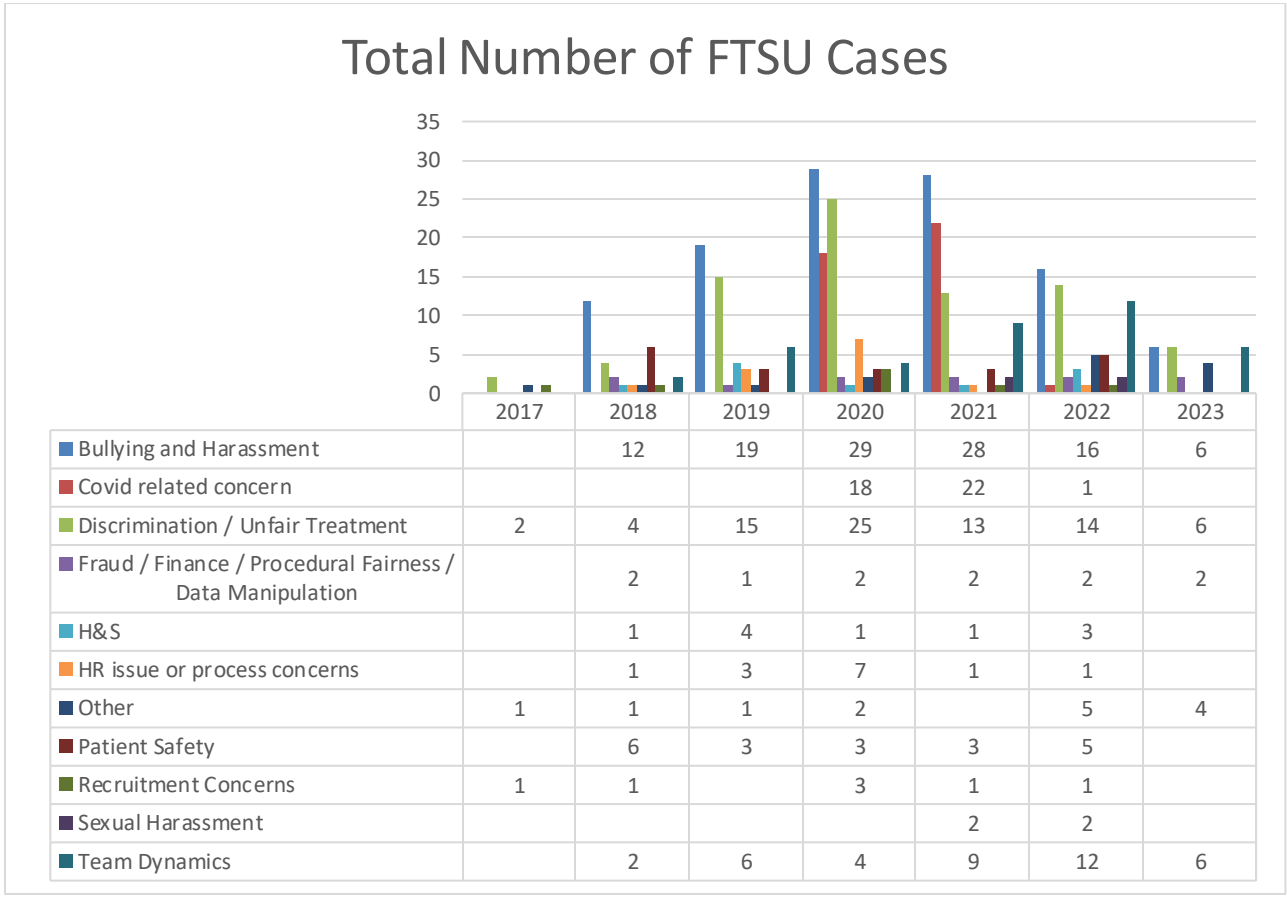
The report also summarises the outcome from the National Guardian's Office self-reflection tool to highlight how UHS benchmarks against the reflection and planning tool published by the National Guardian office.

2. Purpose/Context/Introduction

To provide an update on the Freedom to Speak Up (FTSU) agenda, cases, and report on the reflection and planning tool advised by the National Guardian Office. This will also show comparative information from previous reports to identify trends as well available cases to the Guardian.

3. Case Update

The Trust has received 35 FTSU cases from 15th November 2022 – 12th May 2023. Below is a total summary of the cases and themes received from 2017 – April 2023.



	2017	2018	2019	2020	2021	2022	2023
Bullying and Harassment		12	19	29	28	16	6
Covid related concern				18	22	1	
Discrimination / Unfair Treatment	2	4	15	25	13	14	6
Fraud / Finance / Procedural Fairness / Data Manipulation		2	1	2	2	2	2
H&S		1	4	1	1	3	
HR issue or process concerns		1	3	7	1	1	
Other	1	1	1	2		5	4
Patient Safety		6	3	3	3	5	
Recruitment Concerns	1	1		3	1	1	
Sexual Harassment					2	2	
Team Dynamics		2	6	4	9	12	6

The key themes remain bullying and harassment, discrimination as well as team dynamics as previously reported in the past trust board reports. These themes are the same across all divisions with some divisions being higher than others.

This information is regularly fedback to the different divisions by the FTSU guardian and champions and work with them and HR on different strategies as well as learning. Future plans include working with the OD team to work together on using themes and feedback to work with them in supporting the work culture of the organisation.

Freedom to speak up is one way we get to know the culture of the organisation and is one way we are working with the Patient safety team and the Organisation Development team to continue to review and develop the work within the organisational culture

Current Open Cases

The Trust has received 346 cases since 2017 with 14 currently open and 332 currently closed. The highest number of cases raised was in 2020 and 2021, with a slight decrease in numbers since.

One reason for the peak in cases during 2020 & 2021 appears to be covid related, with a significant number of concerns related covid like lack of PPE, redeployment to other areas and the right to refuse to be vaccinated being raised.

4. The Freedom to Speak Up self – reflection and planning tool.

The improvement tool is designed to help organisations evaluate their FTSU service, reviewing the role of the FTSU Guardian, the Trust's leadership team and the organisation in relation to FTSU, enabling organisations to identify areas of strengths and challenges and where improvement work needs to be undertaken. Completing the improvement tool will demonstrate to senior leadership, the board, and staff the progress that has been made developing the Freedom to Speak Up arrangements.

The tool guides on building a culture and behaviours that are responsive to feedback from workers. It also ensures that the organisation focuses on learning, to continuously improve quality of care and the experience of staff, patients, and service users alike.

Using this tool enables the Trust to demonstrate to regulators or inspectors the work that is being done to develop speaking up arrangements.

Using the scoring below one is to mark the statements to indicate the current situation

- Score 1 = significant concern or risk which requires addressing within weeks
- Score 2 = concern or risk which warrants discussion to evaluate and consider options
- Score 3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach
- Score 4 = an evidenced strength (e.g., through data, feedback) and a strength to build on
- Score 5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

The reflection tool sets out statements for reflection under eight principles. The following are the principles:

The full NGO Reflection and planning tool is attached in Appendix A.

In summary the reflective tool shows that as an organisation we are performing well as a Trust against the metrics identified in the tool. Across all the principles we were able to demonstrate high compliance particularly in the domains around senior support in valuing speaking up, role modelling this, the support available to the FTSU guardian and continually improving our speaking up culture. Details on how we have achieved this are evidenced in appendix A attached.

Areas identified that we need to continue to focus on are set out below.

SUMMARY OF HIGH-LEVEL DEVELOPMENT ACTIONS (6-24 MONTHS)

Action	Target Date	Action Owner
1. Look at ringfencing sometime to support champions	Dec 2023	CM
2. Promote FTSU to our staff and what we do in addressing concerns	Ongoing	CM
3. We need to tell positive stories about speaking up and the positives it can bring.	Ongoing	CM
4. We measure the effectiveness of our communications strategy for FTSU	Jan 2024	CM & Communications team
5. Our HR and OD teams measure the impact of speaking up training	June 2024	OD Team
6. All managers and senior leaders have received training on FTSU	June 2024	OD Team

7. Next Steps / Way Forward / Implications / Impact

The FTSU Guardian and Champion network will work with different teams to achieve the high-level development actions, continue to encourage and support staff to speak up if they are concerned. The importance of doing this is to ensure that a culture were patient and staff safety are at the centre of what we do, as has been noted by the National Guardian Office and CQC.

8. Recommendation

Trust Board is asked to:

- Note the self-reflection and planning assessment tool.
- Note the comparative information of cases in the past 5 years.

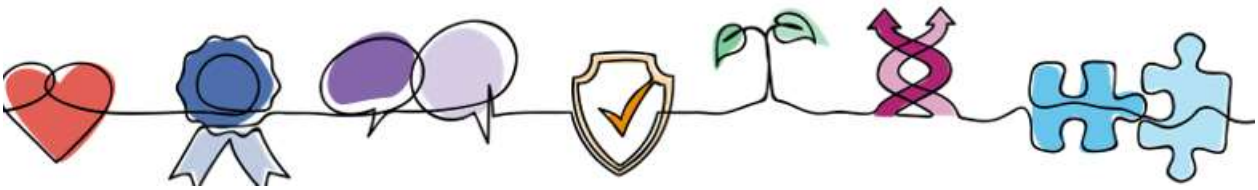
Appendix A – NGO Self-assessment tool

National Guardian
Freedom to Speak Up

NHS

Freedom to Speak up

A reflection and planning tool



Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5
I have led a review of our speaking-up arrangements at least every two years	5
I am assured that our guardian(s) was recruited through fair and open competition	5
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	5
I am regularly briefed by our guardian(s)	5
I provide effective support to our guardian(s)	5
Enter summarised commentary to support your score. **The executive lead is knowledgeable and works with the FTSU guardian on issues raised. She sponsors the FTSU agenda in Trust board meetings and leads the Raising concerns steering group, that reviews cases, lessons learnt and involves different representatives in the organisation.** **I have meetings with my executive lead every 8 weeks and access to her diary when need arises for support.**	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Look at ring fencing sometime to support FTSU champions	
2 Promote FTSU to our staff and wat we do in addressing concerns	

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5
I am confident that the board displays behaviours that help, rather than hinder, speaking up	5
I effectively monitor progress in board-level engagement with the speaking-up agenda	5
I challenge the board to develop and improve its speaking-up arrangements	5
I am confident that our guardian(s) is recruited through an open selection process	5
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	5
I am involved in overseeing investigations that relate to the board	5
I provide effective support to our guardian(s)	5

Enter summarised evidence to support your score.
The non- executive has always provided FTSU with support overseeing investigations that needed his expertise and objectivity.
I am confident that the board is engaged with the speaking up agenda based on challenges and input when I present to the board bi-annually.
The new non-executive director is knowledgeable and is involved in overseeing investigations.
As a guardian this role is currently a fulltime role giving me sufficient ringfenced time to fulfil all aspects of the guardian job description

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	
We regularly and clearly articulate our vision for speaking up –	5
We can evidence how we demonstrate that we welcome speaking up	5
We can evidence how we have communicated that we will not accept detriment-	5
We are confident that we have clear processes for identifying and addressing detriment	5
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up – Feedback form, number of volunteering champions, FTSU cases	4
We regular discuss speaking-up matters in detail – Through the raising concerns steering group	

Enter summarised evidence to support your score.
We have clearly articulated our vision for speaking up and communicated this in the Trust board report of February 2019
We have evidenced how we demonstrate that we welcome speaking up through FTSU policy, through our champions who are willing to inform and signpost staff to the right teams regarding their concerns and well through the FTSU cases and lessons learnt.
Using the Trust board paper of May 2021, I was able to demonstrate the issues regarding detriment and received some challenge from the Trust board about the number of people who had received detriment. Not knowing who it was led to changing of the feedback form to being able to identify divisions or areas where persons are receiving detriment. It is also important to keep the anonymity of the feedback form for persons to be able to say freely what their experiences are hence identification by division and not individuals.

A feedback form has been used as a clear process for identifying and addressing detriment. Knowing that it is anonymous yet able identify people who are able to speak up freely about their experiences and if not, we are still able to identify which divisions they those that are affected by detriment come from.

High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)
1
2

Statements for the person responsible for organisational development	**Score 1–5 or yes/no**
I am knowledgeable about Freedom to Speak Up	5
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	4
We support our guardian(s) to make effective links with our staff networks	5
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	5
Enter summarised evidence to support your score. Work with the Patient safety specialist and PSIRF Implementation lead.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about how much time the guardian(s) has to carry out their role	**Score 1–5 or yes/no**
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	5
We have reviewed the ringfenced time our Guardian has in light of any significant events	5
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	
Enter summarised evidence to support your score. Currently the guardian's job is a fulltime job.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	4
We can evidence that our staff know how to find the speaking-up policy	5

Enter summarised evidence to support your score.

Details of the policy are on staff net and the FTSU staff pages. All staff are advised by our increased number of champions on where to find the policy and sometimes advised on what it all means.

The policy has been updated, consulted on with the raising concerns steering group and changes have been made. The policy is now with the HR Policy Team, and we expect it will be published around June 2023. In the meantime, the current policy is available on staff net and not very different from the changed version.

The policy is well publicised on staff net and easily accessible to everyone and the information it contains is accurate. It has clear information about how to speak up – with clear explanations of procedures of different approaches, emphasising that people can speak up informally through day-to-day conversations. It includes options for workers to speak up internally but also externally if they feel this is preferable.

The leadership take seriously any instances of staff being bullied, discriminate against, harassed or victimised for speaking up.
The best way to reach someone will depend on a range of factors including their role, their hours, whether they are desk based and individual access issues such as language, literacy, disability or health needs and ethnicity. By having FTSU champions from different diverse backgrounds and representing different characteristics helps different groups to communicate and raise concerns or matters regarding speaking up.

FTSU champions are also used as channels to raise awareness regarding speaking up and can be conduits to speaking up.

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	5
We have an annual plan to raise the profile of Freedom to Speak Up	5
We tell positive stories about speaking up and the changes it can bring	4
We measure the effectiveness of our communications strategy for Freedom to Speak Up	4

Enter summarised evidence to support your score.

Posters, leaflets, and screensavers are used effectively to communicate about the guardian and champions as well. October is the annual place to raise the profile of Freedom to Speak up. We need to tell more positive stories about speaking up and the changes it does, we do not do that enough or widely. We have had a positive story told to the board in May 2021, we do need to do more

We do measure effectiveness based on a number of cases received or number of champions recruited or even the posters and leaflets distributed. Usually there is a high number of cases or high number of volunteers – we could this better and smarter

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 To tell positive stories about speaking up and the changes it can bring
2 To measure the effectiveness of our communication strategy for Freedom to Speak Up

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	5
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	5
Our HR and OD teams measure the impact of speaking-up training	2
Enter summarised evidence to support your score. The National Guardian Office training has been incorporated into our Trust induction training – This has been effective from November 2022 so we have not yet measured the impact of the speaking up training hence the score of 2	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Our HR and OD teams to measure the impact of speaking up training.	
2	

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	5
All managers and senior leaders have received training on Freedom to Speak Up	4
We have enabled managers to respond to speaking-up matters in a timely way	5
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	5
Enter summarised evidence to support your score. Board training on Freedom to Speak Up was in 2018. As I guardian I visit many departments and divisions 's team briefs, training to educate managers on adapting their environments to ensure a safe speaking up culture.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Not all managers and senior leaders have received training on Freedom to Speak Up	
2	

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	5
We use triangulated data to inform our overall cultural and safety improvement programmes	5

Enter summarised evidence to support your score.

Triangulating data to identify wider issues

The information gleaned through speaking up is a precious resource that can help boost understanding of our culture. This information helps the board or leadership to identify trends, patterns and potential areas of concern. We have compared the themes in speaking up cases with other data and information. We have used this intelligence to identify "hotspots" where speaking up may be happening more or less often than expected and to identify what aspects of patient safety and quality, worker well-being and culture need attention.

This data is compared to our HR employee relations data which involves grievance numbers and themes, employment tribunal numbers and claims, exit interview themes, sickness rates, retention figures, National staff survey results, National quarterly pulse survey, levels of suspension, Workforce Race Equality Standard and Workforce Disability Equality standards.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	5
We use this information to add to our Freedom to Speak Up improvement plan	5
We share the good practice we have generated both internally and externally to enable others to learn	5

Enter summarised evidence to support your score.

The process of building a speaking up culture requires the organisation to learn over time. As well as putting training in place. It is helpful to learn from other organisations going through similar changes and facing similar issues and sharing good practice. The following are ways we have been applying learning in the Trust:

- Using the recommendations from the National Guardian office speaking up case reviews. We have used these recommendations to identify gaps in what we are doing and have benefited from them – by carrying out a gap analysis.
- National Guardian's office monthly newsletters, blogs and case studies published on its website
- NHS England bulletins
- FTSU guardian regional and national networks
- UHS Raising concerns Steering group

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	5
Our guardian(s) has been trained and registered with the National Guardian Office	5
Enter summarised evidence to support your score. The guardian has been trained and registered with the National Guardian office and is also a registered trainer of Guardians with the National Office	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	5
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	5
Our guardian(s) has access to a confidential source of emotional support or supervision	5
There is an effective plan in place to cover the guardian's absence	5
Our guardian(s) provides data quarterly to the National Guardian's Office	5
Enter summarised evidence to support your score. The guardian has a clinical psychologist and other resources for emotional support	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	5
We are assured that confidentiality is maintained effectively	5
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	4
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	4

Enter summarised evidence to support your score.
All cases are handled by HR or different managers, however avenues like the Employee relations performance board meeting, Raising concerns meetings are created to make sure that cases are treated fairly impartially and the guardian is a critical friend in some of these meetings in order to achieve a positive outcome that is fair and impartial

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	5
We know who isn't speaking up and why	4
We are confident that our Freedom to Speak Up champions are clear on their role	5
We have evaluated the impact of actions taken to reduce barriers?	5

Enter summarised evidence to support your score.

However strong the organisation's speaking up culture, there will always be some barriers to speaking up, whether across the entire organisation or in small pockets. Finding and addressing them is an ongoing process.
FTSU guardians and champions play an important role in identifying the groups of people facing barriers and in helping action to bring about change. Examples of barriers to speaking are; perceptions that nothing will happen as a result, fear of being viewed as a troublemaker and judgement about raising a matter, fear of reprisals from colleagues, peers, managers, fear of impact on career, fear of jeopardising employment or residency status(visa). Language and cultural barriers and lack of confidence in the process and FTSU guardian.

By increasing the number of champions – making sure that they are from diverse backgrounds, diverse protected characteristics goes a long way to create an environment that all person are able to speak up or have someone who can support them when it comes to speaking up – this is also another way

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	5
We monitor whether workers feel they have suffered detriment after they have spoken up	5
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	5
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	5

Enter summarised evidence to support your score.

The feedback form given to all persons who have spoken up is an opportunity to document and find out their experiences. Please see feedback form below – PLEASE DONOT SUBMIT THIS – IT IS A LIVE DOCUMENT

Freedom To Speak Up - Your Feedback Matters (office.com)

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	5
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	5
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	5
Our improvement plan is up to date and on track	5

Enter summarised evidence to support your score.
The strategy and vision is on our FTSU staff pages for all staff and these have been updated and reported to board in the different board papers of 2019 and 2021.

The Trust's progress in achieving the vision and strategy has been measured through:

- The annual Staff Survey and Friends and Family Test results.
- Feedback from those who have raised the concerns
- The Raising concerns steering group reviews lessons learnt from case reviews of past and current FTSU cases. It is used for consultation on FTSU matters, utilising research from NHS bodies on embedding a speaking up culture, ensuring learning is shared across all divisions in the Trust.

The group reports to the UHS People Board on a quarterly basis identifying the work that has been undertaken, cases, themes lessons learnt and National Guidance. (See attached Raising Concerns /Freedom to Speak Up Steering Group Terms o Reference- Appendix A).

- Investigations are carried out by different persons with expertise in the organisation depending on the case details.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	5
Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach	5
Our speaking-up arrangements have been evaluated within the last two years	5
Enter summarised evidence to support your score.	

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	5
We have we evaluated the content of our guardian report against the suggestions in the guide	5
Our guardian(s) provides us with a report in person at least twice a year	5
We receive a variety of assurance that relates to speaking up	5
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	5
Enter summarised evidence to support your score. The guardian has consistently reported to board twice a year in May and November	

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner
1 Look at ringfencing sometime to support champions	Dec 2023	CM
2 Promote FTSU to our staff and what we do in addressing concerns	Ongoing	CM
3 We need to tell positive stories about speaking up and the positives it can bring	Ongoing	CM
4 We measure the effectiveness of our communications strategy for FTSU	Jan 2024	CM & Communications team
5 Our HR and OD teams measure the impact of speaking up training	June 2024	OD Team
6 All managers and senior leaders have received training on FTSU	June 2024	OD Team
7		
8		

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Addressing Violence and Aggression against Staff Update**			
Agenda item:	**5.10**			
Sponsor:	**Steve Harris, Chief People Officer**			
Author:	**Sarah Herbert, Deputy Chief Nurse**			
Date:	**25 May 2023**			
Purpose	**Assurance or reassurance Y**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	Violence and aggression towards our people sadly remains a significant challenge at UHS. Whilst the Violence and Aggression steering group continue to work on addressing unacceptable behaviours within the organisation, whilst supporting staff, incidents of this nature across the organisation continue to increase.			
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 July and outlines the work currently being undertaken 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 results of the staff survey in this area in line with the national picture • Note that reported incidents of violence and aggression across the organisation are likely to increase as a result of raised awareness of the agenda and changes to improve the reporting mechanisms within the Trust • 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 July 2022 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 prior to this and the work that had been undertaken by the steering group across a number of areas had proven impactful with a marked improvement in the 2022 staff survey results in this area.

1.2. This paper outlines the continuing work that is being undertaken 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. Staff survey results

2.1. The staff survey result in the initial period following the relaunch of the violence and aggression group (2021) showed a significant improvement in staff experience in this area and as a Trust we moved from being a national outlier on violence and aggression to being in line with national averages. The 2022 staff survey result however show a mixed picture around staff experiences in this area; whilst 91% of responses report they had not experienced discrimination from patients/service users, their relatives or other members of the public, many of the questions asked around violence and aggression showed no further improvement and a picture largely reflective of that nationally (see appendix 1).The survey data continues to provide the group with valuable insight into specific areas where the group needs to direct its attention to improve the work experience of our staff.

3. Policies and procedures

3.1. The exclusion policy, supported by Trust Board was launched in 2021. It has been well received by staff across the organisation where staff have felt supported and empowered to take action in regard to patients and relatives being violent or aggressive

3.2. As a Trust despite having the process in place we are yet to formally exclude anyone from the Trust and have only issued a very limited number of yellow cards. Feedback suggests that issuing the formal warning is resulting in a change in the behaviour of the individuals involved.

3.3. Work to adopt the same process in our emergency department which was originally excluded from the policy due to area specific complexities, has been undertaken. An adapted version of the main policy has been written, ratified and will now be added as an appendix to the Trust wide policy. This has widely welcomed by the department who feel supported in managing patients who have exhibited repeated unacceptable behaviour.

3.4. It is important to note that not all patients will be eligible for exclusion. As a result, significant work has also been undertaken in some very complex cases across multiple departments when exclusion/transfer of care is not an option for specific patients. Teams have worked collaboratively to create behavioural contracts with the support of the violence and aggression leads with positive outcomes.

3.5. Since launching the exclusion policy at UHS other Trusts within the ICB have undertaken similar work and have moved to exclude patients from their organisations. This has highlighted the need for greater collaboration across the ICB to ensure robust communication and appropriate transfer of care is undertaken with this challenging group of patients.

4. External stakeholder Engagement: Operation Cavell

4.1. Following a regional review of Operation Cavell, Hampshire Police have updated the Service Level Agreement to address the challenges and shortfalls identified within the operational processes and the obligations within the agreement. The update aims to improve the collaborative working between the Police and NHS Trusts. This was briefed to NHS CEO's in February 2023. Following this briefing the Trust engaged with Assistant Chief Constable (Paul Bartholomew) who has strategic ownership for Op Cavell. This was to seek assurance that the Police remain committed to support our staff and get the best possible outcomes when they are victims of violence and aggression or hate crimes. Equally for the trust to assure the Police of our commitment to support and collaborate with them and the criminal justice system to ensure those who commit crimes against our staff are prosecuted for their actions.

4.2. The trust has now formally signed up to the new SLA and we are working towards improving some of our internal processes to align with the obligations under the Op Cavell arrangements.

4.3. One of the things that is now available to staff is a dedicated Op Cavell email address Opcavell@uhs.nhs.uk. we encourage staff to copy all reporting forms to this email when submissions are made. This allows the Trust to track these reports and work with the victims and witnesses of incidents to ensure they have the necessary support via TRiM or other services. It also allows our Security Manager as the Trust operational lead for Op Cavell to work with the Police to ensure the best possible evidence is put forward and that reports are followed up and progressed in a timely manner with the best possible outcomes for our staff. Staff can also use this email address to request advice and support on submitting a report or statement or ask for updates in relation to investigations.

4.4. Recently the Trust relaunch Op Cavell and violence and aggression campaign through communications on the staff briefing and updated staff-net pages. We are determined to publicise the messaging and drive awareness of the violence and aggression campaign and the support available to the wider staff groups, so as an organisation we can send the consistent message that V&A against our staff is not acceptable and we will support staff and take action to tackle this.

4.5. There is still work to do both internally and in building the collaborative relationship with partner agencies and organisations. The trust continues to learn and develop ways we support our staff and reduce V&A in the workplace. This work remains an organisational priority.

5. Reporting Process

5.1. As part of the ways to improve the Trust responses to V&A and relieve our staff of additional reporting burdens, a review of our reporting process has been undertaken. It was recognised that when reporting incidents, it was difficult to navigate through the categorisations of incidents on the reporting form. We have now streamlined and reduced the number of categories to simplify the process. This reduces the pressure on staff who have been victims and witnesses in potential traumatic and unpleasant instances and reduces the time it takes for staff to report an incident.

5.2. We found that due to the difficulties staff encounter navigating the reporting forms, that it was taking them significant amount of time to complete reports taking them away from their other duties. These difficulties also contribute to an under-reporting culture.

5.3. As well as reducing reporter burden, we hope this work will drive a more accurate and increased data set for use to monitoring incidents. This will enable us to manipulate and analyse the data far more effectively to identify trends in V&A across the organisation and allow us to focus effort and resources to reduce risk, incidents and better support staff.

5.4. These changes have been in place since the start of April 23. At present it is too early for us to assess the data for any meaningful output. We anticipate that by end of the quarter we will be able to draw the data to start understanding the impact of these changes and start to establish trends and priorities. It will also highlight if we need to make any further improvements or adjustments to the reporting processes.

6. Training and equipping staff

6.1. The importance of training and upskilling our staff in the management of violence and aggression has from the outset been a priority of the steering group. With the funding provided we now a pool of trainers across the Trust delivering tailored training. To date a total of 141 staff have completed the training across the Trust with a rolling programme of training dates for 2023/24. Feedback from the course has been incredibly successful with comments including 'I've learnt the right/ inappropriate way to de-escalate a patient reduce aggression and after this training I believe it has boosted my confidence,' 'I am very happy to see the shift from "let's restrain" to "let's think." I would like to more training like this, and I think it should be mandatory,' 'The training was excellent, the knowledge of the trainers made it for me as their own experience is a bonus' and 'training was very informative and helpful for my work as an ED nurse.'

6.2. In addition to the Trust wide programme additional funding was provided to train extra train the trainers in critical care, an area previously identified as an area of high incidence of violence and aggression. This has enabled them to run a bespoke version of the training across all units with a plan to have trained over 400 staff by December 2023. This has been incredibly well received across critical care with engagement across the MDT.

6.3. The hope for the whole organisation is that the techniques and tools learnt will become the culture for all in managing violence and aggression.

7. Body Worn Cameras

7.1. Since Feb 23 we have been carrying out a second trial of body worn cameras for clinical staff in our ED. Following the first trial the device we were using was deemed not to be suitable due to size and weight. Another device has been sourced and trialled for a 6-week period. The new device has some additional feature such as a front facing screen, which can disrupt and deter offenders as they can see themselves and their behaviour. This can be a very powerful de-escalation tool and often see people modify their behaviours. The new devices are also more user friendly for clinical staff and are easy to wear and operate with limited training being needed.

7.2. The pilot has been well received by ED staff and will be accompanied by additional media to highlight it use and success. Staff feedback has been overwhelmingly positive:

"I've personally noticed a reduction in the threat of physical violence and aggression just by wearing the camera."
"It makes staff feel safe. It is evidence of the event it is likely I will not have to go through court proceedings."
"As soon as I told the patient that I was recording the incident, they calmed down and were deescalated."

7.3. Several videos captured during incidents have been shared with Hampshire Police to support ongoing investigations into crimes committed against our staff. We hope to see an increase in successful prosecution and sanction of those who are violent and aggressive towards our teams.

7.4. Following the success of the pilot the decision has been made to invest in this capability permanently within ED and AMU for staff completing roles where there is increased potential for V&A. The equipment has now been procured and the aspiration is to be fully operational before the end of May 23. There is also possible opportunity to expand and increase the use of this capability across the organisation where the need is identified.

8. Perimeter Lockdown

8.1. Work is still ongoing for the design phase of the lockdown process for the main and PAH site. During the scoping exercises there were several physical and technical challenges identified, which are being worked through. We anticipate being able to start looking to go to market for the detailed design and mobilisation work by July 2023.

8.2. We are also expecting that the new "Protect Duty" legislation may impact on the lockdown processes and requirements. At present the Home Office have not published the Protect Duty physical or technical requirements that are going to be regulated under the new legislation. We are working to planning assumptions drawn from the physical security guides issued by the NPSA and security services in relation to lockdown. We are proactively trying to ensure the systems and processes we establish will meet the regulator requirements under the protect duty to avoid any future cost to the trust or retrospectively changes.

9. Security Support

9.1. The Trust board will be aware that a previous additional investment was made in security to provide extra cover to ED. As private sector pay inflation has continued during the cost of living crisis our security provider (MITIE) has struggled to offer competitive terms and conditions to its staff within the financial value of the contract. This has led to retention challenges, and difficulties in recruitment

9.2. UHS has made an additional investment in the value of the contract to increase the pay of security staff. This is starting to help improve retention and the attractiveness of the roles. The security contract ends in March 2024 and UHS will consider all options going forward, with a particular view to the vital work the team plays in addressing violence and aggression issues and supporting and protecting our staff.

9.3. The Security teams resource continue to be regularly stretch to its limits. Through the first 3 months of the year there has been a steady increase in the number of incidents security are called to across the organisation (Appendix 3), resulting in an associated increase in the number of incidents that have required the use of physical intervention by the security team (Appendix 4). These incidents are primally attributed to areas such as ED, AMU and Child Health wards. Reasons for this include a significant increase in patients presenting with mental health conditions or significant behavioural problems and being care for in the Acute environment for extend periods of time.

10. Our Inclusion and Belonging Strategy

10.1 In January 2023 the Trust Board signed off its Inclusion and Belonging strategy. This sets our blueprint for improving EDI across UHS. A specific pillar is focused on "*Safe and healthy working environments, free from all racism, aggression, hate and discrimination*." In addition to supporting the V&A committee through representation from the OD and Inclusion team, the Trust remains focused on delivering Allyship training to its people. So far around 20% of Staff have received the training which aims to provide tools to support staff in tackling 'in-the-moment' issues of aggression.

11. Staff Support

11.1 The UHS TRiM service supports all staff on site impacted by traumatising situations. It involves providing post-incident support briefings, where appropriate, and 1:1 risk assessment conversation with trained peer practitioners. The aim is to ensure early support of staff impacted. Incidents around violence and aggression of any kind may be traumatising for all those involved.

11.2 Since 2021, any AERs around violence and aggression were automatically sent to the TRiM service. This has involved substantial processing of a large volume of AERs by a small TRiM service, ensuring that any staff named on the AER were offered a TRiM 1:1 invitation and supplied with the No Excuse for Abuse support leaflet. Whilst this was helpful for those requiring this support, a huge number of emails was generated for very little uptake, in comparison with self-referrals. Many of these AERs were not appropriate for TRiM, e.g reporting colleague rudeness.

11.3 To address this, and at the same time ensure that all staff involved in V&A incidents are aware of TRiM support, a new system was established in Jan 2023. Anyone reporting violence & aggression incidents via AER will get TRiM information and be required to answer whether TRiM support is

required, before being allowed to proceed. At the same time, some promotional/educational TRiM awareness raising is being planned for managers/leaders. In this way, hours of administration time has been saved whilst staff are still supported to know when and how to self-refer to the TRiM service.

12. Communication

12.1 The focus of the communications plan for this last year has been largely internally focussed; building on the foundations set out by the violence and aggression steering group and further embed a culture that makes it clear - violence and aggression towards UHS staff will not be tolerated.

12.2 The thrust has been on raising awareness of the support available but also promoting the improved process for reporting incidents of violence and aggression and our closer working relationship with Hampshire police through Operation Cavell. This partnership is a commitment to report and support emergency and frontline key workers through the management and improved oversight of cases involving our staff where incidents happen. Our key themes have been underlining how staff will be supported in the reporting process, the importance of making sure incidents are reported in the first instance and for all staff to play an active role in creating a culture where violence and aggression is not tolerated. This has been communicated through a series of films, re-introducing the Operation Cavell partnership, pledging as an organisation to further a culture free of abuse, hearing from our partners at Hampshire police, and also encouraging staff to make their own pledges to support this agenda.

12.3 Externally we continue to work with local media to highlight the impact of incidents on our staff and where appropriate use case studies to illustrate the human stories behind the numbers of incidents that are sadly recorded at UHS. We have linked with Hampshire constabulary and plan to send out joint communication on this agenda to the local community to strengthen the message.

13. Next Steps

13.1 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.

13.2 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 violence to NHS workers increases, we need to look to find further measures to support our staff, whilst collaborating with external stakeholders to influence work within our local community.

13.3 Whilst we have put in robust processes within the Trust, we now need to work across the ICB on tackling the issue of violence and aggression. Communication, collaboration and consistency in approach across the system will be key to this.

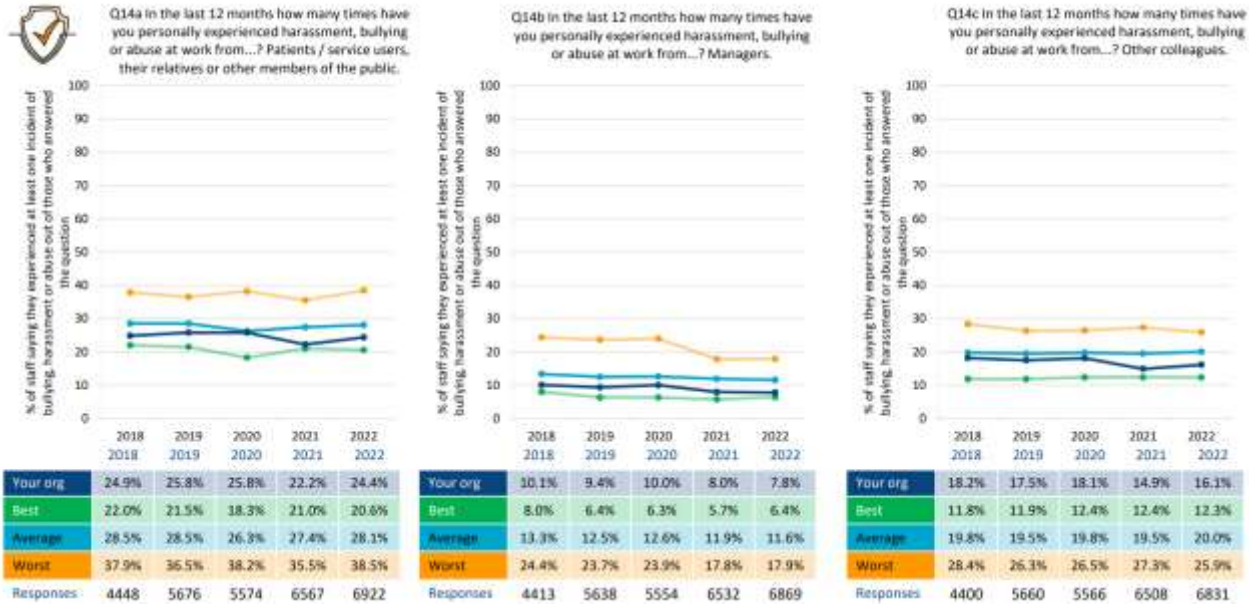
13.4 Increased complexity in patient groups continues to present new challenges in this area, particularly in relation to mental health and behavioural presentations both in adults and children. We need to find new methods to plan and support the safe and legal management of these patients. Working with and listening to these teams will be how this is achieved.

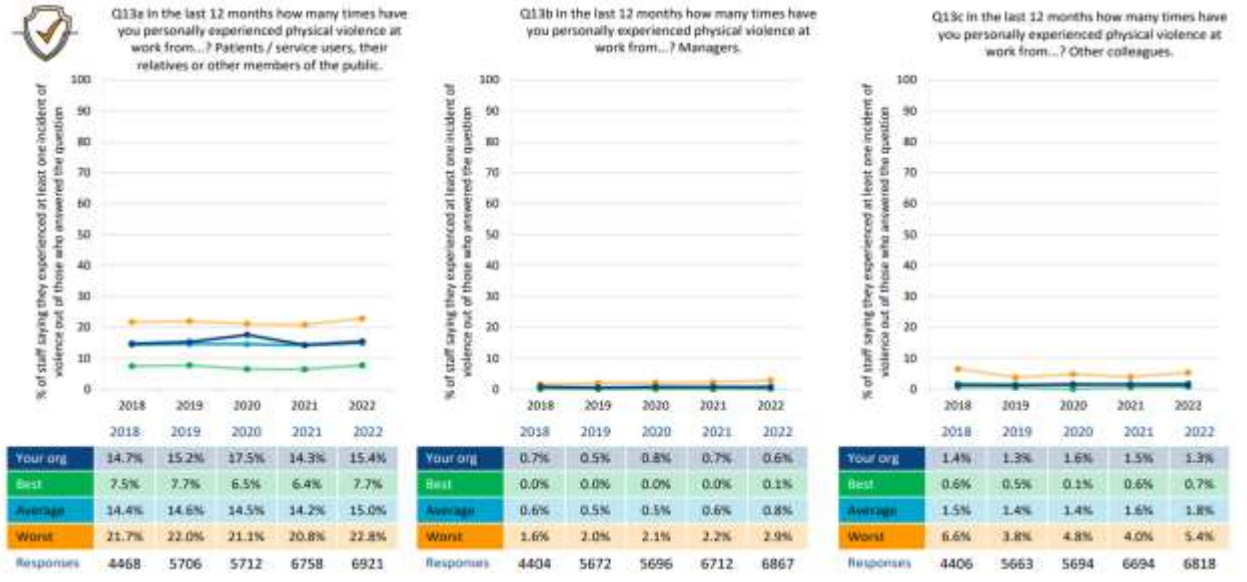
14. Recommendations

The Board is asked to:

- Note the report and progress made to date
- Note the staff survey results and the identified areas where there needs to be continued focus
- Note that as a Trust we need to ensure that we continue to communicate consistently on the issue both internally and with our local community
- 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

Appendix1

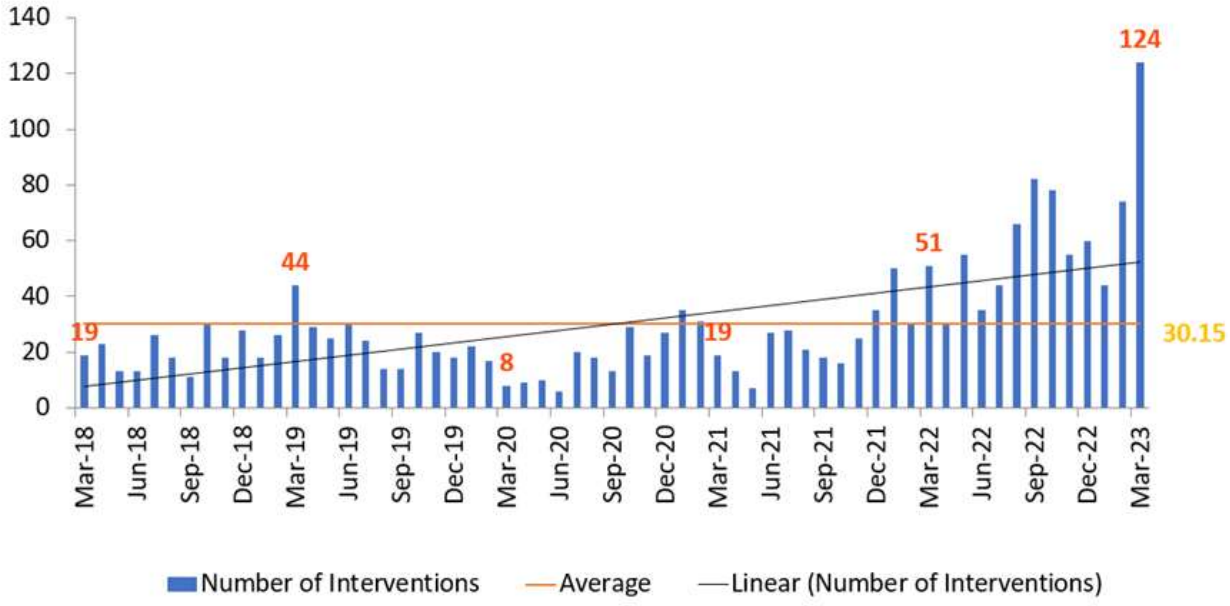




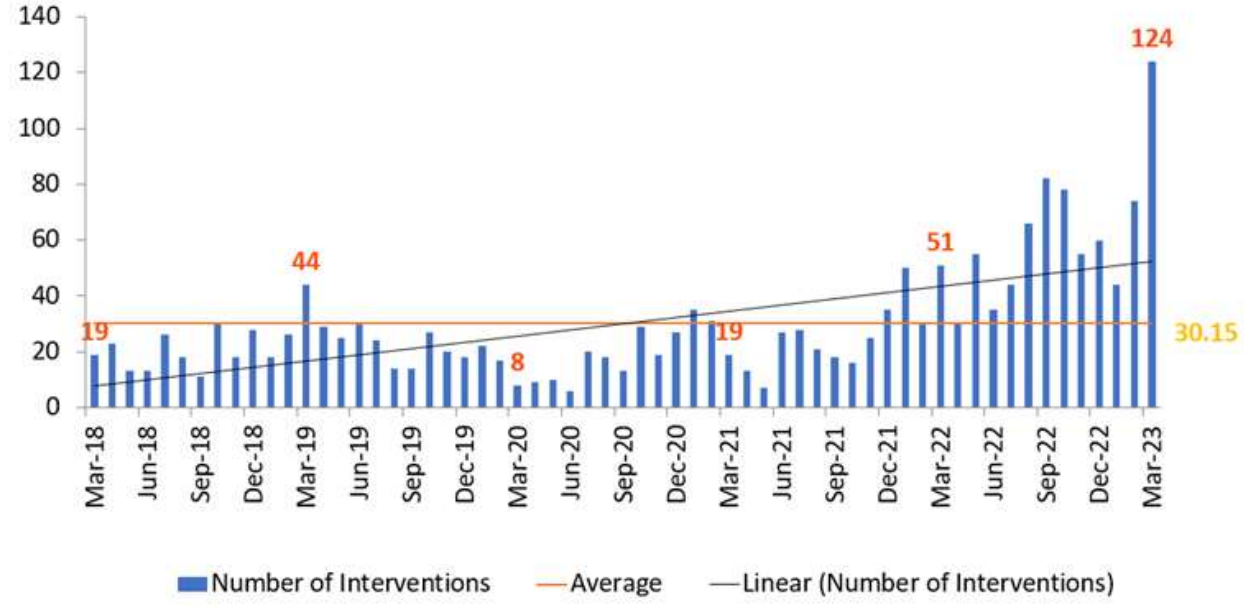
Appendix 2 TRiM V&A Report Jan-March 2023

Row Labels	Count of Incident Type / Theme	Sum of Number of staff sent/given support info	Count of Number of 1:1s
V&A Aggression Verbal	**14**	**23**	
(blank)	13	22	
Staff on Staff	1	1	
V&A Aggression Physical	**12**	**18**	**4**
(blank)	8	13	1
Sexual Behaviour	1	1	
Physical attack on staff	1	1	1
hit across the head with a large metal monopod	1	2	1
Sustained back injury	1	1	1
V&A Aggression Challenging	**2**	**4**	**1**
Sexual Behaviour	1	3	
Difficult patient	1	1	1
TOTALS – All V&A	**28**	**45**	**5**

Appendix 3– Security Incidents Attended



Appendix 4 - Security Physical Interventions



University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Performance KPI Report 2023-24 Month 1**			
Agenda item:	**5.12**			
Sponsor:	**David French, Chief Executive Officer**			
Author	**Jason Teoh, Director of Data and Analytics**			
Date:	**25 May 2023**			
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 Performance KPI 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 performance metrics. 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.			

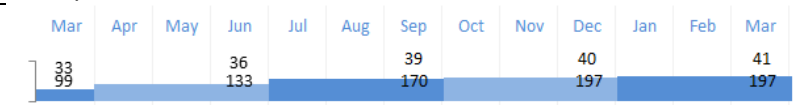
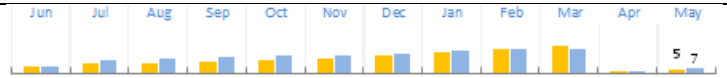
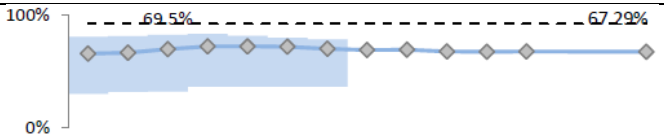
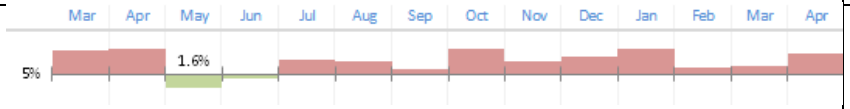
University Hospital Southampton NHS
NHS Foundation Trust

Performance KPI Board Report

Covering up to
April 2023

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 Performance KPI 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.

As part of the new 2023/24 financial year, the opportunity has been taken to refresh the report and the metrics within it. In particular:

- We removed the two COVID-19 metrics (Healthcare acquire COVID infection and Probable hospital associated COVID infection) as they no longer need to be reported nationally.
- We replaced these with MRSA (Methicillin-resistant Staphylococcus aureus) and Gram-negative bacteraemia metrics to align with the wider infection prevention metrics that are being reported nationally. This also reflects the importance of reducing all potential hospital acquired infections.
- Given the national focus on maternity services, we have added three new maternity metrics: birth rate, maternity Opel status, and delivery mode.
- We have removed the Patients waiting longer than 104+ weeks on an RTT pathway as we have delivered this metric. This is to be replaced with a metric measuring the Patients waiting longer than 65+ weeks, which is the current long waiter target.
- We are adding the 28 Day Faster Diagnosis cancer standard. This is line with wider NHS England ambition for patients to receive a cancer diagnosis (or confirmation of no cancer) in a timely manner.
- We are replacing the R&D metric covering comparative ranking of recruitment from a commercial perspective and replacing it with a measure highlighting study set up times. The commercial element is covered within the existing income measure, while study set up times are of greater importance to ensure that research is progressing in a timely manner.
- We have removed all the metrics within the World Class People section as they are already covered within the People report to board, and this is part of the goal of reducing duplication of reporting.
- We have removed the digital correspondence metric as this overlaps with the My Medical Record metrics, and have also removed the voice recognition metric as this programme has completed.

- There will be four additional Digital metrics added around age of the IT estate, system load times, cyber security, and inpatient noting progress. These highlight key areas of risk, or important delivery areas, for the Trust.
- As there have been several metric changes, the KPI numbering structure has been revised to just a numeric format.
- Finally, the report has been renamed the Performance KPI Report. This reflects that the report contains mostly Trust performance KPIs, and some of the other key measures are covered separately within the Finance and People reports presented to the Board, instead of "integrating" them into this single report.

This month, the following changes have been made to the report.

- Update to data source: Metrics 1 and 2: The data set for the Hospital Standardised Mortality Ratio (HSMR) metrics is now being sourced from the Healthcare Evaluation Data (HED) data set rather than from a data set provided by the Dr Foster organisation. Data up until January 2023 is Dr Foster data, with data from February 2023 onwards from HED.
- Data availability: Due to the Bank Holidays, there are several data sets which were not available for update at the time of writing for this report. Measures where this applies are:
    - 3: Percentage non-elective readmissions within 28 days of discharge from hospital
    - 23: Total UHS women booked onto a continuity of carer pathway
    - 24: Total BAME women booked onto a continuity of carer pathway
    - 31: % Patients on an open 18 week pathway (within 18 weeks)
    - 32: Total number of patients on a waiting list
    - 33: Patients on an open 18 week pathway (waiting 52 weeks+)
    - 34: Patients on an open 18 week pathway (waiting 65 weeks+)
    - 35: Patients on an open 18 week pathway (waiting 78 weeks+)
    - 36: Patients waiting for diagnostics
    - 37: % of Patients waiting over 6 weeks for diagnostics

Summary

This month the 'Spotlight' section contains an extended update on Cancer performance.

The Cancer spotlight highlights that:

- In recent months UHS has seen a deterioration in cancer performance. There are a higher volume of referrals which is impacting the Two Week Wait (2WW) "front end" of the pathway, and a number of patients within a "backlog" (patients who have been on the cancer path way more than 62 days) at the "back end" of the process that we are focussing on treating.
- As we clear through the backlog of patients, this is adversely impacting our performance on both the 31D and 62D metrics, as well as our benchmarked performance against other peer hospitals.
- Tumour sites that have had particularly impacted performance have outlined in more detail the underlying challenges, and the action plans that are in place to address performance.
- The diagnostic services of radiology and pathology, which are a key part of the cancer pathway, have also provided updates on performance within their areas, and how they are also experiencing a growth in demand for their services.

Areas of note in the appendix of performance metrics include:

1. A challenging month for Cancer performance which is covered in detail within the Spotlight report for this month.
2. Emergency Department (ED) four hour performance was maintained at 64.0% in April 2023, with improvements seen in the time spent in department. However, our performance relative to teaching hospitals dropped to second quartile.
    a. The average daily ED attendances were lower than the previous year (346 in 2023 vs 360 in 2022) but 44 higher than April 2019. It is likely that lower attendances were partly due to the GP streaming trial which was in place for the first two weeks of April 2023.
    b. Staffing challenges within the department continue with four consultants down, and junior grade rotas running at a circa 50% vacancy. This impacts the speed of decision making within the department.
3. Good reduction in red flag staffing incidents, with only 13 reported in the Aril 2023.
4. The highest proportion of women giving birth via caesarean section (40.6%) within the last 14 months.
5. The percentage of patients with a disability or needs reporting that their needs were met in the patient experience survey has increased to the highest value (93%) within the last 14 months.

6. The number of patients waiting over 78+ weeks reported at the end of March 2023 was 14 – this put us in the top four best teaching hospitals, and is a reflection of the efforts put in by our teams to focus on our longest waiters through the last financial year. However, please note the following paragraph on long waiting patients.

Long waiting patients

As previously reported to the Board, we have been focussing on ensuring that we treat the longest waiting patients. We have been successful in treating any patients waiting over two years and have significantly reduced the number of patients waiting over 78 weeks to a handful of patients. However, we have recently been instructed by NHS England to start counting Corneal transplants on the RTT waiting list. This will add approximately 120 patients onto the waiting list, of which (at the time of writing) 18 have waited over 78 weeks. Historically, we have not counted transplants as part of the RTT waiting list as transplant material is assigned by NHS Blood & Transplant, and is not within the Trust's control. In addition, at present, tissue is only being issued to patients who have waited over two years, and therefore we are going to see a spike in long waiting patients. We have suggested to the ICB and Region that the policy for transplants to be counted as reportable appears to be illogical and in contrast to the way other transplants are counted, but have not had a response.

Ambulance response time performance

The latest unvalidated weekly data provided by the South Coast Ambulance Service (SCAS) shows that UHS does not significantly contribute to ambulance handover delays. In the week commencing 8 May 2023 our average handover time was 17 minutes 30 seconds across 700 emergency handovers, and 20 minutes 7 seconds across 44 urgent handovers. There were 48 handovers over 30 minutes, and 0 handovers taking over 60 minutes within the unvalidated data. Handover times are slightly longer than historic performance, but the team is confident there are no underlying issues with the handover process.

Spotlight: Cancer performance

Introduction

Cancer is a large basket of disparate diseases across every organ and tissue type of the body, unified by its biology in which abnormal cells divide without control and can invade nearby tissues. Cancer cells can also spread (metastasise) to other parts of the body. These cancerous diseases have very different treatments and prognoses. The other uniting factor underlying this name is that for many patients the word cancer generates significant anxiety and fear and recognising this, UHS works hard to provide the most streamlined service that we can offer to patients referred to our service.

There are nationally recommended best practice pathways for the most common tumour sites, and UHS has broadly adopted all of these, often at an early stage. As well as these pathways, UHS also attempts wherever possible to reduce the number of occasions that a patient has to visit the hospital in person, either by phoning them to triage and then sending them straight to test (e.g. colorectal) or by running a one-stop-clinic where they can see a specialist and have a diagnostic procedure at the same time (e.g. head and neck lump clinic). It may be possible to let the patient know on that visit that they don't have cancer and wherever we can, we do that.

The national recommendations to primary care, for referral into a 2WW service are intended to have a pickup rate for cancer of between 4-8% depending on the tumour site. The pathway is intended to have high volumes at the front end and ideally to rapidly reduce in volume as the weeks pass. Patients referred in with symptoms may have other non-cancer pathology and still require specialist diagnosis and treatment, and those patients are usually managed by transferring onto an elective (RTT) pathway and stopping the cancer pathway. The high volumes of cancer referrals therefore have a significant impact, even when there is no cancer present. Over the last decade in England referrals have increased hugely and the percentage of cancers diagnosed in this way has increased from 41% - 52%.

As patients whose cancer is diagnosed through a 2WW are more likely to have earlier stage disease, and therefore better outcomes, this has been estimated to have had a significant population survival effect. However, as the overall numbers have increased, the conversion rates (into a positive cancer diagnosis) have fallen making the system less efficient. This puts pressure on diagnostic services, and patients at risk of anxiety and overdiagnosis. This is a national situation, and UHS has been part of this picture locally. Whilst there have been a multitude of efficiency changes in how we manage referrals over the last decade, we are still seeing and treating more patients each year and the familiar picture of lack of staff, equipment and estates capacity is the underlying story.

UHS is one of 12 regional cancer centres in the UK offering treatment for rare and complex cancers as well as children's cancer and brain cancer. We offer a wide range of treatments including novel therapies. UHS has historically benchmarked in the upper quartile, relative to our teaching hospital peers. Our position slipped in the face of operational challenges in recent months. To help to correct this, we have been holding meetings with each service to understand the position, address any barriers to improved performance and agree clear action plans to support recovery. Whilst most action plans were

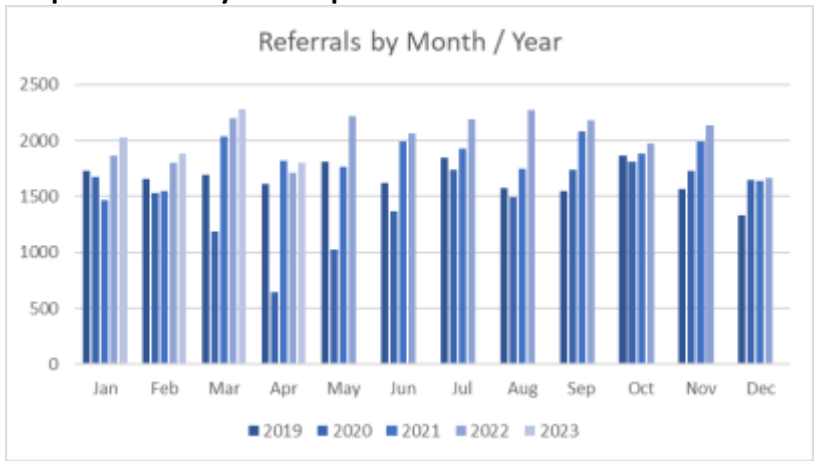
delivered on time, new, unforeseen problems over the following months, often related to loss of key members of staff, but also industrial action, have continued to delay performance recovery. Nevertheless the overall size of the patient waiting list for cancer has reduced since the autumn, and the backlog of patients on the cancer pathway for longer than 62 days has decreased by over 50% since the recovery programme started. This is faster than the recovery trajectory set by the Wessex Cancer Alliance and means that we are now third from top of Wessex on this measure, compared to our position as the lowest in percentage backlog terms in the autumn. The recovery of the backlog patients has had a negative effect on the 31 and 62 day performance figures for the first quarter as these longer waiting patients were treated. More detail is given in the sections underneath.

Cancer 2 week wait (2WW) referrals volumes

Cancer referrals volumes (graph 1) continue to see significant month on month volatility, but the referrals for January, February and March were all the highest for that month for the last five years (graph 2). This volatility in referral volumes does make it hard to deliver the right capacity week on week and operations managers work hard to deliver extra sessions usually with less than a week's notice, whenever they can, to keep pace. Overall, referral volumes in 2022/23 averaged 2,049 patients per month, which was 8% higher than 2021/2 (which was partly Covid impacted), and 28% higher when compared with 2019 volumes.

Graph 1: Monthly cancer referrals

Graph 2: Year on year comparison of cancer referrals



2 week wait (2WW) performance (seen by UHS within 14 days of referral – target 93%)**:**

The 2WW performance is closely related to the volume of referrals received as we are at maximum capacity for most tumour sites, and higher referrals reduce our 2WW performance. Usually this means that we are booking patients into the third week, at 16 – 18 days, but recently there has been a significant loss of staff in Head and Neck and the 2WW appointments have been booked 6-7 weeks ahead (see tumour site section below for more details

and recovery plan). Our validated reported performance for March 2023 was 72.5%. There is considerable variation across tumour sites and Skin, Upper GI and lung all passed the target for March and gynaecology which had poor 2WW performance during 2022 was within half a percentage point of passing at 92.5%. This was as a result of a new gynaecology triage pathway, and additional appointment capacity.

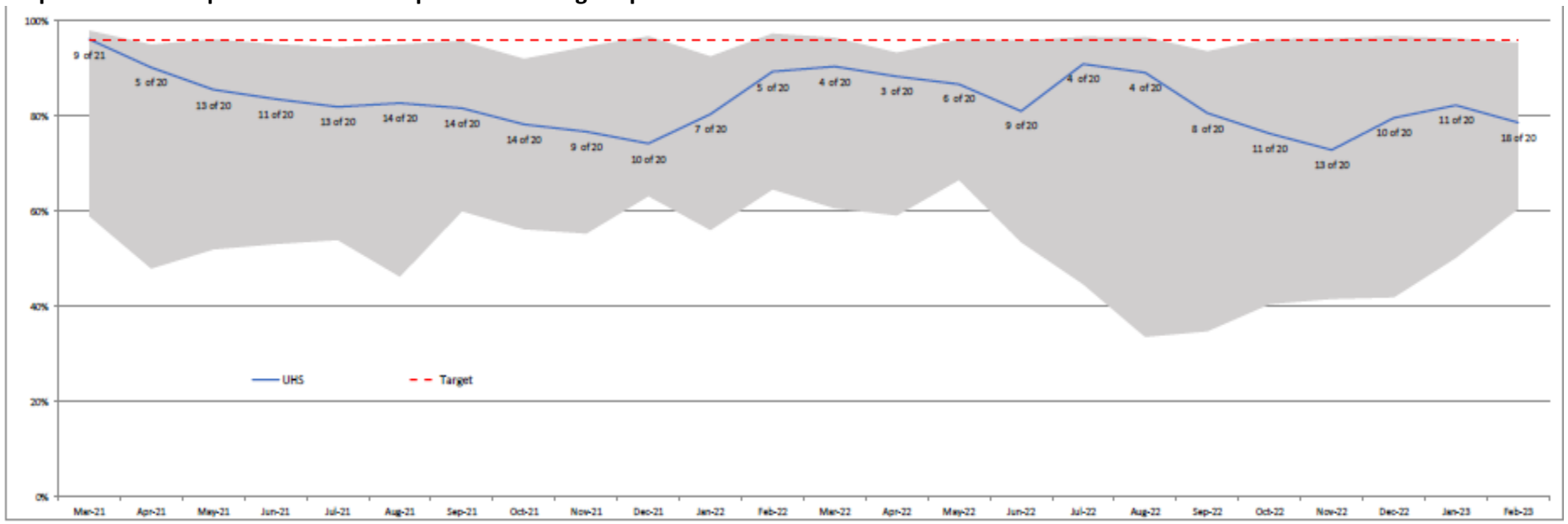
Tumour sites with current challenges include:

- Breast had recovered through Summer 2022 but has again been significantly challenged in recent months, with performance at 37.5% for March 2023, and a provisional performance of 43.3% in April 2023. This has been due in part to consultant sick leave which has reduced capacity in the face of higher demand. Higher referrals at the end of March led to an increased waiting time for diagnostics; the service is currently booking into day 15, with an expectation of booking within target by June 2023.
- Head and Neck referrals in 2022 have been approximately 44% higher than 2019 (249 versus 173 referrals per month), with March 2023 particularly high with 304 referrals. Performance initially demonstrated an improved position when the new associate specialist started (September to November) however this failed to keep pace with sustained increased in referrals, and the Associate Specialist has recently left UHS to add to the problems. This post is being recruited to in May 2023, but until the new post holder(s) start, the care group has drawn up detailed interim plans to reduce the 2WW backlog (already reduced by a third from its peak) and then manage within the 2WW threshold using insourcing capacity. However, there are a cohort of referrals whose late 2WW appointment is likely to spill into worsening 62 day performance as well. Measures are in place to manage the clinical risk.
- Skin has also seen as seen significantly higher demand in 2022 /3 compared to 2019 (462 versus 367 referrals per month). The revised Dermatology pathway which will help to divert referrals started in January 2023 with one Primary Care Network (PCN) and the Alliance are working with other PCNs to ensure process and equipment is available for expanded rollout. The aim for all PCNs to be following the new pathway this year. Skin is a high volume tumour site accounting for around 20% of the 2WW volume and issues with this tumour site always adversely affect the overall trust result. Recent staffing shortages have led to a deterioration in 2WW performance but more recently the tumour site has improved 2WW bookings to within 15-16 days, and will soon be within target.

Other factors which are impacting cancer performance include delays in diagnostic reporting capacity in both radiology and pathology. We have seen an increase in 2WW radiology requests alongside higher inpatient demand (particularly for CT and MRI scans), and this has led to some delays on our 2WW pathway. Within pathology, although the requests are broadly in line with historic trends, the complexity of the requests and the number of slides that need to be produced have significantly increased. Further detail is covered within the diagnostic services part of the paper.

When benchmarking against teaching hospital peers, we have historically been in the and around the second quartile (graph 3). However, in February 2023 our performance has dropped mainly due to the performance challenges in the Breast and Skin tumour sites which have our highest volume referrals.

Graph 3: UHS 2WW performance vs comparator teaching hospitals



28 Day Faster Diagnosis (diagnosed, or cancer ruled out, within 28 days of referral – target 75%):
UHS missed this target for the first time in January 2023 (69.9% against a target of 75% due to our 2WW performance and patients taking longer to be seen) but recovered performance in February 2023 (80.2%) and March 2023 (77.1%).

31 Day Performance (start treatment within 31 days of a diagnosis – target 96%)**:**
UHS is currently failing the target. Our validated performance in March 2023 was 88.9%. This average figure hides considerable variation; the range of performance for March was between 100% for Haematology and children's cancers, to 71% for Skin. There were four tumour sites in the 90s and five tumour sites (including urology) in the 80s, so the patient experience is variable depending on tumour site.

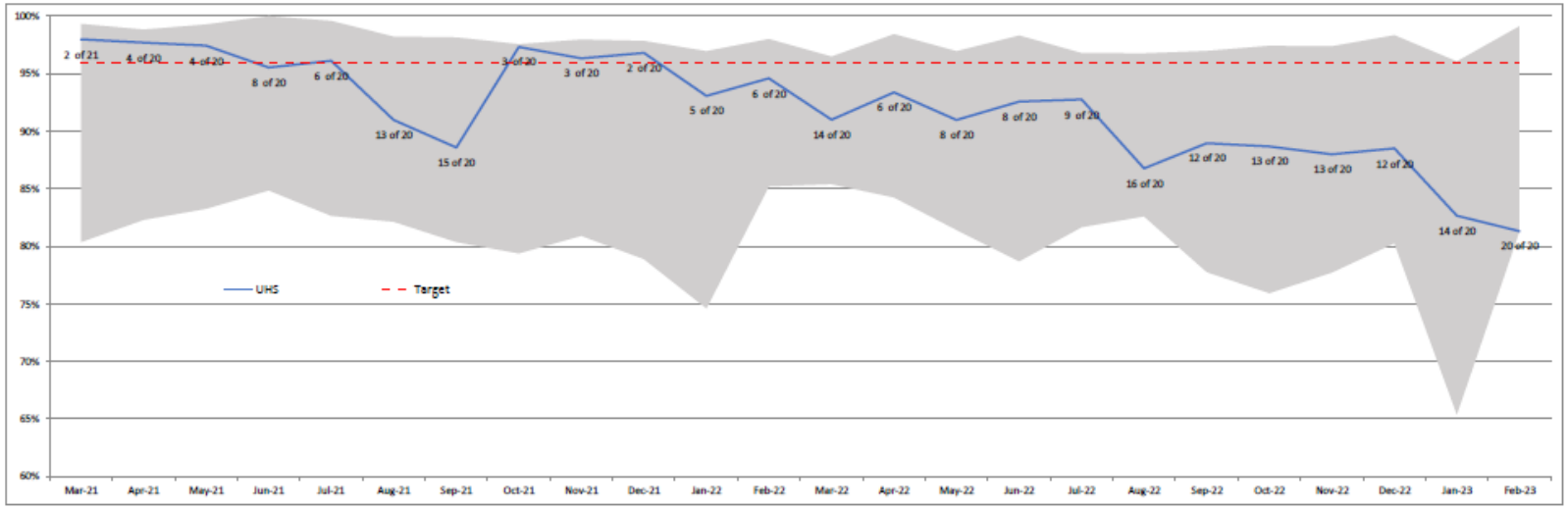
The numbers of patients treated by tumour site also varies with sarcoma being the smallest, and urology being the highest last month and comprising 21% of the total. Skin and Lung are always high volumes as well. This means that the overall trust 31D performance is heavily weighted to the performance of these tumour sites. Whilst Lung is performing well at 93%, Urology and Skin are both performing less well and bringing the overall percentage down.

Skin has been booking patients in for their surgery at between six to seven weeks in the spring due to staffing shortages; however, this wait is now decreasing. It is currently five weeks and should be at 31 days or less by the end of June 2023. The effect on the target is binary, but the patient experience underneath that is slowly improving. From the safety aspect, the dermatology clinical lead has confirmed that this increased wait from 31 days to around 50 days is likely to be immaterial in clinical and prognostic terms.

The shortage of surgical robot capacity for Urology is well rehearsed and this tumour site is likely to continue to fail to meet the target whilst the wait for prostatectomy is around six to seven weeks. The urologists list the patients firstly in clinical urgency order and then in order of waiting time, hence some patients are treated well below the 31 day target, and this helps to reduce the clinical risk, although not helping patient experience for the less clinically urgent patients. For patients with a low grade prostate cancer, the effect of this wait is unquantifiable but likely to be clinically insignificant. However, the team are working to get to a situation where patients can all be treated within the nationally mandated target timeframe.

Looking at our comparative performance (graph 4), UHS are the worst performing of all the comparator teaching hospitals in February 2023 (although this is predicted to return to third quartile when March 2023 data is released). This in line with our forecast previously reported to Board, as we have been working through the backlog of patients awaiting treatment (see Overall Cancer PTL section below). This means that as we treat the patients who have waited over 62 days on the cancer pathway, a significant proportion of them have already failed the 31D standard. This is reflected in our relative performance.

Graph 4: UHS 31D performance vs comparator teaching hospitals

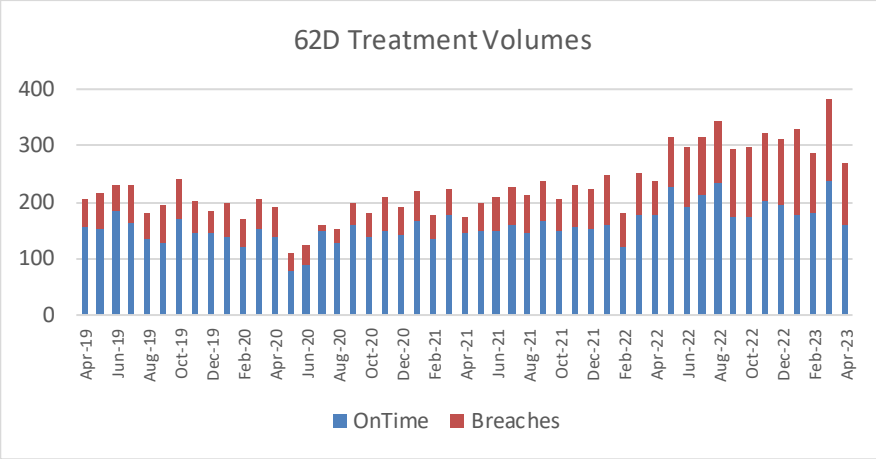


62 Day performance (treatment within 62 days of referral – target 85%):

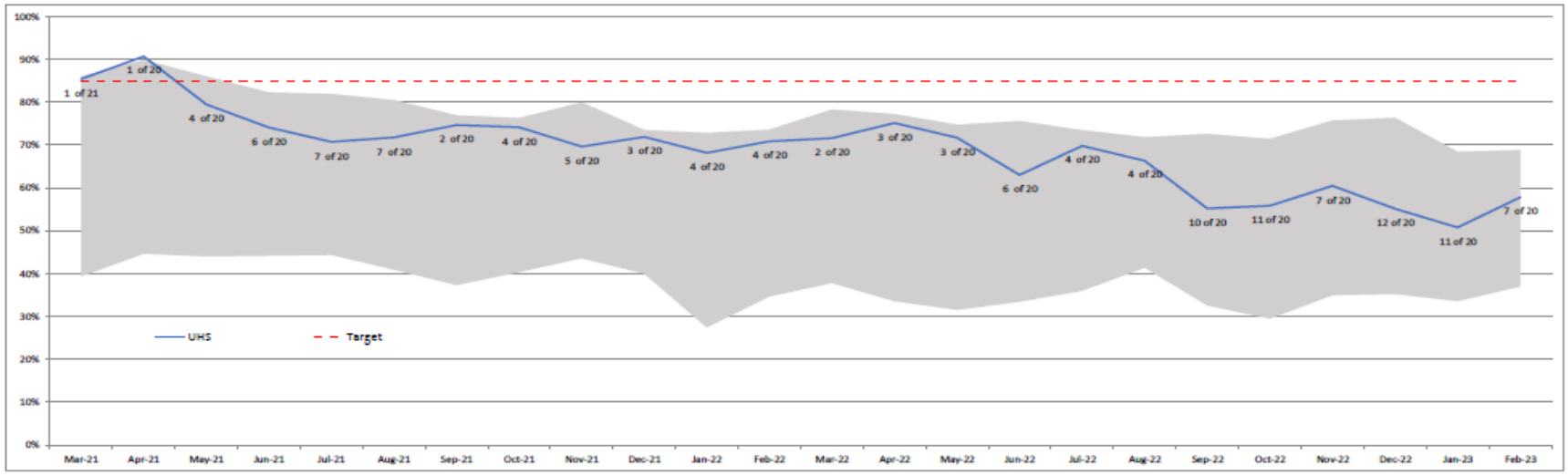
The 62D performance for March has worsened, standing at 51% in March 2023, compared to 57.8% in February 2023. This measure is directly linked to our performance against our 2WW and 31 Day performance, as well as our backlog position.

Although, we were second quartile on 62 day performance in February 2023 compared to other teaching hospitals (graph 6), as our action plans from January have started to clear the backlog of patients waiting for treatment, we are seeing the predicted deterioration in 62 day performance in the short term (expected to drop to third quartile when March 2023 data is released). The March volume of overall 62 day activity was the highest since at least April 2019 (graph 5).

Graph 5: Volume of 62D activity



Graph 6: UHS 62D performance vs comparator teaching hospitals



The number of patients making up the 62D measure is only about one third of the patients treated and included in the 31D measure for several reasons. Some tumour sites present clinically in ways which are not usually referred in through primary care: brain tumours and haematological malignancies are examples of these, and they are hardly present in the 62D dataset. Tumours which are identified through national screening programmes are also not (currently) reported through this dataset and so, whilst present in significant volumes in the 31D treated dataset, they are much smaller volumes in the 62D; this includes breast, gynaecology and colorectal tumours. Finally, lung tumours on the 62D dataset are also small numbers (7 in March 2023 versus 73 treated on the 31D pathway for the same month) as they are referred through a radiology route, not usually a 2ww request. Therefore there are different drivers for the performance of the two datasets.

The largest numerical contributor to the 62 day pathway is Urology at 60 out of the 191 patients. This was also the highest number of breaches (35 out of 87) and had the majority impact on the March 2023 performance. Urology have made good progress on their backlog, reducing it from 95 in January to 37 at the beginning of May 2023 (see pink line, graph 11 in Urology tumour site detail). As these patients had by definition breached 62 days at their time of treatment, treating them was always going to have a negative impact on the target. The care group has some additional plans to reduce the diagnostic time, which will be essential to make more headway on this pathway.

Whilst urology was numerically the largest contributor of breaches, all tumour sites were challenged in March. Treating the backlog, and shortage of surgical capacity were the most significant issues as well as the impact of the lengthening 2WW causing delays at the start of the pathways.

In addition, as a tertiary centre, our performance has been impacted by more complex cancer patients who are transferred from other hospitals. Patients who are transferred from other hospitals often create an additional pressure on our performance, and the gap between UHS and tertiary referrals has increased in recent months. In addition, we are seeing a higher number of late tertiary referrals: in 2022/23 we received 277 referrals which were transferred to UHS with patients having spent over 62 days on the pathway, this compares to 135 in 2019/20. When looking at 62 day performance, Q4 performance (January to March 2023) was 56.4% (85% target) for all UHS patients, compared to our performance on tertiary referrals alone which was at 29.3%.

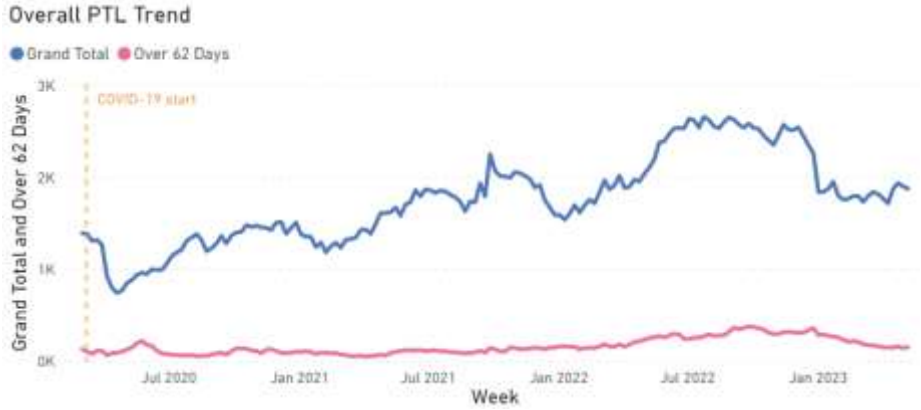
Overall cancer waiting list (PTL) and patients waiting over 62 days(backlog)

As the 31D and 62D metrics only measure performance for patients who have cancer and at the point of treatment, these two additional measures give some further idea of performance and patient experience. The overall waiting list is heavily related to the numbers of 2WW referrals and the speed of seeing these patients, as the large majority of patients will leave the cancer waiting list at the point of being told that they don't have cancer.

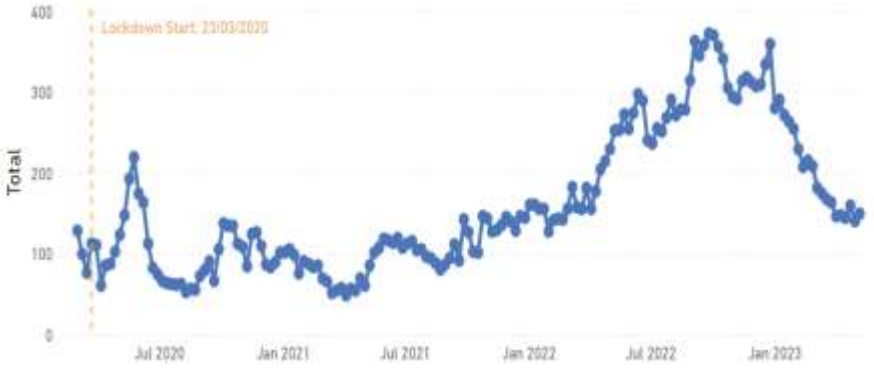
Since January 2023, as the improvement programme actions have come into play the Trust's overall cancer PTL has fallen significantly, even whilst referrals have stayed high. This is partly due to efficient management and navigation in some key pathways, and further improvements can be anticipated (for

example if teledermatology is more widely adopted in primary care). Even with these improvements in place, the PTL remains at levels that are significantly higher than pre-pandemic levels (graph 7).

Graph 7: UHS Cancer Waiting List and 62 day breaches



Graph 8: UHS Backlog



The number of patients waiting over 62D from the date of receipt of referral is the backlog (pink line in graph 7, shown expanded in graph 8). This has been as high as 350 but has come down significantly since January 2023 as we have focussed on addressing these patients. The composition of the back log is mixed as it includes not only patients with cancer who are awaiting their first definitive treatment but also patients whose diagnostic pathway is complex and who may not have cancer. It also includes patients who have had their first treatment already, but who are awaiting pathological confirmation that this is, or isn't cancer. Finally, it includes patients who have other comorbidities, and sometimes more than one primary cancer, where longer diagnostic pathways, and more inter-specialty discussion is essential as well as time for patients to understand and then contribute to decision making. These issues are why the 62 day performance target was set at 85% with a 15% tolerance for longer pathways. The Wessex cancer Alliance has set a target of 6.4% of the overall PTL as a backlog target, as zero is impossible and not clinically desirable.

In January 2023 our backlog was 15.8% and it would have required 172 patients to be removed to reach 6.4%. Whilst the reduction in our overall PTL has paradoxically made this target harder for us to achieve, our backlog reduction has meant that at the end of March 2023 we were only 24 patients away from achieving that target and our backlog has greatly improved to 7.7% of total PTL.

Patients on the backlog are reviewed on a weekly basis by the cancer centre and by the care groups. It is a dynamic list as between 50-70 patients are added on new to the backlog each week, with a slightly higher number removed, in each week that the backlog falls. April and May 2023 will be likely to

see all the performance measures worsen and the backlog increase due to the number of days lost to industrial action and bank holidays, but it is hoped that this will be a temporary effect.

Appendix 1: Tumour site detail

There are tumour sites that, in recent months, have had some deterioration in cancer performance. We have highlighted some of the underlying challenges within these tumour sites, and the actions which are underway to address performance.

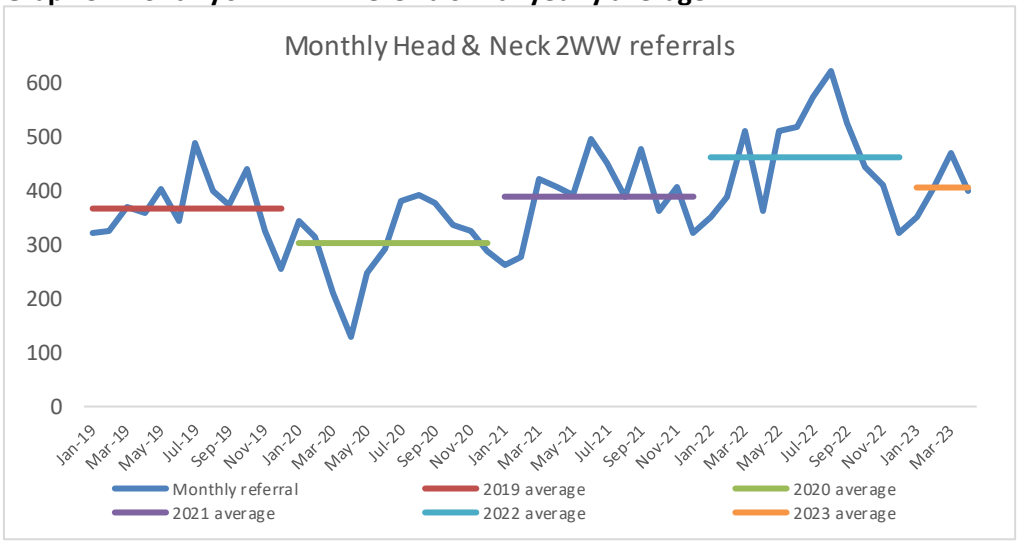
Skin

The skin tumour site has been challenged by a particularly high growth in referrals in referrals in 2022/23 of c25% for 2WW suspected skin cancer compared to the 2019 baseline (graph 9).

Simultaneously, there has been a reduction in workforce compared with 2019/20. There has been a one consultant gap since Mar 22 and further one consultant gap from May 23, and presently also a 0.6 WTE Associate Specialist vacancy and 2 clinical fellow vacancies. Recruitment has taken place with one consultant starting in Sept 23, one in Jan 24, and plans for new fellows to commence in August 23.

Surgical insourcing has been contracted until November 23 to support with long waiter surgery so that UHS surgical capacity can be used to support cancer work. However, despite this we currently do not have enough job planned capacity to meet the 2WW 14 day target based on expected referrals throughout the summer and are reliant on WLI sessions, with an average deficit of 35 slots per week.

Graph 9: Monthly skin 2WW referrals with yearly average



Action plans in Skin

- An agency consultant has been approved to start in May 23 to support a reduction in waiting times for surgery to below 31D from diagnosis. It is anticipated that by the end of June 23 we will have cleared the backlog and be able to offer patients a surgical date within 31D of diagnosis.
- Continued use of insourcing to support surgical capacity until November 23
- Surgical pathway change to increase throughput on day case lists by 15% - 25% commenced in May 23

- Two Wessex Cancer Alliance (WCA) funded pathway navigators who have supported with the oversight and validation of the pathways to minimise any delays and ensure the right escalations are in place
- 2WW teledermatology pathway set up with ICS and WCA support to allow GPs to refer suspected 2WW patients with a dermatascopic photo. We discharge 35% of patients at first appointment and its anticipated teledermatology will streamline the process using Advice & Guidance and direct to surgery pathways. Challenges around primary care roll out and willingness to use due to having to take an image, the rollout is being supported by WCA.
- Review of practice around biopsy vs excision – audit and guidelines being developed by skin cancer lead.
- Recruitment of skin cancer nurse specialist based at RSH hospital to provide a five day diagnosis service (currently only one day a week)

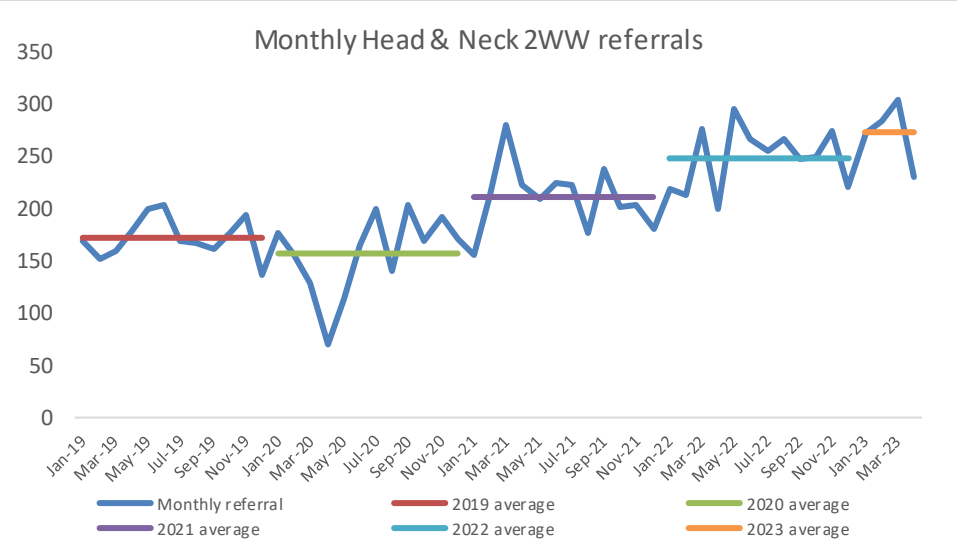
Forecast performance in skin: By the end of June 23 with the additional locum sessions the backlog of surgical cases should be cleared and waiting times for surgery will be less than 31D and waiting times for 2WW will be below 14 days.

Head & Neck

This tumour site has also seen a significant growth in referrals, with average 2023 monthly 2WW referral volumes of 273 patients, 59% higher than the 2019 baseline (graph 10). However, the service has also been impacted from a staffing perspective. We have recently had our Associate Specialist leave UHS (having started in October 2022) due to personal reasons. This role provides the vast majority of our 2WW capacity (28/42 new patient slots per week) and other colleagues are unable to provide sufficient capacity thereby driving a growth in the backlog we have seen in recent months.

The service has been reliant, in the short term, on waiting list initiatives from specialist registrars to address the backlog. However, we are due to appoint a replacement Associate Specialist in September, with funding available to appoint a second Associate Specialist should there be suitable applicants. This will provide a more resilient service rather than relying on one doctor. The service has also received funding (via the CDC) to appoint another consultant to support ENT nasendoscopy activity for Southern Health, with the job plan currently being finalised.

Graph 10: Monthly Head & Neck 2WW referrals with yearly average



In the meantime the division has agreed a three month contract with an insourcing company to clear and sustain 2WW activity (24 new patient slots per week) until the new staff are in post. We have recently completed three clinics with this organisation, and this has already supported a significant reduction in the patients awaiting a 2WW appointment with the expectation that we will be delivering on this standard by July. Weekly meetings with the insourcing company are held to ensure that the contractual arrangements are being met by both parties as 4% of all 2WW Head & Neck referrals result in a cancer diagnosis so each week we can track the patients who need further investigations without delay.

Urology

This service has multiple sub-specialty urological cancers: for example Bladder, Kidney, Prostate. The main focus is on the patients being referred in for prostate investigations to rule out/confirm cancer. There is a national Prostate Timed Pathway which aims to support hospitals in diagnosing prostate cancer within 28 days. To confirm a cancer diagnosis the patient requires an outpatient appointment followed by an MRI (ideally on the same day/following day) with a biopsy within seven days. Each of these steps require health care professionals to carefully manage this pathway.

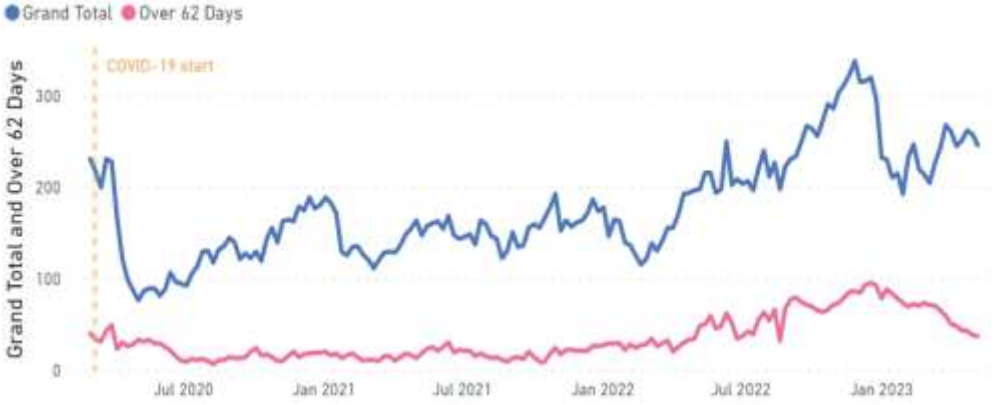
In the past 12 months the service has seen an increase in referrals/demands not only via the 2WW referral route but we have also seen a significant rise in patients who had previously been managed pre-COVID via Patient Initiated Follow UP (PIFU) with support from MyMR being diagnosed with prostate cancer as a result of the surveillance programme we have in place with support from GPs.

Therefore, to free up surgeons to operate on these patients, we have been training nurses to manage the initial 2WW appointment and undertake biopsies. We have recently recruited two new members of staff who are currently in training and will be able to independently see 2WW patients in late June and conduct biopsies by September. This creates additional capacity to enable the service to get back to delivering 93% by September 2023.

With a 20+% conversion rate from OPD referral to a diagnosis of prostate cancer, this has also led to a growth in waiting list for robotic prostatectomy. At present we add seven patients per week onto our waiting list and treat seven patients per week either at UHS or Spire. This has resulted in a frustrating position where our waiting list is balanced rather than reducing. Unfortunately at present local trusts have been unable to assist in providing additional capacity therefore it remains with UHS to resolve this problem.

We have requested an extension to the Spire robot contract until our new theatres open in Spring 2024. This will continue to provide capacity for up to four patients per week.

Graph 11: Urology PTL and Backlog



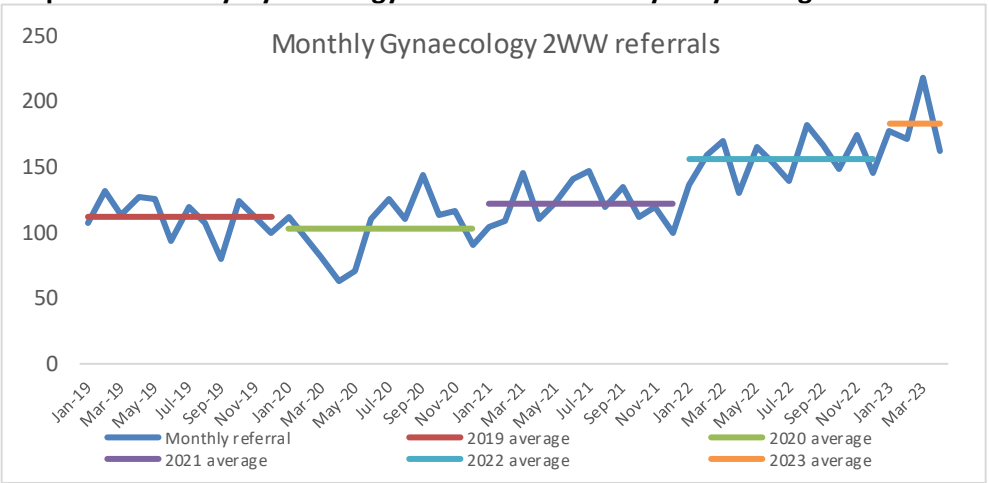
We have also been supported in additional onsite capacity from a Salisbury surgeon and a retired PHU surgeon to complement our three robotic surgeons who pick up additional theatre lists including the use of "Super Saturdays"/additional weekend work. At present we have 67 patients awaiting prostate surgery and with each case taking between four to six hours there is no current timescale to clear our waiting list back down to pre COVID levels which were around 25-30.

At present the next available operating slot is five to six weeks away. While the waiting list remains high, we have focussed on ensuring the longest waiting patients are treated first, and this has seen a reduction in the backlog in recent weeks (graph 11, pink line).

Gynaecology

Gynaecology is another service which has seen significant growth in referrals, with the 2023 average monthly referrals at 183 patients, 63% higher than the 2019 baseline (graph 12). March 2023 also saw significantly higher than usual referrals, with 218 patients referred. While minimal capacity was lost to Industrial Action, bank Holidays have impacted on capacity as there is usually a diagnostics clinic every Monday.

Graph 12: Monthly Gynaecology 2WW referrals with yearly average



Actions underway include:

- There is currently a Pathway Navigator in post for one year to support gynaecology oncology funded by the Wessex Cancer Alliance. We are reviewing how to convert this into a substantive post, alongside increasing the scope of the role to cover the complete diagnostic pathway including CT.
- Recruitment for a Physicians Associate to support the clinical team is in progress. This post will have a key role in increasing diagnostic capacity and providing surgical assistance. The referral triage tool has been embedded and a second consultant returning from maternity leave in June will share the role to provide consistent decision making and faster turnaround of triage decisions and documentation.
- WLIs to replace lost capacity are in place for May and June and planning for summer period leave. These triple clinics also include colposcopy to support demand.
- The ovarian exemplar pathway has been reviewed in the diagnostics working group. An audit has been started to review exemplar pathway timings in other trusts to identify opportunities for improvement at UHS. The diagnostics lead consultant is exploring the use of ultrasound guided ascetic biopsies in the clinic setting to remove the need for additional referral outside the care group.
- A fourth gynaecology oncology consultant business case in in development to support succession planning and capacity.

It is predicted the WLIs will bring the 2WW standards back in target and allow flexibility to provide capacity for fluctuations of demand.

Breast

This service often sees spikes in weekly referral rates. While the overall volume, averaged across a year, remains broadly steady, the nature of the 2WW service means that spikes in referral volumes causes challenges in capacity which can take months to correct. Recently, the Breast service has experienced high referral numbers at the end of March 2023 (circa 130 per week) and coupled with challenges in the consultant team, this has led to an increase wait time for diagnostics. There has also been a need to create follow up capacity as we had cancer patients waiting up to four weeks for results which the clinical team deemed unacceptable; therefore some "OneStop" clinics were converted into follow up appointments. In addition, capacity was lost due to the bank holidays, as well as a small amount to industrial action by doctors. Consequently, at the time of writing the service was currently booking 2WW appointments to day 15.

To further improve capacity:

- We have added WLI clinics on Saturdays (2 in May, one more planned in June) to reinstate the lost slots from Bank Holidays and Industrial Action.
- A replacement consultant has been appointed and starts in June. Further recruitment is underway to replace the Oncoplastic Fellow.
- We are reviewing a project to increase the use of Patient Initiated Follow Up (PIFU). If approved by the clinical team this could support the sustainability of "OneStop" clinics in the future.

There is a national review of the potential for separate breast pain clinics, and our lead consultant is part of the working group for this. While this may not increase capacity, this would further support patient safety by safeguarding 2WW slots for highly suspicious cancer. The forecast is that 2WW capacity will be back to consistently booking within the target by June 2023. This will then support meeting 31D and 62D targets.

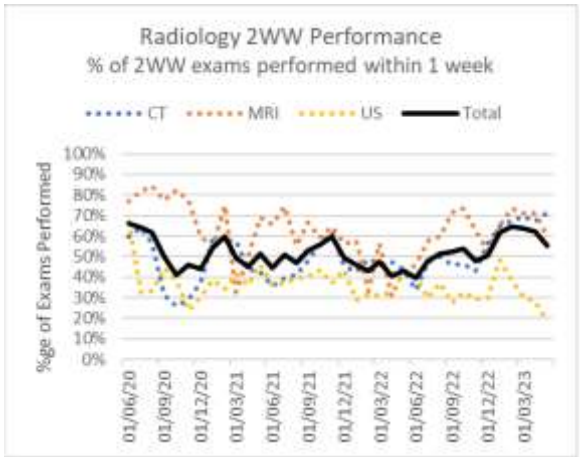
Appendix 2: Diagnostic services update

A key part of our cancer services are the diagnostic services which support the care groups. These services have also been challenged by the growth in referral volumes, and the issues and actions plans are outlined below.

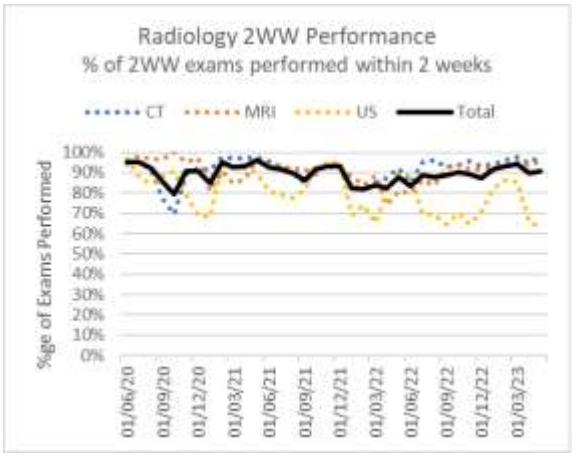
Radiology

Turnaround times from request to attend have been improving overall in 2023. The latest figures show that overall, 56% of patients wait less than a week from request to attend versus 31% this time last year (graph 13), whilst 91% of patients wait less than two weeks compared to 83% this time last year (graph 14). Ultrasound has been most adversely affected in recent months due to specialist Head & Neck radiologist availability. This team comprises 1.5 consultants who are the only clinicians competent to perform specialist scans and Fine Needle Aspiration (FNA) procedures on necks.

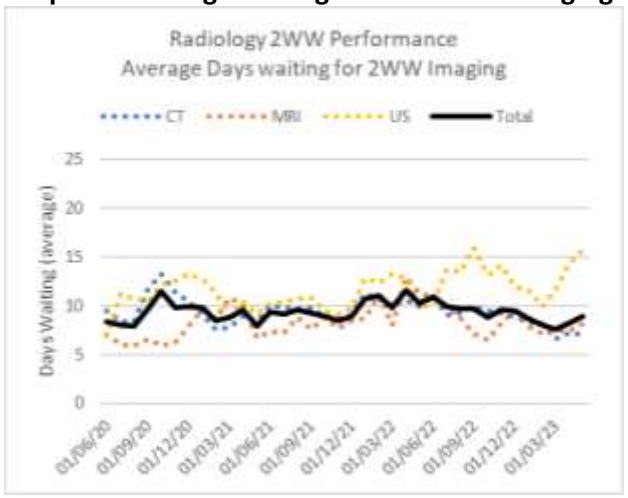
Graph 13: 2WW radiology exams performed within 1 week



Graph 14: 2WW radiology exams performed within 2 weeks

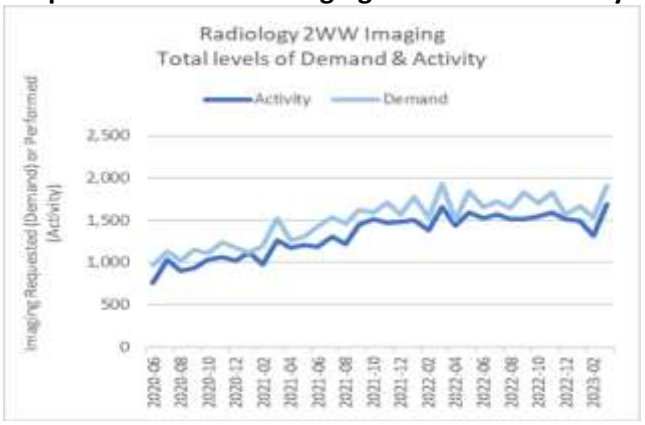


Graph 15: Average waiting time for 2WW imaging

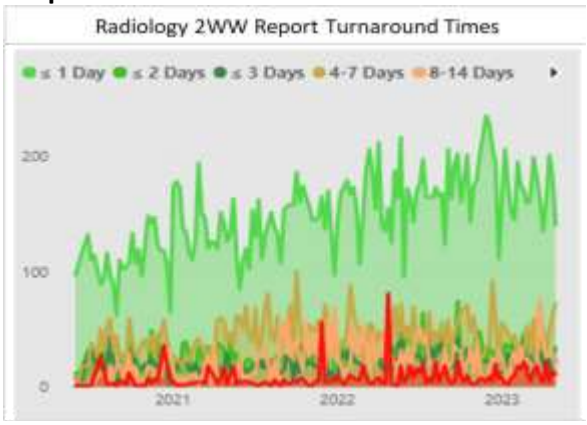


The overall average wait for a 2WW exam in radiology stands at seven days, compared to nine days this time last year (graph 15). This is in the context of increasing demand for 2WW imaging – demand in April 2023 was 5% higher than it was in April 2022 (graph 16). Considering the increased quantity of 2WW imaging, we have increased the number of reports sent to outsourcing companies to meet our report turnaround time targets (graph 17). In April we outsourced 14.8% of our total 2WW reports (graph 18), to deliver a median wait time of two days for a report.

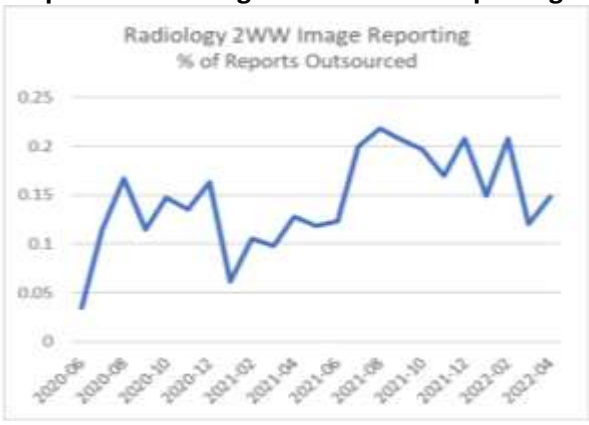
Graph 16: Total 2WW imaging demand and activity



Graph 17: Turnaround times



Graph 18: Percentage of outsourced reporting



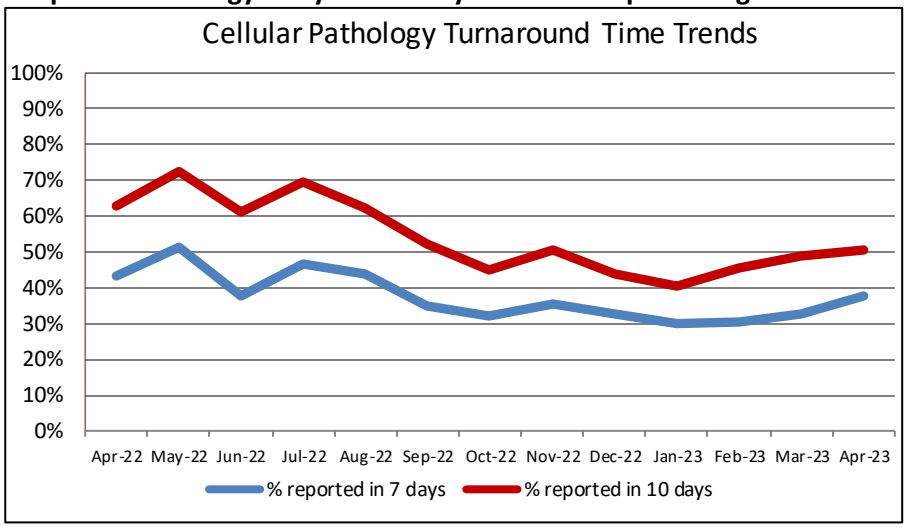
Going forward, Radiology will continue to outsource 2WW reporting when internal reporting capacity is reduced to continue to deliver prompt reporting. Our booking teams will continue to prioritise appointing 2 week wait referrals and will continue to meet with the ops manager and information team at weekly performance meetings to discuss outliers and to support individual areas. With the help of new BI apps, we can proactively review our performance and identify changes in our booking capacity.

Pathology

The high volume of patients referred into UHS, who require specialist diagnostic testing (both cancer and non-cancer) has had a significant and sustained impact on our cellular pathology (histology, non-gynae cytology) turn-around times (TATs). Our published TATs, as agreed locally at UHS are for 75% of referrals to have an authorised report within 10 days. This is from date of receipt to authorised report and includes several steps in the process of a sample before a final report can be issued.

Broadly, TATs measured across the department have been worsening since May 2022 with our lowest performance in January 2023 (40.4 % of requests meeting the TAT of 10 days). Since then, our TATs have seen a small improvement to 50.5% of cases reported with the 10-day TAT in April 2023 (graph 19). Historically in 2018 / 2019 and pre-covid, we were routinely meeting above our 75% TAT across all specialities, but since the summer of 2022 we have struggled to reach even 50% due to demand

Graph 19: Pathology 7 day and 10 day turn around percentages



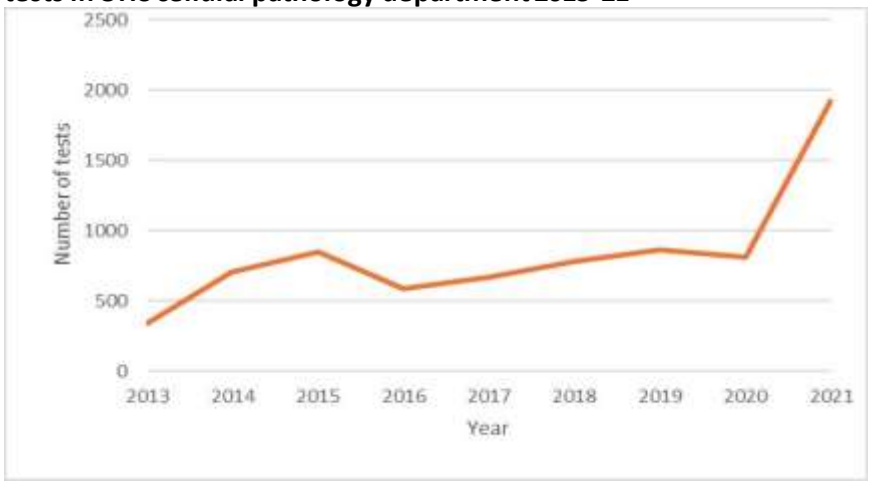
We also capture data on our diagnostic biopsy requests (urgent cancer pathway) separately and we have also seen our TAT performance recover from 52.5% in January 2023 to 60.2% in April 2023.

The volume of referrals and diagnostic complexity of a sample varies significantly by specialty. For example, in a pressure area such as dermatopathology, the demand for exceeds capacity by 38% (due to significant volumes of insourcing). Across all specialties, we have demand for an additional 13% of samples over the base job plan. Of this, 6% is delivered within existing job plans (i.e. no additional remuneration is paid) and the additional 7% is being supported by either Additional PAs or, when appropriate, WLI payments. Other high-volume specialties (GI and gynaecology) are also under significant pressure. This has led to some variation in the TAT performance by tumour site (see Table 22).

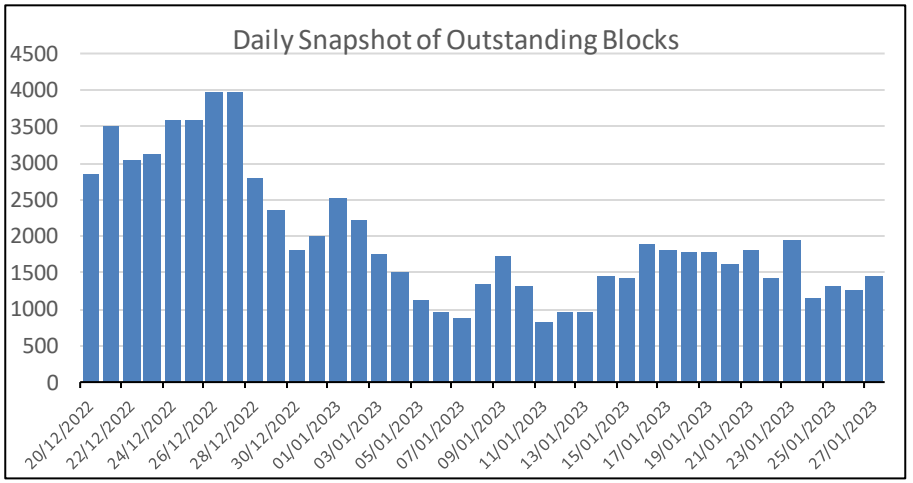
It has been noted in previous sections that, as a specialist tertiary referral centre, our referrals workload makes up approximately 30% of our total demand and as demand for diagnostic histopathology has increased nationally, in direct correlation, so has our referrals workload. Tertiary referrals into our service have increased by 15% (2018 = 4180, 2023 projected = 4911). This is an increase in terms cases which are often the most complex in nature, and often may require added specialist testing for accurate diagnosis which informs patient-specific treatment options and disease management.

Demand for solid tumour sample testing for DNA, RNA and protein-based diagnostic, prognostic and/or predictive markers has massively increased during the past five years and is predicted to continue to do so (graph 20). These service developments are impacting on cellular pathology workload and require recognition and increased resource as well as the development of new skills and knowledge within the workforce. Facilitating these tests requires input from multiple different staff groups within cellular pathology – admin, lab and pathologist (e.g. for tissue preparation, tumour assessment, result integration into reports and other related lab and admin work). We have secured one additional BMS (biomedical scientist) and one additional administrative staff member funded for one year through the WCA, and our challenge now is to build on this to meet the ever-increased need.

Graph 20: Molecular (protein, DNA and RNA based) diagnostic/ predictive tests in UHS cellular pathology department 2013-21



Graph 21: Outstanding block workstack at 6am



We have also been looking for opportunities to focus on small changes / small efficiency gains within our histopathology service. UHS Cellular Pathology have already implemented or are well into their journey to progress some of these recommendations, namely:

- Extended laboratory hours to increase capacity (consultation for 6-day working and extended weekday hours formalised February 2022).

- Modernising technologies to drive efficiencies (additional and replacement IHC (immunohistochemistry platforms / special staining machines) and review of automated processes (embedding and microtomy).
- Establish the correct skill mix for cut up and reporting to maximise productivity & sustainability.
- Effective and sustainable outsourcing, insourcing and overtime arrangements.
- Overseas recruitment to improve workforce supply.
- Implement Digital Pathology to unlock efficiency.

We have also implemented daily checks within the laboratory of the number of outstanding blocks to be embedded after processing and number of blocks to be cut (microtomy). This approach saw a 63% reduction in laboratory block back log (600 blocks equivalent to one day backlog) to our current position where we are running routinely at a 100 – 400 block backlog (graph 21).

In summary, whilst TATs are less than we aspire to we have continued to maintain a safe service which maintains quality despite workload pressures and remains responsive to the clinical needs of our patients and users.

Table 22: Pathology performance by team and tumour site

	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	KPI
Dept	72.5%	61.4%	69.7%	62.0%	52.2%	44.9%	50.4%	43.8%	40.5%	45.6%	49.0%	50.5%	75%
Histology	70.6%	58.4%	67.9%	59.7%	48.6%	40.8%	46.7%	38.8%	36.8%	42.0%	45.7%	46.8%	75%
Neuropathology	87.8%	85.5%	87.0%	87.4%	87.4%	96.3%	91.2%	88.9%	81.4%	78.7%	79.4%	88.4%	75%
Diagnostic Cytology	93.4%	93.4%	94.8%	89.7%	90.8%	94.6%	94.1%	91.4%	87.3%	92.3%	92.4%	91.3%	75%

	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	KPI
BMT	81.6%	87.3%	89.3%	80.0%	88.3%	92.5%	82.5%	75.0%	77.9%	83.9%	77.3%	80.3%	75%
Breast	76.2%	73.4%	84.6%	80.2%	67.1%	70.7%	64.2%	62.9%	68.1%	69.8%	74.8%	75.2%	75%
GI	85.9%	69.4%	74.6%	73.4%	50.1%	36.1%	60.2%	36.8%	35.6%	49.3%	42.8%	48.2%	75%
Gynae	79.0%	65.1%	66.4%	68.1%	58.0%	57.7%	54.5%	44.6%	46.5%	46.5%	64.6%	60.0%	75%
H&N	79.1%	61.8%	78.5%	70.5%	56.8%	56.0%	49.0%	46.6%	50.7%	64.4%	71.4%	65.6%	75%
HPB	68.6%	59.6%	63.3%	57.9%	41.5%	45.3%	33.8%	54.5%	39.1%	45.5%	65.1%	48.8%	75%
Lung	68.5%	46.9%	54.6%	52.8%	50.4%	35.1%	32.0%	35.1%	39.4%	41.2%	66.9%	60.4%	75%
Lymphoma	86.7%	88.3%	81.1%	87.5%	78.3%	69.0%	75.4%	75.0%	74.3%	88.5%	79.4%	84.7%	75%
Paediatric	47.2%	59.3%	68.9%	50.0%	55.4%	47.3%	39.7%	35.8%	31.1%	41.2%	37.0%	38.1%	75%
Skin	45.7%	25.7%	49.9%	22.7%	24.4%	13.7%	10.6%	10.1%	9.5%	10.1%	15.2%	15.1%	75%
Urology	44.8%	40.6%	56.7%	50.3%	39.8%	57.3%	54.6%	52.9%	40.6%	47.0%	49.8%	61.8%	75%

NHS Constitution - Standards for Access to services within waiting times

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

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

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

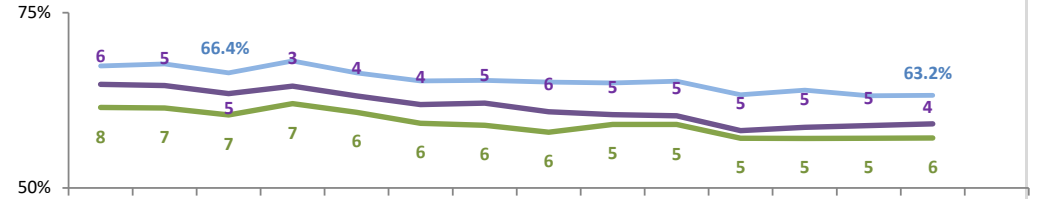
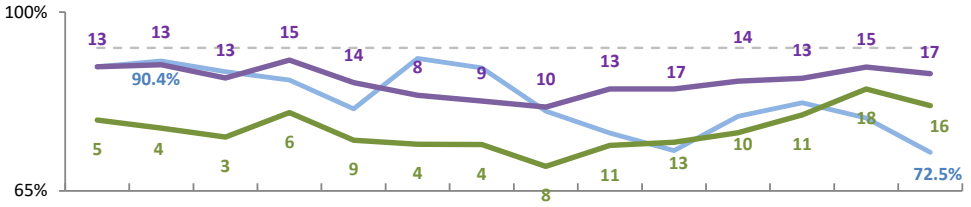
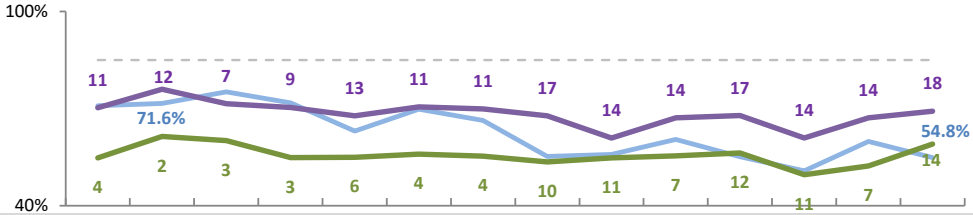
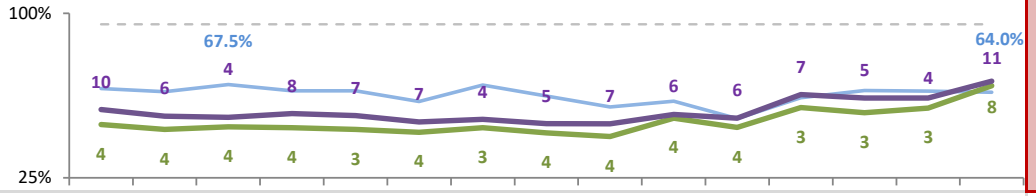
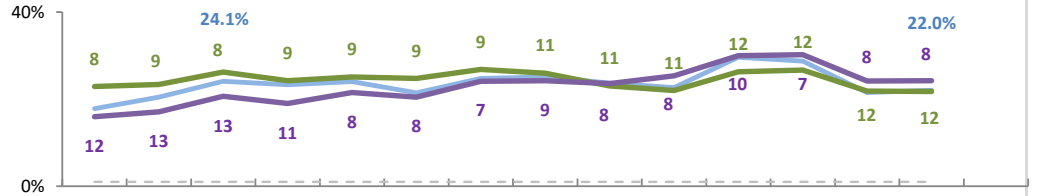
The NHS pledges to provide convenient, easy access to services within the waiting times set out in the Handbook to the NHS Constitution

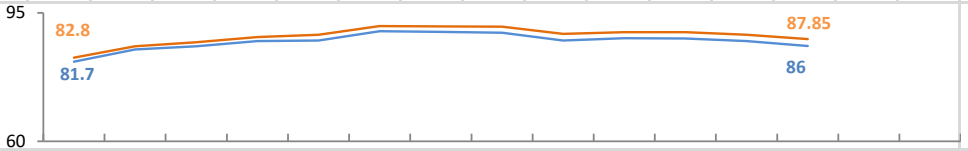
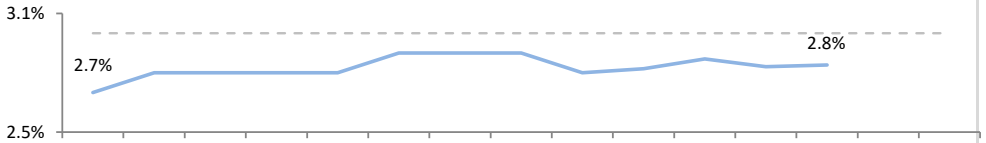
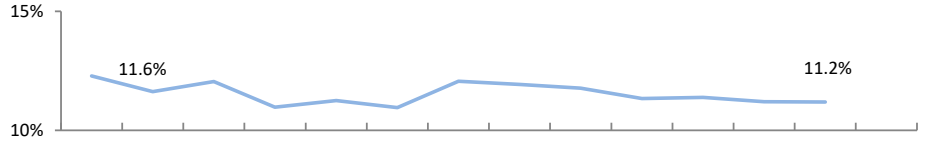
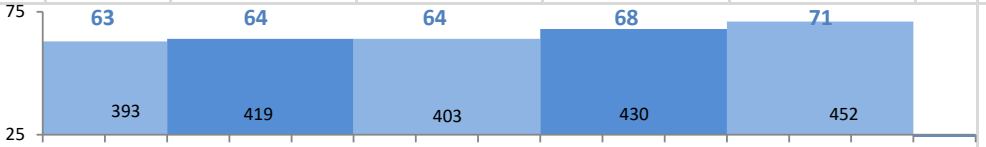
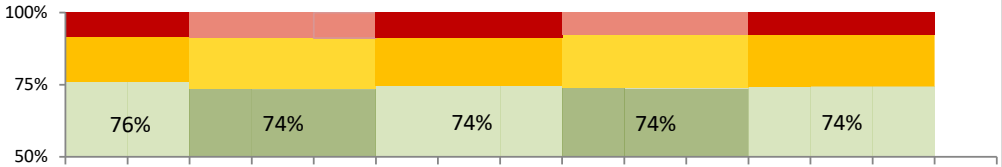
- All patients should receive high-quality care without any unnecessary delay
- Patients can expect to be treated at the right time and according to their clinical priority. Patients with urgent conditions, such as cancer, will be able to be seen and receive treatment more quickly

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

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

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

		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD
31	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)																≥92%	68.7%
55	% 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)																≥93%	81.7%
38	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)																≥85%	61.7%
28	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 16) South East average (& rank of 16)																≥95%	64.0%
37	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching Hospital average (& rank of 20) South East Average (& rank of 18)																≤1%	24.2%

Outcomes		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
1	HSMR - **UHS** HSMR - **SGH**																≤100	87.86	≤100
2	HSMR - Crude Mortality Rate																<3%	2.8%	<3%
1 & 2: At time of IPR publication, the latest information available in HED was from Feb 2023. Metrics are 12 month rolling. YTD is for financial year for UHS up to Feb 2023. Previously, data was sourced from Dr Foster.																			
3	Percentage non-elective readmissions within 28 days of discharge from hospital																-	11.2%	
3	April data not available at the time of publication																		
		Q4 21-22		Q1 22-23			Q2 22-23			Q3 22-23			Q4 22-23				Quarterly target		
4	**Cumulative Specialties** with Outcome Measures Developed (Quarterly)																+1 Specialty per quarter		
5	Developed Outcomes RAG ratings (Quarterly) Red Amber Green																		
	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		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
6	Cumulative Clostridium difficile **Most recent 12 Months** vs. **Previous 12 Months**	7 9	16 11	21 18	25 24	33 28	39 35	44 47	49 55	56 65	64 73	7177	7484			9 9	≤5	9	≤5
7	MRSA bacteraemia	1	1	0	0	0	0	0		1	1	1	0	0	0		0	4	0
8	Gram negative bacteraemia	21	17	22	19	27	17	22	14	24	16	17	14	32			≤17.4	241	≤209
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
9	Pressure ulcers category 2 per 1000 bed days	0.32														0.46	<0.3	0.46	<0.3
10	Pressure ulcers category 3 and above per 1000 bed days	0.32														0.34	<0.3	0.34	<0.3
11	Medication Errors (severe/moderate)														2		≤3	23	≤36
12	Watch & Reserve antibiotics, usage per 1,000 adms **Most recent months** vs. **2018*95.5%**	2,785 2,924												2,788 2,924			2,924	34,452	33,134

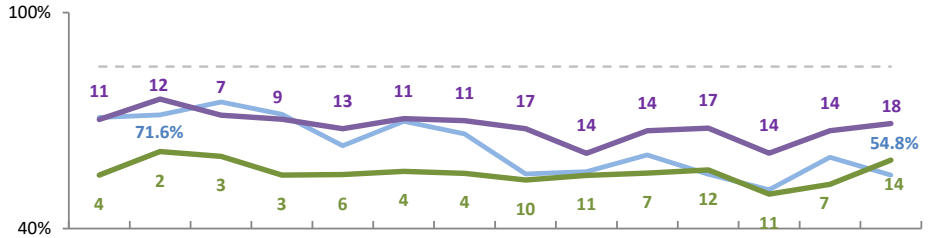
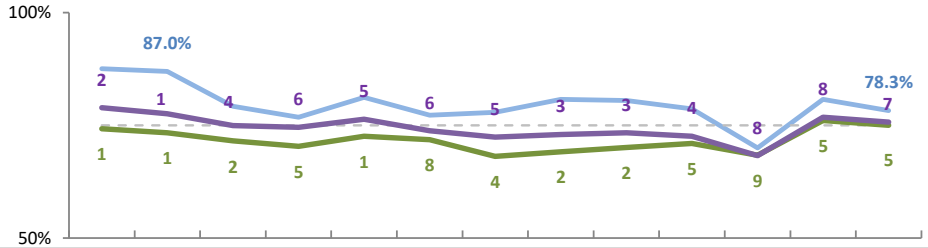
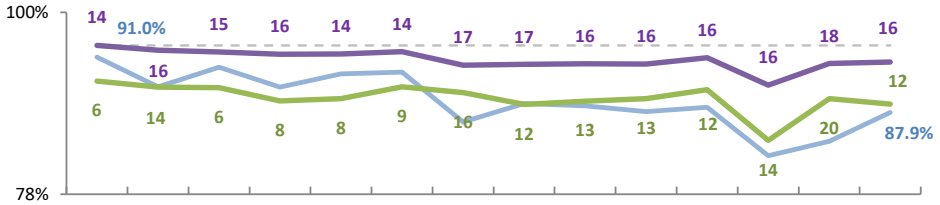
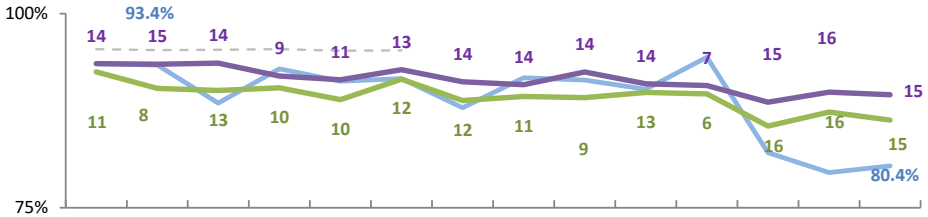
12 - For 2022/23, a new requirement is applied: Reduction of 4.5% from calendar year 2018 usage in combined WHO/NHSE AWaRE subgroups for “watch” and “reserve” agents. The performance data relate to successive FINANCIAL years, however the comparator denominator remains CALENDAR year 2018 (we are not using 2020 or 2021 due to the disruptive effect of COVID on both usage and admissions). Data is reported 3 months in arrears.

Safety		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
13	Serious Incidents Requiring Investigation (SIRI) (based upon month reported as SIRI, excluding Maternity)			22												3	-	3	-
14	Serious Incidents Requiring Investigation - Maternity			1												0	-	0	-
15	Number of falls investigated per 1000 bed days			0.13												0.11	-	0.11	-
16	% patients with a nutrition plan in place (total checks conducted included at chart base)															95.0%	≥90%	95%	≥90%
																844			
16 - monthly audit was paused due to pressure on all ward areas between Dec 2021 to May 2022. The audit was partially restarted in some ward areas in May 2022, and fully restarted in June 2022.																			
17	Red Flag staffing incidents			24												13	-	13	-
Maternity		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
18	Birth rate and Bookings Birth Rate - total number of women birthed Bookings - Total number of women booked	352	437	398	405	458	430	426	460	463	412	440	436	383	387	416	-	-	-
		428	534	444	485	425	405	417	438	416	498	363	453	432	513	449			
19	Staffing: Birth rate plus reporting / opel status - number of days (or shifts) at Opel 4.	0	8	2	1	6	3	2	0	3	1	5	1	0	2	1	-	-	-
20	Mode of delivery % number of normal birthed (women) % number of caesarean sections (women) % other	36.6%	36.2%	37.7%	36.0%	38.2%	37.7%	36.4%	38.7%	36.9%	35.7%	37.5%	37.2%	36.0%	36.7%	40.6%	-	-	-
		51.7%	51.5%	47.5%	48.1%	48.0%	49.1%	51.2%	48.9%	47.1%	48.5%	48.2%	49.3%	53.6%	48.2%	46.4%			

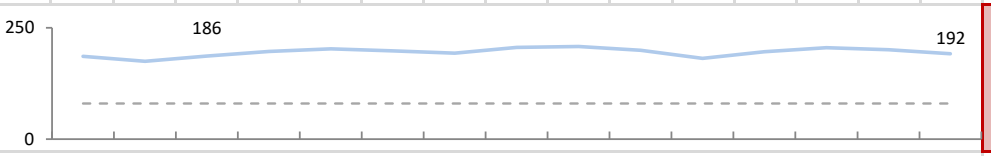
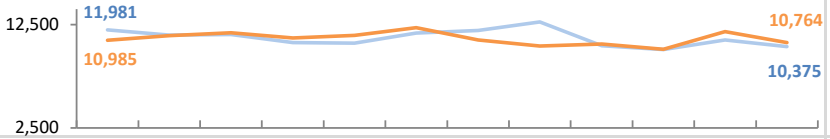
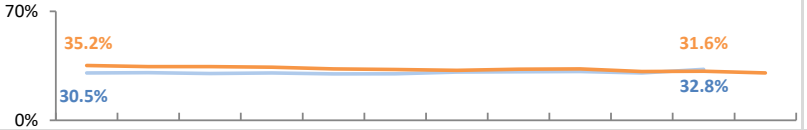
Patient Experience		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
21	FFT Negative Score - Inpatients	0.5%														1.0%	≤5%	1.0%	≤5%
22	FFT Negative Score - Maternity (postnatal ward)	3.0%														1.0%	≤5%	1.0%	≤5%
23	Total UHS women booked onto a continuity of carer pathway	44.3%															≥35%	43.5%	≥35%
24	Total BAME women booked onto a continuity of carer pathway	80.0%														79.6%	≥51%	80.6%	≥51%
25	% Patients reporting being involved in decisions about care and treatment	91.0%														89.0%	≥90%	89.0%	≥90%
26	% Patients with a disability/ additional needs reporting those needs/adjustments were met (total number questioned included at chart base)	92.0%														93.0%	≥90%	93.0%	≥90%
		117	121	120	139	178	173	145	191	214	148	152	928	958	635				
26 - Performance is a scored metric with a "Yes" response scoring 1, "Yes, to some extent" receiving 0.5 score and other responses scoring 0.																			
27	Overnight ward moves with a reason marked as non-clinical (excludes moves from admitting wards with LOS<12hrs)	38														62	-	62	-

Access Standards		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
28	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 16) South East average (& rank of 16)	67.5%														64.0%	≥95%	64.0%	≥95%
		10	6	4	8	7	7	4	5	7	6	6	7	5	4	11			
		4	4	4	4	3	4	3	4	4	4	4	3	3	3	8			
29	Average (Mean) time in Dept - non-admitted patients	02:59														02:58	≤04:00	02:58	≤04:00
30	Average (Mean) time in Dept - admitted patients	04:57														04:53	≤04:00	04:53	≤04:00
31	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	66.4%														63.2%	≥92%	68.7%	≥92%
		6	5	3	4	4	5	6	5	5	5	5	5	5	4				
		8	7	7	7	6	6	6	5	5	5	5	5	5	6				
32	Total number of patients on a waiting list (18 week referral to treatment pathway)	48,458														55,338	-	55,338	-
33	Patients on an open 18 week pathway (waiting 52 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	2,171														2,161	2,011	2,161	2,011
		7	7	7	7	5	5	5	5	5	5	5	5	5	4				
		14	14	14	12	12	13	13	13	12	12	12	12	12	11				

		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
34	Patients on an open 18 week pathway (waiting 65 weeks+) **UHSFT** **Teaching hospital average (& rank of 20)** **South East average (& rank of 17)**	8 1072 15	7 985 15	7 1022 15	7 898 13	7 917 13	7 967 14	7 1043 15	7 1087 15	7 1043 15	7 943 15	7 950 15	7 827 15	6 702 15	4 506 12		-	-	-
35	Patients on an open 18 week pathway (waiting 78 weeks+) **UHSFT** **Teaching hospital average (& rank of 20)** **South East average (& rank of 17)**	8 385 15	7 15	7 15	7 13	7 13	7 14	7 15	7 15	7 15	7 15	7 15	7 15	6 15	14 4 12		-	14	0
36	Patients waiting for diagnostics			10,916											10,438		-	10,438	-
37	% of Patients waiting over 6 weeks for diagnostics **UHSFT** **Teaching hospital average (& rank of 20)** **South East average (& rank of 18)**	8 12	9 13	24.1% 13	9 11	9 8	9 8	9 7	11 9	11 8	11 8	12 10	12 7	8 12	8 12	22.0%	≤1%	24.2%	≤1%
38	% 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 90.4% 5	13 4	13 3	15 6	14 9	8 4	9 4	10 8	13 11	17 13	14 10	13 11	15 18 16	17 72.5%		≥93%	61.7%	≥93%

		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
39	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 20)** **South East average (& rank of 17)**																≥85%	61.7%	≥85%
40	Cancer 28 day faster diagnosis Percentage of patients treated within standard UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)																≥75%	80%	≥75%
41	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 20)** **South East average (& rank of 17)**																≥96%	88.8%	≥96%
42	31 day cancer wait performance - Subsequent Treatments of Cancer (Most recently externally reported data, unless stated otherwise below) **UHSFT** **Teaching hospital average (& rank of 20)** **South East average (& rank of 17)**																≥96.0%	88.4%	≥96.0%

R&D Performance		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
43	Comparative CRN Recruitment Performance - non-weighted	8	9	1	1	3	4	5	6	7	7	14	15	15	13	14	Top 10	-	-
44	Comparative CRN Recruitment Performance - weighted	4	3	6	8	11	7	7	7	8	10	10	10	11	9	9	Top 5	-	-
45	Study set up times - 80% target for issuing Capacity &Capability within 40 Days of Site Selection	New metric still being developed.															-	-	-
46	Achievement compared to R+D Income Baseline Monthly income increase % YTD income increase %	143.0%	359.0%	63.0%	74.0%	56.0%	177.0%	94.0%	48.0%	23.0%	71.0%	79.0%	166.0%	69.0%	36.0%	56.0%	≥5%	-	-

Local Integration		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
47	Number of inpatients that were medically optimised for discharge (monthly average)																≤80	192	-
48	Emergency Department activity - type 1 This year vs. last year																-	10,375	-
49	Percentage of virtual appointments as a proportion of all outpatient consultations This year vs. last year																≥25%	30.7%	≥25%

Digital		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
50	My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month)	113,766														155,849	-	155,849	-
51	My Medical Record - UHS patient logins (number of logins made within each month)	23,015														30,398	-	30,398	-
52	Average age of IT estate Distribution of computers per age in years	2	2	16	51	90	142	374	894	1117	1244	3147	3052	1394	133		-	-	-
		13	12	11	10	9	8	7	6	5	4	3	2	1	0				
53	CHARTS system average load times	Metric still being developed.																	
		Q1 22-23			Q2 22-23			Q3 22-23			Q4 22-23								
54	Cyber attacks / phishing / incidents blocked Average # Malware attempts blocked per month (10s) Average # Phishing emails blocked per month (100s) Average # Ransomware attempts blocked per month	1227	351	10	1222	346	1	3673	262	7	1005	114	5				-	-	-
55	Inpatient noting progress Left axis: IP Noting data recorded (100s) IP Noting unique user views Right axis: IP pages scanned (1000s)	NEU go live			EYE go live			CV&T go live			T&O go live						-	-	-
55	IP Noting went live in Oct-22. CGs going live are marked on green line.																		

Report to the Trust Board of Directors				
Title:	**Finance Report 2023-24 Month 1**			
Agenda item:	**5.13**			
Sponsor:	**Ian Howard – Chief Financial Officer**			
Author:	**Philip Bunting – Director of Operational Finance** **David O'Sullivan – Assistant Director of Finance – Financial Performance**			
Date:	**25 May 2023**			
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:	**M1 Financial Position** UHS is reporting a M1 deficit of £5.4m compared with a deficit plan of £4m. This is therefore £1.4m adverse to plan. This is driven by two interrelated factors. Firstly, staff costs included one off expenditure relating to the backfill of staff on strike totalling £0.4m. Secondly the Trust was £1m behind its ERF income target which is based on the achievement of 113% of 19/20 levels. £0.7m of this is due to junior doctor strikes causing reduced activity throughput. **Underlying Position** The underlying position for April reduced from £5m in March to £4.3m in April consistent with prior months in 22/23. The key drivers for the deficit remain consistent with 22/23 including non-pay inflation, energy, drugs and the volume of patients not meeting the criteria to reside leading to surge bed costs. These have been partly offset with efficiencies in 22/23 but have left a legacy underlying deficit that remains. The financial plan for 2023/24 targets eradication of the underlying financial deficit by the end of the year ensuring that cash reserves don't fall below minimum levels. This is predicated on the achievement of £69m of CIP. With the start of a new financial year resetting NHS contract values, it can be observed that additional income received by the Trust with regards to net tariff inflation and growth funding has been offset in full by covid funding reductions and pay award accruals meaning the underlying position remains neutral in comparison to 22/23. **ERF Position** The activity position in M1 reduced from M12 with achievement of 106% of 19/20 levels (this is currently an estimate). The previous month had seen activity of 111% of 19/20 achieved. A second junior doctor strike, this time lasting four days rather than three days, has created further operational pressure and reduced activity throughput as a result. The underachievement in M1 will require catching up in future months in order to ensure the full year plan of 113% is achieved. Our plan did incorporate additional capacity coming online during the year (theatres once refurbishment work completes in June, additional bed capacity now expected in September & December). We believe there is opportunity to increase activity levels during the year, however catching up will require over-achievement of the 113% target in latter months.			

CIP

The Trust has been working hard to identify plans for 2023/24 in contribution towards a target of £69m. This equates to delivery of 6% of income. £29.7m has so far been identified with further work on going to cost schemes and close the gap.

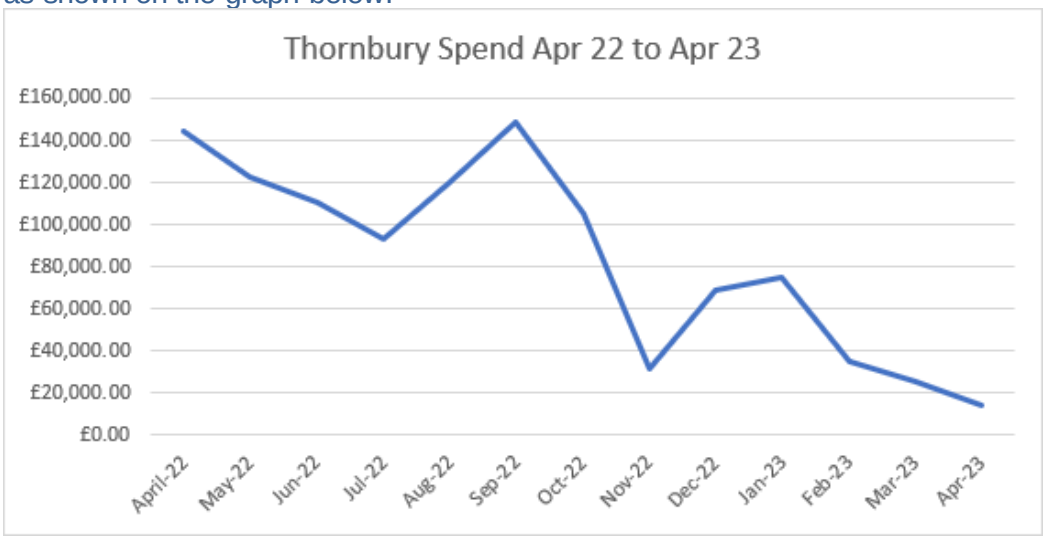
Achievement in M1 was £1.1m against a plan of £4m (£2.9m shortfall). It should be noted that M1 reporting of CIP is usually low and likely to catch-up in future months. Other areas of underspend have mitigated the reported deficit.

A large number of schemes are in development including several that cut across multiple providers with the HIOW system. Secondary to this UHS is taking measures to increase financial grip and control especially around recruitment and temporary staffing to ensure staff growth is as per plan.

Financial Recovery

Financial recovery remains a significant priority for the trust. Progress continues to be made via the Trust Savings Group and Transformation Oversight Group following on from the finance summit held in December.

- Revised financial governance and controls have been discussed and agreed at the Trust Executive Committee
- A review of the trusts balance sheet has taken place with HIOW ICS and NHSE Regional colleagues
- The Transformation Oversight Group (TOG) is in the process of setting priorities for 23/24
- Tightened agency spend controls continue to report reduced spend on high-cost agency as shown on the graph below.



Our financial recovery trajectory challenges an improvement of £1m every quarter, in the monthly underlying deficit, via a combination of increased income and reduced expenditure. This means the exit run rate position is targeted at breakeven.

Workforce Expenditure

In April the junior doctors strike had a significant impact on pay expenditure with £0.4m of backfill costs for consultants acting down and covering out of hours. This includes an accrual for time of in lieu that some doctors have opted to take. There were also additional costs for pharmacists as part of contingency plans. In total it is estimated that 2,500 additional hours have been required to support business continuity through the strike period.

After adjusting for this however pay and workforce trends remain a concern as staffing numbers were 191 wte in excess of plan in April and continue on an upward trend. Pay costs were also

	£0.4m over plan after adjusting for one off strike costs of a further £0.4m. For the financial plan to be delivered workforce growth has been assumed as flat with all investments offset by efficiency savings. Work is therefore underway to develop leading indicators and more robust insight into future trends enforcing greater controls if necessary to avoid unaffordable workforce growth. **Capital** Capital expenditure totalled £1.6m in M1 which was £1.3m behind plan. This follows a significant push on capital expenditure in M12. The plan for 2023/24 totals £49.4m including £5m of externally funded capital. Currently plans are 15% higher than our CDEL allocation with a level of slippage assumed. Spend will be monitored closely through 2023/24 to ensure risks and mitigations are fully understood and managed. **Cash** The cash position remains static at £105m. This is higher than was originally forecast but there still a large volume of accruals that remain within accounts especially relating to capital. An underlying downward trend is still forecast to prevail due to the underlying financial deficit. We are continuing to have a current-account deficit, which is being funded by our capital investment savings account. **NHS Pay Award Update** The pay award for Agenda for Change staff has now been agreed following majority support by staffing unions. This is anticipated to be paid in June with additional funding due to be paid in month. There still remains some uncertainty regarding local differences to the national calculation and we await further clarification over whether funding will be adjusted. For example, the UHS contract with Serco is dynamically linked to agenda for change and therefore we may be contractually (and morally) obliged to match the pay award although this has not been picked up within the funding calculation. This principle also applies to other Trusts e.g., PFI contracts. **HIOW ICB Position** A verbal update will be provided as there is no formal reporting requirement for April.
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 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) and the risk of a reducing internal CDEL allocation for 2024/25 due to the forecast deficit for 2023/24.
Summary: Conclusion and/or recommendation	Members Trust Board are asked to: • Note the update to the financial position.

University Hospital Southampton NHS
NHS Foundation Trust

Finance Report Month 1

Report to:	**Board of Directors and Finance & Investment Committee** **April 2023**
Title:	**Finance Report for Period ending 30/04/2023**
Author:	**Philip Bunting, Director of Operational Finance** **David O'Sullivan, Assistant Director of Finance**
Sponsoring Director:	**Ian Howard, Chief Financial Officer**
Purpose:	**Standing Item**
	The Board is asked to note the report

Executive Summary:

In Month and Year to date Highlights:

1. In Month 1, UHS reported a deficit position of £5.4m which was £1.4m adverse to plan. The plan for the year is £26m deficit which is currently forecast for delivery. This plan is still subject to NHS England sign off following resubmission. The shortfall to plan will need to be recovered in future periods in order to deliver to the full year plan.

2. The underlying position is £4.3m deficit as strike costs combined with supressed activity have created one off pressures of £1.1m. £0.7m relates to reduced ERF income and £0.4m relates to staff backfill costs.

3. CIP delivery was reported behind plan. £29.7m of savings have been identified in plans, 43% of the trust target of £69m. There is continued focus on savings identification and delivery to support financial recovery.

4. The themes seen in M1 were:
    1. UHS is under its elective recovery target in M1 by £1.0m (106% achieved v 113% target).
    2. The pay cost pressure relating to industrial action totals £0.4m.
    3. Underlying drivers for the monthly financial deficit remain as per 22/23 including inflation, energy, drugs and increased volumes of patients not meeting the criteria to reside.
    4. Upward workforce trends remain a risk where unfunded and increased controls have been introduced around recruitment and temporary staffing usage.

Finance: I&E Summary

UHS has submitted an annual plan position of £26m deficit for the 2023/24 financial year.

In April a deficit position of £5.4m was reported, £1.4m adverse to plan.

The in month adverse position is driven largely by under achievement of Elective activity targets of £1.0m and also junior doctor strike backfill costs of £0.4m.

Pay expenditure was down slightly from the previous month although bank costs were over plan in month although these were partially offset with reductions in agency. Pay costs in total were £0.5m over plan.

The overspend within other non pay correlates with unachieved CIP. Clinical supplies were £1.1m under plan in month although can be volatile depending on activity and casemix.

		Current Month			Full Year		
		Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
NHS Income:	Clinical	70.0	68.4	1.6	841.7	841.7	0.0
	Pass-through Drugs & Devices	15.5	14.1	1.5	186.6	186.6	0.0
Other income	Other Income excl. PSF	18.6	18.6	(0.0)	192.6	192.6	0.0
Total income		**104.1**	**101.2**	**3.0**	**1,220.9**	**1,220.9**	**0.0**
Costs	Pay-Substantive	51.9	52.6	0.7	630.4	630.4	0.0
	Pay-Bank	4.0	4.4	0.4	43.6	43.6	0.0
	Pay-Agency	1.4	1.1	(0.3)	15.1	15.1	0.0
	Drugs	3.0	3.0	(0.0)	37.9	37.9	0.0
	Pass-through Drugs & Devices	15.5	14.1	(1.5)	186.6	186.6	0.0
	Clinical supplies	5.7	4.6	(1.1)	70.3	70.3	0.0
	Other non pay	24.3	25.0	0.7	228.8	228.8	0.0
Total expenditure		**105.8**	**104.8**	**(1.1)**	**1,212.7**	**1,212.7**	**0.0**
Remove	Depreciation and Amortisation	3.2	3.2	0.0	38.0	38.0	0.0
	Donated income	(1.0)	(0.7)	(0.3)	(18.4)	(18.4)	0.0
EBITDA		**0.5**	**(1.1)**	**1.6**	**27.8**	**27.8**	0.0
EBITDA %		0.5%	-1.1%	1.6%	1.2%	1.2%	0.0%
	Non operating expenditure/income	(3.7)	(3.7)	(0.0)	(37.9)	(37.9)	0.0
Surplus / (Deficit)		**(3.2)**	**(4.8)**	**1.6**	**(10.1)**	**(10.1)**	**0.0**
Less	Donated income	(1.0)	(0.7)	(0.3)	(18.4)	(18.4)	0.0
	Profit on disposals	0.0	0.0	0.0	0.0	-	0.0
	Gain/ Loss on absorption	0.0	0.0	0.0	0.0		0.0
Add Back	Donated depreciation	0.2	0.2	(0.0)	2.5	2.5	0.0
	Impairments	0.0	0.0	0.0	0.0	-	0.0
					-	-	
Net Surplus / (Deficit)		**(4.0)**	**(5.4)**	**1.4**	**(26.0)**	**(26.0)**	**0.0**

Finance Report Month 1

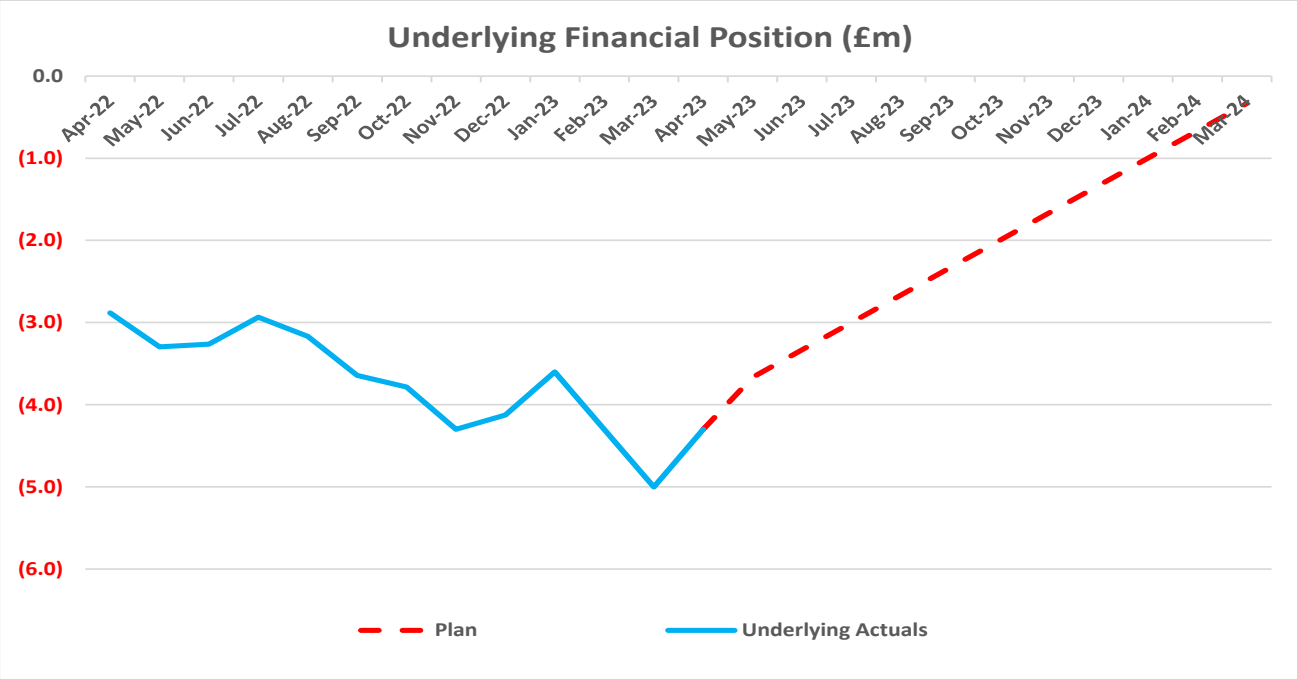
Monthly Underlying Position

The graph shows the underlying position for the Trust from April 2022 to present. This differs from the reported financial position as it has been adjusted for non recurrent items (one offs) to get a true picture of the run rate. The underlying position is a £4.3m deficit in M1 which has improved from £5.0m in M12.

The run rate deteriorated over 2022/23 financial year from c£3m per month to exiting the year at £5m per month. This was driven by increased energy costs and also activity related pressures over the winter period especially relating to surge beds.

The plan for 2023/24 is to eradicate the underlying deficit by financial year end .

A table outlining risks is also shown and will be monitored and added to in year.

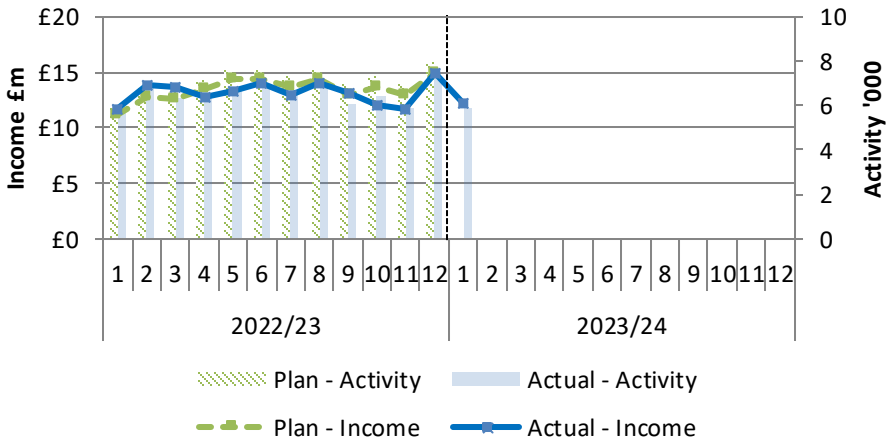


Risk Variable	£m
Unidentified CIP	15.8
System CIP Initiatives	11.2
Identified CIP Delivery Risk	7.0
Inflationary Pressure (non pay and unfunded pay award)	8.0
Total Risk	42.0
Mitigations	
Additonal CIP	(18.0)
Net Risk	**24.0**

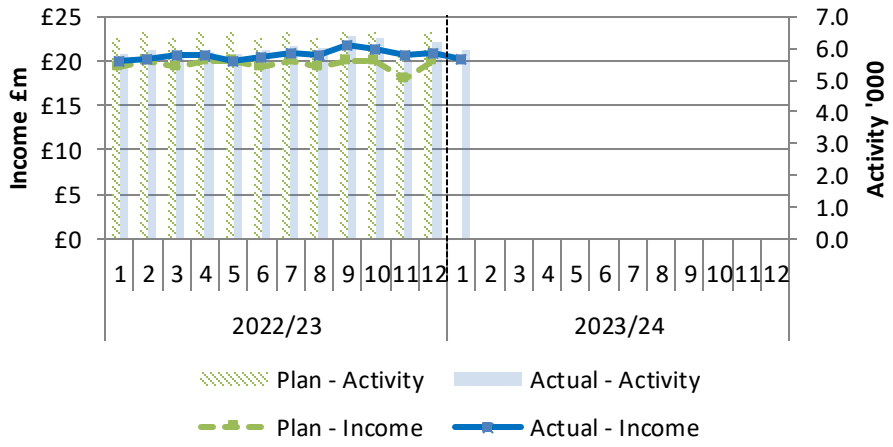
University Hospital Southampton NHS
NHS Foundation Trust

Clinical Income

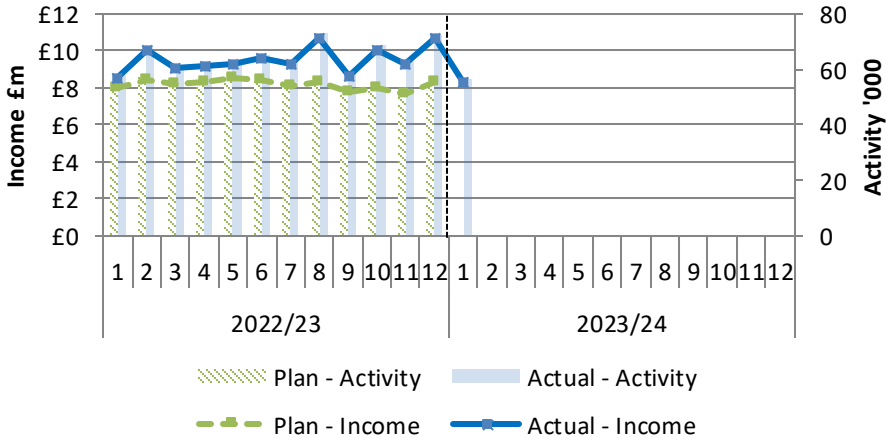
Elective spells



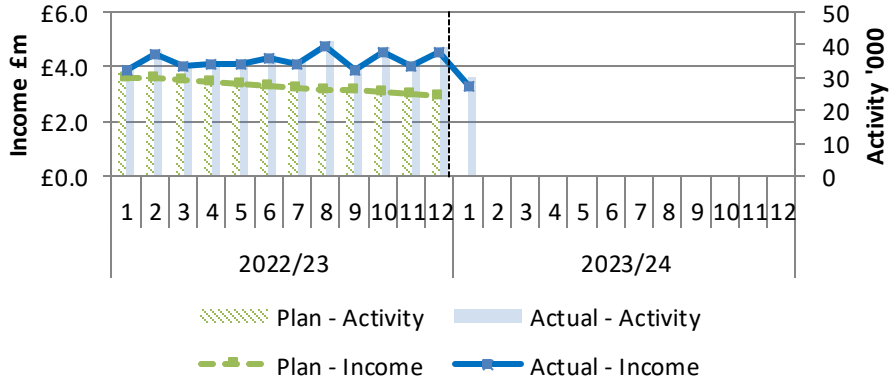
Non elective spells



Outpatients Total



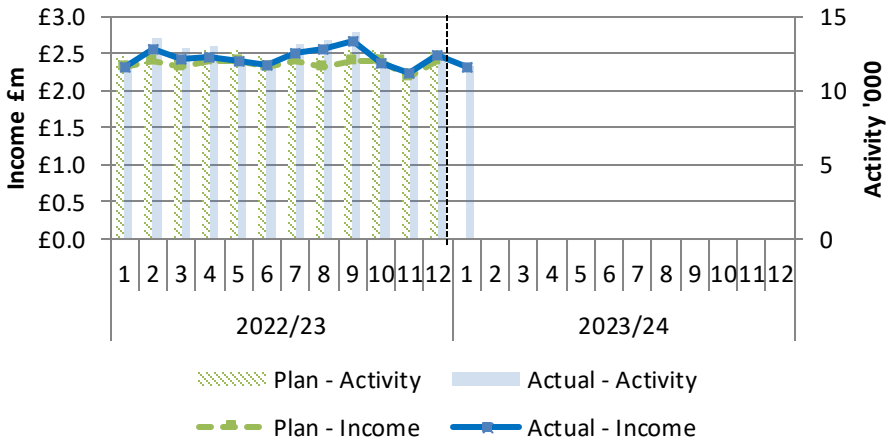
Outpatients - Follow up appointments



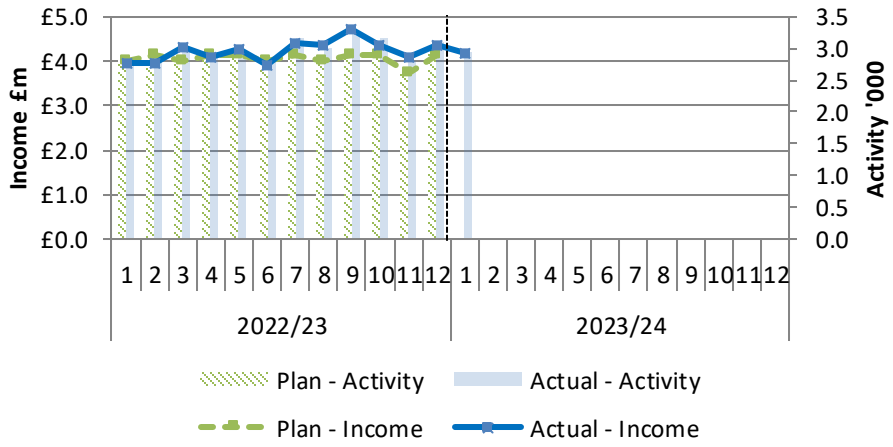
University Hospital Southampton NHS
NHS Foundation Trust

Clinical Income

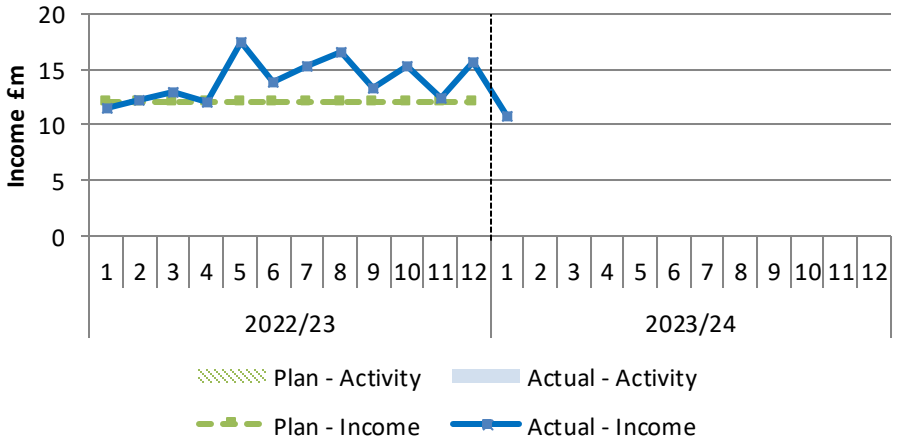
A&E



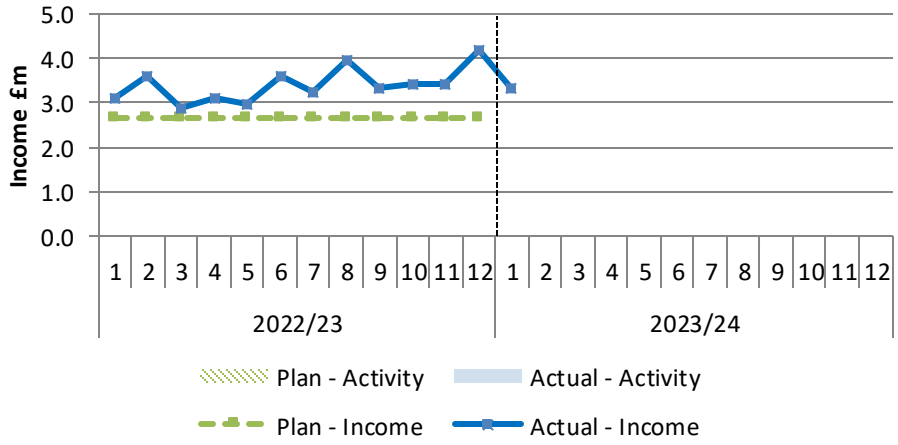
Adult critical care



Tariff excluded drugs



Tariff excluded devices



Finance Report Month 1

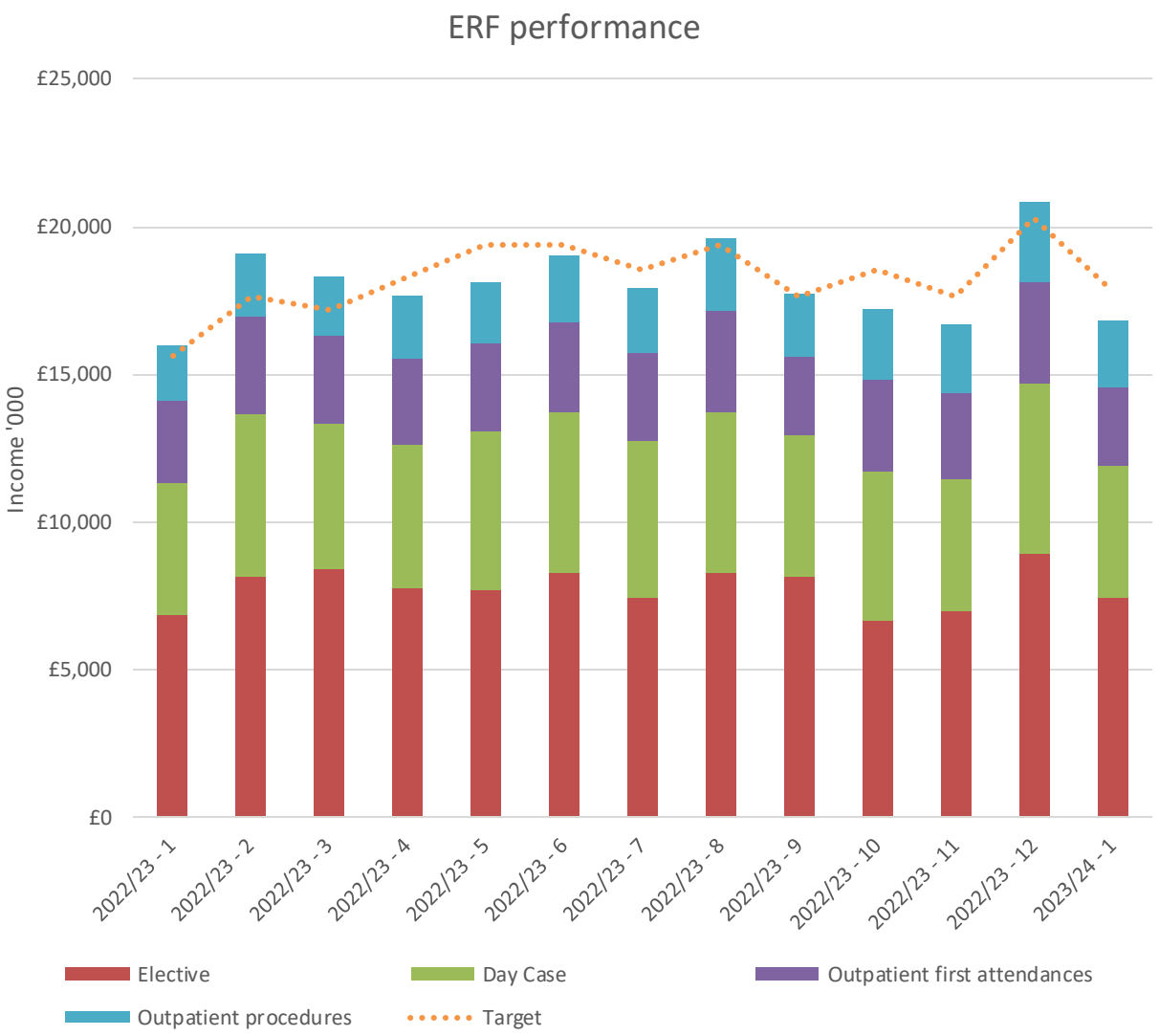
Elective Recovery Fund 22/23

The graph shows the ERF performance for 23/24 as well as a trend against plan for 22/23.

In 23/24 the Trust has a target to achieve 113% of 19/20 activity for elective inpatients, outpatient first attendances and outpatient procedures. Delivery above this targeted level will generate additional funding for the Trust.

The M1 23/24 target is currently an internal estimate which will be updated once full details of the national targets are published. This shows delivery is estimated to be £1.0m below the national target with 106% estimated to have been achieved.

Internal plans anticipate improvement against target during the year as new capacity opens and productivity improvements take effect. This trajectory will be added to reporting for M2 onwards.

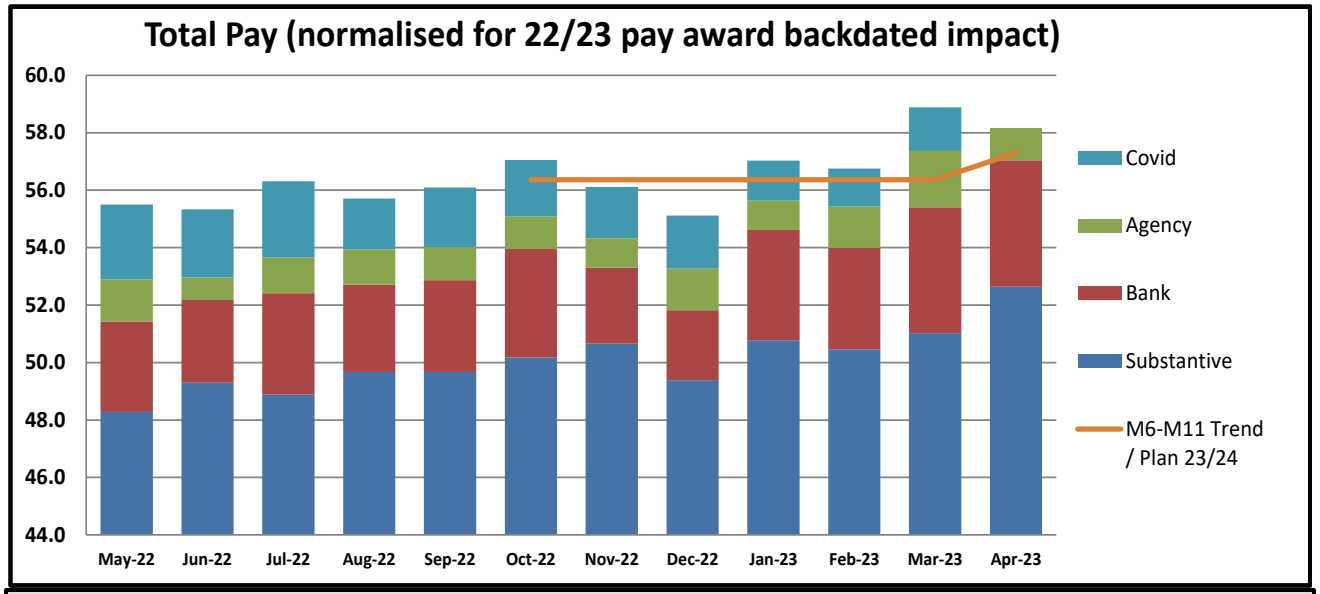


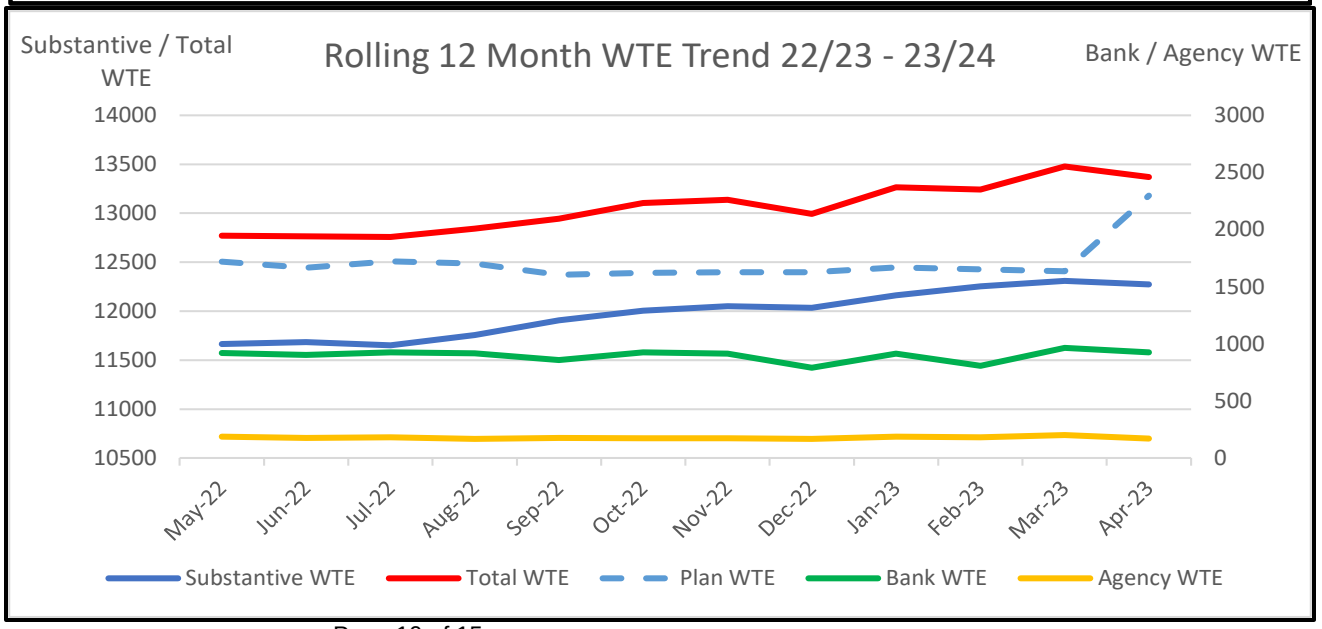
Finance Report Month 1

Staff Costs

Total pay expenditure in April was £58.2m, down from March's high of £58.9m but higher than the previous six month average of £56.4m by £1.8m. £1m of this relates to the 22/23 accrued pay award which is within plan, £0.4m relates to strike backfill costs and £0.4m for other workforce growth. WTE trends are shown on the second graph indicating wtes which were 191 wte over plan in M1.

On the top graph Covid pay costs are no longer separately classified and are included within substantive, bank and agency lines. Bank costs of £4.4m were reduced from M12 but remained above the previous 6 month rate of £4.0m per month. Positively agency costs were down from M12 and the previous six months at £1.1m compared to a run rate of £1.7m per month. Workforce trends continue to be closely monitored with a headcount reduction part of in year efficiency plans.





Finance Report Month 1

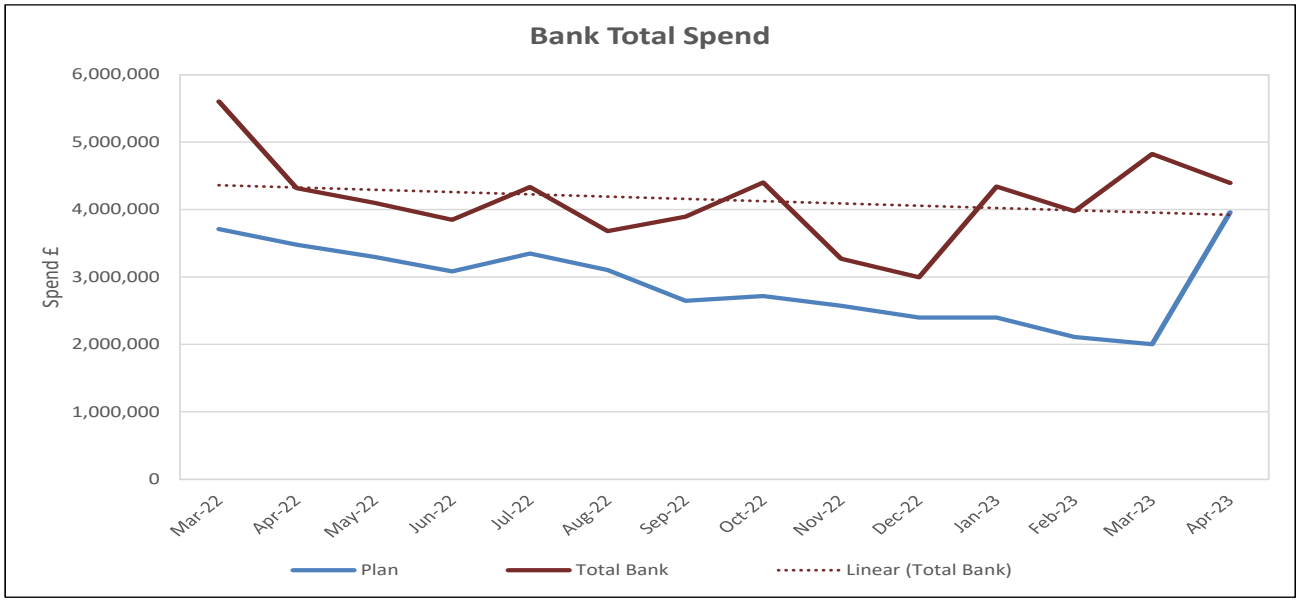
Temporary Staff Costs

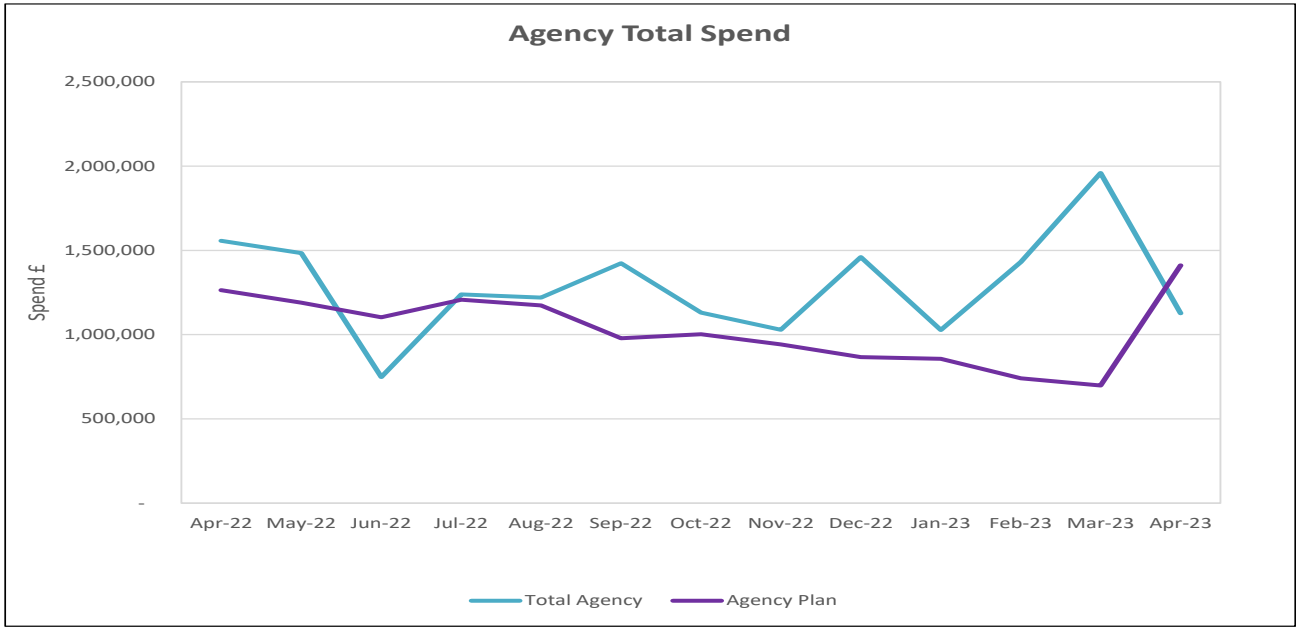
Expenditure on bank staff decreased by £0.4m in month following a higher than average March position of £4.8m.

Costs are continuing at a higher than average level partly as a response to industrial action meaning bank backfill requirements have increased.

Agency spend decreased by £0.8m compared to the previous month, which had been a yearly high position at £1.9m. The in month position returns below the previous run rate (excl M12) and partially offsets some of the increase in bank costs seen above.

Spend remains comparably lower than other similar sized trusts. Significant progress has been made reducing high cost agency usage both within nursing and medical categories. Reducing agency spend remains a focus area for the Trust Savings Group (TSG).





Finance Report Month 1

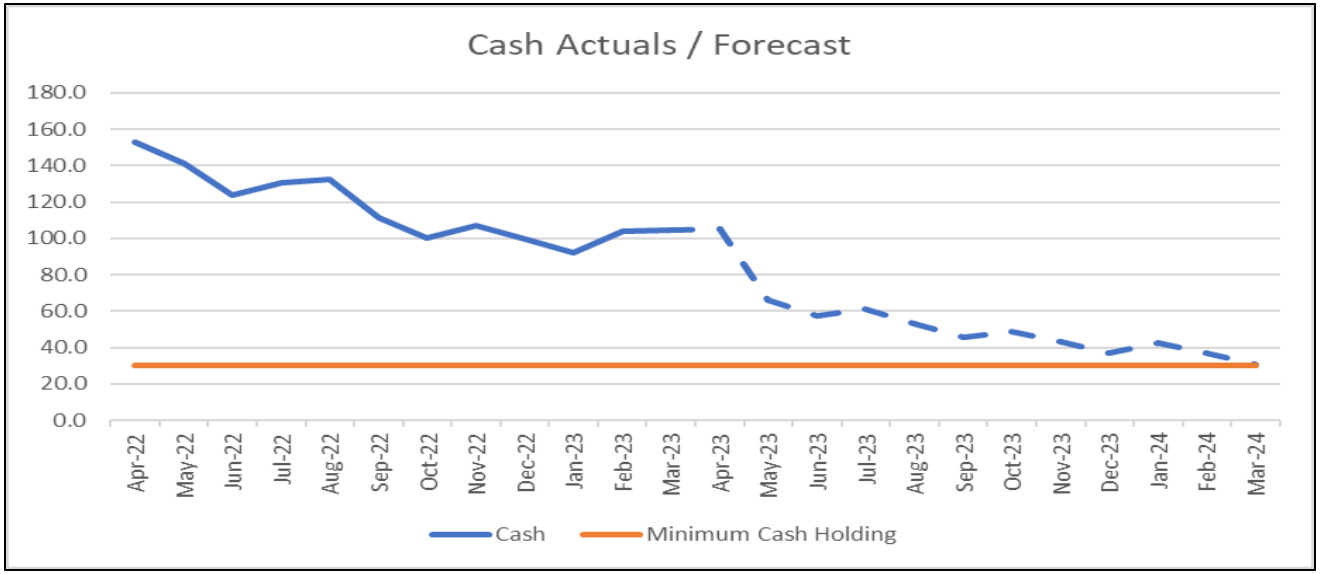
Cash

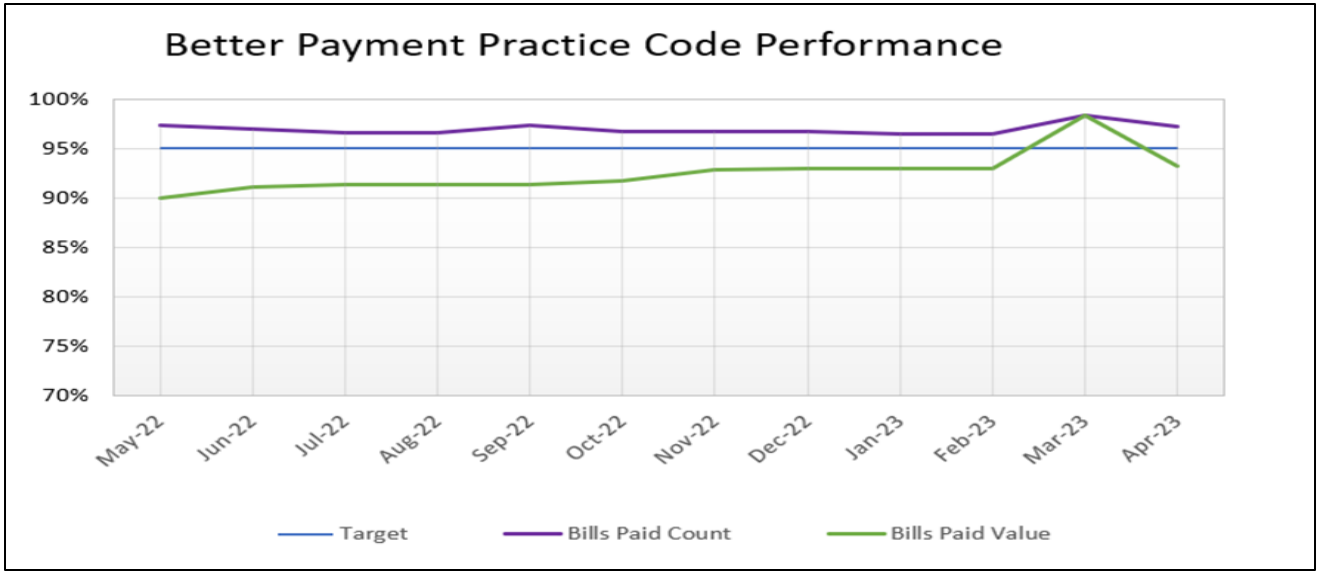
The cash balance remained static at £105m in April. This is analysed in the movements on the Statement of Financial Position.

A cash forecast has been completed for the next 11 months projecting a material decline in cash driven by an underlying deficit and sizeable internally funded capital programme of £44m per annum. This is currently based on the 2023/24 plan submission.

Better Payment Practice Code (BPPC) performance in month for April is over the 95% target for count and marginally below for value at 93.19%.

Improvements in accounts payable processes have helped achieve a sustained improvement following initial challenges with the new finance system implemented in 2019.





University Hospital Southampton NHS
NHS Foundation Trust

Capital Expenditure

(Fav Variance) / Adv Variance

The 23-24 capital budget has been set at £49.5m. This figure includes £5.0m of agreed external awards.

Expenditure in month 1 was £1.6m in total. Significant areas of expenditure were in informatics (£0.6m) and charity funded estates schemes (the staff welfare hub, PAH roof garden, and staff room refurbishments, £0.6m). Reported expenditure was relatively low on the continuing wards scheme (£0.2m) and ward refurbishment schemes (£0.2), but is expected to increase in these areas in May.

It is anticipated that the trust will spend it's CDEL funding allocation and external awards in full this year. The forecast will be monitored on a monthly basis and any mitigating actions taken to ensure this is the case.

	Month			Full Year Forecast		
Scheme	Plan £000's	Actual £000's	Var £000's	Plan £000's	Actual £000's	Var £000's
Internally Funded Schemes						
Estates						
Strategic Maintenance	584	152	432	5,200	5,200	0
Oncology Centre Ward Expansion Levels D&E	750	163	587	7,135	7,135	0
Fit out of F Level Theatres (VE)	339	48	291	8,500	8,500	0
Refurbishment of Theatres 10 & 11	500	0	500	1,104	1,104	0
Neonatal Expansion	0	29	(29)	10,030	10,030	0
Community Diagnostic Centre Phase 2	0	0	0	3,250	3,250	0
General Refurbishment Fund	200	169	31	3,250	3,250	0
GICU Refurbishment	0	0	0	1,000	1,000	0
Donated Estates Schemes	1,000	653	347	2,624	2,624	0
Decarbonisation Schemes	0	0	0	11,259	11,259	0
Information Technology						
Information Technology Programme	363	628	(265)	5,800	5,800	0
Pathology Digitisation	0	90	(90)	90	90	0
Equipment						
Medical Equipment panel (MEP)	0	79	(79)	2,069	2,069	0
Purchased Equipment / Lease Buyouts	0	0	0	0	0	0
Donated Equipment	0	0	0	300	300	0
Divisonal Equipment	39	96	(57)	625	625	0
IMRI	0	0	0	1,310	1,310	0
Targeted Lung Health Checks CT Scanner	0	0	0	1,364	1,364	0
Other						
Other	0	164	(164)	518	518	0
Slippage	0	0	0	(7,181)	(7,181)	0
Donated Income	(1,000)	(743)	(257)	(18,383)	(18,383)	0
Total Trust Funded Capital excl Finance Leases	**2,775**	**1,525**	**1,250**	**39,864**	**39,864**	**0**
Leases						
Equipment leases	31	0	31	500	500	0
IISS	0	0	0	1,870	1,870	0
4th C Level MRI Scanner	0	0	0	650	650	0
CT Scanner	0	0	0	1,560	1,560	0
Total Trust Funded Capital Expenditure	**2,806**	**1,525**	**1,281**	**44,444**	**44,444**	**0**
Externally Funded Schemes						
Asceptic Pharmacy/SSD Building	0	33	(33)	3,000	3,000	0
Community Diagnostic Centre Phase 2 - PDC	0	0	0	775	775	0
Frontline Digitisation	49	0	49	785	785	0
Pathology Digitisation	28	17	11	450	450	0
Total Externally Funded Schemes	**77**	**50**	**27**	**5,010**	**5,010**	**0**
Total CDEL Expenditure	**2,883**	**1,575**	**1,308**	**49,454**	**49,454**	**0**
Outside CDEL Limit						
In year IFR16 Leases	0	0	0	0	0	0
Total Capital Expenditure	**2,883**	**1,575**	**1,308**	**49,454**	**49,454**	**0**

Statement of Financial Position

(Fav Variance) / Adv Variance

The April statement of financial position illustrates net assets of £583m which is £8.1m down on March.

This is predominantly due to the increase in payables which is due to the timing of invoices received. This is accompanied by an increase in receivables and also inventories. The reduction in fixed assets of £3m is driven by the monthly depreciation charge.

Cash remained static at close to £105m but masks an increase in payables for which cash payments will continue to be made in Q1 2023/24. The underlying deficit continues to drive a reducing cash balance over the medium to long term.

Statement of Financial Position	2022/23 - 2023/24		
	M12 Act £m	M1 Act £m	MoM Movement £m
Fixed Assets	620.4	617.2	(3.3)
Inventories	15.8	18.1	2.4
Receivables	88.5	92.9	4.4
Cash	105.0	105.5	0.5
Payables	(224.6)	(237.0)	(12.4)
Current Loan	(1.5)	(1.5)	0.0
Current PFI and Leases	(12.6)	(12.2)	0.4
Net Assets	**590.9**	**582.9**	**(8.1)**
Non Current Liabilities	(23.0)	(22.8)	0.2
Non Current Loan	(5.3)	(5.3)	0.0
Non Current PFI and Leases	(108.6)	(105.6)	3.0
Total Assets Employed	**454.0**	**449.2**	**(4.8)**
Public Dividend Capital	286.2	286.2	0.0
Retained Earnings	102.1	97.2	(4.8)
Revaluation Reserve	65.7	65.7	0.0
Other Reserves			
Total Taxpayers' Equity	**454.0**	**449.2**	**(4.8)**

Efficiency and Cost Improvement Programme

University Hospital Southampton NHS
NHS Foundation Trust

UHS CIP targets for 23/24 have been composed on the following: basis:

A new recurrent CIP cost reduction target for Divisions and Directorates (£25m)

Repeating the value of CIP delivered non-recurrently in 22/23 (£12m)

Contribution from ERF Elective income above the 23/24 plan;
- Additional activity/income above plan (£8.4m),
- Replacing 10% of OPFU with ERF activity

Other Central schemes (£22.6m), including any potential benefit associated with reductions in non-CTR / MOFD bed days

At month 1, UHS has identified £29.7m / 43% of its target for the year.

Recorded delivery in month1 is £1.1m. This is below the planned YTD delivery of £4.1m.

Month 1 CIP	Recurrent ('000s)	Non Recurrent ('000s)	Total ('000s)	Target ('000s)	% Identified
Division A	£1,848	£947	£2,795	£9,068	31%
Division B	£2,092	£717	£2,809	£9,795	29%
Division C	£614	£1,903	£2,517	£8,599	29%
Division D	£1,771	£549	£2,320	£9,281	25%
THQ	£1,535	£685	£2,220	£6,336	35%
Central Schemes	£8,830	£8,210	£17,040	£25,922	66%
Grand Total	**£16,690**	**£13,011**	**£29,700**	**£69,000**	**43%**

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**People Report 2023-24 for Month 1**			
Agenda item:	**5.14**			
Sponsor:	**Steve Harris, Chief People Officer**			
Author:	**Workforce Team**			
Date:	**25 May 2023**			
Purpose:	**Assurance or reassurance** **X**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	The UHS People Strategy (World Class People) sets out our goals to support the delivery of the Trust's Corporate Strategy. The 5-year Strategy, based on the insights from our UHS family, was approved by Trust Board in March 2022. Its key areas of THRIVE, EXCEL, and BELONG shape the work of people focus across UHS. The Monthly People report summarises progress against the delivery of the critical metrics in the strategy. It is provided monthly to Trust Executive Committee and People and OD Committee. The information is based on April 2023 data.			
Response to the issue:	The Chief People Officer can report the following to the Board. Our workforce plan for 23/24 aims to deliver a flat position with no overall growth in the size of our total WTE. This will include continued recruitment to vacancies and new expansions offset by decreases in the use of agency and bank and other targeted reductions. Our workforce planning aligns with our financial position and ICS system and regional plans. • Our efforts on the workforce will focus in 2023/24 on: ○ Targeted recruitment to critical vacancies with controls on non-clinical replacements and new posts ○ Review of our overall establishment levels to ensure affordability. ○ Efforts to further reduce sickness absence through improving prevention measures, a range of well-being measures, and appropriate review of low attendance levels. ○ The recruitment and retention committee will continue leading efforts to reduce attrition. ○ Targeted discrete reductions in posts through CIP plans.			

The plan was constructed in line with national guidance, including the measurement point of Month 10.

In Month 1, UHS is 191 WTE over the workforce plan. This is broken down into 60 WTE substantive staffing and 131 Temp staff. Temporary staffing has seen a reduction in utilisation by 72 overall since March, but this is still greater than planned numbers.

Actions taken:

- Weekly reporting of WTE numbers internally and to the ICB on permanent and temporary staffing
- Expansion in place of posts going through the recruitment control panel (RCP) with rigorous scrutiny at senior level
- Workforce review meetings planned in partnership with finance for May and June to review CIP, and temp staffing expenditure
- Introduction of new leading indicators to the People report on recruitment activity (Adverts placed, offers made) from the M2 report.
- Inclusion of divisional commentary from M2 to enhance narrative and organisational engagement in the report.

Objectives – Year 2 of the People Strategy

Objectives were discussed at the People and OD committee in line with Year 2 of the People Strategy. The committee were supportive of the goals.

This year we will be focusing on critical basics that we know make a difference in our people's lives:

This includes

- Continuing to recruit to critical vacancies to support clinical delivery
- Conversion of agency to bank and bank to substantive where appropriate
- Improving well-being and reducing sickness absence to below 3.9% (rolling average) to drive increased capacity and experience of our people
- Taking a range of measures to reduce rolling turnover to below 13.9% sustainably
- Focusing on improving appraisal rates to 85% support staff development
- Focusing on the delivery of year 1 of our belonging strategy, including focusing on addressing poor cultures and areas of bullying and harassment
- Celebrating our people through various recognition schemes, including our annual awards.
- Overhauling our internal comms to improve engagement

Implications: (Clinical, Organisational, Governance, Legal?)	Implications are for good governance, meeting legal requirements, and providing safe clinical and organisational delivery (as this report includes intelligence on current and future workforce challenges).
Risks: (Top 3) of carrying out the change / or not:	We need to meet our strategic objectives as set out in the business assurance framework for UHS. Specifically: a) We fail to deliver the UHS workforce to meet service demands b) We fail to develop a diverse, compassionate, and inclusive workforce providing a more positive staff experience for all staff c) We fail to create a sustainable and innovative education and development response to meet the current and future workforce needs to be identified in the Trust's longer-term workforce plan.
Summary: Conclusion and/or recommendation	Trust Board is required to: • Note the feedback from the Chief People Officer and the People Report

UHS People Report

WORLD CLASS PEOPLE

May 2023

THRIVE EXCEL BELONG

View from Chief People Officer

April 2023 has seen the lowest sickness level (3.2%) in twelve months, against a revised sickness target of 3.9%. The month has seen 136.5 WTE leavers, one of the highest totals in the last twelve months. Twenty percent (27.5 WTE) were due to retirement.

Our turnover rate on a 12-month rolling basis is now 13.1%, and had been slowly reducing throughout 2022/23. We continue to deliver actions on retention to improve our overall vacancy position.

The total workforce as of M1 is +191 WTE over plan; this is despite improvements in bank and agency usage. The substantive staff total is 60 WTE over the WF plan. Workforce controls were significantly increased in early April for both temporary and permanent workforce.

The objectives for 23/24 have been discussed with the People and OD committee. These primarily focus on the delivery of the workforce plan and year 2 of the People Strategy. There is a focus on temporary resourcing reductions, reductions in absence, turnover, and overall workforce growth control. Revised targets are included within the objectives for turnover, absence, and appraisal

Steve Harris
Chief People Officer

Workforce Summary

HCA Supply
Currently at 19.5% vacancy. HCA SIP increased by +11 WTE in April to 1179 WTE

Turnover
More leavers in April-23 (137 WTE) compared with Mar-23 (88 WTE)

Sickness
Sickness has reduced to 4.1% (r12M), with in-month sickness for April 3.2%

Industrial Action
A daily average of 341 junior medics took strike action in the 4 day strike during Apr 23

THRIVE
In M1 2023/24 UHS is over plan in M1 despite reductions in overall use of temporary staffing.

EXCEL
520 appraisals were recorded in April, a decrease from March

BELONG
Proportion of our staff of BAME backgrounds at B7+ is nearly 11%

Levels of attainment
Job plan sign off has reduced to 14%
Medic eJP is LoA 2

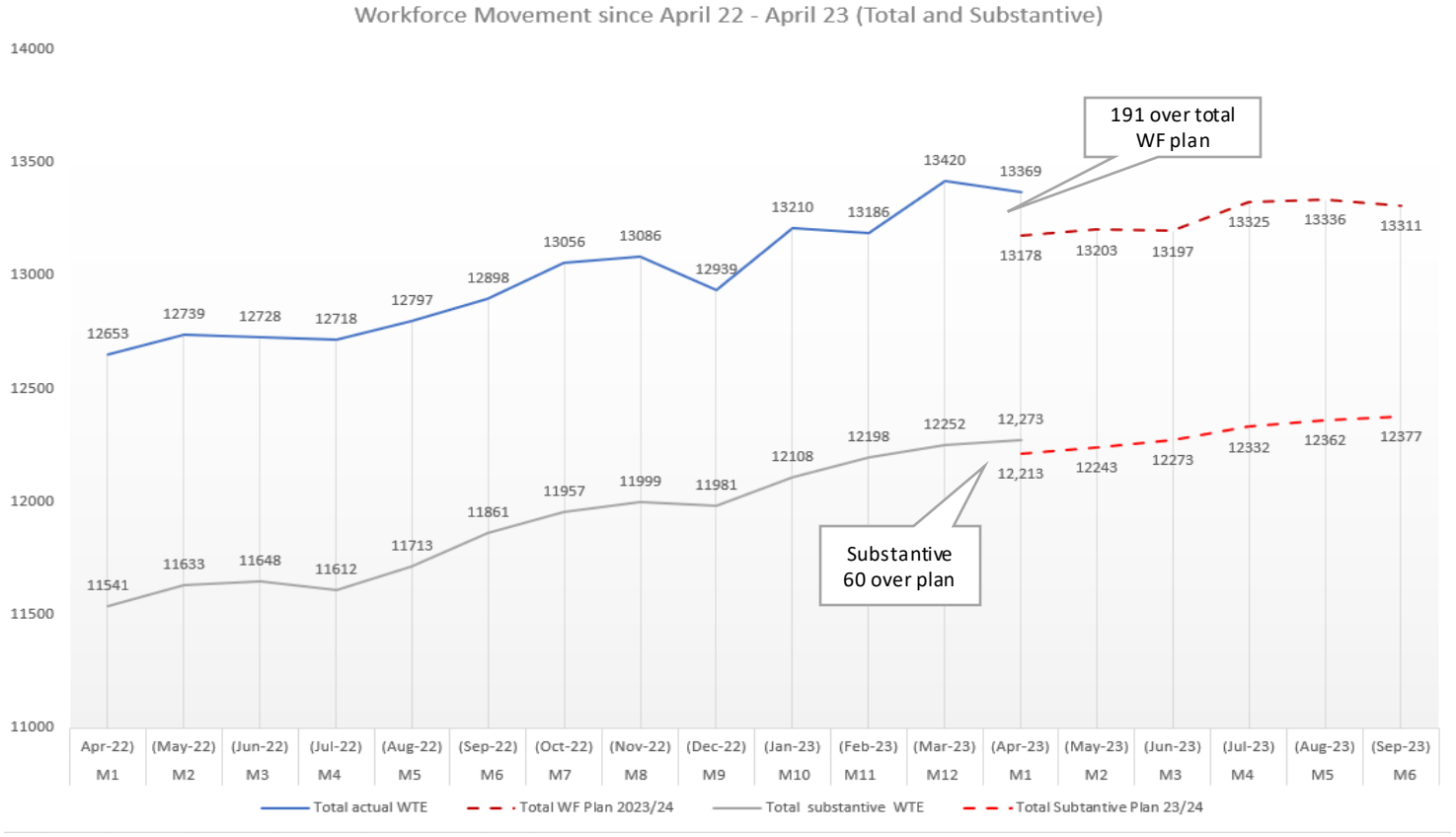
Patient Safety
42 incident reports in April 2023 cited staffing; a decrease from March's 76 reports. This is a significant decrease from the 117 in December 2022

Other contextual updates
Establishment and budget review commenced in April 2023

NHS England and Improvement Operational Planning Update
Planning and budget setting for 23/24 commences; 3% headcount reduction target across divisions (5% for THQ)

People Report

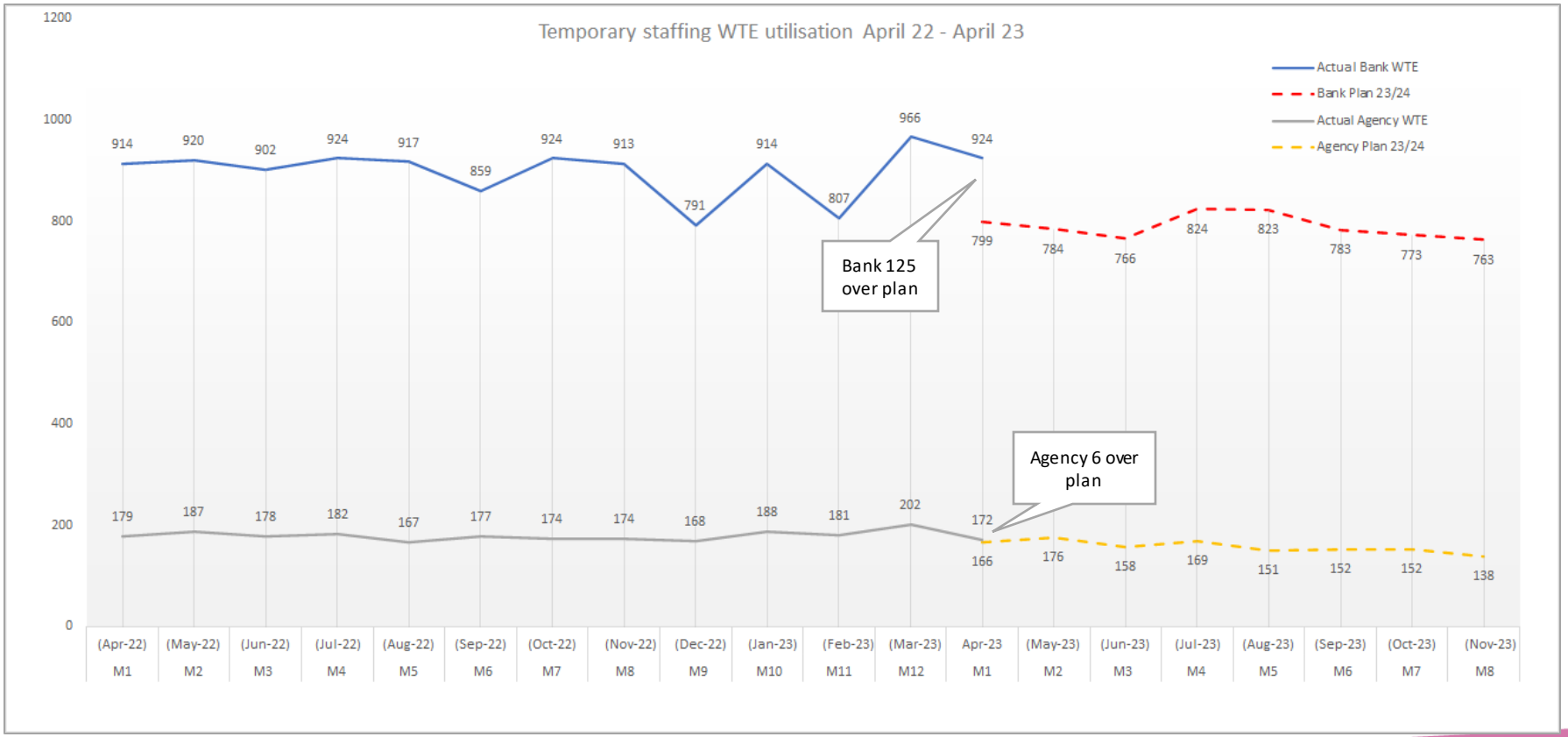
THRIVE | EXCEL | BELONG | PATIENT SAFETY



Source: ESR substantive staff and bank & agency workforce as of 30 April 2023

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY



Source: Bank & Agency Workforce as of April 2023

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

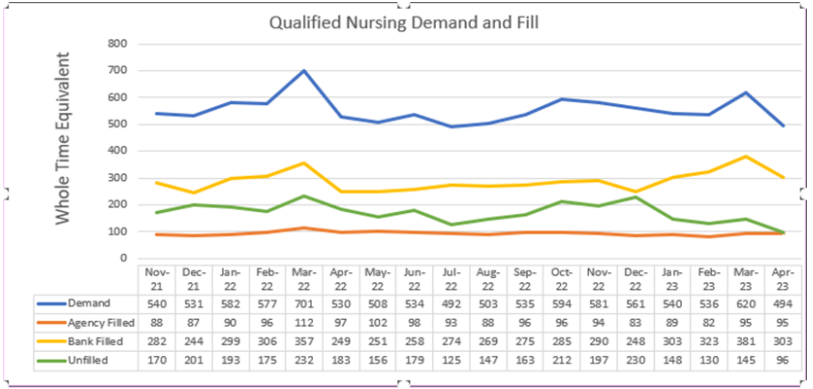
TEMPORARY RESOURCING

Status

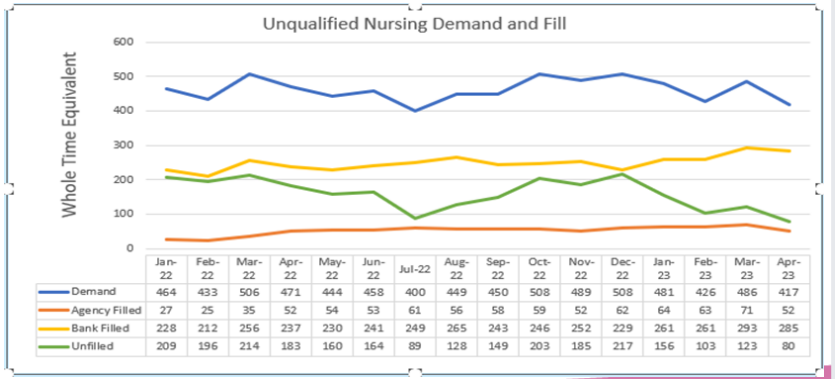
- Qualified nursing demand/fill (WTE): Demand decreased from 620WTE in March to 494 in April, of which, bank filled 303 (78 down on last month), agency filled 95 and 96 remained unfilled
- Bank fill for qualified nursing decreased slightly from 61.41% in March to 61.33% in April.
- Demand for April 2023 is 36 WTE lower than April 2022
- HCA demand/fill (WTE): Demand decreased from 486 WTE in March fo 417WTE in April, of which, bank filled 285, agency filled 52WTE (49WTE were MH HCA's) and 80 remained unfilled
- Bank fill increased from 60.24% in March to 68.26% in April
- Demand for HCA's is 54 WTE lower than in April 2022

Actions.

- Agency switch off for HCA's implemented in April and increased bank fill through the staffing hub.
- Adult Mental Health shifts centralised to the staffing hub which has reduced the average pay rate from £38.41 to £30.28.
- Thornbury spend decreased from £25,316 in March TO £14,301 IN April, this is mostly mental health shifts. It's the lowest spend since October 2021.Only 1 shift was for a general Nurse.
- Continue to review the cascade to make it more difficult for agency to fill.
- Further enhanced bank reductions planned for July 2023.



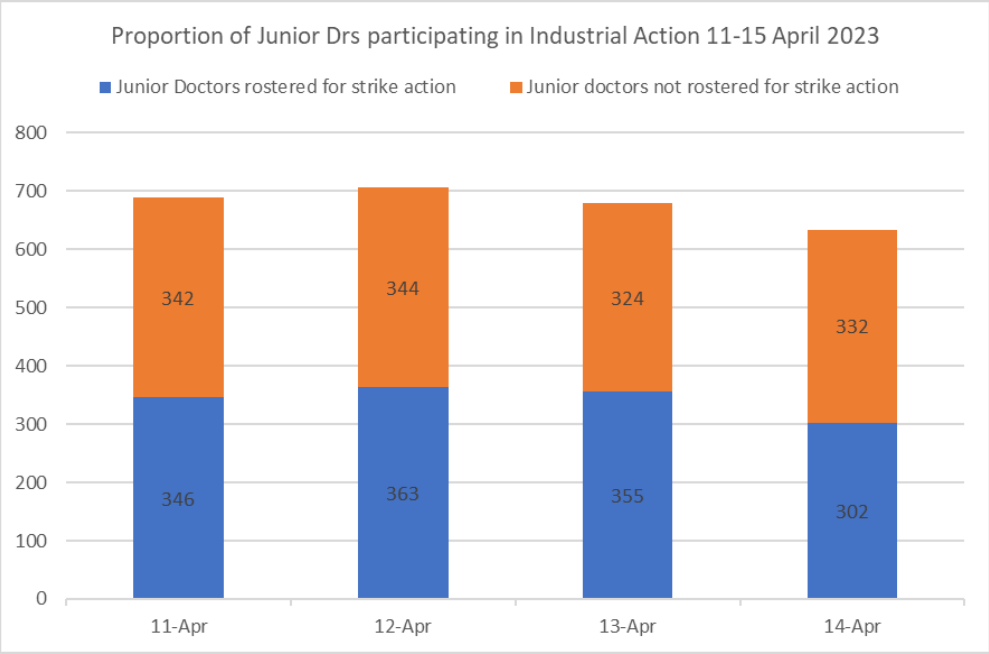
	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Demand	540	531	582	577	701	530	508	534	492	503	535	594	581	561	540	536	620	494
Agency Filled	88	87	90	96	112	97	102	98	93	88	96	96	94	83	89	82	95	95
Bank Filled	282	244	299	306	357	249	251	258	274	269	275	285	290	248	303	323	381	303
Unfilled	170	201	193	175	232	183	156	179	125	147	163	212	197	230	148	130	145	96



	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Demand	464	433	506	471	444	458	400	449	450	508	489	508	481	426	486	417
Agency Filled	27	25	35	52	54	53	61	56	58	59	52	62	64	63	71	52
Bank Filled	228	212	256	237	230	241	249	265	243	246	252	229	261	261	293	285
Unfilled	209	196	214	183	160	164	89	128	149	203	185	217	156	103	123	80

Source: NHSP April 2023

BMA Strike Action – April 2023



The Trust recorded 346 junior doctors rostered for strike action on 11 April, 363 on 12 April, 355 on 13 April, and 302 on 14 April. These figures represent 48-52% of junior doctors who were rostered to work who participated in strike action during this period.

Medicine, Critical Care, Emergency, Surgery and Child Health were the specialties with the highest number of junior doctors rostered for IA during April 2023.

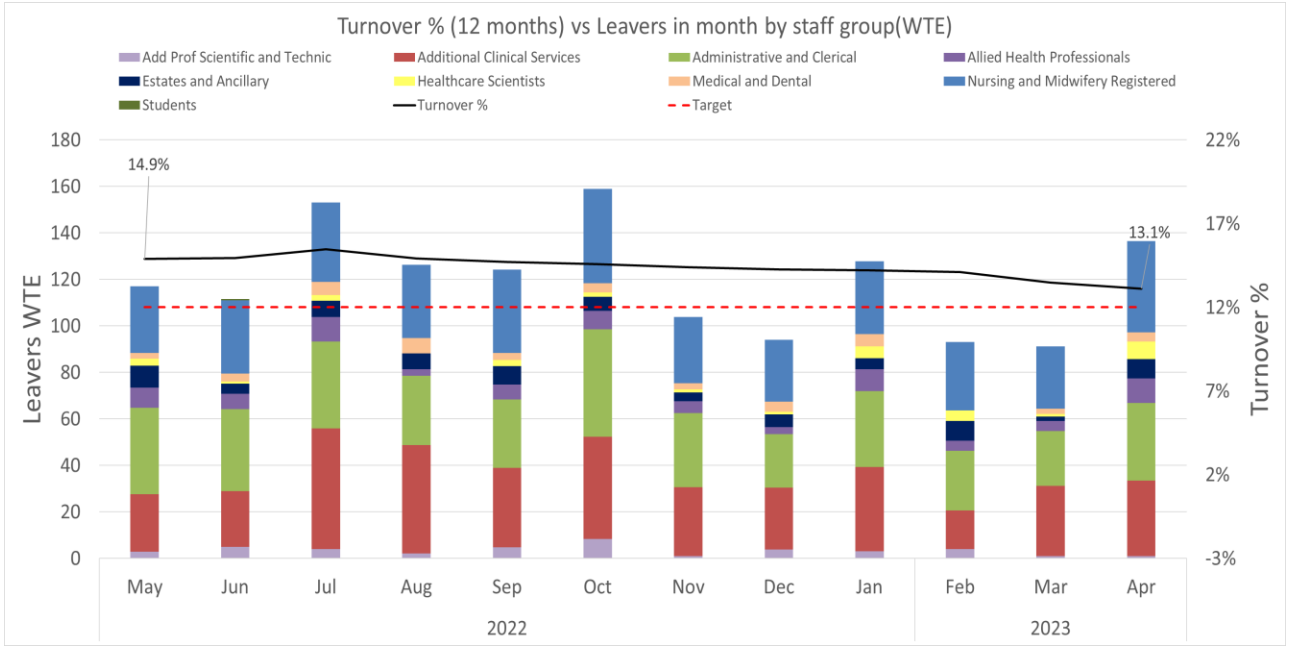
Source: HealthRoster as of 11-14 April 2023

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TURNOVER BY STAFF GROUP

Turnover (12 month rolling) has been decreasing since July 2022; in April 2023 there were 136.6 WTE leavers, which is the highest it has been since October 2022. Turnover is currently 13.1% (rolling 12-month average) which remains higher than the trust-wide target of <12% but is a reduction from 14.9% a year ago.



Staffing group	Leavers (WTE) in month	Turnover 12m rolling %	
Add Prof Scientific and Technic	1	10.90%	↑
Additional Clinical Services	32.5	18.20%	↓
Administrative and Clerical	34.5	16.80%	↓
Allied Health Professionals	10.4	12.10%	↑
Estates and Ancillary	8.4	16.20%	↓
Healthcare Scientists	7.5	7.00%	↑
Medical and Dental	3.9	5.10%	↑
Nursing and Midwifery Registered	39.3	10.40%	↑
UHS total	**137.5**	**13.10%**	↓

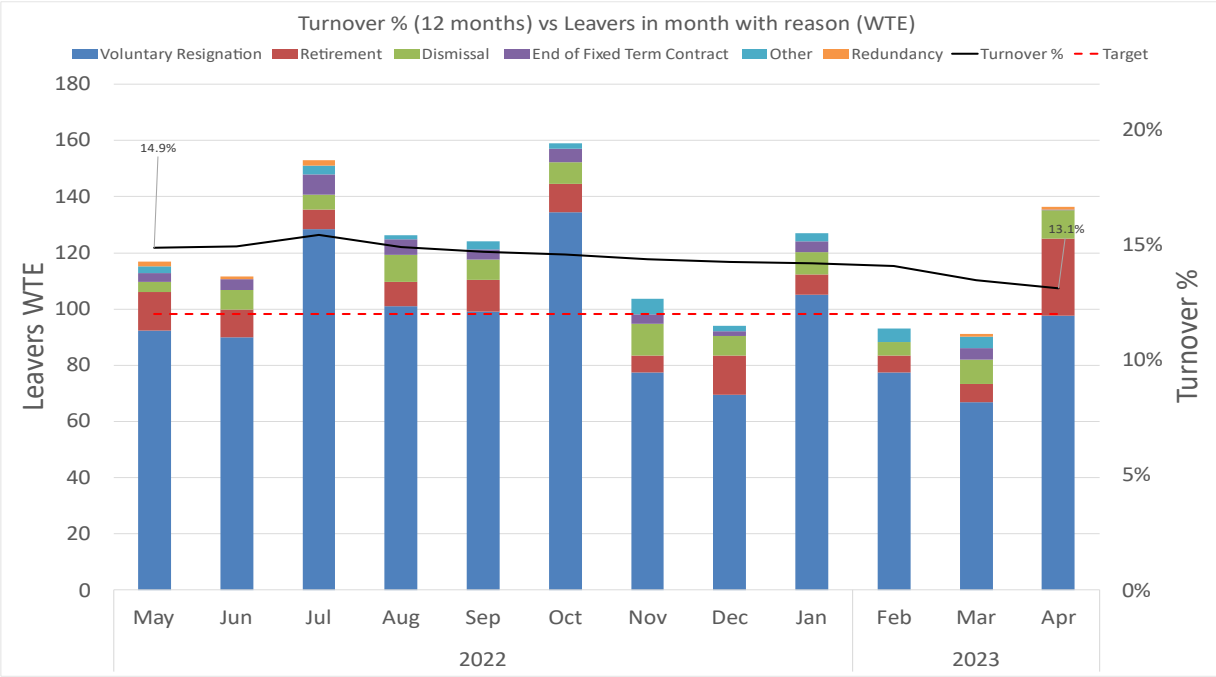
Source: ESR – Leavers Turnover WTE

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TURNOVER BY LEAVING REASON

In April 2023, a total of 136.5 WTE employees left the organisation. The majority of the leavers were voluntary resignations, accounting for 97.6 WTE. Retirement accounted for 27.5 WTE, and dismissal/end of a fixed term accounted for 10.4 WTE.



Staff Group	Exit Survey Primary reason
Additional Clinical Services (includes HCA)	Better pay / reward package
Admin and Clerical	Better pay / reward package
Allied Health Professionals	Retirement
Estates and Ancillary	Better pay / reward package
Healthcare Scientists	Retirement, Change of Career, Want to leave the NHS
Medial and Dental	End of fixed term contract
Nursing and Midwifery	Excessive workload and pressure
Overall Top primary reason	Better pay / reward package

Quarterly Exit Survey data (Q4)
77 responses (25% of leavers completing)

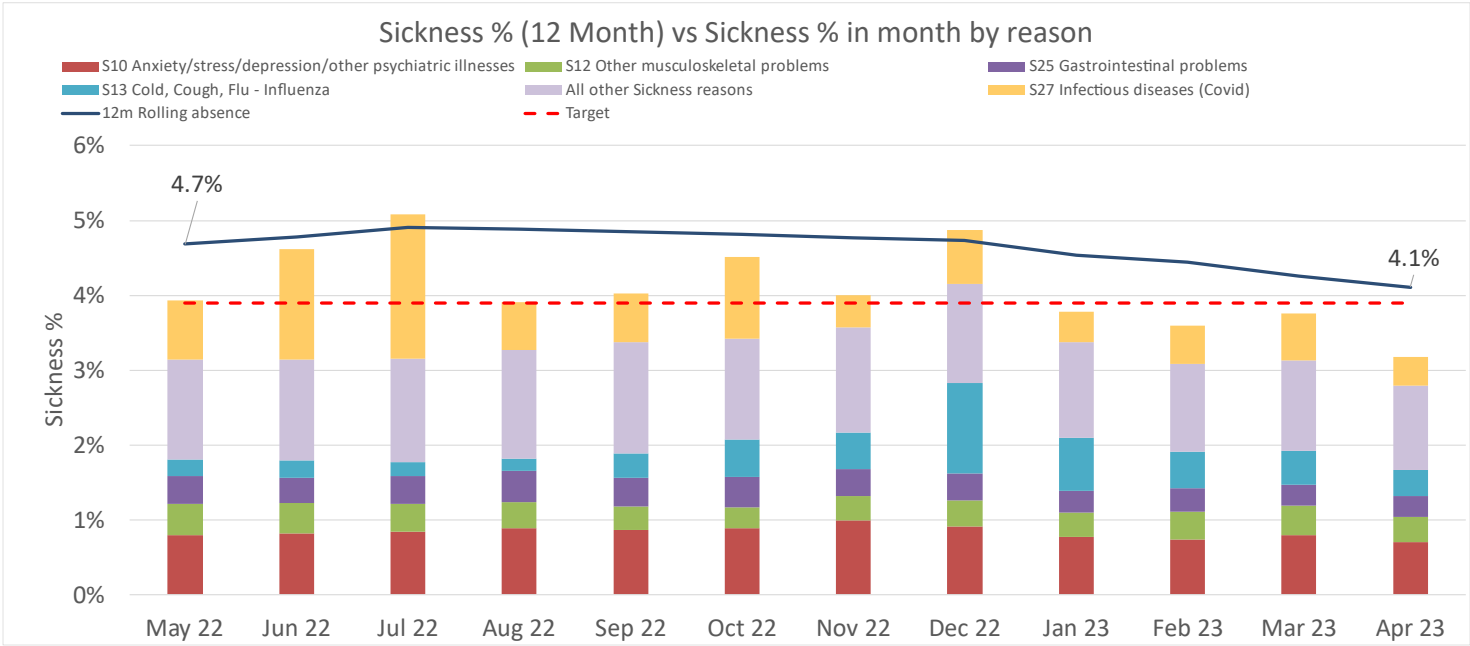
Source: ESR

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

SICKNESS

The rolling sickness rate (4.1%) is lower than 12 months ago (4.7%) and this has been on a downtrend since July 2022. April in-month sickness is 3.19%, which is 0.58% lower than March. The rolling sickness target for 23/24 is 3.9%



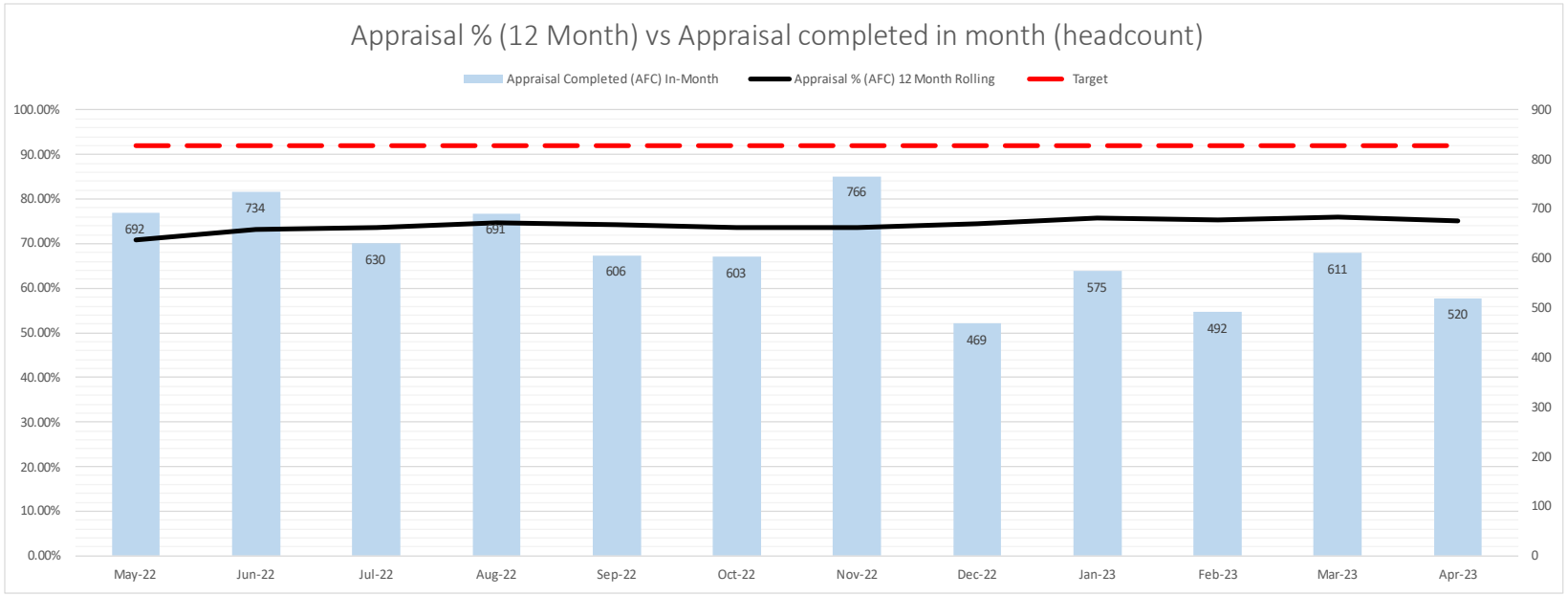
Source: ESR – Sickness data

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

APPRAISALS

In April 2023, 520 appraisals were completed. The rolling 12 month average completion rate has continues to fluctuate around the 75% mark. Appraisal completion has been affected by a combination of factors including annual leave, sickness absence, Industrial Action, and the use of ESR. The Workforce Team are currently scoping the feasibility of moving appraisals to the Virtual Learning Environment (VLE). This is part of an ongoing VLE rebranding project.



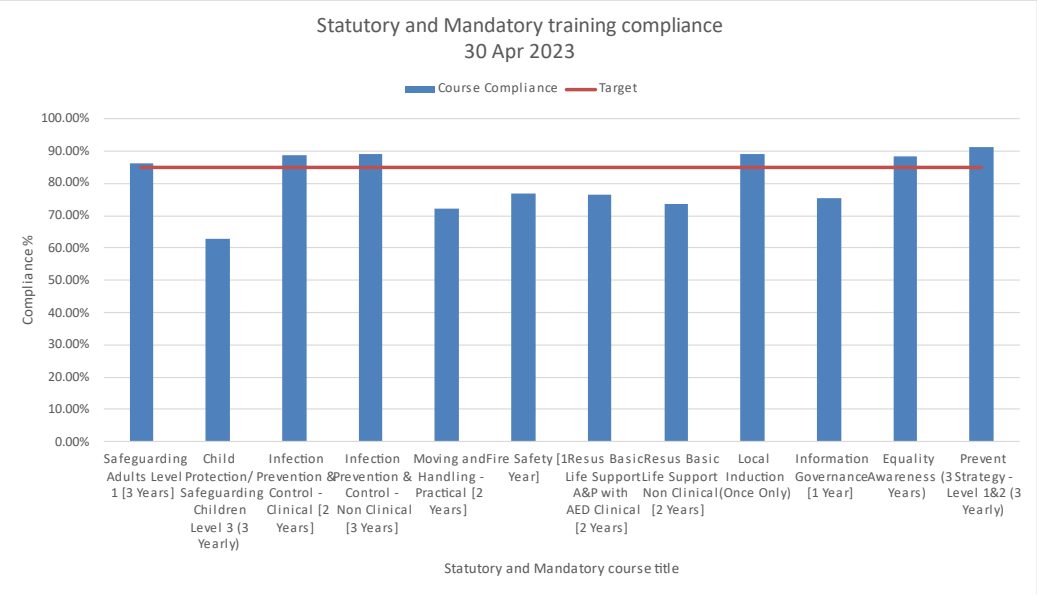
Source: ESR – Appraisal data

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

STATUTORY AND MANDATORY TRAINING

Statutory and Mandatory training and compliance is devolved to the clinical divisions with oversight being held by divisional education leads and flagged at the divisional governance meetings. Benchmarking statutory and mandatory training compliance with other NHS organisations is being carried out, and we are monitoring against the National Core Skills Training Framework. Review of statutory and mandatory training planned for June and July to ensure appropriate content only is included as part of the target in line with national guidance.

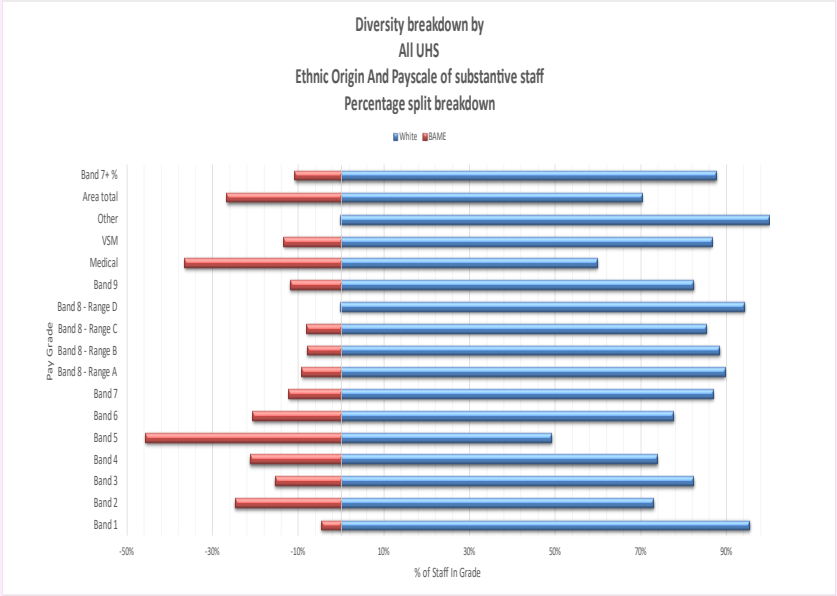


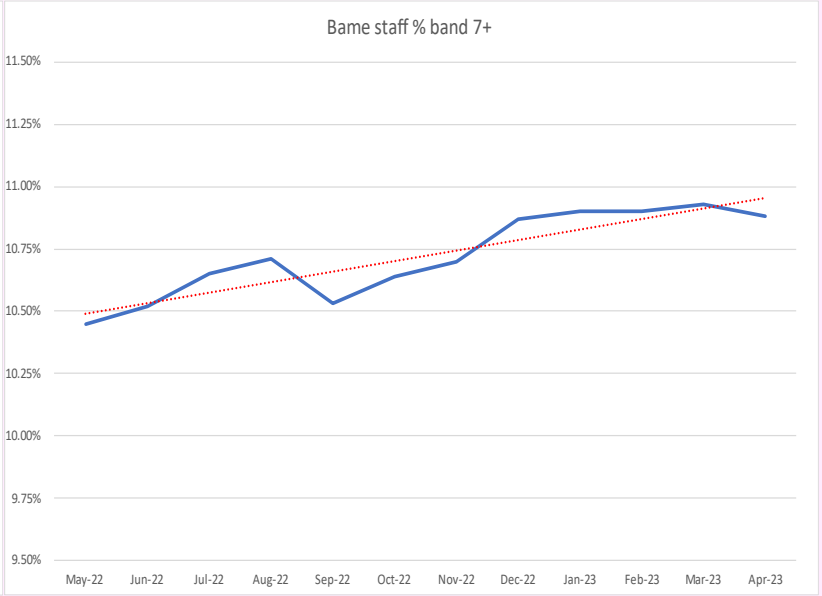
Source: Virtual Learning Environment (VLE)

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

STAFF IN POST - ETHNICITY



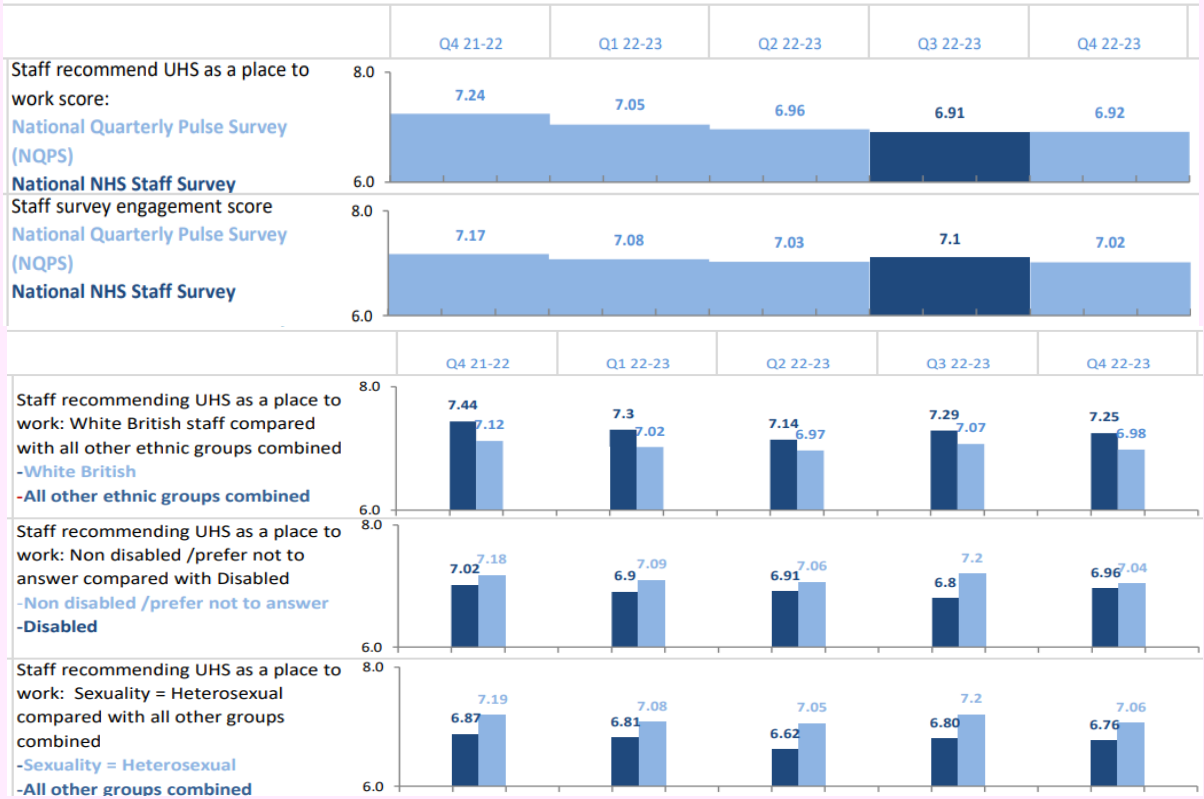


Source: ESR

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

Staff Survey & Pulse Survey



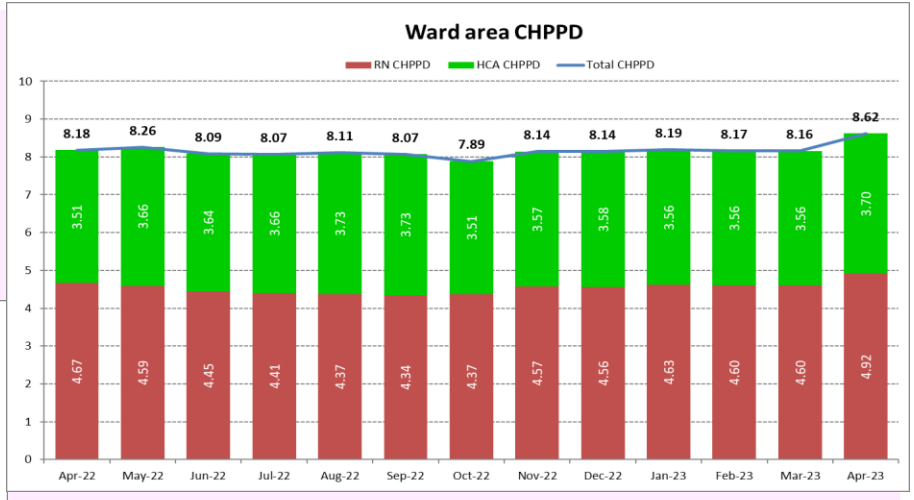
Source: Picker

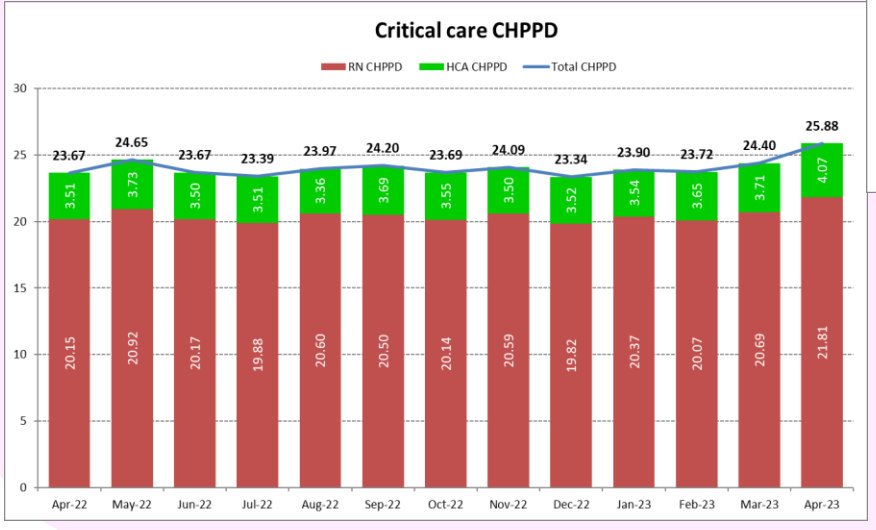
People Report

THRIVE | **EXCEL** | BELONG | PATIENT SAFETY

CARE HOURS PER PATIENT DAY

The Ward areas CHPPD rate in the Trust has increased from last month to RN 4.92 (previously 4.60), HCA 3.70 (previously 3.56) overall 8.62 (previously 8.17). Factors affecting CHPPD is linked to increasing patient numbers and the budgets of additional winter pressure areas available to include in the report this month (THR F10, Eye SSU, Bursledon House).





The CHPPD rate in Critical care has increased overall from last month. RN 21.81 (previously 20.69), HCA 4.07 (previously 3.71) overall 25.88 (previously 24.40). 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..

Source: HealthRoster & eCamis

Appendix – Data Sources

Metric	Data Source	Scope
Industrial Action	HealthRoster	All staff rostered for strike action during IA periods
Substantive Staff in Post (WTE)	ESR (Month-end contracted staff in post; consultant APAs; junior Doctors Extra Rostered Hrs	Exclusions: Honorary contracts; Career breaks; Secondments; Hosted services; UPL; UEL; WPL
Temporary Staffing (WTE)	Bank: ESR (Overtime & Excess Hours, WLI); NHSP (Bank); HealthRoster and MedicOnline (Medical Bank) Agency: NHSP (Non-medical); 247 Time (Medical & Non-medical)	No exclusions
Vacancies	ESR	Hosted services excluded
Turnover	ESR (Leavers in-month and last 12 months)	Trainee Doctors excluded
Sickness	ESR (Sickness absence in-month and last 12 months)	No exclusions
Appraisals	ESR (Appraisals completed in-month and last 12 months)	AfC staff only
Statutory & Mandatory Training	VLE	No exclusions
Staff in Post (Ethnicity & Disability)	ESR	No exclusions
Pulse Survey	Picker (Qualtrics)	No exclusions
Care Hours PER Patient Day (CHPPD)	HealthRoster (In-month shifts) eCamis (In-month daily patient numbers)	Clinical inpatient wards, Critical Wards, and ED only

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Corporate Objectives 2023-24**			
Agenda item:	**6.1**			
Sponsor:	**David French, Chief Executive Officer**			
Author:	**Kelly Kent, Head of Strategy and Partnerships**			
Date:	**25 May 2023**			
Purpose	**Assurance or reassurance**	**Approval** **y**	**Ratification**	**Information**
Issue to be addressed:	Each year our corporate objectives are revised to reflect both our strategy and our operating environment.			
Response to the issue:	The paper proposes UHS Corporate Objectives for year 2023/24. This year our corporate objectives are informed by the strategic ambitions set out in 'Our Strategy 2021-25' and incorporate: • Ongoing recovery of our elective services from the impact of the pandemic facilitated by demand / capacity equilibrium, transformation projects and our Always Improving Strategy. • Building effective clinical networks. • Establishing UHS as an anchor organisation within our community and the ICS. • Continuing to support and retain our world class workforce. • Deliver the UHS financial plan for 23/24 within the wider ICS context. Through discussions during the annual strategy and transformation planning process, it is proposed that, compared to 22/23, fewer and more over-arching objectives are appropriate for 23/24.			
Implications: (Clinical, Organisational, Governance, Legal?)	Determining appropriate corporate objectives which are aligned to our values, strategic ambitions, legal and regulatory requirements will have positive impacts.			
Risks: (Top 3) of carrying out the change / or not:	In the absence of objectives, we would risk: • progress towards our longer term strategic ambitions • not being able to monitor and measure progress or make corrective adjustments when required			
Summary: Conclusion and/or recommendation	The proposed objectives are recommended to the Board for approval.			

Outstanding patient outcomes, safety, and experience

1) Increase the number of reported Shared Decision-Making conversations as evidenced by SDMQ9 questionnaires to >700.
2) Increase number of specialties reporting outcomes that matter to patients to >90%.
3) Roll out PSIRF across the trust by March 2024.
4) Work with patients as partners to improve patient satisfaction in 5 targeted areas: wayfinding, PSIRF rollout, fundamentals of care, activities, and carer involvement.
5) Treat patients according to need but aim for no patient to wait, other than through patient choice, more than 65 weeks for treatment by March 2024.

Pioneering research and innovation

1) Deliver national metrics for site set-up and time to target for clinical research studies (80%) .
2) Improve Trust position against peers to secure Top 5 ranking for CRN portfolio weighted recruitment, and Top 10 ranking for absolute recruitment.
3) Deliver year 3 of the research and innovation investment plan including the Southampton Emerging Therapies and Technologies Centre (SETT), Research Leaders programme (RLP) and delivery infrastructure.
4) Develop the five-year R&D strategy implementation plan for Research for Impact and deliver year 1.
5) Strengthen and broaden the UHS-UoS partnership through mapping alignment and characterising our Research Centres of Excellence.

World Class People

1) Support the delivery of our workforce plan for 23/24 through recruitment to key vacancies, reductions in temporary staffing, and targeted CIP.
2) Reduce turnover to below 13.6% and sickness absence to 3.9% by March 2024.
3) Increase overall participation in the NHS staff survey and maintain our overall staff engagement score and recommendation of place to work in line with comparator organisations (Feb 2024).
4) Increase the proportion of appraisals completed and recording to 85%, and increase staff quality perception of appraisal, by March 2024.
5) Deliver year 1 objectives of the Inclusion and Belonging strategy by March 2024.

Networks and Collaboration

1) Work in partnership with acute trusts to agree and implement the acute services (and planned care) strategy.
2) Produce and embed an internal framework for network development to drive delivery in critical/ prioritised networks, demonstrated by progress against the UHS networks maturity matrix.
3) Work with the Local Delivery System on vertical integration with ambition to halve number of patients without criteria to reside in UHS.
4) Work with system partners to open the surgical elective hub in Autumn 2024.

	5) UHS to be seen as an anchor institution in the local area and have developed projects with partners eg University Technical College (business case approval) and Southampton Renaissance Board (city masterplan).
	Foundations for the future 1) Deliver the UHS financial plan for 23/24, achieving a run-rate breakeven position by April 24. This will be supported by delivery of the CIP plan and improvements in productivity across all Divisions/Departments. 2) Engage the organisation in the challenge to manage demand so that capacity and demand are in equilibrium. 3) Delivery of the Always Improving strategy priorities, including transformation on out-patients, in-patient flow, optimising operating services and organisational culture. 4) Deliver our capital programme in full, including new wards, theatres and neonatal unit redevelopment. 5) Enter into a new Energy Performance Contract and deliver year 1 of the Public Sector Decarbonisation Scheme.

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**CRN Wessex 2022-23 Annual Report**			
Agenda item:	**6.2**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Author:	**Clare Rook, Chief Operating Officer, CRN Wessex** **Graham Halls, Business Intelligence Manager, CRN Wessex**			
Date:	**25 May 2023**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **x**
Issue to be addressed:	• This report covers Clinical Research Network (CRN) Wessex's performance in the 2022/23 financial year (April 2022 to March 2023) against the Department of Health and Social Care's (DHSC) high level objectives (HLOs) for research, and other local metrics.			
Response to the issue:	• The Wessex region is performing well, relative to the English average, on DHSC HLOs to meet recruitment ambitions, provider participation in research and responses to the National Institute of Health and Care Research's (NIHR) Participant in Research Experience Survey (PRES). • The CRN Wessex partner organisations and the CRN's core team have worked together on several initiatives to build a thriving and balanced research portfolio, support the development of a skilled research delivery workforce and begin to identify and engage with communities currently under-served by research opportunities.			
Implications: (Clinical, Organisational, Governance, Legal?)	• All NHS organisations have a duty to their local population to participate in and support health and care research. The NIHR provides service support and grant funding to facilitate research activity within Wessex. Therefore, CRN Wessex and its partner organisations must ensure that this is used effectively during the recovery, resilience, and growth period of health and care research following the COVID-19 pandemic.			
Risks: (Top 3) of carrying out the change / or not:	• CRN Wessex maintains a risk register which can be found in appendix one. The main identified risks are: o End of LCRN contract September 2024 o Winter pressures o Junior doctor strikes. *Please review the risk register in appendix one for details of the already underway or planned responses.*			

Summary: Conclusion and/or recommendation	• COVID-19 studies accounted for less than ten per cent of research activity in 2022/23, having been predominant in previous years. The recovery of the NHS research portfolio in Wessex has been successful during the year, with all sponsors in the region engaging in a DHSC-requested review of the viability of their studies. • The region has met most national high level objectives. A commercial study objective was not met; however, this report demonstrates that performance is trending upward in Wessex. Forty-two per cent of GP practices were research active (ambition forty-five per cent), but with more regional research hubs planned for 2023/24, there will be an opportunity for increased GP participation by identifying and engaging patients. Recruitment to the National Institute of Health Research's Participant in Research Experience Survey exceeded Wessex's allocated target, with over 1,500 responses. • NIHR-supported research is happening across the region in all specialties and care settings, with over 39,000 participants in 2022/23. Overall recruitment and the number of recruiting studies reduced year-on-year, but the complexity of the studies has increased. In addition, commercial activity has increased in the majority of NHS trusts and care settings outside of hospitals. • The Board will continue to be updated on performance quarterly.

University Hospital Southampton
NHS Foundation Trust

NIHR | Clinical Research Network Wessex

CRN Wessex 2022-23 Performance Report

Clare Rook, Chief Operating Officer
Graham Halls, Business Intelligence Manager

May 2023

Introduction

This report informs the UHS Board of Directors of the clinical research activities within the Wessex region. The report covers COVID-19 research, the performance against the National Institute of Health and Care Research's (NIHR) high level objectives, and general research activity in Wessex. This report focuses on the 2022/23 financial year (April 2022 to March 2023).

Key issues

National areas of strategic focus for health research

In June 2021, the Department of Health and Social Care (DHSC) and the National Institute of Health and Care Research (NIHR) published a paper titled *Best Research for Best Health: The Next Chapter*. The report outlined seven areas of strategic focus for the NIHR (Figure 1). These focus areas guide NIHR-supported research activities in Wessex. The areas of strategic focus were also the themes of the 2022/23 CRN Wessex annual plan, under which the network led many regional and national initiatives (see more).

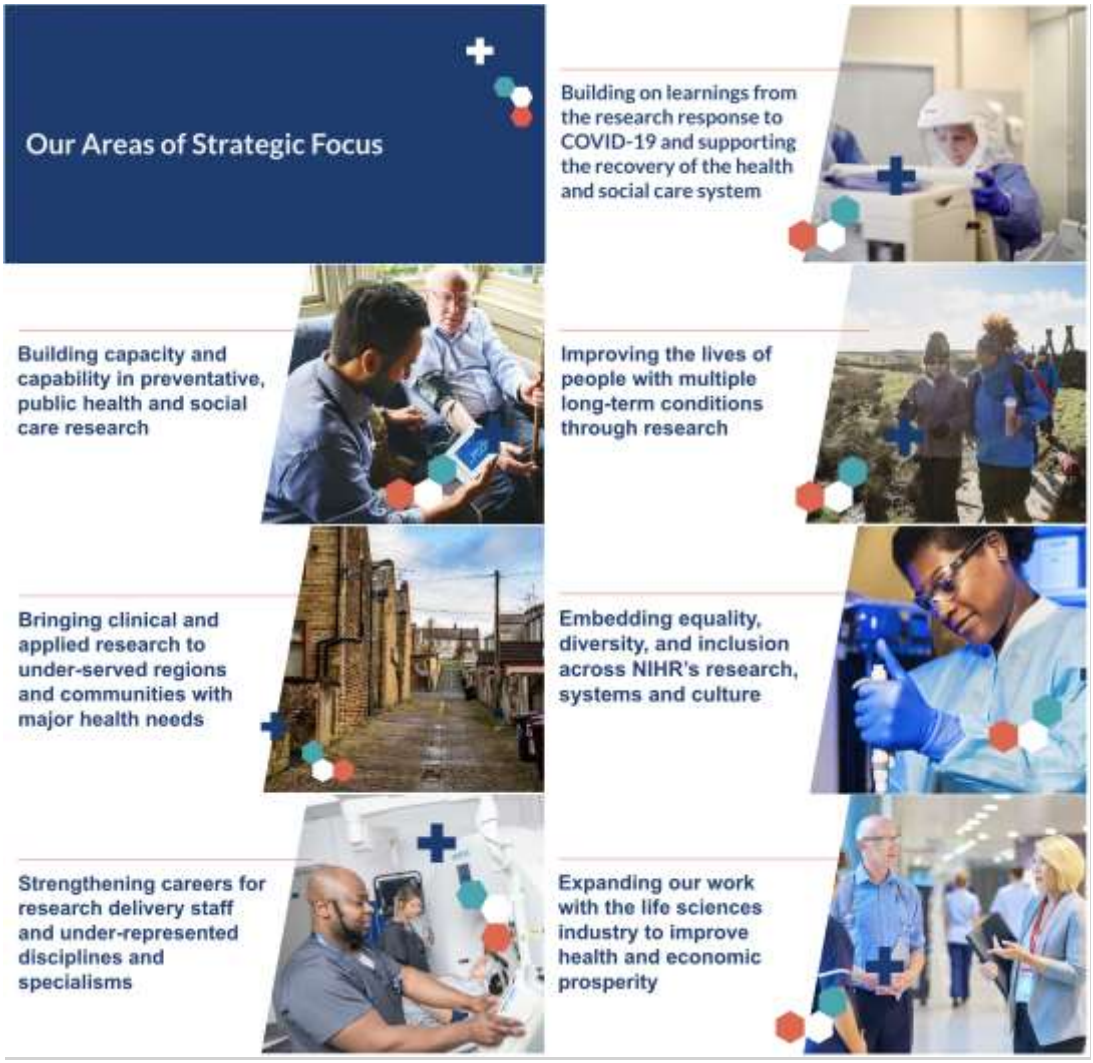


Figure 1 - NIHR Areas of strategic focus from Best Research for Best Health: The Next Chapter.

COVID-19 response and the subsequent recovery and growth of the research system

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

COVID-19 research study recruitment reduced to seven per cent of the total in Wessex at the end of the 2022/23 financial year (Figure 3), following a slight increase during the winter season. CRN Wessex now considers most research activity in the area to be business as usual. Since the start of the COVID-19 pandemic, over 206 thousand participants (patients, carers and staff) were recruited in the Wessex region to 111 studies investigating the disease, supported by over 300 staff (Figure 2). This vast research programme has left a legacy of cross-organisational collaborative research within the region and an innovative model for the delivery of studies, for example, by removing duplication in contracts and further decentralising research activity across the region (community hub, bus and ambulance-based).

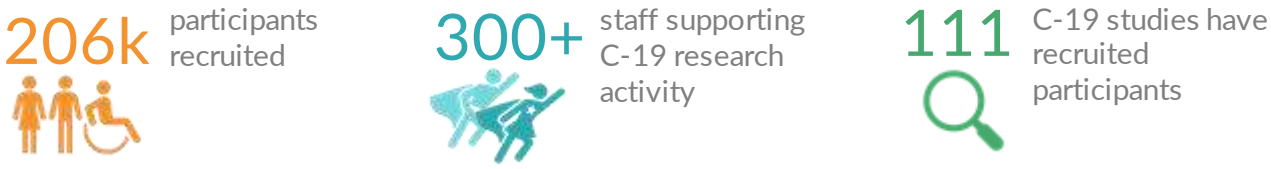


Figure 2 – Summary of COVID-19 research activity in Wessex.

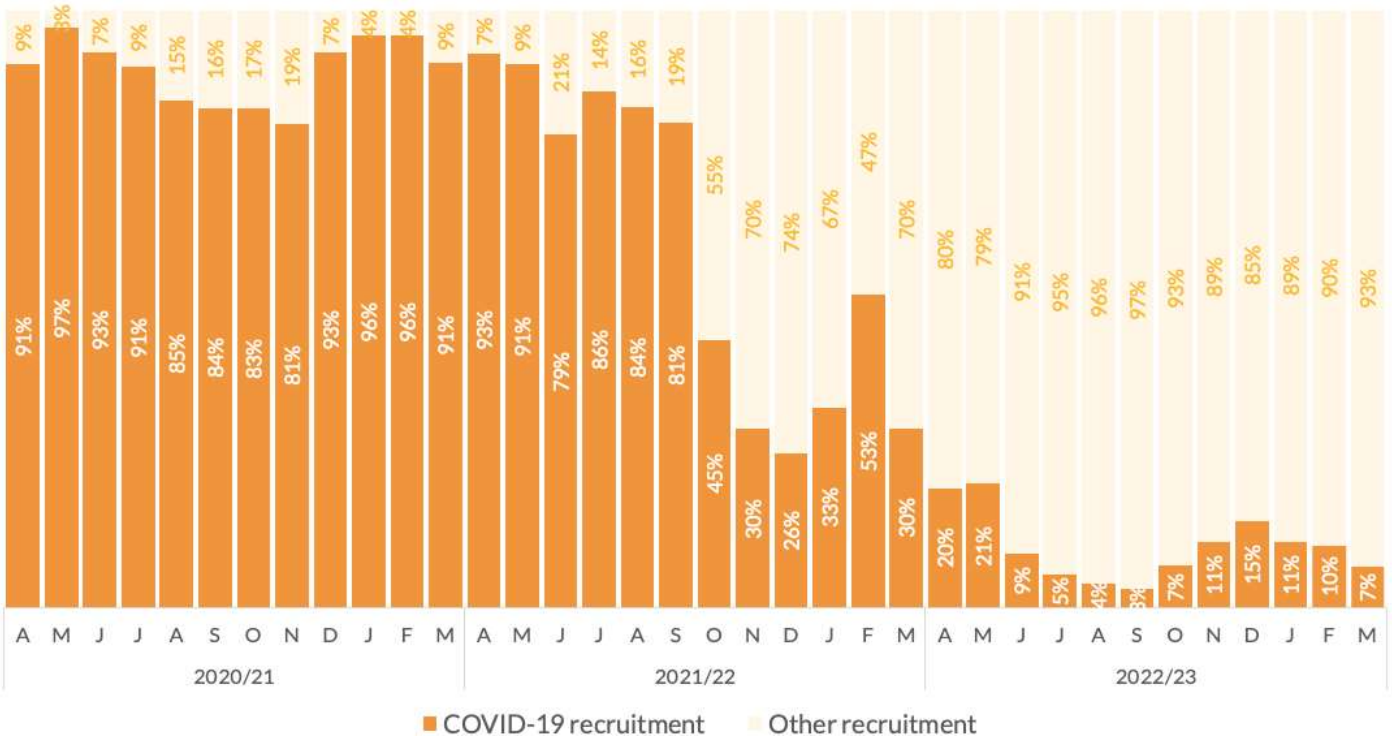


Figure 3 – COVID-19 recruitment as a proportion of Wessex activity: April 2020 - March 2023.

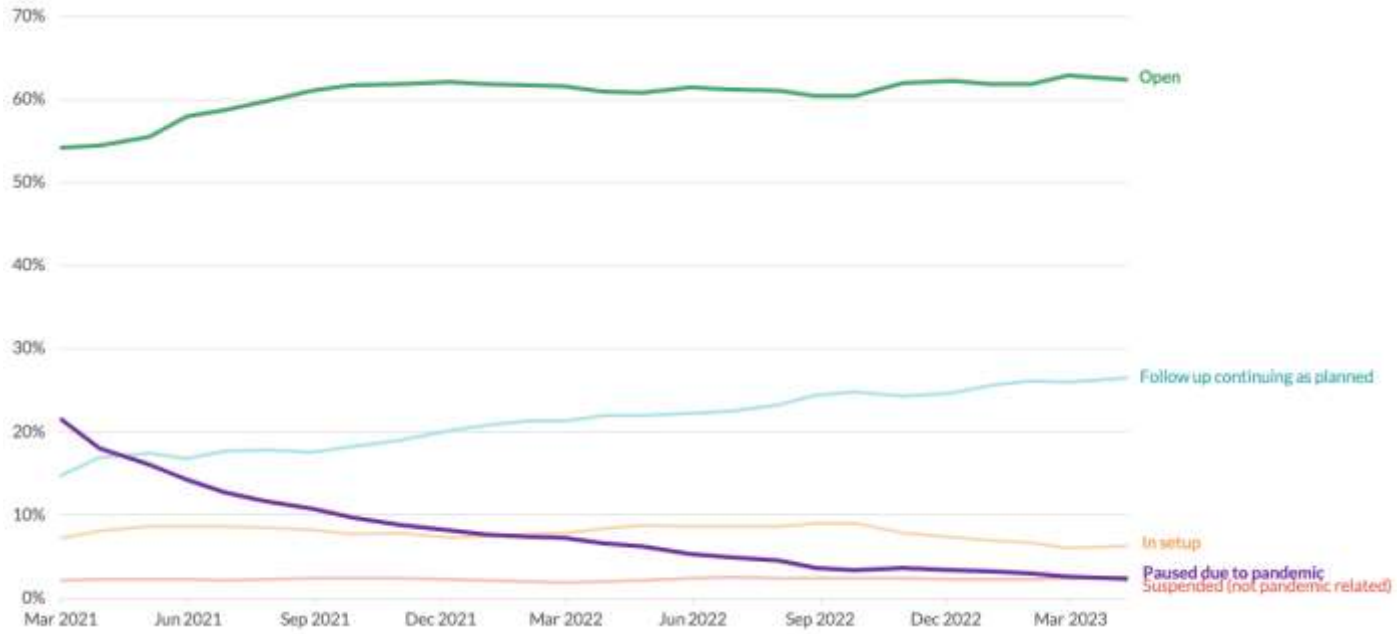


Figure 4 - Wessex research site statuses indicating the recovery following the COVID-19 pandemic.

The pandemic resulted in the pause, and in some cases, closure, of many active research studies in the region. Figure 4 illustrates what has happened in the area during the recovery of the research portfolio. Less than five per cent of Wessex research study sites are now paused for a reason related to the pandemic. As studies have closed to recruitment, the burden of participant follow-up has also increased over time. Study sites paused during setup are opening or being abandoned more recently because the majority of staff capacity diverted to the pandemic has returned.

The Department of Health and Social Care's (DHSC) focus during the 2022/23 financial year has been on resetting and recovering health and care research. The DHSC's 'Research Reset' programme (Research Recovery and Reset | NIHR) is supported by local sponsors and CRN Wessex. It aims to make CRN research portfolio delivery achievable within planned timelines and sustainable within the resource and capabilities the UK currently has in the NHS. The secondary aim is to free up capacity across the research system by working with funders and sponsors to support the review of studies that have already been completed or that are unlikely to be able to deliver their endpoints.

As of May 2023, all studies with a Wessex sponsor have been reviewed, and the sponsor and funder's intention for the study has been recorded for the DHSC (Figure 5). Sponsors have chosen to close thirty-one studies, with a further forty-six recognised as off-track and being addressed. However, most studies are recorded as 'on track to meet their milestones'. The Research Reset programme has now become

business as usual, with expectations from the DHSC of an ongoing review of studies by sponsors and funders.

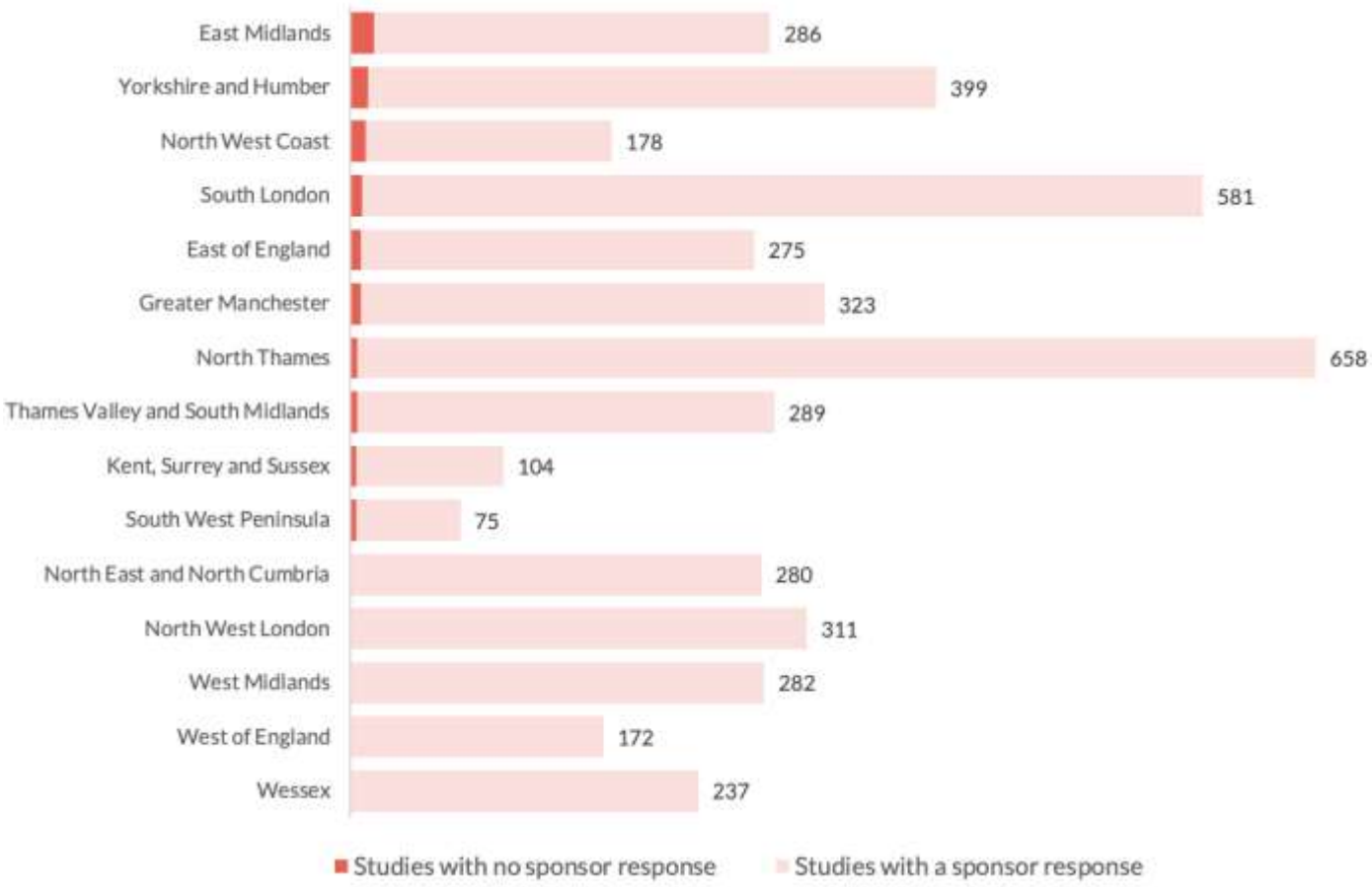


Figure 5 - Summary of DHSC Reset programme responses from study sponsors by local clinical research network region.

DHSC & NIHR Clinical Research Network high level objectives (HLOs) for 2022/23

The purpose of the NIHR CRN is to provide efficient and effective support for initiating and delivering funded research in the NHS and other health and care settings. The performance of the NIHR CRN in meeting this purpose is measured against the HLOs. These are outlined in Figure 6, with current Wessex and English (all local CRNs combined) performance linked to ambitions agreed with the DHSC.

The HLOs, summarised in Figure 6, focus on three areas:

1. *Efficient study delivery:* recruitment meeting the targets and timelines agreed upon with sponsors,
2. *Provider participation:* NHS organisations and general practices actively delivering research, *and*

3. *Participant experience:* delivery of the national Participant in Research Experience Survey (PRES).

Objective		Measure	Ambition	Wessex	England
Efficient study delivery	Deliver NIHR CRN Portfolio studies to recruitment target	(1) Percentage of closed to recruitment commercial studies which have achieved their recruitment target	80%	60% (6/10 Wessex-led studies)	80%
		(2) Percentage of closed to recruitment non-commercial studies which have achieved their recruitment target	80%	86% (50/58 Wessex-led studies)	90%
		(3) Percentage of open to recruitment commercial contract studies which are predicted to achieve their recruitment target	60%	65% (24/37 Wessex-led studies)	68%
		(4) Percentage of open to recruitment non-commercial studies which are predicted to achieve their recruitment target	60%	63% (95/150 Wessex-led studies)	66%
Provider participation	Widen participation in research by enabling the involvement of a range of health and social care providers	(1) Percentage of General Medical Practices with recruitment in NIHR CRN Portfolio studies	45%	42% (111/262)	44%
		(2) Percentage of NHS Acute trusts with recruitment in NIHR CRN Portfolio studies every quarter	99%	Q1 100% (7/7) Q2 100% (7/7) Q3 100% (7/7) Q4 100% (7/7)	Q1-4 100%
		(3) Percentage of NHS Acute trusts with recruitment in commercial contract NIHR CRN Portfolio studies every quarter	70%	Q1 71% (5/7) Q2 71% (5/7) Q3 71% (5/7) Q4 86% (6/7)	Q1-4 74%
		(4) Percentage of NHS Ambulance, Care and Mental Health trusts with recruitment in NIHR CRN Portfolio studies every quarter	95%	Q1 100% (4/4) Q2 100% (4/4) Q3 100% (4/4) Q4 100% (4/4)	Q1-4 94%

Objective		Measure	Ambition	Wessex	England
Participant experience	Demonstrate to participants in NIHR CRN supported research that their contribution is valued through collecting their feedback and using this to inform improvement in research delivery	Number of NIHR CRN Portfolio study participants responding to the Participant Research Experience Survey	1,237	1,516 (123%)	18,000 ambition (national response TBC)

Figure 6 – Local and national performance for the DHSC & NIHR CRN High Level Objectives for the 2022-23 financial year.

For *Efficient study delivery* measures one and two, the region under-performed against the English average for commercially funded and sponsored studies and exceeded the ambition for non-commercial research studies. These metrics track studies led by Wessex organisations that have closed in the 2022/23 financial year. There were fewer locally led commercial studies than in other regions (ten in total); therefore, the effect of four closing below their targets disproportionately reduced Wessex's average performance.

Wessex-led open commercial and non-commercial studies achieved the sixty per cent ambition in measures three and four. The goal is expected to increase to eighty per cent for both in the 2023/24 HLOs.

For a study to meet its recruitment target, its participating sites across the UK must perform well. The CRN plans to address the geographical challenges by working closely with local chief investigators, who will have more significant influence over the sites participating in their study. LCRNs have recently completed a national pilot project that moves the performance review leads for commercial studies from a central coordinating centre to the LCRN where each study's chief investigator is based. The intended effect of this project is to bring commercial study performance up to be in line with non-commercial studies, which already have a decentralised approach to performance review. Performance on this HLO will continue to be monitored in 2023/24.

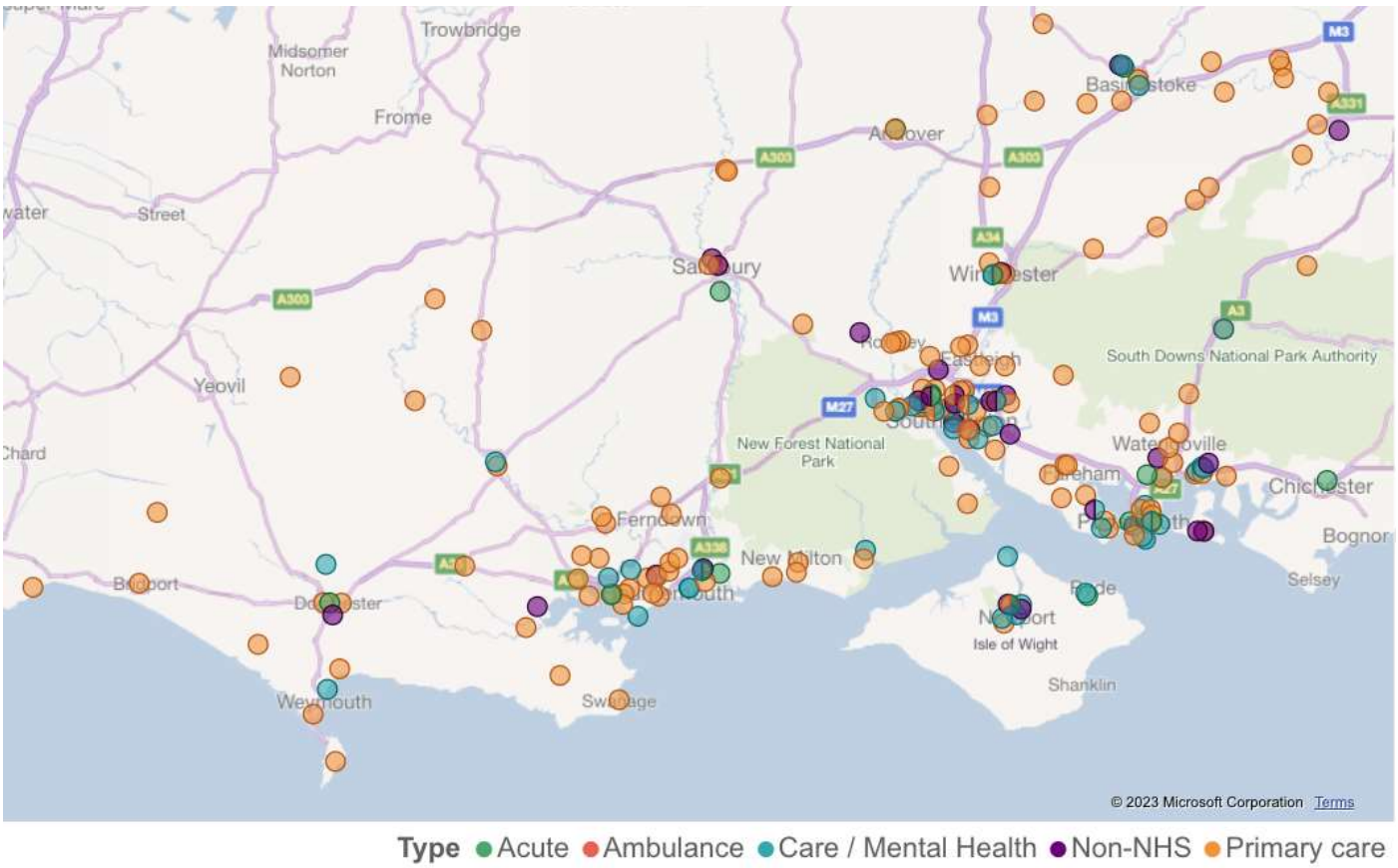


Figure 7 – Recruiting research sites in Wessex in the 2022-23 financial year by health and care type.

For *Provider Participation,* all NHS trusts, over a hundred GP practices and thirty-three sites in the ambulance and non-NHS care settings in the region are research active (Figure 8). 2022/23 research activity covered the whole Wessex region (Figure 7). The wide geographical distribution of all types of research study is essential so that all communities can access and experience the benefits of participating in research. Where communities are considered under-served through lack of access, a higher healthcare burden than research activity or reduced engagement (see the NIHR INCLUDE project), CRN Wessex funds small-grant projects, working with community charities and other local organisations to increase research activity. This successful programme has returned in 2023/24 with a ringfenced budget of £200,000.

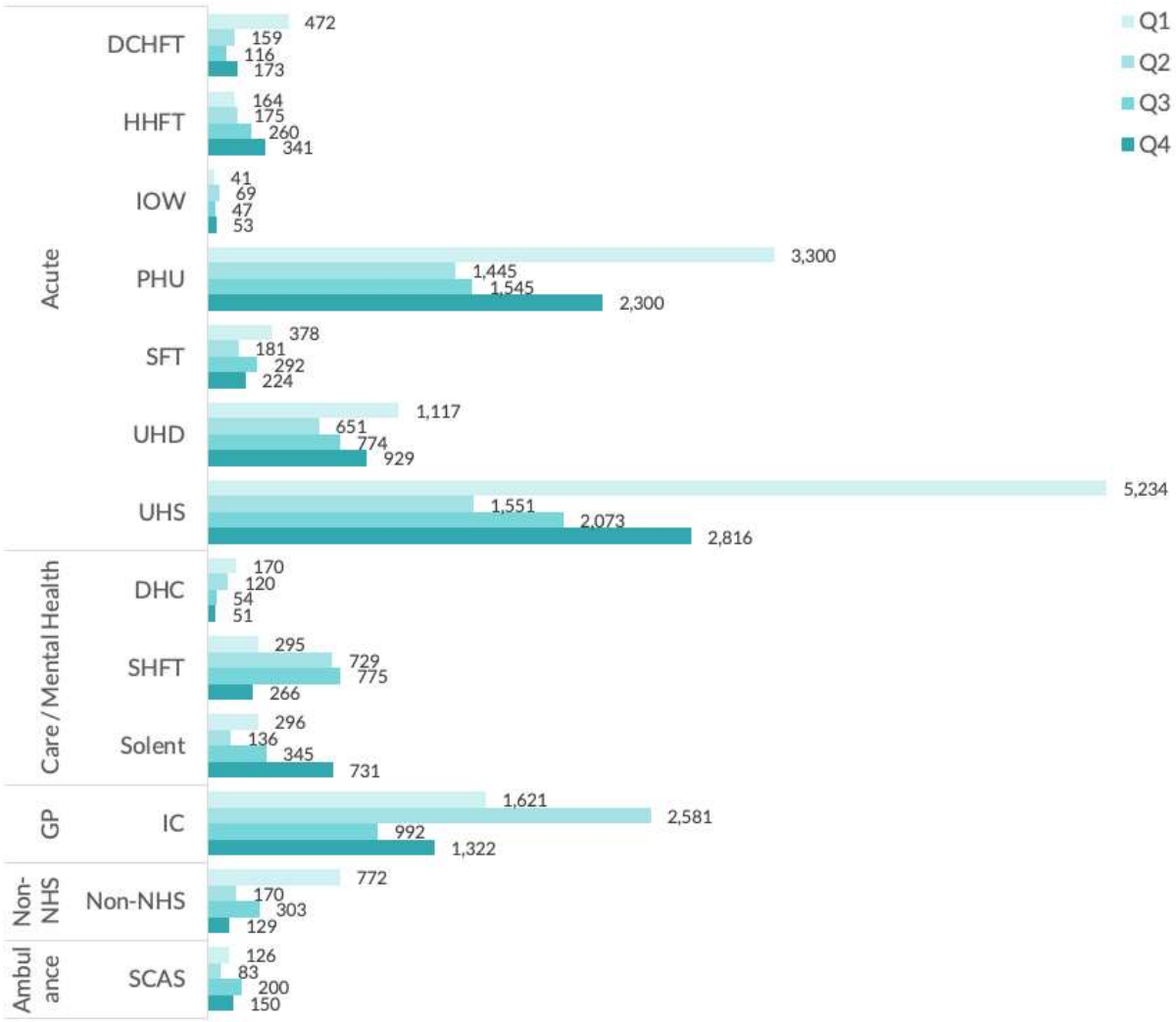


Figure 8 – Quarterly CRN Portfolio study recruitment by organisation type in Wessex for quarters one to three of the 2022-23 financial year.

The final *Participant Experience* HLO relates to the responses to the PRES participant survey, with an ambition for Wessex of 1,237 completed surveys (Figure 9). This ambition was exceeded in 2022/23, with over fifteen hundred responses from organisations across the region. The survey results will be provided in a report due to be completed in the summer of 2023.

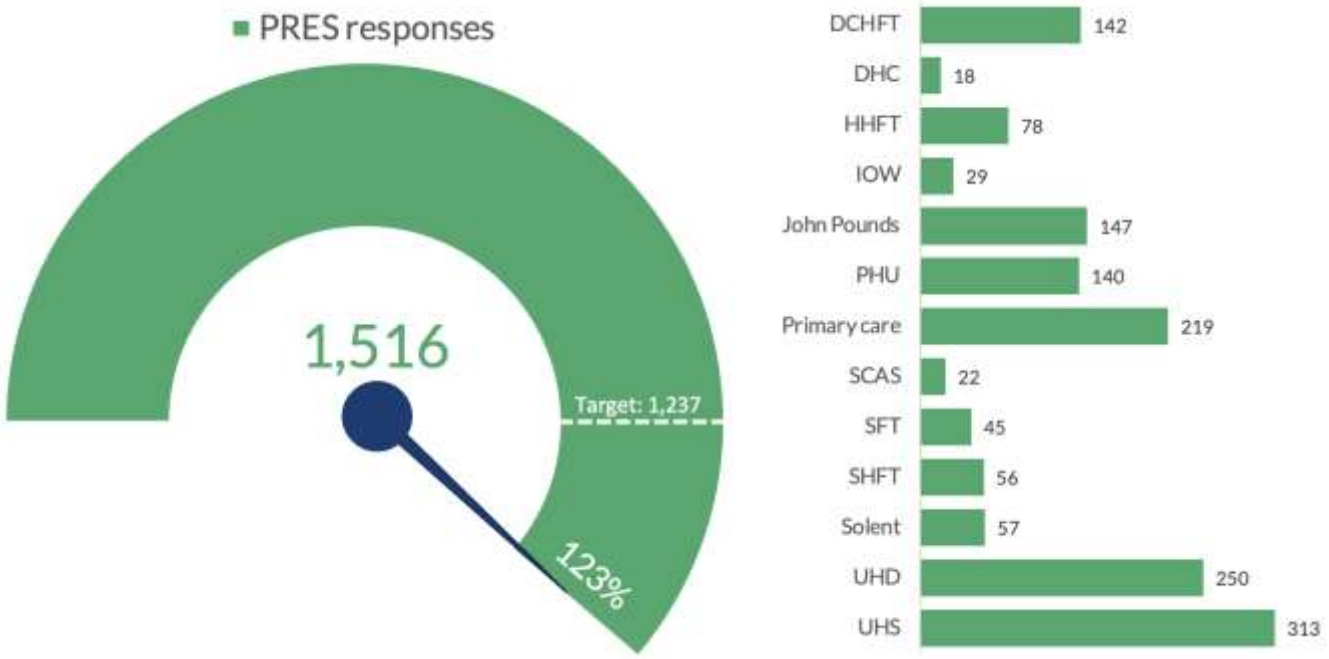


Figure 9 - Participant in research experience survey recruitment in Wessex in the 2022-23 financial year.

Research activity in Wessex

Research activity in Wessex

Over the last two financial years, recruitment has been benchmarked against England's activity in Figure 10. Over 39,000 participants were recruited in Wessex during the year, approximately four per cent of the English total. There has been a general reduction in recruitment activity year-on-year for Wessex and England.

The pandemic response led to the development of abnormally large studies as the world endeavoured to find treatment options and address other aspects of the disease's effect on patients and staff. With the pandemic ending, the portfolio of research activity and capacity for delivery has needed time to recover. The result, based on CRN Wessex's analysis in late 2022, was that Wessex had delivered fewer, smaller, more-complex research studies, therefore affecting the overall recruitment. Recruitment is not a high level objective but is considered a measure of access to research. The CRN will continue to track recruitment and provide this in future Board reports.

Figure 10 - Wessex research recruitment benchmarked against England for the last two financial years (2021/22 to 2022/23).

The number of studies that have recruited in Wessex each quarter since April 2018 is shown in Figure 11. The four quarter rolling average indicates some recovery towards pre-pandemic levels, but in 2022/23, it was maintained at the same level. A goal of the DHSC's Research Reset programme is to reduce the number of studies that were open but not likely to achieve their endpoints.

Figure 11 - Recruiting studies by funding type in the last five financial years.

Commercial research activity in Wessex

Commercial research, funded and sponsored by the life sciences industry, is important to the Wessex region. It provides novel treatment options for patients, supports the expansion of research infrastructure and often generates savings on treatment costs for participating organisations.

Figure 12 - Percentage of Wessex sites on commercial studies that closed each financial year meeting their recruitment target assigned by the sponsor.

The high level objectives are national and focus on the performance of studies rather than participating sites. However, when Wessex's site performance is considered on commercial studies led from any region, Wessex has exceeded the eighty per cent ambition (Figure 12). The excellent site performance further demonstrates the recovery of commercial research following the pandemic.

The Sanofi HARMONIE trial, led by UHS, was the largest commercial trial in England. The trial enrolled over 4,000 participants during 2022/23 from 107 sites. HARMONIE aimed to reduce hospitalisations for patients with the respiratory syncytial virus. Recruitment took place in all major care settings in Wessex and other regions, demonstrating a collaborative delivery model that will be replicated with a future pipeline of vaccine trials.

Commercial recruitment increased year-on-year at the majority of Wessex organisations (Figure 13). Some organisations participated in commercial research for the first time in several years, and activity outside the hospital setting increased, bringing the studies into the community.

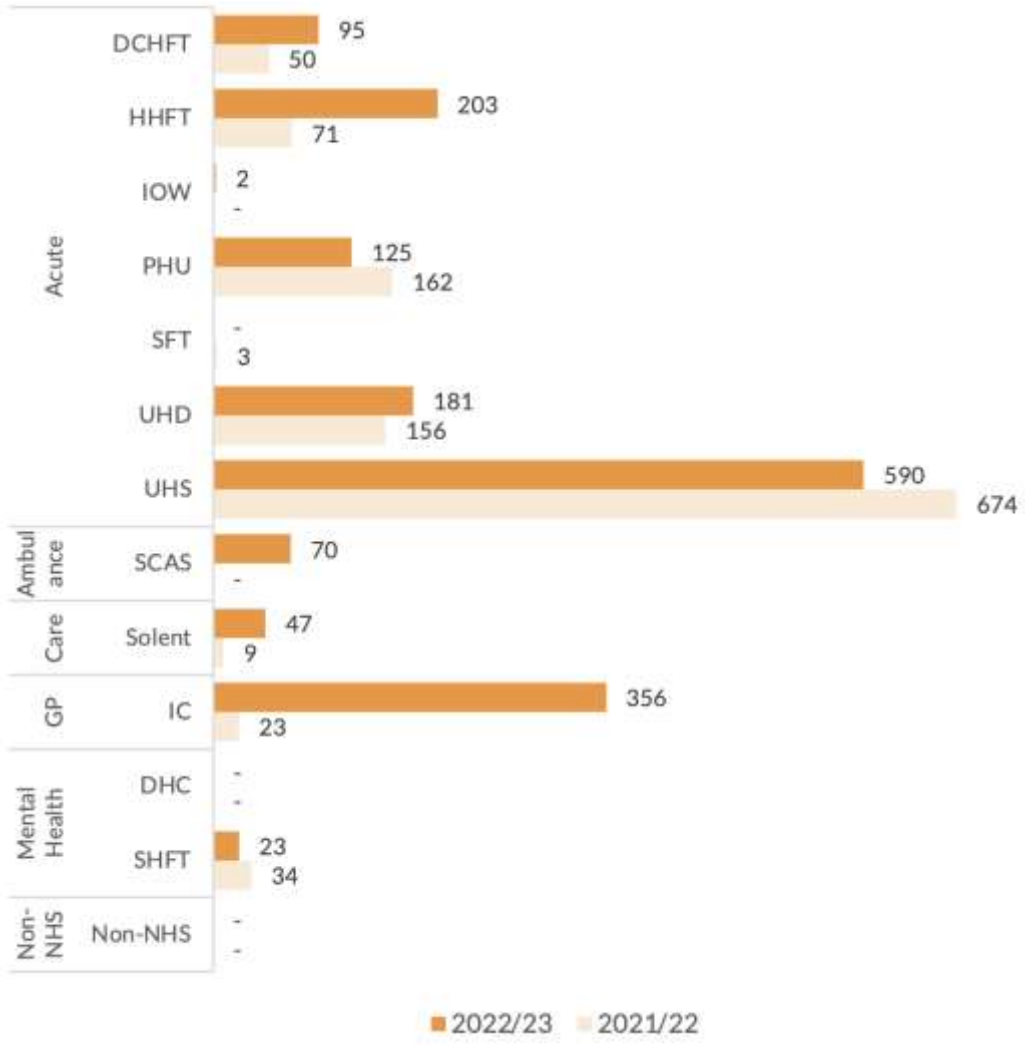


Figure 13 - Wessex commercial study recruitment by organisation in the 2022/23 financial year, compared to 2021/22.

Appendix

Appendix 1 – CRN Wessex Risk Register

PRE-RESPONSE (INHERENT)									POST RESPONSE (RESIDUAL)							
Risk ID	Primary category	Date raised	Risk Owner	Risk Description (to include cause/event, and effect)	Probability	Impact	Value (PxI)	Proximity	Response Actions	Action owner(s)	Action status	Probability	Impact	Value (PxI)	Risk status (open or closed date)	Trend (since last reviewed)
CRN 06	Performance	Jun-20	CDs/COO	Cause: Future waves of Covid-19 pandemic Event: Leading to a reduction in research capacity in NHS and social care Effect: Meaning recruitment to all studies, including priority studies, may be detrimentally affected by future waves of Covid infections. In *extremis* CRN funded staff may be redeployed to clinical duties and shortages in staffing will be exacerbated by staff sickness, sheilding and isolating.	3	4	12	Current	1. Agile staff deployment supported by contractual arrangements between partners and the host. 2. Strong clinical leadership to motivate staff and provide first-hand intelligence to the partners 3. Wessex workforce campaign to recruit additional staff to DDT 4. Active support for POs to restart non UPH studies e.g weekly calls with POs 5. Core team returning to 40/60 split of office/home January 2022	WFD Lead / COO / SSS Lead	All - ongoing	3	3	9	Open	Decreased
CRN 05	Workforce	Mar-20	CDs/COO	Cause: Staff turnover Event: Leading to gap in continuity of service provision and loss of institutional memory Effect: Meaning that the performance of the Network is adversely affected	2	3	6	Current	1. Talent management within team 2. PDPs with identified training needs and subsequent provision of appropriate learning opportunties 3. Job shadowing opportunities 4. Succession planning, e.g deputy COO role 5. Strongly embedded workforce wellbeing initiatives	COO / CD	All - ongoing	2	2	4	Open	Decreased
CRN 06	Workforce	Aug-21	CDs/COO	Cause: Lack of availability of registered nurses Event: Leading to a shortfall in registered staff qualified to deliver clinical trials Effect: Meaning that fewer clinical trials are delivered	4	4	16	Current	1. DDT based from research hubs to relieve trust based research nurses 2. Recruit band 3 CTAs and train up to band 4 level to relieve existing nursing staff of some duties 3. Recruit CRPs to relieve existing nursing staff of some duties 4. Recruitment campaign to attract graduates to research delivery careers	WFD Lead/COO	All - ongoing	2	2	4	Open	Decreased
CRN 7	Workforce	Aug-21	CDs/COO	Cause: Staff burnout Event: Lack of registered staff to deliver clinical trials Effect: Meaning that fewer clinical trials are delivered	2	4	8	Current	1. Ongoing recruitment to the direct delivery team 2. Reinvestment of hub income to increase head count	WFD/COO	All - ongoing	2	2	4	Open	Decreased
CRN 8	Performance	Mar-22	CDs/COO	Cause: Fuel prices/fuel shortage Event: Cost of fuel becomes prohibitively expensive/fuel shortages prevent core delivery team travel across the region to deliver trials Effect: Meaning that fewer clinical trials are delivered	3	4	12	Current	1. DDT based nearer hub locations could pick up some work 2. Look for opportunities for remote trial delivery	COO/DCOO	All - ongoing	3	3	9	Open	Decreased

PRE-RESPONSE (INHERENT)									POST RESPONSE (RESIDUAL)								
Risk ID	Primary category	Date raised	Risk Owner	Risk Description (to include cause/event, and effect)	Probability	Impact	Value (Pxl)	Proximity	Response Actions	Action owner(s)	Action status	Probability	Impact	Value (Pxl)	Risk status (open or closed date)	Trend (since last reviewed)
CRN 9	Performance	Mar-22	CDs/COO	**Cause: Supply chain issues** **Event: Cost of fuel becomes prohibitively expensive/fuel shortages impact on supply chain for drugs and consumables required for trial delivery** **Effect: Meaning that fewer clinical trials are delivered**	2	4	8	Current	1. Raise locally and nationally for advice on prioritisation of key activities/studies	COO/DCOO	All - ongoing	2	4	8	Open	Static
CRN 10	Workforce	Sep-22	CDs/COO	**Cause: End of LCRN contract September 2024** **Event: Exisiting staff may leave for other roles in the system to avoid uncertainty, leading to a depleted team and difficulty delivering to the POF. Difficulty recruiting into vacant posts for the final 'transition' year (2023/24)**	4	4	16	Current	1. Raise locally and nationally for advice on prioritisation of key activities/studies	COO/DCOO	All - ongoing	4	4	16	Open	Static
CRN 11	Performance	Oct-22	CDs/COO	**Cause: Winter pressures** **Event: Staff shortages due to sickness impacting on delivery, pharmacy, imaging: redeployment of research staff to clinical services**	4	4	16	Current	1. Raise locally and nationally for advice on prioritisation of key activities/studies	COO/DCOO	All - ongoing	4	4	16	Open	Static
CRN 12	Performance	Nov-22	CDs/COO	**Cause: Nurses strike action** **Event: Lack of research nurses to deliver clinical trials due to strike action and redeployment to cover emergency care**	4	3	12	Current	1. Raise locally and nationally for advice on prioritisation of key activities/studies	COO/DCOO	All - ongoing	4	3	12	Open	Static
CRN 13	Performance	Feb-23	CDs/COO	**Cause: Teacher strike action** **Event: Staff shortages due to childcare responsibilities**	3	3	9	Current	1. Raise locally and nationally for advice on prioritisation of key activities/studies	COO/DCOO	All - ongoing	3	3	9	Open	Static
CRN 14	Performance	March	CDs/COO	**Cause: Junior doctor strike action** **Event: Redeployment of clinical staff to cover emergency care leading to lack of staff to deliver clinical trials**	5	3	15	Current	1. Raise locally and nationally for advice on prioritisation of key activities/studies	COO/DCOO	All - ongoing	5	3	15	Open	Static

Appendix 2 - Glossary

Partner organisation abbreviations used by CRN Wessex:

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

Local clinical research network or devolved nation abbreviations and their 2022/23 financial year population:

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

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Research and Development Plan 2023-24**			
Agenda item:	**6.3**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Author:	**Karen Underwood, Director of R&D; Chris Kipps, Clinical Director of R&D; Laura Purandare, Deputy Director of R&D; Marie Nelson, R&D Head of Nursing and Health Professions**			
Date:	**25 May 2023**			
Purpose:	**Assurance or reassurance**	**Approval** X	**Ratification**	**Information**
Issue to be addressed:	The purpose of this paper is to inform Trust Board of the plans for 2023-24 to enable delivery against the Corporate Objectives and to seek approval from Trust Board for the UHS R&D Annual Plan 2023-24. The proposed corporate objectives for R&D covered by the 2023-24 annual plan are: • Deliver national metrics for site set-up and time to target for clinical research studies (80%) • Improve Trust position against peers to secure Top 5 ranking for CRN portfolio weighted recruitment, and Top 10 ranking for absolute recruitment • Deliver year 3 of the research and innovation investment plan including the Southampton Emerging Therapies and Technologies Centre (SETT), Research Leaders programme (RLP) and delivery infrastructure • Develop the five-year R&D strategy implementation plan for Research for Impact and deliver year 1. • Strengthen and broaden the UHS-UoS partnership through mapping alignment and characterising our Research Centres of Excellence. To view a full copy of the R&D Annual Plan 2023-24 please see Appendix 1.			
Response to the issue:	The key priorities for 2023-24 are: • Launch the recently approved five-year Research for Impact strategy, developing action and implementation plans to ensure delivery and appropriate oversight. • Continue to restore pre-pandemic levels of research activity and align the research portfolio to strategic priorities. • Determine the desired balance of commercial & non-commercial portfolios across UHS during Q1 and ensure operational and performance monitoring is aligned with achieving that balance. • Explore innovative opportunities for flexible and agile delivery models to ensure equity of access for research participation.			

	• Further utilise existing technology and tools and develop the digital capability of the delivery teams. • Develop action and implementation plans to address the key areas of the O'Shaughnessy review on the future of clinical research delivery. • Develop a robust activity and workforce plan within pharmacy and resolve the studies in set up backlog, clearing all historical studies while maintaining ongoing provisions. • Deliver year 3 of the research and innovation investment plan including the Southampton Emerging Therapies and Technologies Centre (SETT), Research Leaders programme (RLP) and delivery infrastructure – a more detailed update on both RLP and SETT will be presented in a separate study session to be arranged later this year. • Working with the Trust OD team, we will develop an Organisational Development plan focused on: 1) research infrastructure addressing cultural issues identified from the staff survey and 2) Trust wide to support the further integration of research into everyday business at UHS based on findings from the current research culture survey. • Continue raising and growing awareness within clinical areas to develop research engaged workforce and further explore NMAHPP Advanced Practice roles within research delivery.

Implications:
(Clinical, Organisational, Governance, Legal?)
	• R&D is 'mission critical' for a University Teaching Hospital and core to the UHS strategy
	• R&D drives efficiencies and improves value for money
	• R&D creates the clinical services that will be funded in the future (as demonstrated this year with commissioned services including prehabilitation and Advanced Therapy Medicinal Products – case studies included in the annual plan)
	• R&D active organisations have:
	  ○ Better patient outcomes
	  ○ Better workforce recruitment and retention

Risks: (Top 3) of carrying out the change / or not:	Risks of NOT delivering against the Annual Plan • We fail to secure on-going investment to support our pioneering research and innovation, driving clinical services of the future. • We fail to realise the full benefits of being a University teaching hospital, working with regional partners to accelerate research, innovation and adoption meeting the health and care needs of our population. • Lost opportunity to involve patients and staff in R&D leading to poor patient outcomes and negative impact on recruitment and retention of staff
Summary: Conclusion and/or recommendation	**Recommendation:** Trust Board is asked to approve the R&D Annual Plan 2023-24.

NHS
University Hospital Southampton
NHS Foundation Trust

THE UHS WAY

RESEARCH FOR IMPACT

R&D Annual Plan 2023-24

Research for Impact
R&D Annual Plan 2023-24

1. Foreword

Pioneering Research and Innovation is one of five pillars in our strategic framework supporting our Trust ambition of World Class People delivering World Class Care and is vital to the successful delivery of the Trust's clinical strategy.

There is a growing body of evidence that patients in research-active healthcare settings have better outcomes and receive better care, with benefits extending to patients beyond those actively involved in research. National research initiatives and priorities emerging from the Covid-19 pandemic are driving future research ambitions, so it is essential we respond accordingly reflecting the needs of our patients, services and partnerships to maximise the impact of the research we do.

2022-23 was the final year of the UHS Research Strategy: Research for All and saw the development of the new five-year Research Strategy: Research for Impact, which builds on the successes of Research for All and takes research into the post pandemic era. National research initiatives and priorities emerging from the pandemic are driving future research ambitions and it is essential we respond accordingly. Our strategic partnership with the University of Southampton, known for its world-leading research, has been further emphasized by our response to the COVID-19 pandemic. Research for Impact (2023-28) is currently going through Trust approval processes. Under the new strategy our ambition is to increase the relevance, quality and impact of the research we do to deliver world class care.

A key focus for the first half of 2023-24 will be developing and initiating the strategic implementation plan underpinning Research for Impact once Trust approval is secured and ensuring the ongoing alignment of the R&D work programmes.

We celebrated the renewals and extensions of several key components of the research infrastructure across UHS and UoS this year. 2022-23 also saw the formal appointment of the new Director and Deputy Director of R&D, whose appointment along with the Clinical Director of R&D ensure we have a strong leadership team to steer the strategic direction of research at UHS over the next five years.

The UHS R&D annual plan reflects on key achievements in 2022-23 and sets out the programme of work for 2023/24 supporting the delivery of the overall R&D ambition.

1.1 Vision

The vision for research at UHS (under the new research strategy, Research with Impact) is that:

- We deliver research with impact to help bring the future of healthcare closer to today.
- As an academic teaching hospital, we engage and collaborate with our patients, staff, communities and partners to enhance the relevance of our healthcare research.

1.2 Mission

Our mission is to seamlessly integrate delivery of research that supports and enhances our clinical services to achieve world class care.

As a leading UK teaching hospital known for research excellence, we are committed to enhancing our local, regional, and international reputation through the quality and impact of our research. We aim to constantly surpass the benchmarks set by our peers to be a leader in the field.

Together with our patients, communities and partners, we aim to advance healthcare, and work to ensure our research meets real world needs, faster. We will:

- Inspire participation in research by highlighting its positive impact on patient outcomes and experience.
- Engage with our partners, patients and communities to ensure the relevance and impact of the research we undertake.
- Deliver clinical research effectively and efficiently through streamlined systems and processes.
- Instil a culture of research within the Trust.
- Maintain a balanced approach to financial sustainability in all our research endeavours and maximise growth opportunities.

2. Summary of 2022/23 Activities

2.1 COVID 19 Research

Building on the collaborative Wessex clinical trial hub model established by UHS in response to the COVID-19 pandemic to deliver vaccine trials, work commenced this year to expand the model beyond the three established hubs in Southampton, Portsmouth and Bournemouth. The hub model is now extending the reach to West Dorset, with a hub being established in Weymouth due to become operational in Q1 23/24. Plans are also in the early development stages for a hub to be hosted in the north of the region by Hampshire Hospitals with agreement in principle and the exact site to be confirmed.

The hub model pioneered by UHS is now seen as the exemplar delivery model for regional clinical trials and puts Wessex at the forefront for other delivering other large-scale vaccine (and other) research in response to government strategies and future public health threats.

2.2 Delivery Against Corporate Objectives

2.2.1 Corporate Objective 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

SETT centre key achievements in 22/23

Emerging Therapies

- HOPE-B trial underway: the first gene therapy approved by FDA replacing twice weekly infusions with a single infusion for patients living with haemophilia B.
- Through our membership of the Midlands and Wales Advanced Therapy Treatment centre (ATTC) the Polarise trial to provide stem cell treatments with rheumatoid arthritis will be run in Southampton.
- UHS is commissioned as a CAR-T centre to provide emerging cancer therapies (leukaemia and lymphoma) and has treated the first patient

MedTech

- MedTech studies categorised into 3 categories with associated appropriate activities.
- Streamlined pathway for MedTech.
- Collaboration opportunities scoped with UoS and Wessex AHSN.
- Embedding of governance processes with existing R&D quality system.

Data and AI

- Data Mapper tool developed to enable data mapping and visualisation at scale across UHS data systems with possible wider commercial potential.
- Region is part of the national network of federated secure data environments (SDE) being developed (led by UHS) – secured and spent £770K of funding to date and business case submitted for approximately £10M.

- Successful Medicines Optimisation study utilised new SDE (trusted, safe, shareable, data environment) to develop data algorithms to identify safe predictors of dose of bDMARDS reducing risk and cost in clinical settings.
- Successful delivery of HDRUK regional linked data programme to curate and align national data for research (Use cases included Myocardial infarction pathways, avoidable admissions and winter pressures).

Research Leaders Programme key achievements in 22/23

Some of the key achievements from the first two cohorts of the Research Leaders Programme this year are listed below:

Fellowships (which fund clinical time): Dr Stephen Lim secured a NIHR Fellowship which provides 4 years of funding, including 4 sessions (2 days) of consultant clinical time for a multicentre study of an intervention to address hospital associated deconditioning in older adults.

Grants

- Dr Ahilanandan Dushianthan has secured a NIHR EME grant and Clinical Academic Research Partnership grant worth £359,000 for pioneering translational research in critical care for patients with respiratory infections, this is a collaboration with BRC and UoS, which includes funding for 3 PAs of his time.
- Dr Bhaskar Somani is part of a team that has secured £1.3m from the NIHR i4i funding scheme.

Developing future researchers

- Dr Sophie Fletcher has supervised 4 research fellows to complete the NIHR associate PI scheme, training them to be PIs of the future.
- A new research fellow post has been initiated in palliative care.

Integration of research with clinical service

- Dr Mark Banting is establishing palliative care as a research active specialty at UHS, developing a grant proposal in collaboration with Southampton CTU.
- Dr Jessica Bate is the lead applicant for Southampton Children's Hospital accreditation for Multinational Association of Supportive Care in Cancer (MASCC) for Centre of Excellent in Supportive Care in Cancer (awarded 2021) including recognition of supportive care research.
- Dr Phil Hyde has established the Pre-hospital Research and Audit Network (PRANA) for paediatrics.
- Katherine Lachlan has established a PTEN neurodevelopmental tool study.

Prizes

- Dr Steven Lim was awarded the Rising Star award from the British Geriatric Society (BGS) and the Normal Exton-Smith Prize for a poster presentation at BGS.
- Dr Jessica Bate also won best poster prize at the Children's Cancer and Leukaemia Group (CCLG) Research and Member Awards ceremony.

In addition, almost all of our Research Leaders are members of external committees and have been actively publishing this year.

Delivery Infrastructure

We implemented new strategies to address oncology pharmacy capacity issues. These included a member of the clinical trials pharmacy team spending a year training and actively working in oncology pharmacy, and all senior staff receiving training in pharmacy systems. Progress has been continuously reviewed throughout the year and following a year of training, a significant number of studies in the

set-up process backlog were cleared in Q4 22/23. The true impact of this strategy should start to be realised within Q1 of 2023/24. The aim is to start increasing the number of studies in set up incrementally from Q3 23/24.

2.2.2 Corporate Objective 2(b) Strategy and Partnership working

We were very successful at securing major infrastructure awards this year. This is excellent timing as many of the new contracts come into force in the same year as the new research strategy.

Major awards

- The NIHR Biomedical Research Centre (BRC) application was awarded with an £10 million uplift totalling £25 million over the next five years.
- The NIHR Clinical Research Facility (CRF) was awarded £10.5 million over the next five years,
- The CRUK/NIHR Experimental Cancer Medicine Centre was secured totalling almost £188k over 5 years from 1st April 2023.
- The CRUK Southampton Clinical Trials Unit (SCTU) was awarded with approximately a £1m uplift totalling approximately £5m over 5 years from 1st April 2023 – hosted by UoS.
- The NIHR confirmed an funded extension for the Wessex ARC for a further 18 months.
- The NIHR Research Support Service 5-year contract was confirmed, starting on 1st October 2023 and providing just over ~£15m research infrastructure – hosted by UoS.
- Wessex Health Partners was established with system partners, with the business case approved by RDSG for UHS as a founding member. Both the Chair and the MD were appointed in 22/23.

We developed the new five-year Research Strategy - Research for Impact - following strategic review and a series of stakeholder engagement events with our internal and external stakeholders. The strategy was submitted through the Trust approval process in Q4 as planned.

In addition, working as part of the joint UHS / UoS Senior Operations Group, we have mapped research activity within UHS and will present proposed areas of key strategic growth in conjunction with UoS, and seek to incorporate the ambitions for growth and development into the new Research Strategy deliverables.

3. Challenges in 2022-23

3.1 Workforce

We have continued to face significant challenges with staff vacancies within the research infrastructure, particularly within the research delivery teams, mirroring those facing the NHS more broadly. Turnover in the last 12 months as reported in March 2023 was 16.3%.

This has had a significant impact on all research activity, in particular the recruitment of new patients to clinical trials and delays in the study set up pipeline. It is essential that new staff undergo a formal, thorough induction and training programme to ensure high quality service provision meaning that once vacancies are filled, new staff are frequently not working as autonomous practitioners for approximately 6 months.

We have tried to mitigate vacancies by moving away from fixed term contracts and advertising posts as permanent where appropriate to ensure research is seen as a secure and viable career path. Staff survey results have been scrutinised with action plans implemented to ensure that we maintain a continued focus on attracting and retaining world class staff to deliver world class care.

3.2 Impact on Delivering the Research Strategy

As articulated last year, delivery of many of our initiatives aimed at delivering the Research Strategy continue to have been significantly impacted by the pandemic. Despite this, significant progress has been made over the past five years under the Research for All strategy.

We evaluated the strategic goals underpinning Research for All 2017-2022 as part of the preliminary strategic review work to develop the new five-year research strategy, Research for Impact (2023-2025). Overall, we have achieved over 65% of the strategic goals.

Some of the goals which were not achieved within Research for All form an integral part of the implementation plan for Research for Impact - the themes remain as relevant today as they were in 2017 with our new research strategy responding to the current and emerging national drivers around these themes.

Notably:

- We have not achieved an increase in the percentage of our patients participating in our research studies - in fact we have seen a decline. There are many reasons for this, but in part this is due to capacity constraints across the delivery system for a number of years which are still being encountered. A number of themes within the R&D workplans go towards addressing this.
- Reviewing the workforce ambitions under Research for All highlighted that the number of Principal and Chief Investigators has grown, but not to the extent we had hoped. A core measure of success for the Research Leaders Programme is growth in the number of investigators leading research at UHS and feeling supported to do so. With future cohorts of the programme being filled, aligned with national endeavours for workforce growth, it is hoped that we will start to see a step change in this metric in coming years.
- Aligned with the national picture, we have also not delivered against the national set up metrics at UHS. The pandemic impacted on study set up significantly and the system has yet to return to pre-pandemic levels of capacity and timelines. This is the focus of current national strategic work and internally we are focussed on our performance metrics and are reviewing our processes for further efficiency savings.

A summary review of progress against the 34 key strategic goals can be found in Appendix 2.

3.3 Grants and Early Career Researchers

We are still seeing the impact of the pandemic on the grants held by our early career researchers. Most of the grants impacted have now had extensions (often at no-cost) requested and fellowships have been extended accordingly. In addition, the clinical demands on our investigators have led to fewer grant applications being submitted. Charities have had less income available for research, from covid closures and reduced fundraising and now the cost-of-living crisis impact. Although there are still plenty of new calls overall, the reality is that some pots of funding may be/become smaller.

With the BRC awarded for a further five years and the RLP programme starting to demonstrate impact with enthusiastic researchers keen to develop their research portfolios and engaging with the R&D grants team, it is envisaged that we will begin to see grant applications increase again over the coming year.

3.4 Support Department Capacity Constraints

In 2022-23 we implemented a new initiative to address the capacity constraints and trial set up backlogs within oncology pharmacy. This has seen a member of the clinical trials team spending a year working within oncology pharmacy, thus upskilling the pharmacy clinical trials team and supporting the wider capacity constraints within the system. This member of staff returns to the clinical trials team in April 2023 and with other members of the clinical trials team also receiving training, backlogs were starting to be cleared in March 23 and it is envisaged that full capacity will resume by the end of Q1 2023-24. A key piece of work for 2023-24 will be to restore confidence in our abilities to set up and deliver research with critical internal and external stakeholders, enabling us to accelerate the oncology trials portfolio.

It should be noted that the challenges with oncology clinical trial set up being experienced within the Trust are not unique to UHS and reflective of a national crisis requiring a national solution. Acute Trusts and Cancer specialist hospitals (e.g. the Royal Marsden and the Christie) are reporting similar (or worse) capacity constraints, staff shortages and study set up backlogs. Our Chief Pharmacist is part of national discussions with Chief Pharmacist colleagues around the country to galvanise strategies to address this, and the R&D Directors are part of similar discussions in their national groups.

A Lead for Research Imaging was appointed as planned, however, most imaging for commercial trials continues to be outsourced to private providers. In 2023-24 we will look to initiate a plan to try and move some of this research imaging back to UHS, therefore retaining the income and capacity build funding generated from commercial research imaging within the Trust. We do not expect this work to be completed within year. In addition, where clinical trials require PET scans, delays are being experienced with effective study set up and capacity constraints are being cited by the provider which we will seek to further understand and address in 2023-24.

3.5 Research Portfolio

Returning to pre-pandemic research activity levels has remained a challenge this year. The position at UHS is reflected nationally, but this is not making us complacent.

- The total number of participants recruited into NIHR portfolio studies 2022-23 was 11751 - 60% of 2022/23 target (pre-pandemic five-year average of 19,510 participants). A further 1000 participants were recruited into non-portfolio research studies.
- Opened 234 new studies – 82% of 2022/23 target (pre-pandemic five-year average of 284 studies).

The national portfolio reset process has resulted in several studies failing to recruit close, with further work planned nationally in 2023-24 to reduce the number of failing portfolio studies further. Challenges remain with participant recruitment processes for some trials in the post pandemic NHS environment, virtual clinics limit the integration between clinical care and research with research staff unable to approach patients during routine diagnostic appointments. This is being addressed with

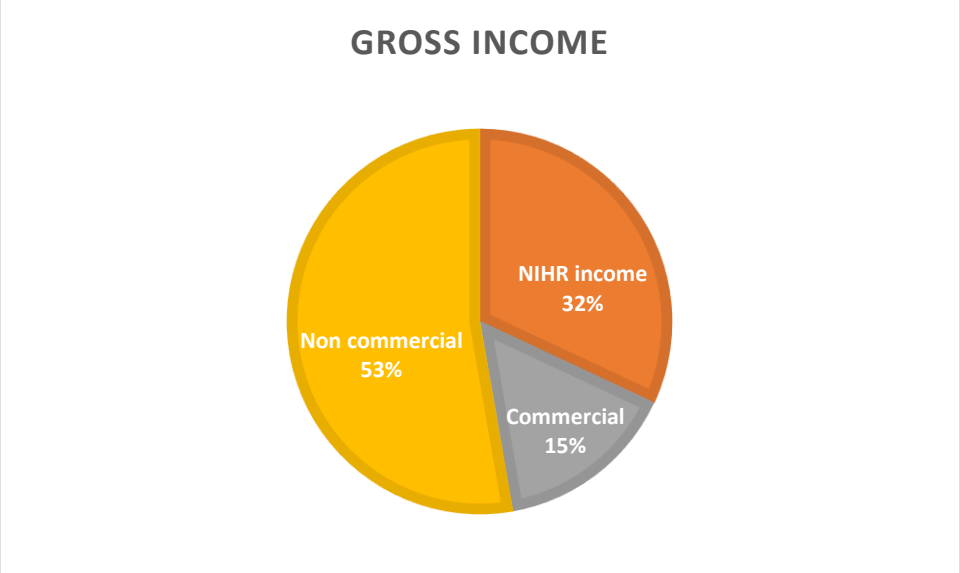
plans to integrate research further with MyMedical record and software such as AttendAnywhere, presence as part of the outpatient transformation programme.

Looking to the future, along with the national reset process, the UK research ecosystem is working together on a coordinated, coherent programme of work to ensure the Recovery, Resilience and Growth (RRG) of UK clinical research delivery. At UHS six workstreams have been established with assigned leads to carry forward the five-year implementation programme, contributing to national working groups to influence national decision making and reviewing local implications of national strategies. The RRG workstreams are aligned with the strategic plans outlined within the new Research Strategy and influence the work plans for 2023-24 with a focus on adoption of digital tools and streamlining efficiencies for research study set up and delivery.

3.6 Finances

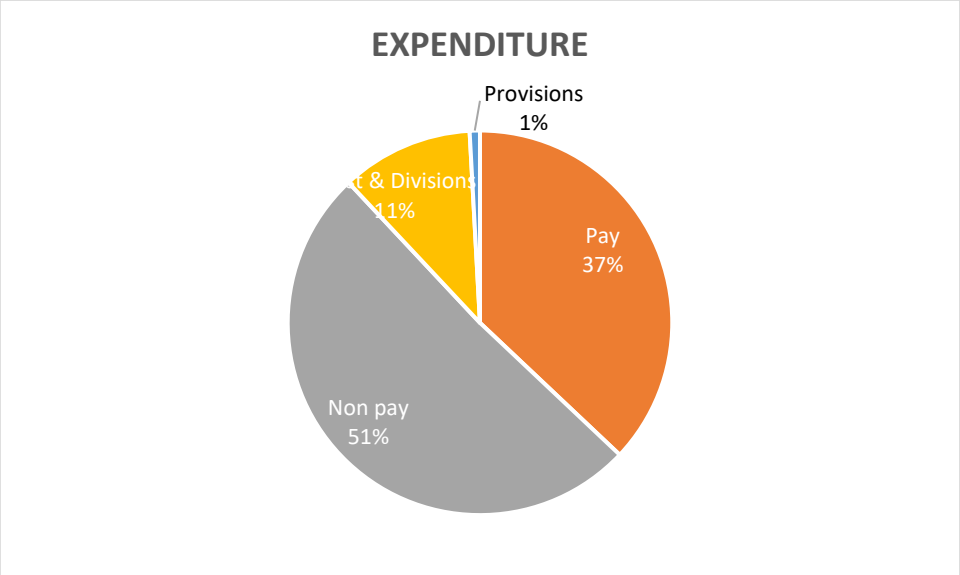
The pandemic has continued to impact on research income and expenditure throughout the year. During the year, there was again more COVID related grant and study income, specifically COV-BOOST grant and Wessex Vaccine Hub commercial study income, but overall income from COVID studies was down from previous the year. In addition, our research recruitment levels to the portfolio did not recover as anticipated (as detailed above), which also impacted on our study related income.

- Full year income of £44.9m (down £1.5m from 21/22 £46.4m) and consisted of:
    - Commercial income £6.9m (down £0.3m from 21/22 £7.2m)
    - Non-commercial income £23.7m (down £1.1m from 21/22 £24.8m). Of this £11.1m is COV-BOOST
    - NIHR income £14.3m (down £0.1m from 21/22 £14.4m)



- Full year expenditure of £46.4m (£2m less than 21/22):
    - R&D Pay costs £17.2m (£1.7m more than 21/22 £15.5m)

- Non pay costs £23.7m (£0.8m more than 21/22 £22.9m)
- Contribution to Trust and Divisions £5.2m (£2.6m less than 21/22 £7.8m). This includes a contribution to overheads, support department infrastructure plus pay and non-pay costs to deliver studies
- Provisions of £0.4m for commitments made in year that will be realised in 2023/34 and beyond for studies insufficiently funded.



4. R&D Corporate Objectives for 2023-24

Our overarching ambition is to be a leading teaching hospital with a growing, reputable and innovative research and development portfolio that attracts the best people and efficiently delivers the best possible research, treatments and care for our patients.

Our draft corporate objectives provide us with a focus on effective and efficient clinical research delivery over the coming year to bring us back to (and exceed) our pre-pandemic levels:

- Deliver national metrics for site set-up and time to target for clinical research studies (80%)
- Improve Trust position against peers to secure Top 5 ranking for CRN portfolio weighted recruitment, and Top 10 ranking for absolute recruitment
- Deliver year 3 of the research and innovation investment plan including the Southampton Emerging Therapies and Technologies Centre (SETT), Research Leaders programme (RLP) and delivery infrastructure
- Develop the five-year R&D strategy implementation plan for Research for Impact and deliver year 1.
- Strengthen and broaden the UHS-UoS partnership through mapping alignment and characterising our Research Centres of Excellence.

4.1 Key Initiatives for 2023-24

The key priorities for the next year are summarised below.

4.1.1 Strategic & Operational

Research strategy: An approved, measurable 'Research for Impact' strategy will be launched following Trust approval (envisaged during Q1 23/24). Action and implementation plans (including KPI measures) will then be enacted to ensure delivery and appropriate oversight.

Optimise UHS Research Portfolio: Our goal for 23/24 as with last year remains continuing to restore pre-pandemic levels of research activity and align the research portfolio to strategic priorities. We will determine the desired balance of commercial & non-commercial portfolios across UHS during Q1 and ensure operational and performance monitoring is aligned with achieving that balance.

Research Delivery

- Explore innovative opportunities for flexible and agile delivery models to ensure equity of access for research participation.
- Further utilise existing technology and tools and develop the digital capability of the delivery teams.
- Develop a robust activity and workforce plan within pharmacy and resolve the studies in set up backlog, clearing all historical studies while maintaining ongoing provisions.
- Continue raising and growing awareness within clinical areas to develop research engaged workforce and further explore NMAHPP Advanced Practice roles within research delivery.

Organisational Development/Culture: Working with the Trust OD team, we will develop an Organisational Development plan focused on: 1) research infrastructure addressing cultural issues identified from the staff survey and 2) Trust wide to support the further integration of research into everyday business at UHS based on findings from the current research culture survey.

4.1.2 Strengthen our existing and develop new partnerships

- We will further align the strategic areas of growth across the UHS/UoS partnership utilising the intelligence gained through the mapping work undertaken for the Senior Operations Group and strengthen the partnership by realising research opportunities outside of existing areas (e.g. operational, economic and environmental research).
- Continue the implementation of UHS/UoS joint research function projects, presenting longer-term proposals to Joint Research Strategy Board.
- With the senior leadership team now in place, expand Wessex Health Partners in order to seek Academic Health Science Centre (AHSC) status at next renewal call.
- Strengthen a sustainable and resilient, well governed Wessex research hub delivery model for regional clinical trials which will also be used as the delivery vehicle in Wessex for the UK Government's strategic 10-year commercial vaccine clinical trial programme with Moderna and Biontech. A new hub will be opened in the west of the region within Q1 and in the North potentially before year end.

- With a significant number of R&D infrastructure renewals confirmed and starting in 23/24, a key piece of work will be supporting the development and delivery of key strategies with the relevant Directors.
- Communications and PPIE strategies will be developed for aspects of our infrastructure including the BRC, CRF, SoAR and SETT with a plan to further develop our Southampton Centre for Research Engagement and Impact (SCREI), expanding joint activities and projects between SCREI teams to advance integrated working and cross-skilling.

4.1.3 Deliver year 3 plan for R&I Business Case for new infrastructure and activity

- With the full senior leadership team formally in place during Q1 23/24, we will strengthen the operational plan and governance processes for the Southampton Emerging Therapies and Technology Centre (SETT Centre):
    - SiCE: Establishing processes and pathways for ATIMP studies, recruiting a QA Manager/HTA licence holder and increasing the number of ATIMP studies in set up.
    - MedTech & Innovation: Drafting the Medtech Assessment pathway and testing this, developing a costing template and reporting dashboard once metrics are agreed and scoping a new study each quarter from Q2.
    - Data & AI: Identify data environment solution for proof of concept (data interconnectivity challenge), strengthen governance processes (reporting and SOPs) and further workforce recruitment.
- Continue to deliver the Research Leaders Programme (RLP), delivering cohort 3 and onboarding cohort 4 in 23/24.

UHS Divisional priorities, as identified by the R&D Divisional Leads working with divisional teams, are provided in more detail in Appendix 4.

5. Budget setting 2023-24

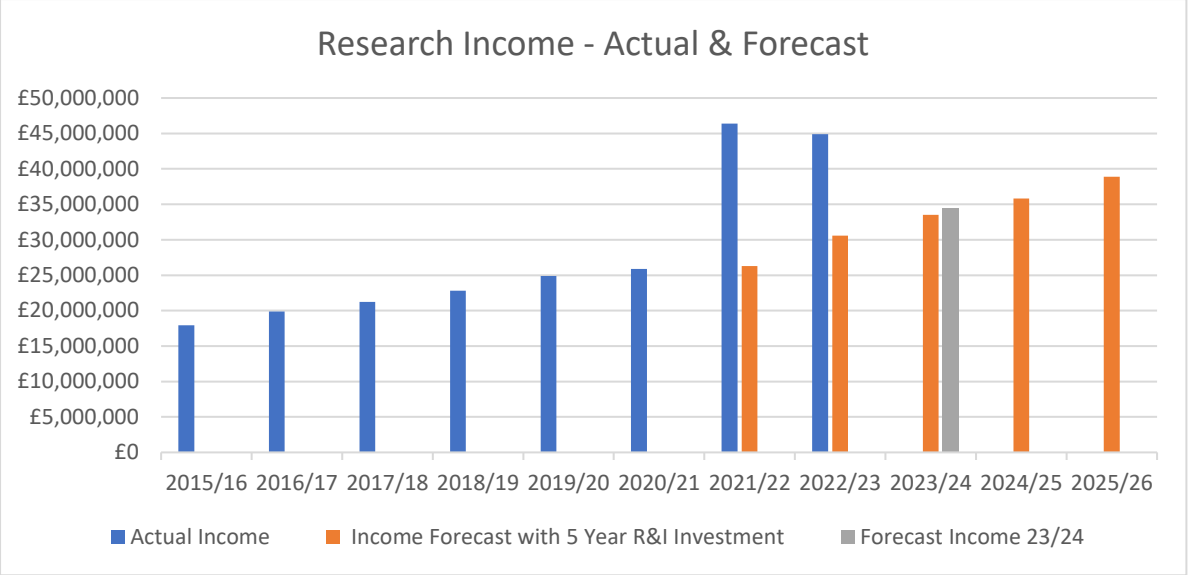
Budget setting for 2023-24 will be in line with previous years' annual budget setting process. A high-level summary of the budget is provided in Appendix 5.

5.1 R&D Budget setting principles

The immediate context for business planning and budget setting for 2023-24 aligns to the growth forecasted within the investment case. This is the third year of the five-year plan, with a Trust investment budget of £3.120m. In addition, the Trust have also provided £0.35m PI fund budget and £0.008m Excess Treatment Cost, which is the national threshold. Therefore, the total expenditure budget is £3.479m. All other expenditure plans must be within forecasted income.

5.2 R&D Income

Over the last two years we have seen a significant uplift in our income from covid grants and studies which we have led from Southampton. In 2023/24 we anticipated that the income from these covid related studies will reduce dramatically, and our forecast income brings us back in line with our income forecasts created pre-pandemic taking into account the R&I investment case (see figure below).

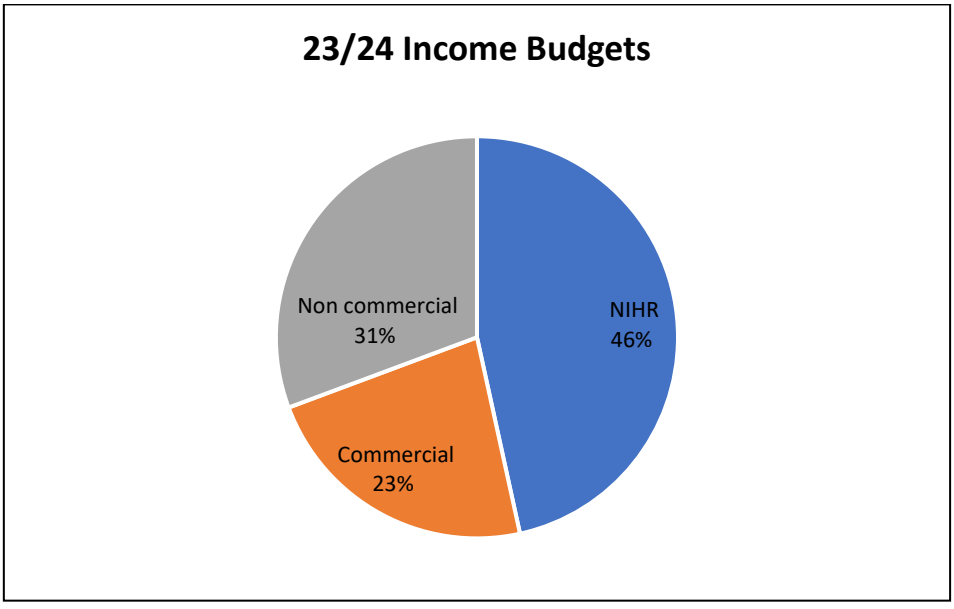


Our total income for 2023-24 is projected to be £34.4m which is £10.5m (30%) lower than the 2022-23 actuals. Whilst this is a significant reduction on last year's income, the 2023-24 projected income is £8.5m higher than our pre-pandemic 2019-20 research income of £25.9m.

Research income for 2023-24 is detailed in Appendix 5, summarised as:

- NIHR income is £16.m which is £1.7m (12%) more than 2022-23 actuals due to an increase in the BRC, CRF and ECMC awards plus £0.4m more Research Capacity Funding (RCF) due to the 'COVID programme' element in the DHSC formula.

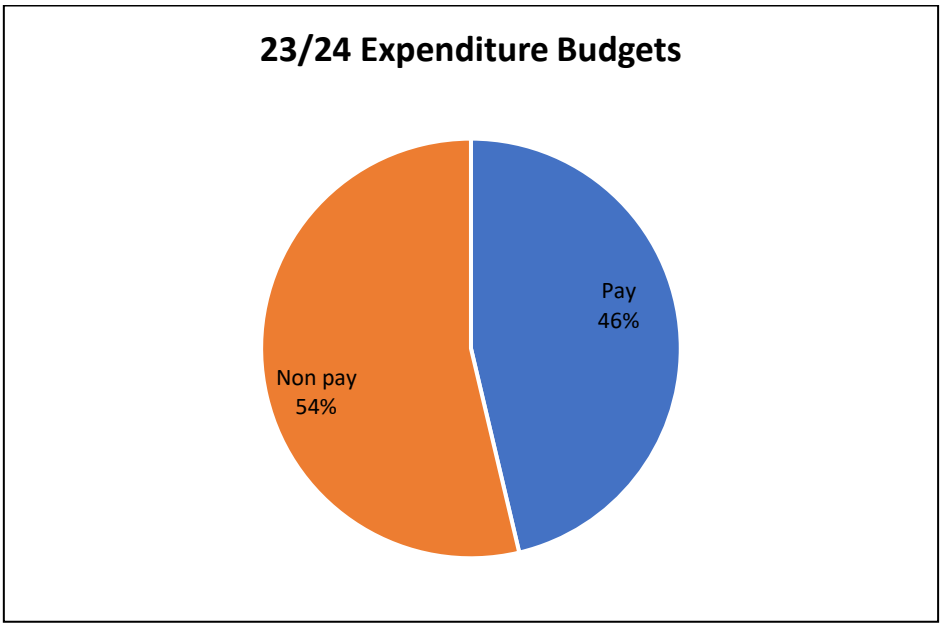
- Commercial and non-commercial study income is projected to be £18.4m which is £12.1m (40%) lower than 22/23 actuals, as most COVID related studies and grants are now closed or closing, including COV-BOOST that bought in £11m alone in 22/23.



5.3 R&D Expenditure

We anticipate that due to the reduction in Covid study related activity, our total expenditure is forecasted to be £37.9m, which is £3.3m (13%) lower than 2022-23 actuals. Expenditure in 2019-20 was £28.4m so our anticipated expenditure for 2023-24 reflects higher research activity levels than pre-pandemic. Our total expenditure in 2023-24 consists of:

- Pay of £17.5m which is £0.4m (2%) more than 22/23 actuals, due to growth in workforce. To note, at the time of writing this, the pay award has not been confirmed, so has not been factored into these figures.
- Non pay of £20.4m which is £3.7m less than 22/23 actuals, largely due to lower COVID study and grant costs.



As income follows activity, research active departments across UHS will realise the benefits from all income streams. The strategy adopted by the Trust of reinvesting R&D income in resource to deliver activity, has resulted in year-on-year benefits to clinical research and thus patients, whilst also minimising the risk to the overall financial position of the Trust. The budgets set ensure that

- All income is spent in accordance with funders' requirements.
- Income offsets all direct and indirect expenditure incurred, including a contribution to overheads.
- Contract commercial income is distributed with the 'profit' re-invested in delivering research for patients.
- Key research activity targets for 2023-24 are achieved.
- R&D budgets are set in detail and in consultation with Divisional Finance Managers as part of the Trust annual budget setting timetable.
- Budgets within R&D are signed off by the relevant budget holder.

5.4 Trust Board Key Performance Indicators

Performance against the following key performance indicators will be reported monthly to Trust Board. More detailed metrics are monitored monthly by the R&D Steering Group. The KPIs will be reviewed during 2023/24 to ensure that they remain fit for purpose and aligned with national strategic research priorities.

No	Title	Subtitle	Description	Target
1	Comparative CRN recruitment performance	Non-weighted	Where UHS is ranked amongst acute Trust for absolute (non-weighted) recruitment to all commercial and non-commercial NIHR portfolio studies.	Top 10
		Weighted	As above for weighted recruitment which takes account of the increased complexity expected in a clinical academic centre. Important for future CRN funding.	Top 5
2	Performance in initiating clinical trials		Number of days taken to set up a clinical trial, negotiate costs and execute the contract. Important for sponsor confidence in UHS as a site.	80% of studies taking ≤40 days
3	Recruitment to time and target		Percentage of studies recruiting the agreed number of participants prior to the study closing (and being on track throughout the course of the study). Important for sponsor confidence in UHS ability to deliver.	80%
4	Increase in income	Monthly increase in income % YTD increase in income %	Percentage of new income target achieved with investment	23% increased income with investment

Appendix 2 Research for All 2017-22 – Delivery against Strategic Objectives

Public, patients and staff

1	Report the impact of 5 practice changing research studies in the next 5 years.	✓
2	Be a founding partner of the Wessex Patient Involvement Network in 2017.	✓
3	In 2018, publish refreshed Patient and Public Involvement and Engagement strategies.	✓
4	For recruitment of research participants to CRN portfolio studies, to be in the top 5 NHS Trusts for interventional studies and 10 NHS Trusts for all studies .	✓
5	By 2022 achieve a 50% increase in early-phase experimental medicine research activity – 20% increase achieved.	-
6	Achieve an annual increase in the percentage of UHS patients participating in research studies.	✗
7	Develop mechanisms to record staff participation in research by 2018, determine realistic goal to increase and achieve by 2022.	n/a

Workforce

1	Increase the number of Principal and Chief Investigators by 50% and 20%, respectively by 2022 – 20% in PIs and 3% in CIs	-
2	For 3% of NIHR CRN portfolio studies to be led by UHS/UoS Chief Investigators – 2.5% led by Southampton CIs	✗
3	Increase by >25% the number of UHS staff included in the Research Excellence Framework in 2021	n/a
4	By 2022 increase the number of UoS/UHS Honorary Associate Professors and Professors by 20%	✓
5	Secure 8 NIHR Senior Investigator awards by 2022	✓
6	Double the number of NIHR and other relevant doctoral, post-doctoral and senior fellowships across the professions by 2022.	✓

Partnerships

1	By 2022, increase the combined, UHS R&D, UoS Faculties of Medicine and Health Sciences annual research income by 30%. – *increased by 53%*	✓
2	Grant funding leveraged by the NIHR Southampton infrastructure to be at least 8 fold increase on NIHR core infrastructure funding by 2022 – *9 fold*	✓
3	Deliver 1 major capital project in partnership with the UoS within 3 years	✓
4	Achieve a 50% increase income from commercial research by 2022 – *38% increase in net income achieved*	–
5	Establish three new strategic partnerships with the industry and charity sectors by 2022.	✓
6	Open new commercial research portfolios in one new clinical area per year – progress against goal impacted by pandemic	–
7	Deliver 10 new SME research and innovation collaborations by 2022.	✓
8	By 2022, deliver at least 5 CRN portfolio studies requiring cross system working in partnership with local NHS organisations and the CRN.	✓

Organisational

1	Establish new research portfolios in one clinical service per UHS Division per annum – active in all specialities with variation across years in activity levels	N/A
2	Secure top 5 ranking for recruitment or weighted for complexity to CRN portfolio studies for 10 specialties with established research portfolios and top 20 ranking for emerging specialties.	✗
3	Increase research income to £25m per annum by 2022	✓
4	Increase total value of successful grant applications led by UHS by 10% per annum - 78% increase grants awarded but not 10% increase year on year for overall value	–
5	Secure: NIHR Biomedical Research Centre with increased themes and funding	✓
6	• NIHR Clinical Research Facility for experimental medicine	✓
7	• NIHR/CRUK Experimental Cancer Medicine Centre – *awaiting outcome*	
8	Secure: NIHR Design Service South Central in 2017 Clinical Trials Unit in 2017/18 and UKCRC registration.	✓
9	Secure CRUK Cancer Centre in 2022.	✗
10	Secure NIHR infrastructure for applied health research (formally CLAHRC) in 2018/19.	✓
11	Open new Southampton Biomedical Informatics Centre and Innovation Space in 2018/19.	✗
12	Deliver 3 new digital platforms to enhance clinical research and support a Learning Health System by 2020.	✓
13	Deliver national metrics for site set-up for research studies.	✗

Appendix 3 – Research Impact

First patient receives pioneering blood cancer treatment

The first patient at University Hospital Southampton (UHS) started CAR T-cell therapy in March 2023, a ground-breaking treatment that continues to be researched.

Patients in and around Southampton with aggressive blood cancers will no longer need to be referred to London hospitals for CAR T-cell therapy, a new treatment that can greatly improve survival after NHS England made the Wessex Bone Marrow Transplant and Cellular Therapy (BMT & CT) Programme at UHS one of the UK's approved CAR T-cell therapy providers.

The team have worked extremely hard to gain this approval, including through their continuing involvement in research into the treatment.

The UHS team's achievement is partly due to their involvement in the TRANSFORM trial which investigated the effectiveness of the CAR T-cell therapy called lisocabtagene maraleucel for patients with large B cell lymphoma. The governance processes and education established by the SETT centre to ensure the trial was conducted to the highest quality standards supported the provider award process.

Nutrition and lifestyle research

Our nutrition and lifestyle research reaches beyond the Trust, supporting our city and nation to be healthier. In August, our data showed almost half of the city's children are not meeting daily physical activity recommendations. Findings followed showing that under half of Southampton mothers met their activity needs. We also demonstrated benefits of vitamin D and dietary supplements in healthy childbirth.

Asthma

Our asthma, allergy and immunology service received World Centre of Excellence status again last year, further endorsing our continued achievements in pioneering research and innovation. Our leadership in asthma research continued this year, pinpointing risk factors for managing the condition. In May 2022 data showed that voice analysis could reveal worsening asthma. This was followed by findings linking lung infections in infancy with school-age asthma. In November we published data showing that obesity-driven gut damage worsens asthma symptoms.

Awards

A stream of awards and prizes underscored our research quality and leadership this year. In June 2022 Prof. Saul Faust's COVID-19 vaccine leadership was recognised with an OBE in the Jubilee honours list. Prof. Faust led trials underpinning many vaccines' licensing, and global booster programmes. He also bolstered public confidence, clearly explaining vaccines and trials throughout.

In July 2022 Dr Luise Marino received the British Dietetic Association's highest accolade. The Rose Simmonds award recognised research developing a tool for spotting nutritional risk in children during remote consultations. That software is known as Paediatric Remote Malnutrition Application (Pedi-R-MAPP). Dr Marinos' team adapted this from an adult application, created during the pandemic. It allows remote assessment of children's nutrition, and creation of care plans if needed.

The 2022 Nursing Times Awards saw UHS take the Clinical Research Nursing award in October 22. It recognised our use of joint roles for collaboration, placing research within care settings and opening opportunities for clinical research. The competitive awards reward teams showing the highest quality of care and skills.

December 2022 saw the iDx Lung trial take the 'Further, Faster, Together' award in the Cancer Research Horizons Innovation and Entrepreneurship Awards. iDx trialled cutting edge molecular tests in spotting lung cancer early, when it's more easily treated. Key to the award was smart working with mobile CT scanner teams to improve access across the region.

Prehab

Southampton researchers are world leaders in prehabilitation.

The approach helps patients prepare for an operation by taking steps to improve their physical fitness, diet and mental health. This is linked to better outcomes and faster recovery times. Evidence suggests it may even shrink tumours.

Our NIHR Southampton Biomedical Research Centre has advanced prehabilitation through clinical studies and international roles, with financial and practical support added from UHS R&D at every stage.

The WesFit trial trained personal trainers to supervise patients exercising in local gyms. Patients were keen to take part and 87% completed the course. This was quickly adapted during the pandemic by launching the Safefit programme.

This research has directly led to University Hospital Southampton (UHS) launching the UK's first NHS Trust-funded prehabilitation service. PeriOpFit was approved in early 2023 and is available to all patients.

Surgery wait times have increased since 2020 because of pressures caused by COVID-19. Patients may be waiting longer for operations and becoming less prepared in the process. PeriOpFit is helping address this and enabling UHS to see patients more quickly.

Appendix 4 – Annual plan 2023-24 Divisional Priorities

Divisional Plans 2023/24	Q1	Q2	Q3	Q4
Division A	To have issued C&C for Division A's first ATIMP study (OPH0307) To assimilate a Research Facilitator from another divisional team into Division A and for them to have a full Division A workload.	Improve current timelines for R&D set up – Div A is meeting the 40 day metric 40% of the time (days between Date Site Selected and Date Site Confirmed.)	Encourage more Pis in Division A to take on studies. (Aim for increase on 56 as of March 2023) Open 1 commercial study in Critical Care speciality.	Aim to have 80% of Commercial studies meeting Time to Target (FY 22/23 it was 55% but 80% is the HLO.) By end of FY 23-24, to have exceeded our commercial portfolio recruitment from 2022-2023 which was 66 recruited participants.
Division B	To have issued C&C for Division B's first ATIMP study (POLARISE) To assimilate a Research Facilitator from another divisional team into Division B and for them to have a full Division B workload.	Capitalise on the Commercial EOIs received in Respiratory (in conjunction with the new Respiratory Clinical Research Group (RCRG) To have issued C&C for the first Division B SETT centre study (under the Data Research pathway)	To support new CTIMP trials for patients with Alpha-1 Antitrypsin Deficiency (AATD) - there is a novel clinical service and some patients have no access to disease modifying drugs. Maintain current timelines for R&D set up – Div B is meeting the 40 day metric 70% of the time (days between Date Site Selected and Date Site Confirmed.)	Aim to have 80% of Commercial studies meeting Time to Target (FY 22/23 it was 55% but 80% is the HLO.) By end of FY 23-24, to have matched our commercial portfolio recruitment from 2019-2020 which was 79 recruited participants. To have at least 4 Portfolio studies recruiting over 100 participants each (FY 22-23 had 2 studies and there is a need for higher recruiting studies).

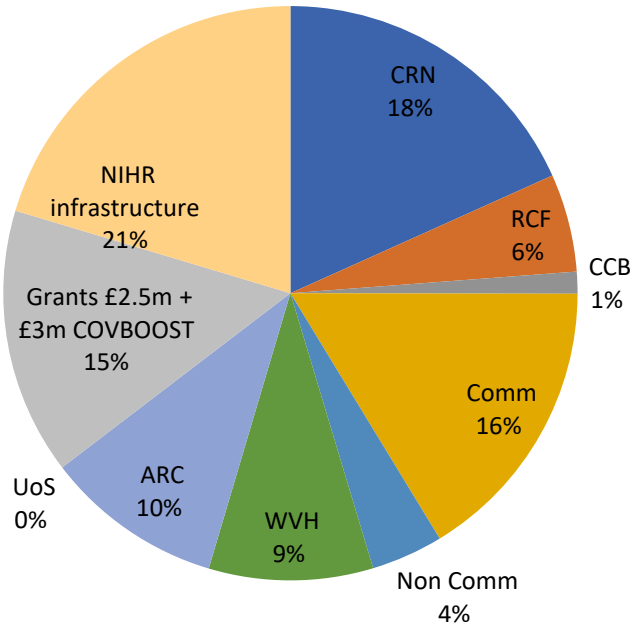
Divisional Plans 2023/24	Q1	Q2	Q3	Q4
				Aim to have 80% of Non-Commercial studies meeting Time to Target
Cancer	Define the metrics that we report to the Division Work with oncology pharmacy to improve setup times and support cancer set up processes	Look to increase PAs to support delivery of ATIMP/Phase I work - discussion ongoing Support the development non-medic Early Career Researchers	Work to balance non-commercial and commercial portfolio through the Cancer Prioritisation Meetings	Work to balance opening studies within Cancer equitable to all tumour groups.
Division C	**To optimise;** i) R&D time to open new studies - reduce set up timelines by half to meet 30-day target, non-covid average is 70 day. ii) to succession plan by identifying research leaders of the future, signposting them to opportunities, iii) to complete a gap analysis identify potentially new PIs for EOIs within the Division iv) throughout the year grow commercial portfolio by at least 5%	**To work with the Div C researchers to;** i) increase recruitment to current studies by 50% & identify high recruiting studies to open on the portfolio for 2022/23, ii) continue to work with stakeholders to support the development of clinical | research roles within NMAHPs & Clinical Scientists, iii) throughout the year grow commercial portfolio by at least 5%	**To work with R&D/ SoAR to ensure;** i) all staff are equipped with research know-how relevant to their roles within Div C ii) to empower all staff within Div C to use knowledge to ensure all patients are offered the opportunity to participate in research, iii) work with the comms team to develop assets for clinical areas identify research studies available to participants as well as results of studies completed within clinical areas	**To work with;** i) encourage engagement with UHS/UoS output metric tools i.e. Pure ii) increased the no. of studies we have opened by 20% utilising the increased set-up timelines

Divisional Plans 2023/24	Q1	Q2	Q3	Q4
Division D	To continue to work in gap analysis with the CRN and trying to shore up resources so that people can carry out activities. To assimilate a Research Facilitator from another divisional team into Division D and complete training of a RF returning from maternity leave and for them to have a full Division D workload	Multiple System Atrophy: To open 1-2 Commercial MSA studies this FY	To increase the number of commercial studies in the division by 100% (10 studies) Parkinson's disease - aim to set up 1-2 commercial PD studies and hope to build a portfolio moving forward.	Aim to meet 80% of all local and national targets By the end of FY 23-24, to have reduced the Div D deficit where the total division d surplus income is sufficient to fully offset the division d deficit

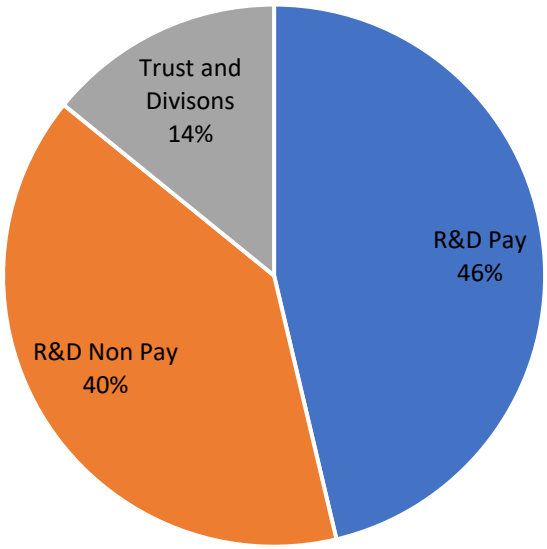
Appendix 5 – R&D Budget Summary 2023-24

	2023-24	
R&D Income source	**Estimated £m**	**23/24 comments**
Income		
CRN core ABF	**6.11**	Allocated
CRN additional (e.g. SGLs)	**0.19**	Allocated
CRN Fellows	**0.34**	Allocated
Commercial study income	**7.83**	Estimated
Non-Commercial study income	**1.47**	Estimated
NIHR grants	**4.90**	As detailed grant spreadsheet, includes £3m COV-BOOST
Other grants	**0.55**	As detailed grant spreadsheet
RCF Funding	**2.00**	Allocated
NIHR infrastructure awards	**11.03**	BRC £5,151,004. CRF £2,076,809. ECMC £162,256 ARC £3,640,500
Total Income	**34.42**	
Expenditure		
Div A pay & non pay	**0.25**	Infrastructure and grant income
Div A pay & non pay	**1.39**	
Div A pay & non pay	**1.41**	
Div A pay & non pay	**0.88**	
Excess Treatment Costs - cross division	**0.01**	National threshold £8k, any more will be funded by CRN
THQ non pay	**1.42**	Agreed amount £1.207m overheads
Contributions to Trust	**5.36**	**14%**
CRF	**4.19**	
BRC	**4.34**	
SCREI	**0.28**	
ECMC	**0.16**	
Patient Participant Involvement team	**0.11**	
SOAR	**0.14**	
RLP	**0.37**	
Strategic Development fund	**0.22**	
Strategic Leadership team	**0.44**	
SETT	**0.67**	
CRN DL and SGLs	**0.06**	
Non-medical trust wide delivery teams	**5.59**	
Trust wide research fellows	**0.70**	
PI funds	**0.97**	
R&D central office	**2.88**	
External study costs	**11.42**	
Sub total R&D	**32.54**	**86%**
Total Expenditure	**37.90**	
Net Budget	**3.48**	PI funds £350k + ETCs £80k + investment case £3,120k

R&D income budgets 23-24 £34m



R&D expenditure type 23-24 £38m



Report to the Trust Board of Directors				
Title:	**Board Assurance Framework (BAF)**			
Agenda Item:	**6.4**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Date:	**25 May 2023**			
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 challenges around risk titles.			
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 is due to be refreshed to align with the 2023/24 corporate objectives. These objectives are scheduled for approval by the Board on 25 May 2023.			

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.

The Board Assurance Framework is due to be refreshed to align with the 2023/24 corporate objectives. These objectives are scheduled for approval by the Board on 25 May 2023. The BAF as at the end of 2022/23 is provided as appendix 1. Meetings are currently being scheduled between the relevant executive director(s) and the Associate Director of Corporate Affairs and Trust Documents Manager. 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.

Trust Status

Trust status

Executive summary:
The key strategic risks for the Trust are:

- capacity (1a);
- staffing (3a); and
- the financial position (5a),

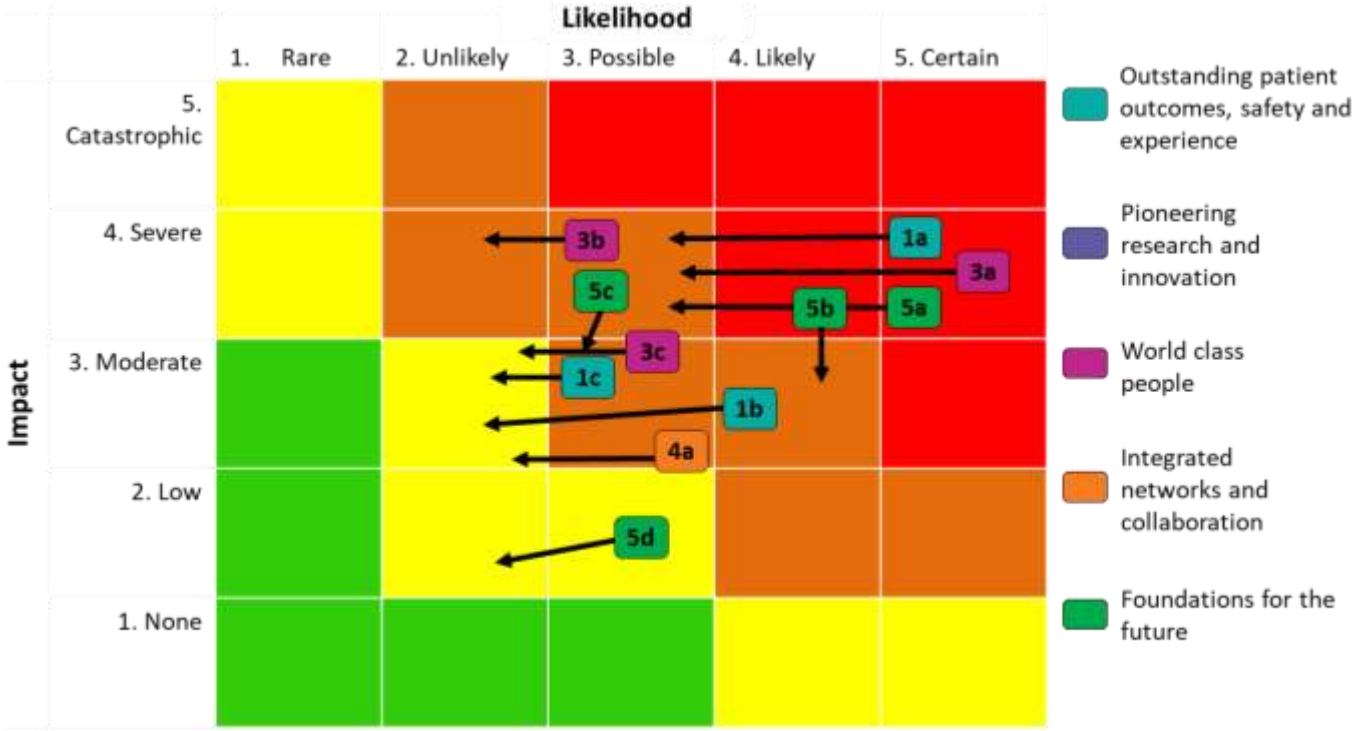
all of which are interrelated.

Following feedback from the Board, the wording of risk 3a has been updated.

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) Lack of capacity to appropriately respond to emergency demand, manage the increasing waiting lists for elective demand, and provide timely diagnostics, that 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	Excess demand on primary care and 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 local delivery system 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 Challenges in staffing ED department during periods of extreme pressure	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.	Limited capacity within the Local Authority to support for patients without a criteria to reside Data suggests waiting lists and ED performance are not likely to improve	Outpatient theatres and inpatient flow transformation programmes Review of ED workforce model Development of final plans for urgent care village 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. Review the robustness of system winter planning.	4 x 3 12 Apr-25

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

1b) Due to the current challenges, we fail to provide patients and their families / carers with a 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 and Experience of care 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	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 4 12	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	Negative outlier on follow-ups for outpatients.	**Introducing a robust and proactive safety culture:** Implement plan to enable launch of PSIRF in Q2 2022/23 Embed learning from deaths lead & lead medical examiner roles (primary and secondary care) and develop objectives and strategy Introduce thematic reviews for pressure ulcers and falls. 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. Baseline assessments and two quarters' submissions have completed and this will form part of the CQINN this year **Always Improving strategy** Delivery of year 1 outpatients and theatres agreed quality, operational and financial benefits Increase specialties contributing to	3 x 2 6 Mar-24

Outstanding patient outcomes, safety and experience					Monitoring Committee: Quality Committee Executive Leads: COO, CMO, CNO	
Programme					CAMEO There is currently no clinical lead for this project. We expect to recruit within three months, and will develop a new strategy linking outcomes, transformation, and safety. Actively managing waiting list through points of contact, escalating patients where changes are identified. Ongoing harm reviews for p2s and recurring contact for p3 and p4 patients.	

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. Review of infection prevention methods for C-diff following missing trajectory.	3 x 2 6 Apr-23

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

3a) We are unable to meet current and planned service requirements due to unavailability of qualified staff to fulfil key roles.

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. Inflation of 11% against national pay awarded of 3% is resulting in cost of living outstripping pay Differential pay grading across the ICS leading to retention difficulties	4 x 5 20	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. Introduce measures to support staff during cost of living increases.	4 x 3 12 Mar-25

World class people				Monitoring Committee: People and Organisational Development Committee		
					Executive Lead: CPO	
3a) We are unable to meet current and planned service requirements due to unavailability of qualified staff to fulfil key roles.						
					Increasing the UHS substantive workforce by 481 by the end of March 2023. Maintaining annual staff turnover below 12%. Developing a longer-term workforce plan linked to the delivery of the Trust's corporate strategy.	

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 Leadership development talent plan 2023-2024 Executive succession planning	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 core training, due to capacity and demand Releasing staff to engage in personal development and training opportunities Limited succession planning framework, consistently applied across the Trust	4 x 3 12	Annual Trust training needs analysis reported to executive Trust appraisal process GMC Survey Education review process with Health Education Wessex Utilisation of apprenticeship levy Talent development steering group People Board reporting on leadership and talent, quarterly	Need to develop quantitative and qualitative measures for the success of the leadership development programme	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? Implement the leadership development and talent plan throughout 2023 and 2024 Strategic leadership programme and positive action programmes Succession planning for executive 1st and 2nd line reports, and hard-to-recruit to senior posts	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 Work to develop a shared pharmacy model with Portsmouth has been delayed, and the Trust is looking at alternative options. The costs associated with the Elective Hub in Winchester may have been underestimated. Additional funding sources may need identifying.	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 Integrated networks and collaborations Board set up for regular meetings at executive level	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** Priority networks agreed **Integrated Networks and Collaboration** Urology Area Network plan agreed and proceeding at pace 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 and recruited to. 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 financial plan. Cost improvement programme (CIP, ~£60mil) and transformation programme (Always Improving) Robust business planning and bidding processes Engagement in revised ICS financial architecture Enhanced finance and workforce controls via 2023/24 business rules 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. Monthly reporting processes from Care Groups to Trust Board level. Monthly Value for Money meetings with each Care Group	Ability to deliver £60m CIP programme. Elements of activity growth unfunded via block contracts Grip of system wide initiatives and assurance of delivery e.g., Criteria to Reside Ability to control and reduce temporary staffing levels	4 x 5 20	Regular finance reports to Trust Board 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 Executive oversight of control groups Trust Savings Group oversight of financial recovery plan and CIP programme actions Operating plan based on cash modelling to ensure affordability of capital programme	Current short-term nature of operational planning	Deliver the planned financial deficit. Create a two-year financial recovery programme to deliver a break-even position in 2024/25 Finalise and deliver £60m savings programme. Support the organisation to understand the impact and required cultural change relating to the new financial infrastructure	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 Identify future funding options for additional capacity in line with the site development plan Delivery of 2022/23 capital plan Implement the HOIW elective hub. Deliver £9m of critical infrastructure backlog maintenance Agree plan for remainder of Adanac Park site Site development plan for Princess Anne hospital.	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: 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)
					Implementation of new Emergency Department patient flow and vital signs systems via Alcidion.	

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 Dec-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, Trust Chair**			
Date:	**25 May 2023**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification** **Y**	**Information**
Issue to be addressed:	This is a regular report to notify the Board of use of the seal and actions taken by the Chair in accordance with the Standing Financial Instructions and Scheme of Delegation for ratification.			
Response to the issue:	The Board has agreed that the Chair may undertake some actions on its behalf.			
Implications: (Clinical, Organisational, Governance, Legal?)	Compliance with The NHS Foundation Trust Code of Governance (probity, internal control) and UHS Standing Financial Instructions and Scheme of Delegation.			
Risks: (Top 3) of carrying out the change / or not:				
Summary: Conclusion and/or recommendation	The Board is asked to **ratify** the Chair's actions. There have been no seals affixed since the last report.			

1 Chair's Actions

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

1.1 **Single Tender Action** for the recharge for Military Consultants in Theatres, to Defence Business Services for the financial year 2022-23 at a cost of £469,890 (no vat). Approved by the Chair on 24 April 2023.

1.2 **Single Tender Action** for Continuing Professional Development (CPD) training modules for staff provided by the University of Southampton, for the financial year 2023-24, at a cost of £784,000 excluding VAT, funded by Health Education England. Approved by the Chair on 27 April 2023.

1.3 **Award of Call Off Contract** under the NHS England Increasing Capacity Framework Agreement for the provision of Trauma and Orthopaedic services at Health Share Hospital Winchester. The proposed term of the contract is 12 months with a three-month notice period, up to a total cost of £579,749 (no vat). Approved by the Chair on 16 May 2023.

2 Recommendation

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

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Charitable Funds Committee Terms of Reference**			
Agenda item:	**7.3**			
Sponsor:	**Steve Harris, Chief People Officer**			
Author:	**Craig Machell, Associate Director of Corporate Affairs and Company Secretary**			
Date:	**25 May 2023**			
Purpose	**Assurance or reassurance**	**Approval** X	**Ratification**	**Information**
Issue to be addressed:	The terms of reference for all Board committees should be reviewed regularly, and at least once annually, to ensure that these reflect the purpose and activities of each committee. The terms of reference have been reviewed by the Charitable Funds Committee.			
Response to the issue:	The proposed changes to the terms of reference are highlighted in the attached version using tracked changes. Changes have been made to adjust the approval limits for the committee to bring these into line with the revised limits set out in the Standing Financial Instructions.			
Implications:	The terms of reference ensure that the purpose and activities of the Charitable Funds Committee are clear and support transparency and accountability in the performance of its role.			
Risks:	1. Non-compliance with the Trust's constitution and the standing orders of the Board of Directors relating to the composition of Board committees. 2. Non-compliance with charities law and the Trust's standing financial instructions relating to the specific responsibilities of the Charitable Funds Committee, including the distinct duties of the Trust as corporate trustee and the management of potential conflict of interests. 3. The Board of Directors and the Committee may not function as effectively without terms of reference in place.			
Summary:	The Board of Directors is asked to approve the revised terms of reference. These have been reviewed by the Charitable Funds Committee and are recommended for approval.			

University Hospital Southampton NHS
NHS Foundation Trust

Charitable Funds Committee Terms of Reference

Version: ~~5~~6

Date Issued:	~~28 April 2022~~25 May 2023
Review Date:	~~April 2023~~May 2024
Document Type:	Committee Terms of Reference

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1. Role and Purpose

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

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

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

2. Constitution

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

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

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

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

3. Membership

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

3.1.1 at least two non-executive directors of the Trust;

3.1.2 the Chief People Officer; and

3.1.3 the Chief Financial Officer.

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

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

3.3.1 the Charity Director

~~3.3.2 four fundholders, as agreed by the Executive Directors;~~

~~3.3.3 the Assistant Director of Finance;~~

~~3.3.4~~3.3.2 the Head of Charitable Giving;

~~3.3.5~~3.3.3 the Head of Charitable Operations;

~~3.3.6~~3.3.4 the Head of Charity Communications; and

~~3.3.7~~3.3.5 ~~the~~ Charity ~~Funds~~Finance Manager~~.~~

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

4. Attendance and Quorum

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

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

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

5. Frequency of Meetings

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

6. Conduct and Administration of Meetings

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

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

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

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

7. Duties and Responsibilities

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

7.1 ***Governance***

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

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

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

7.1.4 Receive all necessary information from the Charity Director.

7.2 ***Strategy***

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

7.2.2 Review and approve annually objectives, a medium-term strategy and an annual operating plan (including a budget).

7.3 ***Fundraising***

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

7.3.2 Establish, prioritise, and approve major fundraising projects and expenditure (between £~~50~~75,001 - £~~100~~1,000,000), each of which should be supported by an appropriate business case; projects and expenditure over £~~100~~1,000,000 will require approval from the Board.

7.3.3 Safeguard donated money.

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

7.4 ***Utilisation of Funds***

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

7.4.2 Endeavour to make an adequate return on prudent investments.

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

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

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

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

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

7.5 ***Reporting***

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

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

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

8. Accountability and Reporting

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

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

9. Review of Terms of Reference and Performance and Effectiveness

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

10. References

10.1 National Health Service Act 2006

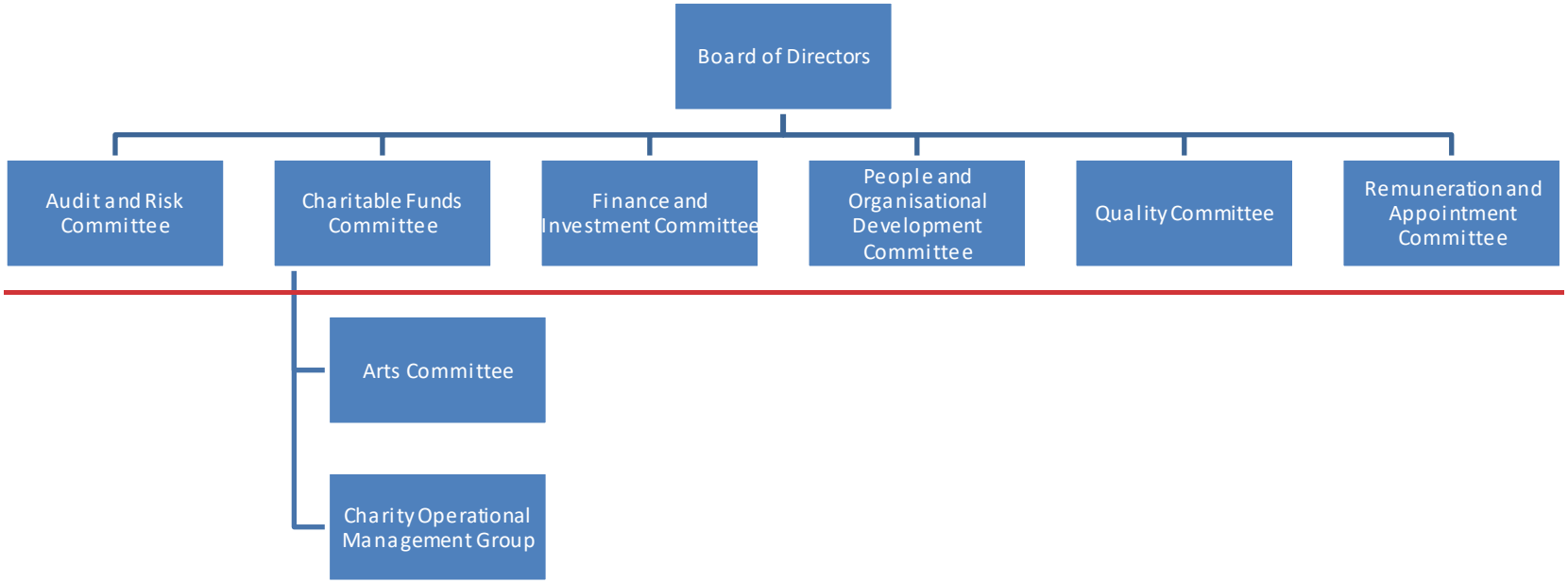
10.2 Charities Act 2011

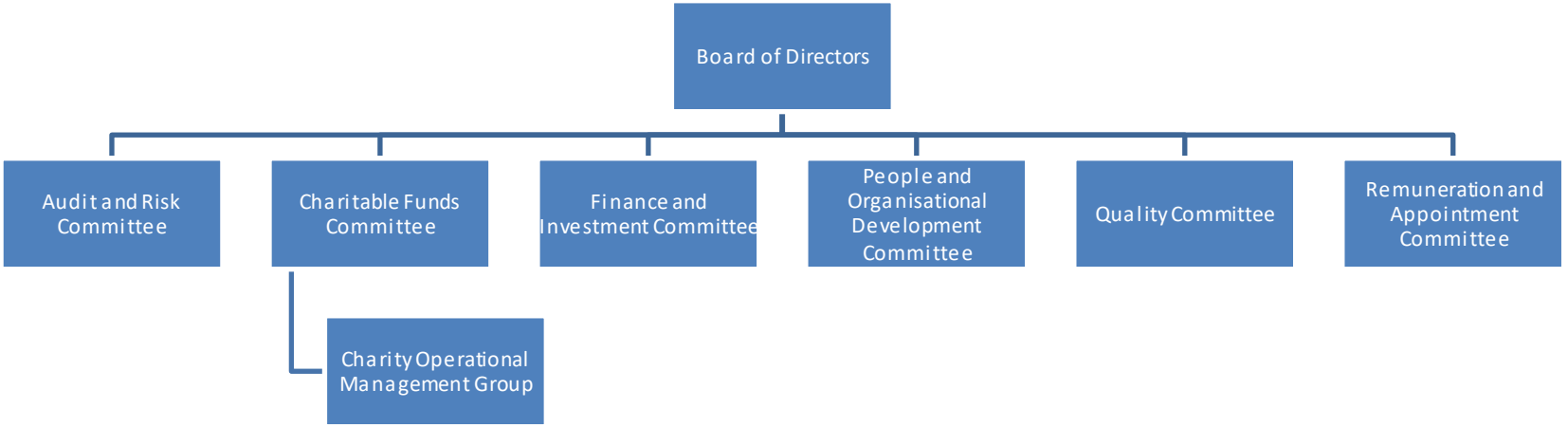
10.3 Charities (Accounts and Reports) Regulations 2008

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

10.5 Standing Financial Instructions

Appendix A


Board of Directors
Audit and Risk Committee
Charitable Funds Committee
Finance and Investment Committee
People and Organisational Development Committee
Quality Committee
Remuneration and Appointment Committee
Arts Committee
Charity Operational Management Group


Board of Directors
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Remuneration and Appointment Committee
Charity Operational Management Group

Charitable Funds Committee Terms of Reference	Version: ~~5~~6

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Does this document replace or revise an existing document?	Yes
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