University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	28/09/2023
Time	9:00 - 12:45
Location	Conference Room, Heartbeat/Microsoft Teams
Chair	Jenni Douglas-Todd
Observing	Laura Cross, Inspector, CQC

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 27 July 2023** Approve the minutes of the previous meeting held on 27 July 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 9:25	**Briefing from the Chair of the Finance and Investment Committee (Oral)** Dave Bennett, Chair
5.2 9:30	**Briefing from the Chair of the People and Organisational Development Committee (Oral)** Jane Harwood, Chair
5.3 9:35	**Chief Executive Officer's Report** Receive and note the report Sponsor: David French, Chief Executive Officer
5.4 10:05	**Performance KPI Report for Month 5 including Outpatient Transformation** Review and discuss the report Sponsor: David French, Chief Executive Officer
5.5 10:35	**Finance Report for Month 5** Review and discuss Sponsor: Ian Howard, Chief Financial Officer

5.6 **People Report for Month 5**

10:50 Review and discuss
Sponsor: Steve Harris, Chief People Officer

5.7 **Break**

11:05

5.8 **Maternity Safety 2023-24 Quarter 1 Report**

11:15 Review and discuss
Sponsor: Gail Byrne, Chief Nursing Officer
Attendees: Emma Northover, Director of Midwifery/Marie Cann, Maternity/Neonatal Safety Lead/Alison Millman, Interim Safety & Quality Assurance Matron

5.9 **Events in the Neonatal Unit in Countess of Chester NHSFT**

11:25 Review and discuss
Sponsors: Gail Byrne, Chief Nursing Officer/Paul Grundy, Chief Medical Officer
Attendee: Sarah Herbert, Deputy Chief Nursing Officer

5.10 **Safeguarding Annual Report 2022-23**

11:40 Receive and discuss
Sponsor: Gail Byrne, Chief Nursing Officer
Attendees: Sarah Herbert, Deputy Chief Nursing Officer/Kirstie Girling, Named Nurse for Safeguarding Children/Corinne Miller, Named Nurse for Safeguarding Adults

5.11 **Patient Safety Incident Response Framework (PSIRF) Policy and Plan**

11:50 Review and discuss
Sponsor: Gail Byrne, Chief Nursing Officer
Attendees: Sarah Herbert, Deputy Chief Nursing Officer/Vickie Purdie, Patient Safety Specialist and PSIRF Implementation Lead/Christina Rennie, Medical Lead for Safety

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

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

12:00 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

6.2 **Health and Safety Annual Report 2022-23**

12:05 Receive and discuss
Sponsor: Gail Byrne, Chief Nursing Officer
Attendee: Jane Fisher, Head of Health and Safety Services

6.3 **People and Organisational Development Committee Terms of Reference**

12:15 Review and approve
Sponsor: Steve Harris, Chief People Officer

7 **Any other business**

12:20 Raise any relevant or urgent matters that are not on the agenda

8 **Note the date of the next meeting: 30 November 2023**

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

24 August 2023
Finance Report 2023-24 Month 4

9.1 **CRN: Wessex 2023-24 Q1 Performance Report**

Note the report
Sponsor: Paul Grundy, Chief Medical Officer

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

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

11 **Follow-up discussion with governors**

12:30

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University Hospital Southampton
NHS Foundation Trust

Minutes Trust Board – Open Session

Date	27/07/2023
Time	9:00 – 13:15
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) Diana Eccles, NED (DE) 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) Ellis Banfield, Associate Director of Patient Experience (EB) (item 5.16) Diana Hulbert, Guardian of Safe Working Hours and Emergency Department Consultant (DH) (item 5.14) Jennifer Milner, Lead Matron for Cancer Care (JM) (item 2) Lauren Kennedy, Engagement Officer (LK) (item 2) 1 member of the public (item 2) 5 governors (observing) 8 members of staff (observing) 4 members of the public (observing)
Apologies	Martin De Sousa, Director of Strategy and Partnerships (MDeS)

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

The Chair welcomed attendees to the meeting.

It was noted that Jane Bailey had been appointed as deputy chair of King's College Hospital NHS Foundation Trust. It was noted that there were no other interests to declare in the business to be transacted at the meeting.

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

2. Patient Story

Jayne Tamlyn was invited to speak about her experience of hair loss when receiving treatment for cancer and how the Trust could better support patients with hair loss when undergoing chemotherapy. It was noted that:

- Work was underway in terms of improving the options for wigs for patients from minority communities.
- Consideration was to be given as to whether to extend the remit of the Cancer Board to also include non-performance related matters.

- The vouchers provided to patients did not necessarily cover the cost of the wig and hence the possibility of charitable funding should be considered.

3. Minutes of the Previous Meeting held on 25 May 2023

The draft minutes tabled to the meeting were agreed to be an accurate record of the meeting held on 25 May 2023.

4. 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.

5. QUALITY, PERFORMANCE and FINANCE

5.1 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 17 July 2023. It was noted that:

- The committee had reviewed the Trust's risk register as well as the Trust's current Freedom of Information Act and Subject Access Request compliance.
- The committee had received a report from the Trust's Fraud team.
- The committee had reviewed the internal audit report in respect of sustainability and noted that the Trust required clearer guidelines and reporting in this area.

5.2 Briefing from the Chair of the Charitable Funds Committee

The chair of the Charitable Funds Committee was invited to provide an overview of its meeting held on 28 June 2023. It was noted that:

- The charity had received £1.6m in income and the legacy strategy was working.
- Expenditure had increased to £2.1m for the year-to-date.
- The charity was on track to raise £1.3m for capital projects.
- Work was ongoing in respect of closing down restricted funds.

5.3 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 24 July 2023. It was noted that:

- The committee had reviewed the latest financial position of the Trust, including understanding the flows within and outside of the organisation.
- The committee received a quarterly report from Informatics, including on the work to align Informatics with the Always Improving programmes of work.
- The committee examined the impact of the Trust's entry into the recovery support programme.
- The 'getting it right first time' data for dermatology was reviewed. It was considered appropriate that Paul Grundy should attend for these discussions.

5.4 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 19 July 2023. It was noted that:

- The committee reviewed the People Report (see item 5.11) and noted some early signs that the controls introduced in respect of use of bank and agency staff were beginning to have an effect and that sickness absence and turnover rates were reducing.

- The committee received the annual employee relations report and noted that 95% of cases related to sickness absence.
- The committee also reviewed the Trust's action plan in respect of bullying and harassment.

5.5 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 17 July 2023. It was noted that:

- The committee reviewed the Trust's key quality indicators and noted a continued and sustained reduction in the number of falls. However, there had been an increase in the number of medication errors.
- The committee received a report from the Quality Governance Steering Group and noted the impact of delayed discharges on patient care and two never events.
- The format of the regular maternity reports would be changing with certain items mandated to be reported to the Board from April 2024 onward.
- There continued to be significant issues in mental health provision with a national shortage of psychiatric staff and changes to policing policy.
- The Trust's waiting list was being managed to avoid harm to patients and the median waiting time was increasing given the focus on 'long-waiters'.
- The police were intending to reduce the level of support provided in respect of responding to incidents involving mental health patients. The Trust was working with Solent and Southern Health and Gail Byrne had established a mental health task and finish group.

5.6 Chief Executive Officer's Report

David French was invited to present the Chief Executive Officer's Report, the content of which was noted. It was further noted that:

- During the industrial action by consultants between 20-22 July 2023, a lower proportion of consultants at the Trust participated than elsewhere.
- There were other planned strikes during August 2023, and it was difficult to see how and when the current situation would end. The prolonged industrial action was having a significant impact on both the Trust and the NHS in general.
- The impact of industrial action was to be reflected in updated Elective Recovery Fund targets for April 2023. The Trust's performance was 111% year-to-date compared to pre-COVID levels, which placed the Trust as one of the highest performers.
- There was a national productivity challenge, similar to that experienced by the Trust, with the NHS facing significant issues including capacity, prolonged industrial action, inadequate capital funding and increased patient acuity.
- NHS England had published the Long-Term Workforce Plan, which pledged an additional £2.4bn in investment in training, retaining and reforming the NHS workforce.
- It was expected that the works due to take place at Basingstoke under the New Hospitals Scheme would be completed in 2032.
- The recently opened Wellbeing Hub had resulted in positive feedback from staff.

5.7 Hampshire and Isle of Wight (HIOW) Recovery Support Programme

The Chair presented the paper 'Oversight Framework 4 and Recovery Support Programme', the content of which was noted. It was further noted that:

- The Trust, along with all other providers in the Hampshire and Isle of Wight Integrated Care System (ICS), had been notified of the entry of the ICS into the recovery support programme on 1 June 2023.
- All providers had agreed to enter into a series of undertakings under this programme.
- A system improvement director had been appointed by NHS England. Their role would include making cases for investment to NHS England on behalf of the ICS.

The Board discussed the Trust's entry into the recovery support programme. The discussion is summarised below:

- The plan to be agreed with NHS England would require all providers to work together in order to achieve its objectives.
- The Trust intended to be on a break-even run-rate by the end of 2023/24, ahead of the rest of the system. However, this plan was dependent on certain assumptions, including regarding patients with no criteria to reside and mental health services provision. The Trust's plan was also dependent on the collective ICS plan.
- The system improvement director's role in identifying issues in the ICS could be used as an opportunity to improve as a system.
- Communications in respect of entry into the recovery support programme should not simply focus on the financial aspects.

5.8 Performance KPI Report for Month 3

Joe Teape was invited to present the Performance KPI Report for Month 3, the content of which was noted. It was further noted that:

- The Trust continued to face significant challenges due to the number of patients without criteria to reside, but it was not possible to discharge them due to lack of appropriate care facilities or similar.
- An increase in the number of births by caesarean section to 43.5% had placed further pressure on the Trust's theatre capacity.

The Board challenged what the cost of the patients without criteria to reside was for the Trust. It was noted that 100 patients would equate to approximately £10m.

The Board questioned the increasing number of caesarean births. It was noted that recent reports on maternity unit failings had led members of the public to believe that a caesarean was safer and that commissioners were no longer applying pressure on trusts to reduce the number of such procedures.

The Board discussed the spotlight in respect of cancer two-week-wait performance. It was noted that:

- The fundamental issue was due to the high levels of demand with June 2023 seeing the highest ever demand in month.
- Approximately 25% of referrals from General Practitioners (GPs) were within the scope of the two-week-wait metric.
- GPs had been encouraged to use this pathway for good reason. The incidence of diagnosis was relatively low, but where cancer was detected, the outcomes were significantly improved.
- However, support was required from the ICS to implement improvements such as mandatory use of the tele-dermatology programme or using alternative pathways, such as sending patients directly for MRI scans.

5.9 Break

5.10 Finance Report for Month 3

Ian Howard and Phil Bunting were invited to present the Finance Report for Month 3, the content of which was noted. It was further noted that:

- The Trust's deficit year-to-date was £13m against the planned £11m. The plan assumed a month-on-month improvement in terms of the monthly deficit.
- There had been a number of contributing factors to the adverse position during June 2023, including the Agenda for Change pay awards and the Elective Recovery Funding (ERF) performance being lower than expected due to industrial action.
- NHS England had agreed to adjust the April 2023 ERF figure to take into account the disruption caused by industrial action, and it was anticipated that other similar adjustments would be made.
- It was understood that any pay settlement with junior doctors would likely have to be funded out of existing Department of Health and Social Care budgets, which would have an impact on other programmes.

5.11 People Report for Month 3

Steve Harris was invited to present the People Report for Month 3, the content of which was noted. It was further noted that:

- The report had been discussed at the meeting of the People and Organisational Development Committee held on 19 July 2023.
- The overall total workforce remained 102 whole-time equivalents above plan, but there had been a reduction in use of bank and agency staff, although it should be noted that there would usually be a spike during the summer period due to annual leave taken by permanent staff.
- The sickness absence rate had fallen to 3.9% on a rolling 12-month basis and 3.2% year-to-date against the Trust's target of 3.9% for 2023/24.
- Turnover was at 12.9%, below the Trust's target of 13.6%.
- The overall completion rate for appraisals remained low largely due to the system used and staff capacity constraints.
- David French and Steve Harris were meeting with the divisions to discuss local plans in respect of the outputs from the staff survey.
- There had been more than 500 nominations for the UHS Champions awards.
- In view of recent announcements in respect of the NHS workforce plan, there was a risk of confusing messaging given the stated intention to invest in the workforce, but at the same time imposing financial constraints on recruitment and other activities.

5.12 Maternity Dashboard/Perinatal Quality Surveillance Report

The paper 'NHSR Maternity Incentive Scheme Year 5 – minimum data reporting to receive and note' was tabled to the meeting, the content of which was noted.

5.13 PMRT (Perinatal Mortality Review Summary) Report

[This item was incorporated within the paper referred to at 5.12 above.]

5.14 Guardian of Safe Working Hours Quarterly Report

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

- It was acknowledged that some of the newer doctors needed additional support in working at the Trust due to its size and complexity, especially where the doctors had also come from overseas.
- A session had been held where participants could offer criticism, but also discuss potential solutions to issues raised.
- The impact of continued industrial action on new starters needed to be monitored.
- It was expected that the renovation work underway in the mess would be completed in the next couple of weeks.

5.15 Medical Appraisal and Revalidation Annual Report including Board Statement of Compliance

Paul Grundy was invited to present the Medical Appraisal and Revalidation Annual Report, the content of which was noted. It was further noted that:

- The Trust had achieved a completion rate of 86.8% - its highest ever.
- Approximately 33% of those in scope had obtained deferrals, a reduction compared to the previous year (37%).
- It was necessary for the Board to confirm compliance with the Medical Profession (Responsible Officers) Regulations 2010 (as amended) and to review and approve the Statement of Compliance included as Appendix A to the annual report.

Decision

Having reviewed the Statement of Compliance included at Appendix A to the annual report, the Board approved the statement and authorised one of the Chief Executive Officer or Chair to sign the statement.

5.16 Annual Complaints Report 2022-23

Ellis Banfield was invited to present the Annual Complaints Report 2022/23, the content of which was noted. It was further noted that:

- All NHS providers were required to produce an annual complaints report in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.
- Whilst the number of complaints had increased during the year, the number was within the levels previously experienced prior to COVID-19, and remained below the average national level.
- The Trust was notified of seven complaints referred to the Parliamentary and Health Service Ombudsman, of which only one was formally investigated and partially upheld.
- The main themes of complaints were consistent with the national picture: clinical treatment, communication and patient care.
- Lessons learned from complaints were shared with the Always Improving team.

Action:

Ellis Banfield agreed to ask the team to investigate the demographics of complainants to identify any trends.

6. STRATEGY and BUSINESS PLANNING

6.1 Corporate Objectives 2023-24 Quarter 1 Review

David French was invited to present the paper 'Corporate Objectives 2023-24 – Quarter 1 Review', the content of which was noted. It was further noted that of the objectives for 2023/24, 17 were 'green', two were 'amber' and six were 'red'.

6.2 Board Assurance Framework (BAF) Update

Craig Machell was invited to present the Board Assurance Framework, the content of which was noted. It was further noted that:

- The Board Assurance Framework had been updated following discussions with the relevant executive directors and their teams.
- The Board provided feedback in respect of risks 3a and 3c.

7. CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

7.1 Feedback from the Council of Governors' (CoG) meeting on 26 July 2023

The Chair presented a summary of the meeting of the Council of Governors held on 26 July 2023. It was noted that the agenda had included:

- Non-executive directors' and Chair's Appraisal Outcomes
- CEO's Performance Report
- Strategic Objectives
- Annual Report and Accounts (including Quality Account) 2022/23 and external auditor's report
- Re-appointment of Jane Harwood
- Appointment of Femi Macaulay as an interim non-executive director
- Governors' Attendance at Council of Governors meetings
- Membership Engagement
- Feedback from the Governors' Nomination Committee and Working Groups

7.2 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'.

7.3 Trust Executive Committee Terms of Reference

It was noted that the Trust Executive Committee had reviewed its terms of reference at its meeting held on 19 July 2023.

Decision:
Having reviewed the Trust Executive Committee terms of reference tabled to the meeting, it was agreed to approve these terms of reference.

8. Any other business

It was noted that this was Jane Bailey's last meeting. The Board expressed its thanks to Jane Bailey for her service as a non-executive director.

It was noted that a regular report regarding the Trust's performance against the recovery plan would likely be required.

9. Note the date of the next meeting: 28 September 2023

10. Resolution regarding the Press, Public and Others

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

The meeting was adjourned.

List of action items

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 25/05/2023 5.9 Freedom to Speak Up Report				
987.	Future TBSS	• Byrne, Gail • Machell, Craig	09/11/2023	Pending
	Explanation action item Craig Machell and Christine Mbabazi agreed to include Freedom to Speak Up on a future Trust Board Study Session agenda. Update: Scheduled for TBSS on 9 November 2023.			
Trust Board – Open Session 27/07/2023 5.16 Annual Complaints Report 2022-23				
1013.	Demographics	• Banfield, Ellis	30/11/2023	Pending
	Explanation action item Ellis Banfield agreed to ask the team to investigate the demographics of complainants to identify any trends. Update: The information will be provided to the November Trust Board meeting.			

Report to the Trust Board of Directors				
Title:	**Chief Executive Officer's Report**			
Agenda item:	**5.3**			
Sponsor:	**David French, Chief Executive Officer**			
Date:	**28 September 2023**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	My report this month covers updates on the following items: • Industrial Action • Strikes (Minimum Service Levels) Act 2023 Consultation • Additional Funding for Winter 2023/24 • Recovery Support Programme • Fit and Proper Persons Test Changes • Regulation of NHS Managers • Local College Opportunities • Annual NHS Staff Survey			
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.			

Industrial Action

There was a further period of industrial action by junior doctors between 20 and 22 September 2023. In addition, consultants also went on strike between 19 and 20 September 2023. This was the first time that both junior doctors and consultants have carried out simultaneous strike action. Further strikes between 2 and 4 October 2023 by both junior doctors and consultants have been announced.

According to NHS Providers, the industrial action since December 2022 has cost in the region of £1bn and has resulted in approximately one million patient appointments being disrupted. In addition, it was recently announced that waiting lists in England have risen to 7.7m – the highest ever number.

The Trust continues to safely manage the ongoing industrial action. However, this is having an impact on both the Trust's surgical and outpatient programmes as well as on staff. Ongoing industrial action will also make achieving no patients waiting over 65 weeks by 31 March 2024 more difficult. That said, initial data suggests that the Trust was a positive outlier on both the number of doctors taking industrial action and the volume of cancelled electives / outpatient appointments.

Strikes (Minimum Service Levels) Act 2023 Consultation

The Strikes (Minimum Service Levels) Act 2023 enables the Secretary of State for Health and Social Care to make regulations to establish minimum service levels for relevant services in the event of strike action. On 19 September 2023, the Department of Health and Social Care announced the start of an eight-week consultation in respect of minimum service levels for 'essential and time-critical hospital services'.

Additional Funding for Winter 2023/24

On 14 September 2023, the Government announced additional funding of £200m for the NHS and £40m for social care capacity in order to support services through the winter months. It is understood that this is additional funding, rather than repurposing of existing budgets, but it is unclear at this stage whether the funding will be for specific initiatives or will be used nationally as additional financial support to offset costs associated with industrial action.

Recovery Support Programme

The Board is aware that the ICB and all providers in the Hampshire and Isle of Wight Integrated Care System including UHS have now formally entered the Recovery Support Programme (RSP). The NHSE website entry for UHS has been updated to show that the Trust is now in RSP. I am joining colleagues from the ICB and other providers in a meeting with the national team on 29 September where the recovery programme and the associated exit criteria will be discussed. A request to the national team for financial support (£2.5m) to facilitate the transformation programmes has been made and we are now waiting to hear whether that has been approved.

Fit and Proper Persons Test Changes

On 2 August 2023, NHS England published its Fit and Proper Person Test (FPPT) Framework. This was in response to the review conducted by Tom Kark QC and Jane Russell, which was published in 2019. The implementation of the recommendations was delayed due to COVID-19.

The FPPT Framework applies to both executive and non-executive directors and will come into effect from 30 September 2023.

There are a number of changes to the existing framework (largely governed by Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). These include:

- Additional information to be included on ESR about individuals and their qualifications and career history.
- Use of a new board member reference template for all new board appointments.
- Completion and retention of the new board member reference for any board member leaving the organisation for whatever reason.

Work is also ongoing in respect of a new NHS Leadership Competency Framework, which will help inform the 'fitness' assessment in the FPPT.

In addition, a new board appraisal framework, incorporating the Leadership Competency Framework, will be published by March 2024. This framework is to be used for annual appraisals of all board directors for 2023/24.

Regulation of NHS Managers

Following the verdict in the Lucy Letby trial, consideration is being given to creating a regulatory regime applicable to NHS managers similar to those applicable to other professions, clinicians and nurses.

In addition, as part of the statutory inquiry announced following the Lucy Letby case, the recommendations contained in the Kark Review regarding a sanctions regime are to be re-examined. In essence, the Kark Review proposed to introduce a definition of 'serious misconduct' (to differentiate it from 'less than competent') and to introduce a body within the NHS which would have the power to suspend and disbar directors covered by Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, who had been found to have committed serious misconduct.

Local College Opportunities

The Trust continues to capitalise on opportunities to expand its partnerships and influence with local education providers.

During August, we were informed that the bid for a University Technical College (UTC) in Southampton had been accepted by the Government. The UTC is set to open in September 2025 and will offer science, engineering, technology and mathematics subjects to students aged from 14-19. The new college aims to boost a lack of STEM skilled workers in the area as well as creating opportunities for young people.

I have taken a personal interest in supporting the bid as a major employer in Southampton, including joining the team to pitch to the Department of Education in London and subsequently meeting with the Education Minister. In addition, the Trust's Head of Widening Participation has played a key role in the bid steering group. The Trust has been invited to take a seat on the board of the UTC which the Chief People Officer will take up.

On 1 August 2023, City College Southampton, Eastleigh College and Fareham College merged to become South Hampshire College Group (SHCG). The Chief People Officer (CPO) is meeting representatives of the new leadership team during October to continue to build relationships.

Both these developments provide a great opportunity to partner with education institutions to develop and nurture talent in the city. Working with these local providers will strengthen our influence on curriculum development and placement opportunities, ultimately creating routes for

recruitment at the Trust. In addition to supporting our People strategy, this underlines our commitment and reputation as an anchor institution in the area.

Separately, Solent University have appointed Professor James Knowles as their new Vice Chancellor following the departure of Karen Stanton. I am meeting with Professor Knowles as part of his induction programme.

Annual NHS Staff Survey

The annual staff survey launched on 18 September 2023. This remains a critical method to support understanding the needs of our workforce and provides insight to guide the Trust's People Strategy implementation.

Last year, over 7,000 staff (54%) completed the survey and UHS is aiming to achieve at least this level in 2023. A communication campaign was undertaken leading up to survey launch, including reminders to our staff of all the supportive actions we have taken throughout the year. I and the CPO have also written to staff to encourage their participation.

The People and Organisational Development Committee has been briefed on the plans enacted prior to launch and the ongoing action to encourage participation. The embargoed public results will not be available until February 2024 but the CPO will advise the Board of any early insights we receive.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Performance KPI Report 2023-24 Month 5**			
Agenda item:	**5.4**			
Sponsor:	**David French, Chief Executive**			
Author	**Sam Dale, Associate Director of Data and Analytics**			
Date:	**28 September 2023**			
Purpose	**Assurance or reassurance** **Y**	**Approval** **Y**	**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 • This month the Board is also asked to approve a self-assessment checklist provided by NHSE, outlined in Appendix 1			
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. However, the Board is asked to **approve** the Trust's self-assessment against an NHSE assurance checklist outlined in Appendix 1.			

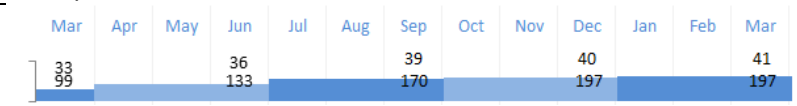
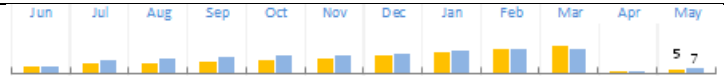
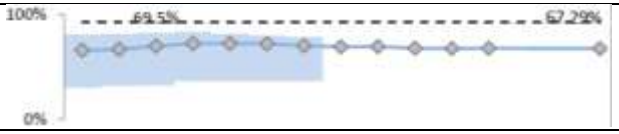
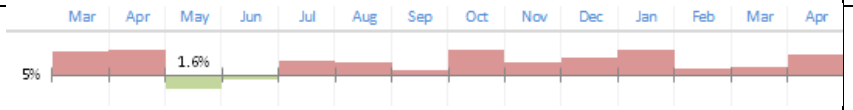
University Hospital Southampton NHS
NHS Foundation Trust

Performance KPI Board Report

Covering up to
August 2023

Sponsor – David French, Chief Executive Officer
Author – Sam Dale, Associate 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.

This month, as well as the Trust's usual performance report, the report contains a letter from NHSE on protecting and expanding elective capacity, and our self-assessment against their checklist. The Board is asked to approve our self-assessment against this checklist.

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.

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

- Data updates: as there was no Trust Board in August, the Performance KPI report now reflects metric updates available since the July publication
- Data correction: the criteria for our reported C Difficile cases was not aligned to the national reporting submission criteria. This has now been corrected and adjusted for relevant prior months.

Summary

This month the 'Spotlight' section contains an update on Emergency Department Performance and Diagnostic Performance. In addition, as an appendix to this report, we have included the UHS self-assessment in response to the NHS England letter on protecting and expanding elective capacity for review by the Board. Despite the ongoing operational pressures within the Trust, we continue to focus on ensuring that we deliver, to the best of our ability, against the national targets for elective recovery.

The Emergency Department spotlight highlights that:

- The department at UHS has seen continual growth since 2019/20 (16%) and is now averaging over 365 attendances per day
- Recent performance against the four hour target is 63.7% for the Trust. However in July 2023, UHS ranked fourth against comparator benchmark Teaching Hospitals, illustrating that Trusts across the country are all facing significant pressure on their emergency services
- A key challenge for the Trust has been maintaining our high performance on ambulance handover times which came under significant pressure in recent months
- A series of actions are being taken to support the situation with the primary aims being to prevent inappropriate ED attendances, increase diagnostic efficiency, streamline effective clinical decision making and increase patient flow across the hospital

The Diagnostic spotlight highlights that:

- Despite the impact of Industrial Action, the Trust has been able to reduce its diagnostic waiting list month on month in 2023/24 and is now below 9,000 patients waiting for the first time since August 2020
- The Trust's performance was at 80% in July and UHS ranked tenth in the latest Trust comparator report against other Teaching Hospitals
- Cardiac MRI has been a key performance challenge, but the Trust has now served notice on transfers from Salisbury and Portsmouth
- Other challenged modalities are Sleep Studies and Neurophysiology. A series of actions around recruitment, additional lists and transformation schemes are being taken forward to support an improved trajectory across the remainder of the year

Areas of note in the appendix of performance metrics include:

1. There have been positive trajectories in our cancer performance statistics since last publication:-
    a. The 2WW performance improved following validation of the May position combined with July's current position of 67.5% moving UHS out of the fourth quartile when compared with other comparator Teaching Hospitals

   b. There has also been a significant improvement in performance for 31 day cancer metrics across the summer months with July's performance at 93.9% and the Trust now benchmarking in the top quartile of comparator Teaching Hospitals
   c. Our focus on the breaches has continued to reflect within our overall 62D performance. This has improved to 67% in July 2023 keeping us in the top quartile of relative performance versus other teaching hospitals.
2. We have two patients who have waited over 104+ weeks for treatment at the end of August 2023. Both patients are waiting for corneal tissue to be issued by the NHS transplant service, with availability of transplant material continuing to be a wider national issue.
3. CRN recruitment performance remains a cause for concern with UHS now ranking at 21st (non weighted) and 15th (weighted) for August. This was in part due to reduced capacity across the infrastructure and study sponsors as a result of planned summer leave which has impacted new studies commencing recruitment. A detailed action plan has been submitted for Trust Board review.
4. The proportion of births delivered through caesarean section has continued to increase. 44.8% is the highest percentage in the last fifteen months continuing to place a strain on the service. This is an ongoing and national trend influenced by NICE guidance asking hospitals to support a birthing person's request to a Caesarean where the hospital are satisfied this is an informed choice. The service is reviewing how to ensure birth preference conversations happen as early as possible.

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 11 September 2023, there was a slightly extended handover period, driven by some operational pressures within the Emergency Department and wider Trust with flow. Our average handover time was 18 minutes 388 seconds across 749 emergency handovers, and 23 minutes 11 seconds across 45 urgent handovers. There were 70 handovers over 30 minutes, and 12 handovers taking over 60 minutes within the unvalidated data.

Spotlight: Emergency Department (ED) Performance

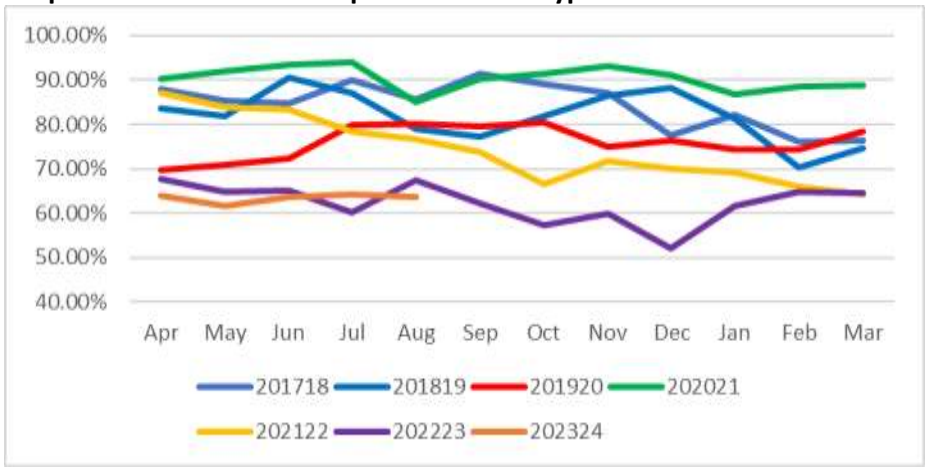
Four hour standard, from arrival to admission, transfer or discharge from the Emergency Department

At a national level, there continues to be challenges in meeting demand on emergency services. This trend is also seen within UHS, and we are currently not meeting the national ED target. Performance stood at 63.70% (Type 1) of patients seen within 4 hours in August 2023 (graph 1). We recognise that this performance is lower than in previous years, and this is partly attributed to Type 1 attendances to ED continuing to be higher compared to pre-COVID levels.

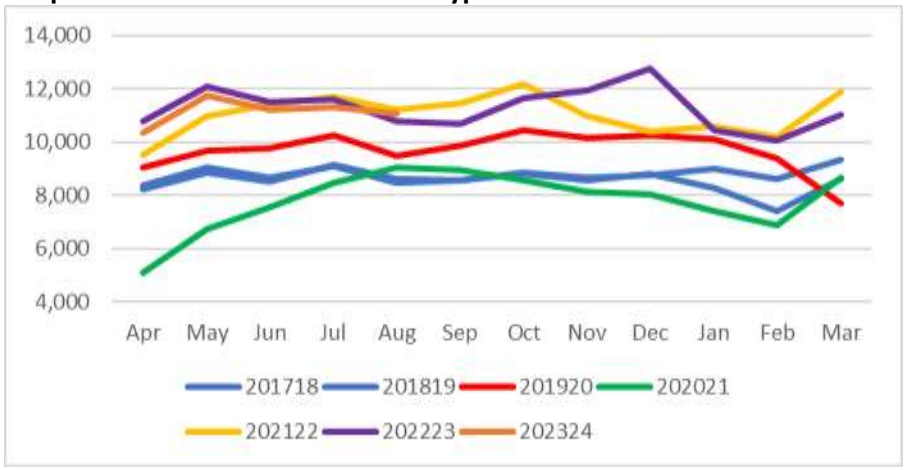
From April 2023 to August 2023 we averaged over 365 attendances per day (graph 2), compared to an average of 316 per day for the same time-period in 2019/20 (a 16% increase).

We are currently doing better than the plan submitted for 2023/24. We do predict challenges in achieving the end of year target of 76% for all types of ED attendances due to rising pressure within the hospital linked to demand, industrial action and covid although our aspiration is to still achieve the national target.

Graph 1: Trended ED 4 hour performance – Type 1

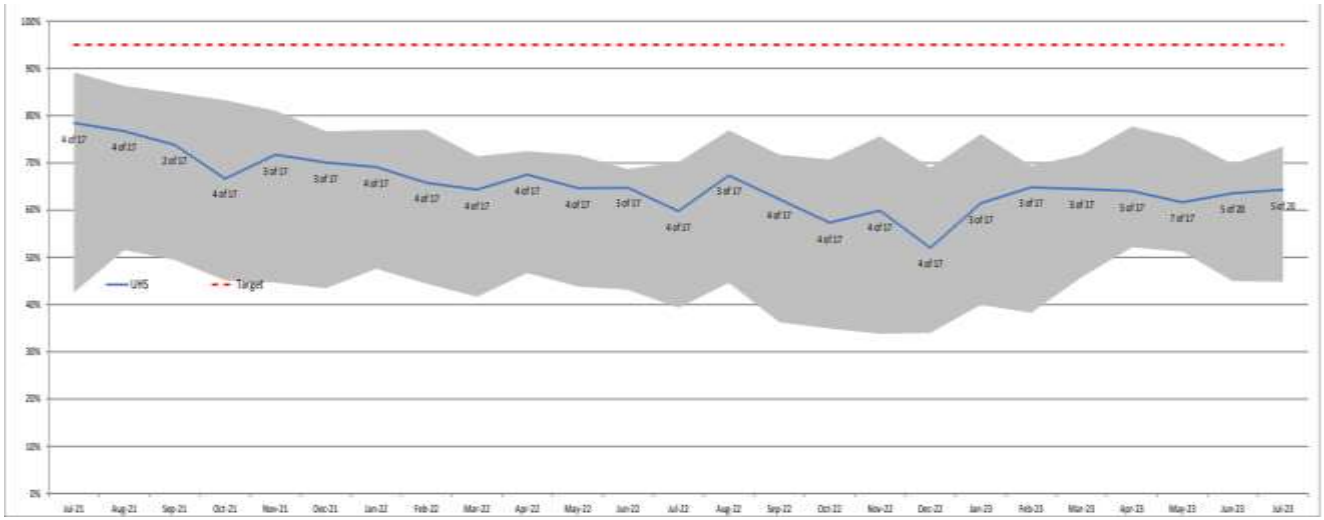


Graph 2: Trended ED attendance – Type 1



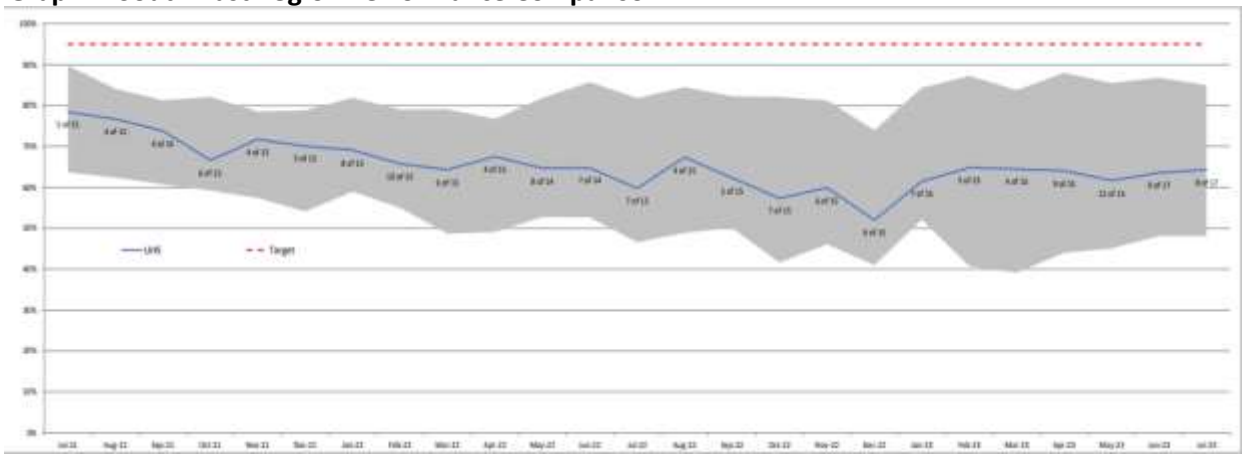
Graph 3: Teaching Hospital Performance Comparison

Our performance relative to other teaching hospitals continues to be relatively good, demonstrating that ED performance is a national issue. Graph 3 highlights our Type 1 performance compared to 20 similar Teaching Hospitals, where UHS ED has consistently ranked in the upper quartile, and in July 2023 was ranked fifth of the teaching hospitals for 4 hour performance.



Graph 4: South-East Region Performance Comparison

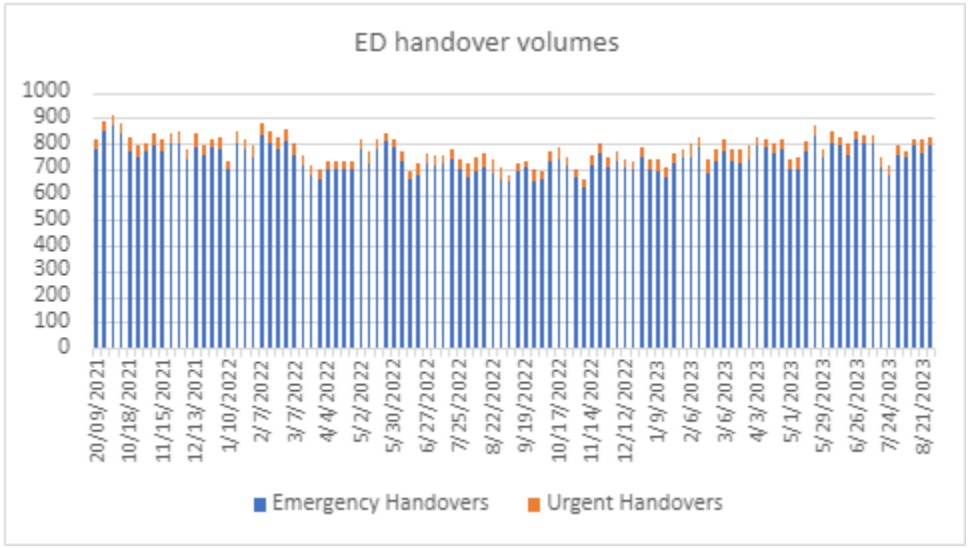
The following graph highlights our Type 1 performance compared to all 17 hospitals reporting results in the South-East region, where in July 2023 UHS ED ranked eighth best.



Ambulance Handover Performance Target "All handovers must take place within 15 minutes with none waiting more than 30 minutes"

Ambulance Handovers are a current focus area for NHS England and is also one of the key priority areas within the national priorities for 2023/24.
UHS has constantly performed very well in relation to measures of timely ambulance handover and continues to do so compared to peers.
Within the last 3 weeks (end of August to current) capacity in majors in UHS has started to trend up again so much so we have been using a SCAS crew regularly to support ambulance crews with handing over to prevent ambulance queues and delays. Unfortunately, due to the unprecedented position of ambulances queuing to get into UHSFT ED we requested support for a divert request on Saturday 9th September from SCAS to neighbouring hospitals for a period of 3 hours. This position is due to the current wicked problems we are facing related to UEC demand, flow and the impact of not having timely decisions at the front door of the hospital.

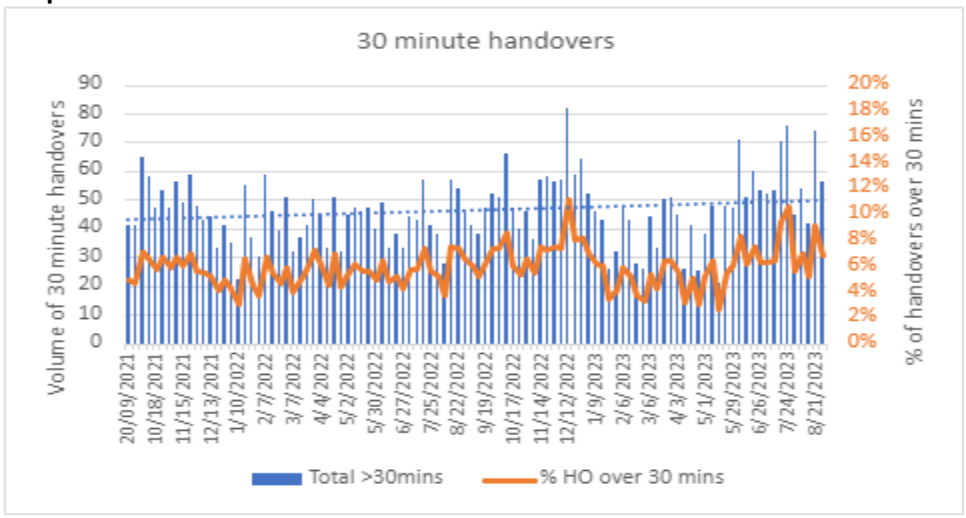
Graph 5: Ambulance handovers to ED (unvalidated)



Total ambulance handover volumes into the Emergency Department per week from September 2021 to August 2023

- There has been a continual increase in the weekly average handovers of patients being conveyed to ED in Ambulances as seen in graph 5.
  - Q1 2023/24 = 810 per week
  - Q4 2022/23 = 773 per week
  - Q3 2022/23 = 744 per week
  - Q2 2022/23 = 732 per week
- Acuity is increasing generally across the board and within the department.
- With increased acuity more focussed work has gone on with the internal queue over past 6-12months with call buzzers being installed along corridor and testing of safety.
- A clear standard operating procedure for SCAS support to the corridor is still being worked on in collaboration with SCAS.
- Focus on pitstop processing model internally at UHS to ensure it remains pitstop and as efficient as possible.
- Written internal escalation plan has provided structure for how we queue patients, focus on ambulance turnarounds remains as it always has but balance of safety is of equal focus.

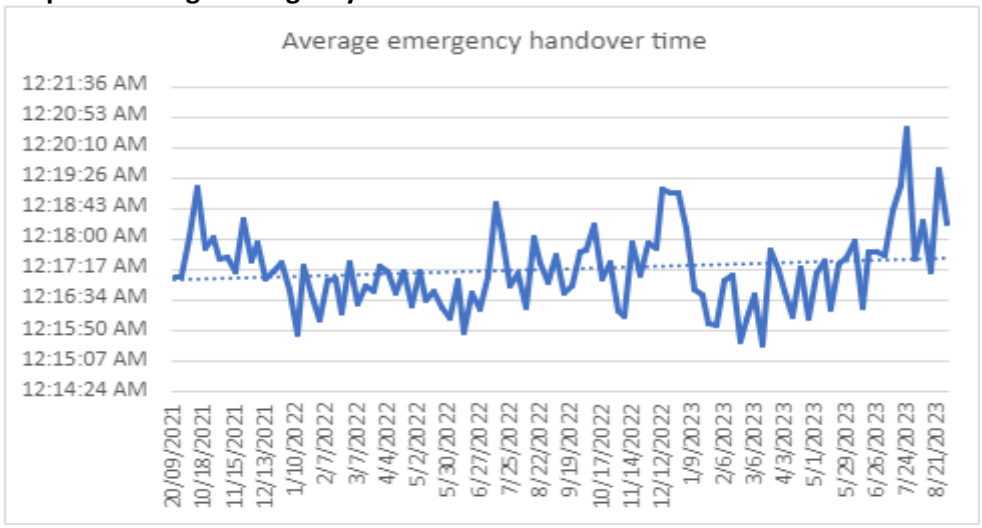
Graph 6: Ambulance handovers to the ED within 30 minutes



Ambulance handovers into the Emergency Department taking longer than 30 minutes as a volume and percentage, per week, from September 2021 to August 2023.

- UHS ED 30 minute handover performance remains strong, although in the last week in August our average handover time was 20 minutes.
- Equally our performances versus 60 minute handover delays continue to hold-up compared to other trusts in the South East and South West regions.

Graph 7: Average Emergency Ambulance handover time to the ED



- Average emergency handover time week commencing 28th August was 18mins, compared to 17 minutes at the end of March 2023.
- Average urgent ambulance handover time for week commencing 28th August was 22 minutes, compared to 18mins at the end of March 2023.
- Actions being followed up to balance the risk of queues inside with outside the ED at UHSFT are identified above.
- We are also working closely with SCAS to support validation of daily handover data as we have provided examples of inaccuracies.

What are we currently doing about the challenges at the front door of the hospital?

The following four actions below have been circulated to all Divisional and Care Group Management Teams in the hospital and asked for written confirmation by the 29th September 2023 by the Clinical Director of UEC and UHS COO.

1. Where patients are referred for admission/assessment, please ensure that CT scans and clinical reviews occur in admission areas, rather than waiting for these to be completed in ED.
2. Where patients require admission from home/community, they should only come to ED if emergency life-saving treatment (resus facility) is required, otherwise patients should be admitted to specialty assessment areas/wards. All services will need to work up options for assessment surge capacity supported by a risk assessment. We must avoid ED remaining as the default admission area. Where patients present to ED with a referral letter to a specialty service, we will expect that these patients are transferred directly to the relevant admission/assessment area rather than staying in ED.
3. Admitting specialties will need to provide early access to a senior decision maker via bleep or phone. In the event that the senior decision maker is unable to speak on the phone an alternative plan needs to be in place such that patients are not waiting unnecessarily in ED.
4. We need to have a careful focus on ward discharges (7 days a week), with patients leaving ward areas much earlier in the day. This will require support from the MDT, with full utilisation of the discharge lounges and identification of a 'golden patient' to be discharged by 10am each day.

Snapshot of internal to ED actions:

- Continued to engage with SPCL on providing support from GPs in ED to support decompressing the ambulatory pathways
- Focus on the workforce by reducing rota gaps, profiling attendances to resource available using national tools, continuing with consultant of the day workshops and the completion of an SOP to support ongoing review
- Rollout of new IT system in ED
- Resetting of 1 hr standard to support flow out of ED – links to the actions highlighted above
- Review of pathways in & out of ED and ensure they are being used effectively and develop were appropriate, include review of the directory of service
- Continue with SDEC focus at the front door and back door. Front door strategy being worked on to support medical flow and timely admission discussions pulling from ED
- Focus on pitstop processing model internally at UHS to ensure it remains pitstop and as efficient as possible.

Spotlight: Diagnostic Performance

The following report is based on the validated July 2023 submission.

Background

The Elective Care guidance from NHS England and Improvement (NHSE/I) states the "ambition is that 95% of patients needing a diagnostic test receive it within six weeks by March 2025". This outcome is aligned with the principle that diagnostic activity levels must support plans to address elective and cancer backlogs as Trusts aim to eliminate waits of over 65 weeks for elective care by March 2024.

This diagnostic target applies to 15 different diagnostic tests, although performance is measured at a Trust level. These tests are broadly divided into three categories:

- endoscopy (e.g. gastroscopy, cystoscopy);
- imaging (e.g. CT, MRI, barium enema);
- physiological measurement (e.g. echocardiogram, sleep studies).

In recent months, we have seen consistent improvements in the diagnostic waiting list (graph 2) as UHS has increased diagnostic activity to meet higher demand. Despite a reduction in activity during the junior doctor, consultant, and radiographer strikes, the August waiting list was 8557 (8924 in July). This is an improvement of 23% since the highs seen in May 2022, and the lowest waiting list size since August 2020.

Activity Volumes

Whilst the consultant and junior strikes have impacted endoscopic services, the impact on radiology activity has been minimal as scans were converted from supervised to unsupervised. However, the first radiographer strike in July has impacted our waiting list and performance due to the volume of required cancellations outlined in table 1 below:-

Modality	Tues 25th July	Weds 26th July	Total Lost Activity
CT	91	72	163
MRI	60	62	122
Planar	214	246	460
Ultrasound	53	48	101
Total	418	428	846

Nevertheless, elective diagnostic activity being delivered at UHS has increased throughout 2023/24 helping to reduce the waiting list despite the strike complications and high referral volumes.

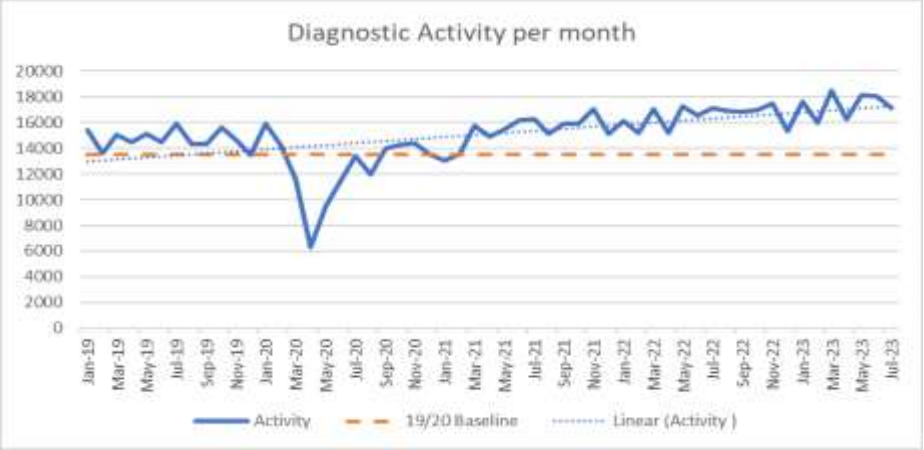
Graph 1 illustrates how recent diagnostic activity is approximately 22% higher than the 2019/20 baseline (approximately 17,000 procedures per month vs baseline of 13,200).

At the start of 2023/24 the care groups developed plans to maintain, and, where possible, increase diagnostic activity to meet the increased demand and to enable UHS to move progressively closer to NHS England's 95% target by March 2025. This remains a challenging target, but actions taken include:-

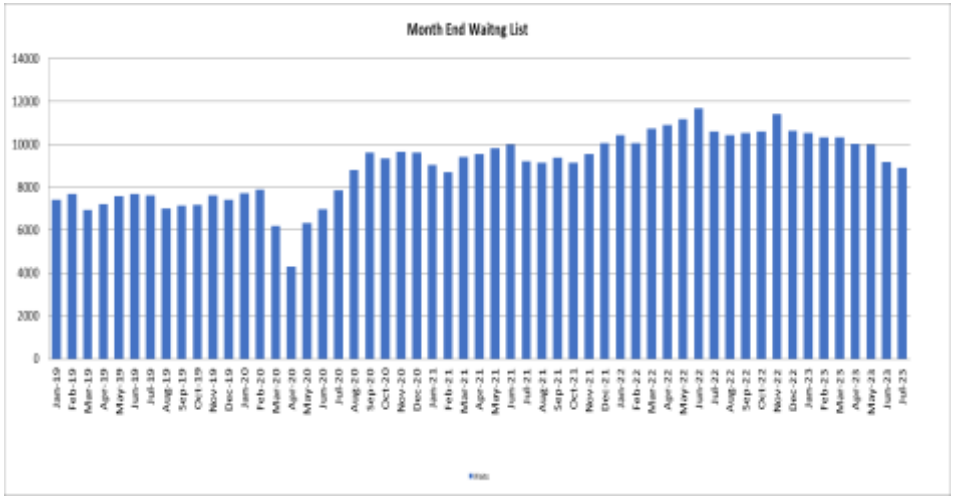
- Working with services to reduce DNAs, improve booking processes and gain assurance on patient validation
- Additional insourcing of services alongside WLIs and weekend lists
- Ongoing recruitment to vacant positions
- Out of area referral prevention
- Service reconfiguration and pathway changes

These positive developments and ongoing challenges are outlined further in the modality sections of this paper

Graph 1: Diagnostic Activity Delivered by Month



Graph 2: Waiting List Size by Month

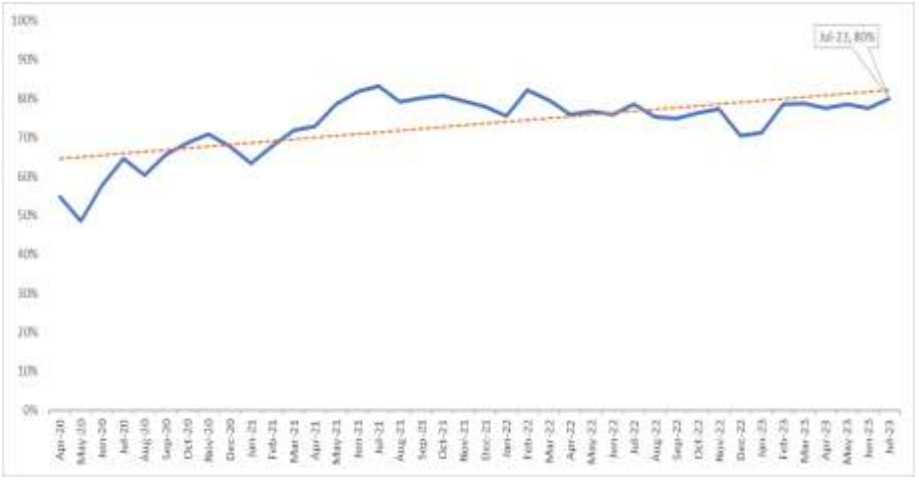


Performance Position

The Trust submitted performance demonstrates a positive, upward trajectory reaching 80% in July which is a significant improvement from the performance dip we saw across the Christmas period.

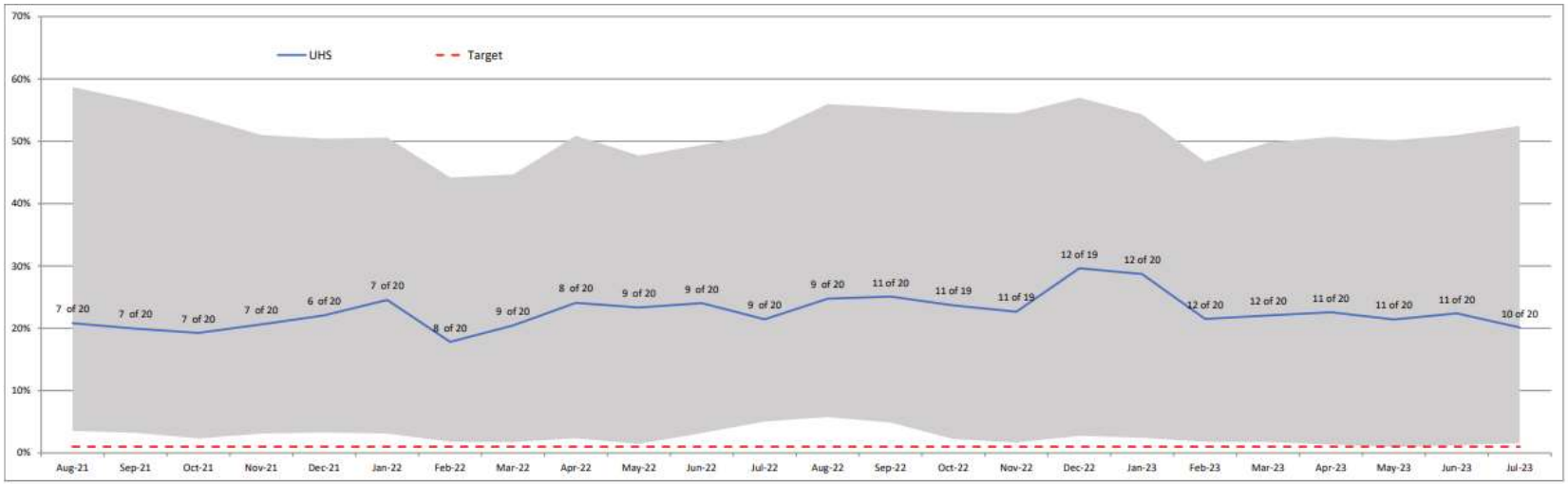
When benchmarking our performance against other peer teaching hospitals (graph 4), the Trust had historically been in the second quartile. Our July performance is now in the second quartile - ranked 10 out of 20 teaching hospitals.

It should be noted, that there is a wide spread of diagnostic performance – with some trusts delivering fewer than 50% of tests within the six-week target.



Graph 3: History of Overall Diagnostic Performance by Month

Graph 4: Trust Comparator Report for UHS Diagnostics



Modality Focus: Endoscopy

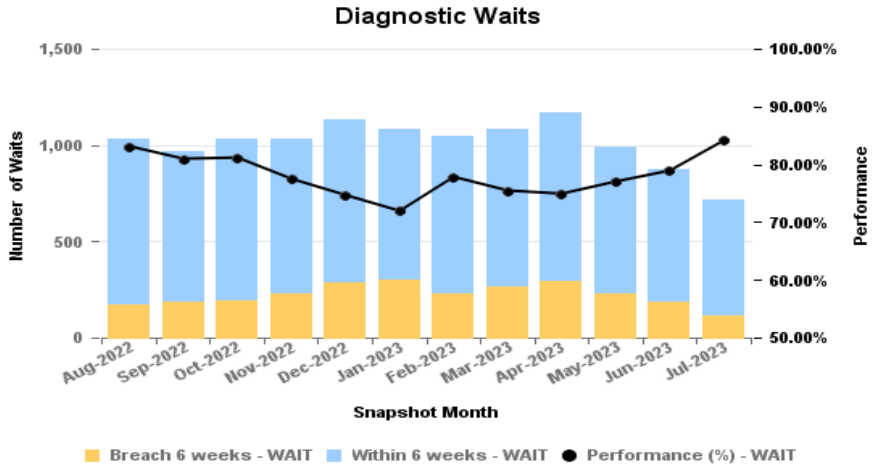
This modality includes include colonoscopy, cystoscopy, flexi-sigmoidoscopy and gastroscopy across both adult and paediatric services.

Diagnostic performance has been in the range of 80-83% which is comparable with Q4 2019/2020 when it was 86%. Demand has remained high, and the additional endoscopy capacity is now evident in a reducing waiting list.

The adult cystoscopy has been the key endoscopy diagnostic service dampening the overall modality performance, averaging 51% performance across the second half of 22-23 financial year. The service has revised the process for reviewing the increasing volumes of surveillance patients that are exceeding their APD (Approximate Planned Date) which was the main group of patients who were breaching six weeks.

The other two groups of patients (cancer and standard six week benign referrals) were taking the majority of the available capacity. However, more recently additional capacity (weekend lists) and a change to the admin booking processes plus new staff having been appointed have significantly improved the position which reached 70% in July. This additional capacity is expected to continue, alongside a new prostate consultant (who will focus on the prostate diagnostics) is joining the Trust in September 2023.

Graph 5: Performance trend and waits for all endoscopy services



The paediatric endoscopy service has consistently faced challenges with performance averaging 43% across 2023/24 and dropping to 24% in June 2023 due to scope equipment failure and lists taken down for strikes and anaesthetic gaps. However the position recovered in July 2023 (44%) and the gastroenterology service have confirmed additional WLIs will take place between now and December. There is also a renewed focus on both the patient validation processes alongside closer scrutiny of the performance position with clinicians.

Modality Focus: Imaging Services

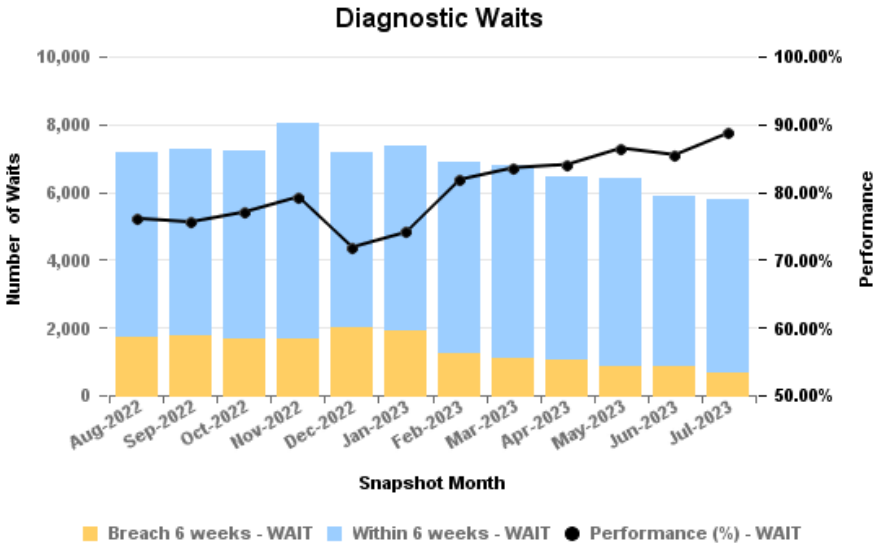
This modality includes include computed tomography (CTs), MRIs, Barium Enema and Non-Obstetric Ultrasounds

The Trust has seen an improved month on month performance position since Christmas 2022 hitting 85% in the validated July 2023 position. Activity levels have remained consistent in recent months averaging 1300 across all imaging services despite the interruptions caused by the industrial action. The waiting list has reduced by 27% since the spike in November 2022 with the July waiting list now below 6,000 patients.

CT performance is positive (92% in July 2023) as demand has reduced in the last three months linked to annual leave and strike impact. Cancer demand has also been relatively flat. The addition of the on-site mobile scanner (four days per week) continues to support diagnostic performance alongside additional in-house lists. There are also longer-term conversations around radiographer's ability to run cardiac lists without consultant supervision.

MRI performance has remained at around 76% in recent months predominantly driven by Cardiac MRI pressures (49% in July). The trust has now given notice to Salisbury and Portsmouth to stop referrals to UHS from November 2023 alongside the preparation of a business case to support one additional day of activity per week. It is anticipated that these actions will significantly improve the MRI position. General MRI performance is 97% and supported by the use of a relocatable MRI scanner seven days a week and additional in-house lists.

Graph 6: Performance trend and waits for all imaging services



A key pressure within Non-Obstetric Ultrasound is the consultant led specialist Head and Neck service which has been impacted by Strike activity. Consultants have agreed to put on additional WLI at weekends and a Portsmouth sonographer will be picking up one additional session per week. UHS is supporting the training of a sonographer in the head and neck speciality and will be working independently in mid 2024.

Modality Focus: Physiological modality

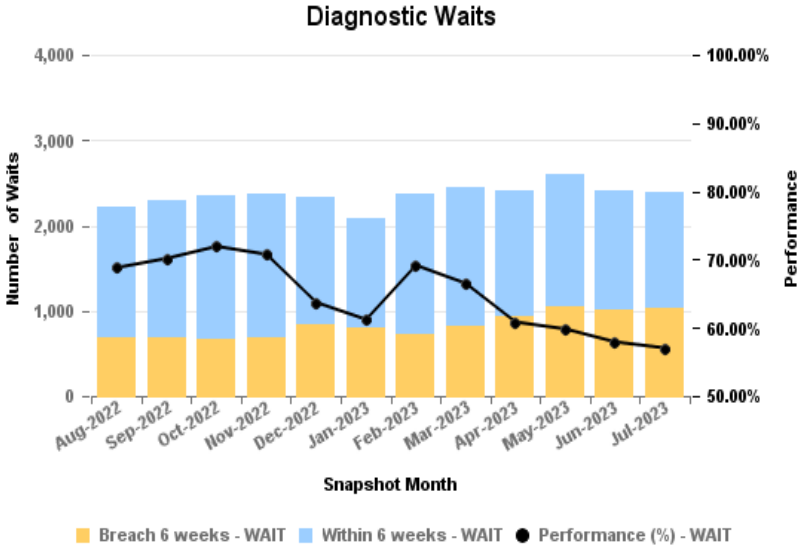
This modality includes Audiology, Echocardiography, Neurophysiology and Sleep Studies. Across the modality group, the performance position has marginally worsened since Christmas 2022 moving from 64% to 57% for the validated July position. This is despite the waiting list remaining reasonably consistent (2,300 per month on average).

Audiology performance is consistently at 100%, but overall performance is offset by continued pressures across the other services in particular sleep studies (56%), neurophysiology (43%) and echoes (62%)

The Neurophysiology service has had historic challenges with reduced Consultant capacity that have led to a significant backlog of patients waiting for diagnostics. The causes for the historic reduction in capacity have been due to gradual erosion of sessions that can be backfilled and higher levels of infection prevention measures in place. The service is optimistic of an upwards trajectory in the second half of the year as an insourcing contract is finalised and a series of transformation recommendations around e-scheduling are implemented. This will be further enhanced by a sixth consultant joining in 2024 (pending a business case).

The Sleep Study service has seen referral numbers increase from on average 15 a week to 35 over the last 2 years. The service has increased capacity by moving to a predominantly outpatient service. The transformation team have also been supporting the Sleep Studies service particularly in trying to address the high DNA rate (22%). The root causes have been the distance to travel (Lymington service) or patients struggling to rearrange appointments.

Graph 7: Performance trend and waits for all physiological metrics:-



Solutions will be worked through in September 2023, and embedded in October to support an upward trajectory alongside the recruitment of an existing Band 6 vacancy which will allow for capacity to meet demand. The service has also been piloting work with NHSP to call all patients 48 hours before their appointment to ensure attendance with results showing a DNA reduction of 10-15 patients per week. The echo service is predicting an improvement in the position after the summer as additional all day lists are being planned alongside a substantive consultant joining the team in October.

The echo service is predicting an improvement in the position after the summer as additional all day lists are being planned alongside a substantive consultant joining the team in October.

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*

Classification: Official

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

To:
- NHS acute trusts:
  - chairs
  - chief executives
  - medical directors
  - chief operating officers

cc.
- NHS England regional directors

4 August 2023

Dear Colleagues,

Protecting and expanding elective capacity

In May, we wrote to you outlining the priorities for elective and cancer recovery for the year ahead. Last week, as part of the winter letter, we also asked you to maintain as far as possible ring-fenced elective and cancer capacity through winter.

We would like to thank you for your continued hard work in these areas, in the face of significant wider operational challenges, including ongoing industrial action. Thanks to the efforts put in by staff across the NHS, we have now virtually eliminated pathways waiting over 78 weeks, down by 94% since the peak of 124,000 in September 2021 (and now representing c0.1% of the total list), and significantly decreased the number of patients with urgent suspected cancer waiting longer than 62 days from a high of 34,000 to around 21,000 today.

However, one area where we know there remains more to do is outpatients. We have listened to your feedback on the support you need for this transformation and have set out the next steps below.

National support for outpatient transformation

To support outpatient transformation, we have met with royal colleges, specialist societies and patient representatives to agree a way forward, working in partnership, to champion and enable outpatient recovery and transformation. At the 'call to arms', colleges agreed to:

- review their guidance on outpatient follow-ups
- support new approaches to increasing wider outpatient productivity, including reducing variation in clinical templates, patient discharge, and following clinically-informed access policies.

Publication reference: PRN00673

Together with this clinical leadership, we need to build on the expectation of freeing up capacity and increasing productivity. This can be achieved through reducing follow up appointments with no procedure, fully validating RTT waiting lists, reducing variation in clinical templates, moving to patient-initiated follow-up where appropriate, following clinically-informed access policies and implementing new ways of working, such as group outpatient follow ups, reviewing clinical pathways and workforce models.

We are continuing to provide support to trusts in this area, through the following:

- Regional support
- NHS England's GIRFT outpatient guidance
- Action on Outpatients series
- The Model Health System
- Support to specific trusts via NHS England's GIRFT Further Faster programme, NHSE Tiering programme and Elective Care Improvement Support Team (IST) – learning from the Further Faster programme will be shared in the Autumn
- Access to additional capacity through the NHS Emeritus Consultant programme
- Luna weekly data quality report, which can be accessed by contacting lunadq@mbihealthcaretechnologies.com and Foundry data dashboards
- RTT rules suite
- Elective Care IST Recovery Hub - FutureNHS Collaboration Platform
- Guidance on shared decision making.

Next steps on outpatient transformation

With the majority (c80%) of patient waits ending with an outpatient appointments, we need to increase the pace in transforming outpatient services to release capacity for patients awaiting their first contact and diagnosis. This will be particularly important ahead of and during winter, when pressure on inpatient beds can be at its highest. Nationally, achieving a 25% reduction in follow up attendances without procedures would provide the equivalent to approximately 1m outpatient appointments per month.

This letter therefore sets out further detail on three key actions that we are asking you to take:

- Revisit your plan on outpatient follow up reduction, to identify more opportunity for transformation.
- Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.

- Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with December 2022 validation guidance) by 31 October 2023, and ensuring that RTT rules are applied in line with the RTT national rules suite and local access policies are appropriately applied.

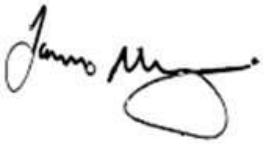
We are now asking trusts to provide assurance against a set of activities that will drive outpatient recovery at pace. This process will require a review of current annual plans, detailing the progress that can be made on outpatients transformation. As part of the above priorities, we are asking each provider to ensure that this work is discussed and challenged appropriately at board, undertake a board self-certification process and have it signed off by trust chairs and chief executives by **30 September 2023**.

The details of this self-certification can be found at Appendix A. Please share this letter with your board, key clinical and operational teams, and relevant committees.

If you are unable to complete the self-certification process then please discuss next steps with your regional team.

Thank you again for colleagues' efforts in this area, which are making a real difference to the timeliness of care we deliver to patients. We look forward to receiving your returns and, as always, if you need to discuss this in more detail, or support in conducting this exercise, please contact england.electiverecoverypmo@nhs.net.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Professor Tim Briggs CBE
National Director of Clinical Improvement
Chair, Getting It Right First Time (GIRFT) Programme
NHS England

Appendix A: self-certification

About this self-certification

To deliver elective and cancer recovery ambitions, high-quality waiting list management and ambitious outpatient transformation are vital. We are now asking trusts to complete this return to provide assurance on these recovery plans.

Nationally and regionally, we will use this to identify providers requiring more support, as well as areas of good practice that can be scaled up to accelerate recovery. Please return this to NHS England by **30 September 2023**, via NHS England regional teams.

Guidance for completing the self-certification

The return asks for assurance that the board has reviewed and discussed specific outpatient operational priorities and has signed off the completed checklist. Please return this to your NHS England regional team.

Trust return: [insert trust name here]

The chair and CEO are asked to confirm that the board:

Assurance area	Assured?
1. Validation The board: a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation. b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation. c. ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.	

d. has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	
2. First appointments The board: a. has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023. b. has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers. National support and information on utilisation of the Independent Sector is available via the IS Co-ordination inbox england.iscoordination@nhs.net	
3. Outpatient follow-ups The board: a. has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan. b. has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty. c. has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments. d. has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking	

data (via the Model Health System and data packs) to identify further areas for opportunity. e. has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	
4. Support required The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	

Sign off

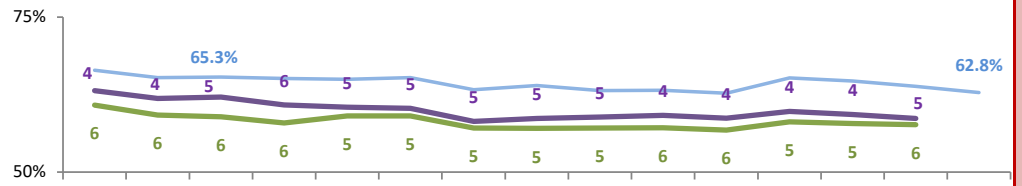
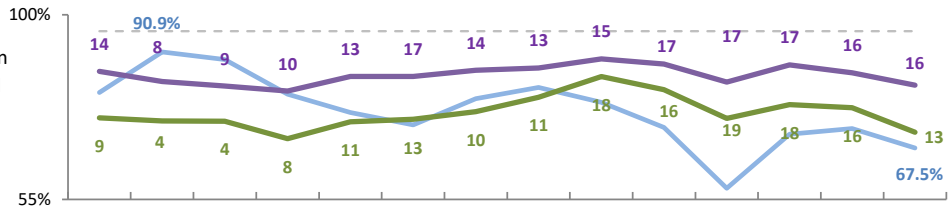
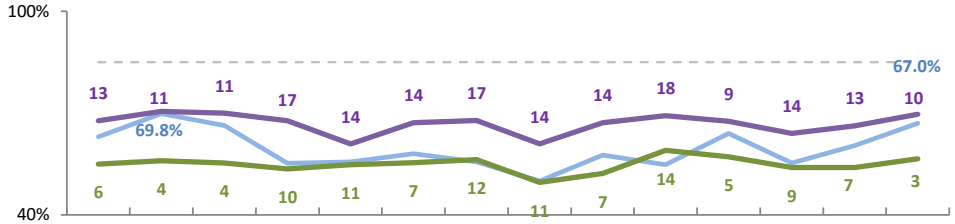
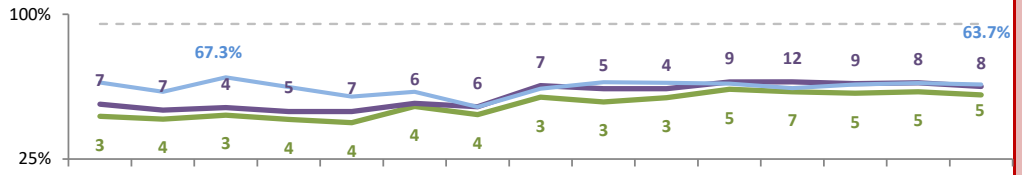
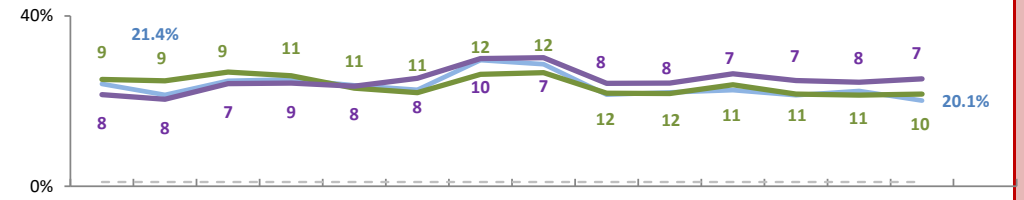
Trust lead (name, job title and email address):	
Signed off by chair and chief executive (names, job titles and date signed off):	

Trust Assurance Response

1. Validation		
Assurance Requirement	**Compliance**	**Narrative**
has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation.	Yes	The Board, and UHS committees, have previously received updates on UHS Validation data quality as measured by the national LUNA platform. UHS data quality has been consistently in the 99.3%+ range, and we continue to work to address any identified data quality opportunities where appropriate. Wider validation performance rates are reviewed at performance meetings with divisional directors. The monthly volume of validations within the Trust has
has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation.	Yes	UHS has a patient contact plan in place for patients on the waiting list. UHS already contacts all patients who have waited over 12 weeks on a scheduled basis in line with their appointment status and clinical urgency.
ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.	Yes	Access policy compliant with national guidance and is followed
has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	Partial	Clinical risk at speciality level is measured by the Clinical Assurance Framework and reported to Trust Executive Committee and on to Board committees. This includes the clinical risk of patients in non-RTT cohorts. Where risks are identified plans to mitigate are created, including where necessary and possible more capacity.
2. First Appointments		
Assurance Requirement	**Compliance**	**Narrative**
has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.	Partial	There are currently 2,887 patients in this cohort of whom 1,465 have an appointment booked before 31st October. Of the remaining 1,422 we have confidence that 899 can be seen before 31st October. Of the remaining 523 patients plans are still being developed but we have confidence that 240 of them will receive a stop on their first appointment so while they may be booked after 31st October are not a year end risk.
has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers. National support and information on utilisation of the Independent Sector is available via the IS Co-ordination inbox england.iscoordination@nhs.net	Yes	We continue to use the Independent Sector where necessary, both for insourcing and outsourcing. We have a virtual outpatient solution and use DMAS where necessary.

3. Follow Up Appointments		
Assurance Requirement	**Compliance**	**Narrative**
has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan.	Partial	In the Elective Recovery Assurance Statement to the June 2023 Trust Board, UHS highlighted that it would be non-compliant with the goal to reduce follow up outpatient appointments by 25%. The internal trust target remains is to reduce OPFU by a minimum of 10% vs 22/23 production plan activity levels with an aspiration to go further, and is a key aim of the Outpatient Transformation programme. At present UHS performance is seeing OPFU activity tracking at c4% lower than last year.
has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty.	Yes	Trust performance is compliant at 5.5% and is 24th of 143 Trusts nationwide (83rd centile). We are using PIFU for cancer follow up in the following Prostate, Colorectal, Breast, Endometrial, Germ Cell, Neuroendocrine, Lymphoma & Bone Marrow Transplant. We are due to go live with Lymphoid, Ocular Melanoma & Thyroid very soon. We also have HPB/HCC in development. All PIFU pathways are supported by the cancer alliance.
has a plan to reduce the rate of missed appointments (DNAs) by March 2024 through: engaging with patients to understand and address the root cause, making it easier for patients to change their appointment by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments	Partial	Reducing the DNA rate is part of our outpatient transformation programme. In line with our access policy we clinically review patients who DNA twice consecutively. We currently do not have a process for engaging with patients to explore why they DNA but we will work to design one before March 2024 Currently our Netcall service does not have the functionality for patients to reply to the reminder to change their appointments.
has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking 6 data (via the Model Health System and data packs) to identify further areas for opportunity.	Partial	UHS utilisation rate has been at least 26 per 100 OPFAs for past 12 month, exceeding the stated target of 21. While some teams have time for specialist advice and guidance job planned, this is not uniformly done and further work to standardise this needs to take place. We continue to use national benchmarking data and GIRFT to identify areas for further improvement.
has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	Yes	We have an outpatient transformation plan identifying areas for improvement and pathway redesign across our specialities

4. Support Required		
Assurance Requirement	**Compliance**	**Narrative**
The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	Yes	Trust Board will discuss and agree this return and any further support at September's Board meeting

		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	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%	63.8%
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)																≥93%	69.9%
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 19) South East average (& rank of 17)																≥85%	63.7%
28	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 16) South East average (& rank of 16)																≥95%	63.8%
37	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching Hospital average (& rank of 20) South East Average (& rank of 18)																≤1%	21.3%

Outcomes		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Monthly target	YTD	YTD target
1	HSMR - **UHS** HSMR - **SGH**	85.76												86.72			≤100	82.8	≤100
		84.21												84.98					
2	HSMR - Crude Mortality Rate	2.9%												2.8%			<3%	2.7%	<3%

1 & 2: At time of IPR publication, the latest information available in HED was from June 2023. Metrics are 12 month rolling. YTD is based on financial year starting in April. Previously, data was sourced from Dr Foster.

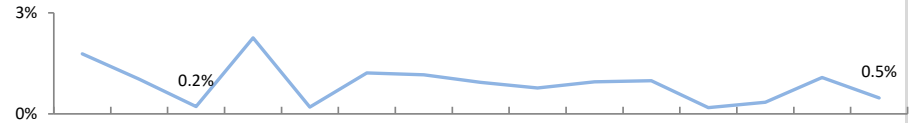
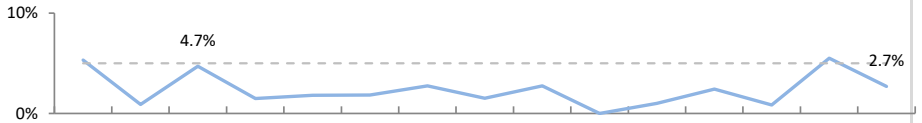
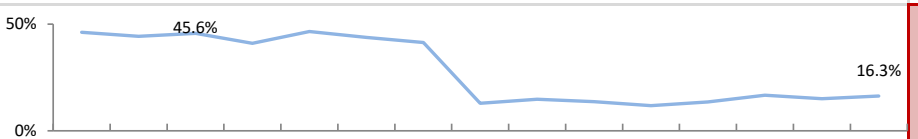
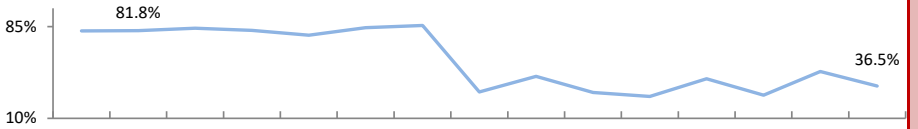
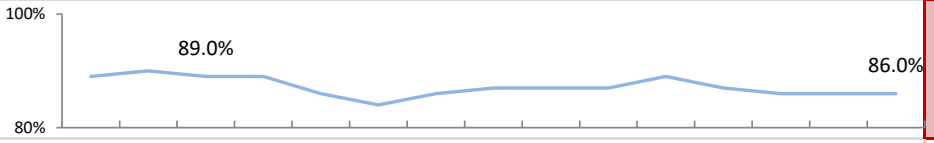
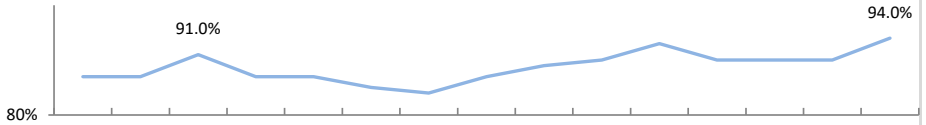
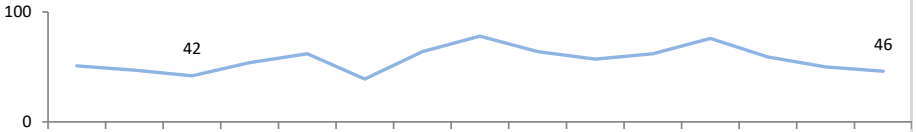
3	Percentage non-elective readmissions within 28 days of discharge from hospital	10.9%												11.6%			-	12.0%	
		Q1 22-23			Q2 22-23			Q3 22-23			Q4 22-23			Q1 23-24			Quarterly target		
4	**Cumulative Specialties** with Outcome Measures Developed (Quarterly)	64			64			68			71			72			+1 Specialty per quarter		
5	Developed Outcomes RAG ratings (Quarterly) Red Amber Green	37			36			34			35			34					
		74			67			79			81			77					
		308			300			317			336			332					

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		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Monthly target	YTD	YTD target
6	Cumulative Clostridium difficile **Most recent 12 Months** vs. **Previous 12 Months**	39	39	44	51	49	59	56	69	64	76	71	80	74	87	9	4	11	8	18	23	24	31	31	45	≤5	45	≤25
7	MRSA bacteraemia	0	0	0	0	1	1	1	0	0	0	0	0	0	1	0	0	1	0
8	Gram negative bacteraemia	17	22	19	27	17	22	14	24	16	17	14	32	14	19	27	≤16	97	≤83
		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Monthly target	YTD	YTD target
9	Pressure ulcers category 2 per 1000 bed days	0.13	0.42	<0.3	0.49	<0.3
10	Pressure ulcers category 3 and above per 1000 bed days	0.28	0.30	<0.3	0.35	<0.3
11	Medication Errors (severe/moderate)	3	4	≤3	14	≤15
12	Watch & Reserve antibiotics, usage per 1,000 adms **Most recent months** vs. **2018*95.5%**	2,884	2,877	2,884	2,752	2,884	13,837	13,582

12 - For 2022/23 and forward, 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).

Safety		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Monthly target	YTD	YTD target
13	Serious Incidents Requiring Investigation (SIRI) (based upon month reported as SIRI, excluding Maternity)			17												3	-	22	-
14	Serious Incidents Requiring Investigation - Maternity			0												1	-	4	-
15	Number of falls investigated per 1000 bed days			0.11												0.05	-	0.07	-
16	% patients with a nutrition plan in place (total checks conducted included at chart base)			92.7%												96.7%	≥90%	95%	≥90%
17	Red Flag staffing incidents			23												10	-	63	-
Maternity		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Monthly target	YTD	YTD target
18	Birth rate and Bookings Birth Rate - total number of women birthed Bookings - Total number of women booked	458 / 425	430 / 405	426 / 417	460 / 438	463 / 416	412 / 498	440 / 363	436 / 453	383 / 432	387 / 513	416 / 449	402 / 477	418 / 450	417 / 382	400 / 424	-	-	-
19	Staffing: Birth rate plus reporting / opel status - number of days (or shifts) at Opel 4.	6	3	2	0	3	1	5	1	0	2	1	1	4	6	1	-	-	-
20	Mode of delivery % number of normal birthed (women) % number of caesarean sections (women) % other	38.2% / 48.0%	37.7% / 49.1%	36.4% / 51.2%	38.7% / 48.9%	36.9% / 47.1%	35.7% / 48.5%	37.5% / 48.2%	37.2% / 49.3%	36.0% / 54.8%	36.7% / 48.8%	40.6% / 46.9%	32.6% / 53.0%	43.3% / 43.3%	43.7% / 38.6%	44.8% / 44.8%	-	-	-

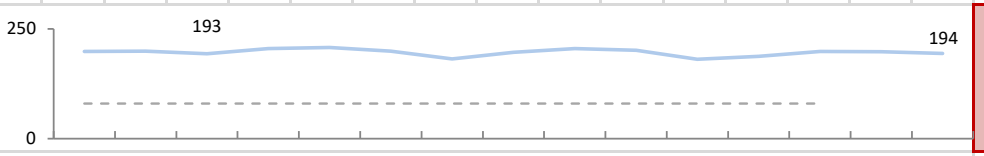
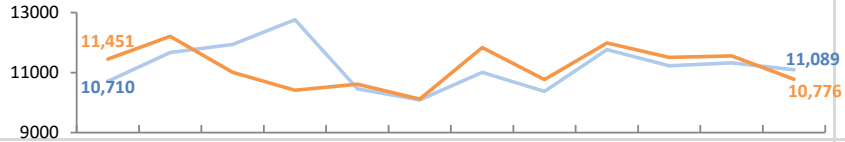
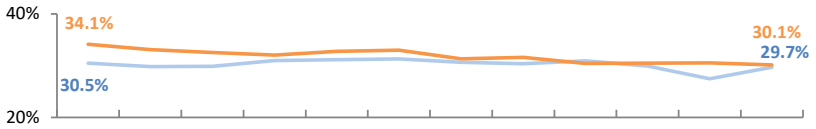
Patient Experience		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Monthly target	YTD	YTD target
21	FFT Negative Score - Inpatients																≤5%	0.6%	≤5%
22	FFT Negative Score - Maternity (postnatal ward)																≤5%	2.5%	≤5%
23	Total UHS women booked onto a continuity of carer pathway																≥35%	15.6%	≥35%
24	Total BAME women booked onto a continuity of carer pathway																≥51%	42.3%	≥51%
25	% Patients reporting being involved in decisions about care and treatment																≥90%	86.8%	≥90%
26	% Patients with a disability/ additional needs reporting those needs/adjustments were met (total number questioned included at chart base)																≥90%	91.4%	≥90%
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)																-	293	-

Access Standards		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	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)	7	7	4	5	7	6	6	7	5	4	9	12	9	8	8	≥95%	63.8%	≥95%
		3	4	3	4	4	4	4	3	3	3	5	7	5	5	5			
29	Average (Mean) time in Dept - non-admitted patients	03:00														03:28	≤04:00	03:29	≤04:00
30	Average (Mean) time in Dept - admitted patients	05:23														05:30	≤04:00	05:41	≤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)	4	4	65.3%	6	5	5	5	5	5	4	4	4	4	5	62.8%	≥92%	63.8%	≥92%
		6	6	6	6	5	5	5	5	5	6	6	5	5	6				
32	Total number of patients on a waiting list (18 week referral to treatment pathway)	52,188														59,277	-	58,247	-
33	Patients on an open 18 week pathway (waiting 52 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	5	5	5	5	5	5	5	5	5	4	4	4	4	3		≤2,011	2,072	≤2011
		2,469														1,934			
		12	13	13	13	12	12	12	12	12	11	11	11	9	8				

		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	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)	6	6	6	6	6	6	6	6	5	5	4	4	4	4	456	-	452	-
		13	13	14	14	13	13	12	13	12	12	11	11	10	9				
35	Patients on an open 18 week pathway (waiting 78 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	7	7	7	7	7	7	7	7	6	4	4	5	8	8	33	0	26	0
		13	14	15	15	15	15	15	15	15	12	10	11	12	11				
35a	Patients on an open 18 week pathway (waiting 104 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	6	6	6	7	5	1	1	1	1	1	1	8	14	17	2	0	2	0
		5	6	6	6	1	0	0	0	0	0	0	1	4	5				
		13	13	14	14	10	1	1	1	1	1	1	13	13	17				
36	Patients waiting for diagnostics	10,604													8,924		-	9,529	-
37	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	9	9	24.8%	11	11	11	12	12	8	8	7	7	8	7	20.1%	≤1%	21.3%	≤1%
		8	8	7	9	8	8	10	7	12	12	11	11	11	10				
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)	14	8	90.9%	10	13	17	14	13	15	17	17	17	16	16	67.5%	≥93%	69.9%	≥93%
		9	4	4	8	11	13	10	11	18	16	19	18	16	13				

		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	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)	13	11	11	17	14	14	17	14	14	18	9	14	13	10		≥85%	63.7%	≥85%
		69.8%													67.0%				
		6	4	4	10	11	7	12	11	7	14	5	9	7	3				
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)	6	5	5	3	3	4	8	8	7	8	7	7	7	6		≥75%	80.5%	≥75%
		81.2%													80.9%				
		5	1	4	2	2	5	9	5	5	8	7	5	3					
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)	14	14	17	17	16	16	16	16	18	16	15	17	15	13		≥96%	90.5%	≥96%
		92.8%													93.9%				
		8	9	16	12	13	13	12	14	20	12	10	14	11					
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)	11	13	14	14	14	14	7	15	16	15	17	16	16	17		≥96.0%	73.1%	≥96.0%
		91.6%																	
		10	12	12	11	9	13	6	16	16	15	15	18	19	18				
															75.4%				

R&D Performance		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Monthly target	YTD	YTD target
43	Comparative CRN Recruitment Performance - non-weighted	3	4	5	6	7	7	14	15	15	13	14	17	19	19	21	Top 10	-	-
44	Comparative CRN Recruitment Performance - weighted	11	7	7	7	8	10	10	10	11	9	9	6	12	14	15	Top 5	-	-
45	Study set up times - 80% target for issuing Capacity &Capability within 40 Days of Site Selection											25%	47%	59%	64%	46%	-	-	-
46	Achievement compared to R+D Income Baseline Monthly income increase % YTD income increase %	55.7%	177.0%	92.7% 93.7%	48.2%	23.5%	71.4%	79.2%	166.3%	69.5%	35.6%	50.7%	32.6%	28.2%	26.0%	45.8% 9.2%	≥5%	-	-

Local Integration		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Monthly target	YTD	YTD target
47	Number of inpatients that were medically optimised for discharge (monthly average)																≤80	191	-
48	Emergency Department activity - type 1 This year vs. last year																-	55,776	-
49	Percentage of virtual appointments as a proportion of all outpatient consultations This year vs. last year																≥25%	29.5%	≥25%

Digital		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Monthly target	YTD	YTD target
50	My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month)	128,901														170,987	-	170,987	-
51	My Medical Record - UHS patient logins (number of logins made within each month)	29,865														31,905	-	31,214	-
52	Average age of IT estate Distribution of computers per age in years	0	0	16	41	87	139	344	880	1100	1157	2476	3065	1658		342	-	-	-
		13	12	11	10	9	8	7	6	5	4	3	2	1	0				
53	CHARTS system average load times - % of pages loaded under 5s												99.75%	99.72%	99.73%	99.81%	99.77%			
53	Data only available from April 2023 onwards																		
		Q2 22-23			Q3 22-23			Q4 22-23			Q1 23-24			Q2 23-24					
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	1222	346	1	3673	262	7	1005	114	5	1005	61	38	2479	71	2	-	-	-
	Latest cyber security data was not available at the time of publication.																		
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			Med go live		Sur go live				-	-	-
55	IP Noting went live in Oct-22. CGs going live are marked on green line.																		

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Finance Report 2023-24 Month 5**			
Agenda item:	**5.5**			
Sponsor:	**Ian Howard – Chief Financial Officer**			
Author:	**Philip Bunting – Director of Operational Finance** **David O'Sullivan – Assistant Director of Finance – Financial Performance**			
Date:	**28 September 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:	**M5 Financial Position** UHS is reporting a deficit of £4.3m in August compared with a deficit plan of £2.7m. This is therefore £1.6m adverse to plan. The in-month variance is driven by a YTD cost pressure of £1.9m resultant from the medical pay award referenced below. YTD the deficit is £20.8m compared to a plan of £16.7m so £4.1m adverse to plan. This is due to the following three specific items: • Unfunded 22/23 non-consolidated pay award (Serco) - £1.25m. • 23/24 unfunded AfC pay award - £1.25m pressure YTD (£3m estimated for 23/24). • 23/24 unfunded medical pay award - £1.9m pressure YTD (£4.5m estimated for 23/24) **In-Month Highlights** • ERF income of £3.6m is reported in month relating to the YTD position. This follows the receipt of national data for April and May that is better than forecast, inclusive of the 2% target adjustment to compensate for industrial action up to the end of April 2023. • Backdated medical pay award cost pressure totalling £1.9m YTD. • The Microsoft licences contract reduction of £0.75m for 23/24 has now been reversed resulting in removal of a £0.3m YTD cost pressure this month. • A contract variation with the ICB has been agreed in month, moving drugs costs to block contracts with an allowance for growth. This enables UHS to invest in delivery of biosimilars and other savings schemes and receive the full benefit. A back-dated saving of £0.4m has been transacted. **Underlying Position** The August reported position included several one-off items meaning the underlying position was £5.6m deficit, marginally improved from the previous month. This excludes ERF over/under performance due to uncertainty around underlying performance and ERF targets, both of which are impacted by industrial action. Prior months continue to be reassessed and normalised for any backdated costs or income. The underlying YTD deficit now stands at £29.1m, averaging a £5.8m deficit per month.			

Deficit Drivers

The underlying deficit of £29.1m YTD continues to be driven by a number of underlying pressures seen in 22/23, for which we have not been able to recover to date:

- Non-pay inflation beyond funded levels
- Impact of energy prices (with gas prices impacting UHS particularly hard)
- High-cost drugs spend (previously pass-through)
- Number of patients not meeting criteria to reside, impacting capacity (opening expensive "surge" capacity / bed capacity restricting elective activity)

In 23/24, we are now seeing further pressures, notably:

- Unfunded elements of pay awards - £0.6m per month.
- Workforce pressures as substantive recruitment is not offset with temporary staffing reductions - £0.3m per month.
- Covid testing funding reductions not immediately offset with cost reductions - £0.2m per month.
- Mental health nursing pressures - £0.2m per month.
- Tariff efficiency reductions not offset by recurrent CIP delivery - £0.5m per month.
- The impact of industrial action is impacting our performance, both activity levels and capacity to deliver recurrent CIP.
- Further growth in patient numbers not meeting the criteria to reside. These were at 225 at the end of August up from 200 in 2022/23.

Unfunded additional activity is a further pressure for UHS where we are YTD providing activity above block funded level for free in the following areas:

- £5.0m of outpatient follow up appointments
- £3.6m of non-elective
- £2.9m of other treatments

ERF and Industrial Action

ERF performance is estimated at 114% against a revised target of 111%, resulting in £3.6m of overperformance. We are awaiting confirmation of national relief of ERF targets relating to the impact of industrial action post-April.

Industrial action continues to significantly impact the level of activity the organisation is undertaking with August including 4 days of junior doctor strikes and 2 days of consultant strikes. Estimates value this activity loss at £3.6m YTD.

The below table summarises the impact of industrial action across April to August showing both the loss of income and direct costs of backfilling staff net of salary savings. Estimates are thought to be on the lower end of the scale with more information still being collected on the impact.

Industrial Action Financial Impact Assessment (£m)			
Month	Estimated Loss of Income	Direct Cost Impact (Backfill less strike pay reductions)	Total Financial Impact
April	1.50	0.30	1.80
May	0.00	0.00	0.00
June	0.30	0.10	0.40
July	1.00	0.30	1.30
August	0.80	0.30	1.10
Total	3.60	1.00	4.60
ERF Overperformance (after 2% reduction)			(3.60)
Net I&E Position YTD			1.00

	Forecast Our submitted forecast to NHS England maintains delivery of a £26m deficit. However, this relied upon a £0.3m month on month improvement to the financial position during 2023/24. The current run-rate is therefore suggesting it will be extremely challenging to achieve the planned position. Several forecast scenarios have been included within the finance report as follows: • Scenario 1: Continuation of the underlying financial position with no financial improvement in the remaining 7 months of 2023/24. A deficit of £62m would prevail. • Scenario 2: Delivery of plan (£26m deficit) requiring **financial improvement of £35m** compared to run rate in the remaining 7 months of 2023/24. • Scenario 3: Delivery of plan (£26m) with the exception of pay award pressures (£9m) generating a prevailing deficit of £35m. This would require **financial improvement of £27m** compared to the prevailing run rate. • Scenario 4: Delivery of the plan (£26m) with the exception of pay award pressures (£9m) and non-delivery of system wide transformation efficiencies (£11m). This would generate a deficit of £46m and require **financial improvement of £16m** compared to the prevailing run rate. The most significant unknown at present is if any further adjustments will be made to the ERF target and if so by how much. Every 1% movement in the target is worth £4.5m for UHS per annum. **Cost Improvement Plans** Whilst £80m of CIP opportunities have been identified, the most-likely risk assessed position sits at £54m. Whilst we have made good progress with CIP performance, it is heavily supported by non-recurrent delivery that cannot be relied upon for underlying financial improvement. **Cash** The cash position has reduced by £4.3m to £62.6m in August 2023. Cash has decreased by £42.4m since the start of the financial year driven by the underlying deficit and capital payments made in Q1 relating to 22/23 projects. Cash is £17m below plan with the underlying deficit driving a higher rate of cash attrition than was planned. A revised trajectory is included within the finance report showing average cash reductions of c£8m per month leading to the minimum cash holding position of £30m now being reached at the beginning of Q4. **Capital** A spotlight was reported to Finance & Investment Committee, where options for bringing forward future capital spend to off-set in year slippage was discussed. However, the cash position is putting a further potential restriction on the capital programme, which puts the affordability of the capital programme at risk. A verbal update on the F&IC conversation will be provided.
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	Trust Board are asked to: • Note the finance position. • Consider the implications of the capital and cash update from Finance & Investment Committee

University Hospital Southampton NHS Foundation Trust

M5 Finance Report

September 2023

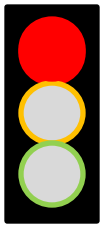
Ian Howard, CFO
Philip Bunting, DOOF
David O'Sullivan, Asst DOF

Summary

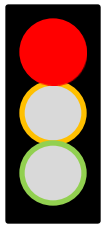
Finance Dashboard

Position (objective 5a)

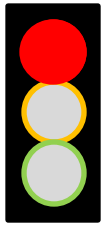
YTD vs. Plan



Forecast

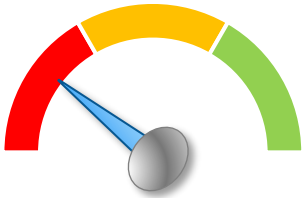


Underlying

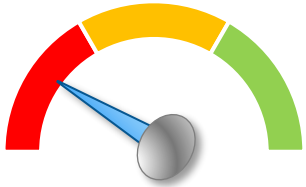


Capital (objective 5d)

YTD

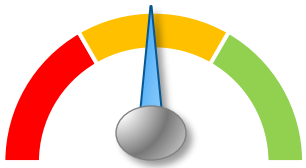


Forecast

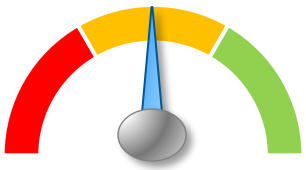


CIP (objective 5a)

Identification



Delivery



Productivity (objective 5a)

Overall Position

Executive Summary

In Month and Year to date Highlights:

1. In Month 5, UHS reported a deficit position of £4.3m which was £1.6m adverse to plan. YTD the deficit is now £20.8m which is £4.1m adverse to plan. The total plan for the year is £26m deficit which is currently forecast for delivery. The YTD shortfall to plan is as a result of funding pressures relating to national pay awards for AFC and Medical staff.

2. The underlying position in August is a £5.6m deficit, an improvement on the previous month of £0.3m. This position excludes the favourable impact of ERF overperformance within the overall trust position in month.

3. CIP delivery is reporting behind plan YTD with £20.8m delivered vs plan of £22.6m. Of the value identified to date, £14.2m is non-recurrently delivered CIP. Annually, £80.2m of savings have been identified in plans, 116% of the trust target of £69m. A risk assessment of schemes has taken place which reduces the expected yield of schemes down to £53.9m - 78%. There is continued focus on savings identification and delivery to support financial recovery.

4. The themes seen in M5 were:
    1. UHS is over its elective recovery target to the end of M5 at 114% / £3.6m favourable. Previous months had been reported at plan following national directives. Performance continues to be impacted by both industrial action and an increase in non-elective activity. Further changes to ERF targets are anticipated but not yet known.
    2. Medical Pay Awards costs have been included within the M5 position. This has resulted in a £1.9m pressure (above funded levels) YTD. The forecast annual impact of this is £4.5m.
    3. Underlying drivers for the monthly financial deficit largely 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 with particular pressures around additional nursing spend related to providing safe care for mental health patients and costs relating to cover for industrial action.
    5. Surge capacity also remains open at times to support flow at times of peak bed pressure.

Overall Financial Position

		Budget	Current			Year to date		
		Full Year £000's	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
Income								
	Clinical Income	839,728	69,979	76,397	(6,418)	349,892	361,957	(12,065)
	Pass-through Drugs & Devices	186,582	15,548	16,359	(811)	77,742	84,950	(7,208)
	Other Income	236,791	19,759	23,563	(3,804)	96,322	107,238	(10,916)
Total Revenue		**1,263,101**	**105,286**	**116,319**	**(11,033)**	**523,956**	**554,144**	**(30,188)**
Costs								
	Pay - Substantive	630,404	52,426	59,271	6,845	260,880	276,749	15,869
	Pay - Bank	43,631	4,079	4,086	7	19,791	20,759	968
	Pay - Agency	15,070	1,279	1,271	(8)	6,967	5,658	(1,309)
	Drugs	35,928	2,994	2,417	(577)	14,971	13,307	(1,665)
	Pass-through Drugs & Devices	186,582	15,548	16,359	811	77,742	84,950	7,208
	Clinical Supplies	67,008	6,027	5,485	(543)	30,003	30,093	89
	Other non pay	285,801	23,749	29,503	5,754	121,001	136,045	15,044
Total Operating Expenses		**1,264,424**	**106,103**	**118,392**	**12,289**	**531,356**	**567,560**	**36,204**
Remove	Depreciation and Amortisation	38,037	3,128	3,076	(52)	15,845	15,359	(486)
	Donated Income	(16,583)	(1,259)	**(1,466)**	(207)	(5,614)	**(3,674)**	1,940
Profit/(Loss) from Operations (EBITDA)		**20,131**	**1,052**	**(463)**	**1,515**	**2,831**	**(1,731)**	**4,562**
Add	Non Operating Income	2,166	181	433	(252)	905	2,195	(1,290)
Less	Non Operating Expenditure	(34,189)	(2,844)	(2,952)	108	(15,810)	(18,455)	2,645
Net Surplus / (Deficit) incl Impairments & Donation		**(11,892)**	**(1,611)**	**(2,982)**	**1,371**	**(12,074)**	**(17,991)**	**5,917**
	Less Donated Income	(16,583)	(1,259)	(1,466)	207	(5,614)	(3,674)	(1,940)
	Less Profit on disposals	0	0	0	0	0	0	0
	Less Gain/ Loss on absorption	0	0	0	0	0	0	0
	Add back Donated Depreciation	2,475	204	182	22	1,021	863	157
	Add back Impairments	0	0	0	0	0	0	0
Total Net Surplus / (Deficit)		**(26,000)**	**(2,666)**	**(4,266)**	**1,599**	**(16,667)**	**(20,802)**	**4,135**

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

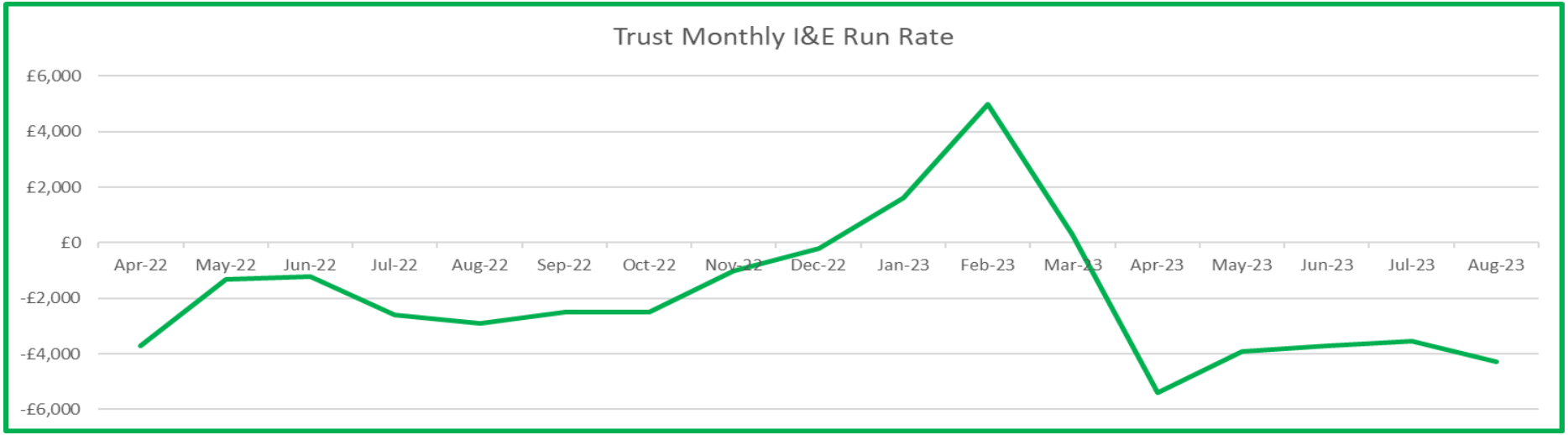
In August a deficit position of £4.3m was reported, £1.6m adverse to plan. The YTD position of £20.8m deficit is £4.1m adverse to the planned deficit target of £16.7m.

In Clinical Income ERF overperformance is reported at £3.6m in month. This follows national directives to set to plan in prior periods. The figures include an adjustment to April ERF baseline target at 2%. Future amendments are anticipated but have not been confirmed to date. The balance of the YTD favourable position on clinical income is as a result of pay award funding received above initial planning assumptions totalling £8m.

Pay expenditure continues to exceed plan, due to pressures from the national pay awards, requirements for mental health nursing support, staffing of surge capacity areas and unfunded workforce growth in prior periods. £8m of the pay variance is additional pay award funding offset within clinical income.

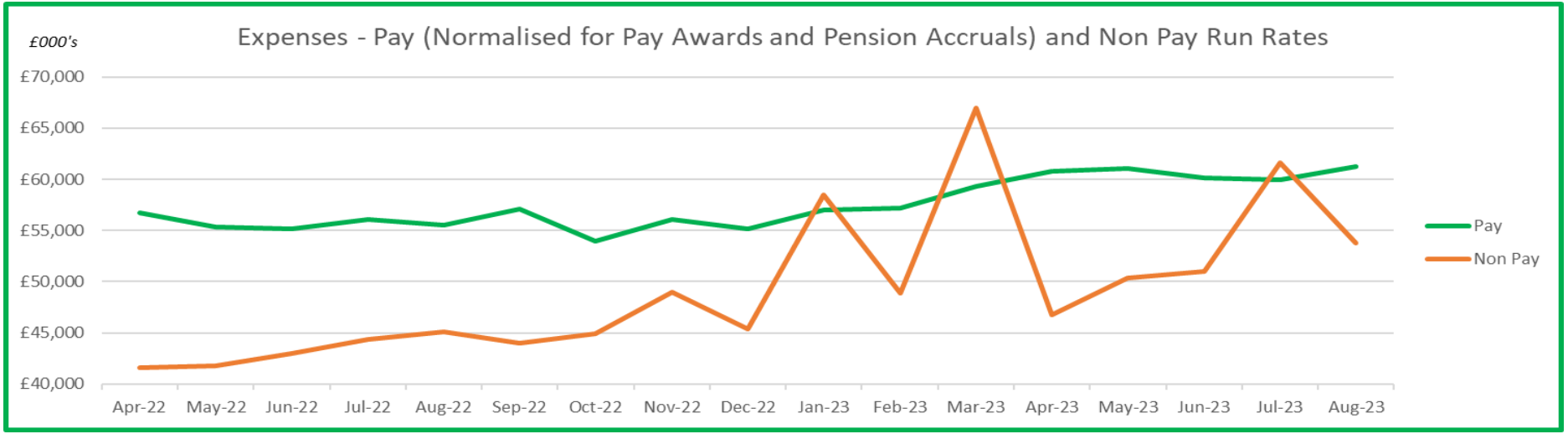
Other income and Other non pay categories contain offsetting transactions of £14m YTD.

Run Rates



- The UHS run rate position has continued in M5 at a deficit of £4.3m which is higher than planned levels despite a number of non recurrent benefits released into the position.
- The improved run rate trend in the second half of 2022/23 financial year was delivered by non recurrent means with the underlying position remaining challenging. This has continued into 2023/24.
- Pressures continue across all expenditure and income types with notable challenges experienced in month detailed below.
- Pay – Continued pressures as a result of national pay awards for AFC and Medical staff, industrial action and mental health nursing.
- Non Pay – Cost pressures relating to Energy increases and inflationary pressures on clinical supplies. Trends can be volatile due to pass through drugs and devices which are not uniform each month.
- Income – the run rate remained high in month due to receipt of funding towards Medical pay awards and ERF. Following national discussions to set ERF performance to plan in prior periods, actual performance is now reporting over plan by £3.6m / 114%.

Run Rates


Expenses - Pay (Normalised for Pay Awards and Pension Accruals) and Non Pay Run Rates
£000's
£70,000
£65,000
£60,000
£55,000
£50,000
£45,000
£40,000
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
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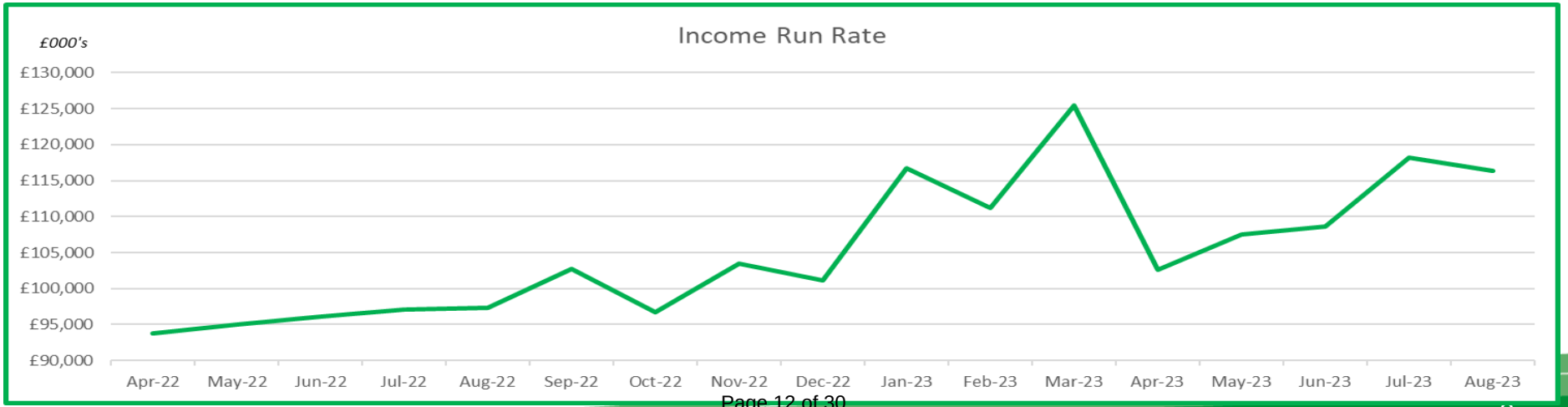
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Pay
Non Pay


Income Run Rate
£000's
£130,000
£125,000
£120,000
£115,000
£110,000
£105,000
£100,000
£95,000
£90,000
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
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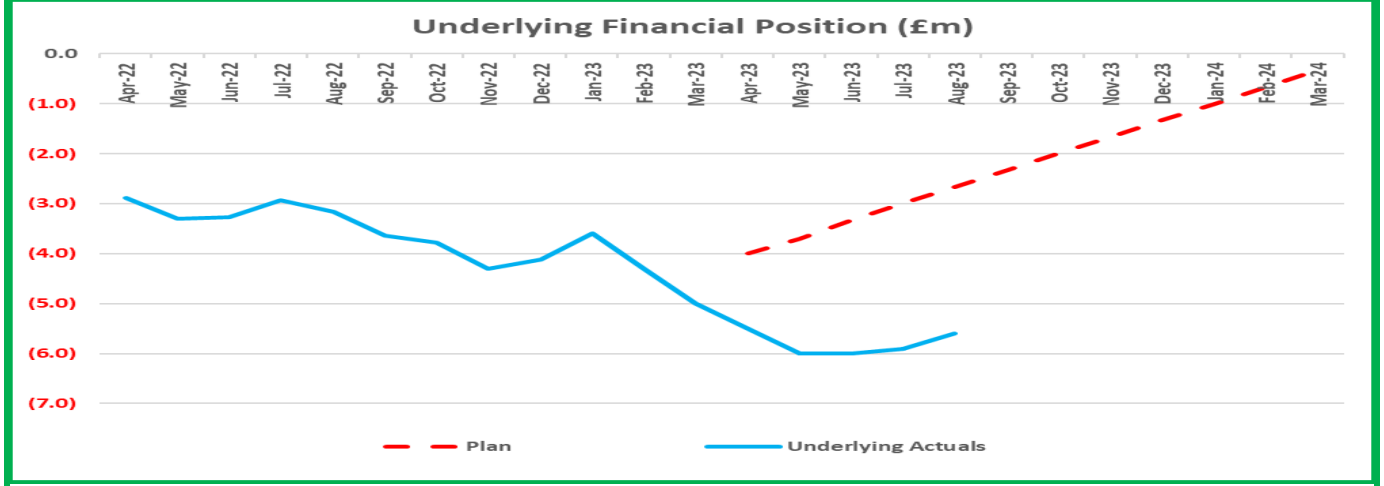
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23

Underlying Position / Risk Analysis



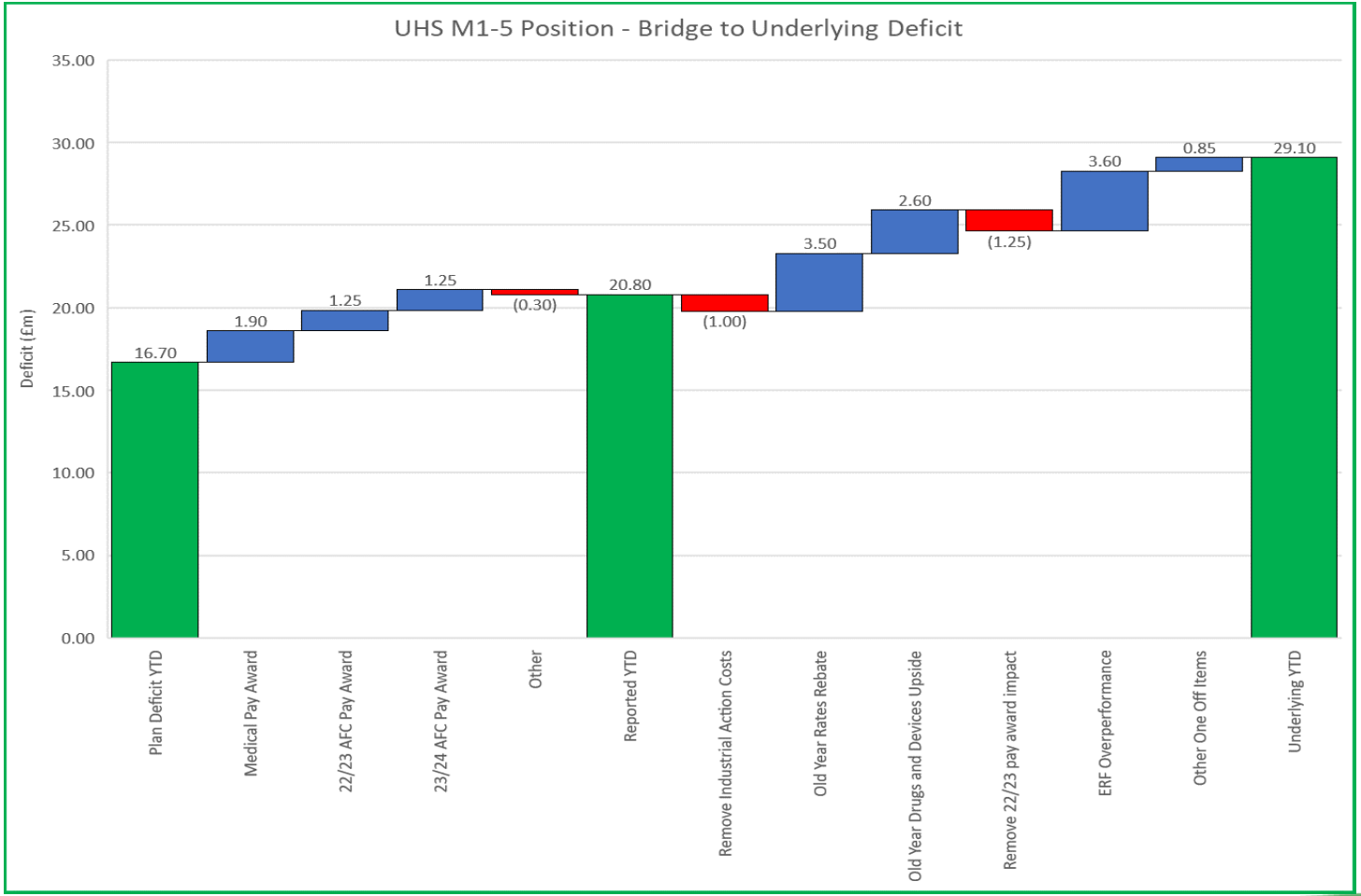
Risk Variable	Risk @ Plan £m	Risk - current £m
Unidentified CIP	15.8	0.0
System CIP Initiatives	11.2	11.2
Identified CIP delivery	7.0	3.8
Inflationary Pressure	8.0	5.0
Income pressure (IA / NEL) - TBC	0.0	0.0
MH Nursing	0.0	2.4
Criteria to Reside / Surge Capacity	0.0	3.6
Energy	0.0	2.1
Unfunded Pay Award	0.0	7.8
Total Risk	42.0	35.9
Mitigations		
Additional CIP	(18)	0.0
Net Risk	24.0	35.9

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 average underlying position for 23/24 to date is £5.8m deficit. M5 figures showed a position of £5.6m. Due to the variability and unknown national picture on ERF (due to industrial action pressures), these figures have been excluded from underlying calculations.

The decline since 2022/23 has primarily been driven by escalating pay award pressures, pressures related to activity, including the need for surge beds and impacts of strike actions in addition to the challenge of delivering efficiencies. A table outlining risks is also shown and will be monitored.

Key Variance Drivers



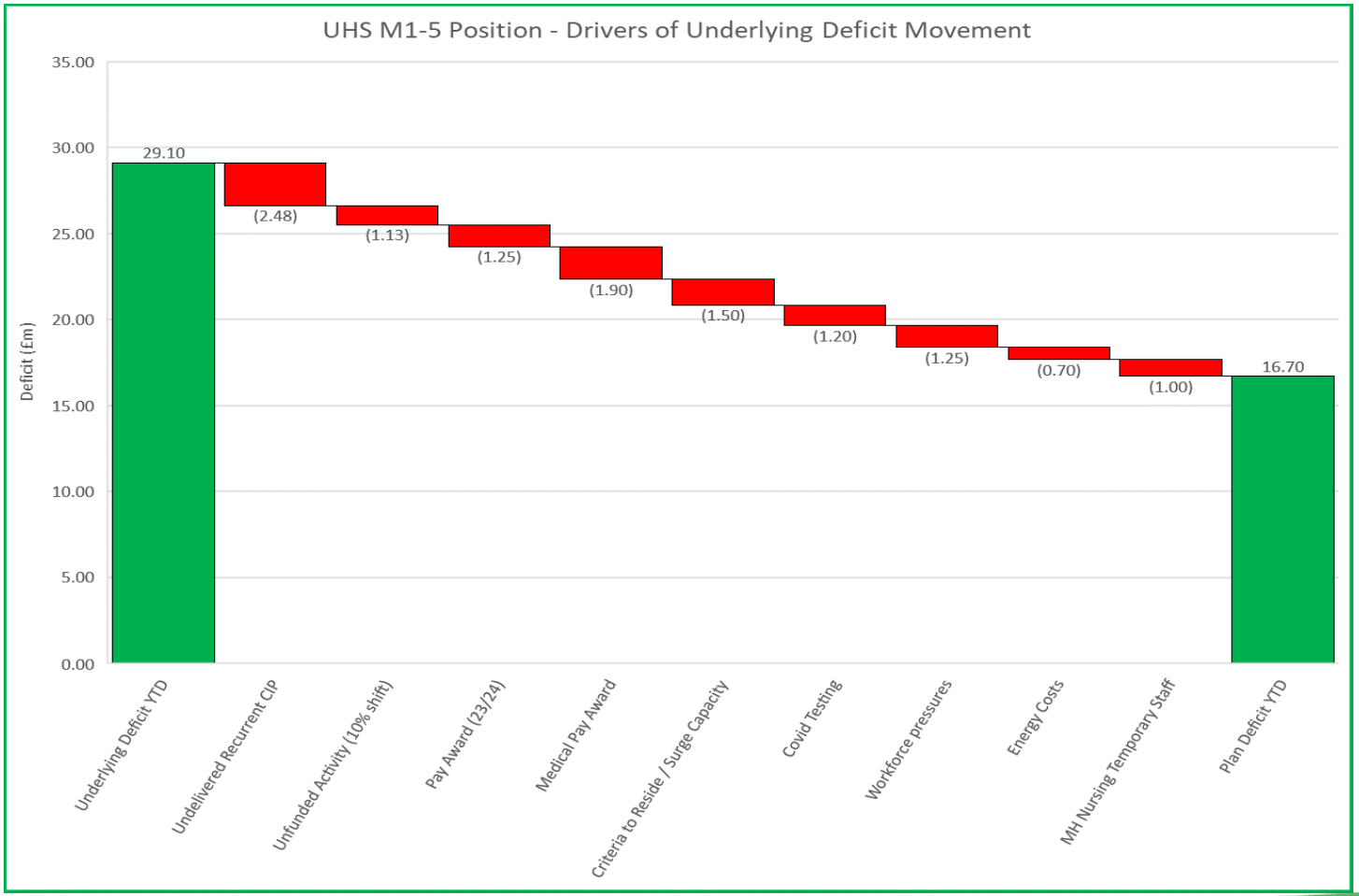
Key variance bridge

A recurrent underlying deficit position was carried forward from the previous financial year of circa £4m per month. Trust plans were for month on month improvement reaching breakeven by financial year end. The graph to the left provides the following analysis:

Stage 1) Items driving the Trust adverse position from planned £16.7m deficit to £20.8m reported YTD.

Stage 2) Sets out non recurrent benefits to the position that bridge to the underlying deficit at M5 of £29.1m. ERF overperformance has also been removed.

Key Variance Drivers



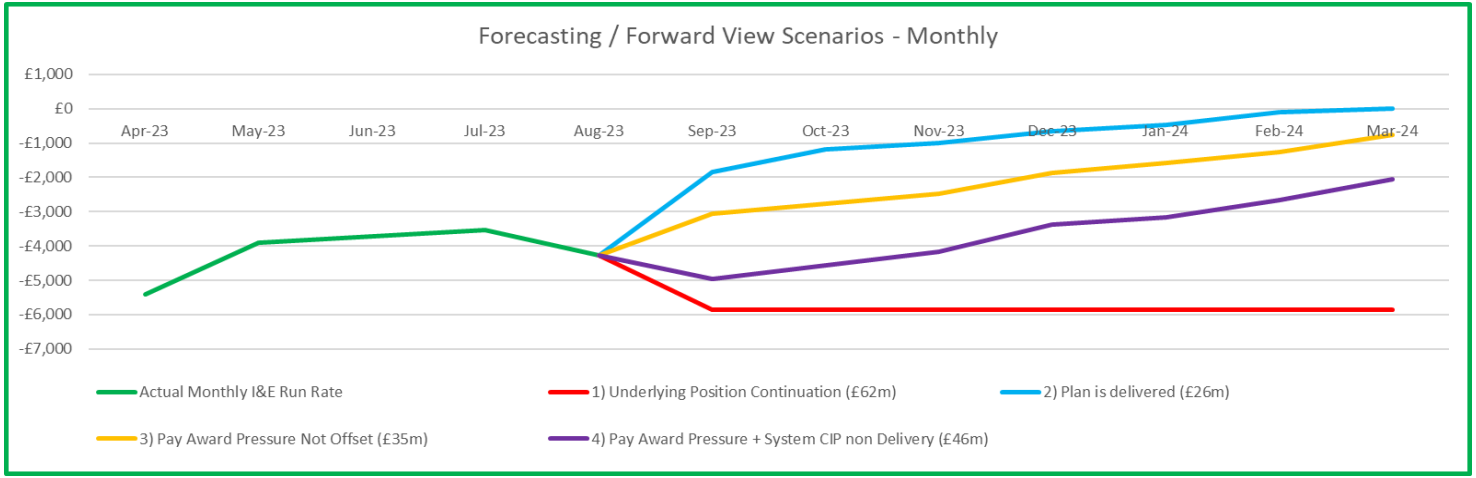
Key variance pressures

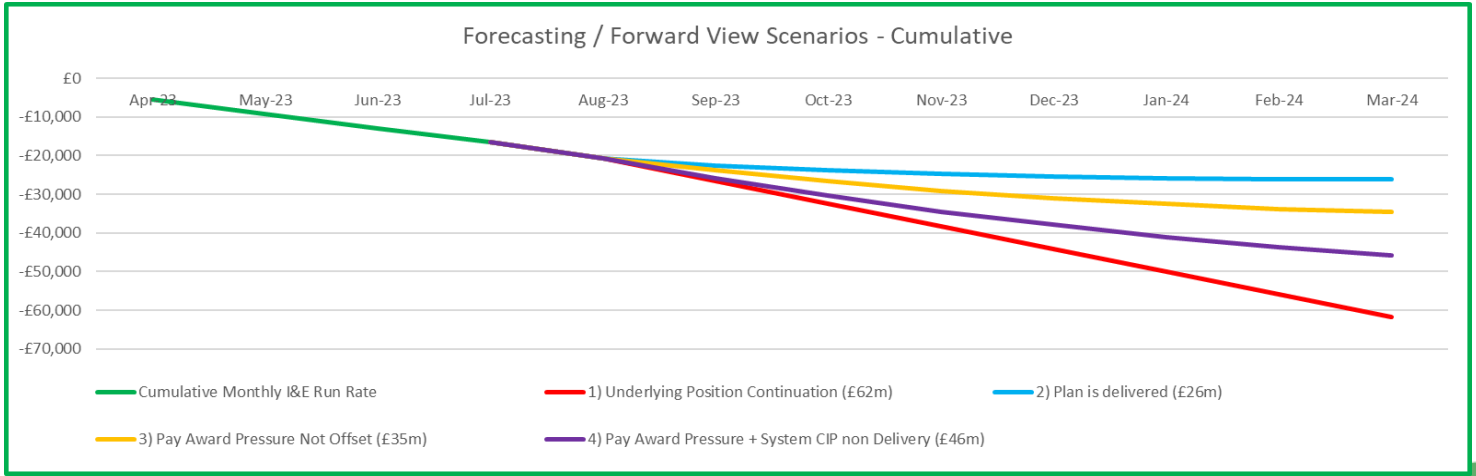
The following table sets out the key recurrent drivers that have resulted in adverse movements to plan in the underlying position during the 2023/24 financial year.

The results of these items is a £12.4m adverse position to the planned YTD underlying deficit of £16.7m at M5.

These items will need to be mitigated in order to deliver a breakeven underlying position moving forwards in addition to delivering the required monthly planned deficit improvement of £0.33m per month.

Forecasting / Forward View





The graphs provide forecast scenarios on a monthly and cumulative scenario for the remainder of the 2023/24 financial year.

Alongside Actual reported figures are three scenarios:

1) Continuation of the underlying position run rate with no mitigating actions. This would result in a year end out turn of £62m deficit.

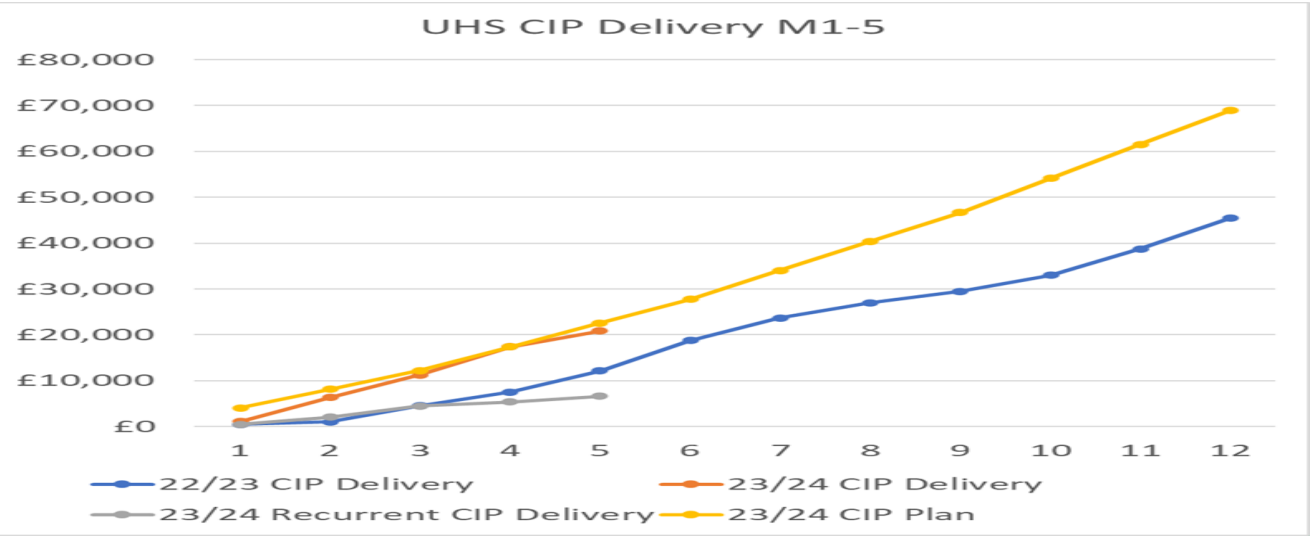
2) Delivery of plan. Resulting in a year end out turn deficit of £26m.

3) Original plan plus full impact of pay award pressures £35m.

4) Original plan plus pay awards and non delivery of system CIP £46m.

Cost Improvement Programme

Month 5 CIP Identification	Non Recurrent (£'000s)	Recurrent (£'000s)	Total (£'000s)	Target (£'000s)	% Identified at M4	% Identified at M5	Change
Division A	£1,614	£3,872	£5,485	£9,068	47%	60%	+14%
Division B	£3,086	£4,559	£7,645	£9,795	61%	78%	+17%
Division C	£2,700	£3,230	£5,930	£8,772	53%	68%	+15%
Division D	£2,245	£6,614	£8,859	£9,281	84%	95%	+12%
THQ	£95	£2,361	£2,456	£3,093	79%	79%	NC
EFCD	£685	£991	£1,676	£3,068	58%	55%	-3%
Central Schemes	£15,488	£25,063	£40,551	£25,992	173%	156%	-17%
Transformation, Procurement and Inpatient Flow Schemes	£0	£7,588	£7,588				
Grand Total	**£25,913**	**£54,277**	**£80,190**	**£69,069**	**116%**	**116%**	**NC**



UHS Total - £80.2m identified 116% of the total 23/24 requirement of £69m. Of the identified UHS total, £14.3m is Pay, £39.0m is Non-Pay, and £26.9m Income.

Divisions and Directorates - £39.6m of CIP schemes identified. This represents 92% of the 23/24 target of £43.1m

Central Schemes - £40.6m of CIP schemes identified. This represents 157% of the 23/24 target of £25.9m

M5 Trust YTD delivery is £20.8m. An increase in month of £3.4m. YTD delivery is below plan by £1.8m.

Of the £20.8m delivered:

£8.2m has been transacted by Divisions and Directorates

£12.6m has been transacted through Central Schemes.

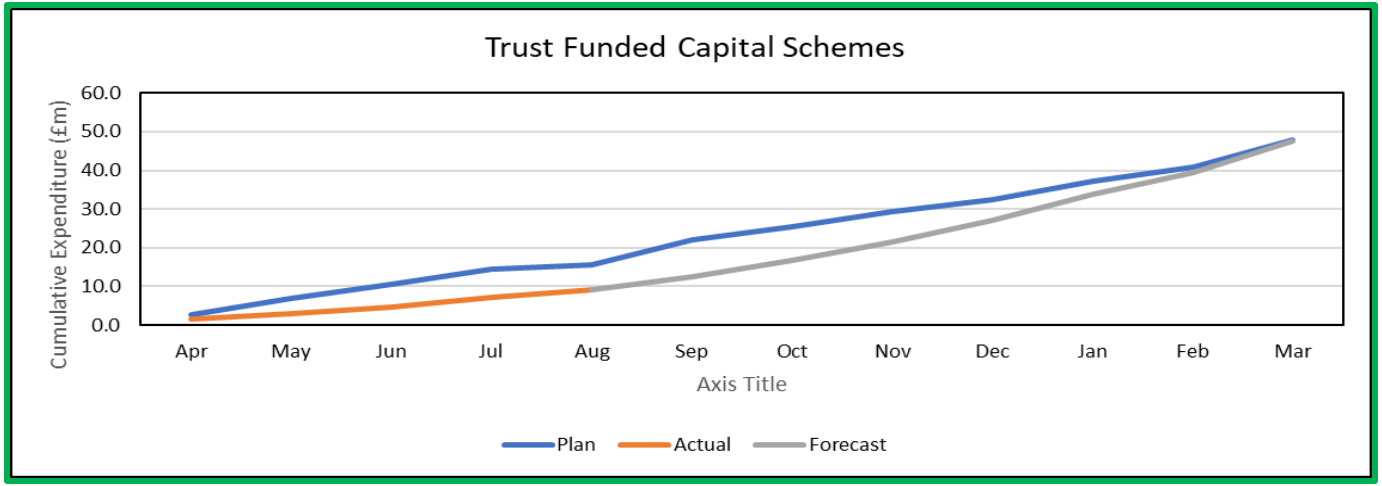
£14.2m is non-recurrent. This includes £8.4m of non-recurrent Central Schemes.

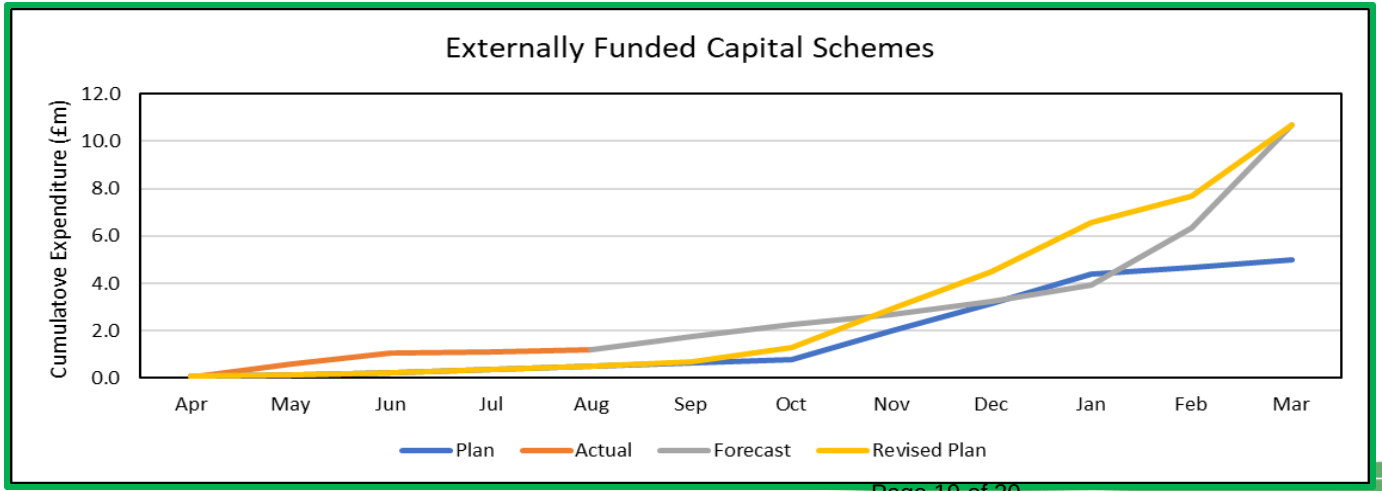
Cost Improvement Programme

Financial Risk Assessment	Number of Schemes	Percentage of Schemes	Value of Schemes (£k)	Percentage of Value	Likely outcome value (£k)
Green	325	65%	£ 40,155	50%	£ 40,155
Amber	165	33%	£ 27,554	34%	£ 13,777
Red	8	2%	£ 1,291	2%	£ -
Crimson	2	0%	£ 11,190	14%	£ -
Total	500		£ 80,190		£ 53,932

- A risk assessment has been undertaken of the identified schemes to date in the table above.
- The expected yield from plans is currently £53.9m, 78% of the 23/24 requirement
- The highest risk assessed items are £11.2m of ICS wide schemes based upon Carnall Farrar opportunity assessment for improved patient flow and reduction of non 'criteria to reside' occupancy.
- These schemes are currently considered to be a high risk of non-delivery by UHS due to insufficient enabling plans / progress and we are seeking further assurance

Capital





Summary Position:

Total capital expenditure (trust and external) YTD is £10.4m vs plan of £16.0m with a forecast outturn of £58.4m.

To achieve the forecast position, £6.9m of expenditure will need to be brought forward from 24/25 to replace slippage on 23/24 schemes.

Trust Funded:

To the end of M5, £9.2m has been spent on trust funded schemes against a YTD plan of £15.5m, with an annual forecast outturn of £47.7m

Externally Funded:

To the end of August, £1.2m has been spent on externally funded schemes vs a YTD plan of £0.5m, with an annual forecast spend of £10.7m.

Capital

Top 5 schemes by YTD Expenditure Value

£000s	Year to Date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance
Oncology Centre Ward Expansion Levels D&E	5,635	2,488	3,147	7,135	6,986	149
Donated Estates Schemes	2,226	2,410	(184)	2,624	3,193	(569)
Information Technology Programme	1,815	1,765	50	5,800	5,800	0
Decarbonisation Schemes	4,000	1,271	2,729	11,259	11,259	0
Asceptic Pharmacy/SSD Building	0	1,143	(1,143)	3,000	1,992	1,008

- Spend on the wards expansion scheme remains high on a monthly basis as the skyway link bridge element is constructed.
- The Banksy funded staff welfare schemes (the welfare hub, PAH roof garden and staff room refurbishment) are complete bar a few final costs
- Informatics YTD expenditure has been incurred mainly on staffing, core infrastructure and the ED & Flow contract.
- The first milestone of the decarbonisation scheme has been reached meaning that £1.3m of costs are now due for payment.

Top 5 Schemes by YTD Variance

£000s	Year to Date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance
Oncology Centre Ward Expansion Levels D&E	5,635	2,488	3,147	7,135	6,986	149
Decarbonisation Schemes	4,000	1,271	2,729	11,259	11,259	0
Fit out of F Level Theatres (VE)	1,696	67	1,629	8,500	6,827	1,673
IMRI	1,310	0	1,310	1,310	1,462	(152)
Asceptic Pharmacy/SSD Building	0	1,143	(1,143)	3,000	1,992	1,008

- The ward expansion skyway link bridge is now expected to complete in December.
- Decarbonisation spend has begun, later than initially planned, assurance has been provided expenditure will be incurred within required timeframe
- The F level Theatres scheme is now due to commence in the autumn.
- Delivery and installation of the IMRI Is now scheduled to occur in November.
- Design fees and initial isolator costs have been received earlier than anticipated.

Statement of Financial Position

Statement of Financial Position	2022/23 YE Act £m	M1 Act £m	M2 Act £m	M3 Act £m	M4 Act £m	M5 Act £m	MoM Movement £m
Fixed Assets	620,431	617,160	619,161	620,900	622,082	621,364	(718)
Inventories	15,753	18,104	18,074	18,455	16,941	19,317	2,376
Receivables	95,056	93,552	89,834	73,434	75,632	92,177	16,545
Cash	105,018	105,475	85,892	81,557	66,895	62,611	(4,284)
Payables	(229,641)	(237,019)	(218,352)	(202,499)	(195,495)	(212,574)	(17,079)
Current Loan	(1,533)	(1,533)	(1,533)	(1,533)	(1,533)	(1,533)	0
Current PFI and Leases	(12,580)	(12,202)	(12,153)	(11,347)	(11,228)	(10,705)	523
Net Assets	**592,504**	**583,537**	**580,923**	**578,967**	**573,294**	**570,657**	**(2,637)**
Non Current Liabilities	(24,624)	(22,798)	(22,759)	(22,848)	(21,545)	(21,307)	238
Non Current Loan	(5,302)	(5,302)	(5,302)	(4,802)	(4,802)	(4,802)	0
Non Current PFI and Leases	(108,576)	(105,561)	(107,100)	(108,888)	(107,948)	(107,416)	532
Total Assets Employed	**454,002**	**449,876**	**445,762**	**442,429**	**438,999**	**437,132**	**(1,867)**
Public Dividend Capital	286,212	286,212	286,212	286,212	286,212	287,328	1,116
Retained Earnings	102,068	97,942	93,828	90,494	87,065	84,082	(2,983)
Revaluation Reserve	65,722	65,722	65,722	65,722	65,722	65,722	0
Total Taxpayers' Equity	**454,002**	**449,876**	**445,762**	**442,428**	**438,999**	**437,132**	**(1,867)**

The August statement of financial position illustrates net assets of £570.7m which is £2.6m down on July.

Cash reduced by £4.3m to £62.6m, the underlying deficit continues to drive a reducing cash balance for the Trust.

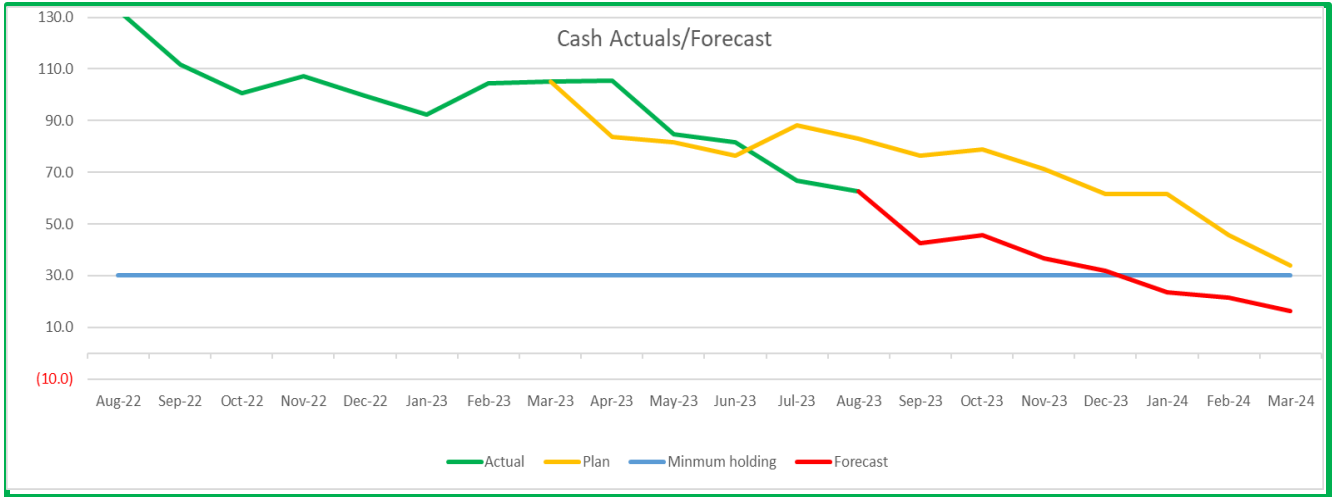
The main movements in month were due to:

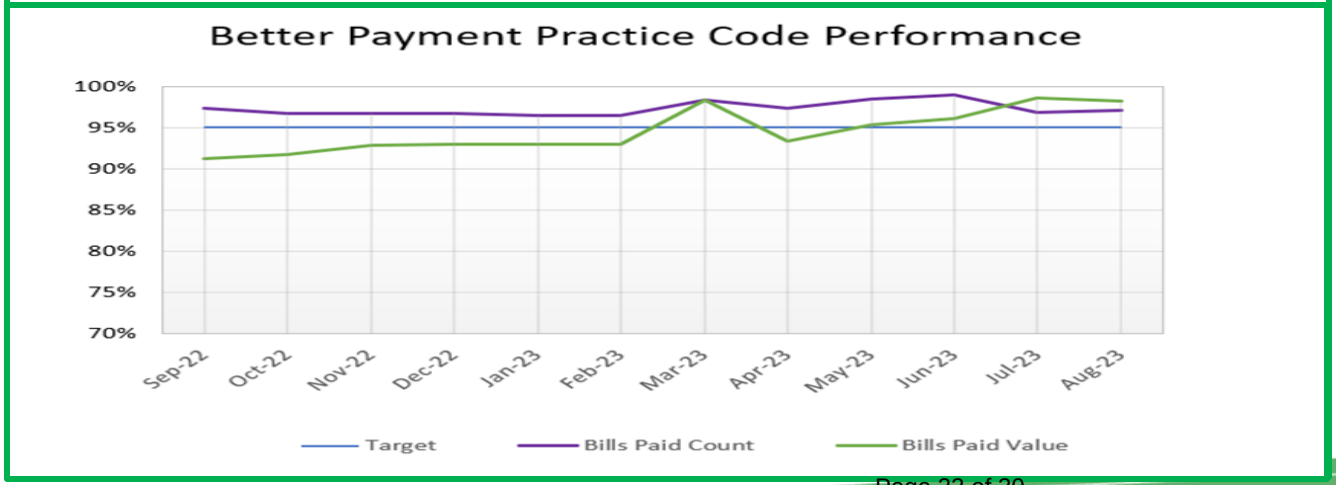
- Receivables: There has been an increase in trade receivables and accrued income of £15.8m which decreases cash. This includes items such as Salix decarbonisation £1.3m and R&D income not yet received £1.1m.

- Inventories: Have increased by £2.4m as a result of pharmacy stock increases as well as UEL reflecting current value stock on the IMS system in M5.

- Payables: An increase in trade payables of £15.1m pushes cash up. This is due to the Trusts move to retain cash by paying invoices on due date instead of when they are available to pay.

Cash and Payments





The cash balance reduced by £4.3m to £62.6m in August. The reduction in year is driven chiefly by the underlying deficit.

In year volatility has however been influenced by:

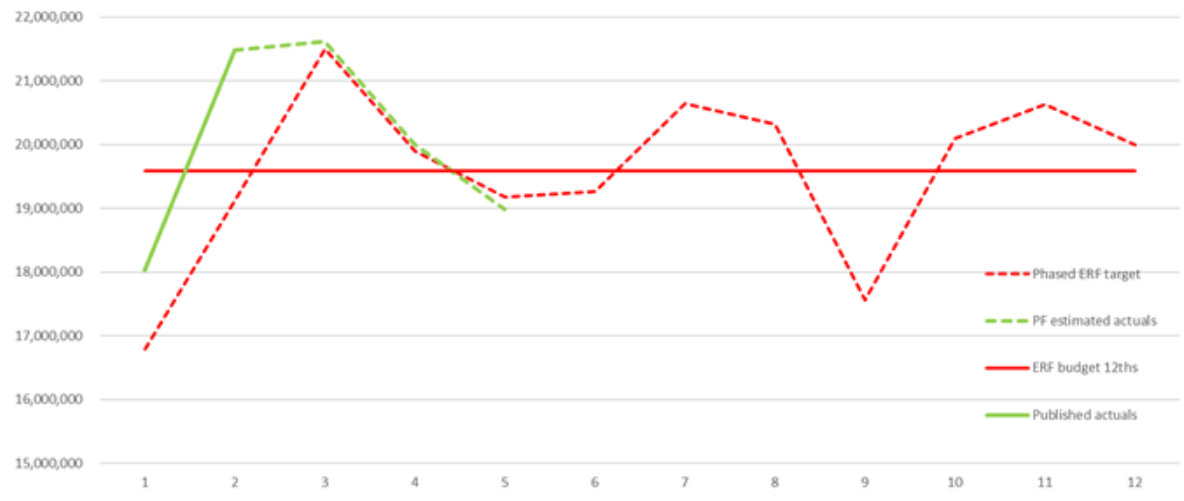
- The timing of pay award funding versus payments made to staff and HMRC/NHS Pensions Authority
- Capital programme timings including slippage versus plan

The minimum cash holding position is set at £30m. Based on the current trajectory, we are expected to reach this level by the end of the calendar year in December 2023. There is on average a £4m cash outflow each month however September is projecting a £20m cash decrease as a result of paying £6m PDC dividend, £4m clinical staff pay award and lower cash inflows due to the profiling of education income and donated income.

Better Payment Practice Code (BPPC) performance in month for August is over the 95% target for both count and value.

Further Analysis of Position

Income / ERF



ERF Performance (Target = 113%)	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
Elective Spells	108%	124%	105%	108%	107%								108%
Daycase	114%	108%	119%	111%	100%								110%
Outpatients Firsts	113%	121%	108%	109%	125%								115%
Outpatients Procedures	132%	134%	127%	131%	122%								127%
Overall ERF Performance	**118%**	**123%**	**112%**	**112%**	**110%**								**114%**
Excess Outpatient Follow Ups £'000s	£863	£1,295	£922	£761	£1,144								£4,985
Excess Non Elective and ED £'000s	£34	£848	£1,667	£48	£1,050								£3,647
Excess Other £'000s	£279	£649	£1,073	£515	£390								£2,906

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 111% (reduced from 113% following industrial action) 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.

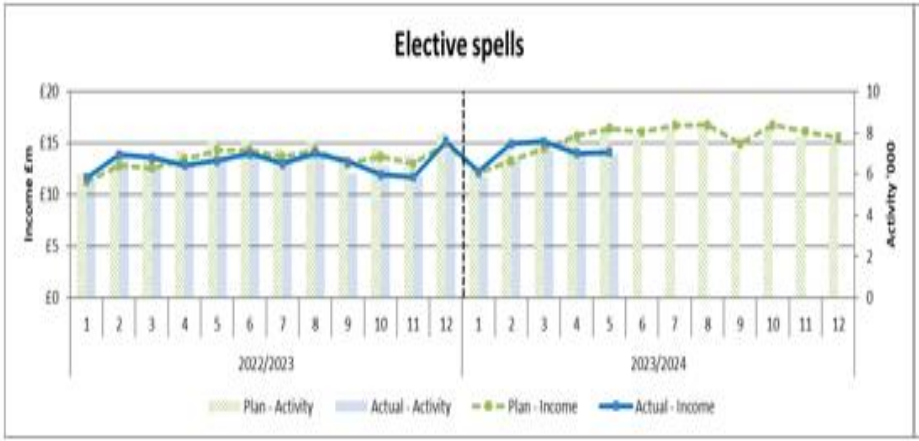
At the end of Month 5, ERF activity has been reported above plan to the value of £3.6m.

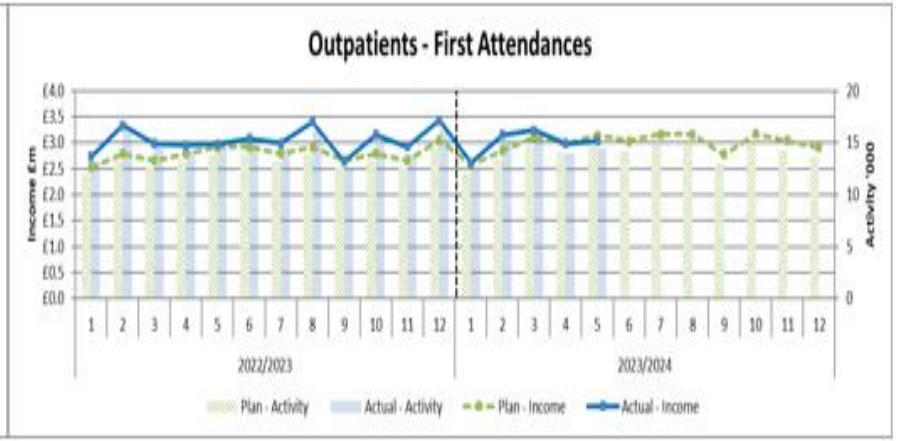
Previous months had been reported at plan following national guidance which has been amended for M5.

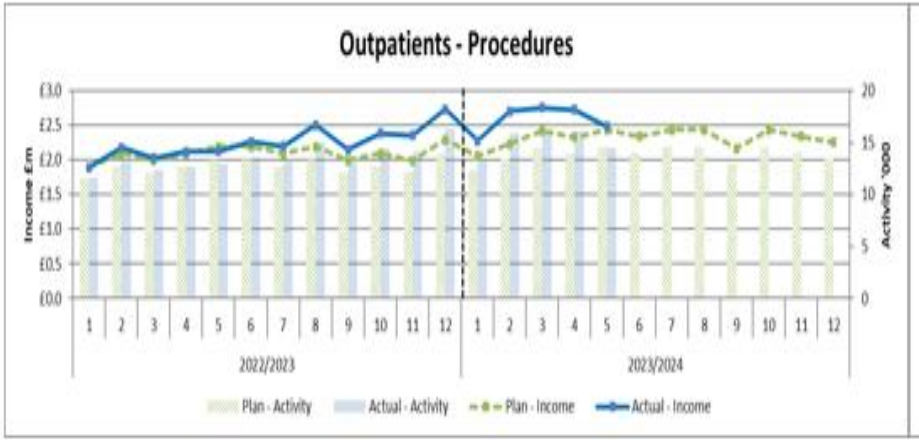
The table shows monthly achievement by POD type vs 19/20 baseline.

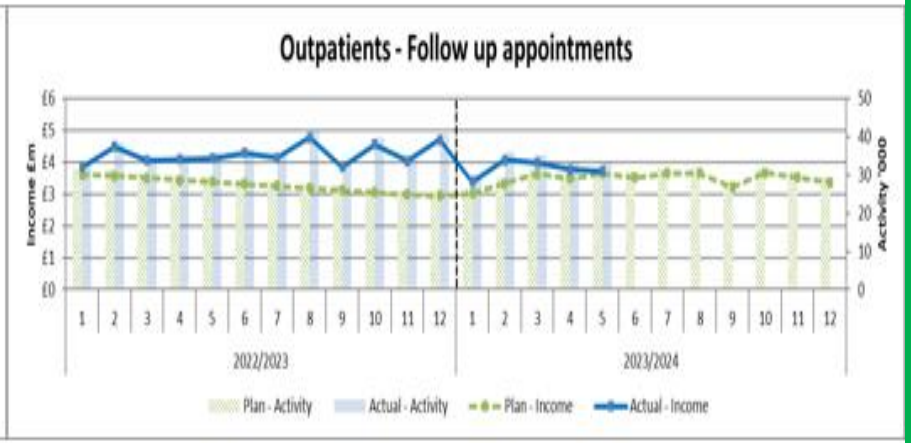
Significant non ERF related activity is currently being provided by UHS above its block funded levels, totalling £11.5m.

Clinical Income - Elective

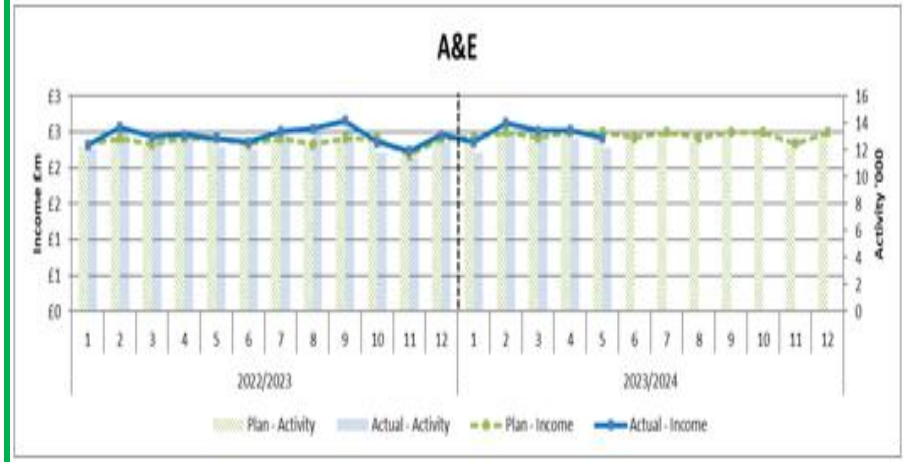


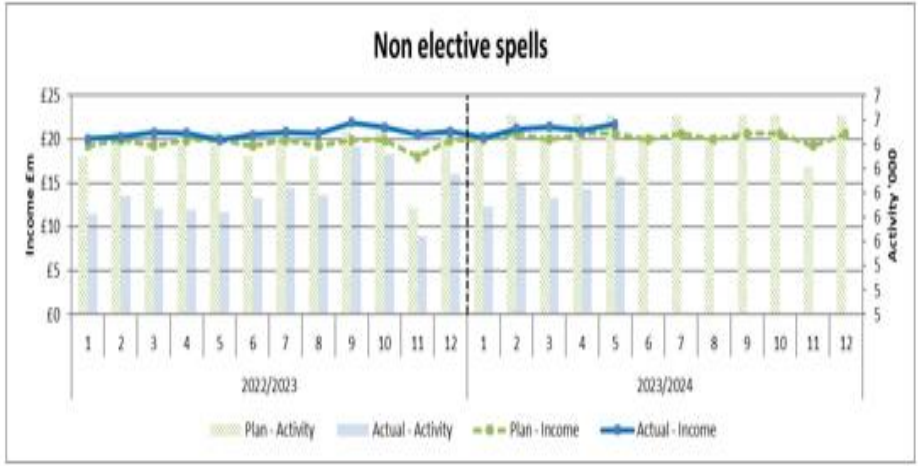


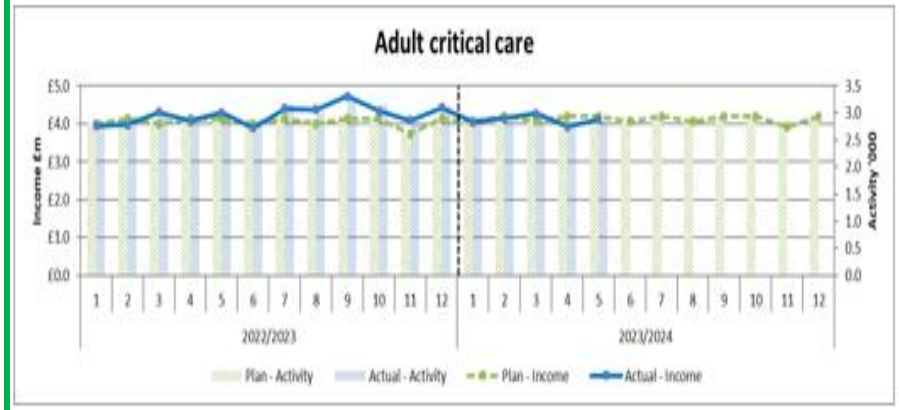


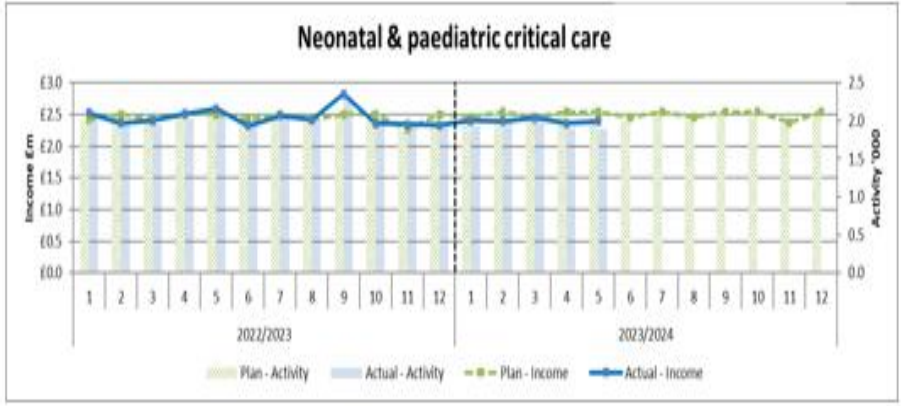


Clinical Income – Non Elective and Other

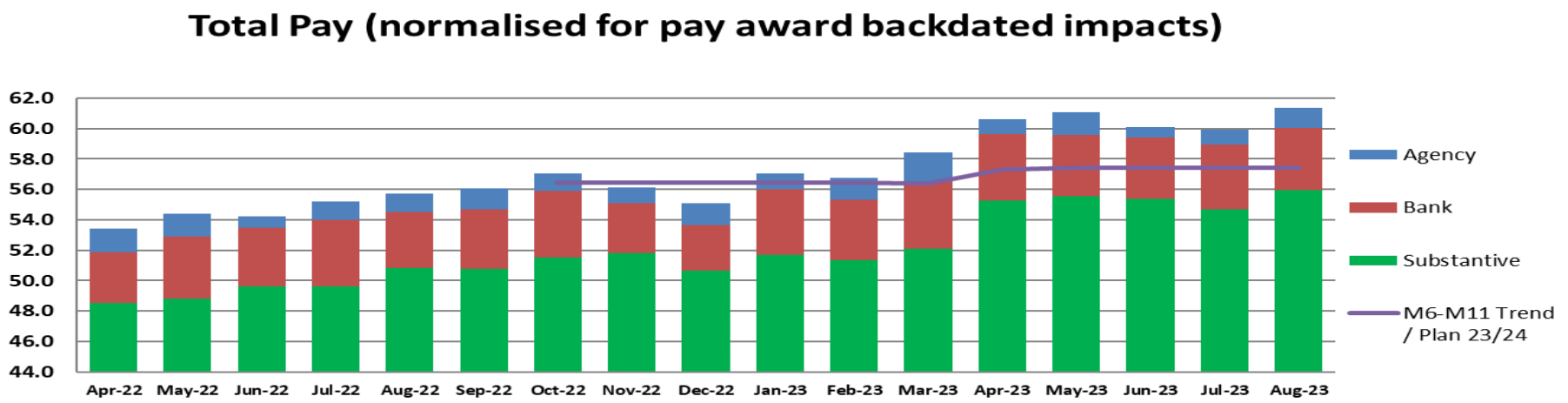








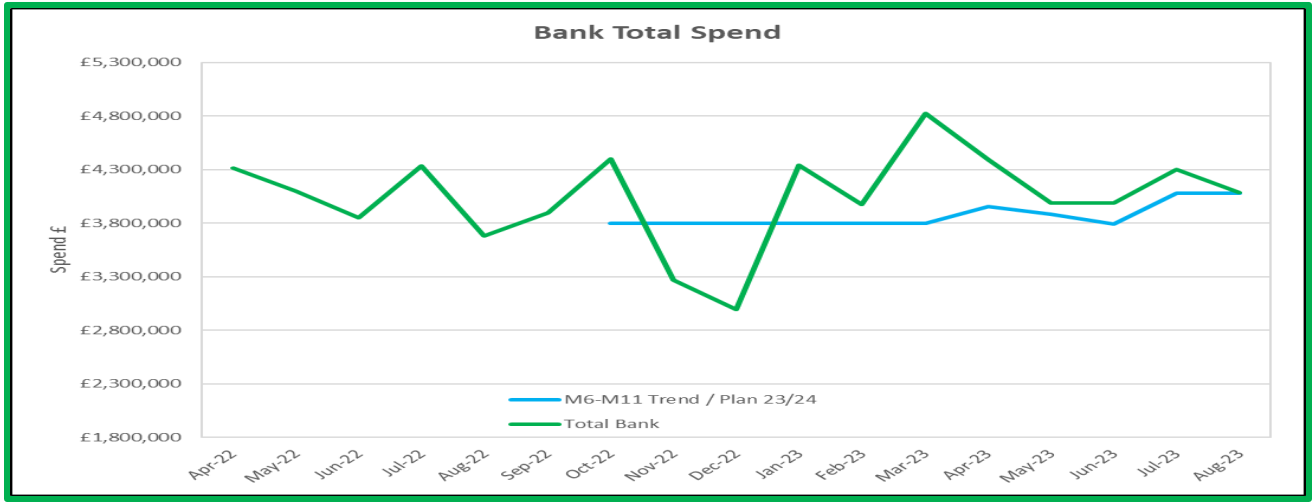
Staff Costs

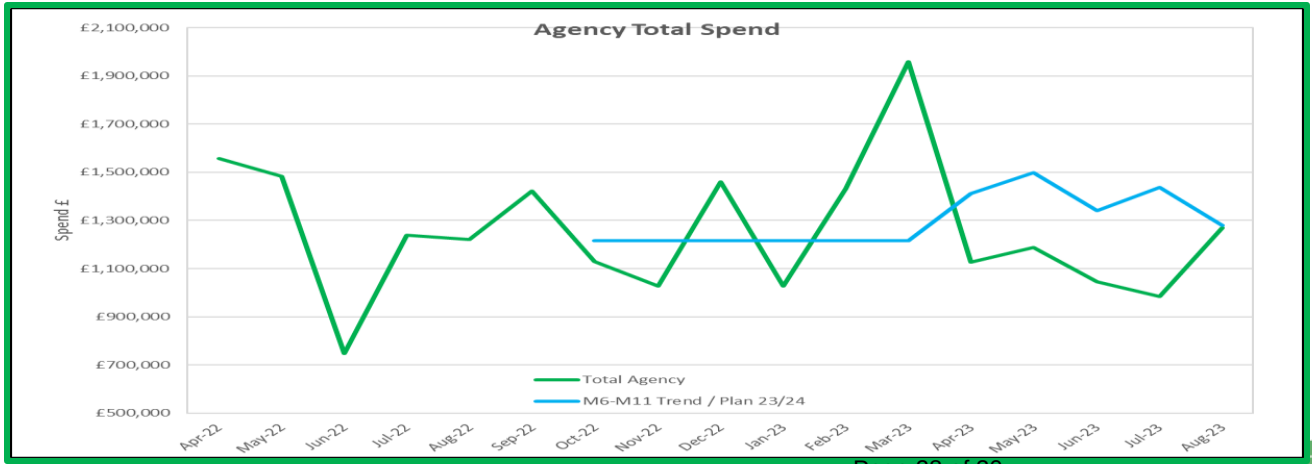


Pay Expenditure:

- Pay costs have been normalised for the backdated impact of pay awards on the above graph.
- The normalised pay spend has therefore increased by £1.3m between July and August. This is driven by £0.3m of bank holiday enhancements, £0.3m of increased MH pressures, £0.2m of fully funded hosted posts and £0.5m of increased substantive costs not offset by temporary staffing reductions.
- Mental health staffing costs are impacting both Bank and Agency: £0.7m month (up from £0.4m in July) and are now £3.3m YTD.
- Costs of staffing surge capacity in month totalled £0.1m which is now £0.5m YTD.
- Staffing WTE has increased by 82 WTE in month. This growth takes WTE actuals further away from planned values for the year.

Temporary Staffing Costs





Bank:

Bank expenditure decreased in month from £4.3m down to £4.1m.

Decreases have been experienced in:

- Nursing down £184k
- Admin staff down £17k
- Scientific and Technical down £33k

Increase of costs were experienced in Medical staff of £15k.

Agency:

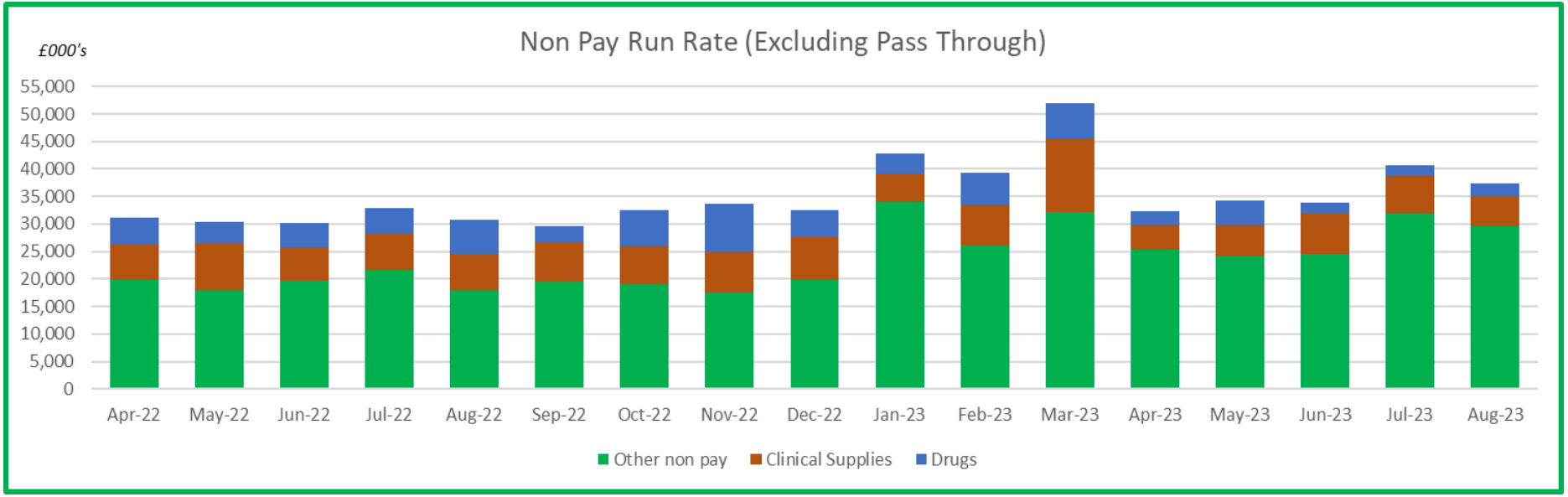
Agency costs increased in month by £0.3m up to £1.3m overall.

Reductions were experienced in Admin Staffing of £93k and Scientific and Technical down by £3k .

Increases were experienced across other staff groups:

- Nursing Staff higher by £358k
- Medical Staff totalling £23k

Non-Pay Costs



Non Pay Expenditure:

- Other non pay has reduced in month following high costs in M4 relating to backdated costs (offset within Other income).
- Non pass through drugs spend has increased in month by £0.5m overall. The primary driver of this increase was within Specialist Medicine care group within Division B. Costs are being investigated in collaboration with pharmacy to understand drivers and if pass through income may be available.
- Clinical supplies costs have reduced in month by £1.4m, largely due to reduced costs and one off stock adjustments within UEL.


FOUNDATIONS
FOR THE FUTURE

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**People Report 2023-24 Month 5**			
Agenda item:	**5.6**			
Sponsor:	**Steve Harris, Chief People Officer**			
Author:	**Workforce Team**			
Date:	**28 September 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 August 2023 data (M5).			
Response to the issue:	Our workforce plan for 23/24 aims to deliver a flat position with no overall growth in the size of our total WTE. This included continued recruitment to vacancies and new expansions offset by decreases in the use of agency and bank, CIP, and other targeted reductions. **Progress areas of the People Strategy:** THRIVE (Workforce Capacity) We continue to report against our NHSE workforce plan, in addition the Finance and Workforce team have created an internal UHS trajectory to reflect the phasing of new budgeted planned service developments (and associated staffing) that has not yet fully opened. For August we can report: • We remain over our total NHSE plan by +74 WTE, but over our internal trajectory by +232 WTE. Substantive staff has grown during August by 69 WTE, underpinned primarily by an increase of +47.8 WTE Junior doctors (specialty registrars), of which 25 WTE are externally funded and hosted by UHS. This is part of the annual junior doctor August rotation.			

	• **Temporary workforce** utilisation increased in August which is a typical feature in August due to significantly higher periods of leave through school holidays. Overall our bank staffing usage rose by 801 to 807 WTE; agency staffing usage increased from 152 to 159 WTE (0.7% and 4.4% respectively). • There has been continued **reductions in the use high cost** off framework agency (Thornbury). Usage is now close to zero. • Mental health challenges continues to drive additional temporary staffing expenditure, with August's temporary resourcing utilisation for mental health needs being the highest since reporting began in April 2022 • Rolling **turnover** is now below the Trust target of 13.6% at 12.3%. There were 103 WTE leavers in August; a slight increase from July, but within planned-for levels. • Rolling **sickness** absence has hit the Trust target at 3.9%. In month sickness was 3.3%. Our sickness rate continues to benchmark well against other acute NHS trusts. Excel (Capability, Reward, Wellbeing) • **The NHS staff survey has launched on 18th September** and will run through to November. Communication has been issued to staff to outline how the Trust continues to respond to feedback in line with our People Strategy. This includes a letter to all Staff from the CPO and CEO. • **Appraisal competition** remains below target at 77%. The importance of appraisals has been reinforced during TEC, in addition to timely reporting on the system to ensure accurate data. Persistent periods of industrial action and operational pressures continue to affect completion rates. Belong (Culture, inclusion, leadership) • The **first cohort of the positive action programme** has completed with 22 participants from diverse backgrounds at band 7 and 8a. The course has been extremely well received and the graduates presented their learning to senior managers and the CPO and CNO during an award ceremony. • 47% of staff have completed the **UHS allyship training** through either our face to face or online module. • EDI steering groups have been established for all Divisions.
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

September 2023

THRIVE EXCEL BELONG

Narrative – 2023/24 M5 (August 2023)

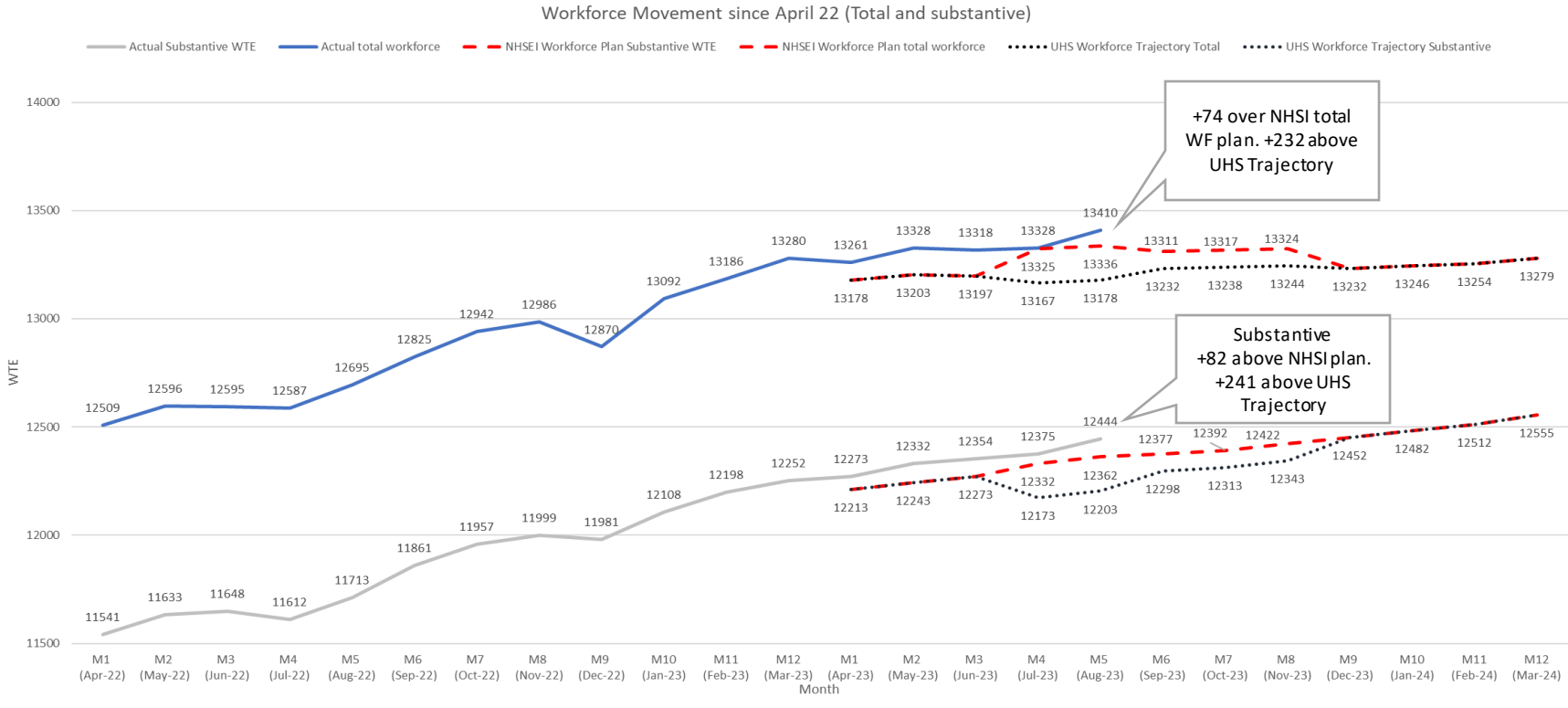
The WTE overall **total workforce** growth from July to August 2023 was +82 WTE

The WTE **substantive** growth from July to August 2023 was +69 WTE. in this period, there have been both net increases and decreases in different staffing groups. These include Medical and Dental (+48 WTE; of which 25 WTE are externally funded) most of whom are specialty registrars, and Nursing and Midwifery (+27 WTE), which sit across all divisions These figures include contracted hours changes.

- There were fewer leavers in August compared with July by 6.2 WTE. A total of 102.6 WTE left the trust in August which has reduced the average to 103.6 leavers per month over the last 12 months
- **Agency** usage from July to August increased by 4.4% (152 to 159 WTE)
- **Bank** usage from July to August increased by 0.7% (801 to 807 WTE)

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

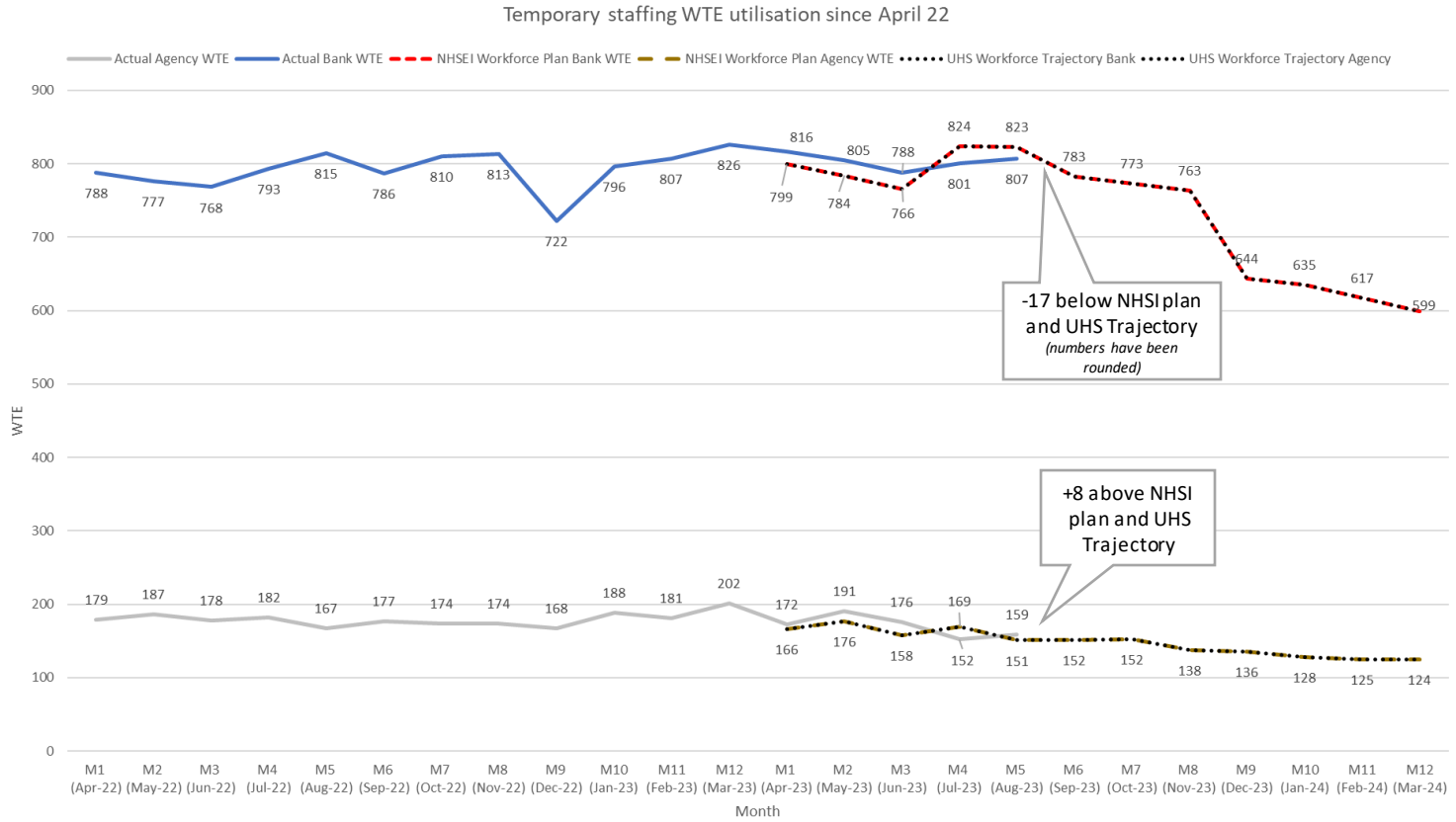


NB: UHS trajectory has been revised based on revised service development timescales; i.e. new ward openings

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

People Report

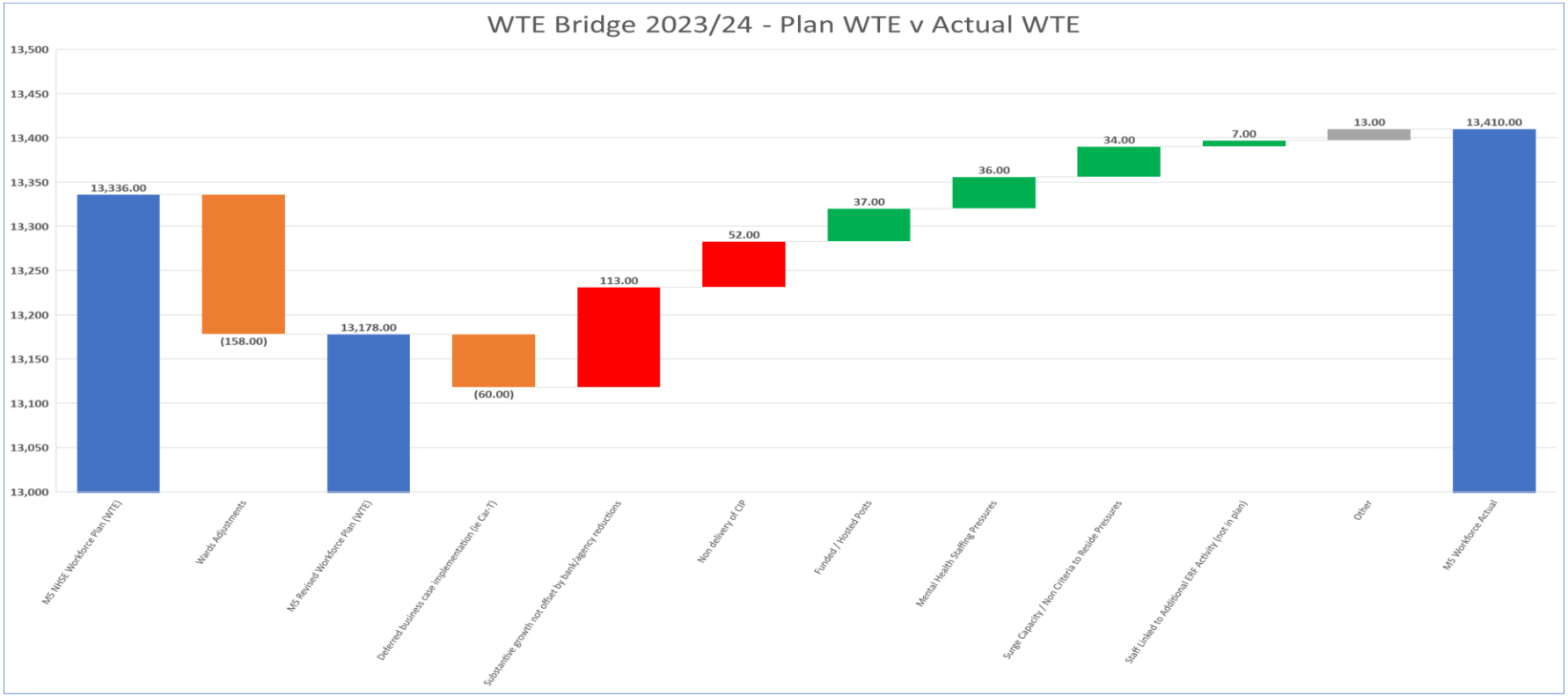
THRIVE | EXCEL | BELONG | PATIENT SAFETY



Source: NHSP Bank + THQ Medical Bank & Agency (NHSP Agency & 247 Agency) as of August 2023

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY



Note: Industrial Action impact is within WLI/Overtime/Excess Hours which is excluded from the above

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

Staff Group	Plan WTE	Actual WTE	Variance WTE	Variance %
Add Prof Scientific and Technic	396	388	(8)	-2%
Additional Clinical Services	2,459	2,540	81	3%
Administrative and Clerical	2,355	2,379	24	1%
Allied Health Professionals	676	721	45	7%
Estates and Ancillary	412	405	(7)	-2%
Healthcare Scientists	484	502	18	4%
Medical and Dental	2,107	2,165	58	3%
Nursing and Midwifery Registered	4,289	4,311	23	1%
Total	13,178	13,410	232	2%

Division	Plan WTE	Actual WTE	Variance WTE	Variance %
Division A	2,517	2,530	13	1%
Division B	3,503	3,658	155	4%
Division C	2,789	2,827	38	1%
Division D	2,400	2,448	47	2%
THQ (inc EFCD and R&D)	1,880	1,889	9	0%
Other	87	57	(30)	-34%
Total	13,178	13,410	232	2%

Variance is against internal UHS trajectory since April

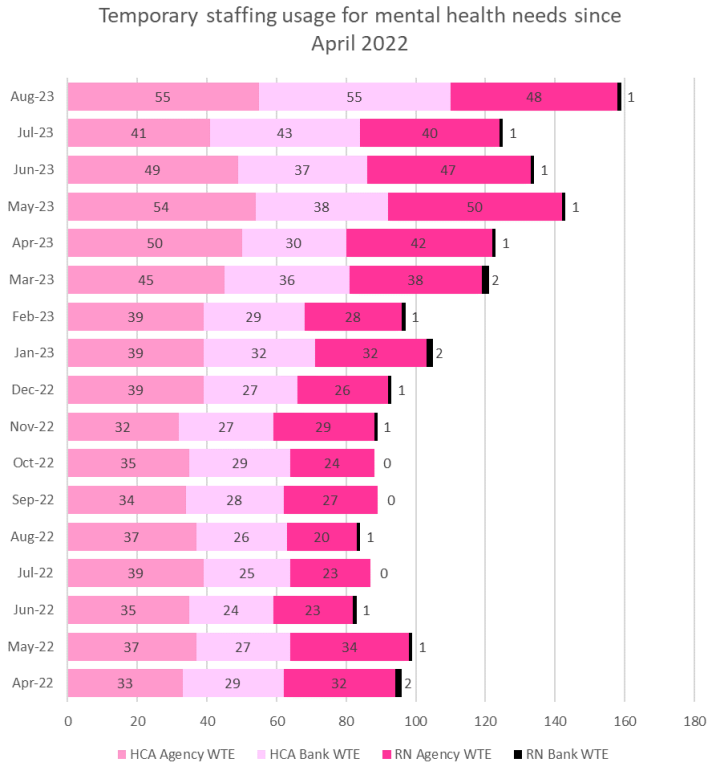
Growth (All Staff) versus plan since April:

- Additional Clinical Services (HCA) continued recruitment to vacancies and reduced turnover
- Medical growth in Junior doctors and additional externally hosted posts
- Continued pressure in Emergency Medicine (Div B), and mental health.
- Allied Health professional growth due to filling vacancies in Occupational Therapy (OT), ODP recruitment and radiotherapy.

Narrative – 2023/24 M5 (August 2023) cont.

Narrative - temporary:

- Sickness rate 3.2% April, 3.1% May, 3.4% June, 3.8% July and 3.3% for August – below 22/23 rate of 4.7% = reduced demand
- Mental Health (August 2023):
  - Total of 159 WTE of temporary staffing needed for MH needs (nursing and HCAs)
  - 49 WTE of which is MH Nursing, nearly all (48) of whom were agency
  - 110 WTE HCAs (55 agency & 55 bank)
- The continued mental health pressures present a safety, quality, and financial challenge to the Trust. UHS continues to escalate to the ICB and press for more comprehensive system solutions to this issue
- Agency use for mental health needs in August 2023 is the highest since April 2022



Workforce Summary

HCA Supply
HCA SIP decreased by 5 WTE in August to 2124 WTE

Turnover
Fewer leavers in August 2023 (103 WTE) compared with July (122 WTE)

Sickness
Sickness has decreased, with in-month sickness for August 3.3%

Industrial Action
Two cohorts of strike action (junior doctors; consultants) in August

THRIVE
In August 2023 we had a substantive SIP growth of +69 WTE
(compared with July 23)

EXCEL
683 appraisals were recorded in August, a decrease from July of 125 reported in month

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

Levels of attainment
There are plans to improve job planning sign-off. Performance figures now included in People Report

Patient Safety
61 incident reports in August 2023 cited staffing; an increase from July's 41 reports

Other contextual updates
Workforce and temporary staffing review meetings scheduled for September 2023

NHS England and Improvement Operational Planning Update
Deep-dive review meeting with the ICB scheduled for 9 October

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

To achieve our ambition of World Class People, our strategy sets out three key areas of focus. These will inform our intention to grow our UHS family.

1. THRIVE

We will thrive by looking to the future to plan, attract and retain great people, and to ensure every area is resourced to meet demand. Working with our education partners, we will invest in opportunities for people to nurture and grow their skills, as well as work with them to grow our future workforce. We will offer flexible careers and make the best use of technology to ensure we plan and deploy our people to provide safe, high-quality care.

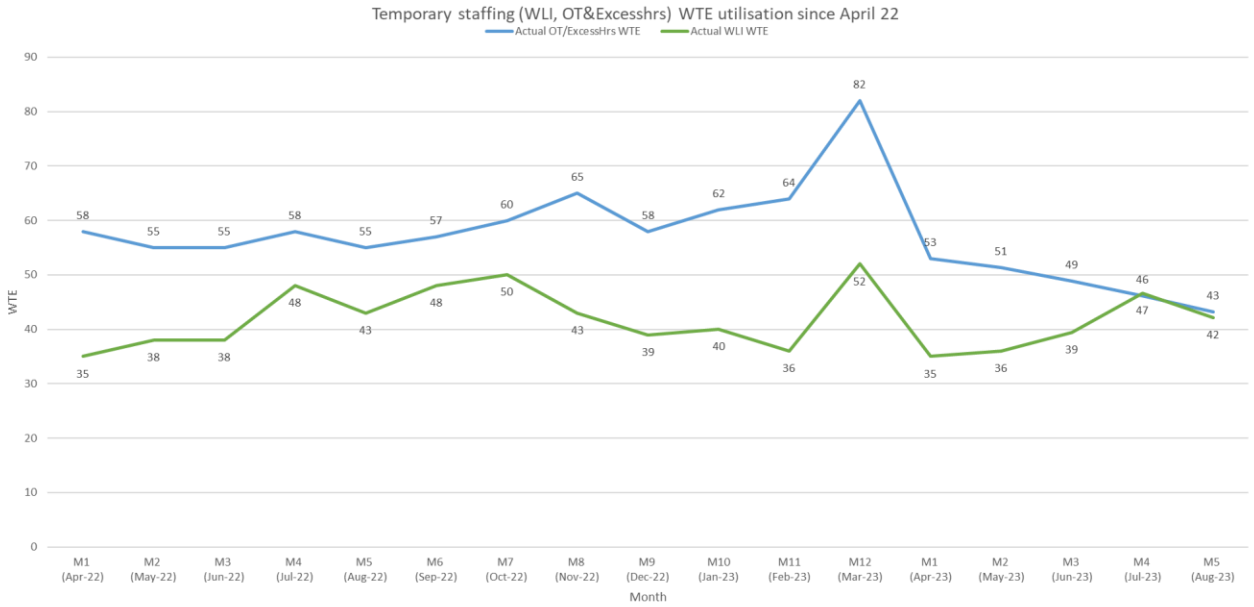
Relevant information:

Workforce Plan 2023/24 | Staff-in-Post | Temporary Resourcing | Turnover | Sickness absence | Job Planning

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

	M11 – M12	M12 – M1	M1 – M2	M2 – M3	M3 - M4	M4 – M5	M11 – M5 Total
WLI Movement	16	-17	1	3	8	-5	6



OT and Excess hours peaked in March 2023 and has seen a steady decline to August 2023, which has seen the lowest numbers since April 2022 in the 2023/24 period

Whilst WLI peaked at the same time, numbers have been more balanced

Source: HealthRoster as of August 2023
Retrospective WLI figures have updated from April 2023

Delivering our financial controls on workforce

Working in partnership, Workforce teams, finance, and CIP teams can report the following:

Area	Action taken forward
Reporting	• Weekly reporting on WF (substantive, bank, agency) internally and to the ICB including quantification of mental health pressure • Divisional WF trajectories completed for all divisions including THQ in • Weekly joint finance and workforce team meeting to review data quality, trends, and reporting.
Divisional Review Meetings	Executive review meetings with each division (June and September) to review: • Divisional grip and control • Substantive growth and CIP delivery • Temporary staffing opportunities
WF Controls	• Expansion of the weekly recruitment control panel (RCP) process in April to include a significantly wider number of posts to review • Increased temporary staffing controls through the temporary resourcing team and Ward Staffing hub • Executive sign-off for all A&C bank and agency
Supporting Leaders	• Temporary staffing agency calculator for ward areas introduced to support booking process • Finance rolling out new budget training, including new rostering guidance.

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

Substantive Monthly Staff in Post (WTE) for 2023/24

	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M7 (Oct)	M8 (Nov)	M9 (Dec)	M10 (Jan)	M11 (Feb)	M12 (Mar)	YTD Growth	Sparkline Trend
Add Prof Scientific and Technic	379	383	381	380	386								9	
Additional Clinical Services	2106	2113	2118	2129	2124								29	
Administrative and Clerical	2256	2271	2284	2287	2282								30	
Allied Health Professionals	682	673	681	690	691								20	
Estates and Ancillary	383	381	385	386	380								-3	
Healthcare Scientists	486	484	486	491	494								8	
Medical and Dental	2087	2074	2065	2061	2109								30	
Nursing and Midwifery Registered	3850	3910	3912	3908	3935								69	
Students	43	43	43	43	43								-1	
Grand Total	**12273**	**12332**	**12354**	**12375**	**12444**								**191**	

Source: ESR substantive staff as of 31 August 2023; includes consultant APAs and junior doctors' extra rostered hours, excludes hosted services. Numbers relate to WTE, not headcount

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TRUST-WIDE TURNOVER (August 2023)

Staffing group	Leavers (WTE) in month	Turnover 12m rolling %
Add Prof Scientific and Technic	1.7	11.0%
Additional Clinical Services	26.7	18.0%
Administrative and Clerical	31.5	15.0%
Allied Health Professionals	6.9	12.2%
Estates and Ancillary	8.5	14.5%
Healthcare Scientists	4.5	7.8%
Medical and Dental	2.5	4.7%
Nursing and Midwifery Registered	20.4	9.6%
UHS total	**102.6**	**12.3%**

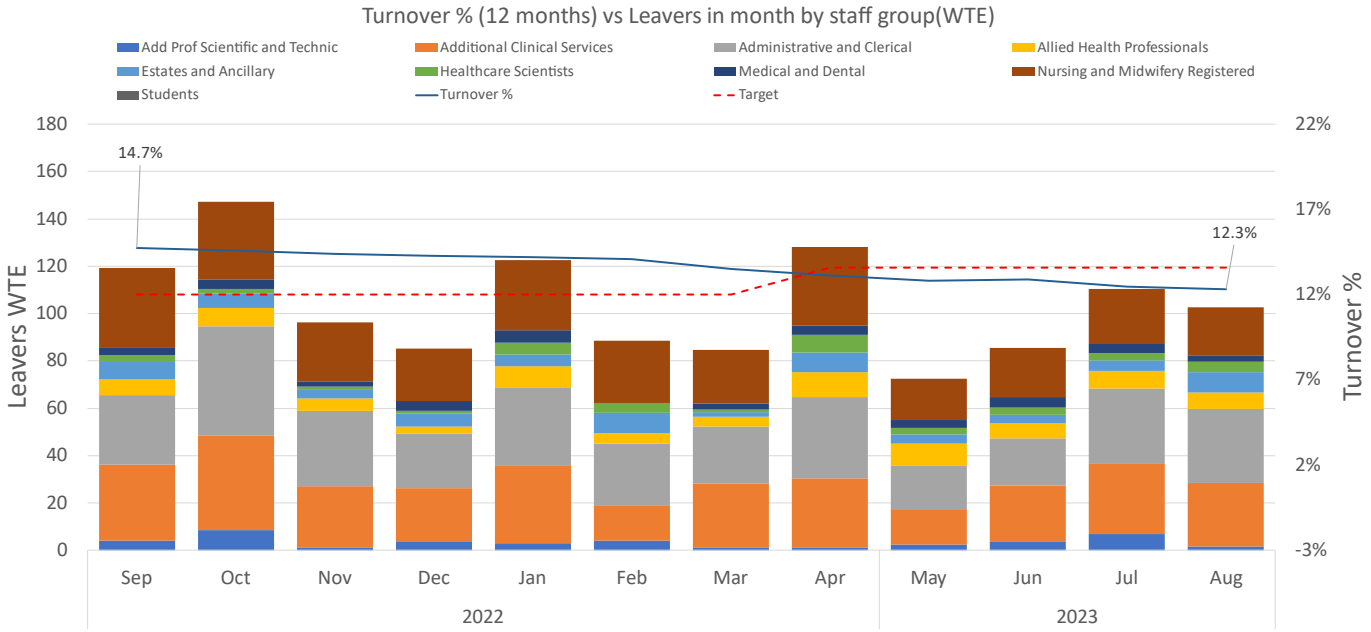
Source: ESR leavers August 2023 – Excludes junior doctors

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TURNOVER BY STAFF GROUP

Turnover (12 month rolling) downtrend continues and remains below the new target of 13.6%; in August 2023 there were 102.6 WT E leavers, which is lower than July 2023. Turnover is currently 12.3% (rolling 12-month average) which is lower than the trust-wide target of <13.6% and is a reduction of 2.4% from 12 months ago.



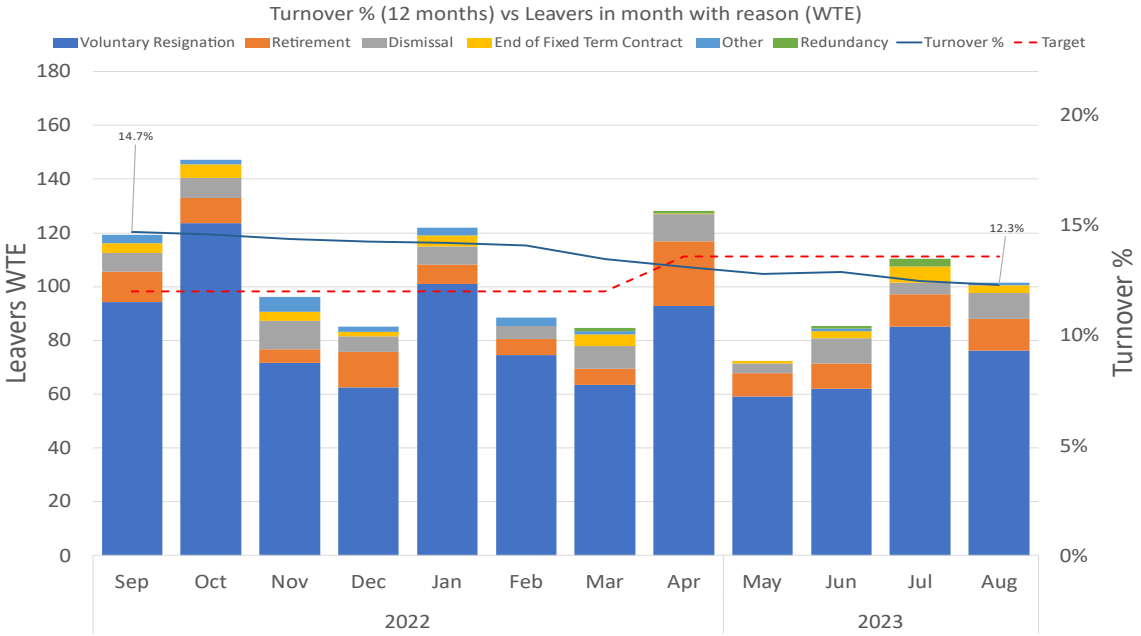
Source: ESR – Leavers Turnover WTE

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TURNOVER BY LEAVING REASON

In August 2023, a total of 102.6 WTE employees left the organisation. The majority of the leavers were voluntary resignations, accounting for 76.3 WTE (74%). Retirement accounted for 11.8 WTE (11%), while dismissal and end of a fixed term accounted for 9.6 (9%) and 2.9 WTE (3%) respectively.



Top reason for leaving by staff group

Additional Prof & Scientific	Personal circumstances
Additional Clinical Services	Retirement; Personal circumstances
Admin & Clerical	Retirement; Personal circumstances
Allied Health Professionals	Promotion
Estates & Ancillary	N/A
Healthcare Scientists	Retirement; Relationship with manager/colleagues; Flexible working; Lack of job satisfaction; Excessive workload/pressure
Medical & Dental	End of fixed term contract
Nursing & Midwifery	Retirement

Source: ESR; Reason for Leaving: Leavers Summary Q1

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

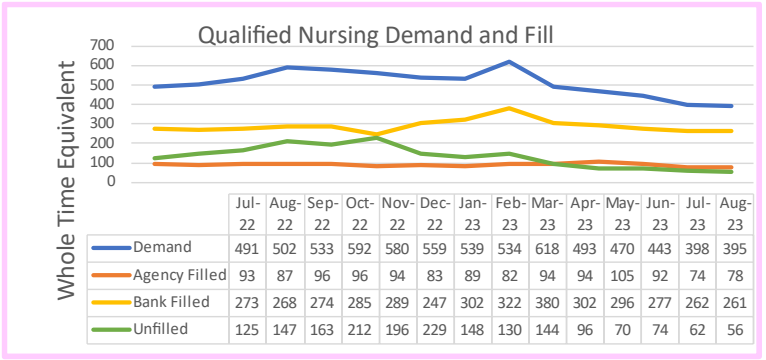
TEMPORARY RESOURCING

Status

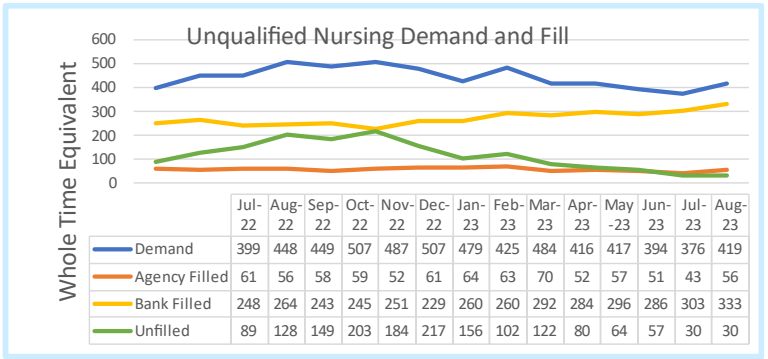
- Qualified nursing demand/fill (WTE): Demand decreased from 398 in July to 395 in August, of which, bank filled 261 (1 down on last month), agency filled 78 and 56 remained unfilled.
- Bank fill for qualified nursing Increased slightly from 65.7% in July to 66.09% in August.
- Demand for August 2023 is 107 WTE lower than August 2022.
- HCA demand/fill (WTE): Demand increase from 376 WTE in July to 419 WTE in August, of which, bank filled 333, agency filled 56 WTE (55 WTE were MH HCA's) and 30 remained unfilled.
- Bank fill decreased from 80.6% in July to 79.5% in August.
- Demand for HCA's is 30 WTE lower than in August 2022.

Actions

- Continued review of the agency cascade to reduce use of agency in Nursing and Midwifery.
- Thornbury have been removed from the cascade and can only be released by phone call in hub or site. High-cost agency shifts can only be authorised by matrons and site.
- Review of Care Support workers for Mental health as current demand is 100 WTE.
- Theatre rates under review.



	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Demand	491	502	533	592	580	559	539	534	618	493	470	443	398	395
Agency Filled	93	87	96	96	94	83	89	82	94	94	105	92	74	78
Bank Filled	273	268	274	285	289	247	302	322	380	302	296	277	262	261
Unfilled	125	147	163	212	196	229	148	130	144	96	70	74	62	56



	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Demand	399	448	449	507	487	507	479	425	484	416	417	394	376	419
Agency Filled	61	56	58	59	52	61	64	63	70	52	57	51	43	56
Bank Filled	248	264	243	245	251	229	260	260	292	284	296	286	303	333
Unfilled	89	128	149	203	184	217	156	102	122	80	64	57	30	30

Source: NHSP August 2023

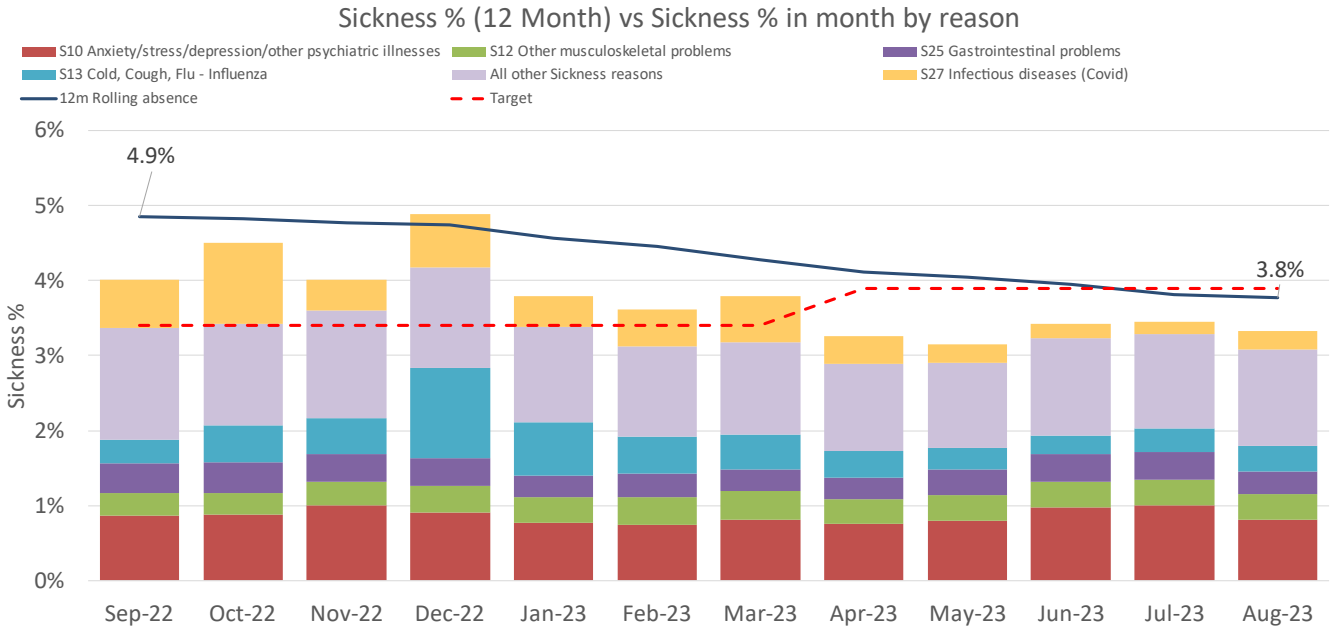
People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

SICKNESS

The current rolling sickness rate of 3.8% is lower than 12 months ago (4.9%) and this has continued the downtrend from December 2022.

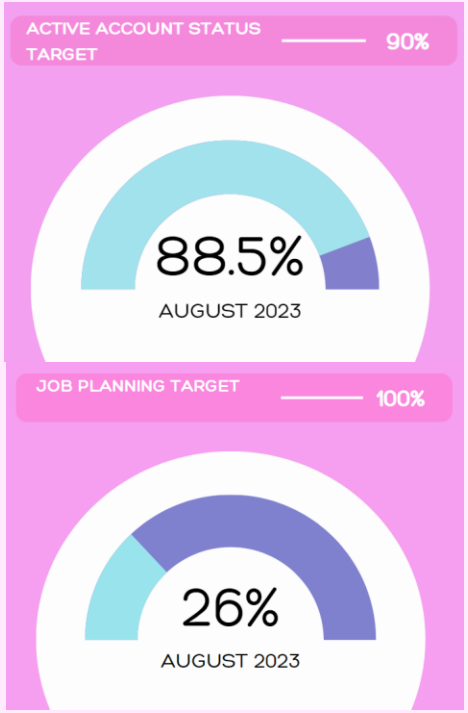
August in-month sickness is 3.3%. The sickness target for 23/24 is 3.9% with the YTD figure at 3.3%. An update on managing sickness absence was taken to the June UHS People Board which set out plans and processes to achieve the sickness target.



Source: ESR – Sickness data

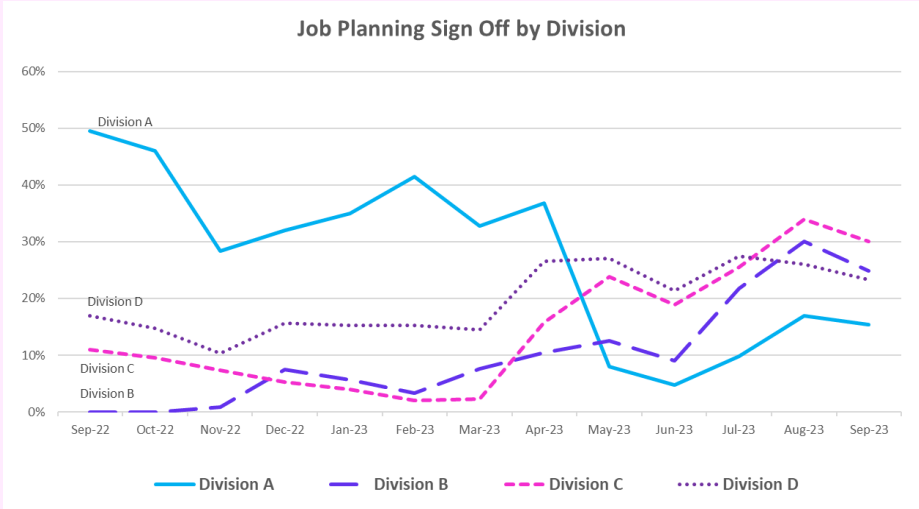
People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY



Job Planning – August 2023

- Job planning sign off levels increased to to 26%
- Active Job Plans up more than 5% from July
- Feedback received on Guidance for Clinical Leads
- 30 Seconds of News – Drop-in Sessions
- Job Planning Policy sent to all Consultants and SAS Doctors



People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

To achieve our ambition of World Class People, our strategy sets out three key areas of focus. These will inform our intention to grow our UHS family.

2. EXCEL

We want to excel within an organisation where forward-thinking people practices are delivered at the right time and where team structures, culture and environment are all designed to support wellbeing and develop potential. We will deliver progressive opportunities for individuals to develop their knowledge and skills to become their best selves. We will recognise and reward our people for the great work they do in well-designed roles that provide the freedom to innovate and improve.

Relevant information:

Appraisals | Statutory and Mandatory Training compliance

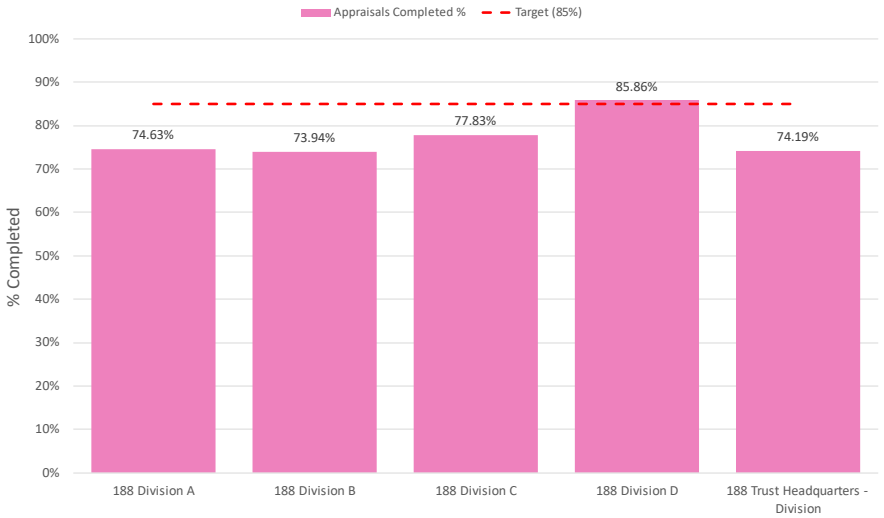
People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

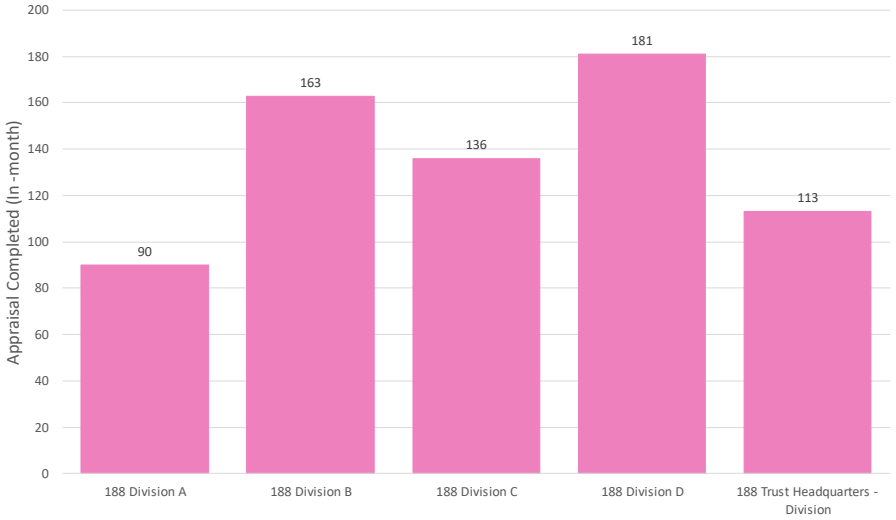
APPRAISALS

A total of **683** appraisals **(77.2%)** were completed in M5 (August 2023); a decrease from the previous month (808) after an additional 80 late inputs for the month of July. Appraisal completion has been affected by a combination of factors including annual leave, sickness absence, Industrial Action, and the use of ESR.

Appraisals Completed by Division %
August 2023



Appraisals Completed In-month
August 2023



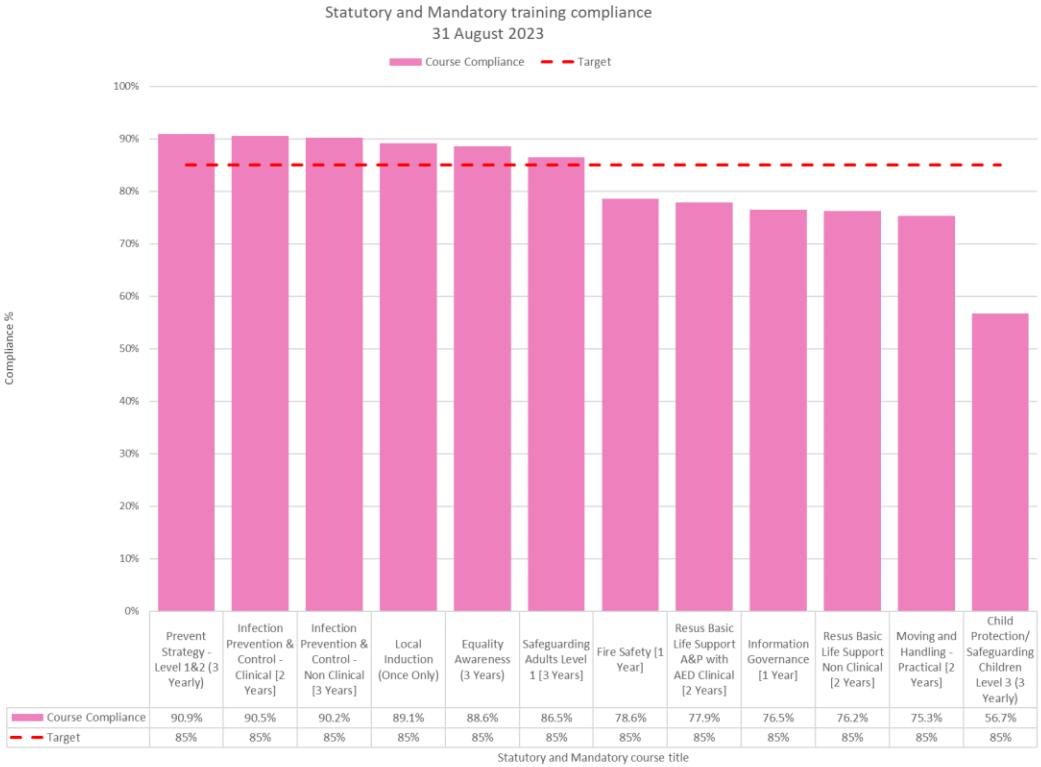
Source: ESR – Appraisal data for Divisions A, B, C, D and THQ only

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

Actions on Statutory and Mandatory Training

- Work is continuing on the revised VLE platform for launch in Q3
- Recommendations were accepted to change Stat & Mand matrix to just be statutory (legal) and mandatory (core skills training)
- Other current courses such as trust essential (e.g. Allyship) and role essentials (e.g. blood transfusion) to be split into separate matrices, and subject matter experts to be responsible for planning, delivery, and compliance
- Revised reporting to be provided to Divisions and THQ



	Prevent Strategy - Level 1&2 (3 Yearly)	Infection Prevention & Control - Clinical [2 Years]	Infection Prevention & Control - Non Clinical [3 Years]	Local Induction (Once Only)	Equality Awareness (3 Years)	Safeguarding Adults Level 1 [3 Years]	Fire Safety [1 Year]	Resus Basic Life Support A&P with AED Clinical [2 Years]	Information Governance [1 Year]	Resus Basic Life Support Non Clinical [2 Years]	Moving and Handling - Practical [2 Years]	Child Protection/ Safeguarding Children Level 3 (3 Yearly)
Course Compliance	90.9%	90.5%	90.2%	89.1%	88.6%	86.5%	78.6%	77.9%	76.5%	76.2%	75.3%	56.7%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Source: Virtual Learning Environment (VLE)

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

To achieve our ambition of World Class People, our strategy sets out three key areas of focus. These will inform our intention to grow our UHS family.

3. BELONG

We want to nurture a compassionate, inclusive and welcoming environment that values and supports every individual, both personally and professionally. We will ensure that every person feels free and comfortable to bring their whole selves to work, safe in the knowledge that they are welcomed, respected and represented.

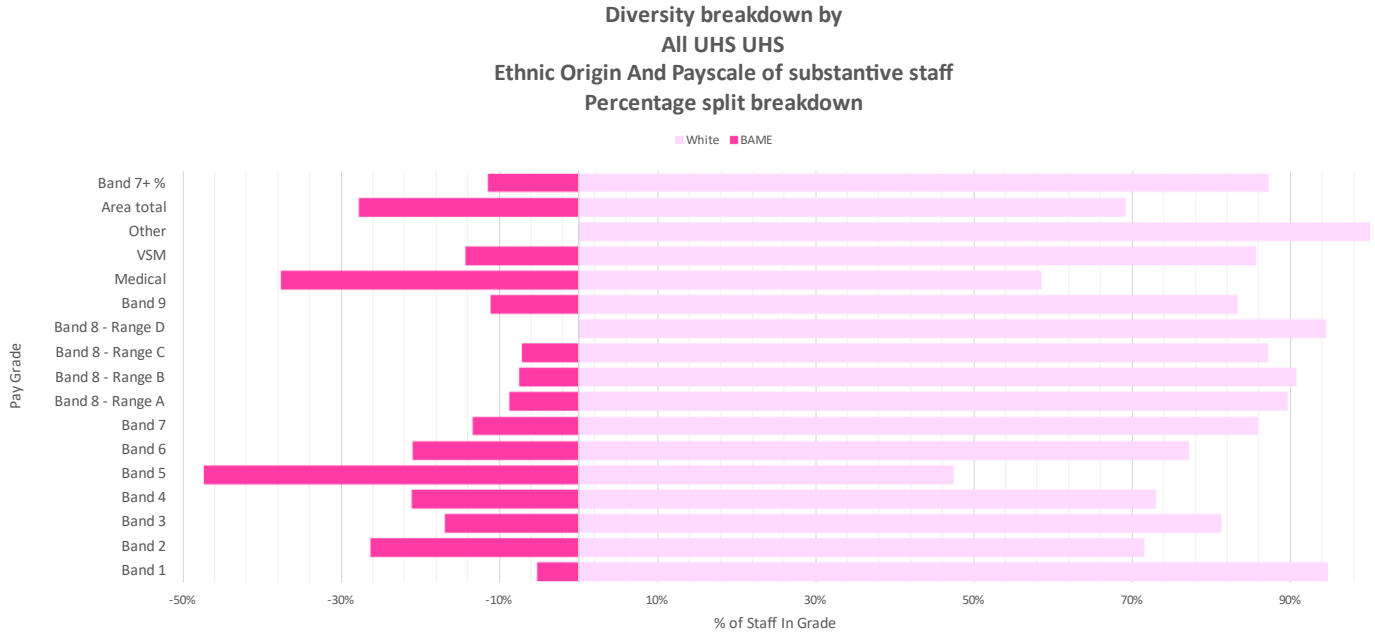
Relevant information:

Percentage of staff employed at AfC B7+ from non-white backgrounds | Percentage of staff employed at AfC B7+ with a reported disability | Staff Survey & Pulse Survey

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

STAFF IN POST – ETHNICITY

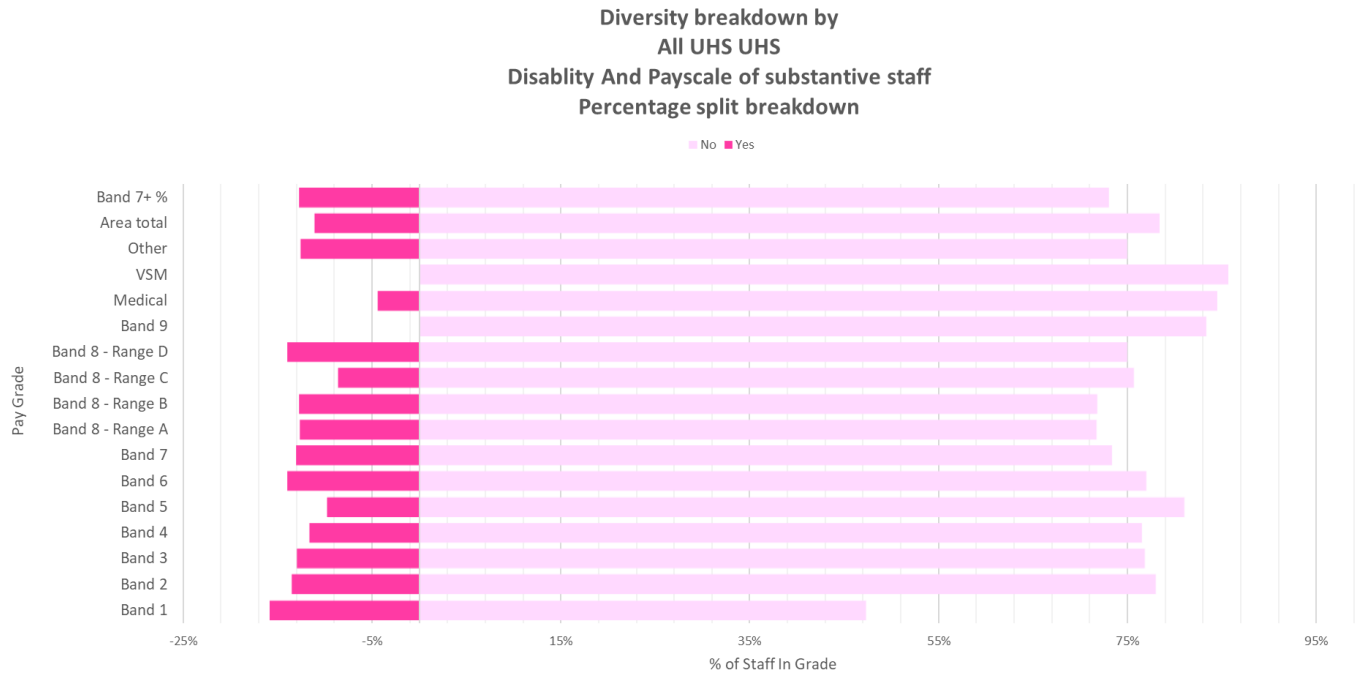


Source: ESR data taken w/c 4th September 2023

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

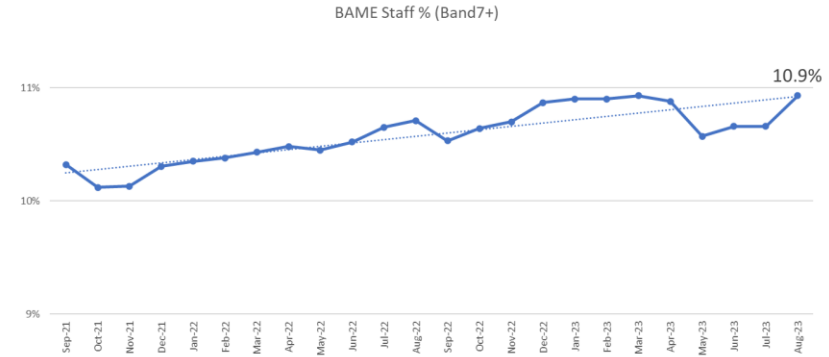
STAFF IN POST – DISABILITY STATUS

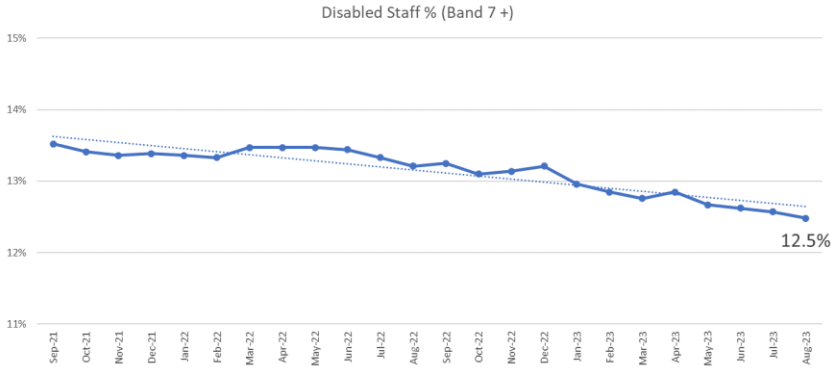


Source: ESR data taken w/c 4th September 2023

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY





STAFF IN POST – ETHNICITY and DISABILITY

Actions being taken:

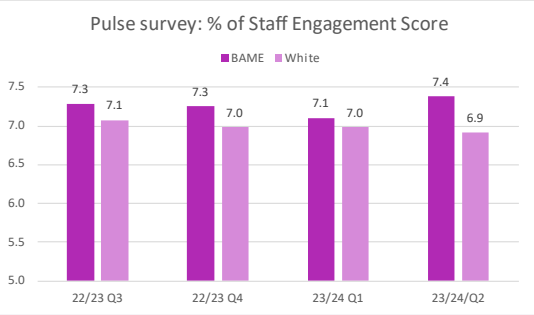
- Trust Inclusion and Belonging Strategy successfully launched.
- Big conversations facilitated the launch of the Maturity Matrix, and highlighted where our people feel we are as an organisation in our EDI Journey.
- Inclusive recruitment programme underway with revisions to process and practice.
- Successfully recruited a cohort of 24 diverse band 7s for our Florence Nightingale Foundation Positive Action Leadership Programmes for Nursing and Midwifery to commence in September.
- Career Development Workshops successfully implemented for PALP candidates, with good feedback.
- EDI steering groups have been established for all Divisions.

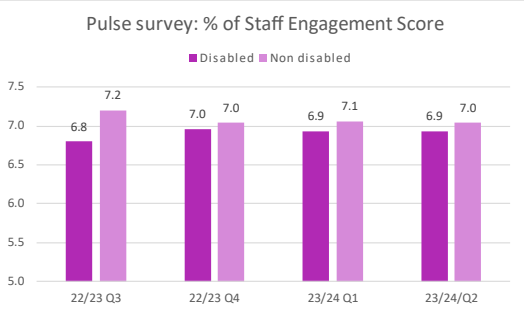
Source: ESR (data taken last working day of August 2023)

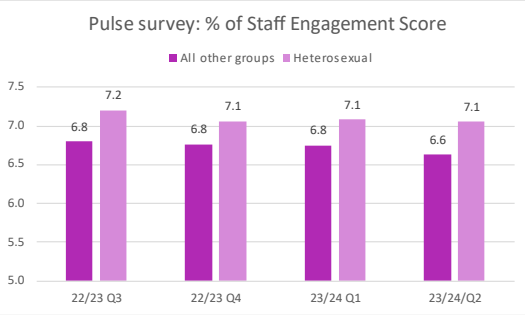
People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

Pulse Survey – August 2023

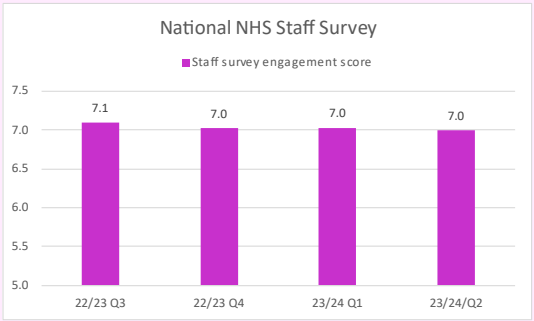


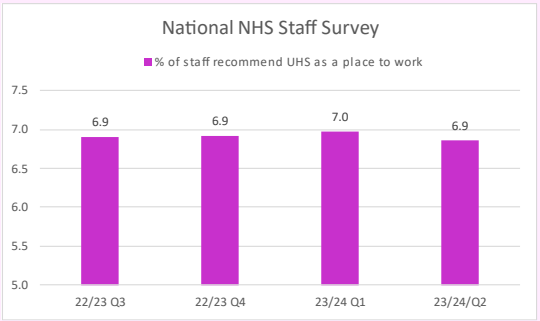




Pulse Survey Dates

Q4 January 2023
Q1 April 2023
Q2 July 2023
The quarterly surveys are live for one month





The annual survey covers Q3 and was live from September to November 2022.

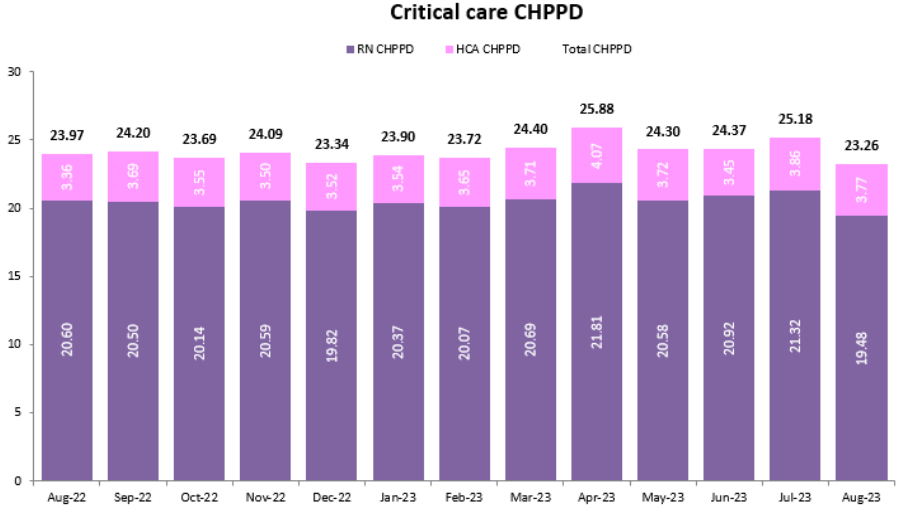
Source: Picker (Qualtrics)

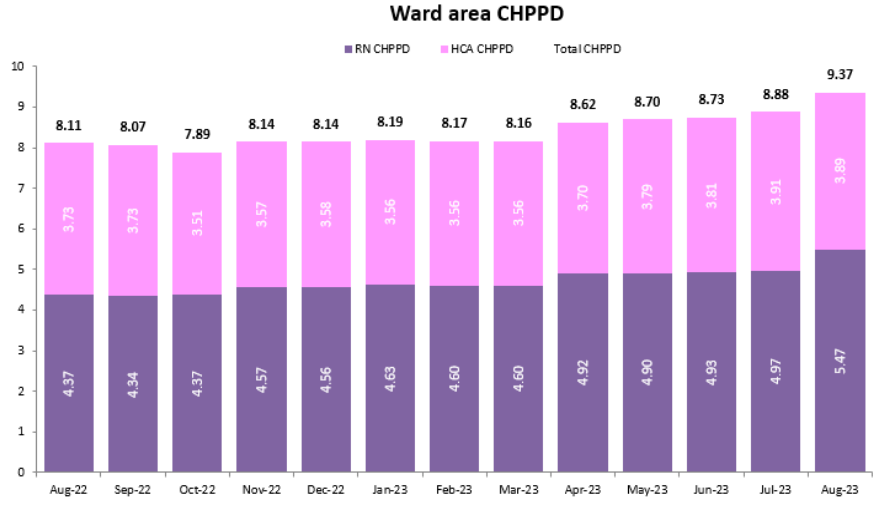
People Report

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

CARE HOURS PER PATIENT DAY
August 2023

The Ward areas CHPPD rate in the Trust has increased from last month to RN 5.5 (previously 5), HCA 3.9 (0.02 decrease, and overall, 9.4 (previously 8.9).





The CHPPD rate in Critical care has reduced overall from last month. RN 19.5 (previously 21.3), HCA 3.8 (previously 3.9), and overall, 23.3 (previously 25.2). 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.

Source: HealthRoster & eCamis

Appendices

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 hours)	Exclusions: Honorary contracts; Career breaks; Secondments; UPL; UEL; WPL; Wessex AHSN
Additional Hours (WTE)	Overtime & Excess Hours; WLIs; Extra Duty Claims; non-contracted APAs	Exclusions: UPL; UEL; WPL; Wessex AHSN
Temporary Staffing (WTE)	Bank: NHSP; MedicOnline Agency: Allocate Staff Direct (Medical & Non-medical); all other framework and non-framework agencies	Exclusions: Vaccination activity
Turnover	ESR (Leavers in-month and last 12 months)	Trainee/junior 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:	**Maternity Safety Report 2023-24 Quarter 1 (deferred from July 23)**			
Agenda item:	**5.8**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Emma Northover, Director of Midwifery and Professional Lead for Neonatal Services** **Alison Millman, Safety and Quality Assurance Midwifery Matron** **Marie Cann, Maternity and Neonatal Safety Lead**			
Date:	**28 September 2023**			
Purpose:	**Assurance or reassurance** **x**	**Approval**	**Ratification**	**Information** **x**
Issue to be addressed:	This report constitutes the agreed Maternity Services safety report to members of the Trust Board. Whilst we were awaiting feedback from our announced CQC inspection it was deemed more helpful to defer our Q1 report so that this could be included. The Maternity and Neonatal Service is now midway through an NHSR Maternity Incentive Scheme Year 5 process and there are some reporting streams mandated which will be submitted and between the quarterly reports. This report includes the following (Mandated reporting is highlighted with an *) **1.** Perinatal Quality Surveillance * – please see the monthly dashboard **Appendix 1** **2.** CQC report and action plan following our announced inspection, **Appendices 2 and 3** **3.** The increase in elective caesarean section activity, **Appendix 4**. **4.** NHSR Maternity Year 5 – progress report **5.** Saving Babies' Lives Care Bundle - progress report **6.** Moderate and Serious Incidents*– **Appendices 5, 5a, 5b** **7.** Avoiding Term Admissions to the Neonatal Unit (ATAIN) an overview of performance*, **Appendix 6** **8.** Perinatal Mortality Review Tool (PMRT) a summary of outcomes and compliance * **9.** Midwifery Workforce report (1of 2 this year) as part of MIS Year 5 compliance, **Appendices 7, 7a, 7b, 7c** **10.** Trust claims card, **Appendix 8** **11.** Appointment into new role for Neonatal Quality and Safety Matron **12.** Perinatal Culture and Leadership Programme **13.** Complaints			
Implications: (Clinical, Organisational, Governance, Legal?)	The risk implications for the UHS Trust and Maternity Service sit within several frameworks including: • **Reputational** – Safety concerns can be raised by the public to both NHS Resolution and the CQC. The CQC can undertake reviews of services who they believe have safety concerns.			

	• **Financial** – Compliance with NHS Resolution Maternity Safety Actions to meet all ten is an expectation for many maternity safety requirements. • **Governance** – Safety concerns can be escalated to the Care Quality Commission for their consideration, and to NHS England, the NHS Improvement Regional Director, the Deputy Chief Midwifery Officer, the Regional Chief Midwife and DHSC for information. • **Safety** - Non-compliance with requirements or recommendations would have a detrimental impact on the women and their families leading to increased poor outcomes and staff wellbeing.

Maternity Safety Report 2023-24 Quarter 1

1. **Perinatal Quality Surveillance * – please see the monthly dashboard , Appendix 1**
   This provides an overview of our Q1 dashboard with any further exceptions for July and August, as appropriate. Our reported increase in caesarean sections (item 3) is also clear on our dashboard. Our 3rd and 4th degree tear rate has been seen to increase and we will perform a deeper dive into this to ensure there are not important themes that need our attention. One week in August saw 3 stillbirths which is noticeable in our data – equally they were all different in nature. Indeed, one included a very unusual presentation of primary syphilis in a woman who had tested negative earlier in her pregnancy – the clinical reviews for both mother and baby are yet to be completed fully.

2. **CQC action plan following their announced inspection**
   On the 15 May 2023, the CQC made an announced National inspection to our Maternity Service under the domains of Safe and Well Led. The outcome from the inspection left us with a rating of Good overall but with Requires Improvement for Safety. The report can be seen as **Appendix 2** with an action plan against the recommendations made in **Appendix 3**.

3. **Increase in elective caesarean section activity – impact:**
   Our Maternity Service has seen a sustained and continued increase in caesarean section due expectation from our service users around mode of birth. Our previous theatre capacity was measured against an expected number of 52 per month which is consistently . Despite increasing capacity, the demand continues to rise, and this trend shows no sign of abating. The structure of our service, our staffing model, theatre provision and the service provision of other specialties are all being affected with some elective activity spilling into our Labour Ward. This in turn reduces available emergency capacity for patients in active labour. Patient flow on our postnatal ward areas is seen to be affected by higher numbers of service users having operative deliveries, with higher patient acuity levels for staff, both in the hospital and the community. In combination, these complex issues are proving difficult to manage from an operational perspective and require some urgent strategic planning both locally and across the LMNS. An overview of this can be seen in **Appendix 4**.

4. **NHSR Maternity Year 5 launched June 2023**
   Following the successful submission against the 10 safety actions, the Year 5 scheme was launched at the end of May 2023 with a further update in July 2023. The 10 safety actions have been further strengthened with an increased ask around the surveillance of our progress by the ICB. An initial meeting with commissioners has occurred and a further meeting will be taking place prior to completion of the reporting period on 7 December 2023.

   The submission date for Trust Board and ICB signoff and the approving of evidence against the 10 safety actions will be by 1 February 2024 at 1200hrs. It is anticipated that the evidence to support compliance will be brought to the December 2023 Trust Board meeting. Work towards achieving full compliance is being expedited.

5. **Saving Babies' Lives Care Bundle version 3 launched June 2023 progress report**
The 3rd version of the Saving Babies' Lives Care Bundle was also released at the end of May 2023. The full care bundle has been strengthened and has an additional (6th) element around pre-existing diabetes in pregnancy. Full implementation of this care bundle is expected by March 2024. To note, NHSR MIS year 5 requirement is that 50% of each element and 70% compliance (or agreed variance) overall is the minimum standard to meet Safety Action 6. Our compliance against this is also being overseen quarterly by the ICB/LMNS ensuring both internal and external scrutiny around our progress.

6. **Moderate and Above Incidents, HSIB cases and closed RCAs from these incidents**
Please see **Appendices 5, 5a, 5b**.

7. **Avoiding Term Admissions to the Neonatal Unit (ATAIN) an overview of performance***
Please see a summary attached as **Appendix 6**. The Trust continues to review each admission to the Neonatal unit to ensure that separating the parent and the baby was not preventable. The target rate is to remain below 5% and our performance indicators sit well within this range. To note, babies who have known structural or chromosome differences are excluded from this data. The NHSR Maternity Incentive scheme requires a deep dive into most common reasons for admission and in our case, this would be respiratory admissions. This ensures that no further themes or modifiable factors are in play which could be actioned to further prevent the separation of a baby from their birthing parent. The current deep dive has shown a limited number of themes for respiratory admissions which we will continue to monitor – an infographic demonstrating this can be viewed in **Appendix 6**. This work will be ongoing alongside our current ATAIN reviews.

8. **Perinatal Mortality Review Tool (PMRT) a summary of outcomes and compliance***
This is now a mandatory future reporting element for all Trust Board meetings. There are no case reviews to report for July and August.

9. **Midwifery workforce report**
This report provides oversight of an effective system on midwifery workforce to the required standard by NHSR Maternity Incentive Scheme Year 5. There will be a second report in December 2023 to meet the ask of NHSR. Please see the report in **Appendix 8**.

10. **Trusts Claims Score Card**
Within the requirements for NHSR reporting is a requirement for Safety Action 10 the Trust claims score but our legal team are awaiting the new score card. This will be included as **Appendix 8**. The NHSR MIS Year 5 initially required all Trusts to share the score card in July 2023, but no Trusts were in receipt of these.

11. August saw the appointment into the new role of Safety and Quality Assurance Matron for the NNU to sit alongside the Safety and Quality Assurance Matron role for Maternity. This brings a fully Mat/Neo approach to safety and quality with the associated leadership driving this important agenda.

12. **Perinatal Culture and Leadership Programme - Cohort A.**
It is nationally recognised in many maternity reports i.e. Ockenden and Kirkup that there are themes around flawed teamworking; lack of compassionate care and deep-rooted cultural issues, especially in respect to learning from events and freedom to speak up. The Perinatal Culture and Leadership Programme (PCLP) is a NHS England led programme designed to support maternity and neonatal services create and craft the conditions for a positive culture of safety and continuous improvement. This will serve to support the key drivers of the national maternity ambition outlined within The Single Delivery Plan. The aim overall is to have a positive

impact on the experiences of women, birthing people and babies and enable a more collaborative, supportive, psychologically safe workplace for all staff members. Compassionate leadership is key to this programme of work and in August the UHS Maternity and Neonatal senior team were invited to form a 'Quad' leadership team as part of cohort A. The initial steps for our Quad (Director of Midwifery, Care Group Manager for Woman and Newborn, Obstetric Lead and Care Group Lead) will focus on the individual development needs amongst these senior leaders before planning for the next stages. A SCORE culture survey will be undertaken which will provide our service with insight into the team's safety culture, as well as identifying strengths and opportunities for improvement.

13. Complaints

The Maternity Service has 3 complaints where the service users were not happy with our provisional response to their complaint, so these are ongoing – with no underlying key themes. There are 2 further complaints in progress. In addition, we have one key complaint related to a poor experience of our service. A new approach is being taken towards this case, with face-to-face discussions planned for later this month involving direct input from our Deputy Director of Midwifery.

Conclusion

Our Maternity Service continues to be mindful of all the safety drivers for maternity and neonatal services and will continue to provide Perinatal Quality Surveillance information on a quarterly, or as required, basis to Board members.

The Maternity dashboard continues to be refined and modified to provide a platform for clear oversight of key outcomes. This provides data for assurance and reassurance and identifies areas for improvements and innovations. We are keen to work closely with our workforce and with families accessing our service to make these improvements so as to improve their pregnancy and birthing experience.

Appendix 1 Working UHS Maternity Quarterly Dashboard

Q1 = April - June Q2 = July - September Q3 = October - December Q4 = January - March

Antenatal Booking	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24	Q2 23/24			Green	Red	Comments
						July	August	September			
Total number of women booked	1373	1276	1300	1405	1376				No performance threshold		Total number of women booked during 2022 - 5390.
Timeliness of testing KPI for Sickle cell and Thalassaemia screening	4.80%	6.10%	6.80%	12.60%	Provisional compliance - 36.8%				Performance threshold of testing Acceptable level >50% Achievable level >75%		The proportion of pregnant women having antenatal sickle cell and thalassaemia screening for whom a screening result is available ≤10 weeks + 0 days gestation.
First point of contact with a midwife ≤ 9+6 weeks	11.10%	12.90%	15.50%	23.90%	64.80%				Acceptable level >50% Achievable level >75%		NICE recommends that Maternity Service's should ***"offer a first antenatal (booking) appointment with a midwife to take place by 10+0 weeks of pregnancy"*** . UHS have a stepped approach to achieving this recommendation, which includes a First Point of Contact with a midwife and an appointment with an MSW for blood tests by 9+6 weeks. Women are risk assessed at the First Point of Contact and appropriate care pathways are started (e.g. risk assessment for aspirin, smoking referral, consultant referrals) The timeframe between FPC and Booking is reducing due to streamlining of processes by the Maternity Self-Referral Team.
% Bookings ≤ 9+6 weeks (NICE recommendation)	5.6%	7.4%	8.8%	9.1%	16.4%						
% Bookings ≤ 10+6 weeks	12.4%	13.4%	20.2%	24.2%	42.0%						

Birth Outcomes - mothers	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24	July	August	September	Green	Red	Comments
Total number of Births (women/people)	1261	1316	1315	1206	1236				1375 or fewer	More than 1375	Total number of births for 2021 - 5355. 2022 - 5094
Predicted birth rate	1219	1299	1287	1166	1229				1375 or fewer	More than 1375	**Predictions as of 03/07/2023 - Q2 1234 Q3 - 1253**
Sets of Multiples	19	13	22	22	21				20	21+	Office for National Statistics 2020 data - National rate 14.4 per 1,000 women/birthing people. UHS multiple rate per 1000 births 2022 - 14.5 UHS Total number of multiple births - 2021 - 84. 2022 - 74 (73 x twins, 1 x triplets)
Home birth rate	0.56%	0.53%	0.38%	0.83%	0.57%				No performance threshold		ONS 2021 - 2.5% of maternities delivered at home
IOL	28.3%	31.2%	30.5%	33.8%	31.6%				Less than 33%	More than 33%	Total number of inductions 2022 - 1540. IOL rate - 30.2% 2021 - 28.0%
Elective Caesarean section capacity	157	188	191	176	189				157 or Less	Greater than 157	The Maternity services have calculated the number of elective caesarean sections capacity as 157 slots per quarter, equalling 627 a year. 2022 total number of Elective C/S - 689
Number of elective section slots cancelled due to complexity of cases on the list	29	32	34	18	14				No performance threshold		New measure added to show the number of elective slots cancelled due to complexity of the lists
PPH 500ml or more - NMPA	34.6%	35.7%	36.0%	34.3%	35.6%				34.0% or less	Over 34.1%	% of term, singleton births with an obstetric haemorrhage more than or equal to 500ml. Source NMPA 2016/17 - UHS 34.5%(unadjusted) & 34.3% (adjusted) - National Mean 34.1%
PPH 1500ml or more - NMPA	3.0%	3.5%	4.2%	3.7%	4.2%				2.8% or Less	Over 2.9	% of term, singleton births with an obstetric haemorrhage more than or equal to 1500ml. Source NMPA 2016/17 - UHS 3.4%(unadjusted) & 3.3% (adjusted) - National Mean 2.9%
Episiotomy rate	27.0%	23.0%	27.0%	25.0%	27.5%				24.6% or less	Over 24.6%	NMPA 2018/19 total episiotomy rate 24.6% Reported figure related to all births, not NMPA specification
3rd/4th degree tears - NMPA	3.3%	3.0%	3.0%	3.7%	4.1%				3.1% or Less	Over 3.1%	% of term, singleton, cephalic, vaginal births with a 3rd or 4th degree perineal tear. **Source NMPA 2018/19 - UHS 3.5%(adjusted) - National Mean 3.1% - Local indicators updated Q1 2022/23 - 3.1%**
ITU Transfers	2	5	0	3	4				1	2 or more	ITU data obtained via Trust BI team from Camis data. All cases shared with Maternity Risk Team and Maternity Audit Midwife for review
Hysterectomy	0	1	0	0	0				0	1+	Hysterectomy data obtained via Divisional BA from Camis held data and BadgerNet. Cases shared with Maternity Risk Team for review

Birth Outcomes - Babies	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24	July	August	September	Green	Red	Comments
Total babies born	1280	1329	1337	1228	1257				1375 or fewer	More than 1375	Total number of babies born during - 2021 - 5441. 2022 - 5169
Total number of registerable babies	1275	1321	1334	1218	1247				No performance threshold		All liveborn babies plus stillborn babies born from 24 weeks gestation
Normal Birth Rate (babies)	47.4%	47.5%	47.4%	50.2%	46.8%				No performance threshold		All babies born via normal vaginal delivery
Apgar's <7 at 5 minutes - NMPA	1.9%	1.9%	2.2%	2.3%	2.7%				1.1% or Less	Over 1.1%	% of liveborn, singleton, term babies with an Apgar score of less than 7 at 5 minutes (BBAs excluded). **Source NMPA 2018/19 - UHS 2.3%(adjusted)) - National Mean 1.1% - Local indicators updated Q1 2022/23 - 1.1%**
Pre-term birth rate (registerable babies)	9.2%	7.3%	8.4%	9.7%	12.1%				No performance threshold		ONS 2021 - 7.6% of liveborn babies were pre-term Pre-term birth rate ambition announced in the NHS Long term Plan aims to achieve a 25% reduction in pre-term births by 2025 by reducing from 8% to 6%. Supportive improvement programmes within our service include SBLs, specialist pre-term birth clinics, implementation of MCoC model of care. The recent improvements lead by MatNeoSIP include peri and post partum optimisation of a very preterm infant additionally contribute to improving outcomes.

Neonatal outcomes	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24	July	August	September	Green	Red	Comments
Encephalopathy >34 weeks (inborn babies, graded moderate and above)	2	2	0	1	2 x Grade 3, 2 x Grade 2, 1 x Grade 1				No performance threshold		Awaiting further clarification from the LMNS on this outcome measure
Term Admission to NNU -All babies	4.6%	4.9%	5.9%	5.4%	4.1%				Less than 5%	More than 5%	2020/21 comparison 4.9% Data source - Neonatal Network. Data shared by WM and VP
Avoidable Term Admission to NNU - Excluding surgical/cardiac/congenital babies	2.9%	3.5%	4.0%	3.9%	3.1%				Less than 5%	More than 5%	2020/21 comparison 3.7% Data source - Neonatal Network and excludes babies coded under the surgical and cardiac categories - Data shared by WM and VP
Appropriate place of birth	100%	100%	100%	100%	100%	100%	100%	100%	100%		Ensuring births occur in an appropriate place for the gestation of delivery is a measure reported upon by the National Neonatal Audit Programme and also falls part of Safety Action 6 (Saving Babies Lives) in the Trust's yearly submission of evidence to NHSR
Number of neonatal deaths	8	4	5	5	4				No performance threshold		Safer Maternity Care Progress Report published in 2021 removes the performance threshold for Neonatal Deaths occurring at any gestation. Moving forward the measure have changed to reflect liveborn from 24+0 weeks gestation who sadly die. Dashboard measure to be adjusted going forward
Neonatal deaths per 1000 live births	6.30	3.03	3.76	4.11	3.22				No performance threshold		

Public Health Outcomes	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24	July	August	September	Green	Red	Comments
Infant feeding - Breast Feeding Initiation (mothers)	77.9%	80.6%	79.3%	75.9%	75.7%				More than 75.0%	Less than 75.0%	Source - NHS Digital 2018/19 - 75% Q2 2021/22 - Data taken from the BadgerNet feeding summary report - On BadgerNet Breastfeeding initiation is defined as "The mother is defined as having initiated breastfeeding if, within the first 48 hours of birth, either she puts the baby to the breast (including familiarisation) or the baby is given any of the mothers breast milk". We were unable to provide this level of detail from HICSS Maternity
Infant feeding - Breast Feeding at Discharge to community (babies)	73.3%	71.5%	71.8%	70.2%	74.8%				More than 70.6%	Less than 70.6%	Source NMPA 2016/17 - UHS 70.5% - National Mean 70.6% Q2/Q3 - its worth noting there has been an increase in the number of records with missing data, this has been highlighted to the Digital Midwives and Infant Feeding Lead
Smokers at booking	12.1%	11.3%	9.4%	9.8%	11.4%				No performance threshold		Percentage of women who declare a smoking status at booking. In response to the National Tobacco Dependency Long Term Plan, UHS Maternity have trained nearly all community midwives as Tobacco Advisors who will be offering support to women who wish to undertake a supported quit attempt. And the inpatient pathway is being developed.
Smoking at Delivery	10.2%	8.8%	9.4%	9.5%	7.8%				Less than 6.0%	More than 6.0%	The smoking at the time of delivery data is used to monitor the national ambition to reduce smoking in pregnancy to 6% by the end of 2022. Dashboard target changed from 11% to 6% December 2019
% of delivered women who quit during pregnancy	24.1%	30.5%	29.8%	28.5%	31.5%				No performance threshold		New measure. This figure is our quit rate comparing the smoking status declared at booking and whether the women is a smoker or non-smoker at time of delivery
Southampton City Smoke Free Pregnancy Monitoring	26.7%	21.8%	21.1%	66.7%	Reportable next quarter				Greater than 35%	Less than 35%	% of women / pregnant people who successfully quit smoking following the quit programme offered by Southampton midwives.

Booked Continuity of Carer	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24	July	August	September	Green	Red	Comments
Booked - total women/pregnancy people booked onto a CoC pathway	44.1%	43.6%	43.9%	13.8%	14.0%				Greater than 35%	Less than 35%	Maternity continuity of care model is a key workforce model for our service ensuring all families, particularly those most vulnerable, have safer and improved pregnancy and birth outcomes. During COVID, and in response to the Final Ockenden Report, we were asked to consider suspending the MCoC model, so as to preserve our staffing resources and provide a safer workforce overall. After careful consideration, we decided that it would be safe for us to continue providing care within a continuity framework to our vulnerable families, but would not expand the model further, hence the work around the two pilot sites was paused. The current reduction in compliance reflects these changes. It is important that we know that the most
Booked - total BAME women / pregnant people booked onto a CoC pathway	78.2%	82.5%	82.7%	35.7%	33.1%				Greater than 51%	Less than 51%	

Booked - total women living within an IMD-1 area booked onto a CoC pathway	82.7%	55.1%	79.0%	24.9%	34.0%				Greater than 51%	Less than 51%	vulnerable families are still supported by our Needing Extra Support teams (NEST) and as we progress workstreams around future workforce plans it will be likely that new and more sustainable MCoC models of care may be successfully implemented which in turn will see an increase in compliance levels.
Ockenden review	**Q1 22/23**	**Q2 22/23**	**Q3 22/23**	**Q4 22/23**	**Q1 23/24**	**July**	**August**	**September**	**Green**	**Red**	**Comments**
% Risk assessments undertaken at each AN contact	37.8%	53.8%	57.7%	52.5%	63.5%				Acceptable level ≥ 80% Achievable ≥ 90%		New dashboard measure. Data for these performance indicators is currently under review by the Quality/Digital Team. Risk assessment at each antenatal contact and place of birth continue to be monitored via local audits where compliance is greater. Compliance via BadgerNet is reliant on the authorisation of each note on Badgernet therefore there is some data quality work to be undertaken.
% Place of birth risk assessments undertaken at each AN contact	67.0%	79.3%	77.7%	74.5%	76.4%						
% High Risk women allocated a named consultant at any point during pregnancy	92.16%	94.11%	92.45%	94.4%	Reportable next quarter						
Saving Babies Lives v2	**Q1 22/23**	**Q2 22/23**	**Q3 22/23**	**Q4 22/23**	**Q1 23/24**	**July**	**August**	**September**	**Green**	**Red**	**Comments - UHS is awaiting the publication of SBLs version 3.0, the new standards will be reviewed by the UHS SBLs working group led by the Quality Assurance Matron and these measures will be updated as required.**
% Precept Mag Sulphate Criteria (<30 weeks)	100%	100%	100%	86%	80%				Greater than 80%	Less than 80%	% of singleton live births <30 weeks receiving Magnesium Sulphate within 24 hours prior to birth
Number of Stillbirths	6	3	5	1	5				5 or less	6 or above	Actual number of Stillbirths each quarter
Stillbirth rate per 1000 births	4.69	2.32	3.75	0.82	4.01%				4.1 or less	4.2 or above	National rate 2021 4.2 per 1000 births
% <3rd centile >37+6 weeks				0.0%	2.1%				To be defined		Data from LMNS dashboard
Low Birth Weight at Term (<2500g)	2.4%	2.0%	3.3%	1.8%	1.9%				Less than 2.8%	More than 2.8%	Source Public Health England 2017 National average 2.82% of live term births.
Risk and Patient Safety cases	**Q1 22/23**	**Q2 22/23**	**Q3 22/23**	**Q4 22/23**	**Q1 23/24**	**July**	**August**	**September**	**Green**	**Red**	**Comments**
Total number of cases UHS have reported to HSIB	3	2	0	3	1				n/a	n/a	Q4 - 3 therapeutic cooling cases referred to HSIB following uncomplicated pregnancies but were in poor condition at birth. No major findings at Clinical Events Review.
Total number of UHS cases accepted for review by HSIB	3	2	0	3	1				n/a	n/a	
Term Intrapartum Stillbirths	0	0	0	0	0				n/a	n/a	
Early neonatal death	1	0	0	0	1				n/a	n/a	
Severe brain injury	2	1	0	3 patients with HIE grade 3 (2 Outborn, 1 inborn)	1 (HIE Grade 3)				n/a	n/a	
Maternal death	2	1	0	0	0				n/a	n/a	
The number of incidents logged graded as moderate or above and what actions are being taken	10	12	17	9	7				n/a	n/a	Moderate incidents are reported to the Board Level Maternity Safety Champions and the LMNS on a monthly basis. These figures now include moderate neonatal incidents but do not include HSIB reportable incidents.
Number of SIs reported and under investigation	2	2	4	5	1				n/a	n/a	New figure reporting to provide clarity around SIs reported and under investigation per quarter. Only incidents reported as a SIRI (i.e. on STEIS) have been included. These may not include cases under HSIB investigation. Q4 - 5 cases reported and undergoing investigation (including 3 HSIB cases)
Number of major complaints received for Maternity Services	0	2	7	1 major / 1 severe	1 Major case - Closed on 02/06/2023 - Not Upheld				n/a	n/a	The number of major complaints and themes received for Maternity Services are reported to the LMNS on a monthly basis. 1 New major + 1 Severe Maternity complaint in Q4 however there were also 2 minor and 2 moderate complaints totalling 6 for this quarter. Themes/learning: Mismanagement of labour /Delay/Failure to diagnose /Inadequate pain relief/Communication issues

Education and training	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24	July	August	September	Green	Red	Comments
Provider Board Level Measure - Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training											
	Jul-22	Sep-22	Dec-22	Mar-23	Jun-23				Month		
Fetal Monitoring Training (SBL2 & NHSR)	88.2%	94.2%	94.0%	89.7%	92.2%				Midwives	90% compliance target	Q1 2021/22 onwards, these percentages relate to Fetal Monitoring training provided via the Fetal Surveillance study day (previously included as part of PROMPT). **June 2023 - all non-compliant obstetric trainees are rostered to attend PROMPT during July and August.**
	72.2%	95.0%	81.0%	85.0%	90.0%				Consultant Obstetricians		
	69.2%	92.0%	56.3%	54.3%	85.3%				Obstetric trainees		

Friends and Family Test	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24 - Provisional compliance	July	August	September	Green	Red	Comments
Responders as % of eligible populations	28.1%	29.0%	27.3%	31.3%	28.0%				20% or more	Less than 20%	Ongoing review of rates, noted that there has been a reduction in feedback across the Trust, not just maternity. It is hoped once the Maternity Services Facebook page is running again feedback will increase as reminders will be sent more regularly. Work ongoing with the digital team to ensure reminders are being sent to women via BadgerNotes to provide feedback.
Recommenders as % of responders	86.7%	85.7%	88.5%	88.5%	87.0%				90% or more	Less than 90%	
NOT recommending as % of responders	4.4%	4.3%	3.7%	3.2%	3.3%				Less than 5%	5% or more	

HR	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24	July	August	September	Green	Red	Comments
Appraisal Rate	70.30%	68.52%	Unavailable	66.40%	59.95%				92% or more	Less than 92%	Our maternity service has undertaken a workforce project gathering thoughts from the workforce and shaping the future service. development of the workforce and listening to their concerns has been a key feature.

Service monitoring	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24	July	August	September	Green	Red	Comments
Black Alerts / OPEL 4	9	5	9	3	6				0	1 or more	2020/21 - Average 0.75 a quarter 2021/22 - Average 7.5 a quarter

Appendix 2

University Hospital Southampton NHS Foundation Trust

Princess Anne Hospital

Inspection report

Coxford Road
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Date of inspection visit: 15 May 2023
Date of publication: N/A (DRAFT)

Ratings

Overall rating for this service	Good
Are services safe?	**Requires Improvement**
Are services well-led?	**Good**

Our findings

Overall summary of services at Princess Anne Hospital

Good 

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Princess Anne Hospital.

We inspected the maternity service at Princess Anne Hospital as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

Princess Anne Hospital provides maternity care and treatment to women, birthing people and babies from Southampton and surrounding areas, as well as providing more complex maternity and neonatal care to others from the Local Maternity and Neonatal System (LMNS). The LMNS covers Southampton, Hampshire, the Isle of Wight and Portsmouth. Staff at the hospital delivered 5220 babies between April 2021 and March 2022 and there were 480 births in April 2023.

Maternity services at Princess Anne Hospital includes an obstetric consultant-led delivery suite, maternity assessment unit (triage) and wards for antenatal and postnatal care. Broadlands Birth Centre, a midwifery-led birth centre, provides intrapartum care for women and birthing people who meet the criteria and are assessed to have lower risk pregnancies.

We will publish a report of our overall findings when we have completed the national inspection programme.

We carried out an announced focused inspection of the maternity service, looking only at the safe and well-led key questions.

We did not review the rating of the location therefore our rating of this hospital stayed the same, Princess Anne Hospital is rated good.

We did not inspect the other service run by University Hospital Southampton NHS Foundation Trust, the New Forest Birth Centre, as it is currently dormant for delivery of babies.

How we carried out the inspection

During the inspection we spoke with 23 staff including the chief nursing officer, director of midwifery, head of midwifery, obstetricians, doctors and midwives, the non-executive safety champion and the Maternity Voices Partnership chair. We attended handover meetings, reviewed 8 records and spoke with 2 women or birthing people and families.

We received over 300 'give feedback on care' forms through our website from women and birthing people, of which about a quarter were positive. A quarter were negative and about half of all responses included mixed feedback about their experience.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Maternity

Good ➔➔

Our rating of this service stayed the same. We rated it as good because:

- Most midwifery staff had training in key skills and worked well together for the benefit of women and birthing people, understood how to protect women and birthing people from abuse, and managed safety well.
- The service controlled infection risk well and staff assessed risks to women and birthing people, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service.
- Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities. The service engaged with women and birthing people and the community to plan and manage services.
- People could access the service when they needed it and did not have to wait too long for treatment. Staff were committed to improving services continually.

However:

- Staffing levels did not always match the planned numbers which may have caused delays to care and treatment.
- Medical staff had not completed all mandatory training, such as safeguarding.
- The service estates lacked investment and affected the experience for women and birthing people as well as staff.
- The security of the wards was not always effective putting the safety of women and birthing people and babies at risk.
- Checks on emergency equipment were not always completed on a daily basis.
- There had been a general improvement in infection prevention and control, although we continued to find isolated incidents.

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills, however not all staff had completed up-to-date training.

Not all medical staff were up to date with their mandatory training. The trust provided training compliance for medical staff, which showed that junior medical staff training fell short of trust targets of 95% for information governance and

85% for all other training. Fire safety training had been completed by 18 of the 34 staff listed on the training, information governance was completed by 16 staff, basic life support had been completed by 18 staff. Only one junior medical staff member had completed all of the mandatory training and only 2 of the 19 training sessions had been undertaken by all junior medical staff.

Midwifery and nursing staff received and kept up to date with their mandatory training. Between 83 and 94% of midwives, maternity nurses and maternity support workers had completed this training, which included basic life support and perinatal mental health. Most of these staff were also up to date with other mandatory training, such as fire safety, moving and handling, and infection prevention and control.

The trust provided other training that was specific to maternity staff. However, records for May 2023 showed similar trends to other training, as the level of completion by junior doctors was lower than that for midwives or consultants. Sixty eight percent of junior doctors had completed fetal surveillance training, which did not meet the trust target of 85%. Records showed 95% of consultants and 92% of midwives had completed fetal surveillance training.

The service made sure multi-professional simulated obstetric emergency training was available, although not all staff had received it. The service provided a whole day for staff to complete scenarios, which included neonatal life support and pool evacuation training. Records for May 2023 showed that 94% of midwives, 63% of junior doctors and 79% of consultants had completed their obstetric emergency training, which fell short of the trust's 95% target for this training. The impact of lack of simulated training is that during emergencies some staff may not respond effectively.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. There was an emphasis on multidisciplinary training, which included midwives, junior doctors and consultants learning together. This ensured all staff were given the same information, they developed better working relationships by learning together, which led to better outcomes for women and birthing people and babies. Training included cardiotocograph (CTG) competency, skills and drills training and neonatal life support. Staff were tested at the end of the training day to ensure they had absorbed the information presented.

Training schedules also included additional maternity courses, such as a midwifery professional study day, medical devices and Avoiding Term Admissions to Neonatal units (ATAIN) e-learning module.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts, so they knew when to renew their training. Overall staff training compliance figures were reported in governance meeting minutes. This recognised the lower compliance for junior doctors, due to a shortfall in staffing. Action plans were in place and completion rates had increased by 10% in the last 12 months.

Safeguarding

Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. Not all staff had received training on how to recognise and report abuse.

Not all staff had received recent training specific for their role on how to recognise and report abuse. Information provided by the trust showed medical staff compliance for safeguarding adult and child protection training only went to level 2. National safeguarding intercollegiate guidelines state that all staff risk assessing women and birthing people should complete training to level 3. Of the 36 junior doctors on the maternity rota, 19 had not received adult

safeguarding and 17 had not received child protection training at level 2 in the last 3 years. The information we received showed that 7 junior doctors may not have had any safeguarding training since August 2016. This meant the trust could not be assured that safeguarding needs were accurately identified or that all staff had the skills and knowledge to make appropriate referrals.

Following the inspection the service leaders informed us that obstetricians did not work independently of midwives and would never be the only clinician dealing with safeguarding issues. An agreement was therefore reached in 2021 for the safeguarding training requirement that all obstetric medical staff (except trainees) only needed to complete level 2 safeguarding training. The care group clinical lead and director of education were the exception required to complete level 3 training.

Records for April 2021 to April 2022 showed that 91% of midwives and maternity support workers had completed both Level 3 safeguarding adults and child protection training against a trust target of 85%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified staff developed birth plans for women and birthing people with input from the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had a safeguarding team who staff could turn to when they had concerns. The team was made up of a band 7 lead midwife, supported by a band 6 midwife, a domestic abuse midwife and an administrator. They reviewed safeguarding referrals and made sure women, birthing people and families received the appropriate interventions and support when needed. Staff explained safeguarding procedures, how to make referrals and how to access advice. Patient records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff demonstrated their understanding during our conversations with them and showed how they had considered the needs of patients with protected characteristics.

Staff followed the baby abduction policy, although not all staff undertook baby abduction drills. Staff explained the baby abduction policy, but we saw that not all ward areas were secure. This was because there were estates issues with door security. On F-level there was no intercom system to allow the receptionist to speak with visitors before allowing them access. On E-level, doors to Broadlands Birth Centre did not always shut when left to self-close. After the inspection we raised these security issues with the trust, who responded swiftly. F-level had an intercom system installed and the doors on E-level were adjusted to make sure they always closed properly. Staff in the Broadlands Birth Centre had not practised what would happen if a baby was abducted within the previous 12 months of the inspection.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women and birthing people, themselves, and others from infection. They kept most equipment and the premises visibly clean.

Maternity

Most maternity service areas were clean and had suitable furnishings which were clean and well-maintained. We saw that most areas, such as corridors and patient rooms, were visibly clean and free of dust in folds in chairs. However, there were some issues of infection control risks. We found a towel in one baby resuscitaire was soiled and had not been changed after the equipment was previously used. Temperature checks of the milk fridge had not been fully completed, leading to a risk of deterioration of stored breast milk. Infection control was identified as an issue in our last inspection report and although overall there had been some improvement, there continued to be incidents of poor practice.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning staff told us they recorded when they had cleaned each area on checklists, which provided information to other cleaning staff and assurance that areas that had not been cleaned were identified.

The service generally performed well for cleanliness. Staff performed monthly ward round cleaning audits for each area and completed a documented audit. Staff recorded information on a cleaning action required report which stated areas for improvement. For example, March 2023 reports showed that limescale had built up on taps and needed to be removed. The overall audit data for April 2023 showed that compliance was 99%.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff made sure their clothing was bare below the elbows, all areas stocked PPE at various intervals along walls as well as hand sanitiser. Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. In the last year compliance was consistently above 85%. The service did not report any hospital acquired infection incidents during April 2022 to April 2023.

Staff cleaned equipment after contact with women and birthing people and labelled equipment to show when it was last cleaned. Staff cleaned couches between use and it was clear equipment was clean and ready for use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Staff did not always carry out daily safety checks of specialist equipment. The service had enough suitable equipment to help staff safely care for women, birthing people and babies. Service leaders monitored emergency trolley checks which contained the defibrillator and records for January to April 2023 confirmed that labour ward staff checked 97.8% of the time. However, ward compliance for the same period was lower at 87.8%. Managers developed actions including a review of the current process and identifying a clinical lead to be accountable for the checks. However, we found this was not entirely effective.

During the inspection we reviewed specialist equipment, including emergency adult and neonatal resuscitation equipment and observation equipment. We found daily checks were not always recorded, such as on the resuscitaires, as being carried out every day in the labour ward and the antenatal and postnatal wards. Daily checks of emergency equipment are vital to ensure staff have the appropriate equipment available immediately.

Women and birthing people could reach call bells and staff responded quickly when called. We saw that call bells were within easy reach and staff responded in a timely manner when these were rung.

Maternity

The design of the environment did not follow national guidance. Whilst there was security out of hours for access to Princess Annes Hospital the maternity service did not have a monitored entry and exit system at entrances to maternity wards, units and reception areas.

Staff told us of their concerns in not knowing who people were when arriving at the ward areas. We saw some doors did not readily close and were easy to leave on the latch. There were concerns at our last inspection about security. We raised these concerns at this inspection and the trust responded with an action plan. They made some immediate improvements to improve security including reducing the risk of tailgating at doorways and admitting people to maternity areas in a more controlled way.

The midwife-led Broadlands Birth Centre was described by staff as not as "homely" as they would like it to have been. Most birthing rooms were sparse and clinical, lacked ambiance and some had views only of industrial pipes. However, the rooms with a birthing pool had been adapted and had softer lighting and candles.

The storage cupboards in clinical rooms, such as those for medicines storage, were hard to clean surfaces and wooden domestic style cupboards. There had been limited evidence of significant investment to update the facilities fixtures and fittings in recent times.

The triage area configuration was narrow, which made it easy to make contact with patient curtains when they were drawn. One bed's curtains were adjacent to the entrance door, the foot of the bed and the midwives workstation, with its busy thoroughfare, meant it was very easy for these curtains to come into contact with people walking into and through the unit and potentially fail to provide adequate privacy. It was easy to hear everything discussed for the treatment of and conversation by staff with women and birthing people or when staff were on the telephone or speaking amongst themselves.

The service had dedicated maternity theatres, including an emergency theatre, a high dependency unit for women and birthing people, and transitional care beds for babies requiring a higher level of monitoring during and after delivery.

Staff had developed a bereavement suite at the end of the delivery suite, which women and birthing people could access and leave from without going through the delivery suite. The suite included two rooms, one for delivery and the other decorated in a comfortable, home style area for women, birthing people and their partners to rest in. The room included tea and coffee making facilities, as well as relevant literature. This was a recommendation in the Stillbirth and Neonatal Death charity (Sands) position statement (Bereavement care rooms and bereavement suites 2016).

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water. We saw this during our visit to the Broadlands Birth Centre.

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, in the birth centre there were pool evacuation nets in all rooms and on the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment. Records showed that the service had recently completed portable appliance testing (PAT) on all its equipment in January 2023.

Maternity

In March 2023 NHS England issued guidance on actions NHS trusts should take to minimise staff exposure to nitrous oxide. The service monitored staff exposure prior to this guidance and following had developed a risk assessment and action plan to consider the further actions they needed to take and how best to protect staff.

Staff disposed of clinical waste safely. Sharps bins were not over-filled, although not all were labelled correctly. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

Ninety-one per cent of clinical staff had received ligature point and cutter training as part of basic life support training. The trust had a standard operating procedure (SOP) for the 'Management and Care of Ligature Cutters and Ligature Pack' which expired in August 2022. The SOP included details on how to store, check and use ligature cutters. The service provided evidence of ligature removal training. However, there was no data to show how many staff had received it.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and birthing person and took action to remove or minimise risks. Staff identified and quickly acted upon women and birthing people at risk of deterioration.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for each woman or birthing person. The trust completed an audit on staff compliance to the use of MEOWS charts and found that 80% of staff correctly completed them. All the observations that were recorded as not within normal parameters had been escalated to senior staff. The audit identified that some staff needed to receive additional training on how to appropriately record observations like respiration rates.

Staff completed antenatal risk assessments when women and birthing people booked for their care at the start of their pregnancy, we reviewed 8 sets of records and found that staff had completed all risk assessments for these patients. However, trust information showed full risk assessments of women and birthing people were not completed at each antenatal appointment. The maternity dashboard data for January 2023 to April 2023 showed that only 53% of women or birthing people had a completed risk assessment. The data was collected as part of the Ockenden report (2022) recommendations for safer care. Risk assessments are pivotal to making sure women and birthing people receive the right care. The service were reviewing data measuring for this as audits completed at a more local level (ward or unit) showed a greater compliance.

Following this inspection the service carried out an audit of 20 records for the period January to April 2023 and they identified a 100% compliance.

Staff used the five elements of the 'Saving Babies Lives Care Bundle version 2' (SBLCB), which are:

1. Reducing smoking in pregnancy

2. Risk assessment, prevention, and surveillance of pregnancies at risk of fetal growth restriction

3. Raising awareness about fetal movements

4. Effective monitoring of fetal monitoring during labour

5. Reducing preterm birth

Leaders completed audits to show compliance to the SBLCB. These showed that 87% of women and birthing people were offered carbon monoxide (CO) monitoring in accordance with the SBLCB, which advises trusts to monitor levels at booking and at 36 weeks of pregnancy. The service also monitored women and birthing people who smoked and this showed 57% were referred to support to stop smoking. All women and birthing people were assessed for risks of fetal growth restriction at booking and 89% had a further assessment at 16-20 weeks gestation.

Audits showed that 100% of women and birthing people were given the 'Your babies movements' leaflet and that midwives discussed fetal movements at all antenatal appointments. Eighty nine percent of women who attended the hospital with reduced fetal movements had a computerised CTG.

The service collected ethnicity data on their maternity dashboard to make sure that Black, Asian and minority ethnic women and birthing people were placed on the right care pathways. This is because they are known to be at higher risk of having certain health conditions, like diabetes and high blood pressure.

Staff completed risk assessments for each woman or birthing person on arrival to the hospital, using a recognised tool, and reviewed this regularly, including after any incident. Staff used an evidence-based, standardised prioritisation risk assessment tool for maternity triage. Records showed that from January 2023 to April 2023 women and birthing people accessed triage 3,526 times. The triage tool used a traffic light, red, amber, green (RAG), system to help staff identify and highlight the most at risk patients to prioritise their care.

Leaders monitored waiting times and made sure women and birthing people could access emergency services when needed and received treatment within agreed time limits and national targets. The maternity triage waiting times for review audit for January to April 2023 showed midwives reviewed 86% of women and birthing people within 15 minutes of arrival.

The telephone triage line was effective at managing incoming calls, providing advice and liaising with the service to ensure appropriate information was available. The service included a dedicated telephone line outside of the trust, for access to a midwife 24 hours a day, for help and advice and referral to the appropriate maternity service. This had commenced in November 2022 with this trust being part of the LMNS for the design and delivery. Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) Maternity Referral is an NHS service providing a single point of access for all maternity referrals in these areas. The aim was to make sure women and birthing people had access to the right care as soon as they contacted the service. SHIP Maternity Referral staff triaged women and birthing people's concerns based on the information provided by them and then gave advice or recommended the person attend hospital.

The referral service was based in a local ambulance hub, staffed by 3 midwives at all times. The service ensured a speedy response to all callers and prevented the need for staffing a telephone in the limited space available at the Princess Anne Hospital. The referral monitor included a list of who was coming in and essential details for midwives ready to receive the women and birthing people in the triage unit. All information was linked to the electronic records system the trust used.

Leaders monitored the telephone triage helpline traffic to identify themes for women and birthing people calling the helpline. Records from December 2022 to April 2023 showed that on average 90% of calls were answered within 30 seconds.

Staff knew about and dealt with any specific risk issues. For example, staff followed a Sepsis guideline when they identified abnormal observations during admission. Sepsis is an infection that can be life threatening if untreated and staff used a sepsis 6 care bundle for women and birthing people at risk of Sepsis. Managers monitored compliance and records for May 2023 confirmed that staff followed the correct procedure 100% of the time.

Also, staff used the fresh eyes approach to carry out fetal monitoring safely and effectively. Leaders audited how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG). The December 2022 audit showed staff did 'fresh eyes' at each hourly assessment in 80 % of cases. Managers released a CTG peer review compliance update presentation in spring 2023 which showed there had been a gradual improvement over the previous year. The update discussed actions taken by leaders to ensure staffs knowledge, skills and compliance were in line with best practice and included plans to update the electronic patient records with prompts to remind staff to complete reviews on time.

Staff in theatres completed a WHO Stop point safety checklist, which is a safety check list to decrease errors and adverse events and increase teamwork. Audit data from November 2022 showed that overall staff completed the checklist appropriately 85% of the time. Service leaders set out actions to make sure staff understood why the checklist was important and planned a re-audit.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns. The trust had a perinatal mental health lead midwife who covered the whole service and reviewed all new referrals, trained staff and liaised with the community mental health team.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide. The perinatal mental health lead midwife told us staff had benefitted from training in this area and they now received appropriate referrals as staff had increased confidence in caring for women and birthing people with mental health difficulties.

Staff shared key information to keep women and birthing people safe when handing over their care to others. Staff used the SBAR (Situation, Background, Assessment and Recommendation) tool to handover patients to others. The communication tool prompts staff to record key information and recommendations about patients. Leaders monitored compliance and the January to April 2023 audit showed that 100% of staff in the audit used the tool correctly.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had 2 safety huddles a shift to ensure all staff were up to date with key information. Each member of staff had an up-to- date handover sheet with key information about the patients. The handover shared information using a format which described the situation, background, assessment, recommendation for each patient.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. At birth, staff completed a Neonatal Early Warning Score (NEWS) to effectively monitor neonatal observations. The tool used a RAG rated system to alert staff to those babies who may require additional or transitional care. An audit for January 2023 - April 2023 showed that staff completed the tool correctly most of the time. However, 30% of babies had one set of observations delayed or missed. The delays were attributed to feeding or prioritisation of maternal care and a problem with the electronic records system pulling information through to the correct field for data collection. Leaders identified the need to remind staff to manually add information into this field if needed.

Service leaders planned to continue with quarterly audits to ensure recording of observations for women, birthing people and babies are embedded and completed effectively.

Leaders monitored postnatal readmissions to identify key themes for women and birthing people re-admitted to the maternity services following discharge. Data for January 2023 to February 2023 showed there were 42 re-admissions. The reasons for re-admission were separated into mother or baby categories. Out of the 42 readmissions, 30 were for issues with babies (e.g. jaundice or extreme weight loss) and 12 women or birthing people who needed a medical review. In all cases the appropriate medical review was requested.

Midwifery Staffing

The service had issues with recruitment which reflected the national midwifery shortage. Staffing levels usually matched the planned numbers and the service mitigated any risks to prioritise the safety of women and birthing people and babies.

Managers accurately calculated and reviewed the number and grade of midwives, maternity support workers and healthcare assistants needed for each shift in accordance with national guidance. Leaders used a nationally recognised staffing acuity tool and completed a maternity safe staffing workforce review in line with national guidance in May 2023. This review confirmed that the current establishment was correct and midwife staffing was at required levels 85% of the time. Records confirmed the required staffing levels were 207 whole-time equivalent (WTE) midwives band 5 to 8. In addition, the trust had 23 WTE specialist midwives which reflected national guidance.

However, staffing levels did not match the planned numbers on the day of our inspection. On the day of inspection midwifery staffing should have been 17 midwives and maternity support workers plus 1 supernumerary coordinator but we saw there were 13 midwives plus 1 supernumerary coordinator. On the day of our inspection the service was quiet with lower numbers of women and birthing people as inpatients. Although lower staffing levels were not ideal, this did not provide an unsafe environment in labour suite or triage, as these areas took priority for staffing levels.

On the day of inspection we attended the SHIP daily safety huddle, where each trust explained their staffing acuity for the day and if help was needed to support each other, known as mutual aid such as taking or not taking of referrals. This meeting was chaired by Princess Anne Hospital head of Midwifery. On the morning call Princess Anne Hospital said they were Opel 2 and had a short fall across their service, from an expected 17 staff each shift of 4 midwives on the early/ 6 on the late and 4 on the night shift. As result they were not taking referrals but set a time for review later in the day.

Following our inspection the service leaders advised their actual midwifery staffing for 15 May 2023 had, on review, included 15 out of a possible 15 midwives; the MDAU had 3 midwives; induction of labour had 1 midwife, recovery had 1 midwife, 3 supernumerary midwives including the labour ward, operational coordinator and ward leads and in addition there were 3 supernumerary band 5/6 midwives working in the service.

In the midwifery-led birth centre at the morning safety huddle staff confirmed they had the correct staffing of 4 on shift for the early with 4 women or birthing people postnatal and 2 women or birthing people in labour after a busy shift the night before. However, later in the day they did not know how well the night shift was going to be covered but staff felt confident it would be addressed in time. Staff said generally in the daytime there would be 1 band 7 supernumerary, 2 midwives and 1 maternity support worker plus 1 to 2 supernumerary students. Staff said they did get breaks. We noted, however, there were not always 2 midwives at night, contrary to the service policy.

In triage the department had no planned dedicated staffing between 2.30am to 8.30am daily, when the service was covered by labour suite staff only. There was always a 24-hour onsite operational coordinator (band 7). On the day of inspection at 7.45am there were no women or birthing people in triage; the triage call system had 4 patients listed, 3 yet to come in and 1 who had already arrived the previous night and went straight to labour ward. At 8.30am as per rota 2 midwives arrived for the day shift.

The service had low vacancy rates, turnover rates, sickness rates and high use of bank midwives. Records showed that from December 2022 to May 2023 on average the service had a 13 WTE shortfall of midwives (6.2%), and a 3 WTE shortfall of MSWs (3%) per month. Sickness rate records showed from December 2022 to May 2022 was low at 3% for MSWs and averaged 13 (6%) for midwives per month. Staff told us they were normally able to cover shifts themselves through bank shifts in addition to their usual work schedule.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings'. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. Records showed that there were 63 red flag incidents from November 2022 to April 2023, with 33 reports of delays for induction and beginning the process.

Leaders had full oversight of staffing. To support the national staffing acuity tool, the maternity service developed a systematic process for workforce planning in the form of a monthly dashboard. The live data reflected total staff unavailability to include vacancy rates, sickness ratios, maternity leave, and study time, all of which were compared alongside the budgeted versus actual staffing establishment overall.

There was a supernumerary shift coordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. Staff told us there was always a supernumerary shift coordinator in labour ward and a supernumerary operations coordinator covering the whole service.

The operations coordinator had the resources to adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas.

Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service.

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development when they had time to do so.

Managers supported some staff to develop through yearly, constructive appraisals of their work. A practice development team supported midwives. The team included one band 7 practice development lead midwife supported by 3 band 6 midwives. Managers monitored appraisal rates and records showed that 56% of staff had an appraisal, while 44% were overdue.

Managers made sure staff received any specialist training for their role. The service had band 7 specialist midwives for the following, diabetes, immunisation, bereavement, infant feeding, safeguarding, public health, antenatal screening, fetal medicine and fetal surveillance. Each specialist lead delivered training specialist to their role and supported staff to make evidence based decisions about care and treatment.

Medical staffing

Maternity

The service had enough medical staff with the right qualifications, skills and experience, although not all junior medical staff had undertaken required training. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number. The service had low vacancy, turnover and sickness rates for medical staff.

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. The service had a standard operating procedure named 'Employment of agency locum doctors' which was implemented in May 2022. The SOP included a vetting checklist to ensure that locums had produced their General Medical Council (GMS) registration and could communicate effectively in English. The document also checked their competency levels. On arrival to the service locums received a full induction and orientation of the maternity department.

The service always had a consultant on call during evenings and weekends. The service had 8.7 whole time equivalent (WTE) obstetric consultants and 11 combined obstetric and gynaecology consultants. Consultants were on site from 8.30am until 5pm every night and on Wednesdays and Thursdays consultants remained on-site until 9pm. During nights, 8.30pm to 8.30am, consultant cover was off site and they could be called remotely to assess patients.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service used on site registrar cover around the clock. The service employed 6.7 WTE senior registrars, where there was a shortfall of 0.3 WTE and 9.25 WTE junior registrars with no shortfall.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Records showed that 76.5% of medical staff had started their online appraisal and another almost 15% were due to start this process. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop.

Records

Staff kept detailed records of women and birthing people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Women and birthing people's notes were comprehensive and all staff could access them easily. The patient care record was on a secure electronic patient record system used by all staff involved in the woman or birthing person's care. Each episode of care was recorded by health professionals and was used to share information between care givers. We reviewed 8 records and found records were clear and complete.

Service managers completed clinical records audits. The digital team audited data completeness monthly to highlight missing fields to the relevant member of staff. The most recent audit January 2023 to April 2023 looked at 20 care records, which showed examples of gaps in record keeping. For example, 1 set of notes lacked depth to the clinical narrative, the relevant fields were completed for patient care. Five of the caesarean births did not have the perineal tear tab completed, and there was ongoing learning and education around using the electronic patient care record, 100% had had the birth notification sent, which is the most important field.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records. This was because the electronic records system linked to other trusts using the same system. All NHS trusts in the region used the same electronic system for maternity services. Women and birthing people accessed their own electronic records using an online or mobile app. If a woman or birthing person did not have access to an electronic device staff could print records for them.

Records were stored securely. Staff were issued with individual passwords to access care records and locked computers when not in use and stored paper records in locked cabinets.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had electronic prescription charts for medicines that needed to be administered during their admission. We reviewed 10 prescription charts and found staff had correctly completed them.

Staff reviewed each woman or birthing person's medicines regularly and provided advice to women and birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed. These checks were recorded in prescription charts.

Staff completed medicines records accurately and kept them up-to-date. Medicines records were clear and up-to-date. The service conducted 28 medicines training sessions per year and doctors using the electronic prescribing systems completed training before being provided access to the system. Medicines recorded on the digital systems for the 10 sets of records we looked at were fully completed, accurate and up-to-date. The service expected all new doctors to pass the medication safety assessment and if they failed the test they were offered supervision until they re-sat the examination.

Midwives completed medicines management training which included a medicine management competency test on administration of Patient Group Directive (PGD) medication. Records showed the 91.4 % of midwives had completed the training and 75% had passed the test first time. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff stored and managed all medicines and prescribing documents safely. The clinical rooms where the medicines were stored were locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to take action if there was variation.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted or they moved between services. Staff on the wards completed 4 medicine rounds a day and checked patient details and electronic prescribing charts prior to administration.

Staff learned from safety alerts and incidents to improve practice. Service leaders issued 'theme of the week' newsletters which reported on current safety alerts and practice improvements.

Incidents

Maternity

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed 6 incidents reported between January to April 2023 and found them to be reported correctly.

The service had not reported any 'never' events in the last 12 months.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. Moderate and serious incidents were reported to the Board level maternity safety champions and the Local Maternity and Neonatal System (LMNS) monthly. Data from the maternity dashboard showed that from January 2023 to April 2023 there were 3 incidents reported to the Health and Safety Investigation Branch (HSIB), and 9 moderate incidents (meaning patients required follow up care and treatment due to the adverse incident).

Staff reported serious incidents clearly and in line with trust policy. The trust had 5 serious incidents that required managers to complete a rapid review to identify immediate actions or learning. Records showed that in May 2023 the service had 2 outstanding incidents over 60 days.

The service's Perinatal Mortality Review Group met monthly and included the risk and governance lead, the consultant midwife, the consultant pathologist, and the bereavement midwife. The group reviewed incidents to make sure they identified in gaps in care and created reports for the Board.

Managers investigated incidents thoroughly. They involved women and birthing people and their families in these investigations. We reviewed 3 serious incident investigations and found staff had involved women and birthing people and their families in the investigations. In all 3 investigations, managers shared duty of candour and draft reports with the families for comment. Managers reviewed incidents potentially related to health inequalities and these were recorded in the case review report. We looked at 3 of these reports and saw where women or birthing people's social or mental health needs impacted on their pregnancy experience, this was recorded. None of the 3 reports recorded risks in relation to the woman or birthing person's ethnicity.

Managers shared learning with their staff about never events that happened elsewhere. The service had a specific midwife who was responsible for sharing learning from incidents with staff.

Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if and when things went wrong. Governance reports included details of the involvement of women and birthing people and their families in investigations and monitoring of how duty of candour had been completed.

Serious case review reports showed other agencies involved in the review and external agencies that the service needed to report the outcome of the review to. The reviews also identified immediate actions and support for staff groups involved in the incident. However, minutes of meetings, such as Maternity Safety Champions Meeting and the Women

and Newborn Governance Group Meeting, only showed statistical information about serious incidents. Board reports included a patient story item, although this was not specific to maternity, so they could reflect on the experience of patients and understand what the trust could do better. The lack of detail about serious incidents did not provide assurance that more senior staff in the service were familiar with and understood all aspects of the incidents.

Managers debriefed and supported staff after any serious incident. Staff told us that managers spoke to and supported them after any serious incident. We saw, however, that this could take some time if the different parties involved in the incident were busy elsewhere and could not return immediately. Staff on one ward were still waiting for a debrief a few hours after an incident on the day of our visit.

Is the service well-led?

Good  

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Maternity services at Princess Anne Hospital were managed as part of the Division C directorate. There had been a lot of change in the maternity service leadership due to restructuring and the maternity services were led by a team of 5 people. This consisted of the director of midwifery, the interim divisional director of operations, the divisional clinical director, the care group clinical lead and a consultant obstetrician. They had a clear understanding of the challenges to quality and sustainability within the service and the plans to manage them, which were shared with staff.

Leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected, approachable, and supportive. Staff told us they were supported by their line managers, ward managers and matrons. The 2022 NHS staff survey also indicated staff felt they were valued, listened to, and supported by managers, although these figures were slightly less than in the 2021 survey. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were.

Maternity safety champions and non-executive directors supported the service. The director of midwifery met with the Board maternity safety champion regularly. Both the maternity Board safety champion and the director of midwifery were aware of issues relating to the quality and safety of the service and were advocates for the service at Board level. We reviewed minutes of the safety champion walk abouts for September to December 2022. These showed a clear structure which covered relevant safety areas.

They supported staff to develop their skills and take on more senior roles. Leaders encouraged staff to take part in leadership and development programmes to help all staff progress.

Vision and Strategy

Maternity

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had developed a 5 year strategic plan that started in 2021 and identified 5 key themes, which were aligned to their vision and values. The maternity service had its own vision and improvement plan, also based on the trust's vision and strategic plan. One of the key national drivers for maternity services was to continue improving outcomes for women, birthing people and babies by reducing maternal and neonatal deaths and brain injury from birth. The service's improvement plan identified delivery of this key national driver required "local transformation, where providers, Commissioners and service users work together as part of a Local Maternity and Neonatal System (LMNS)."

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to integrate them and monitor progress. University Hospital Southampton NHS Foundation Trust formed partnerships with other local trusts to collaborate on improving healthcare provision. This formed one of the priorities in the trust's strategy with the aim to create a high-quality integrated care system for the Local Maternity and Neonatal System (LMNS).

During our inspection we saw how the service worked effectively to ensure the safe care of women, birthing people and babies, with other trusts that were part of the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) LMNS. They had daily contact with other trusts in the LMNS to look at each trust's status in regard to staffing and risk, and then to determine whether transfers of women, birthing people or babies was possible and what may be required to enable those transfers if needed. This worked well and showed a cohesive system that provided the safest care to as many women, birthing people and babies across the region as possible. Staff could explain this vision and understood the need for and value in sharing care across the wider LMNS area.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services at The Shrewsbury and Telford Hospital NHS Trust and planned to revise the vision and strategy to include these recommendations. There were 5 recommendations made, including recording the twice daily ward rounds, embedding standard operating procedures, engaging with the Maternity Voices Partnership and improving personalised care and support plans. Delivery of the service's Ockenden action plan was regularly mentioned as part of monitoring and governance processes, such as the Safety Champions Meeting minutes.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear.

Staff we spoke with during our inspection visit felt respected, supported, and valued**.** They were positive about the hospital, its leadership team and felt able to speak to managers and leaders about difficult issues and when things went wrong. Staff told us they were happy at work and were supported by other staff.

Staff felt respected, supported, and valued**.** Staff were positive about the department and its managerial leadership team and felt able to speak to leaders about difficult issues and when things went wrong. However, the 2022 NHS staff survey showed satisfaction about this compared with the 2021 survey results was slightly reduced.

Maternity

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed patient care at the heart of the service and recognised the power of caring relationships between people. Partners were encouraged to stay with women and birthing people during labour and were also able to stay postnatally. Staff recognised this provided support for women or birthing people and helped form a close family bond. Dignity, caring and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this. We saw that women and birthing people were spoken with respectfully and included in decisions about their care. Women and birthing people we spoke with told us staff were, "Very caring," and they, "Can't fault staff."

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Staff said that it helped them understand the issues and provide better care. The trust had developed a community team of staff who visited and supported women and birthing people from ethnic minority and disadvantaged groups in their own homes throughout their maternity journey. This provided support during and following pregnancy for women and birthing people who may have greater difficulty accessing maternity services.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Leaders and staff could explain the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement. Staff told us they worked in a fair and inclusive environment.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. The service clearly displayed information about how to raise a concern in women, birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints, identified themes, and shared feedback with staff and learning was used to improve the service. This was a fixed agenda item on each regular team meeting.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had a strong governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings. These included Governance for Patient Safety within Maternity Services meetings, Executive Management Board meetings, and Women and Newborn Governance Group meetings. Meeting minutes show these were well attended and discussions included updates on how the service was performing in relation to national guidance and audits, the risk register for maternity and serious incident learning.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were up to date. Governance Group meeting minutes showed guidance that needed to be reviewed was identified and where it was on the review and approval pathway.

We reviewed clinical guidance, including those for triage and reduced fetal movements, which were in date.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service participated in relevant national clinical audits. The service reported outcomes to the NHS Digital Maternity dashboard, the National Neonatal Audit Programme, the National Maternity and Perinatal Audit and MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiry).

As part of the National Maternity and Perinatal Audit the trust looked at how many women and birthing people had been supported with written information or a conversation about reduced fetal movements. Data for Princess Anne Hospital showed staff recorded this in 100% of records between January and March 2023.

Outcomes for women and birthing people reported against national standards. These showed the service was higher than the national average for both third and fourth degree tears, and post partum haemorrhage (PPH) of more than 1500ml. Managers monitored outcomes on the maternity scorecard, which provided statistical information on a monthly basis. When these statistical figures were outside national standards, these were discussed at risk meetings to ensure appropriate actions were taken to improve. Data supplied by the trust showed effective fetal monitoring during labour was recorded 80% of the time. Managers and staff used the results to improve women and birthing people's outcomes. Staff developed a 'Current Audits and Quality Improvement Work' newsletter in April 2023 that showed the PPH audit had found 36% of notes were not fully completed with medicines given in the 3rd stage of labour, and that there was a 3rd stage drugs and PPH bundle for staff to use.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. However, only category 2 caesarean sections were audited, which did not identify whether other category caesarean sections were completed within timeframes to comply with national guidelines. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits.

Staff completed an audit of completion of the Modified Early Obstetric Warning System (MEOWS), which is a set of clinical observations that provide a guide about how well the women or birthing person is. The audit identified that

these were correctly recorded 80% of the time, against a target of 75%, but that where these had not been completed properly staff had failed to record respiration rate. An action plan was developed to educate staff of the importance of completing respirations and to produce an example of the record for staff, and then to reaudit recording of MEOWS later in the year.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make change where risks were identified. The service recorded risks on their risk register, which included maternity and medical staffing, theatre capacity, acuity within maternity services, insufficient space in induction of labour and maternity day assessment. Mitigating actions were identified and reasons for difficulties in increasing staffing numbers.

There were plans to cope with unexpected events. They had a detailed local business continuity plan.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected reliable data and analysed it**.** They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The service had a digital midwife who was able to support staff to navigate the system at Princess Anne Hospital and who looked at data validation across the service. They were also able to pull data from the system to support the trust analysis of performance. The trust had a strategy to reduce the amount of paper records used and fully implement their electronic system.

The information systems were integrated and secure**.** The trust used a digital recording system, which staff in all areas of the service had access to. Staff were required to log in and out electronically before being able to see records.

Data or notifications were consistently submitted to external organisations as required. Staff made referrals to external organisations, such as the Healthcare Safety Investigation Branch (HSIB), following serious incidents.

Engagement

Leaders and staff actively and openly engaged with women and birthing people, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and birthing people.

Leaders had a limited working relationship with the local Maternity Voices Partnership (MVP) in decisions about patient care, which was because it did not fully fit with their preferred programme for engagement. Despite this, staff did take part in meetings with the MVP and shared areas of concern and improvement, and upcoming plans with the MVP. The MVP chair had a named staff member in the trust who they spoke with regularly and were able to discuss any concerns with.

The service used their own mechanism for gathering patient feedback from women and birthing people. This included text messages a week after birth, family and friends paper feedback forms that were available in the service and given out on discharge, and feedback in the annual NHS Maternity Survey. Information from the trust shows these surveys identified an improvement in women and birthing people's postnatal experience, but some issues around communication and staffing. The NHS Maternity Survey for 2022 showed the service had significantly better scores in 6 areas and better scores in 3 areas, while 42 other questions were the same as the year before. The service had particularly good scores in mental health queries, treating women and birthing people with dignity and respect, involvement of the pregnant person in induction of labour decisions, decisions about how to feed their baby and postnatal care.

In response to the findings of the Ockenden report, the trust had implemented a Maternity Voices Partnership action plan, which included quarterly meetings, building relationships with local community groups, and holding listening events. Meeting minutes showed the MVP had started work on developing promotion of events to targeted groups, they had relayed feedback from women and birthing people they had spoken to, identified concerns that needed to be addressed immediately and offers of support to ensure information was inclusive of all gender groups.

Leaders engaged with other trusts in the region on a daily basis to discuss staffing levels and bed availability for high risk women, birthing people and babies. Staff also had a follow up call at 4pm and regrouped to reassess the situation before night shift started. They were able to call emergency meetings and had access to a WhatsApp group where they could share issues with the wider LMNS.

The service made available interpreting services for women and birthing people and collected data on ethnicity. Staff had access to Language Line, a telephone interpreting service.

Leaders understood the needs of the local population. The service had identified local areas of social deprivation, close knit ethnic minority communities and the difficulties women and birthing people sometimes had in accessing maternity care early. They had developed specific teams who worked solely in these areas to build relationships and provide access to services.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. Staff were involved in ongoing monitoring of both national programmes, such as Saving Babies Lives, and quality improvement programmes specific to the service. This included a project looking at the reasons for readmissions to the maternity service and showed the majority reason for this was possible sepsis or wound infection.

Another programme looked at maternity and neonatal improvement outcomes to reduce unwarranted variation and provide a high quality healthcare experience. As a way of ensuring babies needing admission to the neonatal unit were able to have a cuddle when they were born, staff help this to happen even if the baby is on a ventilator. Staff also

developed an innovative method of providing respiratory support using existing equipment while the umbilical cord is still attached, to improve rates of optimum cord management. This is delayed clamping of a baby's umbilical cord after birth. It helps prevent a sudden drop in the baby's blood pressure by allowing extra blood from the placenta to replace the blood that flows into the baby's lungs when they take their first breaths.

The service had a quality improvement training programme and a quality improvement champion who coordinated development of quality improvement initiatives.

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies.

Outstanding practice

We found the following outstanding practice:

- The telephone triage line provided a dedicated phone line for access to a midwife 24 hours a day for help and advice and referral to the appropriate maternity service. The referral service was based in a local ambulance hub, staffed by 3 midwives at all times and ensured a speedy response to all callers, while preventing the need for a phone service at Princess Anne. The referral monitor included essential details and linked to the electronic records system.
- The service worked with the LMNS to develop and implement a joint maternity and neonatal process to ensure women, birthing people and babies received the most appropriate care at the most appropriate service. They linked with other LMNS services at least once a day to look at staffing and capacity issues at each service so women, birthing people and babies that needed more specialist care, or who could be cared for in a different setting were able to receive this.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Maternity

- The trust must ensure medical staff are up to date with all training, including mandatory, safeguarding to level 2, skills and drills training modules. Regulation 12(1)(2) (c)
- The trust must ensure the security of the unit at all times. Regulation 12 (1) (2) (a) (d)
- The trust must ensure staff complete daily checks of emergency equipment. Regulation 12 (1) (2) (a) (d)

Action the trust SHOULD take to improve:

Princess Anne Hospital

Maternity

- The trust should continue to monitor and review infection control practices by staff to ensure poor practice is eliminated.
- The trust should consider investment in the estate to help modernise the service and experience of the patients and staff.
- The trust should consider review of training for medical staff for level 3 safeguarding training in line with current guidance.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, an inspection manager, and 3 specialist advisors (2 midwives and an obstetrician). The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Healthcare.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

UHS Maternity and Midwifery Services CQC Quality Improvement Action Plan 2023

Appendix 3

University Hospital Southampton NHS
NHS Foundation Trust

On 15 May 2023, the Care Quality Committee (CQC) inspected the maternity and midwifery service at Princess Anne Hospital as part of their national maternity inspection programme. This was an announced focused inspection of the maternity service, looking only at the safe and well-led key questions.

Ratings
Overall rating for this service - Good
Are services safe? - Requires Improvement
Are services well-led? - Good

This quality improvement plan addresses the Must and Should do recommendations from the inspection.
Link to full report: https://www.cqc.org.uk/location/RHM12

Governance Oversight

- The Head of Clinical Quality Assurance will hold the primary copy of this Quality Improvement (QI) action plan.
- Each Speciality Lead will hold and maintain a working copy of the plan to monitor their local progress.
- Each Specialist Lead will email an updated version of their plan to the Head of Clinical Quality Assurance serena.gaukroger-woods@uhs.nhs.uk along with evidence of the impact of the progress made on the last working day of each month commencing 31 August 2023.
- Gail Byrne, Chief Nurse, will chair an CQC action plan update meeting with the Speciality Leads and their teams on a bi-monthly basis to support and explore the progress of the actions until completion.
- Oversight and assurance will be provided to the Quality Governance Steering Group (QGSG) as per Part Three of this document.
- Actions will only be formally closed when members of the QGSG are assured that compliance with the Regulation has been achieved.
- The action plan will then be submitted to the Quality Committee and Trust Board for their sign off as per Part Three of this document.
- The actions will remain subject to periodic scrutiny by QGSG until either the CQC re-inspect, or we have shared the signed off version of the plan and they have confirmed they are satisfied that the required standard has been met and sustained.

PART ONE								
MUST DO, Maternity Services **An action the trust MUST take which is necessary to comply with its legal obligations.**								
Regulation breach **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment**								
No	**Domain**	**Item**	**Actions**	**Executive Lead**	**Speciality Lead**	**Target date**	**Success indicator**	**RAG** **Review at QGSG** **Sign off at Trust Board**
M1	Safe Regulation 12	The Trust must ensure medical staff are up to date with all training, including mandatory, safeguarding to level 2, skills, and drills	Mandatory training (including safeguarding level 2 training) is currently incorporated into the Trust and departmental induction. However, investigation has shown us routine reporting of compliance or management of non-compliant staff is not being captured. This will be expedited. Medical HR colleagues will submit a report of all mandatory training compliance every 3 months to the care group.	Gail Byrne & Emma Northover.	Fiona Lawson & Dr Nazia Irshad.	These actions will begin with the October 2023 cohort of trainees. Fully embedded by Dec 2023.	Evidence of 80% compliance.	

		training modules. Regulation 12(1)(2) (c) *	This report will be used to follow up with all staff who have less than 80% compliance and highlight their out-of-date modules (compliance indicator 17 out of the 22 modules required).					
			Run a rolling annual report of compliance for whole workforce to ensure minimum 80% compliance overseen by care group governance meeting .					
			Rota all new- to- Trust trainees one day within their first month (in addition to their face-to-face induction time), to complete the online components of VLE mandatory training.					
			Add BLS, moving and handing practical and ANTT training to the induction programme.					
			'Skills and drills' training is part of the monthly induction programme, PROMPT. All new staff are currently rostered to attend. A process of checking attendance and implemented and anyone who was unable to attend as planned will be re-rostered into the next available programme.					
How will people who use the service(s) be affected by you not meeting this regulation until this date?			Education and training can break down barriers to providing safe care, creating an environment where all staff learn from error, patients are at the centre of care, are treated with openness and honesty ,and where staff are trained to focus on patient needs. By achieving the actions above we will improve the education and training we offer and consequently improve these key metrics. Failing to achieve them in a timely manner will raise the level of risk to patient safety.					

No	Domain	Item	Actions	Executive Lead	Speciality Lead	Target date	Success indicator	RAG Review at QGSG Sign off at Trust Board
M2	Safe Regulation 12	The Trust must always ensure the security of the unit. Regulation 12 (1) (2) (a) (d **	The security and estates team took immediate remedial action post inspection to address the issues described in the verbal feedback from the inspectors on the day. Local CCTV and security access systems were purchased and installed, and broken locks repaired.	Gail Byrne & Emma Northover	David Jones	Complete. Order has been placed, installation due w/c 04/09/2023.	Completion of works w/c 04/09/2023. Authorised funding of new security system in October 2023. No security breaches will have been reported.	
			A further in-depth review of security on the site was undertaken post inspection with an action plan recommending the following:			All doors revisited and fixed.		

			• Immediate installation of perimeter alarms. • Re-repair of doors broken since the inspection. • Install new security system across all maternity services that links back to a single, centralised swipe access system. • Bring CCTV control onto main staffed site and slowly move to a single UHS system. • Empowering all staff to undertake two actions: - Reporting issues to either security or estates at the earliest possible time when an issue with the security systems in place are compromised. - To ensure that local staff do not compromise the security systems that are put in place.			Business case in preparation. Due to present at TIG in October 2023. Cost proposal to be included as part of the October 2023 TIG proposal.		
How will people who use the service(s) be affected by you not meeting this regulation until this date?			The security and privacy of patients are of paramount importance in any healthcare facility, and this is particularly crucial in maternity wards. Maternity wards manage sensitive and emotional situations, with new-borns and their parent requiring a safe and secure environment. Failure to achieve our actions above may increase the level of risk to the babies, our patients, their families and carers and our staff.					

No	Domain	Item	Actions	Executive Lead	Speciality Lead	Target date	Success indicator	RAG Review at QGSG Sign off at Trust Board
M3	Safe Regulation 12	The Trust must ensure staff complete daily checks of emergency equipment. Regulation 12 (1) (2) (a) (d)***	The maternity digital team to launch the implementation of a digital 'check list' for equipment checking via an application to all areas of maternity.	Gail Byrne and Emma Northover	Carly Springate	Currently implemented across Burley and Lyndhurst Wards.	Digital 'check list' for equipment checks via an application will have been introduced across all areas of the maternity service.	

			Implement of an audit programme to ensure compliance with completion of the digital 'check list' for equipment application.				Audit of the digital 'check list' for equipment application compliance will demonstrate a 100% compliance rate.	
			Develop a process for Matrons and ward leads to provide oversight and to immediately address areas of non-compliance. Daily intentional rounding will be introduced to monitor progress while the process is developed to ensure immediate action is taken.			Full implementation to be achieved by October 2023.	Matron /ward lead oversight of digital 'check list' for equipment application will evidence compliance, ensuring escalation and immediate action in place.	
How will people who use the service(s) be affected by you not meeting this regulation until this date?			Standardising emergency equipment throughout an organisation makes it easier to locate things quickly in an emergency and ensures continuous availability of emergency equipment in those areas. Failing to check emergency equipment can increase risk, and checking the equipment also creates familiarity. This familiarity is important if there is an emergency as it will enable all team members to feel confident when finding and using the equipment.					

Extracts from CQC inspection report.

*Medical staff had not completed all mandatory training, such as safeguarding.

**The security of the wards was not always effective putting the safety of women and birthing people and babies at risk.

*** Checks on emergency equipment were not always completed daily.

PART TWO

SHOULD DO: Princess Anne Hospital

Action a Trust SHOULD take because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Related regulation
Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

No	Domain	Item	Actions	Executive Lead	Speciality Lead	Target date	Success indicator	RAG Review at QGSG / Sign off at Trust Board
S1	Safe	The Trust should continue to monitor and review infection control practices by staff to ensure poor practice is.	Monitoring of Trust infection prevention and control (IP&C) practices and standards will be effectively completed for all professional groups.	Gail Byrne & Emma Northover	Julie Brooks, Julian Sutton & Carly Springate	1-4 actions complete.		

		eliminated ****	Completion and submission of IP&C audits will be monitored for compliance as per annual infection prevention audit programme. (These are both self-assessments carried out by clinical teams of all professional groups and audits undertaken by the Infection Prevention Team (IPT)).					
			Focused IPT ward rounds will be conducted to review and support practice (including focus on isolation care, PPE, cleanliness, invasive devices).					
			Observations of practice will be incorporated into UHS peer review walkabout programmes and ward/department visits undertaken by the IPT.					
			Targeted IP&C practice reviews will be completed in response to incidents of infection. Lessons learned will be shared via governance structures.					
			Completion of annual infection prevention and control spotlight reviews of inpatient/outpatient areas (focus on IP&C practice and the environment). Lessons learned will be shared via governance structures.					
			Observations of practice on walkabouts and ward/department visits will be undertaken the Matrons. Trends and themes will be					

			shared via the Matron-led walkabout programme quality assurance quarterly reports.					
			All clinical midwifery staff to undertake the infection prevention training as outlined in the training for ANTT.					
			All clinical midwifery staff to undertake the infection prevention training as outlined in the training for Hand Hygiene.					
			All clinical midwifery staff to undertake the infection prevention training as outlined in the training for Infection prevention practises.					
			All non-clinical midwifery staff to undertake the infection prevention training as outlined in the training for infection prevention practises.			Target for spotlight reviews in maternity to be completed by 30/09/2023.		
			Where there is evidence from the above that expected practices/standards are not being met, improvement actions will be agreed with appropriate leads to drive quality improvement with ongoing monitoring via the above mechanisms.			Matrons-led quality walkabouts quarterly report due December 2023.		

						Currently at or above Trust target for all maternity actions (90% or above compliance).		

How will people who use the service(s) be affected by you not meeting this regulation until this date?	Infection prevention and control (IPC) is a practical, evidence-based approach preventing patients and health workers from being harmed by avoidable infections. Effective IPC requires constant action at all levels of the health system, including policymakers, facility managers, health workers and those who access health services. IPC is unique in the field of patient safety and quality of care, as it is universally relevant to every health worker and patient, at every health care interaction. Defective IPC causes harm and can kill. Without effective IPC it is impossible to achieve quality health care delivery.

No	Domain	Item	Actions	Executive Lead	Speciality Lead	Target date	Success indicator	RAG Review at QGSG Sign off at Trust Board
S2	Effective	The Trust should consider investment in the estate to help modernise the service and experience of the patients and staff.*****	The Trust has set down a masterplan for both the development and refurbishment of the clinical services. The maternity services are identified as one of the key departments that require upgrading to modern standards. The requirements of the service will be reiterated at the next budget setting process and will be prioritised according to risk.	Gail Byrne Emma Northover	David Jones	2024/2025 Budget setting process.	The facilities will have been refurbished.	
How will people who use the service(s) be affected by you not meeting this regulation until this date?			The quality of healthcare estates has a direct impact on the health, safety, and wellbeing of staff and patients. Healthcare facilities in poor condition present greater risk to staff and patient safety and both create and exacerbate negative working conditions.					

No	Domain	Item	Actions	Executive Lead	Speciality Lead	Target date	Success indicator	RAG Review at QGSG Sign off at Trust Board
S3	Safe	The Trust should consider review of training for medical staff for level 3 safeguarding training in line with current. guidance. ******	The decision to have two named safeguarding obstetricians was made in 2021 in partnership with UHS safeguarding leads and W&N governance team. The consultant body are compliant with this standard. In 2023 we will review this standard via a group which will include W&N CGCL, obstetric clinical lead and the safeguarding team and the Director of Midwifery and W&N Governance.	Gail Byrne and Emma Northover	Fiona Lawson & Dr Nazia Irshad	December 2023.	Where actions are evidenced as required , all will have been achieved by the target date.	
			An action plan will be generated depending on the outcome of this group.					
			Should the requirement be that all trainee doctors are required to be L3 compliant, the process for achieving this has already been mapped. Foundation doctors and GP trainees receive this training as part of their rotational					

			education, so we will target speciality trainees, fellows and consultants and include : - Mandated 30 mins training as part of induction. - Annual PROMPT training which includes one hour session to be mandated. - 50% of training can be achieved via eLearning. Introduce compulsory training via VLE on arrival and every 3 years. - We have identified there is a significant amount in their curriculum which matches with aspects of the requirements. As they must fulfil their curriculum completely every 2-3 years, this will far exceed the time required.					
			The care group manager for W & N will also specifically request support to manage the VLE profile of our two named safeguarding leads to ensure it is possible to record their L3 compliance on their VLE record, and therefore evidence.					

How will people who use the service(s) be affected by you not meeting this regulation until this date?	Receiving regular safeguarding training and updates will help create an effective safeguarding culture, which is key to ensuring people thrive. Training will also help staff to recognise signs of abuse, stay informed about emerging risks and ensure they know how to respond to concerns.

Extracts from CQC inspection report.

**** The trust should continue to monitor and review infection control practices by staff to ensure poor practice is eliminated.

***** The trust should consider investment in the estate to help modernise the service and experience of the patients and staff.

****** The trust should consider review of training for medical staff for level 3 safeguarding training in line with current guidance

PART THREE: MONITORING AND GOVERNANCE				
Progress and governance timetable				
August 2023	September 2023	October 2023	November 2023	December 2023
25 August: 1st progress submission from speciality leads.	22 September: 2nd progress submission from speciality leads	27 October: 3rd progress submission from speciality leads	20 November: 4th progress submission from speciality leads	22 December: 5th progress submission from speciality leads
	W/B 25 September: 1st CQC action plan update meeting Chaired by CNO (GB).		2W/B 27 November: 2nd CQC action plan update meeting Chaired by CNO (GB).	
	QI action plan presented for noting at QGSG.	03 October: QGSG update report – Head of Clinical Quality Assurance (SGW).	Share progress with CQC.	05 December: QGSG update report- Head of Clinical Quality Assurance (SGW).
				Progress to Quality Committee and then Trust Board if actions are completed and plan is ready for sign off.
				Submit final version to CQC once signed off as completed by Trust Board.

KEY

Name	Abbreviation	Job Title
Gail Byrne	GB	Chief Nursing Officer
Emma Northover	EN	Director of Midwifery
Dr Nazia Irshad	NI	Education lead for trainees in Women and Newborn
Fiona Lawson	FL	Care Group Manager Women & Newborn
Julie Brooks	JBr	Head of Infection Prevention Unit
Julian Sutton	JSu	Consultant Infectious Diseases & Microbiology
Carly Springate	CS	Obstetrics Manager
David Jones	DJ	Director of Estates, Facilities & Capital Development
Serena Gaukroger-Woods	SGW	Head of Clinical Quality Assurance

GLOSSARY

Abbreviation	
BLS	Basic life support
ANTT	Aseptic non touch technique
VLE	Virtual learning environment
PROMPT	PRactical Obstetric Multi-Professional Training
W & N	Women and Newborn
IP&C	Infection prevention and control
IPT	Infection prevention team
PPE	Personal protective equipment
TIG	Trust investment group

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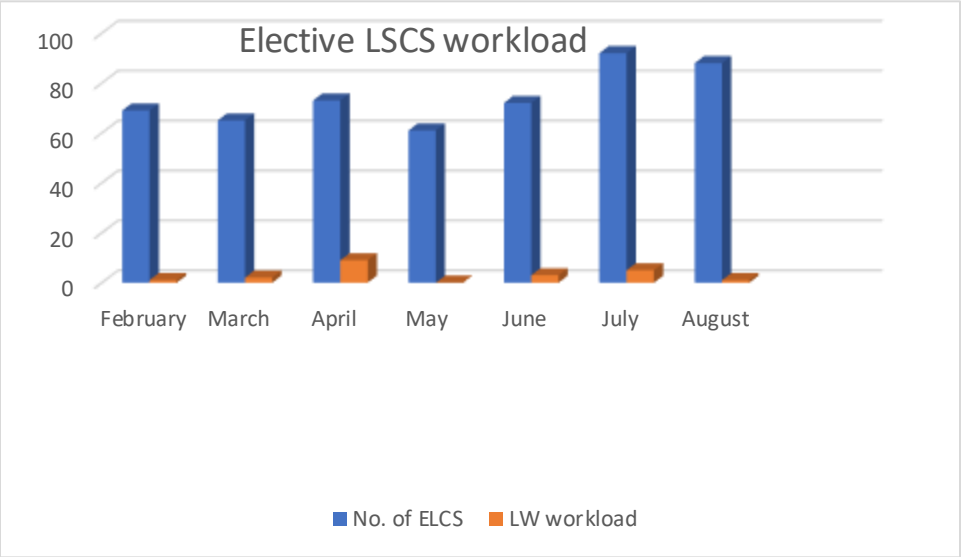
Appendix 4

1. UHS EL LSCS (Scheduled caesarean birth) availability.

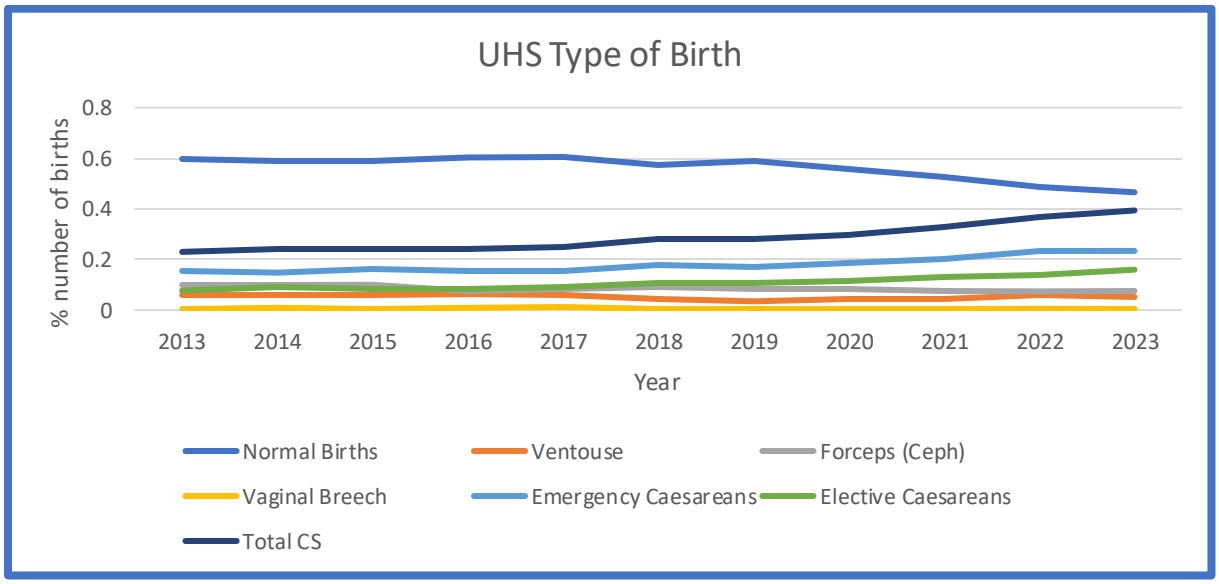
Elective LSCS slots = 52 per Month, 157 per Quarter & 627 per year.



Data captured on the UHS monthly dashboard

We have been consistently >52 per month and exceeding >157 per quarter since Q2 22/23 and predictions show that this is continuing to rise.

Actions: We have a scheduled double caesarean section lists to meet demand (scheduled on a Thursday), this is consistently being exceeded and further demand on the LW emergency theatre to deliver all the EL LSCS planned.



The scheduled caesarean birth rate has increased over the last year and is continuing to rise.

Care location at booking	No. of women	%
Princess Anne Hospital	469	89.85%
Portsmouth	14	2.68%
Hampshire	31	5.94%
IOW	2	0.38%
Dorset	4	0.77%
Dorchester	2	0.38%

NB. Of the women who birthed via scheduled caesarean birth with us Jan-Aug 2023, 53 initially booked at a neighbouring trust and transferred care to UHS for delivery.

2. Staffing

EL LSCS list requires 1x midwife, 1x RN/MSW **or** 2x midwives.

Running a scheduled caesarean list requires the correct skill mix for midwives and the right team to ensure safety during the post operative recovery. This is routinely rostered for the AM list but staffing the PM/additional list requires extra staff and the correct skill mix.

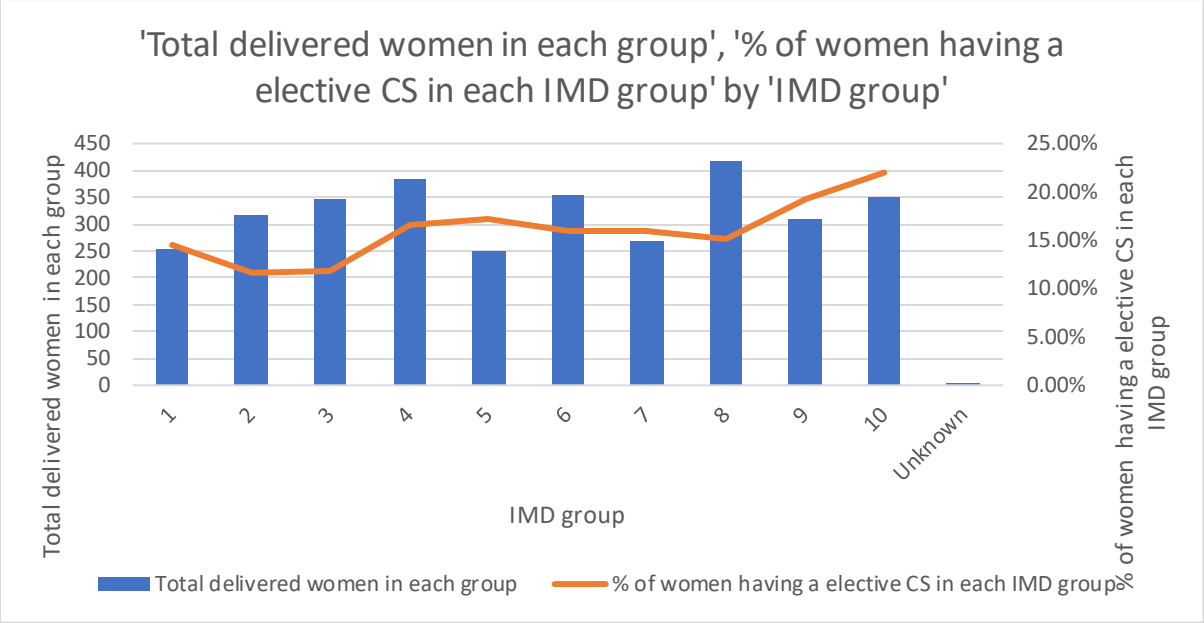
3. Reason for EL LSCS breakdown

Reason for CS	Number of women	% of women
Baby reason	15	2.87%
Declined IOL	3	0.57%
Declined VBAC	65	12.45%
Failed IOL	3	0.57%
Malpresentation	58	11.11%
Maternal Request - (no medical indication)	**101**	**19.35%**
Multiple pregnancy	7	1.34%
Other maternal reason	37	7.09%
Placenta praevia/accreta	11	2.11%
Previous C-Section	189	36.21%
Previous traumatic vaginal birth / previous 3b + tear	33	6.32%

4. Maternal request EL LSCS breakdown

CS reason Maternal Request	Para 0	Para 1	Para 2	Para 3+
Number of women	65	30	4	2
% maternal request	**64.36%**	**29.70%**	**3.96%**	**1.98%**

5. IMD Breakdown for unscheduled LSCS



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El LSCS are categorised into complexity and prioritised accordingly.
Basic: Standard low risk, no previous LSCS or risk factors
Intermediate: Intermediate risk, 1 previous LSCS
Complex: High risk, additional risk factors

Total EL LSCS: 87	
LW completed: **7 LSCS** Extra list: **6**	
Extra 13 Slots	
Complexity breakdown	
Basic	**57**
Intermediate	**18**
Complex	**12**

A complex case requires a double slot, takes longer, and puts increasing demand on the LW acuity.

7. CAT 3 LSCS not in labour – reason for LSCS

Cat 3 emergency NOT in labour - reason for CS	Number of women	% of women		
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Cat 3 emergency CS NOT in labour	
Number	235
% of total births	7.21%
% of total CS births	18.30%

Ongoing care

Birth rate plus was previously used to categorise the postnatal care requirement, but this is not currently in use. When undergoing a scheduled or emergency caesarean, women require an enhanced level of post operative care with 4 hourly observations for a minimum of 24 hours vs a minimum of 6 hours for a vaginal birth, ultimately a longer hospital stay which impacts on workforce resources and cost.

Community care: Day 1 home visit, Day 3 (hub), Day 5 (hub) and Day 10 discharge.

Subsequent pregnancies are at increased risk of complications such as:

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Care during future pregnancies:

- Electronic fetal monitoring
- Care on Labour ward/high risk environment.

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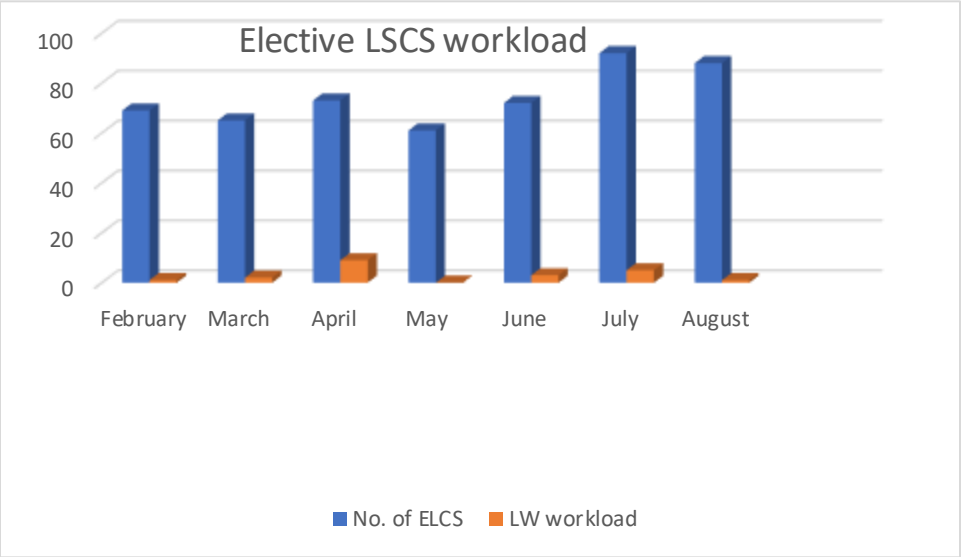

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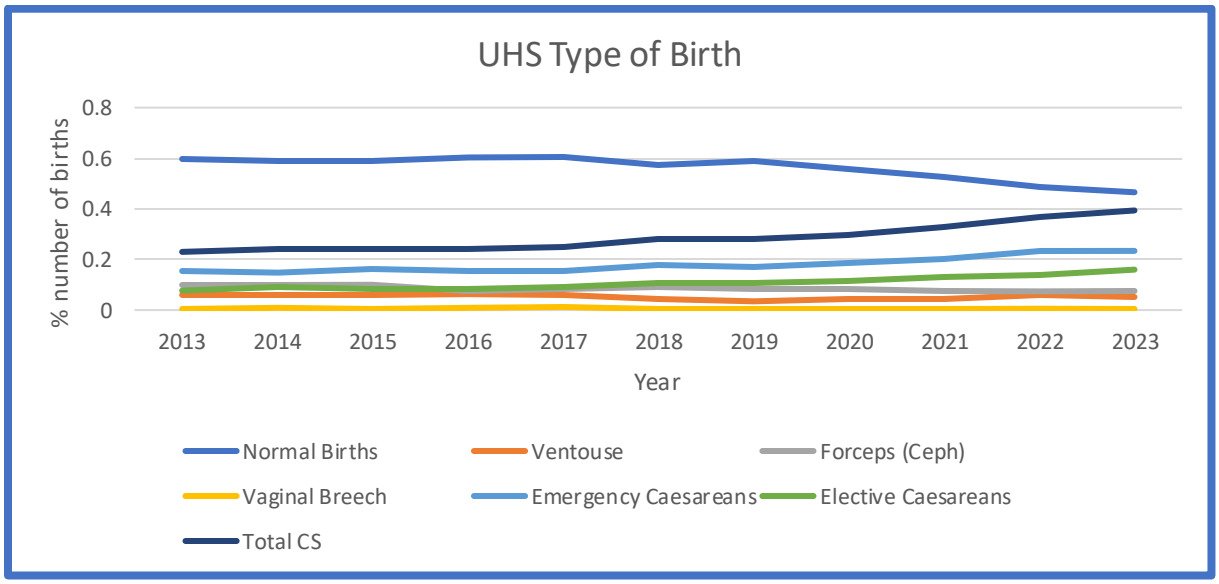

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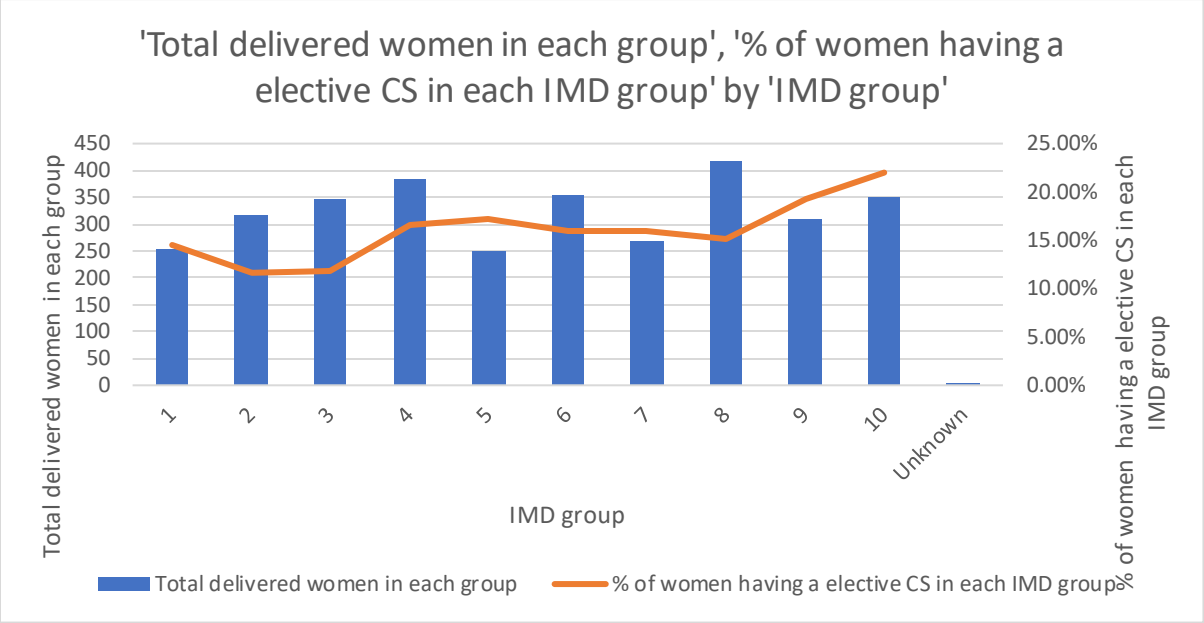

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Care during future pregnancies:

- Electronic fetal monitoring
- Care on Labour ward/high risk environment.

Appendix 5 for Trust Board Report

Appendix 2 – Q1 Incident Overview, Moderate, Serious and HSIB cases

New cases

Case type	Incident form	HSIB /PMRT	Log Date	Incident Trigger	Summary of incident	Outcome of incident
HSIB SIRI	9949000	MI 026554 87388	09/05/23	Neonatal death	Low Risk pregnancy -Attended BBC in latent phase of labour. Bradycardia heard, transferred to Labour ward immediately. Examined -2cm and bradycardia of 20 mins now. Taken to theatre for LSCS. Routine LSCS with 2.5l PPH however baby born in poor condition and was taken to NNU for therapeutic cooling. Baby did not improve and care was redirected and baby passed away on Sun 07/05/2023	Baby RIP at 2 days of age HSIB investigation ongoing Gestational age: 41+2 PMRT started, awaiting completion of NNU aspects of care
SIRI	9949437	N/A	20/06/23	Opel 4 alert	NNU on OPEL 4 ALERT for just over 24hrs	Reported as a SIRI Investigation ongoing
HSIB SIRI		MI 000-00	29/06/23	Therapeutic cooling	NVD Born in poor condition with meconium aspiration. Admitted to NNU -not cooled however began fitting and has now had an MRI scan which shows evidence of severe acute profound hypoxic brain injury.	Awaiting results of further imaging. Possibility cause could be metabolic and therefore may not be taken forward by HSIB
PMRT	N/A	86905	08/04/2023	Antepartum stillbirth	Initially booked at Salisbury. Care transferred to UHS with regular attendance at fetal medicine unit. Twin 1 had demised on scan at 24weeks diagnosed on 22/03/202. Appropriate scan to exclude anaemia in surviving co-twin performed. Monochorionic twin complications with selective growth restriction Twin 2 born at Apgars 6;1 9;5mins Weight 1190g	Gestational age: 24+6 Reported to PMRT 18/04/23 Clinical event review PMRT completed
PMRT	N/A	86987	17/04/2023	Antepartum stillbirth	Low risk, uncomplicated pregnancy. Attended MDAU with history of reduced fetal movements since the previous night. Intrauterine death diagnosed following	Gestational age: 40+2 Reported to PMRT

Case type	Incident form	HSIB /PMRT	Log Date	Incident Trigger	Summary of incident	Outcome of incident
					admission.	18/04/23 Clinical event review 24/04/23 PMRG review PMRT completed
PMRT	N/A	87025	18/04/2023	Neonatal death	Baby known to have small long bones and likely uretorocele and abnormal left kidney. Under the care of the renal team and fetal medicine team. At routine scan at 31+5 weeks, baby noted to be hydropic and bradycardic. Cat 1 LSCS performed. Initially no baby heartbeat, with resuscitation gained a heartbeat for 6 minutes but then became bradycardic again and decision made to stop resuscitation.	Gestational age: 31+5 Baby RIP at 0 days of age Reported to PMRT 02/05/23 clinical event review Awaiting PMRG PMRT completed
PMRT	N/A	87189	27/04/2023	Antepartum stillbirth	Seen at 27weeks for ANC with Midwife -Reported good FM's however MW unable to auscultate FH. Sent to MDAU where IUD was confirmed via scan. Routine IOL was commenced, uncomplicated birth Severe IUGR	Gestational age: 27+4 Reported to PMRT 02/05/23 Clinical event review PMRT completed
PMRT	N/A	87593	28/06/2023	Antepartum stillbirth	History of recurrent APH Booked late as she thought she had miscarried In January. Attended MDAU with APH then delivered very quickly after admission CoD Extreme prematurity	Awaiting PMRG review
PMRT	N/A	87602	23/05/2023	Neonatal death	24+2 weeks Twin pregnancy (DCDA) SROM then attended DCH as was in the locality. Transferred back to PAH due to gestation. Normal delivery -transferred to NNU however sadly died 8 days later Extreme prematurity at 24weeks, post haemorrhagic hydrocephalus, Twin 1 DCDA	Gestational age: 24+2 PMRT started, awaiting completion of NNU aspects of care

Closed cases

Case type	Incident form	HSIB /PMRT	Closure Date	Incident Trigger	Summary of incident	Outcome of incident
HSIB SIRI	9922146	MI-008503	23/09/22	Therapeutic cooling	Patient awaiting IOL for Obstetric cholestasis however process was delayed due to high acuity on the whole Unit. Propess given however was awaiting ARM on LW, Mum was scoring on MEOWS and becoming increasingly unwell. Reviewed by Obs team and transferred to LW for further monitoring. On admission to LW there were concerns with the CTG. Cat 2 LSCS decided in view of suspected fetal compromise. Baby born in poor condition, blue and pale. Skin to skin contact not established. Apgars 1&2. Significant meconium. cord pH <7.05. Venous cord pH 6.826 BE -22.10. Baby admitted into the neonatal unit. Therapeutically cooled	HSIB report completed Local action plan written Closed at SISG on 06/04/2023
HSIB SIRI	9933353		18/05/23	Therapeutic Cooling	Therapeutic Cooling case shoulder dystocia Large for gestational age baby.	HSIB report completed Local action plan written Closed at SISG on 18/05/2023
SEC	9937114		01/06/23	Iatrogenic injury	Catheter inserted in theatre in preparation for LSCS. Noted during surgery that the balloon wasn't in the bladder. Urology clinician called to attend to repair two tears in the ureter thought to have been caused by the use of an incorrect catheter (Tiemanns tip catheter) being accidentally inserted into the right ureter.	RCA completed Closed at SISG om 01/06/2023
SIRI	9942078 2023-2734		01/06/23	Delayed management of twin 2	A 32 week pregnant woman with twins had had a BBA at home. Emergency services attended - both babies and placentae delivered. Mum was a fetal med patient with PPROM from early pregnancy in Twin 2 with concerns re	RCA completed Closed at SISG on 01/06/2023

					oligohydramnios, talipes and poor lung development. The mum had received steroids to safeguard twin one and was due to have a feticide of Twin 2 today 19/1/23. The paramedics in attendance transferred one baby (assumed to be Twin 1) to PAH but mum did not wish intervention for Twin 2 (assumed) and wanted the baby to die at home. Both babies were showing signs of life and the paramedics were not happy to provide no support to a baby who was clearly showing signs of life without a clear and obvious plan for no intervention. The Badgernet notes were complex and a decision was made to transfer mum and baby into PAH. After arrival Twin 2 was with mum and Twin 1 was c/o NNU. Twin 2 then became more pink and mobile so was transferred to NNU and continues to receive care there.	
PMRT	N/A	86005	31/05/2023	Neonatal death	Born in poor condition. Immediate cord clamping and brought to resuscitaire. Pale, floppy, no respiratory effort, no auscultatable heart rate. Resuscitation performed and saturations gradually improved to >90%. Transferred to NICU on FiO2 100%, PIP/PEEP 30/5. Was discharged home for palliative care and died one week post discharge.	PMRT completed
PMRT	N/A	86577	May-23	Neonatal death	Booked initially in Poole Hospital then transferred to UHS following diagnosis of Tricuspid atresia with H/plastic rt ventricle and severe tracheo-broncho malacia Oesophageal atresia and tracheo-oesophageal fistula. Aqueduct stenosis	PMRT completed
PMRT	N/A	86688	May-23	Neonatal death	Hypoglycaemia and apnoeas. Intubated and noted large bleed in ventricle. Developed renal failure and redirected care	PMRT completed

Moderate incidents

Incident Date / Number	Type of incident	Summary of incident	Outcome of incident	Key Learning and Recommendations
30/04/2023 9949367	Moderate incident	Issues with catheter being expelled at delivery with balloon fully inflated. Urethral tears incurred /PPH1350mls	For review at CER	Awaiting review at CER
02/05/2023 9948749	Moderate incident	Dopamine infusion replaced - incorrect concentration - made as per term baby protocol in error (existing Dopamine infusion re-prescribed in error by medic when prescribing evening fluids - to incorrect concentration which was in turn not identified by nursing staff - identified at 2am by nursing colleague).	Reviewed at NNU risk meeting Feedback given to staff involved	This incident has occurred as result of several contributory factors. So there are several learning points for all staff to prevent further incidents. 1) Request for fluid prescriptions for daily changes are to be presented to the doctor responsible for the nursery by 4pm please. 2) Doctors please prescribe all your nursery fluids, at around this time. Please do not leave till the night team. Please clarify with nurses if not sure what needs prescribing. 3) Nursing staff please be clear on what prescriptions you are asking to be re prescribed. 4) Nursing staff please ensure you check all prescriptions carefully against formulary. Completed 03/05/2023
05/05/2023 9949000	Moderate incident	Term baby admitted to the neonatal unit for more than 24 hours for cooling.	Case reviewed at CER and referred to HSIB for further investigation	Case is now being investigated by HSIB Completed 03/06/2023
08/05/2023 9949079	Moderate incident	Exposure of long line in premature neonate	Reviewed at NNU risk meeting Feedback given to staff involved	Feedback to staff to ensure ll sites are checked hourly checking that dressing as are intact and escalation if not. Accurate documentation of findings. Appropriate reporting of these incidents

Incident Date / Number	Type of incident	Summary of incident	Outcome of incident	Key Learning and Recommendations
17/06/2023 9952020	Moderate incident	Inappropriate escalation of baby requiring NNU care	Reviewed at NNU risk meeting Feedback given to staff involved	1. The situation occurred during medical handover. With most of the team on E level. The SC team were on the unit on D level with all the crash bleeps. On reflection the consultant involved feels that a bleep should have been in the medical handover on D level. This is something she plans to bring up with her colleagues in their consultant meeting. 2. During the resuscitation the first resuscitaire ran out of gases (happens when used a lot) the second resuscitaire was completely out of all gases so needed to be moved to a third one. During this time this was all happening in the corridor on labour ward, with several labour rooms free and available. Could this have moved into there? Then the gases have been plugged directly into the wall supply to prevent this occurring. 3. During this resus the consultant was informed the baby had been born through meconium (this was found out later not to be true) this information led the consultant to respond in a way she wouldn't have if this hadn't been mentioned. She escalated to the highest treatment from the start because of the meconium. Baby was put on the senor medics for HFOV and started nitric. The baby responded very quickly to this treatment. The feeling from the consultant is that by the time they responded to baby they were already in a spiral and if they had got there earlier the baby may not have needed as much support that they had. Baby spent less than 24 hours ventilated. Baby is still on the neonatal unit establishing feeds on some low flow oxygen. Completed on 17/06/2023

HSIB

HEALTHCARE SAFETY INVESTIGATION BRANCH

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Appendix 5a

Maternity Investigation

MI-014443

Independent report by the
Healthcare Safety Investigation Branch (HSIB)

Final report February 2023

Contents

Section 1. HSIB investigations

1.1 How HSIB decides what to investigate

HSIB will undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions, 2018), taken from Each Baby Counts and MBRRACE-UK.

In accordance with these defined criteria, eligible babies include all term babies (at least 37+0 weeks of gestation) born following labour, who have one of the following outcomes:

Intrapartum stillbirth: when a baby was thought to be alive at the start of labour and was born with no signs of life.

Early neonatal death: when a baby dies within the first week of life (0-6 days) of any cause.

Potentially severe brain injury diagnosed in the first seven days of life, when a baby:

- was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) or
- was therapeutically cooled (active cooling only) or
- had decreased central tone and was comatose and had seizures of any kind.

The defined criteria for maternal death investigations are:

Maternal death: death of a mother while pregnant or within 42 days of the end of the pregnancy*, from any cause related to or aggravated by the pregnancy or its management, and not from accidental or incidental causes.

- Direct: deaths resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), from interventions, omissions, incorrect treatment or from a chain of events resulting from any of the above. This excludes cases of suicide.
- Indirect: deaths from previous existing disease or disease that developed during pregnancy and which was not the result of direct obstetric causes, and which was aggravated by the physiological effects of pregnancy in the perinatal period (during or within 42 days of the end of pregnancy).

*Includes giving birth, ectopic pregnancy, miscarriage or termination of pregnancy.

1.2 HSIB investigation approach

It is the role of HSIB to investigate safety incidents without attributing blame or liability. The focus is to identify opportunities to learn and to improve patient safety across the system.

HSIB is funded by the Department of Health and Social Care. It is hosted by NHS England and NHS Improvement. HSIB acts independently. It is independent from regulatory bodies including the Care Quality Commission (CQC). HSIB's ambition is to bring a new perspective and develop meaningful and influential recommendations to support improvements in patient safety.

HSIB's maternity investigations replace any local incident conducted by the healthcare organisation in which the mother and baby received care.

HSIB investigations are independent, it does not investigate on behalf of families, staff, organisations or regulators. Where recommendations are made, these are directed to a specific organisation, and to other organisations or bodies who can influence and support change.

Findings and safety recommendations

On completion of the investigation, the report will contain **findings** which reflect information that was discovered through analysis of the evidence collected during the investigation.

Safety recommendations are made to organisations when the findings identified during an investigation are considered to be contributory to the outcome.

Not all reports will contain **safety recommendations** and organisations are guided to use the findings to support learning and change.

Section 2. Referral, investigation and terms of reference

2.1 Referral of the case

The Trust contacted the Healthcare Safety Investigation Branch (HSIB) about the incident, which met the criteria for HSIB to conduct a maternity investigation.

2.2 Investigation process and methodology

HSIB uses a standard process in all its maternity programme investigations:

- Gather all relevant evidence
- Establish the factual circumstances leading up to the incident
- Analyse the evidence
- Identify the most significant safety factors and safety issues that contributed to the incident being investigated
- Formulate safety recommendations and findings

This process is supported by the following:

2.2.1 Review of medical records

After consent is obtained from the family to access the appropriate medical records, these are uploaded by the trust and HSIB may commence the review/investigation.

Records that can be accessed can include (and are not limited to), hospital records, GP records or ambulance service records and transcripts.

All relevant trust policies, procedures and practices are reviewed. This may include a review of acuity tools, records of acuity levels and staff duty rosters. Additionally, investigators may undertake a walk-through of a mother's and baby's journey within the maternity service.

2.2.2 Family interviews

Introductory and supplemental interviews are held with the family to understand their recollection of events and to hear their concerns. Involvement of families in the investigation process is a fundamental part of HSIB's work, adding value to the evidence gathered and the learning outcomes.

2.2.3 Subject matter review panels

The panels during this investigation were attended by experienced subject matter advisors in obstetrics, midwifery, and neonatology, who provided advice and guidance. This guidance includes signposting to evidence, national guidance and current best practice. The panel assists in formulating the investigation's terms of reference and key lines of enquiry. The investigators also have access to human factors specialists throughout the investigation process.

2.2.4 Staff interviews

Face to face or virtual interviews are conducted with key participants of the incident, who are able to provide a depth of information in addition to the medical records. HSIB may also request interviews with other members of a trust who may be able to provide further background information to support the investigation. Where individuals may be able to provide small pieces of information relevant to the investigation, investigators may conduct telephone or email enquiries.

2.2.5 Analysis

A range of resources assist in understanding factors that may contribute to an incident occurring. HSIB promotes use of the Systems Engineering Initiative for Patient Safety (SEIPS) model (Carayon, 2006; Holden et al, 2013) as one way to help understand why incidents occur. Our maternity investigations aspire to utilise SEIPS to consider the relationships and interactions between people, tasks, technology and tools, the environment, organisational factors, and national policies and professional guidance, that contribute to how incidents occur.

Once analysis is complete HSIB may form safety recommendations and findings based on the relevant factors of the case, aimed at reducing the chance of reoccurrence and optimising learning for all members of trust staff.

Findings and safety recommendations from individual reports are analysed and may be used nationally to share wider thematic learning.

2.2.6 Communication during investigations

Throughout the investigation process, HSIB maintains regular contact with both families and trusts. The frequency of this may vary according to need. If a serious safety concern is identified this will be escalated back to a trust prior to publication of

the report. This ensures an opportunity for a trust to address safety issues in a timely manner.

2.2.7 Quality assurance

Following evidence collection and analysis a report is produced which is reviewed by a second subject matter review panel. Our aim is to ensure that the advisors are different to those on the first panel in order to ensure a fresh perspective. Following internal quality assurance, external quality assurance is undertaken with both the trust and the family before a report is finalised and shared with the trust and the family. The definitions and standard wording used within HSIB reports are written and quality assured by HSIB clinical advisors in their relevant field and updated as needed.

2.2.8 Modifications to investigation processes during COVID-19

During the COVID-19 pandemic period, HSIB continued to accept all referrals that met the 'Each Baby Counts' criteria. Where a baby was found to have a normal neurological outcome following therapeutic cooling (assessed by neurological examination or normal MRI), and where the trust and family did not express concerns around care, HSIB did not pursue an investigation during the COVID-19 period. In these cases, trusts were asked to follow their internal investigation process.

HSIB followed HM Government guidelines regarding work practices during the COVID-19 period. This required the stopping of face-to-face interviews and hospital visits. Instead, investigators used technology to conduct video and teleconferencing interviews with both families and trust staff.

Trusts were also challenged by the changed working practices during COVID-19. This was recognised within the investigation process and report.

2.2.9 Post-mortem examination

In cases which have been referred to the HM Coroner and a post-mortem examination (PME) has been completed, the HSIB report will reflect the cause of death as stated in the PME. In cases where an inquest is planned to take place, the cause of death will not be confirmed until the inquest is concluded. On occasion the

wording in relation to the cause of death may by changed or added to as part of the inquest process, this may occur after the HSIB report has been completed.

2.3 Terms of reference

- The investigation will consider the care of the Baby up until the point active cooling therapy was initiated
- Consider how the infrastructure and resources available within the organisation and the structure of maternity services within the Trust impacted on the care provided to the Mother.
- Ensure that the perception of events is captured from the Family, the Trust and staff directly involved in the care of the Mother.
- To explore the Mother’s care in the context of the COVID-19 pandemic.

A note of acknowledgement

We are grateful and give our thanks to the family whose experience is written about in this report. The family gave generously their time and shared openly their thoughts with us. We would also like to thank the Trust and members of staff who participated in this investigation process and openly shared their perceptions of the incident and maternity services with us as well as expressing their empathy for the family involved. To preserve anonymity, the family are referred to as the Mother and the Father throughout. The baby may be referred to as the Fetus, fetal or the Baby until the birth and is referred to as the Baby after the birth.

Section 3. Summary report

A 36-year-old mother booked for maternity care at 12 weeks and 4 days' gestation (12+4 weeks) in her second pregnancy. She followed a low-risk antenatal care pathway, with a plan to give birth in an alongside birth centre.

The Mother's antenatal period was complicated by a single episode of reduced fetal (baby) movements (RFM) at 36+1 weeks and severe haemorrhoids throughout pregnancy that required a self-referral to the accident and emergency department at 39 weeks.

The Mother went into spontaneous labour at 41+3 weeks and attended the birth centre (BC). Spontaneous rupture of membranes (SROM) occurred with the presence of significant meconium and the Mother was transferred to a room on the labour ward with concerns regarding the Baby's heart rate. The Baby was born in poor condition approximately one hour later after an assisted vaginal birth (ventouse) and shoulder dystocia (where the baby's shoulder is impacted behind the mother's pubic bone) that lasted 10 minutes. At birth the Baby weighed 4,800g which was on the 100th centile for growth, large for gestational age.

The Baby was resuscitated and transferred to the local neonatal intensive care unit (NICU) for therapeutic cooling that started at three hours of age and continued for 72 hours. The Baby was diagnosed with a left arm Erb's palsy on day one. An MRI of the Baby's brain was performed at four days of age and showed, 'no definite evidence of hypoxic ischaemic injury. Slender subdural haemorrhage which is likely birth-related'.

The placenta was sent for histology (examination under a microscope) and returned with findings within expected ranges.

The Baby was discharged home at nine days of age. At the time of concluding the investigation the Baby was requiring community physiotherapy reviews, and neonatology and neurological team follow-up care.

Section 4. Facts of the case

4.1 Incident criteria: Potential severe brain injury – Therapeutic cooling

Therapeutic hypothermia (active cooling) should be considered in infants that meet specific criteria following birth. The UK total body cooling trial confirmed that 72 hours of cooling to a core temperature of 33-34C within six hours of birth for babies with potentially moderate or severe HIE reduces death and disability at 18 months of age and improves neurodevelopmental outcome in survivors. Therapeutic hypothermia is a procedure where a baby is cooled to between 33C and 34C, with the aim of preventing further brain injury following a hypoxic (lack of oxygen) injury. Therapeutic cooling therapies are described as:

- Passive – Prior to active cooling, a baby once resuscitated can have passive cooling by turning off heating equipment and removing any coverings from the baby.
- Active – Hypothermia is usually induced by cooling the whole body with a blanket or mattress and this is referred to as active cooling.

Further information from: British Association of Perinatal Medicine 2020 – Therapeutic Hypothermia for Neonatal Encephalopathy | British Association of Perinatal Medicine (bapm.org).

4.2 The incident

A 36-year-old mother booked for maternity care at 12+4 weeks in her second pregnancy. The Mother's first baby was born at 39+2 weeks by vaginal birth, weighing 3,930g. The Mother's medical, obstetric, and social history was obtained, and she followed a low-risk antenatal care pathway, with a plan to give birth in an alongside birth centre (BC). The Mother's body mass index (BMI) was calculated as 23kg/m2 at booking, within the expected range, and no risk factors were identified.

Body mass index in pregnancy

BMI is a measure for indicating nutritional status in adults. It is defined as a person's weight in kilograms divided by the square of the person's height in metres (kg/m^2) (WHO). The World Health Organisation (WHO) classifies BMI as follows:

BMI	Nutritional status
Below 18.5	Underweight
18.5 - 24.9	Normal weight
25. 0 - 29.9	Pre-obesity
30.0 - 34.9	Obesity class I
35.0 - 39.9	Obesity class II
Above 40	Obesity class III

Obesity in pregnancy is associated with an increased risk of several serious adverse outcomes, including miscarriage, fetal congenital anomaly, thromboembolism, gestational diabetes, pre-eclampsia, dysfunctional labour, postpartum haemorrhage, wound infections, stillbirth and neonatal death. Fetal heart rate monitoring can be a challenge, and closer surveillance is required, with recourse to fetal scalp electrode or ultrasound assessment of the fetal heart if necessary. (RCOG 2018)

The Mother's first trimester screening was performed at 13+6 weeks when her expected date of delivery was confirmed, and her BMI calculated using her pre-pregnancy weight. The Mother's and Baby's observations were within expected ranges.

Combined test/First trimester screening

This test, which is available between 10-14 weeks screens is for specific chromosomal conditions. Chromosomes are where a person's genetic material is contained within the cells of the body. The combined test tests for three conditions where an extra chromosome is found in cells; these are called Down's (extra chromosome 21), Edwards' (extra chromosome 18) and Patau's (extra chromosome 13) syndromes. The combined test uses a sample of a mother's blood together with the measurement of the fluid at the back of a baby's neck (known as nuchal translucency). The measurement is taken at the dating ultrasound scan along with other factors including a mother's age to work out the chance of a baby having Down's, Edwards' or Patau's syndromes. (HSIB maternity team)

At a routine antenatal appointment at 16+1 weeks the Mother reported feeling well with an allergic reaction on her legs. She was advised to seek advice from a pharmacist. The Mother's and Baby's observations were within expected ranges.

The Mother's routine anomaly ultrasound scan at 19+6 weeks was within expected ranges.

Mid pregnancy anomaly ultrasound scan

The mid-pregnancy anomaly ultrasound scan (USS) looks for some physical abnormalities in a baby. The USS only looks for these problems and can't find everything that might be wrong. It looks in detail at a baby's bones, heart, brain, skin covering the spinal cord, face, kidneys and abdomen. It allows the sonographer or doctor to look specifically for 11 conditions, some of which are very rare.

Further information available from: NHS - anomaly scan

The Mother attended a routine antenatal appointment at 25+1 weeks and reported symptoms of a sore throat that had been present for two months. The Mother had been previously reviewed by a general practitioner (GP) and throat swab returned within expected range. The Mother was advised to seek further help from the GP.

At 28+1 weeks the Mother attended a routine antenatal appointment and reported having previously sought advice from her GP about her throat. She had been

prescribed a medicine for gastric reflux. The Baby's movements were described as good and the Mother's symphysis-fundal height (SFH), plotted on an Intergrowth chart, was on the 90th centile.

Symphysis-fundal height

This is a measurement of the size of the uterus which is used to assess a baby's growth during pregnancy. It is measured from the top of the uterus to a mother's pubic bone. (HSIB maternity team)

INTERGROWTH-21ST

The INTERGROWTH-21st project is a worldwide study that has developed tools to monitor a baby's growth before birth.

Further information available from: INTERGROWTH-21st

The Mother further attended a routine antenatal appointment at 34+1 weeks and reported some mild discomfort under her left ribs. An abdominal palpation was performed and concluded that the discomfort was likely due to the position of the Baby on her left side. The Mother's SFH plotted on the 90th centile.

After experiencing reduced fetal (Baby) movements (a change in a baby's pattern of movement) for a few days the Mother attended the maternity day assessment unit for assessment at 36+1 weeks. The Mother's and Baby's observations were within expected ranges. A cardiotocograph (CTG) was performed and the Dawes-Redman criteria were met at 24 minutes. The Mother's SFH plotted between the 90th and 97th centiles.

Dawes-Redman CTG analysis

Cardiotocography (CTG) is an electronic means of recording the unborn baby's heart rate pattern, to assess their well-being. Sometimes in the antenatal period (before labour or induction of labour), this can be analysed by a computer. The software used, is known as Dawes-Redman. A CTG from a healthy baby would be expected to meet the Dawes-Redman criteria. The antenatal use of computerised CTG analysis is recommended in national guidance due to its potential to reduce the risks of human error (NHS England, 2019). (HSIB maternity team)

At the Mother's routine antenatal appointment at 37+1 weeks, the Mother's SFH plotted above the 97th centile. The Mother's and Baby's observations were within expected ranges. Plans were made to accommodate the Mother's request to change her routine appointment day. The Mother was re-weighed and her BMI calculated as 29kg/m2, within the expected range. The investigation did not find record of a planned discussion about the Mother's birth plan.

The Mother reported having previously attended accident and emergency (A&E) at her next routine appointment at 39+1 weeks. She attended A&E with intense discomfort from haemorrhoids (swollen veins in the lower part of rectum and anus). She was reviewed by medical staff and prescribed oral pain relief and was not currently taking the medication. The notes recorded that the Mother expressed concerns about how her haemorrhoids may affect her labour. She was advised that the haemorrhoids would be assessed on her admission in labour. The Mother's and Baby's observations were within expected ranges. The Mother recalled that this was a particularly important concern for her and perceived that her concerns were 'minimised'. The investigation did not find record of further assessment of her haemorrhoids.

The Mother reported feeling very well at her routine antenatal appointment on 40+1 weeks. She was provided with advice to attend the labour ward if her membranes (the bag of waters around the baby) ruptured or labour started. The Mother's and Baby's observations were within expected ranges. The Mother's SFH measurement plotted above the 90th centile.

At 41+1 weeks the Mother attended a routine antenatal appointment and reported feeling well and awaiting the birth of her Baby. The Mother's and Baby's observations were within expected ranges. The Baby's movements were reported as good. A membrane sweep was performed. The Mother's SFH measurement, not plotted on the intergrowth chart, was recorded as 42cm.

Membrane sweep

A membrane, or cervical sweep, involves having a vaginal (internal) examination that separates the membranes of the amniotic sac surrounding a baby from the cervix (neck of the womb). This separation releases hormones (prostaglandins)

that may trigger natural labour. It is not uncommon to experience some discomfort or slight bleeding afterwards.
Further information available from: NHS - induction of labour

The Mother and Father recalled that, on numerous occasions during the antenatal period, the Mother expressed anxiety over the size of her Baby and worries that her Baby may be large [for gestational age]. She expressed concerns about the potential effects of a large baby on labour and birth. They further recalled that they were provided with reassurances that confirmed that 'everything would be ok'. The investigation did not find a record of these conversations in the Mother's notes.

Large for gestational age (macrosomia)
Babies who measure above the 90th centile on either a personalised or population based growth chart, or are estimated to weigh more than 4000 grams, are considered to be large for gestational age (LGA). Current NICE guidance recommends that the options for birth for mothers (without diabetes) with suspected fetal macrosomia are expectant management, induction of labour or caesarean birth. As there is not enough evidence to recommend one method over another, NICE states that women be provided with information about different modes of birth so they are able to make an informed decision. The RCOG recommend that mothers with suspected LGA babies are counselled about the risks of shoulder dystocia. (HSIB maternity team)

The Mother telephoned the local maternity triage service at 09:07 hours on 41+3 weeks reporting that she was on her way to the hospital contracting at a frequency of three contractions in every 10 minutes (3:10). She reported that the Baby felt 'very low [in her pelvis]'. The Mother was advised to make her way to the BC and the triage service telephoned the BC office to notify them of the Mother's arrival.

The Mother arrived at the BC and was recorded to be requesting 'gas and air' as her contractions were increasing in strength and frequency. The Mother was cared for by a midwife and student midwife.

'Gas and Air'

‘Gas and air’ is a gas made up of 50% nitrous oxide and 50% oxygen that is used for pain relief during birth. It is administered through a mask or mouthpiece. It is simple and quick to act and wears off in minutes.
Further information available from: NHS - gas and air

The Mother’s notes recorded that staff experienced problems with the laptop computer, and tablet devices used to access the maternity records system. Further notes were recorded by hand.

Retrospective written notes recorded that the Mother was low risk and multiparous (a mother who has given birth to one or more babies) and on visual assessment was thought to be in established labour at 10:40 hours. The Baby’s heart rate was auscultated (listened to) with a handheld Doppler device at 137 beats per minute (bpm), which was recorded as accelerative with no decelerations. The Mother’s contractions were 4:10 and described as long and strong.

Intermittent auscultation
Intermittent auscultation (IA), or ‘listening in’, is the recommended method of a listening to a baby’s heart rate in labour, in pregnancies where there are no anticipated complications. This is performed by using either a hand-held (Pinard) stethoscope or a hand-held Doppler machine. During labour, midwives listen into a baby’s heartbeat for at least a minute, immediately after a contraction. This is repeated at a minimum of every 15 minutes in the first stage of labour, and at least every 5 minutes in the second stage of labour. A mother’s pulse should be measured, recorded hourly in the first stage of labour and every 15 minutes in the second stage of labour. The pulse may then be compared to a baby’s heart rate, to check both heart beats are being monitored.
Further information available from: NICE - care in labour (includes IA)

At 11:00 hours care was taken over by a student midwife. The Baby’s heart rate was auscultated for one minute after a contraction and noted to be at 133bpm with no decelerations heard.

The Baby's heart rate was recorded as 140bpm at 11:17 hours and no decelerations were heard. The Mother was feeling pressure in her vagina and had no spontaneous urges to push. The Mother continued to experience strong regular contractions.

At 11:48 hours a mucous blood show was seen and the Mother was reassured. The Baby's heart rate was recorded as 134bpm.

Show
This is when the plug of mucus at the neck of the womb (cervix) comes away. This may indicate the start of labour. It may contain some blood. (HSIB maternity team)

A midwifery staff member returned at 12:00 hours and the Baby's heart rate was recorded as 129bpm and 'accelerative'. The Mother was standing up supported by the Father.

The Mother adopted an 'all fours' position on the floor at 12:29 hours and the Baby's heart rate was recorded as 127bpm at 12:27 hours. Accelerations and no decelerations of the Baby's heart rate were documented.

'All fours' position
During the birth of a baby, a mother may choose to adopt the 'all fours' position by getting onto her hands and knees. This position may help to relieve a mother's back pain and can help babies rotate into a better position for birth. In circumstances where there is a shoulder dystocia, a clinician may assist a mother into the 'all fours' position to create space in her pelvis and help to release the baby's shoulder. (HSIB maternity team)

The Mother request an artificial rupture of membranes at 12:38 hours and staff explained that this was not clinically indicated at present.

At 12:41 hours the Mother experienced spontaneous rupture of her membranes (SROM, waters breaking) and 'significant meconium' was noted in the amniotic fluid.

Meconium
Meconium is a baby's first bowel motion (poo), usually passed after birth, and formed mainly of mucus and bile. If a baby passes meconium before they are born

it may be found in the amniotic fluid (waters that surround a baby). Approximately 15-20% of babies have meconium-stained fluid in labour. In babies born after their due date, the presence of meconium, may indicate that their gut is mature. It can also indicate that a baby's wellbeing has been compromised.
Meconium in the amniotic fluid can vary from light to heavy staining. Significant meconium may be dark green or black in colour, thick or lumpy. If significant meconium is present, a mother should be advised to have continuous electronic fetal monitoring, in an obstetric led unit, where obstetricians and neonatologists are on hand to help if needed.
Further information from: Meconium-stained liquor, NICE; Intrapartum care

Staff escalated the Mother's significant meconium and SROM findings to the BC office staff to ask for urgent transfer of the Mother to the labour ward. Staff returned to the BC room to prepare the Mother for transfer to the labour ward. The Mother was encouraged onto a ward bed prior to performing a vaginal examination. A CTG was brought into the room to monitor the Baby's heart rate.

Cardiotocograph (CTG)
Cardiotocography (CTG) is an electronic means of recording the unborn baby's heart rate pattern, to assess their well-being. This is used both during the antenatal period, and during labour. During labour, a mother's contractions are also monitored by this machine which produces a printed or electronic record referred to as the CTG. It is usually performed externally, using two devices (transducers) placed on a mother's abdomen.
Further information available from: NICE - care in labour (includes CTG)

At 12:43 hours the Mother's vaginal examination revealed her cervix to be an anterior lip (when a mother's cervix is almost fully dilated). The Mother's notes recorded that a CTG was started at 12:50 hours and that 'late prolonged decelerations [were] heard' and urgent transfer of the Mother was commenced. The investigation did not find the CTG recording during this period and staff later recalled that in view of the urgency for transfer a recording may not have been made.

Decelerations

A deceleration is a temporary slowing of a baby's heart rate. Decelerations can be described in multiple ways.

- Early – the lowest point of the deceleration is at the same time as the peak of the contraction
- Variable – the timing and shape of the deceleration varies
- Late - the lowest point of the deceleration comes after the peak of the contraction
- Baroreceptor – a deceleration related to changes in a baby's blood pressure
- Chemoreceptor – a deceleration related to a build up of cardon dioxide and acid in a baby

(HSIB maternity team)

The Mother was transferred to a labour ward pool room at 12:54 hours. The notes recorded that this was the only room available and that there was no CTG or labour ward bed present in the room. Lithotomy poles and a delivery bed were requested.

A CTG monitor was brought into the room by the labour ward coordinator and started at 12:59 hours. Notes recorded that the CTG screen 'was not turning on', and late prolonged decelerations were heard.

A further vaginal examination was performed, and an anterior lip was confirmed. The anterior lip was manually displaced and the Mother was encouraged to start directed pushing. The Baby's heart rate was recorded as 77bpm, below the expected range.

At 13:05 hours, in view of the CTG concerns and meconium, a request was made to bleep the obstetric team and this call was received at 13:09 hours. The lithotomy (when a mother's legs are elevated and supported in rests) supports arrived at 13:11 hours.

The Mother continued her directed pushing with minimal movement of the Baby's head reported. Further midwifery staff support was requested.

An obstetric consultant attended at 13:15 hours. An assessment of the Baby's CTG using the DRCBravado mnemonic provided an overall description of the CTG as 'pathological'.

DR (M)C(Q) BRaVADO

A mnemonic (memory tool) used to describe a CTG. The letters stand for:

- DR – Define Risk (an outline of a mother's risk factors)
- (M) – Movements (whether a baby is moving during the CTG monitoring. These may be perceived by the mother or registered by the CTG machine. This parameter is not always used)
- C – Contractions
- (Q) – Quality (of the recording – are there periods of loss of contact?- not always used)
- BRa – Baseline Rate (of a baby's heart rate)
- V – Variability (of a baby's baseline heart rate)
- A – Accelerations (a temporary rise in a baby's heart rate)
- D – Decelerations (a temporary drop in a baby's heart rate)
- O – Overall (whether the CTG is considered normal or otherwise)

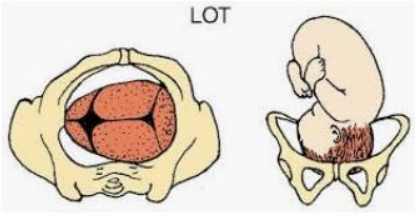
The Dr M C Q BrRaVADO mnemonic is a non-evidenced based descriptive tool and does not support clinicians in their decision making or categorisation of CTGs. (HSIB maternity team)

Pathological CTG

If a CTG is categorised as pathological this requires prompt senior review and action to further assess fetal wellbeing and consider if a baby should be born sooner. (HSIB maternity team)

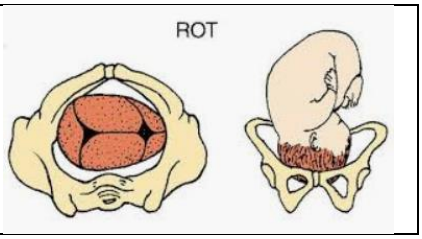
A vaginal examination was performed and the Mother's cervix was found to be fully dilated. The Baby's head position was described as right occipito transverse (ROT) and at the level of the ischial spines.

Occipito transverse (OT) position



Left occiput transverse (LOT) is where a baby is head down and the back of a baby's head is against the mother's left side.

Right occiput transverse (ROT) is where a baby is head down and the back of a baby's head is against the mother's right side. (HSIB maternity team)



Ischial spines

The ischial spines are a landmark in a mother's pelvis. Clinicians describe a baby's position in relation to the spines as a measure of how far through the birth canal a baby has travelled.

- Midpoint of the birth canal = spines
- High in the birth canal = above spines
- Low in the birth canal = below spines
- Visible at the vaginal opening = +3

(HSIB maternity team)

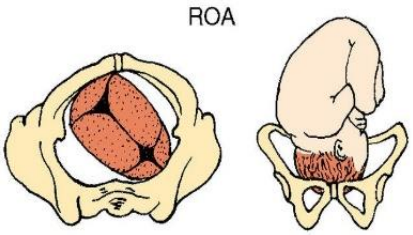
Manual rotation of the Baby's head was performed to the right occiput-anterior (ROA) position.

Manual rotation of the fetal head prior to vaginal birth

Manual rotation may be performed to turn a baby's head to the occipito-anterior (facing backwards) position. This may be from either the occipito-transverse (facing sideways) or occipito-posterior (facing forwards) positions. Manual rotation entails the use of the clinician's hand or fingers to rotate a baby's head. It may take two or three contractions to be performed and the position is commonly held for two contractions. (RCOG Robust)

Right occipito anterior (ROA) position

Right occipito anterior (ROA) is when a baby is head down and the back of a baby's head is against a mother's abdomen to her right side. (HSIB maternity team)



A fetal scalp electrode (FSE) was applied to the Baby's head at 13:23 hours. The Mother's bladder was catheterised using an in/out urinary catheter at 13:29 hours. Her consent was obtained for an assisted vaginal birth using a ventouse (vacuum extraction device) and episiotomy at 13:30 hours. The Baby's heart rate was recorded as 112bpm.

Fetal scalp electrode

Fetal scalp electrode (FSE) is a small clip placed on the unborn baby's head or bottom, if external monitoring produces an unreadable CTG. It is applied during a vaginal examination. (HSIB maternity team)

Assisted vaginal birth

An assisted vaginal birth is when a healthcare professional uses specially designed instruments to help a mother to give birth to her baby. Assisted vaginal birth includes birth helped by use of a vacuum cup or forceps or both. The majority of babies born this way are well at birth and do not have any long term problems. In the UK, approximately 1 in 8 mothers have an assisted vaginal birth and this is more likely (1 in 3) for those having their first baby. Assisted vaginal birth may also be referred to as instrumental or operative vaginal birth.

For more information see RCOG – assisted vaginal birth

Ventouse

A ventouse (vacuum extractor) is an instrument that uses suction to attach a plastic or metal cup on to a baby's head. The obstetrician waits until a mother is having a contraction and then asks her to push while they gently pull to help birth a baby vaginally.

Further information available from: RCOG - assisted vaginal birth

The Mother's perineal area was infiltrated with a local anaesthetic at 13:34 hours, and the Baby's FSE was removed. A ventouse cup was applied to the Baby's head at 13:35 hours, the position checked, and the first pull made at 13:36 hours. The

Baby's heart rate was recorded as 131bpm and two minutes later 53bpm. A second pull of the ventouse was made at 13:39 hours with good descent of the Baby's head recorded. The Baby's heart rate was recorded as 61bpm. An episiotomy was performed.

Episiotomy
A cut made at the end of labour to widen the vaginal opening.
Further information available from: NHS - episiotomy

A third pull was made at 13:42 hours and the Baby's head was reported as slow to deliver. The episiotomy was extended at this point and the Baby's chin delivered at 13:45 hours. A shoulder dystocia was anticipated at 13:46 hours and the labour ward coordinator was called to the labour room to assist.

During the Mother's next contraction, at 13:47 hours, a shoulder dystocia was verbally declared and the notes recorded the Baby's shoulder was not delivered with routine axial traction and the Mother's pushing effort. An emergency 2222 call was made to call further obstetric and neonatal staff. Staff recalled that the 'non-resident' on-call obstetric consultant could not initially be contacted by telephone.

A neonatal consultant was present at 13:48 hours and a decision was made to perform neonatal resuscitation in the corridor outside of the pool room due to space constraints in the pool room.

The Mother was placed into the McRoberts' position, the Baby's back was noted to be on the Mother's right side and suprapubic pressure was performed from the Mother's right side. The Baby was not able to be delivered with axial traction. An attempt was made to deliver the Baby's posterior arm and this could not be made. An attempt to rotate the Baby's anterior shoulder was made without success. A further unsuccessful attempt at 13:48 hours was made to deliver the Baby's posterior arm and further rotate the Baby's anterior shoulder.

'2222' emergency response call
In the event of an emergency involving a mother or baby, urgent help may be requested using the standard emergency telephone number 2222. When this number is used, the hospital telephone switchboard operators prioritise the call

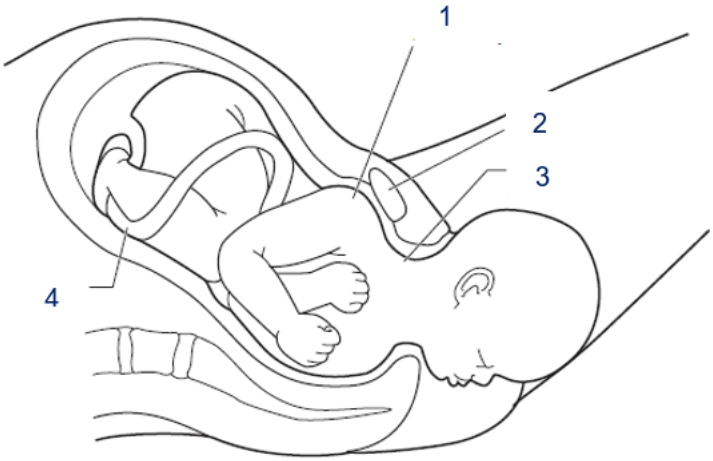
above all others. Using a standard telephone number helps to avoid confusion which may arise when clinicians move between hospitals. (HSIB maternity team)

The Mother's episiotomy was extended and McRoberts' position with suprapubic pressure was repeated at 13:49 hours. The Mother was rotated onto the all fours position at 13:51 hours and a further attempt at delivering the Baby's posterior arm was made. The notes recorded that the Baby's posterior (right) arm was 'still slow to deliver'. The Baby's right arm was delivered at 13:55 hours by the attending midwife and the Baby was born.

Note: The investigation found a small discrepancy in the time of the Baby's birth recorded from the clinical narrative notes (13:55 hours) and the account of the attending neonatal team (13:54 hours). The investigation has continued the neonatal resuscitation timings from the neonatal team's account.

Shoulder dystocia

Shoulder dystocia is when a baby's head has been born and one of the shoulders becomes stuck behind a mother's pubic bone, delaying the birth of a baby's body (see figure). If this happens extra help is usually needed to release a baby's shoulder. Further information available from: RCOG - shoulder dystocia



1. Shoulder stuck behind mother's pelvic bone
2. Pubic bone
3. Nerve, or area of nerve, stretching
4. Umbilical cord

McRoberts' position

A mother is laid flat, and pillows are removed from under her back. With an assistant on either side, a mother's legs are hyperflexed against her abdomen so that her knees are up towards her ears. McRoberts' position increases the internal space within a mother's pelvis for a baby, and straightens the sacrum (tailbone) giving a baby room to rotate and birth. It has a low rate of complication and is one of the least invasive manoeuvres and therefore it is recommended to be used first.
(PRactical Obstetric Multi-Professional Training (PROMPT) 2018)

Suprapubic pressure

Pressure on a mother's abdomen just above the pubic bone to try and release a baby's shoulder. (HSIB maternity team)

Delivery of a baby's posterior arm

A manoeuvre used, during a shoulder dystocia, to assist the birth of a baby. A clinician uses their hand to identify the baby's posterior arm and, by grasping the wrist, gently withdraws the baby's arm from the mother's vagina in a straight line. This will reduce the width of the baby's shoulders and may assist the baby's birth. (HSIB maternity team)

Internal rotation manoeuvres

A manoeuvre used during a shoulder dystocia to try to birth a baby. A midwife or doctor will use their hand to press on the front or the back of the shoulder, to encourage a baby to rotate in a mother's pelvis. When pressure is placed on the back of the shoulder it should also reduce the diameter of a baby's shoulders. (HSIB maternity team)

The Mother's placenta remained adherent and at 14:03 hours she was taken to obstetric theatre for planned manual removal of placenta (MROP) under general anaesthetic. The Mother's total estimated blood loss of 1500ml was thought to be mainly the result of blood loss from her perineal tears. Notes record that she was haemodynamically stable throughout the repair and MROP. The Mother was taken to recovery at 15:24 hours.

General anaesthesia

For a general anaesthetic, the anaesthetist gives a mother medication to make her go to sleep and passes a tube through the mouth into her airway to allow oxygen to be delivered to the lungs. General anaesthesia is used less often nowadays. It may be needed for some emergencies, if there is a reason why a regional anaesthetic is not suitable or if a mother prefers to be asleep.

Manual removal of placenta (MROP)

Manual removal of placenta is when the placenta is detached from a mother's uterus by hand following a vaginal birth. It is usually carried out in an operating theatre under anaesthesia. (HSIB maternity team)

As part of the initial assessment, Apgar scores were attributed to the Baby and were 1 at 1 minute, 2 at 5 minutes and 2 at 10 minutes of age. A breakdown of the scores was not seen by the investigation.

The Apgar score

Soon after birth, observations are made of a baby's heart rate, breathing, colour, muscle tone and response to stimulation. These are performed at 1 minute and 5 minutes of age and the purpose is to determine if a baby needs extra support. There may be a third assessment at 10 minutes. The five observations are each given a score of 0, 1 or 2. The total of these scores is referred to as the Apgar score. The lower the score the greater the need for a baby to receive additional support. (HSIB maternity team)

Samples of blood were taken from the umbilical cord for testing and analysed at 14:05 hours to 14:16 hours. The umbilical cord gas results were as follows:

Arterial: pH 7.227; BE (base excess) -7.10mmol/L; lactate 5.5mmol/L

Venous: pH 7.231; BE (base excess) -8.00mmol/L; lactate 6.2mmol/L

Umbilical cord blood testing

The umbilical cord contains three blood vessels. One large vein carries oxygenated blood to the unborn baby. Two smaller arteries carry deoxygenated blood from the unborn baby.

Two indicators of a baby's wellbeing are measured in the cord blood. These are known as the pH and the base excess (BE). These indicators are significant because they can be associated with an increased risk of brain injury due to lack of oxygen (hypoxic ischaemic encephalopathy, or HIE).

A cord pH less than 7.0; or cord BE less than -16mmol/L, may be associated with HIE. Because of this it may be necessary to cool a baby. Some babies may be born in poor condition despite the cord gas results outside the description above. They may also need cooling. (HSIB maternity team)

The Baby's cord was clamped and cut immediately and the Baby was carried to the resuscitaire in the corridor outside of the pool room to commence resuscitation by the neonatal team. The neonatal team comprised of a neonatal consultant (leading the resuscitation), three senior neonatal doctors, the neonatal coordinator, three neonatal nurses, and two student neonatal nurses (scribe and support roles).

The Baby was described as pale with no respiratory (breathing) effort. The Baby's heart rate was audible, described as 'feeble', at less than 60bpm.

Resuscitaire

A piece of equipment which combines a warming therapy platform along with the additional equipment required for managing neonatal clinical emergencies and resuscitation. (HSIB maternity team)

The Baby received five inflation breaths in 100% FiO2 with good chest wall rise noted. There was no improvement in the Baby's heart rate. An initial attempt to intubate the Baby was made by a senior neonatologist without success. A further attempt to intubate the Baby was successful at 13:59 hours and carbon dioxide monitor colour change was noted. Meconium was noted in the Baby's oesophagus

(the tube connecting their mouth and stomach) and not on the vocal cords (the entrance to the baby's windpipe).

Inflation and ventilation breaths

If a baby is not breathing by themselves following birth, they may require inflation breaths to help fill their lungs with air and expel the fluid that is within the lungs in the womb. These are given using emergency breathing equipment designed for newborn babies on a resuscitaire or carried by the midwife at a homebirth. Once the lungs have been adequately inflated, if a baby still needs support with breathing the same equipment is used to provide shorter, more frequent ventilation breaths to a baby. (HSIB maternity team)

Fraction of inspired oxygen

The fraction of inspired oxygen (FiO_2) is the concentration of oxygen that is being inhaled by a baby. (HSIB maternity team)

Intubation of a baby

When a baby needs additional support with breathing, a tube may be passed through the mouth and into the windpipe to allow oxygen to be delivered directly to the lungs**.** A breathing machine, called a ventilator, may be used to move the oxygen into and out of the lungs. (HSIB maternity team).

Carbon dioxide monitoring

The neonatal team may use a carbon dioxide (CO2) sensor. The sensor is attached to a baby's breathing tube and will change colour when CO2 is detected. The colour change indicates that the breathing tube is in the correct place and that there is a heart beat or effective cardiac compressions which are moving CO2, present in the blood, back to a baby's lungs. The CO2 is then exhaled (breathed out). Sometimes when a breathing tube is inserted correctly, there may be no colour change. This is because there is no circulation of

a baby's blood around their body or if the breathing tube is blocked. (HSIB maternity team)

The Baby was noted to have good chest wall rise and their heart rate remained less than 60bpm with the skin colour remaining pale.

An umbilical venous catheter (a thin tube inserted into the vein in a baby's cord) was sited at 14:00 hours (at 6 mins of age), a blood gas sample was taken and chest compressions were started. Adrenaline (a medicine given to stimulate a heartbeat) was given at 14:03 hours (at 9 minutes of age) with the Baby's heart rate at less than 60bpm.

Blood gas

As well as carrying oxygen from the lungs, blood also carries carbon dioxide back to the lungs, so we can breathe it out as waste gas. Measuring the levels of carbon dioxide, as well as other waste chemicals carried by the blood, can give information about a baby's overall condition. It can also help tell how other organs, such as kidneys, are working. The sample can be taken from an artery (arterial blood gas (ABG)), a vein (venous blood gas (VBG)) or from a capillary. (HSIB maternity team)

Cardiac/chest compressions

Cardiac/chest compressions are used as part of neonatal resuscitation following inflation and ventilation breaths, if a baby's heart rate is less than 60 bpm, to move oxygenated blood from a baby's lungs to the rest of their body. (HSIB maternity team) Further information available from: NHS - CPR

Medicines used in neonatal resuscitation

Adrenaline - Adrenaline is a medicine which may be used during a baby's resuscitation. Adrenaline works most effectively when given into a baby's blood vessel (intravenous) or bone (intraosseous).

Sodium bicarbonate - Sodium bicarbonate is a medicine used to treat acidosis in response to low oxygen levels in a baby's body during resuscitation.

Dextrose – Dextrose is a sugar-based medicine used to provide energy to a baby during resuscitation.
Further information from Resuscitation Council (UK) - Guidelines for resuscitation and support of transition of babies at birth

At 14:04 hours (at 10 minutes of age) bicarbonate was given and a second dose of adrenaline followed at 14:05 hours (at 11 minutes of age). The Baby's heart rate was recorded to have improved to 60-80bpm, chest compressions were stopped, and ventilation breaths continued. The Baby's skin colour was described as pale.

O negative blood was transfused to the Baby at 14:06 hours (at 12 minutes of age) at an estimated 10ml/kg.

The Baby's venous blood gas (taken at 14:00 hours) result returned at 14:07 hours with pH 6.83, BE -16.9 mmol/L, lactate 10.8 mmol/L (outside of the expected ranges).

At 14:08 hours (at 14 minutes of age) a plan was made to transfer the Baby to NICU and assess before the decision to start therapeutic cooling. The Baby met criteria A for therapeutic cooling after prolonged resuscitation and a previous venous blood gas outside of expected range. Calcium was given to the Baby ("to make sure there was no arrythmia to the heart") and the Baby's heart rate was greater than 100bpm. The Baby's oxygen saturations in FiO2 75% were 95% and good chest wall rise and bilateral air entry described.

Criteria for therapeutic cooling
A baby may be considered for treatment with therapeutic cooling if they meet the following three criteria;
Criteria A
Babies of more than 36 weeks who are less than 6 hours old with at least one of the following:

- Apgar score equal to or less than 5 at 10 minutes of age
- Continued need for resuscitation at 10 minutes of age

- pH of less than 7.00 or base excess less than -16mmol/L in any blood sample taken within 60 minutes of birth.

Criteria B

Development of encephalopathy evidenced by abnormal neurological examination including seizures,

- reduced or absent response to stimulation and at least one of the following:
- abnormal reflexes
- poor muscle tone

Criteria C:

Abnormal cerebral function monitoring (CFM) (which measures the electrical activity of the brain). It is recognised that CFM may not be available in all circumstances, and inability to obtain CFM should not prevent or delay treatment if there is evidence from A and B criteria.

Further information from: British Association of Perinatal Medicine 2020 - Therapeutic hypothermia for neonatal encephalopathy

Calcium chloride

Calcium chloride is used during cardio-pulmonary resuscitation when there is also a raised potassium level. (HSIB maternity team)

Oxygen saturation

Oxygen saturation is measured by placing a special probe on the hand or foot of a baby. This is an indicator of the amount of oxygen flowing through a baby's blood vessels. (HSIB maternity team)

At 14:11 hours (at 17 minutes of age) the oxygen on the first resuscitaire was running low and the Baby was moved to a second resuscitaire. The Baby was transferred to NICU at 14:12 hours on the resuscitaire and arrived at 14:18 hours (at 24 minutes of age).

The Baby's cerebral function monitoring was started at 15:08 hours (at approximately one hour of age)

Cerebral function monitoring (CFM)
Cerebral function monitoring is a minimally invasive tool to detect/confirm the presence of seizure activity in newborn babies. It is performed by attaching electrodes to a baby's head which provide a continuous read out of electrical activity in the brain, generally over a period of hours to days. (HSIB maternity team)

An umbilical arterial catheter (UAC, a thin tube inserted into an artery in a baby's cord) was inserted at 15:48 hours (at approximately two hours of age). The Baby's UVC was removed and replaced at 15:54 hours.

The decision to start the Baby's therapeutic cooling was made after consulting the second on-call neonatal consultant and started at 16:45 hours (at approximately three hours of age). The Baby met criteria B and C for cooling, with absent / weak suck and possible seizures, and moderately abnormal CFM monitoring. The Baby was reviewed by the on-call neonatal consultant at 20:21 hours (at approximately six hours of age) and was thought to be 'hyper irritable' at that time rather than having seizures.

Some areas of bruising were noted on the left side of the Baby's neck at 21:12 hours (at approximately seven hours of age, day 0) and a likely left arm Erb's palsy noted on day one of age.

Erb's palsy
Erb's Palsy is a type of brachial plexus paralysis, a condition which is mainly due to birth trauma. It can affect one or all of the five primary nerves that supply the movement and feeling to an arm. The paralysis can be partial or complete, the damage to each nerve can range from bruising to tearing. Most babies recover on their own, a few may require specialist intervention. (HSIB maternity team)

Therapeutic cooling was discontinued on day three of age.

The Baby's MRI scan on day four showed,

‘No definite focal parenchymal abnormality is found. No focus of restricted diffusion is seen. There is evidence of myelin within the PLIC bilaterally of appropriate volume for a term neonate. No definite signal abnormality is shown within the basal ganglia and thalami. No cortical signal abnormality is found. Note is made of slender subdural haemorrhage, mainly over the right cerebral convexity posteriorly, with a small amount on the left also, extending over the tentorium and layering posteriorly in the posterior fossa. This is likely birth related. No focal parenchymal haemorrhage is demonstrated. Ventricular size is normal. Conclusion: No definite evidence of hypoxic-ischaemic injury. Slender subdural haemorrhage which is likely birth-related’.

Magnetic resonance imaging (MRI)

MRI is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body. Brain MRI may be performed on a baby suspected of having brain damage due to lack of oxygen, bleeding, structural and other abnormalities. There are no risks of MRI although as babies need to lie still, sedation may be suggested for them. (HSIB maternity team)

Subdural haemorrhage

A subdural haemorrhage is a condition where blood collects between the skull and the surface of the brain. (HSIB maternity team)

A lump noted under the Baby’s right armpit on day four of age and further reviewed on day eight of age was thought to be related to fat necrosis, and required further monitoring at home after the Baby’s discharge from hospital with a repeat blood test to check calcium levels observed to be high on day one of age.

Subcutaneous fat necrosis of the newborn (SCFN)

Subcutaneous fat necrosis of the newborn (SCFN) is an uncommon condition characterised by nodules (lumps) or large hardened areas over the back, buttocks and limbs of babies which appear in the first weeks of life. It is more common in babies that have undergone therapeutic cooling. SCFN may be complicated by high levels of calcium in a baby’s blood. Babies with SCFN may need to have their

blood calcium checked. SCFN usually spontaneously resolves without treatment. (HSIB maternity team)

An x-ray of the Baby's left humerus (upper arm bone) on day five of age revealed the impression of a fractured humerus or a shadow from an overlying vessel (nutrient artery, providing the main blood supply to long bones).

A repeat x-ray on day 22 of age showed the bone alignment to be within normal limits and no new bone growth in response to suspected injury.

Fractured humerus
The humerus is the upper arm bone that runs from a baby's shoulder to their elbow. On rare occasions, during birth, a baby's humerus may fracture (break). (HSIB maternity team)

The Baby's placenta was sent for histology and findings returned within expected ranges. In summary the report concluded, 'there are no… features convincingly suggestive of fetal vascular malperfusion or evidence of decidual arteriopathy in sections examined. There is no chorioamnionitis or evidence of fetal inflammatory response'.

The Baby was discharged home at nine days of age with follow-up care for repeat calcium blood test at 16 days of age (within expected range), physiotherapy, and neonatal / paediatric developmental checks at 3, 12, and 24 months of age.

Section 5. Investigation findings and analysis

5.1 Antenatal care

5.1.1 Growth surveillance

The Mother's body mass index (BMI) and weight gain were within expected ranges during pregnancy. The Mother was risked assessed in line with national guidance to monitor the Baby's growth, and as she had no risk factors the Mother was assigned to symphysis fundal height (SFH) monitoring. SFH measurements were plotted on five occasions after 28 weeks (Fig 1). Three measurements plotted at or above the

90th centile before 37 weeks, and at 37+1 weeks the SFH plotted above the 97th centile. The Baby's birth weight was on the 100th centile for growth.

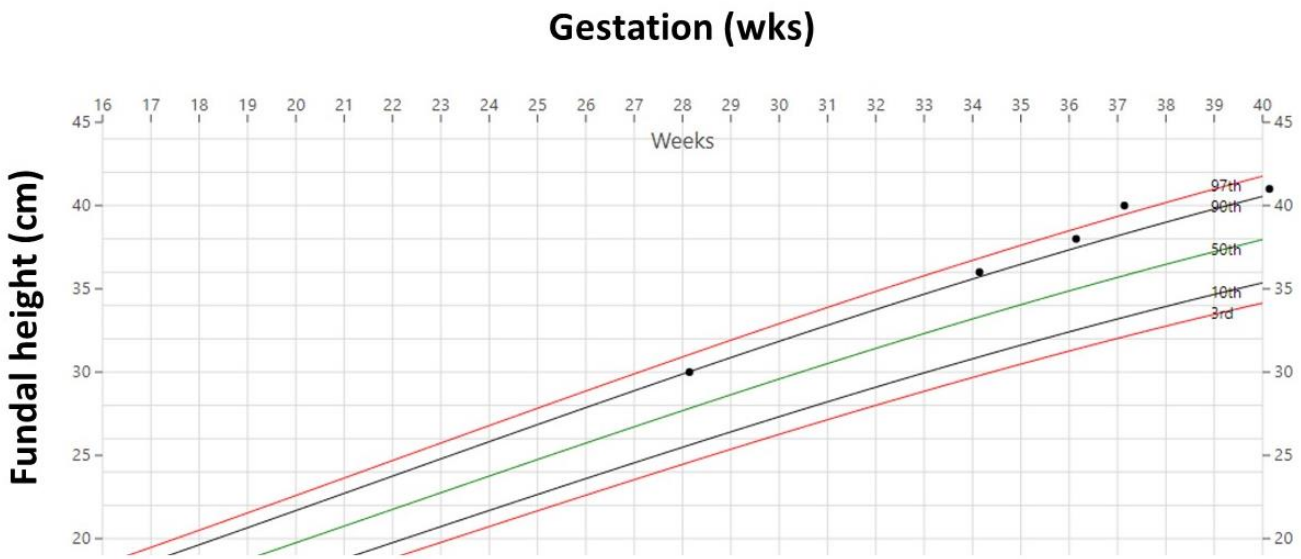


Figure 1: Mother's Intergrowth chart

The Mother and Father recalled that during antenatal appointments the Mother expressed concern for the size of her Baby and was assured by staff that they had no concerns related to the Baby's growth risk. The investigation was informed that staff did not recall parental concerns regarding the size of the Baby. The notes do not record discussions were made.

Staff recalled that they had no concerns for the growth of the Baby using SFH measurements and that, in usual practice, referrals to the ultrasound scanning department for elevated SFH measurements had previously been met with a challenge for need. The Trust does not have guidance on what to do when there are raised SFH measurements. Local guidance does allow for referral to senior obstetric or midwifery review if parental concerns fall outside of guidance. This was not done in this case.

HSIB acknowledges that there is no clear national guidance on when to scan if there is a raised SFH, and all national guidance applies to concerns regarding identification of small babies.

National intrapartum guidance (NICE 2019) (discussed in section 5.2.5) does recommend discussion, explanation, and choice for mode of delivery when babies are suspected to be large for gestational age.

A Cochrane review (Boulvain et al, 2016) classifies large babies as those over 4000 grams. From the evidence that is available, induction of labour (IOL) in these babies at or near term (37-40 weeks), reduces the incidence of shoulder dystocia and associated fractures. The incidence of brachial nerve damage (Erb's palsy), babies with low Apgar scores and low cord blood gases was not reduced. Boulvain et al (2016) recommend that the advantages and disadvantages of IOL should be discussed with parents when a baby is suspected to be large, following an ultrasound assessment of estimated birth weight. They note that estimating the birth weight from ultrasound can be inaccurate. The review suggests further trials are needed, concentrating on the optimum gestation for induction and improving the accuracy of diagnosis of large babies. This is the subject of a large multi-centre trial (Quenby and Gardosi, 2018).

HSIB considers that the absence of any national guidance means that it is not possible to produce a safety recommendation to advise mothers with a suspected large baby. Individual trusts should review their own local guidance in relation to macrosomia using the Cochrane review (induction of labour at or near term for suspected fetal macrosomia). The HSIB national learning report (2021) has highlighted the complexities of managing a pregnancy with a suspected large for gestational age baby. The report makes a recommendation to the RCOG to consider these issues when compiling national guidance that may be applicable to suspected large for gestational age babies.

HSIB considers that there was an opportunity at 37+1 weeks to discuss options and risks for potential modes of delivery and facilitate further informed decisions for the Mother and Father. This may have impacted on the outcome for the Baby.

HSIB Safety recommendation

The Trust to ensure that mothers have the opportunity to discuss options for birth when suspected deviation in the Baby's growth trajectory is recognised or parental concerns are expressed.

5.1.2 Timing of IOL

National induction of labour guidance (NICE 2021) recommends discussing the risks associated with a pregnancy continuing beyond 41+0 weeks with mothers, explaining that some risks (increase likelihood of caesarean section, admission to NICU and stillbirth or neonatal death) may increase with time. They also recommend that induction of labour from 41+0 weeks may reduce these risks, and the impact of induction on their birth experience should also be considered.

There was no indication in the medical records that the Mother was offered, or a discussion was made for IOL at 41 weeks gestation. The Mother went into spontaneous labour at 41+3 weeks. HSIB considers that the Trust review their guidance around timing and discussion of IOL in line with national guidance.

5.2 Intrapartum care

5.2.1 Preparation for birth

The investigation learned that after the Mother's membranes had ruptured with significant meconium present concerns were escalated to staff in the local birth centre office and then the labour ward coordinator with a plan to transfer the Mother to the pool room on labour ward. Staff recalled that there was significant pressure on room capacity on the labour ward at the time of the incident and that the only rooms available were the pool room or the bereavement suite.

The Mother was transferred from the birth centre to the pool room on the floor below within 13 minutes of spontaneous rupture of membranes (SROM), and staff recalled not having enough time to prepare the pool room for the Mother's arrival. The investigation learned that the pool room was relatively small and not often used, and equipment and beds normally present in labour ward rooms were not available. The investigation further learned that the Mother's transfer bed from the birth centre was of a different type to that routinely used on labour ward and required different accessory equipment (lithotomy poles) that were later sourced from the birth centre by the operational coordinator in preparation for a potential assisted vaginal birth.

The limited available space in the pool room also contributed to the decision of senior neonatal staff to conduct the Baby's resuscitation in the corridor outside of the room, discussed in section 5.3.1.

HSIB considers that staff made necessary and timely accommodations to facilitate the Baby's birth given the availability of birth rooms. This did not impact the outcome for the Baby.

5.2.2 Fetal monitoring in labour

The Baby's HR was initially monitored by IA at least every 15 mins in first stage of labour. There were no concerns noted with the Baby's heart rate. The CTG was commenced following meconium, seen at SROM. Decelerations of the Baby's heart rate were heard after the Mother's membranes ruptured, and late prolonged decelerations were heard after the CTG was started again on labour ward. The Mother's CTG was assessed on labour ward using the mnemonic DRCBRaVADO with an overall (O) interpretation of 'pathological'. Local fetal monitoring guidance (2017) recommends the use of NICE guidance for interpretation and categorisation / classification of CTGs. There is no national guidance for the use of the DRCBRaVADO mnemonic to interpret CTGs (antenatal or intrapartum).

HSIB agrees that the categorisation of the Baby's CTG was pathological. HSIB further considers that the use of the DRCBRaVADO mnemonic is not referenced in the local fetal monitoring guidance (2017) as a descriptive tool. HSIB acknowledges that the DRCBRaVADO mnemonic is a widely used, non-evidenced based tool and considers that it does not support clinicians in their categorisation of a CTG. Categorisation is carried out using national guidance.

HSIB considers that the Baby's CTG was correctly assessed as pathological, the emergency was escalated, and timely provision was made to facilitate the Mother's assisted vaginal birth.

5.2.3 Decision and management of assisted vaginal birth

On vaginal assessment at 13:15 hours, staff recalled that the Baby's head was in a transverse position at the ischial spines and a manual rotation of the Baby's head was made towards the occiput anterior (OA) position prior to the ventouse delivery. A decision was made to perform an assisted vaginal birth in the pool room with staff

describing the elements of their rationale as a multiparous mother, who was pushing well and confidence that a vaginal delivery could be achieved. Further transfer to the operating theatre for pain relief was thought to potentially delay the birth. A contingency plan was relayed to the attendant anaesthetist for a ‘quick’ transfer of the Mother to theatre should the delivery not be successful.

Prior to the application of the ventouse, the Baby’s head was described as just below the spines. The assisted vaginal birth, starting with the first pull of the Baby’s head to the delivery of the Baby’s head, took 10 minutes and required three pulls.

National guidance (RCOG 2020) recommends to complete vacuum-assisted birth in the majority of cases ‘with a maximum of three pulls to bring the fetal head on to the perineum. Three additional gentle pulls can be used to ease the head out of the perineum’. Staff recalled that the slow birth of the Baby’s chin alerted them to the likelihood of potential shoulder dystocia and early preparation for that emergency.

HSIB considers that it was reasonable to conduct the Mother’s assisted vaginal birth in the pool room and the ventouse assisted birth was conducted in-line with national guidance. Contingency plans were made should the birth mode have been unsuccessful.

5.3 Shoulder dystocia risk assessment and management

5.3.1 Antenatal risk assessment for shoulder dystocia - previous birth details

The Mother and Father recalled that the Mother’s previous birth, five years previously, was accompanied with manoeuvres that were similar to those used at this birth. Specifically, they recalled the Mother lying flat at delivery, and the use of McRoberts position and ‘all fours’ position to facilitate the baby’s birth.

The Mother’s previous baby’s birth weight was 3,930g at 39+2 weeks (88th birth weight centile). The Mother’s booking summary records note that the previous baby’s birth weight was ‘between the 75th and 91st WHO [World Health Organisation centile] centile’.

The investigation reviewed the Mother’s previous birth notes and found that the Mother’s previous birth on labour ward was facilitated using semi-recumbent and left lateral position with the Mother’s right leg support in a single lithotomy pole. The

Baby's head to body interval was one minute and no emergency manoeuvres were required or shoulder dystocia recognised.

HSIB considers that access to the Mother's previous pregnancy notes show that the Mother did not have a previous shoulder dystocia and further discussion about the Mother's previous birth was not necessary in her current pregnancy.

5.3.2 Antenatal risk assessment for shoulder dystocia - fetal growth

The Mother and Father recalled that during antenatal appointments at later gestations the Mother expressed concern for the size of her Baby and was reassured by staff that they had no concerns related to growth risk. The investigation learned that the Mother and Father were open to all information about the Mother's pregnancy and birth that may have allowed them to make fully informed decisions and felt, in retrospect, that shared decision making was not present.

Staff confirmed that the Mother's risk status remained low and that they had no concerns over the Baby's growth.

National guidance (NICE 2019) states that mothers with a suspected large for gestational age baby should be provided with information about different modes of birth so they are able to make an informed decision. Whilst there is not enough evidence to recommend one method of birth over another, they advise discussing the possible benefits and risks of vaginal birth and caesarean section, including:

'• a higher chance of maternal medical problems such as infection with emergency caesarean section

• a higher chance of shoulder dystocia and brachial plexus injury with vaginal birth

• a higher chance of instrumental birth and perineal trauma with vaginal birth. Explain to the woman and her birth companion(s) what it might mean for her and her baby if such problems did occur.'

National guidance on shoulder dystocia (RCOG 2012) further recommends that mothers with suspected LGA babies are also counselled about the risks of shoulder dystocia. The guidance states that risk assessments for the prediction of shoulder dystocia are not sufficiently predictive to allow prevention of shoulder dystocia in the large majority of cases.

HSIB considers that there was no indication to refer the Mother for ultrasound growth scanning.

HSIB considers that there was an opportunity at 37+1 weeks, when the Baby's SFH measured above the 97th centile, to discuss options and risks for potential modes of delivery and facilitate further informed decisions for the Mother and Father. A clear and open exchange of information between a clinician and a mother is essential to achieving this in the context of shared decision making. This may have impacted on the outcome for the Baby.

HSIB Safety recommendation

The Trust to ensure that mothers have the opportunity to discuss options for birth when suspected deviation in the Baby's growth trajectory is recognised or parental concerns are expressed.

5.3.3 Management of shoulder dystocia

The investigation found that the Baby's shoulder dystocia was recognised after the rest of the Baby's body remained undelivered and pre-alerted by the slow delivery of the Baby's head and chin at 13:45 hours. The investigation found that on recognition of a shoulder dystocia, senior staff were present and further recruited to assist. The emergency was escalated to include an emergency 2222 call which alerted the neonatal team to attend. An anaesthetist was already in attendance.

National shoulder dystocia guidance (RCOG 2012) recommends the systematic sequential use of designated manoeuvres to resolve a baby's shoulder dystocia. McRoberts', suprapubic pressure, episiotomy, internal rotation, delivery of the posterior arm and 'all fours' manoeuvres and positions were used in sequence to deliver the Baby after recognition. A shoulder dystocia proforma was used to document times, staff involvement and manoeuvres, in keeping with national guidance. The investigation found that the training needs analysis for the previous year showed a high level of staff compliance in training for obstetric emergencies.

The Father recalled that his observations of the shoulder dystocia were particularly traumatising. He recalled that members of the team appeared to 'run out of ideas and options' for delivery.

Staff recalled that the persistence of the Baby's posterior arm lying flexed behind the Baby's back and the tight application of the Baby's body to the birth canal made for a particularly challenging resolution of the shoulder dystocia. The head to delivery interval for the Baby's shoulder dystocia was 10 minutes and experienced staff recalled that it was one of the most challenging cases of shoulder dystocia they had managed.

Local shoulder dystocia guidance (2020) recognises that,

'this is a frightening and stressful time both for the mother and her birth partner(s) (who can see more of what is happening). Every effort should be made to allocate someone to provide support to them during the emergency process'.

HSIB considers that the emergency team were called to assist and appropriate manoeuvres were made when the Baby's shoulder dystocia was recognised. Staff rotated their assistance with recognised manoeuvres within their experience and this is considered good practice.

The Baby's venous cord blood gas analyses (taken after birth) were noted to be difficult to obtain, and arterial and venous blood analysis showed parameters that reflected normal oxygenation. Both samples were likely taken from a single (arterial) vessel. HSIB considers that umbilical cord gases may often show normal oxygenation after a shoulder dystocia as the gas exchange has ceased once the head is born due to cord compression, and the blood gases reflect the Baby's condition prior to the birth of the head. HSIB further considers the Baby's condition was due to the difficulty in the delivery as a result of the shoulder dystocia.

Local guidance recommends that,

'debriefing the whole multi-professional team immediately after a shoulder dystocia should be offered. Issues concerning teamwork, communication and how the manoeuvres were documented can all be included. This should be encouraged to improve patient safety, ensure quality improvement, encourage team performance analysis as well as identify any possible communication or equipment deficiencies. This is also a means of reducing staff stress and signposting staff (where appropriate) to support if it's felt to be needed'.

Staff recalled that the incident had had an emotional impact on all of the team involved and psychological support and opportunities to debrief had been offered in-line with local guidance.

HSIB considers that the resolution of the Baby's shoulder dystocia was managed in-line with national guidance, and very likely impacted the Baby's outcome. Thorough documentation of the shoulder dystocia using a proforma was considered good practice.

5.3.4 Erb's palsy

The Baby was noted to have a likely left arm Erb's palsy on day one of age. An x-ray of the Baby's left humerus (upper arm bone) on day five of age revealed the impression of a fractured humerus or a shadow from an overlying vessel (nutrient artery, providing the main blood supply to long bones). A repeat x-ray on day 22 of age showed the bone alignment to be within normal limits and no new bone growth in response to suspected injury.

HSIB acknowledges that upper brachial plexus injury is a recognised complication of shoulder dystocia, and national guidance (RCOG 2012) recognises that there is up to 90% recovery rate within 12 months of injury. Follow-up for the injury was appropriate.

5.4 Neonatal care

5.4.1 Neonatal resuscitation

The investigation learned that the neonatal resuscitation team were well staffed with appropriate expertise. The team was led by a consultant neonatologist who was able to take a wider 'helicopter' view of the resuscitation whilst the experienced team dealt with the technical aspects of resuscitation, scribe and provide support for the Father.

The resuscitation team provided resuscitative drugs in response to the Baby's ongoing physiological needs and directed by the Baby's venous blood results. Neonatal blood was administered to the Baby in response to the Baby's continued pale pallor and concern that potential differential diagnoses.

The Baby's resuscitation was prolonged and the dedicated cylinder of oxygen on the resuscitaire became depleted prior to transfer of the Baby to NICU. This was recognised and a second resuscitaire with oxygen was accessed prior to transfer. HSIB considers this did not impact the outcome for the Baby.

HSIB considers that neonatal team support was requested in a timely manner and technical aspects of the Baby's care were handed over to appropriately experienced members of the team during the Baby's resuscitation. HSIB considers that the Baby's resuscitation met national guidance (Resuscitation Council UK 2022) and resuscitation teamwork met standards recommended in national Each Baby Counts guidance (2017).

HSIB considers the Baby's resuscitation to be exemplary. The application of interventions during the Baby's resuscitation were very timely and an example of good practice.

5.4.2 Therapeutic cooling

The Baby's therapeutic cooling commenced at three hours of age after criteria A, B and C were met.

HSIB considers that the decision to provide therapeutic cooling was reasonable and in line with national guidance.

5.5 Management of debrief

The Mother and Father recalled that they were provided with a debrief by senior obstetric staff on several occasions after the birth of their Baby. Whilst this was welcomed on the first occasion, they perceived that the timing of the counselling on subsequent occasions, whilst their Baby was being cooled, was 'inappropriate and inconsiderate'.

Senior obstetric staff recalled that debriefs and duty of candour conversations to parents were often challenging and were usually made in-line with professional guidance in an attempt to balance the need for early information exchange with consideration of the ongoing stresses and psychological recovery for the parents. They further recalled in discussion with the parents that they relayed HSIB's involvement with the incident and that it was not appropriate to comment on whether

an elective caesarean section should have been recommended to the Mother before labour. This would be considered as part of the review process.

Debriefing and duty of candour conversations are recommended throughout national guidance. In relation to the Mother's birth experiences, national assisted vaginal birth guidance (RCOG 2020) recommends to,

'review women before hospital discharge to discuss the indication for assisted vaginal birth, management of any complications and advice for future births. Best practice is where the woman is reviewed by the obstetrician who performed the procedure'.

Local guidance (2020) recommends that 'following birth where shoulder dystocia has occurred, an explanation should be given to the parents including what happened, reassurance that the baby will receive follow up with a full medical examination and recommendations for any subsequent births. Information regarding birth reflections should be offered to all parents'.

The General Medical Council (GMC) guidance (GMC 2015) on professional duty of candour states that,

'Every health and care professional must be open and honest with patients and people in their care when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that health and care professionals must:

- tell the person (or, where appropriate, their advocate, carer or family) when something has gone wrong
- apologise to the person (or, where appropriate, their advocate, carer or family)
- offer an appropriate remedy or support to put matters right (if possible)
- explain fully to the person (or, where appropriate, their advocate, carer or family) the short- and long-term effects of what has happened'.

HSIB acknowledges that staff have an obligation to perform a duty of candour discussion as soon as possible after birth. HSIB recognises that in a time of heightened anxiety and distress, the perceived level and quality of communication

between clinicians and the mother and father is subjective and difficult to quantify and can also play an important role in the way information is offered and received.

HSIB considers that clinicians should seek, where possible, to balance the need to provide information to keep the family updated with consideration for ongoing stresses that they are experiencing.

5.6 Placenta

The placenta was sent for histological examination (studying cells using a microscope) following the admission of the Baby to the neonatal unit. The Royal College of Pathologists (Evans and Cox, 2019) recommend that 'As a minimum, all placentas from stillbirths, fetal growth restriction (FGR – below 10th centile with abnormal fetal growth curve during pregnancy), immaturity (less than 32+0 completed weeks gestation), and cases of severe fetal distress requiring admission to a neonatal intensive care unit (NICU), maternal pyrexia (>38°C) and late miscarriages (20+0 to 23+6 completed weeks gestation) should be referred' for full pathological examination including histology.

The Baby's placenta was sent for histological examination in line with national guidance and the report was not available for review at the time of writing this report.

5.7 COVID-19

The Mother's care and Baby's birth was during the COVID-19 pandemic period. The investigation did not find evidence of COVID-19 infection and the COVID-19 pandemic did not have an impact on the care / outcome for the Mother or Baby.

Section 6. HSIB findings and safety recommendations

6.1 Findings

1. The Mother's antenatal care was conducted in-line with national guidance.
2. The Mother's symphysis fundal height measurement at 37+1 weeks plotted above the 97th centile and this was an opportunity to discuss mode of birth with the Mother and Father, so that an informed decision could be made. This may have impacted the outcome for the Baby.
3. The Mother was not offered induction of labour at 41 weeks and this meant she was not fully informed and could not adequately assess her risks or mode of delivery options.
4. The Mother was transferred from the birth centre to the labour ward after concerns with the Baby's heart rate and significant meconium were recognised. The transfer was timely and appropriate and did not impact on the outcome for the Baby.
5. An assisted vaginal birth using ventouse was conducted in line with national guidance.
6. A shoulder dystocia was recognised, and appropriate staff support summoned, and manoeuvres made to resolve the emergency. The Baby's shoulder dystocia lasted for 10 minutes and likely impacted on the outcome for the Baby, including the Baby's Erb's palsy.
7. The Baby's small subdural haemorrhage recognised on MRI was likely to be birth-related.
8. The Baby's resuscitation was conducted in an exemplary way with resuscitative interventions made in a timely manner by an experienced team led by senior neonatal support. This likely impacted on the outcome for the Baby.
9. The Baby's therapeutic cooling was commenced at three hours of age, in line with national guidance and was considered good practice. The area of fat necrosis noticed after cooling is a recognised risk factor.
10. The COVID-19 pandemic did not have an impact on the care or outcome for the Baby.

6.2 Safety recommendations

It is recommended that:

1. The Trust to ensure that mothers have the opportunity to discuss options for birth when suspected deviation in the Baby's growth trajectory is recognised or parental concerns are expressed.

Appendices

Appendix 1: Evidence log

Appendix 2: Reference list

Appendix 1. Evidence log

Clinical records

- Previous pregnancy and birth notes
- Antenatal notes
- Intrapartum notes
- Neonatal notes
- Neonatal MRI
- Acuity data
- TNA data

Trust guidelines

- Ultrasound guidance
- Assisted vaginal birth
- Fetal monitoring in labour
- Shoulder dystocia

National guidelines

- General Medical Council and Nursing and Midwifery Council 2015
- NICE 2019
- NICE 2021
- RCOG 2012
- RCOG 2020

Investigation evidence

- Family interview
- Staff interviews
- Clinical specialist review panels

Appendix 2. Reference list

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Appendix 5b

July & August 2023 Incident Overview of Moderate, Serious and HSIB cases

New Cases

Case type	Incident form	HSIB/PMRT	Log date	Incident trigger	Summary of incident	Outcome
HSIB SIRI	9914366	MI 031668	17/08/2023	HIE	Baby born 15/11/2021 at 39/40. Admitted to MDAU with reduced fetal movements and early labour signs. Required ventilation breaths following delivery Apgars 6 & 9 transferred to postnatal ward. Baby observed experiencing dusky episodes on postnatal ward and following review was admitted to NNU. Cranial USS and MRI scan performed and some changes noted. Scoping meeting held. Baby did not meet criteria for cooling at the time or referral to HSIB.	Baby discharged home at 9 days of age. Developmental delay noted at 18 month follow up appointment and attributed to HIE which prompted subsequent re-review of care. Referred for HSIB investigation in retrospect. Parental consent gained and awaiting confirmation of triage with HSIB at their clinical advisory panel w/c 19/9/23.

PMRT	9954400	88538	21/07/2023	Neonatal Death	32/40 week baby born on 8/7/2023 at QAH. PROM at 29+5/40. Transferred to UHS NICU at 11 days old on 19/07/2023 due to suspected sepsis, increased requirement for respiratory support and deteriorating clinical picture.	Baby RIP at 13 days of age. Cause of death - Disseminated enterovirus myocarditis. Referred to coroner and completion of responses to parental questions currently being finalised. Bereavement care and support ongoing.

Closed cases

No cases for July and August

Moderate & Above Incidents

Incident date / number	Type of incident	Summary of incident	Outcome of incident	Key learning and recommendations
24/07/2023 9954560	Moderate incident	UVC extravasation of baby on NNU for 7 days which led to a large collection of fluid in the liver. The UVC was aspirated, removed and long line sited. Extravasation is a known risk and was detected in this case following deterioration in clinical condition. Review of the case notes revealed signs of extravasation 2 days previously which could have prompted review sooner.	Reviewed at NNU risk meeting.	Missed opportunity to detect extravasation prompting action sooner. Learning points as follows: 1) Ensure all lines and manufacture codes are documented when put in. 2) Ensure that if lines are re secured and sutured that position of lines is reviewed,

				documented and followed through. 3) Ensure all lines are checked on x-ray, even where an x-ray has been undertaken for other reasons.
24/07/2023 9954569	Moderate incident	NNU OPEL 3 Alert. 5 episodes of NNU escalation to OPEL 3 over 5 days. Concern about the lack of QIS staff (qualified in speciality – Intensive Care) and the ongoing pressure on the NNU service.	Item is on Risk register	Capacity, acuity and deficit in QIS staff all contributed to this sustained period of intense workload. Ongoing workstream to review recruitment and retention of staff. NNU expansion plans in progress.
24/08/2023 9957634	Moderate incident	Information governance breach. Two patients with same name, both first and surnames identical. Patient A arrived for a scan and vaccination appointment where it was noted that her NHS number was incorrect. On investigation, staff recognised the error and discovered patient A's pregnancy had been logged under patient B. Patient B's demographics were updated to reflect patient A.	Patient notes rectified and updated appropriately	Review in progress.

MatNeo – ATAIN Deep Dive

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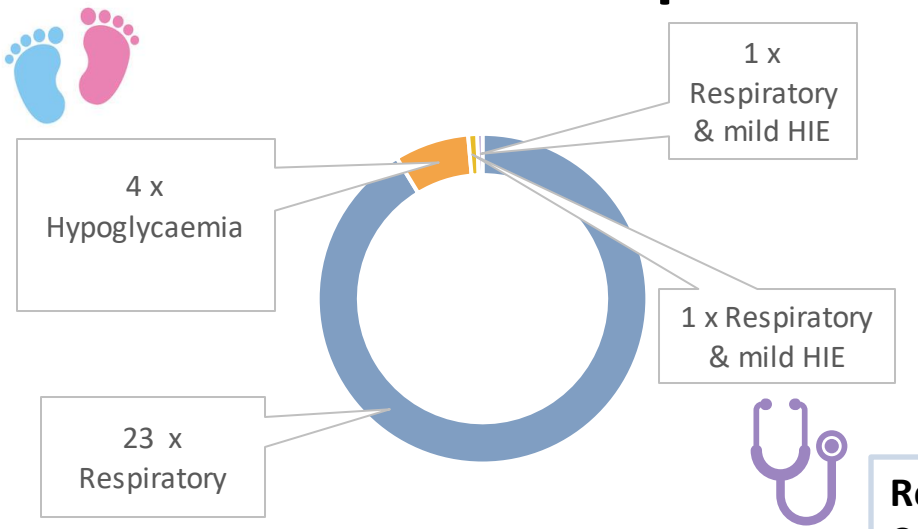
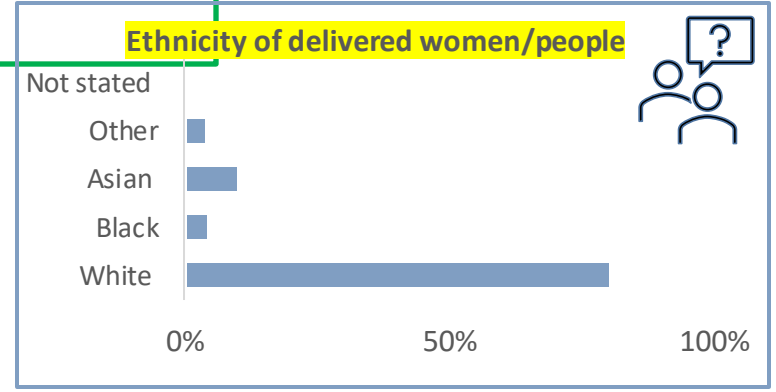
Appendix 6

Qtr. 1 2023 included 29 babies



Thematic learning from Qtr. 1

- Majority of respiratory cases unavoidable
- Higher numbers out of hours : decision making
- Avoidable numbers : 6
- Out hours admission, elective CS <39 weeks, scope for further review and respiratory support beyond 'think 60'



Respiratory – 23 cases reviewed

Of the 23 cases reviewed no single theme was identified and the overall care grading categorized as satisfactory or good. 12 of the cases were recorded as well managed, 4 minor sub optimal, 6 incidental and 1 ungraded case. No single theme identified but some issues noted as escalation, identification of deterioration, staffing, acuity, communication and equipment issues.

Respiratory & Mild HIE –1 case reviewed

On review of the case no theme identified and care grading categorized as 'satisfactory', with no issues identified and no theme.

Respiratory & Hypoglycaemia –1 case reviewed

On review of the case no theme identified and care grading categorized as 'incidental sub-optimal'.

Current and Ongoing Quality Improvements

- Management of hypoglycaemia processes and pathways
- Management of thermoregulation processes and pathways
- Implementation of Infant Feeding Initiative
- Think 60 mins: Peep in delivery room

Hypoglycaemia – 3 of 4 cases reviewed (1 x exclusion)

Of the 3 cases reviewed no single theme identified and care grading categorized as 'incidental sub-optimal'.
Incidental issues identified included CTG interpretation and Ultrasound management.

New 2023 Quality Improvements

- Management of jaundice increasing use of bilirubinometers
- Implementation of NEWTT/NEWS – Up coming regional implementation in 2023/4
- Pilot project: Inreach Nurse to support Think 60/ ATAIN (Ockenden Funding)

University Hospital Southampton NHS Foundation Trust

Appendix 7

Report to the Trust Board				
Title:	**Midwifery Workforce Report**			
Agenda item:	**5.8**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Emma Northover, Director of Midwifery and Professional Lead for Neonatal Services** **Carly Springate, Head of Midwifery**			
Date:	**28 September 2023**			
Purpose:	**Assurance or reassurance** **x**	**Approval**	**Ratification**	**Information** **x**
Issue to be addressed:	This report is being presented to the members of the Trust Board to provide information relating to the Maternity workforce as part of the requirements for NHS Resolutions (NHSR) Safety Action 5. These requirements can be seen in italics within the report. In addition, the report provides an overview of future workforce planning and actions to mitigate our current challenges.			
Response to the issue:	**1.** ***A clear breakdown of BirthRate Plus (BR+) or equivalent calculations to demonstrate how the required establishment has been calculated*** In line with national drivers for assurance in relation to safe staffing levels within maternity services, UHS Maternity Services currently utilise BirthRate Plus (BR+) as a system and framework for workforce planning and strategic decision making. The last assessment of UHS Maternity Services by BR+ in 2018 suggested an overall clinical establishment based on a midwife V birth ratio of 1:24, calculated against an annual birth rate of 5500 births. At the time, the required total establishment as calculated by BR+ to ensure safe staffing levels equated to **226.55** WTE which was inclusive of support staff contribution. **2.** ***In line with Midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations*** Over the last 3 years, UHS Maternity Services have at times been working with midwife V birth ratios that are more suggestive of 1:26. Indeed, this has felt uncomfortable but with contingency frameworks in place (on-call midwives and the authorised use of temporary staffing against vacancy levels) the service has remained manageable and safe.			

With a vacancy rate of 20 WTE currently for registered staff and a projected vacancy rate of **24** WTE by November 2023, we are presently operating with a midwife V birth ratio of 1:28. This situation is further compounded by short-term sickness, maternity leave and an increased demand for education and training in maternity and as such the workforce are significantly overstretched.

Whilst the annual birth rate at UHS has seemingly stabilised over the last 3 years at around 5200 births, the complexity of cases is vastly increasing. In July 2023, 91% of women / birthing people delivered on our labour ward. This is the first time the rate of births on labour ward has exceeded 90%. Proportionally, 38% of women achieved a normal birth which is considerably lower than our usual rates.

3. ***Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls***

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

The monthly dashboard not only records an accurate position for midwifery staffing at the current time but also offers a projected forecast for staff unavailability in the months going forward. This ensures and supports an ongoing process for rolling recruitment, involving both qualified and unqualified staff groups.

The recording of monthly maternity dashboard data dictates that effective measures are continued to be taken in ensuring an accurate account of midwifery staffing at any one time. This will enable vacancies and gaps within the workforce to be accounted for and managed accordingly.

Whilst we observe a rolling recruitment process within UHS Maternity Services, over the summer months we very successful recruited 20 newly qualified midwives. We look forward to welcoming this cohort of midwives into the service from November 2023. This will see our vacancy rate reduce to 9.2 WTE for registered staff.

4. *Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing*

When considering clinical staff contribution, BR+ identify several budgeted leadership / specialist roles that should be excluded from total calculations. The recommendation from BR+ is that this "non-clinical establishment" should equate to **22.66** WTE. Current UHS workforce calculations for this cohort of staff sit in line with these recommendations with a full establishment of **22.66** WTE. Whilst these members of the team are otherwise exclusive from contributing clinically, they absolutely sit as part of the contingency framework for additional staffing during periods of escalation. If activated, the expectation would see these individuals supporting all areas across the service within a clinical capacity.

For 2022/23, the total number of funded clinical midwives for UHS Maternity Services is **207** WTE. At UHS however, the caseload model (NEST team) provides intrapartum care within PAH, as well as antenatal and postnatal care in the community, to vulnerable women as part of their model of care. It is recognised that the workload from women with significant safeguarding needs requires higher than average midwife hours within this care package and therefore any forward workforce planning should consider this additional midwife time.

5. Maternity Workforce Development – Next Steps/Way Forward

Over the next few months, a series of listening events, involving the Director of Midwifery and members of the Senior Midwifery Leadership Team, are scheduled to take place with a view to reviewing and potentially restructuring the Maternity Service workforce to align with current service needs. Staff wellbeing will be a central focus within this piece of work, with drivers around retention needs and flexibility around different ways of working being a direct focus.

In terms of strategic workforce planning, there is currently a significant focus around the issue of supply and demand for maternity staff, particularly registered midwives. UHS Maternity Services currently host the regional midwifery lead for workforce development who has been incremental in establishing a collaborative working group across the LMNS and has made an impressive start into exploring and implementing a variety of recruitment pipeline opportunities.

Some of these options for workforce development see alternative training pathways for health care workers who previously may not have benefitted from such openings and include shortened midwifery conversion courses for registered nurses, return to practice midwifery courses, midwifery apprenticeship models and foundation programmes for aspiring maternity support workers.

	It is anticipated that by broadening the gateway into careers within maternity services, whilst allowing training and education to be both accessible and affordable, a wider audience of prospective candidates will be achieved. In these current times where maternity workforce tensions are so prominent, we recognise that succession planning is of prime importance, and therefore are busy creating new opportunities for staff upskilling and professional development. UHS Maternity Services are committed to investing in their people and as such have dedicated programmes for career development starting at Band 2 and progressing to Band 9. Our prime focus is to consider new ways in which we can future proof our maternity services going forward.

Labour Ward Acuity v Staffing 2023/2024 Q1

University Hospital Southampton NHS
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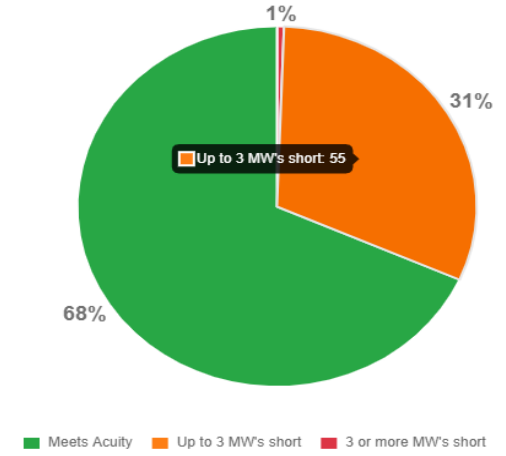
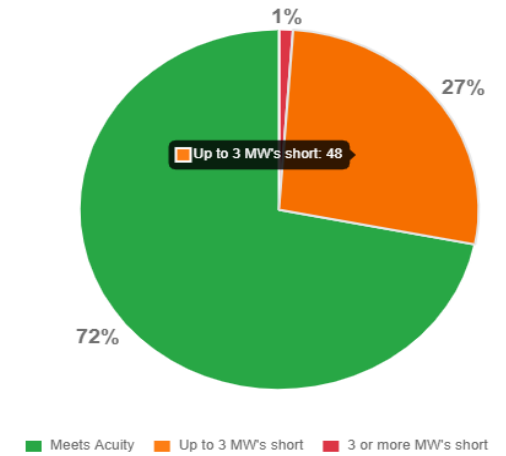
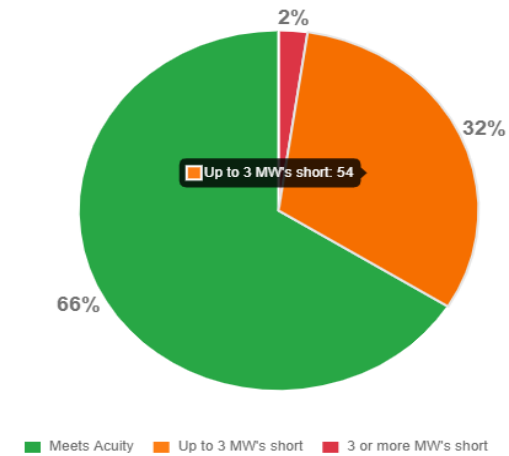
Acuity by RAG status (Percentage) for April 2023



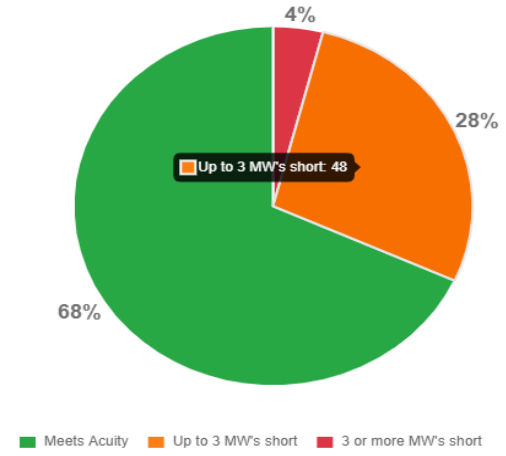
Acuity by RAG status (Percentage) for May 2023



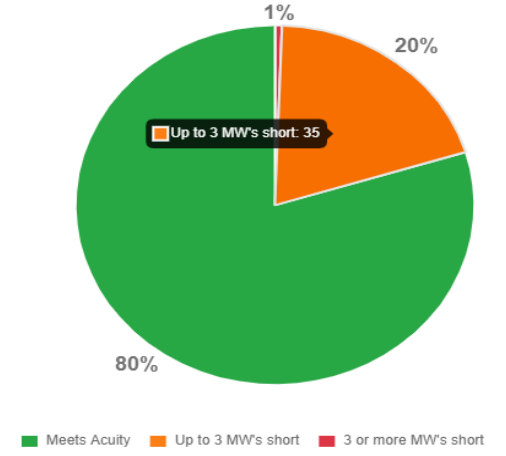
Acuity by RAG status (Percentage) for June 2023



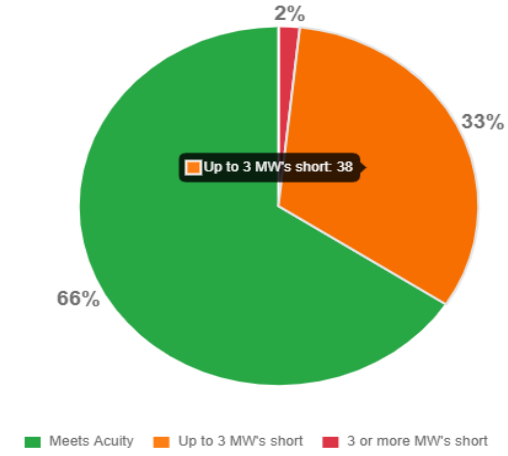
Acuity by RAG status (Percentage) for July 2023



Acuity by RAG status (Percentage) for August 2023



Acuity by RAG status (Percentage) for September 2023



Appendix 7b

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UHS Maternity Services 2023 - 2024 Q1

Maternity Services OPEL Status April 2023			
April	EARLY	LATE	NIGHT
1		2	2
2	2	1	2
3	2	2	1
4	1	1	1
5	1	1	1
6	1	1	1
7	1	1	1
8	1	1	1
9	2	2	1
10	1	1	1
11	1	1	1
12	1	1	1
13	1	2	2
14	3	3	3
15	3	2	2
16	2	2	2
17	1	1	3
18	2	3	2
19	2	2	1
20	2	3	2
21	2	3	3
22	3	2	1
23	1	1	1
24	1	1	1
25	2	2	2
26	1	1	2
27	1	1	3
28	3	3	3
29	1	1	3
30	3	3	1

No diverted patients
2x patients transferred due to maternity or neonatal staffing and capacity

Maternity Services OPEL Status May 2023			
May	EARLY	LATE	NIGHT
1	2	2	1
2	3	2	2
3	2	3	2
4	2	3	1
5	2	2	3
6	3	3	3
7	2	2	2
8	1	1	1
9	1	3	2
10	2	2	2
11	2	3	4
12	4	3	3
13	3	2	2
14	3	3	3
15	2	3	2
16	3	3	3
17	2	2	2
18	1	1	1
19	2	2	2
20	2	2	2
21	1	1	1
22	1	1	1
23	2	3	3
24	3	3	3
25	3	3	3
26	3	3	3
27	3	3	1
28	2	2	2
29	1	1	1
30	1	1	1
31	3	3	3

No diverted patients
6x patients transferred due to maternity or neonatal staffing and capacity

Maternity Services opel Status June 2023			
June	EARLY	LATE	NIGHT
1	3	3	3
2	3	3	3
3	3	3	3
4	2	3	3
5	4		4
6	3	2	2
7	2	2	2
8	2	2	2
9	3	2	2
10	2	2	2
11	1	1	1
12	1	1	2
13	1	1	1
14	2	2	3
15	2	2	2
16	2	2	2
17	1	2	2
18	2	2	2
19	3	4	3
20	2	2	2
21	2	2	2
22	2	2	2
23	3	3	3
24	4	3	3
25	3	3	4
26	1	1	3
27	2	2	2
28	2	2	2
29	2	2	3
30	2	2	2
31	1	3	3

No Diverted patients
17x patients transferred due to maternity or neonatal staffing and capacity

Appendix 7c

University Hospital Southampton NHS
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UHS Maternity Services 2023 - 2024 Q2

JULY	EARLY	LATE	NIGHT
1	2	2	2
2	1	3	3
3	2	2	2
4	2	2	1
5	2	2	2
6	1	1	1
7	2	2	3
8	2	2	2
9	2	2	3
10	3	3	3
11	3	3	1
12	1	1	1
13	1	1	1
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17	3	1	2
18	2	2	2
19	3	3	3
20	2	2	2
21	2	3	4
22	4	3	3
23	3	3	3
24	2	1	1
25	3	3	4
26	3	4	4
27	3	3	4
28	3	3	4
29		4	3
30	3	3	3

No patients diverted in labour to other Maternity units
8x patients transferred due to maternity or neonatal staffing and capacity

AUGUST	EARLY	LATE	NIGHT
1	3	4	3
2	3	3	3
3	2	2	2
4	3	3	2
5	2	2	2
6	1	1	1
7	1	1	1
8	1	1	1
9	2	2	1
10	1	1	1
11	2	2	2
12	3	3	3
13	3	3	3
14	3	3	3
15		3	3
16	3	3	3
17	3	3	3
18	1	1	1
19	1	1	1
20	1	1	1
21	1	1	1
22	1	1	1
23	2	3	2
24	2	2	1
25	1	2	2
26	3	2	2
27	2	2	2
28	2	2	2
29	2	2	3
30	2	2	2
31	2	2	2

No diverted patients
3x patients transferred due to maternity or neonatal staffing and capacity

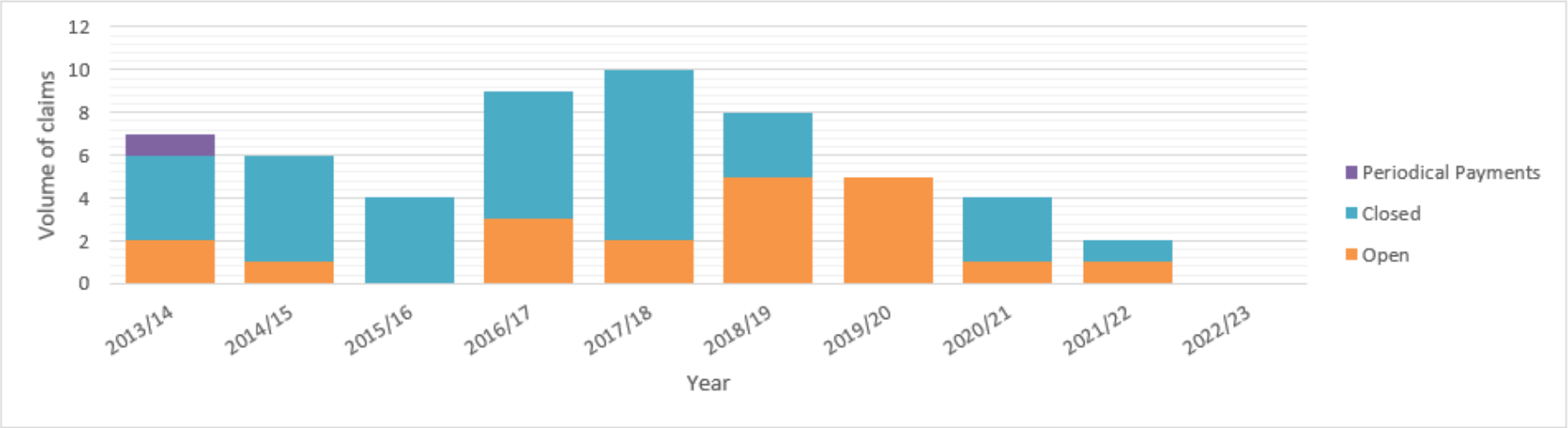
SEPTEMBER	EARLY	LATE	NIGHT
1	2	3	3
2	3	3	3
3	2	3	3
4	3	4	3
5	3	2	2
6	1	1	1
7	1	2	3
8	3	3	2
9	3	3	4
10	3	2	2
11	3	3	3
12	3	3	3
13	3	3	2
14	2	3	3
15	3	3	3
16	3	3	1
17	1	1	1
18	2	3	4
19	3	3	3
20	2	2	2
21	2	2	
22			
23			
24			
25			
26			
27			
28			
29			
30			
31			

3x patients in labour diverted to other maternity units
1x patients transferred due to maternity or neonatal staffing and capacity

Appendix 8 – Maternity Claims Score Card

% of Trust Clinical Claims - Volume
Obstetrics accounts for 10% of claims
% of Trust Clinical Claims - Value
Obstetrics accounts for 44% of the value of claims

Volume of claims by year



Current status for obstetric claims

Top 5 injuries by volume for Obstetrics

					% of Specialty	
	Injury	Volume	Value	Ave Claim Value	Volume	Value
1	Brain Damage	9	60,796,722	6,755,191	16%	39%
2	Fatality	7	2,241,662	320,237	12%	1%
3	Psychiatric/Psychological Dmge	6	341,187	56,864	11%	0%
4	Adtnl/unnecessary Operation(s)	5	213,550	42,710	9%	0%
5	Cerebral Palsy	5	61,806,232	12,361,246	9%	40%
Total Top 5 injuries by Volume for Obstetrics		**32**	**125,399,352**	**3,918,730**	**56%**	**80%**

Top 5 causes by volume for Obstetrics

					% of Specialty	
	Causes	Volume	Value	Ave Claim Value	Volume	Value
1	Failure/Delay Diagnosis	9	32,770,314	3,641,146	16%	21%
2	Fail / Delay Treatment	9	29,504,691	3,278,299	16%	19%
3	Fail To Monitor 2nd Stg Labour	7	28,555,681	4,079,383	12%	18%
4	Inappropriate Treatment	6	438,150	73,025	11%	0%
5	Fail To Make Resp To Abnrm FHR	4	33,601,664	8,400,416	7%	22%
Total Top 5 causes by Volume for Obstetrics		**35**	**124,870,500**	**3,567,729**	**61%**	**80%**

Top 5 injuries by value for Obstetrics

					% of Specialty	
	Injury	Volume	Value	Ave Claim Value	Volume	Value
1	Cerebral Palsy	5	61,806,232	12,361,246	9%	40%
2	Brain Damage	9	60,796,722	6,755,191	16%	39%
3	Hypoxia	2	14,140,351	7,070,176	4%	9%
4	Developmental Delay	1	14,130,000	14,130,000	2%	9%
5	Fatality	7	2,241,662	320,237	12%	1%
Total Top 5 injuries by Volume for Obstetrics		**24**	**153,114,967**	**6,379,790**	**42%**	**98%**

Top 5 causes by value for Obstetrics

					% of Specialty	
	Causes	Volume	Value	Ave Claim Value	Volume	Value
1	Fail To Make Resp To Abnrm FHR	4	33,601,664	8,400,416	7%	22%
2	Failure/Delay Diagnosis	9	32,770,314	3,641,146	16%	21%
3	Fail / Delay Treatment	9	29,504,691	3,278,299	16%	19%
4	Fail To Monitor 2nd Stg Labour	7	28,555,681	4,079,383	12%	18%
5	Birth Defects	2	14,151,262	7,075,631	4%	9%
Total Top 5 causes by Volume for Obstetrics		**31**	**138,583,612**	**4,470,439**	**54%**	**89%**

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Events at the Neonatal Unit in Countess of Chester NHSFT**			
Agenda item:	**5.9**			
Sponsors:	**Gail Byrne, Chief Nursing Officer** **Paul Grundy, Chief Medical Officer**			
Author:	**Adam Pitt (Associate Director of HR), Sarah Herbert (Deputy CNO), Christine Mbabazi (FTSU Guardian)**			
Date:	**28 September 2023**			
Purpose:	**Assurance or reassurance** **X**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	• Verdict in the trial of Lucy Letby. • NHS England's letter to all ICBs, NHS Trusts, and primary care networks requesting assurance of proper implementation and oversight of governance arrangements. • Strengthening of patient safety and Freedom to Speak Up arrangements.			
Response to the issue:	• Continue the roll out of the Patient Safety Incident Response Framework (PSIRF) to focus on effective learning and improvement, compassionate engagement and embedding of a patient safety culture. • Continue to embed the Freedom to Speak Up agenda and increase the number of FTSU Champions throughout the organisation. • Triangulate patient outcomes, patient safety incidents, FTSU & HR metrics, and staff survey data to identify any areas of concern.			
Implications: (Clinical, Organisational, Governance, Legal?)	• Clinical: Ensuring staff feel supported to raise concerns they have about patient safety and clinical practice. • Governance: Ensuring the Trust has robust governance process in place to identity patient safety concerns and remedy them. • Organisational: Ensuring that the Trust patient safety/HR/FTSU processes align with NHS England's expectations.			
Risks: (Top 3) of carrying out the change / or not:	• Patient Safety: Risk to patients if reporting mechanisms do not identify where there are areas of concern in the Trust. • Legal: Potential litigation relating to patients who have come to harm. • Reputational: Adverse impact on reputational risk if patient safety and FTSU mechanisms are not seen to be acted on appropriately.			
Summary: Conclusion and/or recommendation	It is requested that Trust Board: • Note and support the creation of an annual report that triangulates patient outcomes, clinical incidents, staff survey, FTSU, and HR data. • Note the existing patient safety and FTSU arrangements that are in place now and are in the process of being implemented. • Note and support the role out of the Patient Safety Incident Response Framework (PSIRF) • Note the recommendation that further consideration and analysis is given to the culture of medicines security in UHS.			

1. Executive Summary

1.1. Lucy Letby was convicted of murdering seven babies and attempting to kill six others at the neonatal unit at the Countess of Chester NHSFT between 2015 and 2016. She was sentenced to imprisonment for life. A statutory inquiry is due to commence.

1.2. Trust leaders were asked to attend a meeting held by NHS England to reflect on the issues arising from the Countess of Chester NHSFT. The key themes of culture, leadership & management, and patient safety were discussed on the day.

1.3. A Trust Board Study Session was held on the 12th September 2023 to reflect on the issues arising from the Countess of Chester and consider UHS's patient safety and FTSU arrangements.

1.4. The Trust has reviewed the governance requirements set out by NHS England and have provided evidence of compliance (see below), however continues to take measures to review and strengthen patient safety and FTSU arrangements.

2. Verdict in the trial of Lucy Letby

2.1. Following the verdict, the government announced a statutory inquiry[1] into the events at the Countess of Chester hospital, which will investigate the wider circumstances around what happened at the Trust, including what actions were taken by regulators and the wider NHS. The terms of reference for the inquiry will be published in due course and a suitable chair appointed.

2.2. NHS England sent a letter dated 18th August 2023 to all ICBs, NHS Trusts, and primary care networks[2] expressing shock and that the actions were beyond belief for staff working so hard across the NHS to save lives and care for patients and families. The letter also noted the steps NHS England are taking to strengthen patient safety monitoring:

- The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.
- Updated Fit and Proper Person Framework – additional background checks, including a board member reference template.
- This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.
- Revised FTSU policy was updated and expected to be in place at all NHS Trust by Jan 2024 (already in place at UHS)
- Asked ICBs to consider how all NHS organisations have accessible and effective speaking up arrangements.
- Request for NHS leaders and Board to ensure proper oversight of patient safety / FTSU processes.

2.3. It has also been widely reported that there is consideration of formal regulation for senior leaders and managers in the NHS.

2.4. The NHS England letter also stressed the importance of good governance, and that NHS leaders and Boards must urgently ensure the below:

NHS England Requirements	UHS Response

[1] Press release – Legal powers given to Lucy Letby inquiry 30/08/23: https://www.gov.uk/government/news/legal-powers-given-to-lucy-letby-inquiry
[2] Verdict in the trial of Lucy Letby – NHS England 18/08/2023: https://www.england.nhs.uk/long-read/verdict-in-the-trial-of-lucy-letby/

1. All staff have easy access to information on how to speak up.	All staff are provided with FTSU information on the corporate induction. There is also a dedicated FTSU staffnet page with information on the type of concerns that should be raised and to whom. FTSU posters are distributed throughout UHS noticeboards, staff rooms, and communal areas. There is a dedicated phone number and e-mail address for raising concerns: 07818 521753 / RaisingConcern@uhs.nhs.uk
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.	The HR and FTSU teams are aware of the Speaking Up Support Scheme and how to make a referral.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.	UHS has a FTSU Guardian and 52 * FTSU Champions who are from various staff groups and levels of seniority. During FTSU Month in October, the aim is to increase the number of FTSU Champions we have to ensure that staff from all backgrounds feel supported to speak up if they have any concerns at work. This includes recognising potential barriers of speaking up for those from an ethnic minority background.
4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.	A FTSU report is taken to Trust Board on a bi-annual basis. This includes detailed information of the number of FTSU concerns that have been raised and any themes behind the data. The FTSU Guardian meets with the Trust's CEO and FTSU NED on a regular basis to discuss cases. The National Guardian's Office self-assessment tool was completed in May 2023. This will be repeated every 2 years.
5. Boards are regularly reporting, reviewing and acting upon available data.	Clinical effectiveness, quality indicators and spotlight reviews are reviewed and analysed by the Quality Committee and concerns escalated to Trust Board.

3. Patient Safety Mechanisms at UHS

3.1. As noted by NHS England's letter, the new Patient Safety Incident Response Framework (PSIRF) will be implemented across the NHS this autumn. At UHS, PSIRF will replace the current Serious Incident Framework (2015) with effect from October 2023.

3.2. PSIRF sets out a new direction for how the NHS responds to patient safety incidents, focusing on effective learning and improvement, compassionate engagement and embedding a patient safety culture. The four key aims of PSIRF are:

1. Compassionate engagement and involvement of those affected by patient safety incidents.
2. Application of a range of system-based approaches to learning from patient safety incidents.
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement.

3.3. The PSIRF implementation plan and policy has been approved by the Trust's Quality Governance Steering Group and Quality Committee and is due to be submitted to Trust Board for approval on the 28/09/2023.

3.4. In addition, the Trust has established governance mechanisms to review adverse clinical incidents, near missus, and deaths via the following mechanisms:

- Morbidity and Mortality Meetings (M&Ms)
- Independent Medical Examiners Group (IMEG)
- Adverse Event Reporting process
- Learning from deaths report - TMRG
- Call 4 Concern
- Divisional Governance and Quality Governance Steering Group

3.5. The discussion at the Trust Board study session identified the need for improved triangulation of data relating to patient outcomes, clinical incidents, staff survey, FTSU, and HR cases to establish any themes or areas of concern. It is proposed that an annual report is submitted to Trust Board to do this.

Safe and Secure Handling of Medicines

3.6. One aspect to consider as part of the Letby case relates to the organisational culture regarding the secure storage of medicines and, as a result, the availability and traceability of medicines that can be used to cause harm.

3.7. In cases where healthcare professionals are misusing or misappropriating medicines, there are limitations regarding the additional controls that can be put in place due to their legitimate access for patient care. Nevertheless, there are examples where lapsed medicines governance processes have been a key focus of the case (e.g. Gosport), and there have been missed opportunities to intervene, resulting in significant reputational damage for those organisations. Furthermore, this has been a longstanding area of focus for CQC inspections, and as such it is reasonable to conclude it will feature with greater scrutiny in future inspections.

3.8. A culture within which a high standard of medicines governance is normalised and expected will provide the necessary regulator assurance. It may also be a catalyst to identifying individuals such as Letby where either local vigilance or central data capture provides evidence of nefarious intent.

3.9. It is recommended that further consideration and analysis is given to the culture of medicines security in UHS. The UHS Pharmacy team has been reviewing and considering this aspect of the case and will make recommendations in the annual medicines management plan due to be tabled at Trust Board in the next two months.

4. Freedom to Speak Up at UHS

4.1. The National Guardian's Office and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis's report "The Freedom to Speak Up" (2015). These recommendations were made as Sir Robert found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result.

4.2. The Trust's Freedom to Speak Up Guardian (Christine Mbabazi) was appointed in 2017. Since then, the Trust has implemented the national NHS England FTSU policy and has established a quarterly Raising Concerns Steering Group to provide governance and assurance on cases raised through the FTSU process. This group also considers any case reviews that are published nationally, which has included reviews at e.g. Southport and Ormskirk NHS Trust, Royal Cornwall NHS Trust, and NHS Ambulance Trusts in England, to ensure that any recommendations and lessons learnt are considered for local implementation. The HR team also have a monthly ER Performance Board that acts as a governance and assurance process, which the FTSU Guardian and Trust's Staff-side Chair attend.

4.3. The Trust has also commissioned an external learning review of ER and FTSU processes to seek assurance on the effectiveness and identify any learning to improve them.

4.4. In addition to the FTSU Guardian role, the Trust has 52 FTSU Champions who across the clinical divisions and THQ departments. The network of FTSU Champions aims to promote open, honest, and patient/staff focused cultures across the organisation and support staff who wish to speak up about something they are worried about. The FTSU Champions are from various staff groups and levels of seniority.

4.5. In October 2023, the Trust will be taking part in 'Freedom to Speak Up Month' and will be holding listening events across the divisions with the aim of providing a forum for staff to raise any concerns they have or suggestions about improving staff experience. We will also be recruiting for more FTSU Champions to increase these roles in areas that do not currently have one in place.

4.6. In the staff survey results for 2022, for the two questions relating to staff feeling secure about raising unsafe clinical practice and confidence in the organisation addressing those concerns, UHS scored in the top 20 Acute and Acute Community NHS Trusts:

- **Q19A: I would feel secure raising concerns about unsafe clinical practice.** 75% Strongly Agree / Agree (18th/124 Acute / Acute Community)
- **Q19B: I am confident that my organisation would address my concern.** 61% Strongly Agree / Agree (19th/124 Acute / Acute Community)

4.7. The Trust's FTSU Guardian will be targeting areas with low positive responses to these questions for FTSU Champion recruitment and to also engage with the management teams to consider what measures can be implemented to give staff more confidence in raising concerns about unsafe clinical practice and being assured that the Trust would address those concerns.

5. Next Steps / Recommendations

It is requested that Trust Board:

- Note and support the creation of an annual report that triangulates patient outcomes, clinical incidents, staff survey, FTSU, and HR data.
- Note the existing patient safety and FTSU arrangements that are in place now and are in the process of being implemented.
- Note and support the role out of the Patient Safety Incident Response Framework (PSIRF)
- Note the recommendation that further consideration and analysis is given to the culture of medicines security in UHS.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Safeguarding Annual Report 2022-23**			
Agenda item:	**5.10**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Karen McGarthy, Named Nurse Safeguarding Children** **Corinne Miller Named Nurse Safeguarding Adults**			
Date:	**28 September 2023**			
Purpose:	**Assurance or reassurance** **X**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	The safeguarding annual report summarises the key achievements and activity for 2022/2023 and highlights key areas of work for 2022/2023 for adult, child, and maternity safeguarding within UHSFT. This includes the Paediatric Liaison Nursing Service, the LD and Autism Liaison Service and the MCA/DoLS Service. This year has seen an increase in activity across all services, excepting children's safeguarding, although complexity has remained a feature across all services. The newly formed MCA/DoLS Service was established in June 2022 and since this time there has been an increase in the number of DoLS applications and Court of Protection applications. All teams have continued to adapt their collaborative working approaches both within UHSFT and across the multi-agency partnership in order to meet service demand. The report has been written to provide high level assurance as to the safeguarding arrangements within UHSFT.			
Response to the issue:	Board Members are asked if the report gives the required assurance around UHSFT adult (including learning disability), child and maternity safeguarding services. Summary of key points within the report include: • Progress updates and what we have achieved since the last annual report. • Activity data and analysis • Patient stories for adult, child, Maternity, LD and MCA services. Key areas of work for 2023/24.			
Implications: (Clinical, Organisational, Governance, Legal?)	The safeguarding report outlines the strategic and operational work of the safeguarding team which encompasses clinical, organisational and governance implications.			

Risks: (Top 3) of carrying out the change / or not:	Not applicable.
Summary: Conclusion and/or recommendation	The safeguarding annual report has highlighted the safeguarding team's activity for 2022/23. From a strategic and operational perspective this is pivotal to ensure we continue to improve outcomes for children and adults. The key areas of work for 2023/24, are outlined at the end of the report, and align with the 2022-2025 Safeguarding Strategy standards.

Introduction

This year's Safeguarding Annual Report summarises the key achievements and activity for 2022/2023 and highlights key areas of work for 2022/2023 for Adults, Children and Maternity Safeguarding within UHSFT. This includes the Paediatric Liaison Nursing Service, and the Learning Disability and Autism Team. This report has been written to provide high level assurance to the Executive Team in relation to the safeguarding arrangements within UHSFT.

With the ongoing impact of COVID-19 and industrial action, the Safeguarding Team have continued to be innovative and adaptable to enable a continued robust, responsive and supportive service to both UHSFT colleagues and multi-agency partners in order to promote the welfare and safeguard our vulnerable children and adult population. This has meant over the last year some of the safeguarding work has remained remote however alongside this, there has been more on-site presence.

As highlighted in last year's annual report, the teams have continued to adapt their collaborative working approach both within UHSFT and across the multi-agency partnership. However due to the continued increased activity, further staff sickness, staff resignations and the retirement of the Named Nurse for Safeguarding Children, this has had an impact on work demands. Although the report will highlight progress with some work streams, capacity and demand has meant that operational case management has needed to be the priority, with some workstreams needing to be put on hold. This increase in demand upon the system has also been acknowledged across the wider Hampshire and Isle of Wight footprint. This will be reflected in this year's report.

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Progress updates – Safeguarding

Last year (21/22) we said we would;	We have achieved (22/23);
Review and refinement of the joint safeguarding supervision policy	The Safeguarding Supervision Policy requires a review across adult, children and maternity safeguarding This is in progress with a plan to finalise in Q2 (23/24).The safeguarding teams continue to offer responsive supervision for staff who require additional advice and support via the advice line available during core working hours and on-site safeguarding ward rounds.
Planning and implementation of the Mental Capacity Amendment Act (2019) and the Liberty Protection Safeguards	Mental Capacity Act/Liberty Protection Safeguards Lead Practitioner commenced in post in June 2022. The postholder is working to raise the profile of the Mental Capacity Act across the Trust as everyday business and with a focus on supporting frontline staff with existing requirements in relation to the Deprivation of Liberty Safeguards (DoLS) and reviewing MCA training provision across the Trust.
As an action from the safeguarding strategy , to develop a safeguarding training strategy	A draft training strategy has been developed in relation to Safeguarding Adults, Children and the Mental Capacity Act with a view to include with Maternity Safeguarding The Safeguarding Strategy focuses on key priorities, aligning this with the Trusts Values. Date of review 2025.
To further develop domestic abuse processes in collaboration with Maternity, ED, all adult areas, Children's Hospital and wellbeing lead which encompasses support for both our patients and staff	Domestic Abuse Working Group established with core membership from all Divisions, Maternity Safeguarding Team, ED, Employee Relations and Staff Wellbeing Lead. The Trust continues to progress the Priority Plan which was devised in collaboration with standing Together Against Domestic Abuse (STADA).

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Activity – Safeguarding Adults

Safeguarding Referrals = **2414 – 22/23** (13% increase from 21/22 -2142)

DoLS = **755 – 22/23** (17% increase from 21/22 - 646)

Total number of SAMA cases: 50 (32% increase from 21/22 - 38)

Training delivered; adult sessions = 11 / joint adult & child sessions = 9

- **Number of Court of Protection cases supported:** 9 (1 21/22)

Prevent referrals: **1** (0 21/22)

Safe and Well Referrals = **8** (data not collated for 21/22)

Statutory Activity

- 8 statutory scopings for SARs.(6 – 21/22)
- Panel representation for 4 SARs.
- 3 Practitioner Workshops attended.
- 2 referrals made to SSAB for consideration of SAR's

LeDeR Reviews

- Deaths reviewed: **24** (this number includes **5** deaths from the previous year).

AER's screened: 1204 (44% increase from 21/22 - 836)

Complaints screened: 6 (82% decrease from 21/22 - 34)

Section 42 enquiries:

Total number: 351 UHS led: 87

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Activity – Safeguarding Children

22/23 Safeguarding referrals to UHSFT Safeguarding Children Team =976 (1318 in 2021/22) . Of these referrals the main reason for referral was a child with a mental health issue -282 (475 in 2021/22) , Parent an inpatient – 70 (213 in 2021/22) , Actual harm – 100 (191 in 2021/22), Suspected harm - 100 (138 in 2021/22)

Telephone/email advice = 291 (482 in 2021/22), this indicates a slight increase from last year.

Serious Incident reporting = 38 (65 in 2021/22) completed for unexpected child deaths, non-accidental injury, complex cases and distributed to key leads within the organisation.

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

Total number of LADO cases = 27 (this includes UHSFT – 18 and staff not employed by UHSFT -9). This is higher than 2021/22 -**21**, but similar to 2020/21 - **29**

Paediatric Liaison Nurse Specialist (PLNS) Team,

The team triaged 6184 Information sharing forms (ISF) in 2022/23. This represents a 3% increase from 6004 forms completed in 2021/22 and 3759 in 2020/21.

Safeguarding Children Training Level 3 –40 sessions delivered (40 sessions delivered in 21/22).Planned and bespoke. A further 13 sessions were cancelled due to low numbers /UHS safeguarding children sickness and of these 13, 4 were cancelled due to RCN strike action.

Statutory Activity

30 (27 in 21/22) requests for statutory scoping's for Serious Case Reviews.

- Of the 30 requests submitted, the Safeguarding children Team have contributed to 7 of these, due to the child/sibling/parents receiving care at UHSFT. This is slightly less from 9 in 2021/22.

Activity Maternity Safeguarding

ICO applied for after birth by CSC: 29 (2021-22:22)

Child in Need Plan: 76 (2021-22: 70)

UBB's on CP Plan: 72 (2021-22: 81)

MASH referrals: 274 (2021-22: 291)

Safeguarding Liaison Forms: 786 (2021-22: 813)

Child Protection Information Share: 14 (2021-22: 46)

FGM-IS: 16 (2021-22: 10)

FGM: 24 (2021-2022: 10)

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Activity – Learning Disability and Autism Team

Adult Patients: 1619 (2021-22: 1315)

LD: 1062 (2021-22: 826)

ASD: 428 (2021-22: 299)

LD and ASD: 47 (2021-22: 51)

Inappropriate referrals: 82 (2021-22: 139)

Paediatric Patients: 871

LD: 394

ASD: 312

LD and ASD: 156

Inappropriate Referrals: 9

Due to data collection changes for paediatric patients, a breakdown of data by diagnosis is not available for the previous year.

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Training Compliance
Mandatory training report by Division Groups as of 20.04.23

	Div. A % (Targeted audience)	Div B % (Targeted audience)	Div C % (Targeted audience)	Div D % (Targeted audience)	Trust HQ % (Targeted audience)	Trust % (Targeted audience)	Trust Target
Safeguarding Adults level 1 (3yr)	**85.6% 2312**	**85.7% 2516**	**89.2% 2517**	**86.6% 2190**	**85.8% 924**	**86.7% 10455**	>85%
Safeguarding Adults level 2 (3yr)	**72.5% 2119**	**76.2% 2424**	**76.3% 2223**	**74.1% 2139**	**72.7% 531**	**79.4% 9292**	>85%
Mental Capacity Act level 1	**80.0% 75**	**66.5% 333**	**76.4% 339**	**78.8% 624**	**84.4% 135**	**76.1% 1506**	>85%
Mental Capacity Act level 2	**65.3% 2153**	**68.5% 2407**	**67.8% 2229**	**66.9% 1440**	**55.5% 402**	**66.7% 8628**	>85%
Prevent levels 1&2	**88.5% 278**	**92.2% 1004**	**92.9% 934**	**88.1% 353**	**92.2% 1564**	**91.8% 4130**	>85%
Child Protection level 1	**71.4% 182**	**80.9% 735**	**88.1% 396**	**79.5% 257**	**85.8% 1278**	**83.4% 2845**	>85%
Child Protection level 2	**76.3% 2068**	**78.5% 1993**	**81.1% 944**	**80.5% 2126**	**67.5% 520**	**78.0% 7648**	>85%
Child Protection level 3	**59.6% 114**	**48.3% 491**	**68.9% 1445**	**54.7% 53**	**75.8% 33**	**63.4% 2135**	>85%

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Key areas of work for 2022/23

Joint

- Review and refinement of the joint safeguarding supervision policy
- Continued development of the joint safeguarding training strategy
- To further develop domestic abuse processes in collaboration with Maternity, ED, all adult areas, Children's Hospital and wellbeing lead which encompasses support for both our patients and staff
- Continue to promote awareness of Transition Safeguarding Service and Under 18s in Adult areas

Adult specific

- Audit: Making Safeguarding Personal.
- Completion and launch of level 3 safeguarding adult training.
- Launch of new policies: Allegations Management (Adults at Risk), Was Not Brought (Adults at Risk), Offender Management.

MCA Specific

- Continue work to improve and embed the application of the Mental Capacity Act (2005) in practice.
- Audits: DoLS, role of IMCA

Children specific

- Audits – complete safeguarding proforma audit, ED Voice of the Child Audit
- Continue to improve the use of technology – APEX, children's dashboard and ISF
- Robust supervision template to capture all safeguarding supervision, planned and ad hoc
- Review level 3 training guidelines in January 2024, following January 2021 implementation of new process and anticipated updated Intercollegiate Document (2019) .

Maternity specific

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

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Patient Safety Incident Response Framework (PSIRF) Policy and Plan**			
Agenda item:	**5.11**			
Sponsor:	**Gail Byrne, Chief Nursing Officer** **Paul Grundy, Chief Medical Officer**			
Author:	**Vickie Purdie, Head of Patient Safety and Patient Safety Specialist**			
Date:	**28 September 2023**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	In August 2022 NHSE launched the Patient Safety Incident Response Framework (PSIRF) describing the plan for NHS organisations to spend a year preparing for transition away from the Serious Incident Framework onto the PSIRF in Autumn 2023. UHS has agreed a transition date of 2nd October 2023 with our ICB and to support the transition the enclosed Policy and Plan have been developed.			
Response to the issue:	The patient safety incident response plan and policy set out how University Hospital Southampton NHS Foundation Trust (UHS) intends to respond to patient safety incidents over a period of 12 to 18 months. Both documents will be reviewed at 6 months. The policy and plan were agreed at Quality Committee on 21st August 2023 and reviewed and agreed in principle with HIOW ICB 22nd August 2023. Subsequently they were approved at Quality Governance Steering Group on 5/9/23 and final approval also now received from the ICB. To develop the plan and identify our safety priorities We used a thematic analysis. To do this review we utilised a variety of data sources including: • Serious Incidents (SI's) recorded on STEIS including falls and pressure ulcers. • Patient safety incidents reported through our local management system including all levels of reported harm. • Risk registers			

- Review of After-action reviews completed during first three months of pilot
- Learning from deaths data
- Inquests
- Complaints and concerns

Key findings of the thematic analysis were (Highlights and link to ICB presentation are in appendix 1)

- Average number of SI's for last 3 financial years was 98 (60 when falls/PU and VTE excluded). These include SI's reported where patients have either died from a hospital acquired Covid 19 infection or those who have come to severe harm due to delays caused by the covid pandemic.
- Our top themes during the last 3 years include:
  - Covid (infections and harm secondary to waits caused by Covid)
  - Failure to rescue[1]
  - Lost/ Delay to follow up
- Average number of inquests for the last three years is 249 per year
- Inquests highlighted the following themes:
  - Documentation
  - Communication
  - Falls
  - Deterioration
  - Consent
- Further analysis of the failure to rescue using the Yorkshire Framework identified Communication as the most common theme.
- Medication and falls were the highest reported incident each year. Categories for number 3 slot were medical devices 20/21, Staffing 21/22 and Behaviour 22/23. All reflective of the focus and workload of the organisation for those years.
- Complaints from 22/23 identify the top themes as:
  - Clinical treatment
  - Communication
  - Patient care

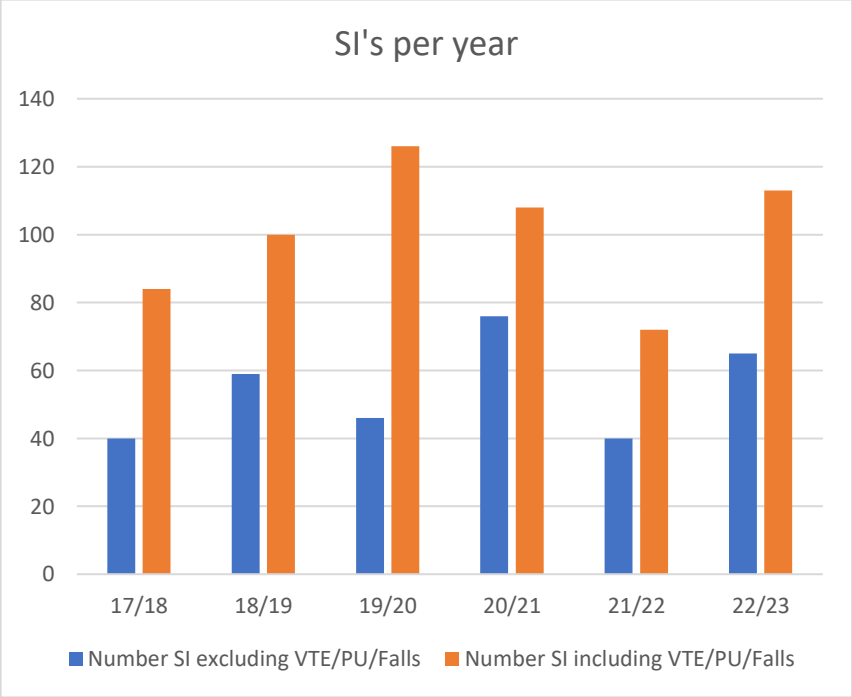
[1] Failure or delay in recognizing and responding to a hospitalized patient experiencing complications from a disease process or medical intervention

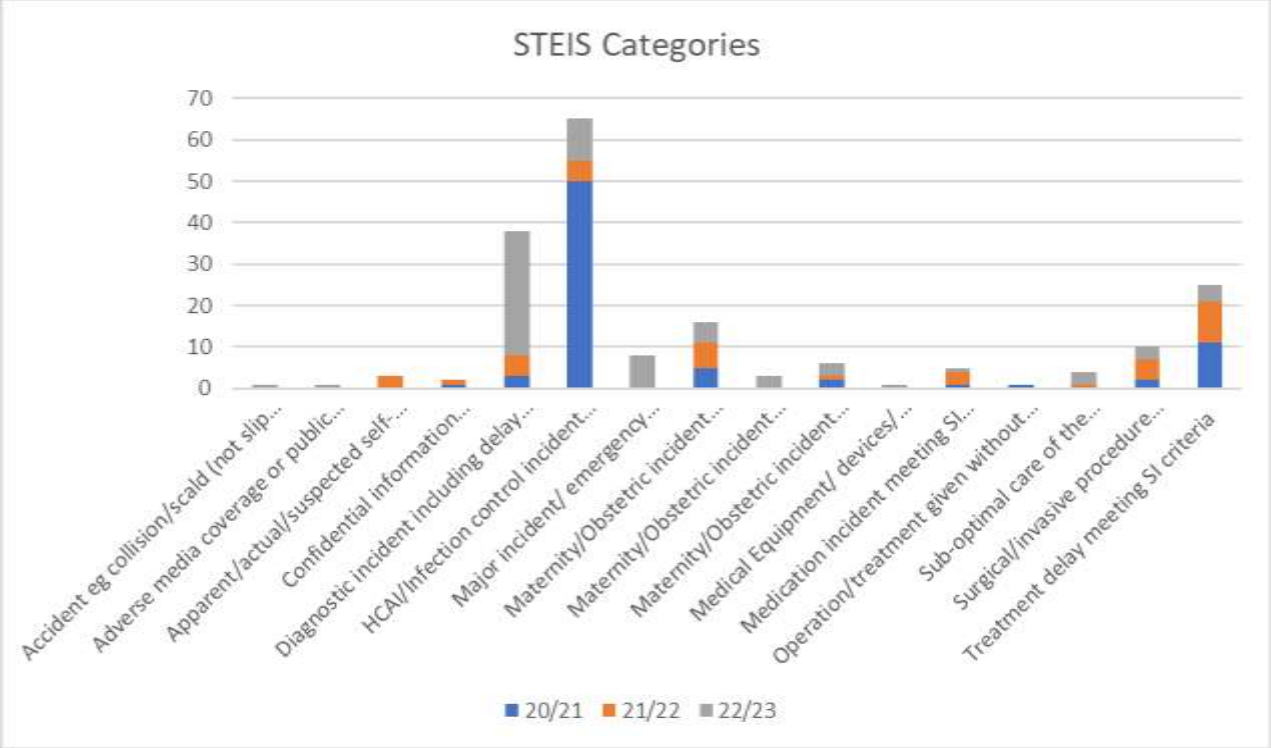
	Stakeholder engagement: To support the Plan's development, we consulted with a range of stakeholders including Commissioners/ Integrated Care Board (ICB) ○ Members of staff through a number of workshops/ engagement events ○ Trust Board executives and non-executives and delegated committees ○ Trust governors ○ Quality and patient safety partners ○ Governance teams ○ Medication Safety Officer ○ Coroner ○ Healthwatch
Implications: (Clinical, Organisational, Governance, Legal?)	PSIRF is a nationally driven change in patient safety and is included in our contract. It is a very positive change to Patient Safety allowing organisations to utilise a range of system-based tools to ensure learning from incidents is proportionate and has a great focus on involving and supporting staff, patients and families when they have been involved in a patient safety incident.
Risks: (Top 3) of carrying out the change / or not:	1. Reputational Risk 2. Breech in contractual requirements
Summary: Conclusion and/or recommendation	We ask that QGSG note the PSIRF Policy and Plan

Appendix 1
Summary of Thematic Analysis
Completed July 2023

The full presentation to the ICB can be found ICB workshop 6 July 2023 Final

Never Events





Top 3 STEIS codes

22/23

1. Diagnostic incident including delay meeting SI criteria (including failure to act on test results) – 30
2. HCAI/Infection control incident meeting SI criteria – 10
3. Major incident/ emergency preparedness, resilience and response/suspension of services – 8

21/22

1. Treatment delay meeting SI criteria – 10
2. Maternity/Obstetric incident meeting SI criteria: baby only (this includes foetus. neonate and infant) – 6
3. Diagnostic incident including delay meeting SI criteria (including failure to act on test results) -5
3. HCAI/Infection control incident meeting SI criteria – 5

3. Surgical/invasive procedure incident meeting SI criteria – 5

20/21

1. HCAI/Infection control incident meeting SI criteria – 50
2. Treatment delay meeting SI criteria – 11
3. Maternity/Obstetric incident meeting SI criteria: baby only (this includes foetus. neonate and infant) – 5

Top 3 UHS themes

22/23

1. Covid – 33
2. Failure to rescue - 11
3. Capacity issues - 8

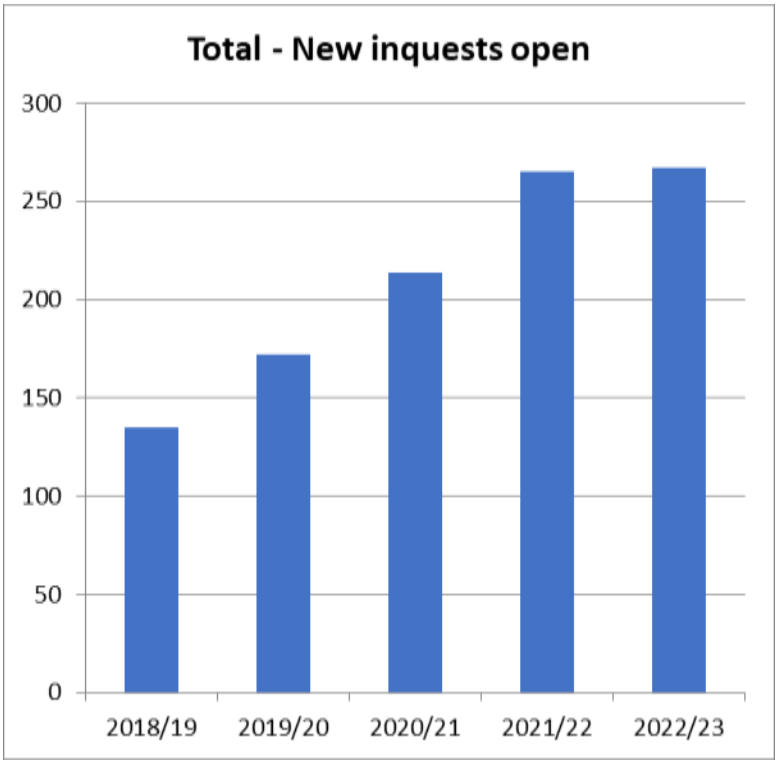
21/22

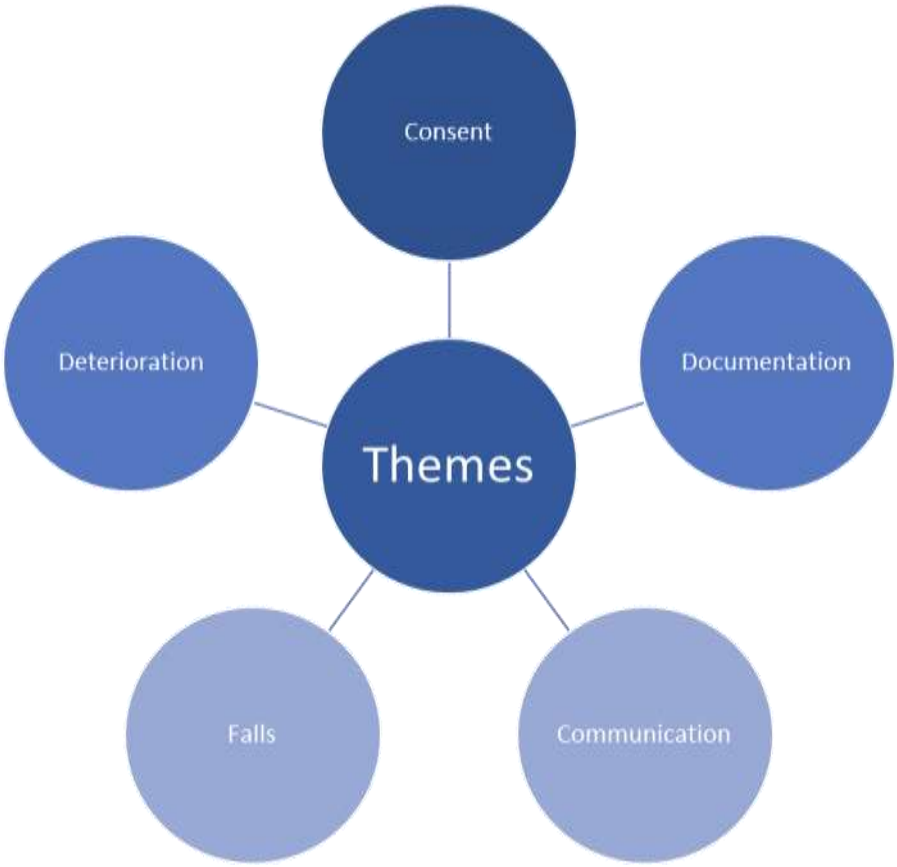
1. Failure to rescue – 15
2. Covid – 7
3. Never Event – 5

20/21

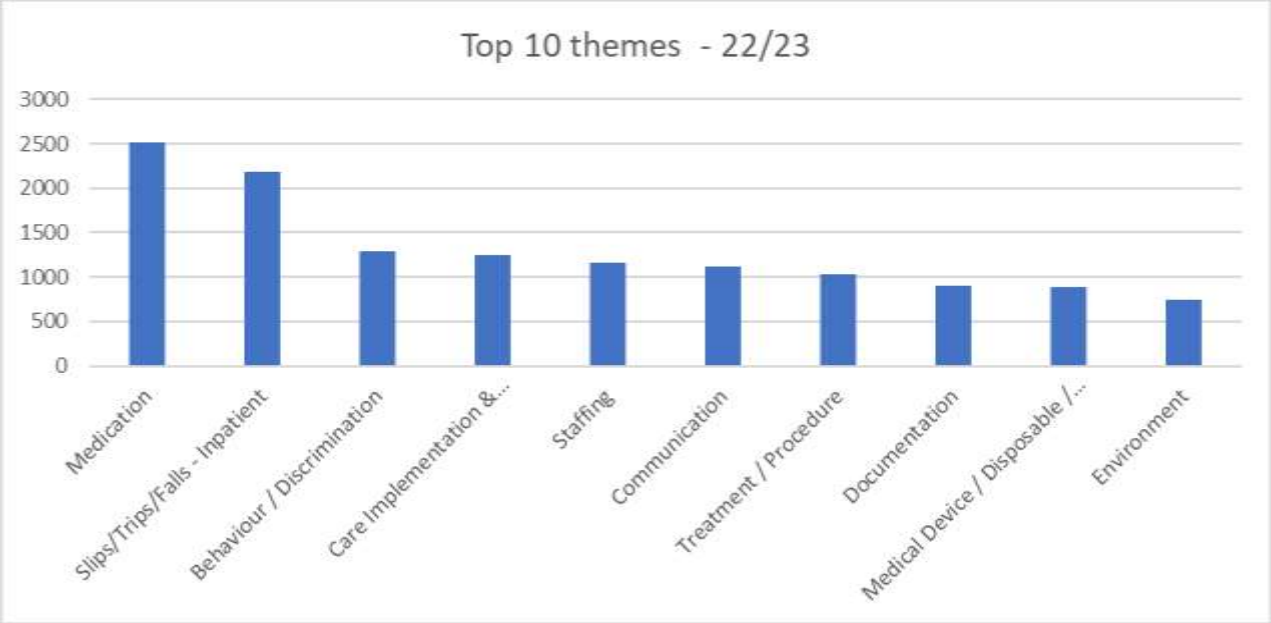
1. Covid – 50
2. Lost/ delay to follow up – 9
3. Failure to rescue - 7

Inquests

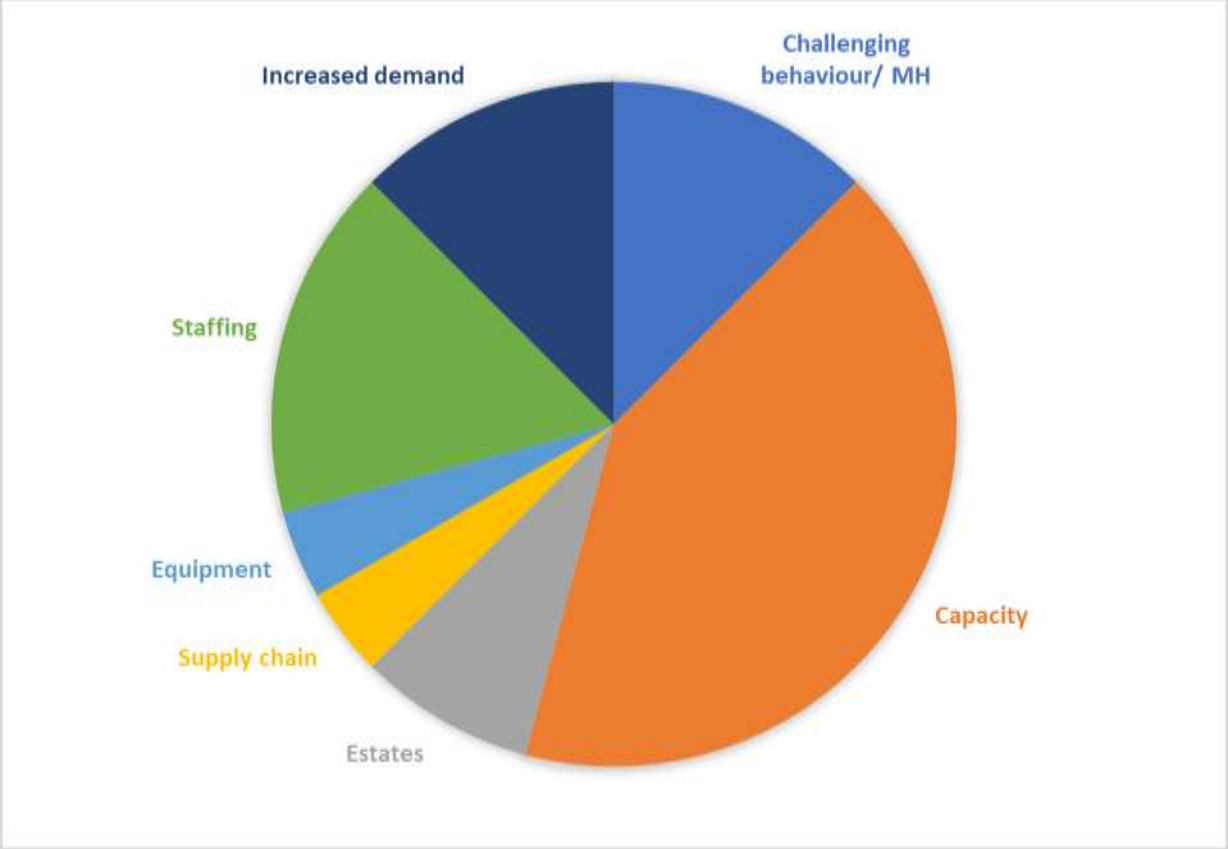

Total - New inquests open
300
250
200
150
100
50
0
2018/19
2019/20
2020/21
2021/22
2022/23


Consent
Deterioration
Documentation
Themes
Falls
Communication

Incidents (AERs)



Snapshot July 23 of top divisional risks



University Hospital Southampton NHS Foundation Trust (UHS)

Patient safety incident response policy

Effective date: 2nd October 2023

Estimated refresh date: 2nd October 2024 with a review at 6 months.

	NAME	TITLE	SIGNATURE	DATE
Author	**Vickie Purdie**	**Patient safety specialist**		
Review Group	**Quality Committee**	**Approved**		**21/8/23**
Review Group	**Quality Governance Steering Group**	**Approved**		**5/9/23**
Review Group	**Trust Board**			**28/9/23**
HIOW ICB	**Teressa Gallard Helen Eggleton Gemma Seymour**	**Final approval from ICB received 5/9/23**		**22/8/23**

Contents

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out University Hospital Southampton NHS Foundation Trust (UHS) approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents.
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

This policy will incorporate and replace the need for separate policies on:

- Duty of Candour – being open policy
- Incident management policy
- Incident reporting policy

It is important to note that the requirements for both professional and statutory Duty of Candour remain unchanged as we move to PSIRF.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all services provided by UHS across all sites including:

- Southampton General Hospital
- Princess Anne Hospital
- Lymington Hospital
- Royal South Hants Hospital
- Helicopter Emergency Medical Service
- New Forest Birthing Centre

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources (HR) investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

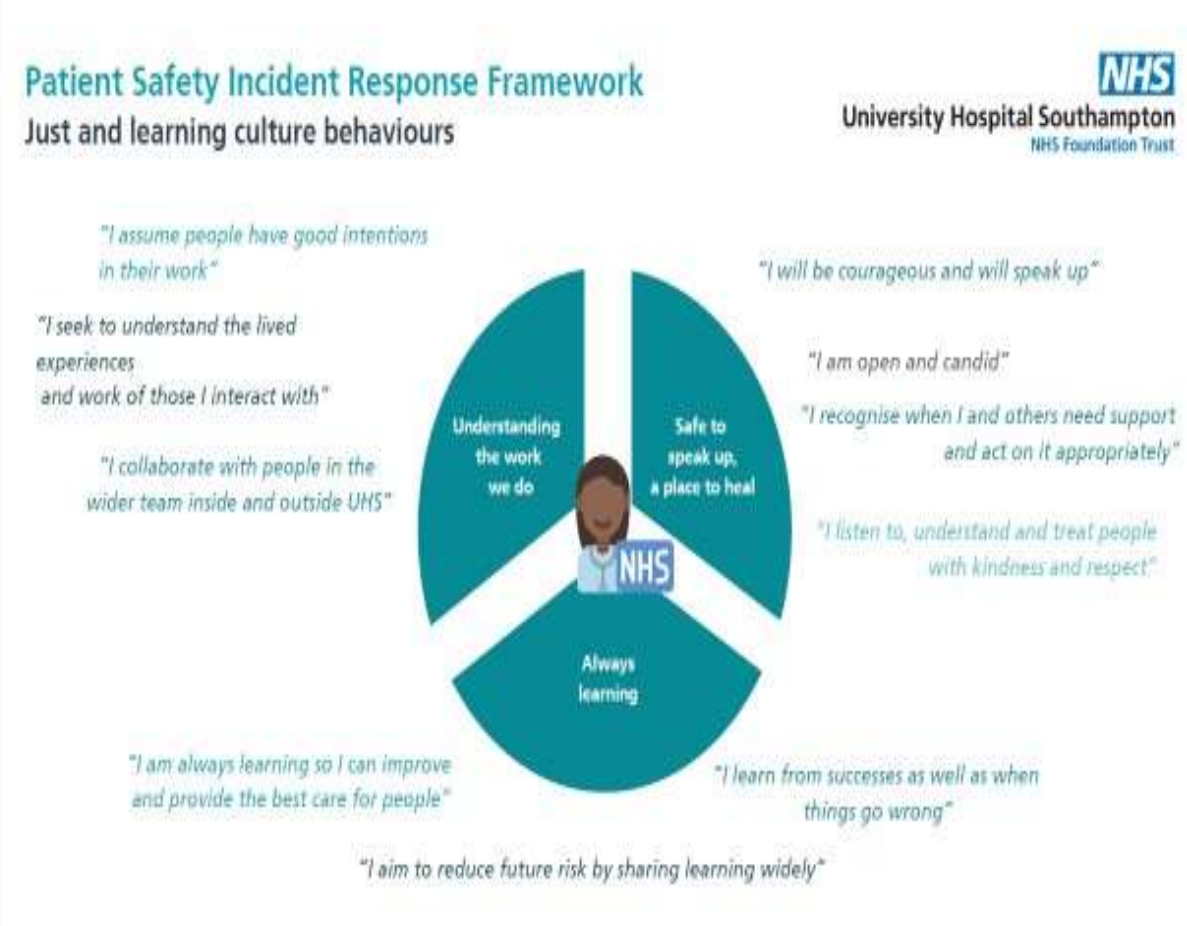
Responses outside of the scope of this policy (not exhaustive):

- HR investigations
- Coronial Inquests
- Complaints
- Professional standards reviews
- Criminal investigations
- Litigation claims.

The following appendices provide the detail to support patient safety at UHS following the transition to the Patient Safety Incident Response Framework:

Appendix 1: Our patient safety culture

Just and Learning Culture:



What is a just and learning culture?

The just and learning culture recognises that we a work in a highly complex environment where things do not always go to plan, and we seek to learn from these events. The just culture approach adopts a respectful, compassionate approach that assumes good intention and works alongside the trusts other policies to establish the facts. We seek to understand how the system works and why decisions made sense at the time in the situation they were taken in. The emphasis of this approach is always learning so that we can improve as much as possible and provide the best care for our patients. This also includes ensuring support for those involved, both patients and families, as well as staff.

Why do we need a just and learning culture?

To build a strong patient safety culture we need everyone who works at UHS to feel safe and supported to speak up about things that concern them. A just and learning culture enables this.

Do we still hold people to account?

A just and learning culture does still mean that people are accountable for their actions and may be managed under the appropriate policies. The majority of people come to work to do a good job. In rare cases there may be serious concerns about the incident where safeguarding and HR need to be involved immediately.

How will we know if we are using a just and learning culture approach?

The aim is of the just and learning culture is to create an environment that enables both individuals and organisations to learn, heal, grow and excel.

What happens if I do not follow the just and learning approach?

A blame culture may ensue where employees feel blamed for incidents or raising concerns. This can lead to poor morale, failure to speak up and raise concerns, worsening patient safety with further incidents and individuals and the trust not learning, growing and healing.

How do individuals and UHS learn from incidents?

We learn from undertaking incident investigations to understand what happened using a systems-based approach. These reports and their action plans are shared via local governance meetings, and where appropriate learning is shared with the wider hospital and networks. Individuals involved are given the opportunity be part of the investigation and will receive feedback and any learning from the incident.

We are also keen to share our learning from favourable events which can be reported via the FERF process on staffnet. Complete a FERF here

How is learning recorded?

Learning is shared through your local, divisional, and corporate governance meetings and can be escalated to the board or outside the organisation.

You can also find information on the patient safety staff net pages and workplace.

For more information follow the link to the relevant page on the staff net. Link to Just culture

Appendix 2: Our planned outcomes for the next 2 years

Strategic

Adopting an 'Systems based' approach to patient safety incidents.

Delivering patient safety education and coaching to those involved in safety investigations, risk and governance to embed PSIRF methodology across the organisation and aligning with core behaviours of the UHS way of thinking.

Resulting in an just and learning culture that allows us to learn, grow, heal and excel, with patient safety at its core, to develop an engaged and ambitious workforce who consistently deliver safe and outstanding care

Operational

Patient safety investigations focus on where there is greatest learning for the organisation

A range of tools are used to learn from incidents and regular thematic reviews are carried out.

Patients involved in projects that lead to improvements in patient safety

All staff understand their role in patient safety and we support those staff involved in patient safety incidents

Quality

Build confidence, capability and capacity for patient safety learning and improvement across the Trust so staff feel empowered to deliver PSIRF in their areas

Build on our Educational offering - PSII, human factors, appreciative inquiry for staff involved in patient safety

Train ALL staff in level 1 patient safety

Support and coach staff to deliver PSII and local investigations, and ensure involvement of those affected

Effectiveness

Measure implementation effectiveness and organisational readiness over the next year

Measure impact of PSIRF implementation, including impact on patients and staff involved.

Design and embed robust measures for every PSIRF investigations

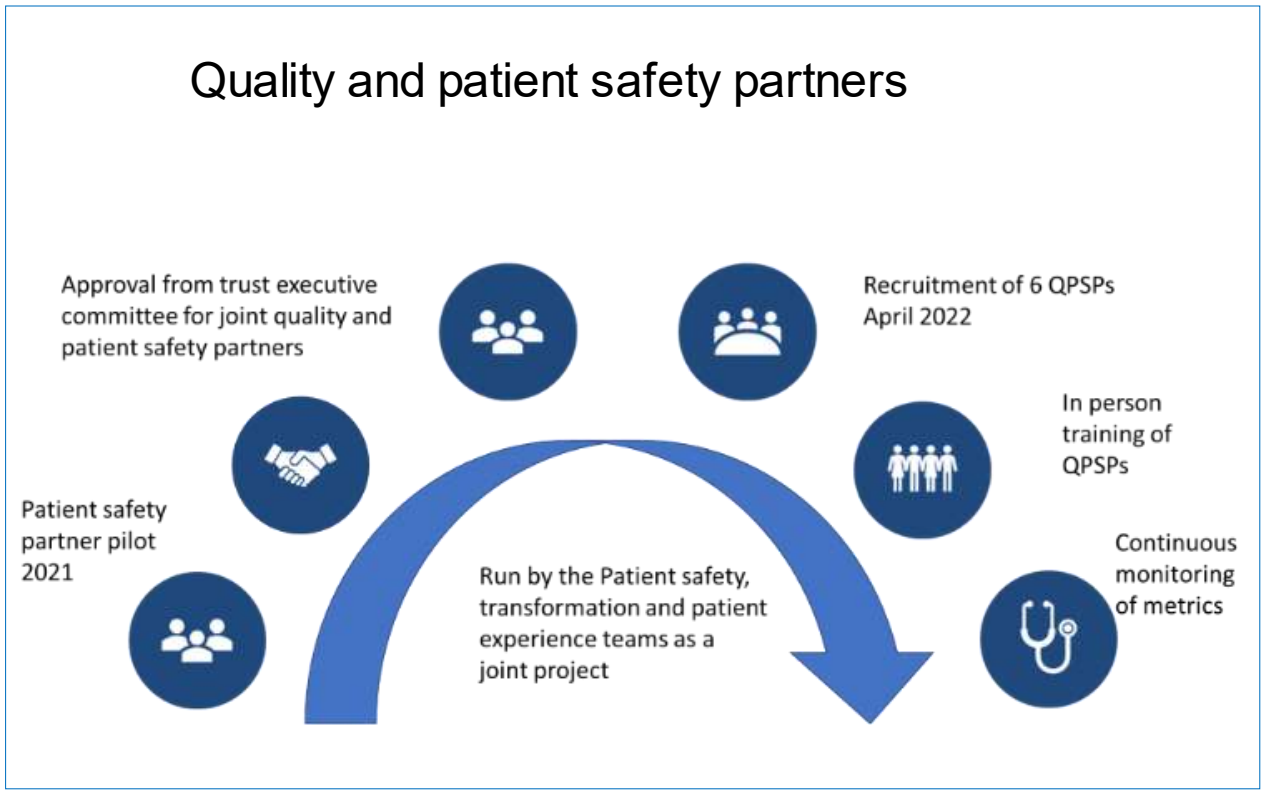
Appendix 3: Patient safety partners

Getting it right for patients

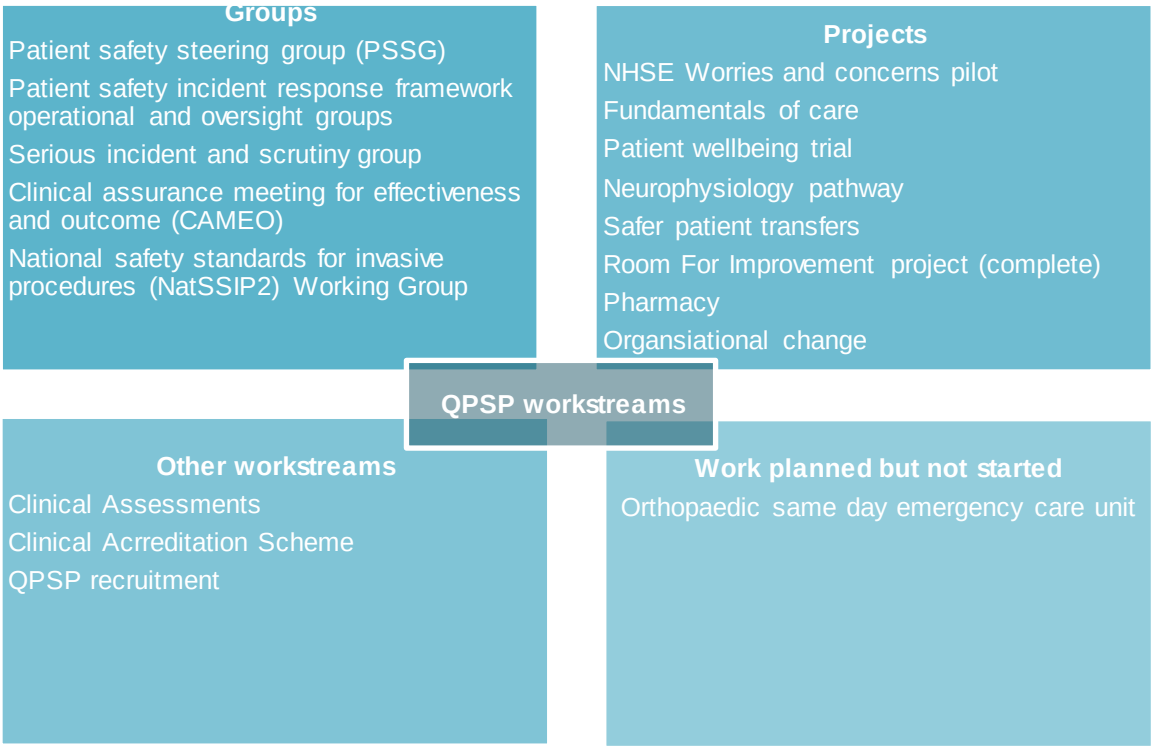
UHS has combined its patient safety programme with its quality improvement programme, creating Quality and Patient Safety Partners (QPSPs).

Our volunteers come from a range of backgrounds and provide a unique insight into the work of the trust. They have undertaken the same patient safety training as staff and can access a mentor to support them in their work. Within patient safety they sit on the serious incident scrutiny group contributing the patient voice to ensure there is learning from investigations and will continue to do this as part of PSIRF. As part of PSIRF they will contribute to setting the Terms of Reference through the New Cases Oversight Group.

Their next focus is on recruiting new QPSPs and ensuring they reflect the make-up of the trust's users, including its diverse population. They are also continuing their work as part of a patient safety partners network and are supporting other NHS trusts in developing similar programmes to put patient voice centre stage.



Our QPSP's work includes:



Appendix 4: Addressing health inequalities.

Healthcare itself is an important contributor to health inequalities

This is additive to the widely acknowledged impact of the social determinants on health inequalities

Patients ethnicity, socioeconomic background, and other personal characteristics can increase their risk of experiencing patient safety events

Viewing health inequalities through the lens of differences in patient safety identifies actions for which healthcare systems and workforce have clear responsibility

The Trust recognises that the NHS has a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

The Trust as a public authority is committed to delivering on its statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patient from across the range of protected characteristics.

As part of our initial case review, we will consider whether health inequalities was a factor and seek to highlight any learning to rectify this. Regular thematic analysis includes consideration of the role of health inequalities, including assessing protected characteristics to ensure that they are not disproportionately represented.

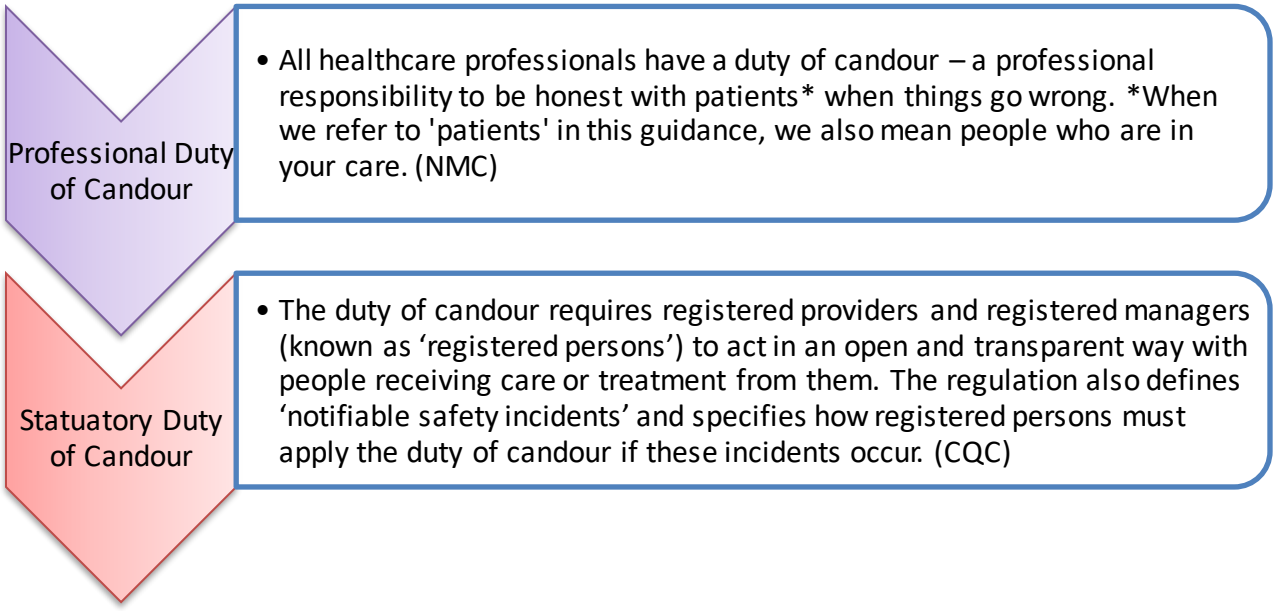
Engagement of patient, families and staff following a patient safety incident is critical to review of patient safety incidents and their response. We will ensure that we use available tools such as easy read, translational interpretation services and other methods appropriate to meet the needs of those concerned and maximise their potential to be involved in our patient safety response.

The Trusts has a zero acceptance of racism, discrimination, and unacceptable behaviours from and toward our workforce and our patients, carers, and families.

Appendix 5: Duty of Candour - Being Open and Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

Following the transition to PSIRF the Duty of candour requirements do not change.
The effects on patients, relatives, carers, and staff when things go wrong, can be devastating. *'Being Open- a duty to be candid'* outlines the principles that healthcare staff should use when communicating with patients, their families and carers following a patient safety incident where a patient was harmed or had the potential to be harmed. It supports a culture of openness, honesty, and transparency.
Incidents that do not go through a full PSIRF investigation but are subject to a local learning review still require duty of candour. Duty of candour can be either professional or statutory. Both the statutory duty of candour and professional duty of candour have similar aims – to make sure that those providing care are open and transparent with the people using their services, whether something has gone wrong.



For all Duty of candour discussions please record on the e Docs form.

Duty of Candour, this section identifies the Trust's policy for being open.

SCOPE AND PURPOSE- EXECUTIVE SUMMARY

The effects on patients, relatives, carers and staff, when things go wrong, can be devastating. *'Being Open- a duty to be candid'* outlines the principles that healthcare staff should use when communicating with patients, their families and carers following a patient safety incident where a patient was harmed or had the potential to be harmed. It supports a culture of openness, honesty and transparency.

Being open and candid when things go wrong ensures that any investigation incorporates the patient view in getting to the root cause and major contributory factors of the event and promoting organisational learning.

'Being Open-a duty to be candid' includes apologising and explaining what happened. Openness and honesty at the point of an incident occurring can help prevent such events becoming complaints or litigation claims. The *'Duty of candour'* is now a legal requirement, sanctionable in law, a contractual requirement in the DH Operating Framework, a fundamental standard of the care quality commission (CQC) and is a professional responsibility under the NHS Constitution. It is fully endorsed by the GMC and NMC.

This policy incorporates the 2015 amendments to the Health and Social Care Act 2008, and includes the professional guidance published by the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) 2015. The 'Duty of Candour' has also been written into the latest revision of the NHS Constitution. It is endorsed by (among others) the Department of Health, the Medical Defence Union, the NHS Litigation Authority, the NHS Confederation, and the Royal Colleges.

This policy addresses University Hospitals Southampton NHS Foundation Trust's (UHS) response to the ethical, professional, contractual, and statutory responsibility and duty of candour when an incident occurs. The terms, 'Being open' and 'duty of candour' are used interchangeably in this policy.

DETAILS OF PROCEDURE TO BE FOLLOWED.

What needs to happen in terms of 'duty of Candour' is dictated by the level of harm.

Grade of Incident	Level of response
No harm (including prevented patient safety incident ('Near miss') **(Professional Duty)**	The General Medical Council (GMC) and Nursing and Midwifery Council (NMC) advise that the event is evaluated on a case-by-case basis whether 'no harm' events (including 'near misses') are discussed with patients, their families and carers, depending on circumstances. Where failing to disclose a near miss or no harm incident would damage trust in the clinical teams, the incident should be disclosed. This decision will need to be made based on clinical judgement.
Low harm	Unless there are specific indications or the patient requests it, the communication, investigation and

Grade of Incident	Level of response
(Professional Duty)	analysis of the event, and the implementation of changes will occur at local service delivery level with the participation of those directly involved in the event. Reporting to the Patient Safety team will occur through the standard incident reporting system. Communication should be an open discussion between the staff providing the patient's care and the patient, their family and carers, which should be recorded in the medical records and e-reporting system.
Moderate harm – Statutory duty of Candour applies in addition to professional duty	Once the level of harm is validated to be moderate or higher, the local risk manager/ Patient Safety Advisor should be notified immediately and are available to provide support and advice. A conversation must be held with the patient or their representatives, IN PERSON, either face to face (which can include, if appropriate, on the telephone, WITHIN 10 working days (and sooner if possible) of it being known that there is a safety incident. This should be followed up in writing. It should include an apology, an explanation, details of the investigation or learning response and what and when any feedback would be expected. A single point of contact should be given and the opportunity to ask any questions given. It should also be explained that questions can be asked at a later stage. How the investigation results will be shared must also be discussed. The conversation should be recorded on the 'Duty of Candour' Edocs and become part of the formal medical records. The details of the conversation should also be recorded on the incident form.
Severe, significant harm or death **Statutory duty of Candour applies in addition to professional duty**	The duty of candour process is identical to that of moderate harm (above). The local risk manager/ Patient Safety Advisor should be notified immediately and be available to provide support and advice during the *'duty of candour'* process if required. Where the level of harm is severe or death, additionally, Divisional management team should also be immediately notified, who will escalate further if required. As for moderate harm cited above, a fully documented conversation must be had within 10 days of it becoming clear that a notifiable incident has happened.

WHAT TO DO IF YOU THINK A SPECIFIC NOTIFIABLE INCIDENT SHOULD BE EXCLUDED FROM THE DUTY OF CANDOUR PROCESS

Within regulation 20, if an incident is 'notifiable', that is, of moderate harm or above, then it must be discussed with the patient or their family/carers.

The regulation does not allow for non-disclosure on the basis that to do so would likely cause harm to the patient or their families/ carers. The incident is subject to the duty of candour requirements if harm has arisen in the process of providing care, irrespective of whether there was an error. This also includes complications of treatment that have been disclosed during the consent process. To trigger the duty of candour, the harm must relate directly to the incident, rather than to the natural course of illness or underlying condition.

However, on occasions, it may not seem clinically appropriate to have a duty of candour discussion with the patient or their representatives. This cannot be a unilateral decision but must be made in conjunction with the patient safety team, who will ensure a robust discussion of the incident in a multidisciplinary setting (such as the Patient Safety Incident Investigation Oversight Group (PSIIOG) which happens on a twice monthly basis. Additionally, the clinical ethics committee can be approached for advice. Please contact the patient safety team if you require further advice. Additionally, the Department of clinical law can be contacted for advice. Details are on the staffnet Link. The result of any external discussions should be documented in the patient medical record.

Where the Trust has undertaken a review of care (e.g., Falls, Pressure Ulcers, Venous Thrombo Embolism (VTE), patient safety case reviews that do not result in a formal investigation).

Where there has been a review of a patient's care, for example, because of a significant fall, or pressure ulcer, or a VTE, it may appear that it is due to the patient underlying condition. An example might be of a patient with a fall resulting in a fracture, where there was no possibility of preventing it. The expectation of the trust is that the outcome of the review will be discussed with the patient, under the professional duty of candour. This should be documented in the patient's medical records and on the incident form relating to the incident.

Where there has been a formal patient safety case review of care that does not result in the decision to undertake an investigation, the patient or their representative should be updated, and this documented in the patient's medical records and on the incident form relating to the incident.

It is acknowledged that the process for identifying and reporting VTE may lead to a time lag in notification to the patient. However, there remains a professional duty to inform that patient that their care has been reviewed, and the findings of that.

Process for acknowledging, apologising and explaining when things go wrong.

The first step of the process is the recognition of an incident and when the level of harm dictates that it is appropriate to apply the 'Being Open-a duty to be candid' policy.

Immediate clinical care should be given to prevent further harm if necessary.

Initial Discussion

Following identification of an incident, a preliminary team discussion should be had, as near as possible to the time of to the incident, once the patient has been made safe

- Basic clinical facts
- Assessment of the incident and determine level of immediate response required
- Individual responsible for discussing/ liaising with the patient/relative/carer
- Whether patient support is required
- Immediate support required for staff involved
- A clear communication plan

Identifying who should be responsible

In determining who will be responsible for communicating with the patient/family carers the individual should, if possible:

- Have a good relationship with the patient and/or their carers
- Have a good understanding of the relevant facts
- Be senior enough or have sufficient experience and expertise in relation to the type of incident to be credible to patients, carers and colleagues
- Be willing and able to offer an apology, reassurance and feedback to patients and/ or their carers
- Be able to maintain a relationship with the patient and/or their carers and to provide continued support and information.
- Be culturally aware and informed about the specific needs of the patient/relatives or their carers

When should the initial discussion be held?

The initial candid discussion with the patient and/or their carers should occur as soon as possible after recognition of the incident, wherever possible, face to face (includes telephone conversations).

What should the initial discussion include?

It should be disclosed that something has gone wrong but that the cause is not yet known. It must be communicated to the patient and their family/ carers that we will be taking the event extremely seriously, that the event will be investigated and that the findings of the investigations will be shared with them. Through sharing the report/ local learning response, in draft form if appropriate, and meeting with the patient and family/carers, the patient will have opportunity to influence the investigation/ local

learning response and ensure any questions or concerns they have are adequately addressed. The discussion should be factual and should acknowledge where there is currently uncertainty.

Factors to consider when timing this discussion include:

• Clinical condition of the patient. The patient (or their representative) may require more than one meeting to ensure that all the information has been communicated to and understood by them

• Availability of key staff involved in the incident and in the Being Open process

• Availability of the patient's family and/or carers

• Availability of support staff, for example a translator or independent advocate, if required

• Patient preference (in terms of when and where the meeting takes place and who leads the discussion)

• Privacy and comfort of the patient and arranging the meeting in a sensitive location

Provision of additional support:

Support of the patient, their family / carers

Patients, their family / carers should be provided with support as is necessary during the process of fulfilling the 'duty of candour'. At any face-to-face meeting, they should be encouraged to be accompanied by another family member / friend / representative. Where appropriate, an independent advocate or interpreter should be offered. The patient is also at liberty to request a second opinion or independent review and this should be facilitated. Information on how patients can access additional support services and other relevant bodies should be offered, for example:

- Patient Safety team can be contacted on internal extension 4005
- Patient Support Services can be contacted on internal extension 8498
- Interpretation services via extension 4688
- Chaplaincy via internal ext. 6517
- Bereavement team via internal ext. 4587

External bodies which may be able to provide support for the patient:

- Action against Medical Accidents (AvMA)
- CRUSE (bereavement counselling support)
- ICAS- Independent Complaints Advocacy Services
- Relevant charitable organisations
- The patient's own GP

Where the patient is assessed not to have capacity

Where the patient has a formal assessment of lack of capacity, the principles of 'Being Open- a duty to be candid' still apply. In circumstances where the patient has a registered person with lasting power of attorney (LPA), it may be a legal requirement

that they are informed (dependent on the terms of the LPA). If there is no LPA for the patient, it is best practice that the family and or carers for the patient are informed of the incident. The occurrence of this conversation and the grounds for it must be recorded in the patient's medical record. Where the patient without capacity is 'unbefriended', their independent mental capacity advocate (IMCA) should be contacted to support the patient. The Trust's safeguarding team can be contacted for further advice.

Professional support

It can be traumatic for healthcare staff to be involved in an incident. UHS is committed to ensuring that staff feel supported through the 'Being Open-a duty of candour' process. Staff are also encouraged to seek support from their relevant professional body. A range of staff support is available via the Staffnet Wellbeing pages
UHS supports a Just and Learning culture and further information can be found: Justculture

Multi-professional responsibility

UHS acknowledges that patient care is delivered through multi-professional teams and the investigation into a patient safety incident is focused on systems and processes, rather than individuals. For this reason, senior clinicians and managers must participate in the investigation process and are responsible for ensuring patient's under their care are fully informed in the event of a patient harm event.

Confidentiality

Details surrounding an event are confidential. Full consideration should be given to maintaining the confidentiality of the patient, carers and staff involved, in line with the 'Data protection confidentiality policy'. Where the patient has capacity, their permission must be sought before disclosing details of an incident to their family or carers. It is good practice to inform the patient (or their representatives) about who will be involved in the investigation and give them opportunity to raise any objections. The patient and their family are in a unique position to give another perspective to the investigation and the opportunity to engage with them should be proactively sought out.

Communication outside the clinical team should be strictly on a 'need to know' basis. Equally the relatives may need specific questions answered by the investigation process and should be given the opportunity to raise these.

Continuity of care

Patients have the right to expect that their care will continue, and that they will receive all their usual treatment with the care, respect and dignity that they are entitled to. If the patient prefers their care to be delivered by another team, the appropriate arrangements should be made.

Requirements for documenting all communication

All discussions and communication with the patient, their family or carers should be carefully detailed in the patient medical case notes and on the incident form. Additionally, in reviewing the care for that patient, the interaction with the patient, their family or carers should be detailed within the investigation report or local learning response.

A duty of candour template is available via edocs and should be used for all incidents of moderate harm or above. The edocs can also be used for other any other level of harm if it would be helpful on a case-by-case basis. The discussion should also be recorded on the incident form.

Process for encouraging open communication between organisations, teams, staff, patients/carers.

'Being Open-a duty to be candid' forms part of education programmes. Guidance documents are available on staffnet, as are several template letters for the beginning of an investigation or local learning response. Other resources are available that encourage staff to 'be open' with patients, their relatives and carers, and make explicit their requirement to do so. Where an incident involves outside agencies (e.g., other healthcare providers, the Commissioners or social services) whether raised by UHS or the other agency, there is an obligation to fully co-operate with them and to communicate collaboratively with them.

Appendix 6: Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

The tables below set out the national and local (UHS) patient safety priorities:

OUR PATIENT SAFETY INCIDENT RESPONSE PLAN: NATIONAL REQUIREMENTS

	Patient safety incident type	Required response
1	Incidents meeting the Never Events criteria or its replacement	UHS led Patient Safety Incident Investigation (PSII)
2	Death thought more likely than not due to problems in care	UHS led PSII
3	Maternity and neonatal incidents meeting the HSIB (or its replacement)	Referred to Healthcare Safety Investigation Branch (HSIB) for independent patient safety incident investigation
4	Child deaths* * this should exclude expected deaths for those on end-of-life pathways	See local priorities for how we will decide level of investigation
5	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Local LeDeR panel review
6	Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence.	Refer to local authority safeguarding lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.
7	Incidents in the NHS screening programme	Refer to local Screening Quality Assurance Service for consideration of locally led learning response. See: Managing safety incidents in NHS screening programmes
8	Deaths in custody (e.g., police custody, in prison etc) where health provision is delivered by the NHS	In prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations. Healthcare providers must fully support these investigations where required to do so.

	Patient safety incident type	Required response
9	Deaths of patients detained under Mental Health Act (1983) or where Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the Learning from Deaths criteria)	PSII – likely to include other organisations
10	Mental Health related homicides	Referred to the NHS England and NHS Improvement Regional Independent Investigation Team for consideration for an independent PSII Locally led PSII may be required with mental health provider as lead and UHS participation if required
11	Domestic Homicide	A Domestic Homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a Domestic Homicide Review (DHR) are met, they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, sets out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide review

OUR PATIENT SAFETY INCIDENT RESPONSE PLAN: LOCAL FOCUS

Patient safety incident type or issue	Planned response	Anticipated improvement route
Hospital acquired category 3/4 or unstageable pressure ulcer	After action review (AAR)	Local safety actions to be identified and quarterly thematic analysis through patient safety steering group and pressure ulcer steering group
Falls within hospital leading to an injury (consider if it is a non-accidental injury (NAI) e.g., infant or adult who is tetraplegic)	After action review (AAR) If NAI – consider safeguarding	Local safety actions to be identified and quarterly thematic analysis through patient safety steering group and Trust falls steering group
Child deaths that are unexplained with UHS paediatric involvement within 12 months <18 years (Excluding neonates[1])	All reviewed by the Child Death and Deterioration (CDAD) panel to determine investigation type for e.g. Concerns regarding care – PSII On a child protection plan or safeguarding concerns refer to local authority safeguarding lead via UHS safeguarding Other child deaths consider Local learning response e.g., Morbidity and Mortality (M&M)	Local safety actions to be identified. Learning shared through Children's hospital governance group To contribute to trust wide learning from deaths learning.
Interruptions to clinical services leading to temporary closure / service diverts lasting >24 hours	Has this service previously experienced this issue? Yes – review previous incident(s) if no new learning complete a harm review tool. PSII if new learning identified No - PSII	Local safety actions to be identified. Learning shared through divisional governance and Quality Governance Steering Group

[1] A Neonate is a child under 28 days of age

Patient safety incident type or issue	Planned response	Anticipated improvement route
Infections	Healthcare associated C/Difficile - Initial Infection Prevention Team case review followed by an AAR if there are concerns about practice Hospital associated MRSA and Gram-negative blood stream infections - initial review with Senior IPN and Lead IP consultant to determine if more detailed IPT case review required followed by an AAR if there are concerns about practice Infection outbreaks/ incidents leading to bed closures. IPT/ Operational review of impact. Is there new learning? Yes – PSII No – Revisit previous actions Single infection incident e.g., Hospital acquired legionella or case of CJD – PSII	Local safety actions to be identified. Learning shared through divisional governance and Infection Prevention Committee.
Incidents relating to failure to rescue (Failure or delay in recognizing and responding to a hospitalized patient experiencing complications from a disease process or medical intervention).	Do we understand all the contributing factors? Yes – Review at M&M No - PSII	Local safety actions to be identified. Thematic reviews of incidents at Deteriorating Patient Group Learning shared via Patient Safety Steering Group

Patient safety incident type or issue	Planned response	Anticipated improvement route
Maternal or neonatal death not meeting the HSIB criteria I.e., maternal suicide	PSII	Local safety actions to be identified.
Maternal/ Neonatal cases that are externally reportable i.e., PMRT/ MBRRACE/ ATTAIN	All cases would be triaged when externally reported. PSII will be completed if significant learning identified.	Local safety actions to be identified.
Interruptions to supply of medication or equipment leading to disruption to patient care	PSII – If within UHS sphere of control Consider MHRA yellow card (in discussion with MDSO or MSO) If not significant learning or has been seen previously – local learning response Outside UHS sphere of control - ensure Duty of Candour has been completed and consideration of any mitigations required and escalate appropriately.	Local safety actions to be identified.
Incidents where patients care has been impacted by delays to treatment and or appointments and or investigations	Are the reasons for the delay understood e.g., Covid – harm review tool If not understood - PSII	Local safety actions to be identified.
Medication safety	Does the incident identify system-based learning? – Yes PSII No use of appropriate tool to identify local learning e.g., AAR	Review of individual and thematic learning through the Medication Safety Group. Trust wide learning escalated via Quality Governance Steering Group

Patient safety incident type or issue	Planned response	Anticipated improvement route
Incidents where patient care has been impacted on due to flow through the hospital. E.g., ED long waits[2], ICU bed capacity, patients no longer meeting the criteria to reside	Is there significant systems-based learning? Yes – PSII No – Local M&M / Case note review Align with improvement workstreams	Local safety actions to be identified.

Maternity

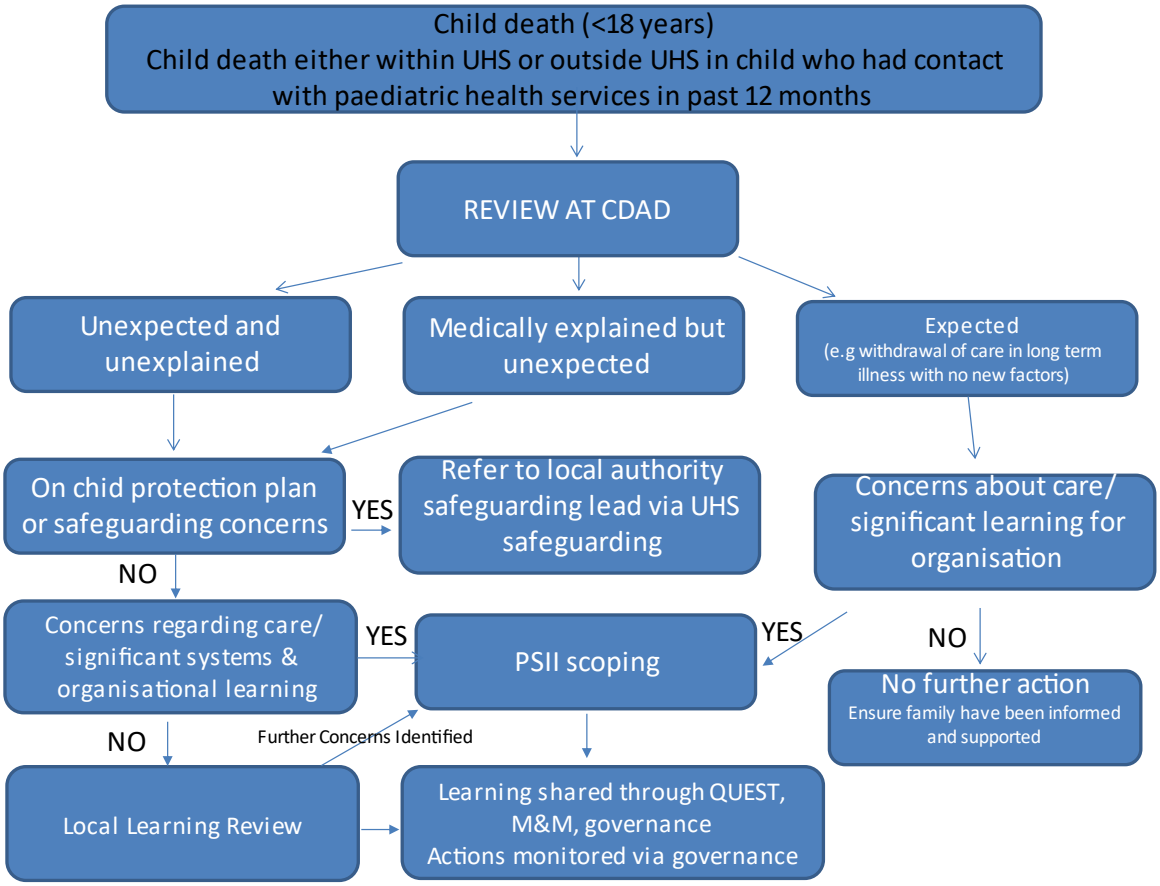
The University Hospitals Southampton NHS Foundation Trust (UHS) maternity and neonatal service are committed to providing a focus on patient safety, professional and public accountability, whilst acting responsibly within the financial and resource constraints imposed upon it. Responding appropriately when things go wrong in the care and treatment of women, neonates and their families is a key part of the way that the maternity and neonatal services will continually improve the safety of the services that it provides. Additionally, responding appropriately to incidents or circumstances that have caused or may have caused harm to staff, including contracted staff, or visitors is key to the service maintaining the safety and wellbeing of all.

For full governance arrangements for maternity patient safety please use this Link

Children:

The following flowchart shows the process to be followed for children (Excluding neonates). A detailed Governance document for patient safety within the Children's Hospital is in development and will be linked within this document.

[2] This is not defined by time but based on the clinical condition of the patient.



Research

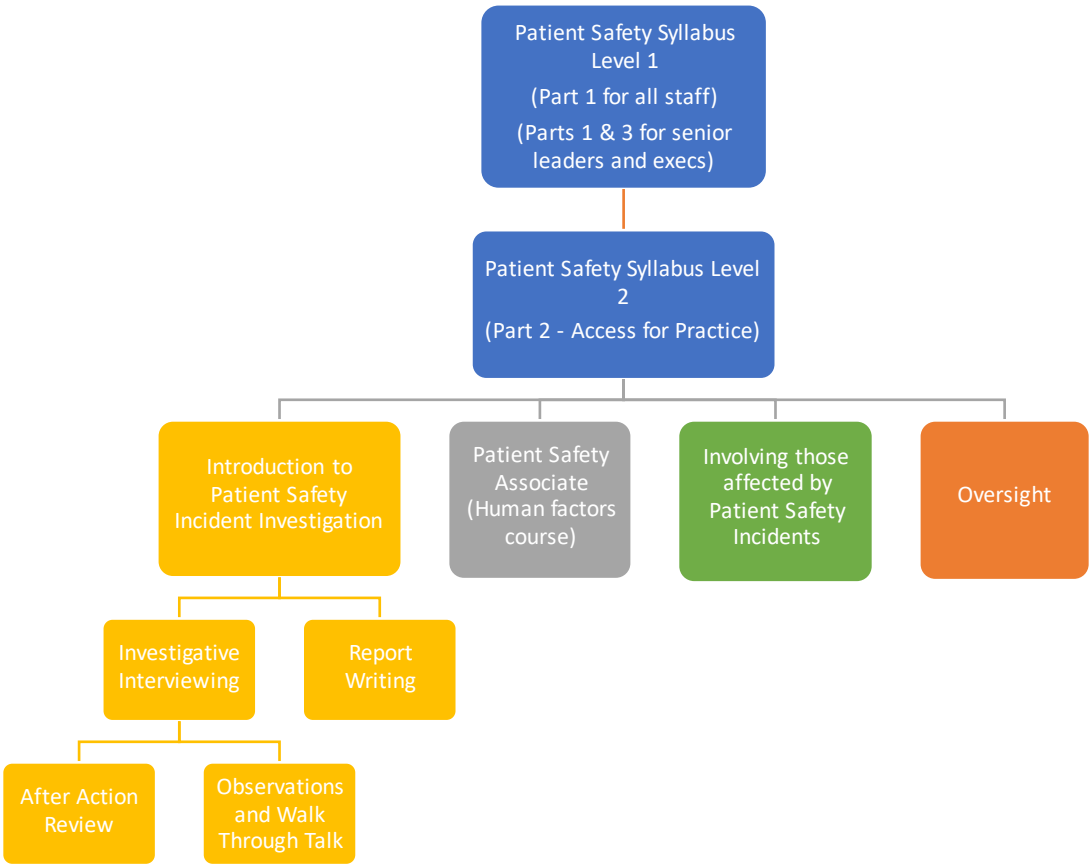
Significant research events that impact patient safety as per the patient's safety incident response plan and / or would normally be notified to the sponsor should be recorded on the trust incident reporting system.

Appendix 7: Patient Safety Education

Resources and training to support patient safety incident response

UHS Patient Safety Training Pathway

This is a suggested pathway and does not reflect the availability of the courses. The emphasis should be on the patient safety syllabus, introduction to patient safety incident investigations then the different investigative tools.



PSIRF Standard Mandated Training Requirements for accredited (HSIB) courses

Role	Patient Safety Syllabus Level 1	Patient Safety Syllabus Level 2	Level 2 - A systems approach to learning from patient safety incidents	Involving those affected by patient safety incidents in the learning process	Oversight of learning from patient safety incidents
Learning Response Lead	☐	☐	☐		
Engagement Lead	☐	☐		☐	
Oversight	☐	☐	☐		☐

HSIB Investigation Tools (not mandated but useful)

Role	Investigative interviewing	Safety investigation for strategic decision makers and senior leaders in healthcare	Demystifying thematic analysis	After Action Review	Report Writing	Use of Systems Engineering Initiate for Patient Safety (SEIPS) (under development)	Level 3 – A systems approach to learning from patient system incidents: theory into practice (under development)
Learning Response	☐		☐	☐	☐	☐	☐
Oversight	☐	☐			☐		
Divisional Governance Roles (including Patient Safety Nurses)	☐		☐	☐	☐	☐	☐
Patient Safety Team	☐	☐ **(HoPS, DHoPS, CDPS and Education Lead)**	☐	☐	☐	☐	☐
Medical Scoping Leads	☐		☐	☐	☐	☐	

Internal Courses – unaccredited training

Role	Introduction to Patient Safety Incident Investigations	After Action Review (in development)	Investigative Interviews (in development)	Observations and Walk Through Talk Through (in development)	Report Writing (in development)	Involving those affected by PSIs	Oversight (in development)	Patient Safety Associates Course
Patient Safety Team	☐							☐
Divisional Governance Roles (including Patient Safety Nurses)	☐							☐
Medical Scoping Leads	☐							☐
Staff involved in investigations but not identified as leads	☐	☐	☐	☐	☐	☐	☐	☐

Appendix 8: PSIRF Learning Response Methods

Introduction

1. The transition to PSIRF will enable the Trust to choose what methods of investigation are used for different patient safety incidents. The Patient Safety Incident Response Plan will indicate what incidents will be investigated and to which levels, whether a patient safety incident investigation or a local learning response.

2. The different methods that can be used to obtain further information about the incident can be found in the table below. They can be used for either patient safety incident investigation or a local learning response.

Patient Safety Incident Investigations (PSII)

PSIIs are undertaken to identify new opportunities for learning and improvement. PSIIs focus on improving healthcare systems; they do not look to blame individuals. Other organisations and investigation types consider issues such as criminality, culpability or cause of death. Including blame or trying to determine whether an incident was preventable within an investigation designed for learning can lead to a culture of fear, resulting in missed opportunities for improvement.

The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.

PSIIs begin as soon as possible after the incident and are normally completed within three months. This timeframe may be extended with the agreement of those affected, including patients, families, carers and staff.

If a PSII finds significant risks that require immediate action to improve patient safety, this action will be taken as soon as possible. Some safety actions for system improvement may not follow until later, according to a safety improvement plan that is based on the findings from several investigations or other learning responses.

The investigation team follow the Duty of Candour and the Engaging and involving patients, families and staff after a patient safety guidance in their collaboration with

those affected, to help them identify what happened and how this resulted in a patient safety incident. Investigators encourage human resources teams to follow the Just Culture guide in the minority of cases when staff may be referred to them.

PSIIs are led by a senior lead investigator who is trained to conduct investigations for learning. The investigators follow the guidance set out in the Patient Safety Incident Response Framework and in the national patient safety incident response standards.

Within UHS all new cases will be reviewed at the New cases meeting, chaired by an expert in Patient Safety and Human Factors. The group will ensure that the investigation terms of reference meet the needs of the investigation and agree the plan for engagement with those affected.

At the conclusion of the PSII it will be presented at the Patient Safety Incident Investigation Oversight Group who will ensure that the investigation has answered the Terms of Reference, involved those affected and has identified appropriate safety actions.

Table highlighting some of the methods available:

Name of method	Description	Links
After Action Review (AAR)	The after-action review is a structured approach to reflect on the work of a group and identifies strengths, weaknesses and areas for improvement. It usually consists of a facilitated discussion lasting approximately 1 hour to answer 4 questions – a. What were we trying to do? b. What did we do? c. Why is there a difference? d. What can we learn?	QSIR After Action Review learning-handbook-after-action-review.pdf (england.nhs.uk)
Multidisciplinary Team (MDT) Review	The multidisciplinary team review supports health and social care teams to identify learning from multiple patient safety incidents (includes incidents where multiple patients are harmed or where there are similar types of incidents. Key stakeholders are identified and invited to a workshop. The aim of the workshop is to understand work as	B1465-MDT-review-v1_FINAL.pdf (england.nhs.uk)

Name of method	Description	Links
	done using a systems approach such as AcciMap or SEIPS. This is to identify weakness in the system and areas for improvement.	
Patient Safety Incident Investigation (PSII)	A patient safety incident investigation is undertaken when an incident or near miss indicates significant patient safety risks and potential for new learning. The focus of a patient safety incident investigation is to explore and understand decisions and actions related to the incident.	B1465-PSII-overview-v1-FINAL.pdf (england.nhs.uk) B1465-PSII-Report-Template-v1.1.docx (live.com)
Swarm Huddle	A swarm huddle takes place as soon as possible after a patient safety incident occurs. Staff meet at where the incident happened. This is a quick analysis of what happened, how it happened and what needs to be done to reduce risk. It is similar to an after-action review but has a more systems thinking focus to it. It uses a systems framework such as AcciMap or SEIPS to guide the discovery. A major difference is that the swarm huddle asks where else in the organisation this could happen. It also identifies actions, leads and deadlines (if possible).	B1465-Swarm-huddle-v1-FINAL.pdf (england.nhs.uk)
Interviews	This is a conversation with a purpose. The purpose is to understand what happened and how. The interview will assist in the exploration of system interactions that could have influenced the decisions and actions taken at the time.	NHS England » Guidance on planning and conducting interviews as part of a patient safety incident learning response
Link Analysis	A link analysis (spaghetti diagram) is a visual representation of the number of interactions that occur in a specific location or environment. It is particularly useful when understanding work as done.	B1465-Link-analysis-v1-FINAL.pdf (england.nhs.uk)

Name of method	Description	Links
Observations	A researcher/investigator observes work as done. This allows the real time interactions between the parts of a system to be observed, the transactions each practitioner makes to achieve their actions is seen.	B1465-Observations-v1-FINAL.pdf (england.nhs.uk)
Walk Through Talk Through	A walk-through talk through is a structed process to collect and analyse information about a specific task or process. It uses observation and discussion where someone unfamiliar with process is guided through it with a practitioner/subject matter expert.	B1465-Walkthrough-analysis-v1.1-.pdf (england.nhs.uk)
Harm review Tool	Initially developed to support RTT long waits and adapted for use during Covid, this is a tool that clinicians can use to identify if and level of harm of their patients and the likely cause of delay. It also allows for immediate actions to be identified.	

Appendix 9: Reviewing our patient safety incident response policy and plan.

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan at 6 months and then every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

We will review our implementation through a range of metrics including:

- Number of PSII undertaken – Total
- Number of PSII undertaken against each priority
- Patient and family feedback
- Staff feedback
- Investigation team and patient safety feedback
- Thematic analysis of AAR including PU and Falls
- Numbers and themes of incident reports

Appendix 10: Responding to patient safety incidents.

Patient safety incident reporting arrangements

There is overwhelming evidence that NHS organisations with a high level of incident reporting are more likely to learn and subsequently increase safety for their patients, staff and visitors. Learning is the end point for any patient safety investigation and this policy sets out the way incidents are investigated and learning embedded in the Trust. UHSFT is committed to learning from incidents and communicating the findings openly and transparently with patients and their families. This requires a robust process which is balanced and fair.

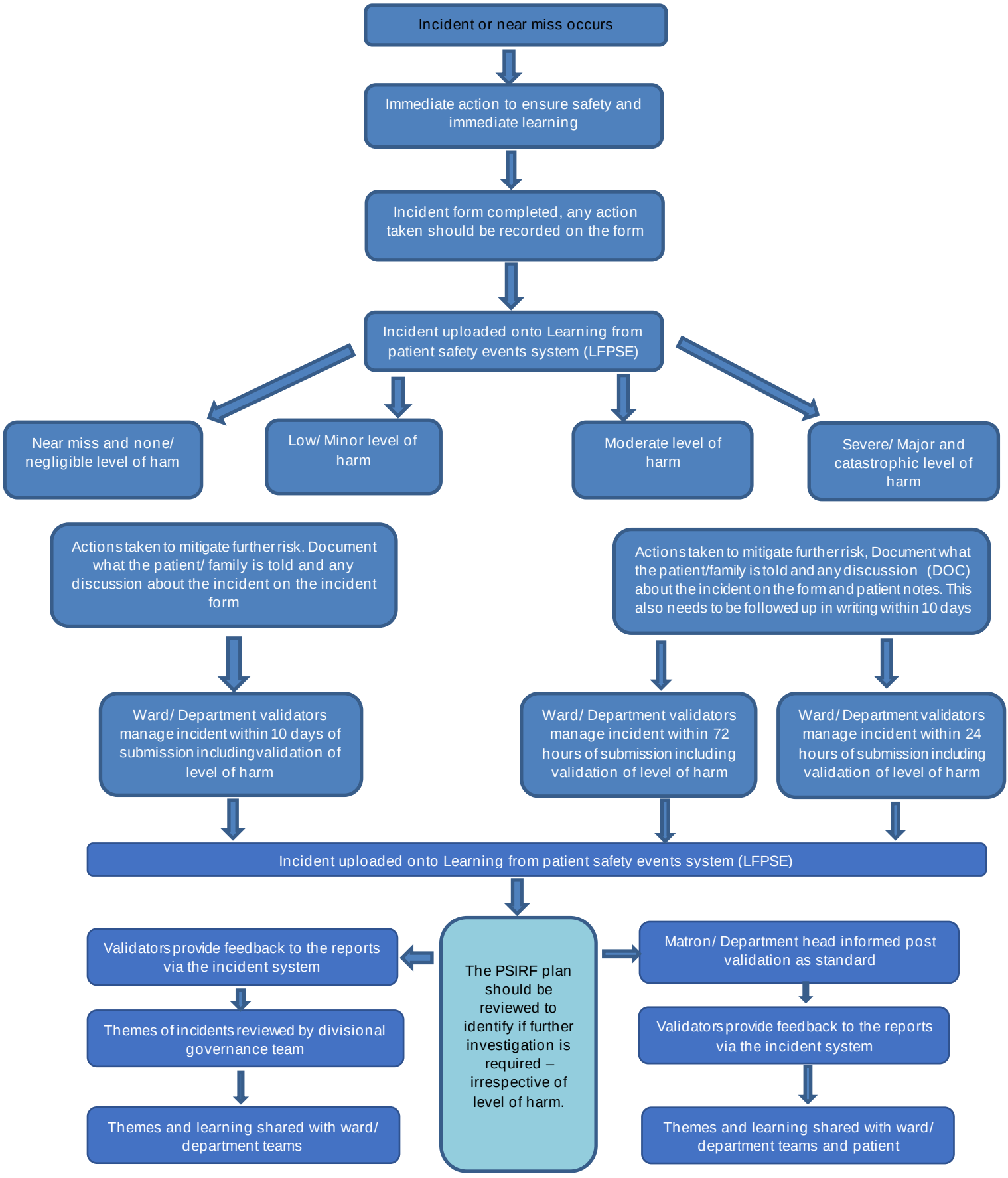
SPEAK UP

LISTEN UP 

FOLLOW UP

The flowchart below demonstrates the process for completion and validation of incidents reported on Ulysses.

Incident Reporting, management, and escalation process



Incident reporting

INCIDENT REPORTING – THIS SECTION IDENTIFIES THE TRUST'S PROCESS FOR INCIDENT REPORTING.

UHSFT is committed to learning from incidents and communicating the findings openly and transparently with patients and their families. This requires a robust process which is balanced and fair. This policy describes the principles and processes for managing all types of incidents of all levels of harm, whether it be to patients, visitors, staff or contractors.

SCOPE AND PURPOSE

This policy applies to all incidents, whether patient safety or non-clinical, to provide a consistent approach to incident management and reporting. It applies to all members of Trust staff and all staff employed by other organisations who are working on Trust premises.

This section of the policy sets out University Hospital Southampton (UHS) NHS Foundation Trust systems, processes and expectation in relation to incident reporting. It includes:

- Process for reporting all incidents, accidents and near misses involving staff, patients and others.
- Process for reporting to external agencies.
- Training requirement for staff.
- Process for monitoring this policy.

Compliance with this policy will ensure that incidents are systematically identified, recorded, reported and appropriately investigated resulting in learning and thus improving safety for future patients, staff and visitors.

It should be noted that whilst the principles of this policy apply to all incidents there are some specific incidents and terminology which are used in respect of reporting to bodies such as the Human Tissue Authority and in research related events. Those areas which are required to report to such external bodies will have local procedures for managing such externally reportable incidents which should be followed in addition to this policy.

Details of Procedure to be followed

Incidents cover a wide range of events and may affect patients, staff and others. The table below gives examples of incidents/accidents and near misses.

Clinical Incidents	Non-Clinical/ Health and Safety
• Delays / Failure of treatment / care • Incorrect patient identification • Inadequate / incomplete health records • Failure to obtain valid consent • Inadequate observations / checks undertaken • Medical device failure / unavailability • Significant or unexpected complications of a clinical procedure / treatment • Hospitalisation of patients undergoing research trials • Venothromoembolism (VTE) • Pressure Ulcers category 2,3, 4 and unstageable • Patient falls • Diagnostic error • Unplanned re-admissions • Breach in confidentiality • Unexpected death* • Healthcare associated infection outbreaks • Exposure to blood/bodily fluids • Patient exposure to excess radiation * Incidents resulting in unexpected death or serious injury must always be reported immediately to a senior member of staff (usually to include line manager and named on-call consultant as appropriate).	• Visitor / Staff slip, trip and fall • Needlestick / inoculation injuries • Back Injury • Hazardous substances exposure • False fire alarms • Passenger lift failure • Struck by moving object/machinery • Utility failure (water, electricity, gas, etc.) • Equipment failure / unavailability • Adverse publicity – risk to reputation • Significant disruption to service delivery • Breach of statutory legislation • • Staffing levels that reduce service quality / staff well being
Security Incidents	**Medication Errors**
• Absconding patients • Breach of confidential information (Information Governance) • Theft*/damage to Trust or personal property (including fraud) • Suspicious person *All incidents involving theft must be reported to Security.	• Prescription errors • Administration errors • Inadequate storage • Dispensing errors • Disruption to supply
Violence, Abuse, and harassment (Staff/Patients or visitors)	**Occupational ill health**
• Verbal abuse • Racial / sexual harassment • Physical assault	• Occupationally acquired infections • Occupationally acquired dermatitis

PROCESS FOR REPORTING ALL INCIDENTS, ACCIDENTS AND NEAR MISSES INVOLVING PATIENTS, STAFF AND OTHERS

Any staff member/student involved in or who has witnessed an incident, accident or near miss involving patients, staff or others must complete report the incident.

All incidents, accidents and near misses can be reported directly onto the incident reporting database, Ulysses, which is available from all networked PCs within the organisation and via a VPN outside of the organisation. The electronic incident reporting system is accessible to any person directly employed by the Trust via the hyperlink Link on Staffnet for all other staff they should report using the e mail address reportmyincident@uhs.nhs.uk or Reportandsupport@uhs.nhs.uk if it's an incidence of violence and aggression.

All incidents will be uploaded onto the Learning from Patient Safety Events (LFPSE) which replaced National Reporting and Learning System (NRLS) in early 2023. LFPSE allows for outside organisations to report incidents directly to UHS via the LFPSE and vice versa.

The incident must be reported to the appropriate ward/department manager for the ward/department in which the incident occurred on the electronic incident reporting system to ensure the collection of all relevant and significant facts. Incident forms must, wherever possible, be completed promptly by the member of staff who first becomes aware of the incident.

Any incidents that have been graded as severe/catastrophic actual harm or red/red-red potential future risk) must be reported to the Patient Safety Team immediately (in hours) or to the Site Coordinator/Duty Manager (out of hours) if urgent advice or immediate action required.

Any immediate action taken to minimise the risk of the incident recurring should be documented on the incident form. When completing the incident form, you should record **facts** only and not personal opinion or best guess as to what happened.

As a minimum the following must be reported:

- What happened?
- When did it happen?
- Where did it happen?
- Who was involved (including the recording of any injuries sustained and treatment given)?
- Has the patient or relative been informed of the incident (duty of candour)?
- What is the initial risk assessment (identifying the likelihood/probability of that incident from re-occurring in similar circumstances and the

consequence/harm that may subsequently occur)?
- What impact did the incident have (actual harm to the person(s) involved or the organisation)?

There are some incident types that will require additional sections of the incident form to be completed; these sections will appear depending on the category selected by the reporter.

The additional sections are:

- Medical Devices (if reporting a medical device incident)
- Medication (if reporting a medication incident/error)
- Witnesses (if there were any witnessed to the incident)
- Police Involvement (if the police had to be contacted as a result of the incident)
- Questionnaires (these are generated dependent on the category chosen, primarily those relating to sharps injuries, slips/trips/falls, staffing, and violence and aggression)

If any equipment is involved the incident should be actioned in accordance with the specific requirements of the Medical Devices and Equipment Management and Training Policy. **The equipment must labelled and quarantined until reviewed by the medical device safety officer or deputy.**

INCIDENTS INVOLVING STUDENTS IN PRACTICE

There is a requirement for any student working in any capacity at UHS to report an incident using the e mail address reportmyincident@uhs.nhs.uk . If any student is involved, either directly or indirectly in an incident that requires the completion of a UHS adverse event report, the student will also need to refer to their university faculty with regards to the completion of the required university documentation which will support agreed dual reporting processes if needed. It is the student's responsibility to complete this document and return to their university.
Any incident that is related to incidents in practice must also be reported to the Education Quality and Learning Environment Lead who will forward information as appropriate and liaise with the universities as required.
If the incident is a RIDDOR reportable, there will be a need for a joint reporting process which will require statements and investigation through the UHSFT health and safety department as per the RIDDOR policy. The Health and Safety Department can be contacted for support and advice.

INCIDENTS INVOLVING JUNIOR MEDICAL STAFF

The Division, Care Groups and Patient Safety Team must ensure that the education supervisor/mentor of the junior medical staff and the Director of Education is informed, in order that they may inform the Deanery so that appropriate support mechanisms can be put in place and actions taken to ensure lessons are learned

and any fitness to practice or individual learning needs are addressed.

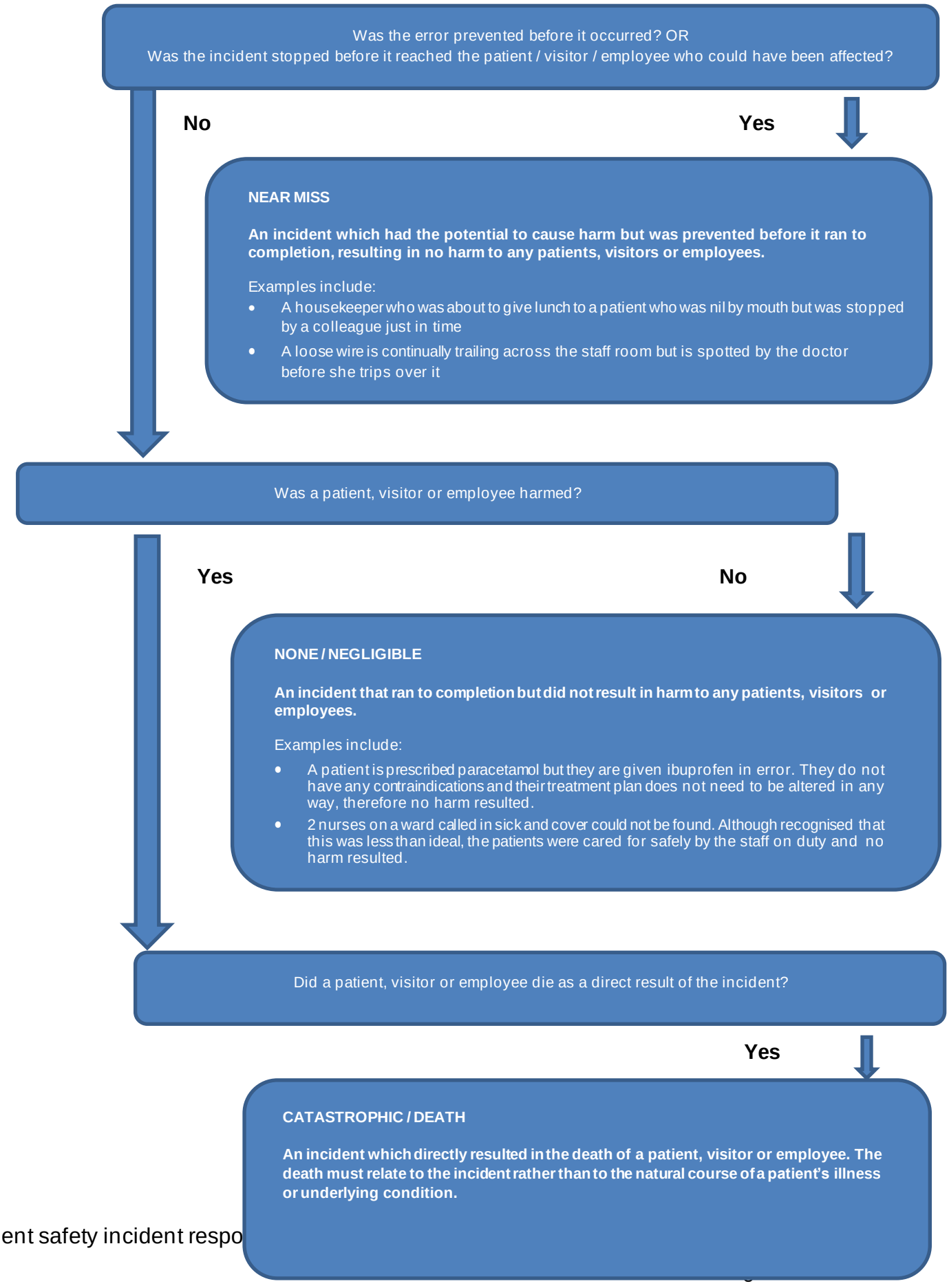
INCIDENTS INVOLVING TEMPORARY STAFF

Bank and agency staff should report and incidents immediately to the Nurse in charge or shift leader. They should then send an e mail to reportmyincident@uhs.nhs.uk with the details to enable the patient safety team to complete the online incident form.

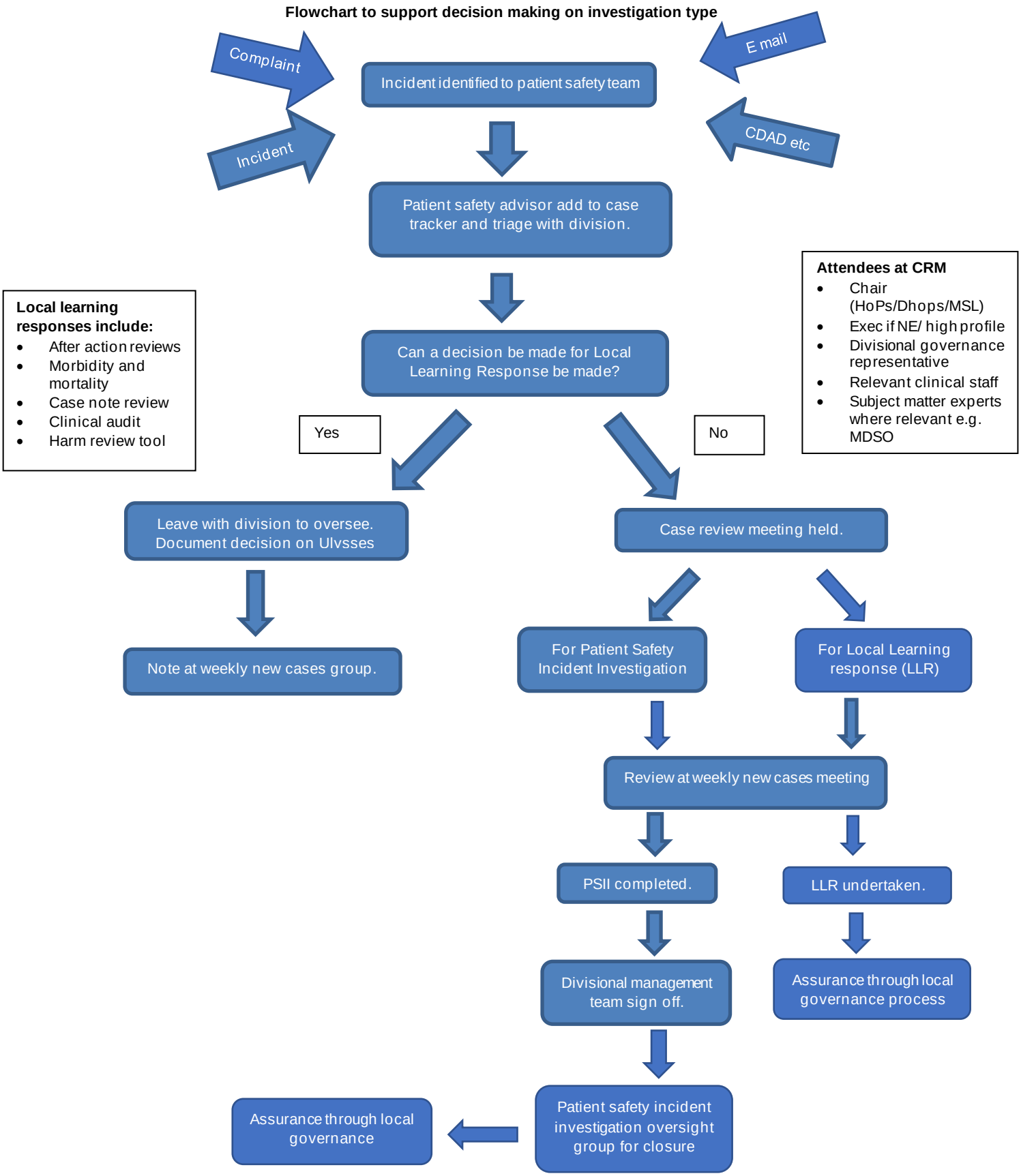
PROCESS FOR STAFF TO RAISE CONCERN

All concerns relating to the safety of patients or others should be raised in accordance with guidance outlined in the Trust's Raising Concerns / Whistle Blowing Policy Link

Actual impact decision making tool



Patient safety incident response decision-making



Responding to cross-system incidents/issues

UHS will follow the Patient Safety Response Standards (Link) Key principles:

- Integrated Care Systems (ICS) provide necessary support to facilitate cross-system learning responses.
- Where multiple organisations need to be involved in a single learning response, the response is led by the organisation best placed to investigate the concerns. This may depend on capability, capacity, or remit.
- Organisations consider whether a learning response needs to examine the care provided throughout a specific care pathway as opposed to focussing solely on the part of the pathway most proximal to the incident.
- Organisations actively engage partner organisations that provided care to the patient(s) involved where that care may have played a role in the incident being examined.
- Organisations work together and co-operate with any learning response that crosses organisational boundaries.

Timelines for patient safety investigations / learning responses

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident has been identified and should ordinarily be completed within one to three months of their start date. No local PSII should take longer than six months to complete.

The timeframe for completion of a PSII will be agreed with those affected by the incident, as part of setting the terms of reference, provided that they are willing and able to be involved in that decision. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

In exceptional circumstances (e.g., when a partner organisation such as the police requests an investigation is paused, or the process of an external body delays access to information) the Trust can consider whether to progress the PSII and determine whether new information indicates the need for further investigative activity once this is received. This would require agreement at the Patient safety incident oversight group.

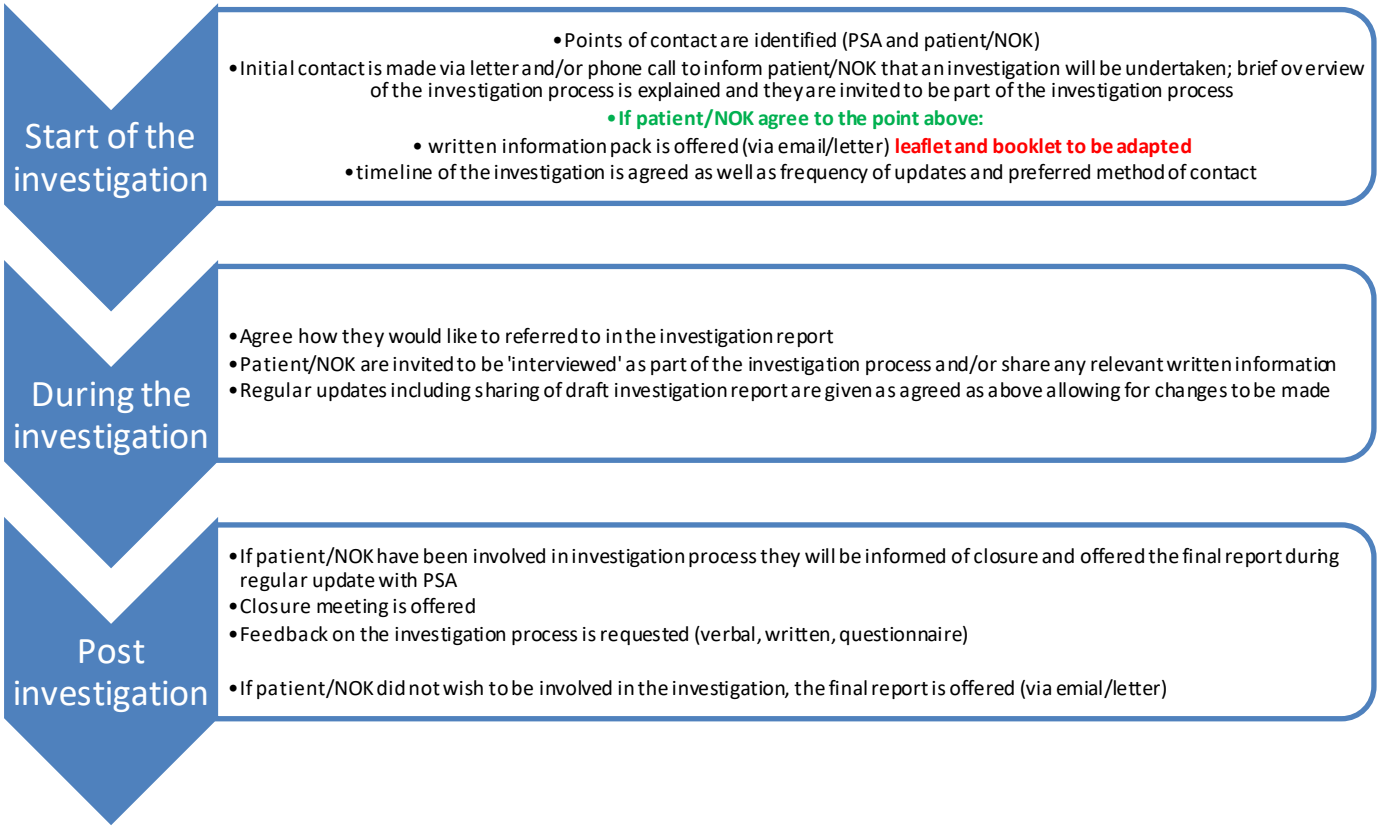
In exceptional circumstances a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the trust and those affected.

Timescales for other forms of learning response will be shorter than when completing a PSII and should be completed within 1 to 3 months unless agreed with the patient and the Patient Safety Incident Investigation Oversight group.

Process for involving patients & families

The PSIRF recognises that meaningful learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. The PSIRF supports development of a patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents. 'Those affected' include staff and families in the broadest sense; that is: the person or patient (the individual) to whom the incident occurred, their family and close relations. Family and close relations may include parents, partners, siblings, children, guardians, carers, and others who have a direct and close relationship with the individual to whom the incident occurred.

The graphic below shows the principles for engaging with patients and families at UHS.



Safety action development and monitoring improvement

The systems-based patient safety incident investigation will identify key themes for learning. From these the areas for improvement will be identified and safety actions developed. These safety actions should be developed with those involved in delivering the service/ those involved in the incident.

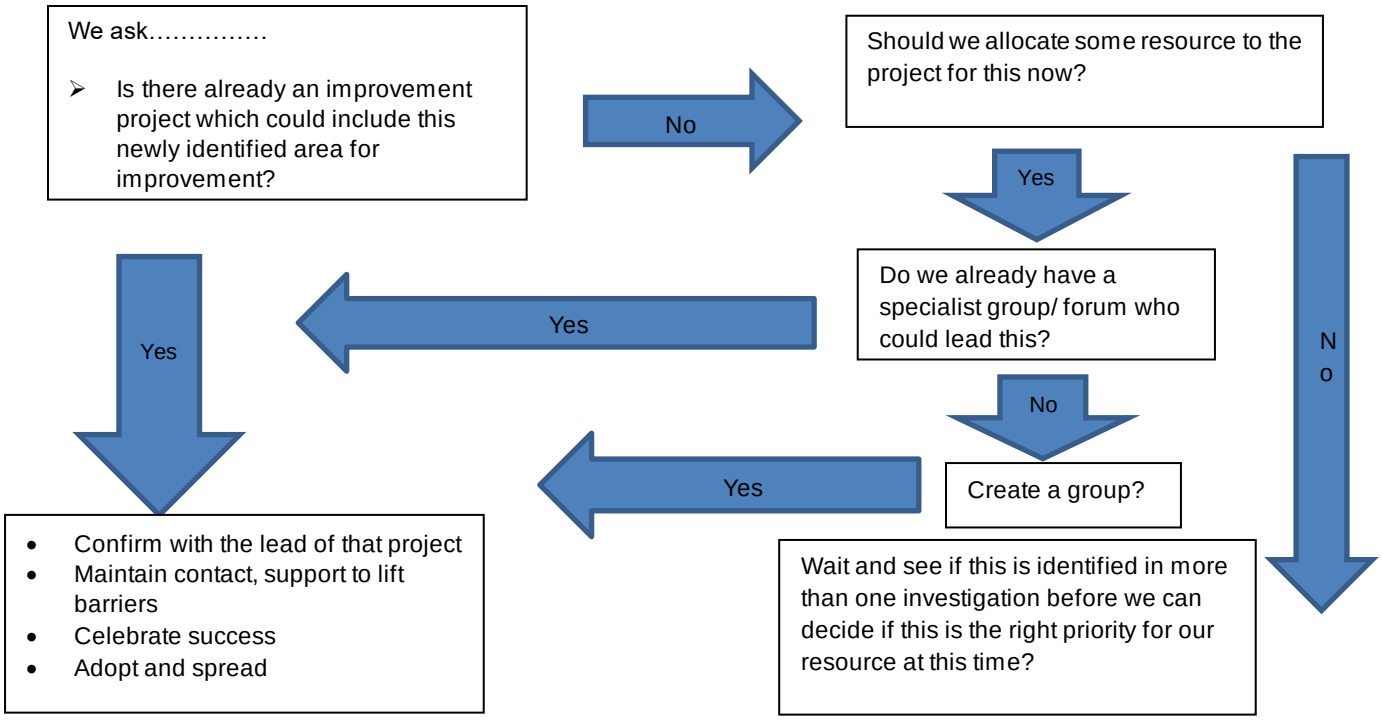
Identify immediate safety actions – scoping/ case review

Review of initial safety themes will be made at the scoping/ case review with those involved to identify any immediate safety actions.

Safety actions following investigation

Following the PSII the areas of improvement and safety actions for those areas of improvement will be identified, and measurements agreed at the Patient Safety Incident Investigation Oversight Group. Actions identified will be assessed to see how they align with current quality improvement projects and will be considered as to whether they are local or trust wide QI improvement actions.

Process for a move into improvement - Principles



Action plans/ patient safety learning recommendations:

Purpose – to ensure future harm is reduced

System-level problem actions usually fall into one of these:

- Standardizing equipment
- Ensuring redundancy, such as using double checks or backup systems
- Using forcing functions that physically prevent users from making common mistakes.
- Changing the physical architecture
- Updating or improving software
- Using cognitive aids, such as checklists, labels, or mnemonic devices
- Simplifying a process
- Educating staff
- Developing new policies

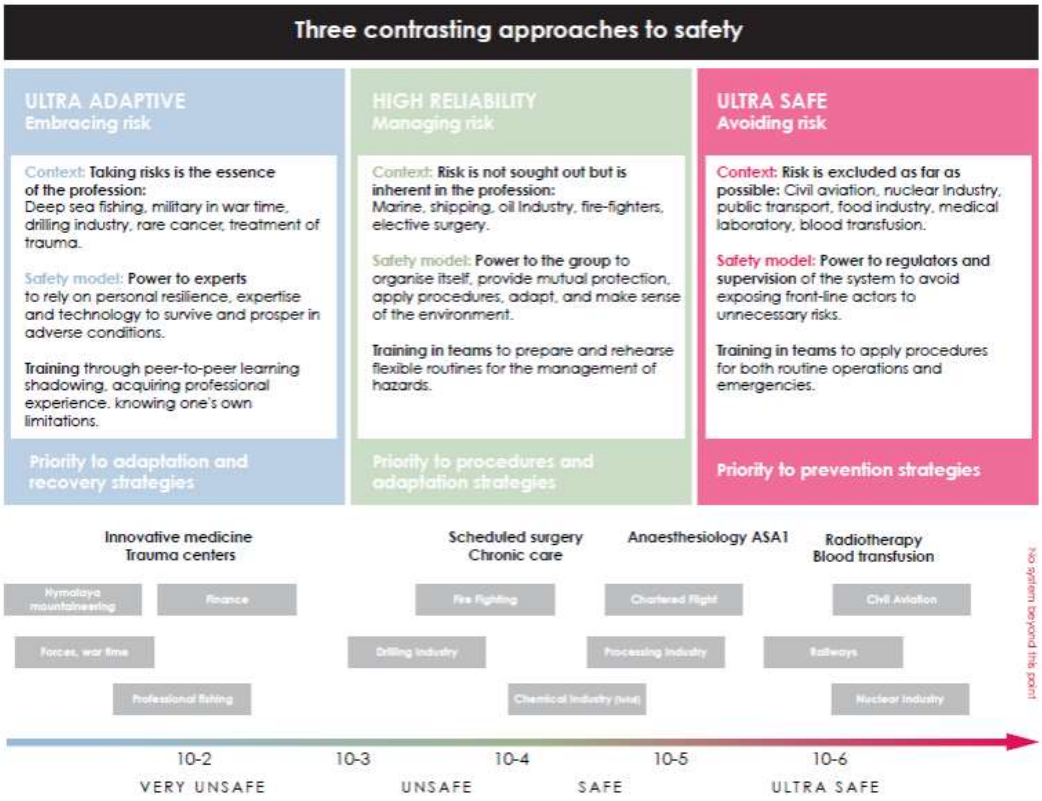
Action strength	Action examples
Stronger	Architectural/physical changes New devices with usability testing Engineering control (force the function) Simplify process Standardise equipment/process Tangible involvement by leadership
Intermediate	Redundancy Increase staffing/decrease workload Software enhancement/modifications Education Checklist/cognitive aids Eliminate look-and-sound-alikes Standardised communication tools Enhance documentation, communication
Weaker	Double checks Warnings Training New procedure/policy

Hierarchy of actions

Kaiser Permanente health system

Whilst the hierarchy of actions is important to consider we also need to be aware of the risk system that is being affected. Are we looking at risk avoidance (e.g. blood transfusion) where standardisation is very important or is this a ultra adaptive situation where we need to embrace risk and things like training and simulation may be really important.

Diagram below is from Vincent and Amalberti, Safer Healthcare (2016)

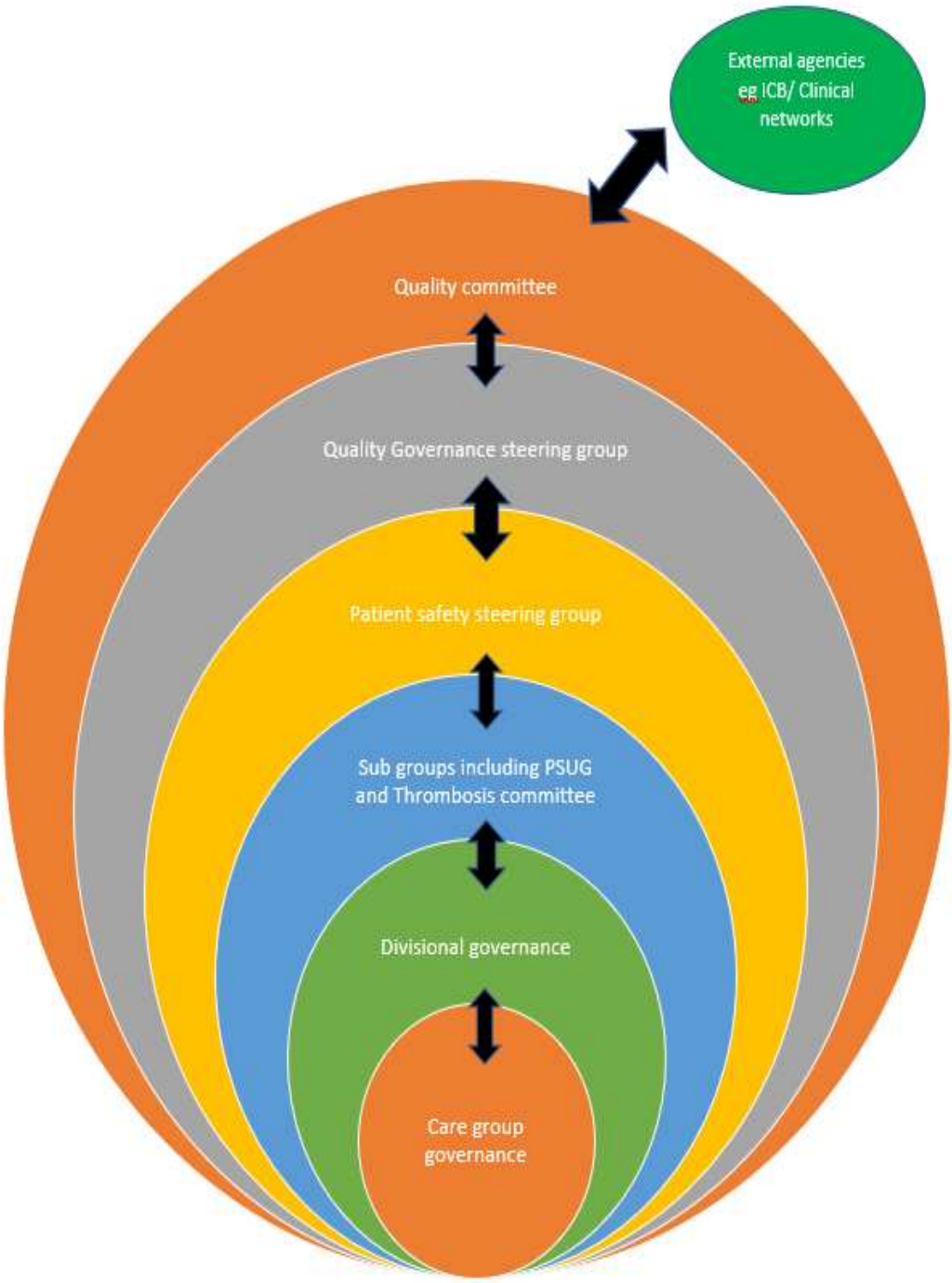


Monitoring of actions/ Assurance

The process for the Trust to ensure that there are appropriate assurances around actions and improvement plans will be through the current governance processes, with the expectation that the divisions will utilise their monthly reports to Quality Governance Steering Group to escalate concerns and requests for support.

Sharing of themes and learning

It is important that we share the learning from Local Learning Responses as well as PSII's. The main place for learning to be shared with frontline staff is via the care group/specialty governance and M&M meetings.



Safety improvement plans

As we move into PSIRF and begin embedding the creation of system-based actions we will work to generate our Patient safety improvement plans. This patient safety improvement structure will be described in a later version of this policy.

We will provide thematic analysis of elements of patient safety to the relevant subgroup (e.g., Pressure ulcer steering group or Thrombosis committee) and then to QGSG and Quality committee

Appendix 11: Oversight roles and responsibilities

Oversight of patient safety incident response has traditionally included activity to hold provider organisations to account for the quality of their patient safety incident investigation reports. Oversight under PSIRF focuses on engagement and empowerment rather than the more traditional command and control. This means that UHS has the accountability for oversight of their patient safety learning and improvements.

Oversight mindset

The following 'mindset' principles should underpin the oversight of patient safety incident response:

1. Improvement is the focus: PSIRF oversight should focus on enabling and monitoring improvement in the safety of care, not simply monitoring investigation quality.

2. Blame restricts insight: Oversight should ensure learning focuses on identifying the system factors that contribute to patient safety incidents, not finding individuals to blame.

3. Learning from patient safety incidents is a proactive step towards improvement: Responding to a patient safety incident for learning is an active strategy towards continuous improvement, not a reflection of an organisation having done something wrong.

4. Collaboration is key: A meaningful approach to oversight cannot be developed and maintained by individuals or organisations working in isolation – it must be done collaboratively.

5. Psychological safety allows learning to occur: Oversight requires a climate of openness to encourage consideration of different perspectives, discussion around weaknesses and a willingness to suggest solutions.

6. Curiosity is powerful: Leaders have a unique opportunity to do more than measure and monitor. They can and should use their position of power to influence improvement through curiosity. A valuable characteristic for oversight is asking questions to understand rather than to judge.

Questions to guide provider board oversight of patient safety incident management and improvement B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf (england.nhs.uk)

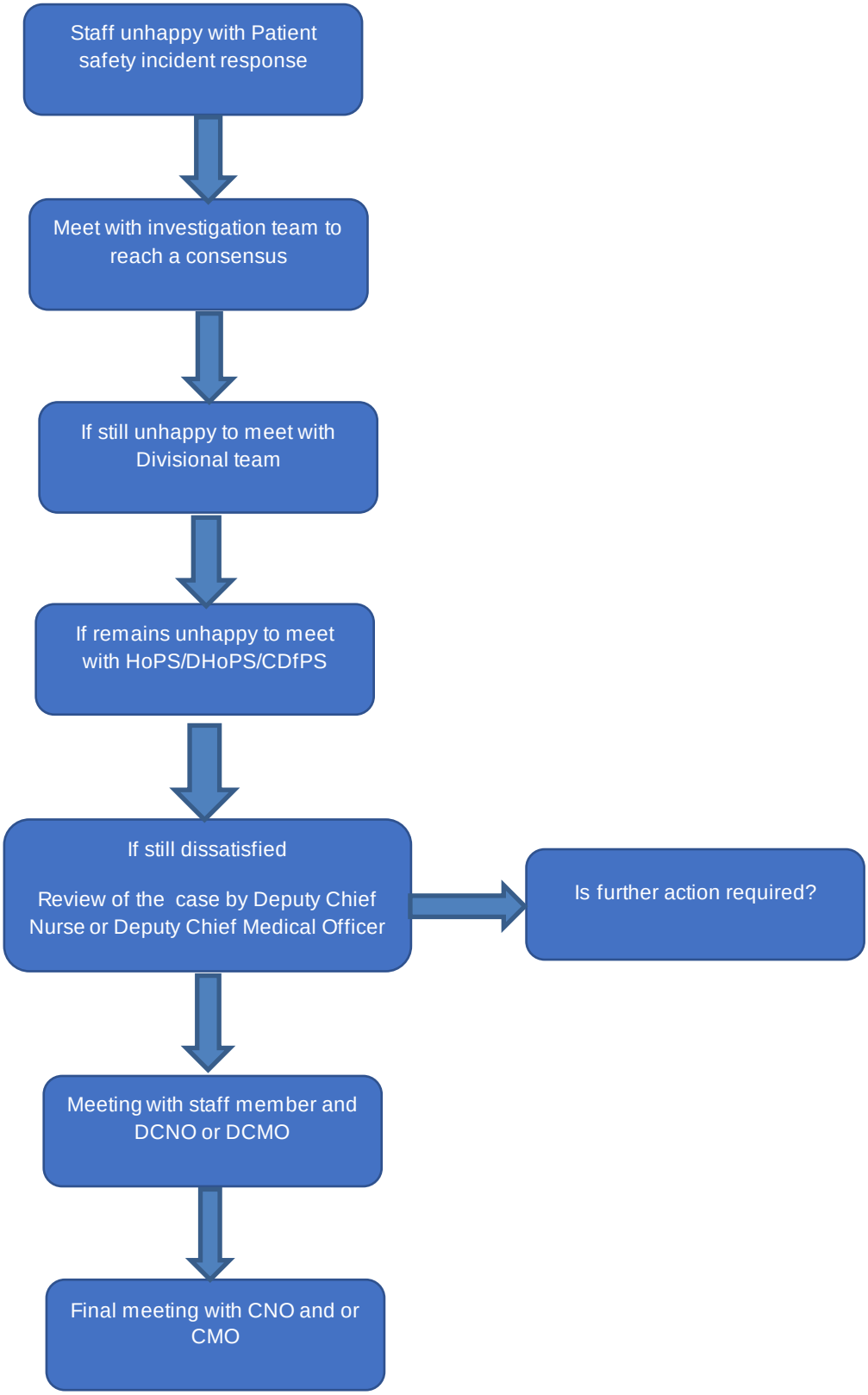
Oversight Questions	
Engagement and involvement of those affected by patient safety incidents	• How do we ensure those affected by patient safety incidents are engaged and involved in any learning response? • Does engagement include prompt and effective communication between those affected by a patient safety incident and our organisation? • Does engagement and involvement occur respectfully and according to individual needs? • How do we know how well our processes are working? What are the current barriers? • Are patients or staff with protected characteristics represented more often than others in any of our incidents and responses? What are the organisational or cultural reasons behind this?
Policy, planning and governance	• Does our patient safety incident response plan match the risks that feel tangible to us as an organisation? • Does emerging intelligence match our assumptions about the biggest risks in our plan? • Can we demonstrate wide collaboration and stakeholder involvement in the development and maintenance of our plan? • Does our plan demonstrate a thorough analysis of data and provide a clear rationale for the selection of patient safety incidents for further learning? • Is our ICB assisting cross-organisation working and information sharing? • How do we choose our response to a patient safety incident? • How do we support those who bring 'bad news' or surprises about organisational safety?
Competence and capacity	• Are we employing and continuously developing expertise in patient safety science for key roles? • Are our learning responses adequately resourced (including funding, time, equipment, and training)? • Are training and competence requirements met for learning response leads? • Do we have the competence within our teams to feel we can confidently have conversations with patients and families about patient safety incidents? • Does our ICB have its own continuous development plans in patient safety science training and competence to enable it to participate effectively? • Are our teams confident in having conversations with patients and families affected by an incident but where an individual learning response will not be completed in response?
Proportionate responses	• How are we triangulating insight from our responses to patient safety incidents? • Are we using recognised system-based methodologies for data collection and analysis?

Oversight Questions	
	• Is external guidance/information used to inform patient safety responses and findings? • Do we have collaborative arrangements with our ICB to facilitate cross-system learning responses? This includes processes for recognising when support may be required and raising this with ICB colleagues. • Are learning responses completed in a timely manner in line with expectations of those affected?
Safety actions and improvement	• How easy is it to make an improvement in our organisation? Is time, priority and expertise given to those who need it? • Do we have and use processes to share emergent intelligence and receive support from external partners (e.g., ICSs, regional and national NHS teams, royal colleges, professional associations, patient groups, charities etc) • How do we assess the sustainability of our safety actions and improvements?

Appendix 12: Complaints and appeals.

Complaint process (following a patient safety incident) – Patient and families.

Complaint process (following a patient safety incident) – Staff.



Appendix 13 – Roles and responsibilities

Chief Executive Officer (CEO) - As accountable officer the Chief Executive is responsible for the overall leadership and management of the Trust and its performance in terms of service provision, financial and corporate viability, ensuring that the Trust meets all its ***quality and safety,*** statutory and service obligations and for working closely with other partner organisations. The CEO delegates aspects of this responsibility to relevant Executive Directors according to their organisational portfolios. The CEO directly manages communications, information services and corporate affairs and is ultimately responsible for ensuring that UHS is complaint with all aspects of the 'duty of candour'.

Chief Medical Officer – The Chief Medical Officer has delegated authority and responsibility within the Trust for clinical practices and outcomes; professional regulation and clinical standards; clinical effectiveness; research and development and relationships with general practitioners.

Chief Nursing Officer - The Chief Nursing Officer has delegated authority and responsibility for all aspects of infection prevention and control; clinical practices and outcomes; professional regulation and clinical standards; training and development; governance (including compliance, risk management, patient safety and experience); human resources and workforce.

Deputy Chief Medical Officer – Has delegated authority from the CMO to support all aspects of the patient safety work at UHS and can provide senior oversight and support as required.

Deputy Chief Nursing Officer – Has delegated authority from the CMO to support all aspects of the patient safety work at UHS and can provide senior oversight and support as required.

Executive Leads for Safety – The chief nursing and medical officers have designated responsibility for patient safety. In practice, they have delegated the operational implementation of the 'duty of candour' to the Clinical Director for patient safety and deputy chief nursing officer.

Non-Executive Director - there is a nominated Non Executive Director to support '*Being Open/Duty to be Candid'.*

Clinical director for patient safety - has responsibility for the medical aspects of patient safety and is closely involved in ensuring that the organisational requirements for the 'duty of candour' are met.

Head of Patient Safety - has responsibility for overseeing the strategic and operational aspects of safety across the organisation and developing a patient safety culture that is open and honest. The Head of Patient Safety has joint delegated responsibility with the clinical director for patient safety for ensuring that the organisational requirements for the duty of candour are met.

Patient Safety Team- has responsibility for supporting the Head of Patient Safety and clinical director for patient safety with the implementation of the strategic and operational aspects of safety. This includes ensuring that the patient or their representative is effectively communicated with following a severe harm incident. For example, in drafting communications to be sent on behalf of the clinical director for patient safety, or head of patient safety to patients or their representatives in the event of a severe harm incident.

Corporate Department Heads – All Department Heads have accountability and responsibility to ensure effective management and communication of safety processes throughout their departments.

Research and Development Facility – University Research Governance Officer and NIHR Wellcome Trust Clinical Research Facility have the responsibility to process all incoming research incident reports and ensure they are reported and investigated appropriately with regular safety reports to Trust Board and where relevant (e.g. non research related incidents involving trust patient or staff) to the Patient Safety Team. There are specific reporting requirements for research related events which involve research and which are contained in the Research Related Adverse Event Reporting Policy.

Divisional/ Care group responsibility and accountability
The multi-professional team, including the senior clinician involved in the care of the patient has responsibility for managing any incident in line with the relevant policy.

Meeting as soon as possible after the event to:

- Establish the facts of the case
- Assess the incident to determine both the level of harm and the immediate response required including urgent actions
- Identify who will be responsible for the discussion between the patient, and / or their carers, involving Patient Support Services if an incident is also the subject of a complaint. Consider whether support from patient advocate, independent healthcare professional or facilitators are warranted
- Where Never Events or cases meeting the criteria for Patient Safety Incident Investigations, to escalate to the Head of Patient Safety and Clinical Director for Patient Safety who will convene an initial patient safety case review.
- Ensure that the patient or their representative is effectively communicated with following any notifiable safety incident of a moderate level or above
- Ensuring that there are robust systems at ward, Care Group and Divisional level for being open and candid with patients where the level of harm does not reach the 'notifiable' threshold.

All Trust staff - All staff, including temporary, agency or volunteer staff, have a responsibility for identifying actual or potential hazards, safety incidents and risks and reporting / escalating issues in accordance with this, and other trust policies. All registered professional staff have a duty to ensure they support the duty of candour at all levels of patient harm. It is essential that all communication with the patient, their family or carers be fully, explicitly, and contemporaneously documented.

Appendix 14: Related Trust Policies

This policy should be read in conjunction with:

- Analysis and learning from Aggregated Incidents, Complaint and Claims Policy
- Risk Management Policy and Procedures
- Research Related Adverse Event Reporting Policy
- Supporting staff involved in an incident, complaint or claim policy
- Whistle Blowing Policy
- Helpline Policy
- Major Incident Plan
- Medical Devices and Equipment Management and Training Policy
- Decontamination of Medical Devices Policy
- Medical Devices Disposal Policy
- Safeguarding Adults and Adults Protection Policy
- Child Protection and Safeguarding Procedures
- Sharps Policy
- Waste Management Policy
- Ionising Radiations the safe use of Policy
- Non-Ionising Radiations the safe use of Policy
- Patient Falls Policy
- Medicines prescribing, acquisition, storage and administration Policy
- Health and Safety Policy
- Training Needs Analysis
- Disciplinary Policy and Procedures
- Safeguarding allegations management policy

Appendix 15: Consultation of document

UHS has undertaken extensive consultation of the PSIRF Policy and plan, this has included internal and external stakeholders.

Internal Stakeholders
Executives with patient safety in portfolio Non – Exec Director with Patient safety in portfolio Patient safety Team Members of Serious Incident Scrutiny Group Divisional Governance Managers Divisional Governance teams Matrons Divisional Heads of Nursing/professions Divisional Clinical Directors Associate Director of Company Affairs Complaints lead. Tissue Viability Team Associate Director for Always Improving CDAD lead Director of Clinical Law Medication Safety Officer Consultant nurse for infection prevention Education and Quality Assurance lead for Research Maternity risk lead
External Stakeholders
Integrated Care Board – Southampton place quality team Quality and patient safety partners Healthwatch Area Coroner

Appendix 16 – Glossary

Accident – Any unplanned, uncontrolled event or series of events that resulted in injury to people, damage to plant, machinery or the environment and/or some other loss.

Actual Incident – Any unintended or unexpected incident which could have, or did, lead to harm

Adverse Event Report (AER) – An incident form or incident report completed on the Ulysses Safeguard system.

Advocate An individual speaking on behalf of an individual affected by a patient safety incident, and/or supporting them to speak for themselves when they can

Apology An 'apology' is an expression of sorrow or regret in respect of a notifiable safety incident; It is not an admission of guilt.

ATAIN – Avoiding term admissions into neonatal units

Being Open – The process by which the patient, their family, their carers are informed about a patient safety incident/complaint/claim involving them.

Candour – any patient (or their representative if the patient is without capacity, a child or deceased) harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

Care Quality Commission (CQC) - Independent regulator of all health and social care services in England.

Catastrophic or Death – any incident that directly resulted in the death of one or more persons receiving NHS funded care. Death must be related to the incident rather than the underlying condition or illness. Any catastrophic or death harm incident is a 'notifiable safety incident'.

CDfPS – Clinical Director for Patient Safety

DHOPs – Deputy Head of Patient Safety

E Docs - UHS electronic document management system

Engagement- Engagement in this guidance refers to the prompt, effective liaison between persons affected by a patient safety incident and the organisation; this is done respectfully and according to individual needs.

Engagement lead - Person who leads on engaging with, and involving those affected by, a patient safety incident, e.g., with patient, close family (or relations or

carer) and staff members. Organisations may differ in how they approach engagement – this activity may be led by the person leading the learning response or by a family liaison officer (or similar). We use the term 'engagement lead' to capture both possibilities.

Family - Family refers to the person or patient (the individual) to whom the patient safety incident occurred, their family and close relationships. Family and close relations may include parents, partners, siblings, children, guardians, carers, and others who had a direct and close relationship with the individual to whom the incident happened.

Harm – Any injury (physical or psychological), disease, suffering, disability or death. Unexpected harm to a patient is considered to have occurred when it is not related to the natural course of the patient's illness or underlying condition.

Healthcare Associated Infections (HCAI) - Infections that develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting.

Helicopter Emergency Medical Service - Hampshire and Isle of Wight Air Ambulance (HIOWAA) brings an advanced critical care team to sick and injured people in emergency situations across the area.

HoPS – Head of Patient Safety

HSIB - Healthcare Safety Investigation Branch. The Healthcare Safety Investigation Branch (HSIB) is the independent national investigator for patient safety in England.

ICB - Integrated care board. ICBs have a responsibility to establish and maintain structures to support a co-ordinated approach to oversight of patient safety incident response in all the services within their system.

ICS - Integrated care system

Incident - An event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors or members of the public

Involvement - The process of being involved in a learning response

Learning From Patient Safety Events (LFPSE) – This replaced the National Reporting and Learning System (NRLS) and is a national central database of patient safety incident reports.

Learning response - Any response to a patient safety incident that incorporates a system-based approach to capturing learning to inform safety actions for improvement. This may be a patient safety incident investigation, but other methods can be used such as multidisciplinary team debriefs, huddles and after-action reviews

Learning response lead - Previously known as 'lead investigator'. This is someone who leads a learning response into a patient safety incident.

Low harm – any incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS funded care.

Lymington Hospital - Lymington New Forest Hospital is a community hospital located in Lymington and managed by Southern Health NHS Foundation Trust. UHS manages the surgical services at the hospital.

MBRRACE – UK - 'MBRRACE-UK' is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to run the national Maternal, New-born and Infant clinical Outcome Review Programme (MNI-CORP) which continues the national programme of work conducting surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths.

Moderate harm – 'Moderate harm' means harm that requires a moderate increase in treatment, and significant, but not permanent, harm, for example a "moderate increase in treatment" means an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care).

National Health Service Resolutions (NHSR) – Authority responsible for handling negligence claims in the NHS (previously the NHS Litigation Authority – NHSLA).

Near Miss – A near miss is any incident that had the potential to cause harm but was prevented, resulting in no harm.

Never Event (NE) – Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

New Forest Birthing Centre - Run by experienced UHS midwives and support staff, the New Forest Birth Centre offers a safe, friendly environment for mothers and babies .

No Harm – no injuries or obvious harm. No loss of property. No significant likelihood of service issues arising from incident.

Non Clinical Incident – Any event or circumstance that does not involve a patient's treatment or care which leads to, or could potentially lead to, unintended or unexpected harm, loss or damage to staff, financial loss or injure the reputation to the Trust.

Notifiable safety incident – is defined in law as any "unintended or unexpected incident" occurring during the delivery of treatment, which "in the reasonable opinion of a healthcare professional could result in, or appears to have resulted in:

Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered

Oversight - of patient safety incident response has traditionally included activity to hold provider organisations to account for the quality of their patient safety incident investigation reports. Oversight under PSIRF focuses on engagement and empowerment rather than the more traditional command and control.

Patient Safety Case Review – chaired by a senior member of the patient safety team, these meetings seek to establish whether and at what level an investigation is needed. It establishes the key questions for the investigation, support for patient and staff and any urgent actions required.

Patient Safety Incident (PSI) - A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

Patient Safety Incident Investigation (PSII) – A technique for undertaking a systematic investigation that seeks to understand the underlying causes and environmental context in which the incident happened.

PMRT – Perinatal mortality review tool to support standardisation of perinatal mortality reviews across NHS maternity and neonatal units.

Princess Anne Hospital – Hosts the maternity and neonatal units and has two wards for patients from medicine for older people and T&O. Other services provided at the Princess Anne Hospital include genetics and breast screening.

Psychological harm - means psychological harm which a patient has experienced, or is likely to experience as a result of the incident, for a continuous period of at least 28 days.

Registered Persons, in terms of the CQC requirement is taken to mean the organisation registered to provide care. In this case, UHS.

Relevant Persons – used interchangeably with patient representative, means the service user or, in the following circumstances, a person lawfully acting on their behalf— (a) on the death of the service user, (b) where the service user is under 16 and not competent to make a decision in relation to their care or treatment, or (c) where the service user is 16 or over and lacks capacity in relation to the matter

RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations. These are incidents which are reportable to the Health and Safety Executive. Employees who are absent from work or have change in work role due to injury must be RIDDOR reported via the H&S team. See RIDDOR page on Staffnet Link

Royal South Hants Hospital - The Royal South Hants Hospital is located near the centre of Southampton and is managed by NHS Property Services Ltd. A small number of UHS services are provided here including dermatology.

Severe harm – any incident that appears to have resulted in permanent14 harm to one or more persons receiving NHS funded care– related directly to the incident and not to the natural course of the patient's illness or underlying condition. Any severe harm incident is a 'notifiable safety incident'.

Southampton General Hospital - is the Trust's largest location, with a great number of specialist services based here, ranging from neurosciences and oncology to pathology and cardiology. Emergency and critical care is provided in the hospital's special intensive care units, operating theatres, acute medicine unit and emergency department (A&E), as well as the dedicated eye casualty. Southampton General also hosts outpatient clinics, diagnostic and treatment work, surgery, research, education and training, as well as providing day beds and longer stay wards for hundreds of patients.

Those affected - include staff and families in the broadest sense; that is: the person or patient (the individual) to whom the incident occurred, their family and close relations. Family and close relations may include parents, partners, siblings, children, guardians, carers, and others who have a direct and close relationship with the individual to whom the incident occurred

Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

University Hospital Southampton NHS
NHS Foundation Trust

Patient safety incident response plan

Effective date: 2nd October 2023

Estimated refresh date:2nd October 2024 with informal review after the first 6 months.

	NAME	TITLE	SIGNATURE	DATE
Author	Vickie Purdie	Patient Safety Specialist		
Review group	Quality Committee	Approved		21/8/23
Review group	Quality Governance Steering Group	Approved		5/9/23
Review group	Trust Board			28/9/23
HIOW ICB	Teressa Gallard Helen Eggleton Gemma Seymour	Final Approval from ICB received 5/9/23		22/8/23

Contents

Introduction

This patient safety incident response plan sets out how University Hospital Southampton NHS Foundation Trust (UHS) intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

As the major university hospital on the south coast, we provide tertiary medical and surgical specialities to over 3.7 million people in central southern England and the Channel Islands. We are a leading research and teaching hospital and a centre of excellence for training the doctors, nurses and other healthcare professionals of the future. We work with the University of Southampton and Solent University to educate and develop staff at all levels, including a large apprenticeship programme, undergraduate and postgraduate education.

This is a large and complex organisation, with about 14,000 employees and a turnover of >£1bm. We work in a dynamic and fast paced environment, where we are always evolving and always improving. We also play an integral role in our Integrated Care System (ICS) and have developed mature and productive relationships with our system partners.

We are recognised as a 'Good' and 'Well-led' trust by the CQC, with a long record of effective financial management. We are also one of NHS England's Digital Exemplars, pioneering the world-class use of digital technologies and information.

Through our long-standing values of *Patients First, Working Together and Always Improving*, we are proud of the care we provide and the outcomes we achieve.

OUR MISSION: TOGETHER WE CARE, INNOVATE AND INSPIRE

OUR VALUES

PATIENTS FIRST

Patients, their families and carers are at the heart of what we do. Their experience of our services will be our measure of success

WORKING TOGETHER

Partnership between clinicians, patients and carers it's critical to achieving our vision, both within hospital teams and extending across organisational boundaries in the NHS, social care and third sector.

ALWAYS IMPROVING

We will ensure we are **always improving** services for patients through research, education, clinical effectiveness and quality improvement. We will continue to incorporate new ideas, technologies and create greater efficiencies in the services we provide.

OUR STRATEGIC FRAMEWORK THEMES

OUTSTANDING PATIENT OUTCOMES, SAFETY AND EXPERIENCE

A national reputation for outstanding patient outcomes, experience and safety, providing high quality care and treatment across an extensive range of services from fetal medicine, through all life stage and conditions, to end of life care.

PIONEERING RESEARCH AND INNOVATION

A leading teaching hospital with a growing, reputable and innovative research and development portfolio that attracts the best staff and efficiently delivers the best possible treatments and care for our patients.

WORLD CLASS PEOPLE

Supporting and nurturing our people through a culture that values diversity and builds knowledge and skills to provide rewarding careers paths within empowered, compassionate, and motivated teams.

INTEGRATED NETWORKS AND COLLABORATION

Delivering our services with partners through clinical networks, collaboration and integration across geographical and organisational boundaries.

FOUNDATIONS FOR THE FUTURE

Making our corporate infrastructure (finance, digital, estate) fit for the future to support a leading university teaching hospital in the 21st century and recognising our responsibility as a major employer in the community of Southampton and our role in delivering a greener NHS.

Building on a firm foundation

When shaping an approach to improvement it's important that we build on our assets and what makes us different to other NHS hospitals so that we harness the best of our organisation in helping us move forward.

UHS Asset: Clinical Outcomes

The clinical outcomes that we deliver for our patients are World Class. This gives us the confidence that we are at the leading edge of improvement and helps attract staff, investment and attention for our improvement efforts.

UHS Asset: Our Culture, Our People

We have a really positive culture that compares favourably in our staff survey. At UHS our people are our greatest asset and we are able to attract the top talent to collaborate and innovate to deliver great care. We encourage and celebrate diversity and inclusion across the organisation.

UHS Asset: Patient Safety

We have a positive patient safety culture with people able to report incidents and learn from them. We have senior clinical leadership which gives us a strong foundation for our just and learning culture. We are actively developing patient involvement with patient safety partners and co-design.

UHS Asset: Partnering in Research

UHS is a leading research and teaching hospital working in close partnership with the University of Southampton. Through Covid we have proven our ability to lead national research. We are actively pursuing closer ties with UHS clinical research teams and the University around our Improvement initiatives

UHS Asset: Improvement Approach

Our work on the Always Improving Inpatients programme gave us a clear organisational approach to improvement that trained over 1,000 staff through bootcamps in the high level approach and gave us 18 practitioners of the methodology. This provides a platform for our improvement culture and approach that is recognised in the Trust to build from.

UHS Asset: System Partnership

We have mature relationships with our system partners and the Covid-19 has supported us to work closer and progress the integration agenda. A core part of our Improvement framework is to focus on system transformation.

Successfully unlocking the value and potential will require a coherent, collaborative and coordinated approach which is supported widely within the Trust and by its key partners.

Our services

UHS is registered with the Care Quality Commission (CQC) to provide services in the following locations:

Southampton General Hospital is the Trust's largest location, with a great number of specialist services based here, ranging from neurosciences and oncology to pathology and cardiology. Emergency and critical care is provided in the hospital's special intensive care units, operating theatres, acute medicine unit and emergency department (A&E), as well as the dedicated eye casualty. Southampton General also hosts outpatient clinics, diagnostic and treatment work, surgery, research, education and training, as well as providing day beds and longer stay wards for hundreds of patients.

Princess Anne Hospital - Is a centre of excellence for maternity care, providing a comprehensive service, including home birth, for about 5,000 women each year from around Southampton. We are also a regional centre for fetal and maternal medicine, providing specialist care for women with medical problems during pregnancy, and for those whose baby needs extra care before or around birth. Other services provided at the Princess Anne Hospital include genetics and breast screening.

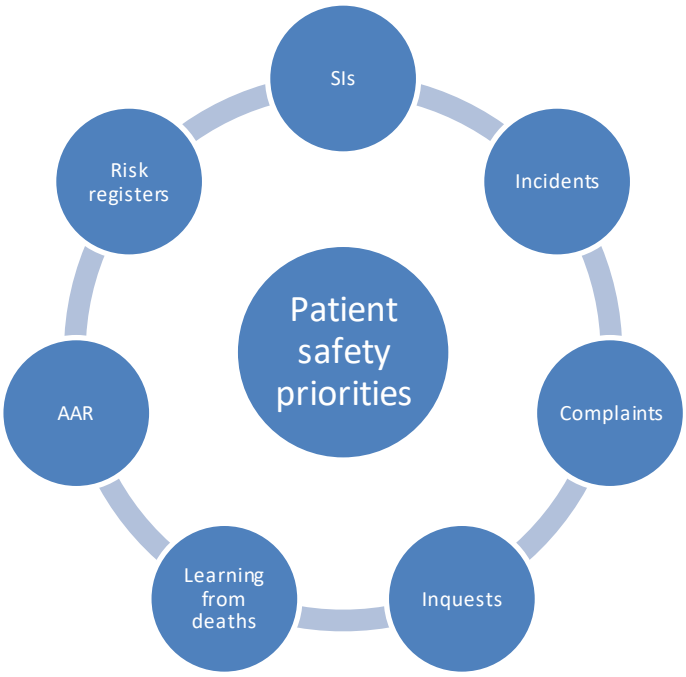
Lymington Hospital - Lymington New Forest Hospital is a community hospital located in Lymington and managed by Southern Health NHS Foundation Trust. UHS manages the surgical services at the hospital.

Royal South Hants Hospital - The Royal South Hants Hospital is located near the centre of Southampton and is managed by NHS Property Services Ltd. A small number of UHS services are provided here including dermatology.

Helicopter Emergency Medical Service - Hampshire and Isle of Wight Air Ambulance (HIOWAA) brings an advanced critical care team to sick and injured people in emergency situations across the area. On 1 November 2018, a partnership was formalised between UHS as the major trauma centre for the southern region, HIOWAA and South Central Ambulance Service NHS Foundation Trust (SCAS). The air ambulance charity is fully responsible for funding the service, while UHS manages and provides clinical governance for the critical care teams of doctors and paramedics. SCAS continues as the dispatch authority.

New Forest Birthing Centre - Run by experienced UHS midwives and support staff, the New Forest Birth Centre offers a safe, friendly environment for mothers and babies . The birth centre also provides antenatal support in preparation for parenthood, private spaces and ongoing support including breastfeeding support groups.

Defining our patient safety incident profile



We used a thematic analysis approach to determine which areas represented our patient safety priorities. To do this review we utilised a variety of data sources including:

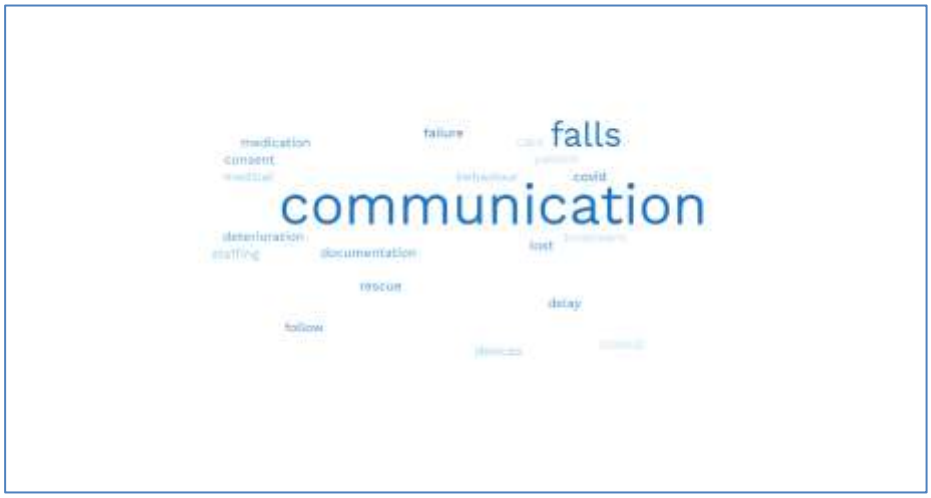
- Serious Incidents (SI's) recorded on STEIS including falls and pressure ulcers.
- Patient safety incidents reported through our local management system including all levels of reported harm.
- Risk registers
- Review of After-action reviews completed during first three months of pilot
- Learning from deaths data
- Inquests
- Complaints and concerns

Key findings of the thematic analysis were

- Average number of SI's for last 3 financial years was 98 (60 when falls/PU and VTE excluded). These include SI's reported where patients have either died from a hospital acquired Covid 19 infection or those who have come to severe harm due to delays caused by the covid pandemic.
- Our top themes during the last 3 years include:
    - Covid (infections and harm secondary to waits caused by Covid)

    - Failure to rescue[1]
    - Lost/ Delay to follow up
- Average number of inquests for the last three years is 249 per year
- Inquests highlighted the following themes
    - Documentation
    - Communication
    - Falls
    - Deterioration
    - Consent
- Further analysis of the failure to rescue using the Yorkshire Framework identified Communication as the most common theme.
- Medication and falls were the highest reported incident each year. Categories for number 3 slot were Medical devices 20/21, Staffing 21/22 and Behaviour 22/23. All reflective of the focus and workload of the organisation for those years.
- Complaints from 22/23 identify the top themes as:
    - Clinical treatment
    - Communication
    - Patient care

Word cloud to summarise themes highlighted



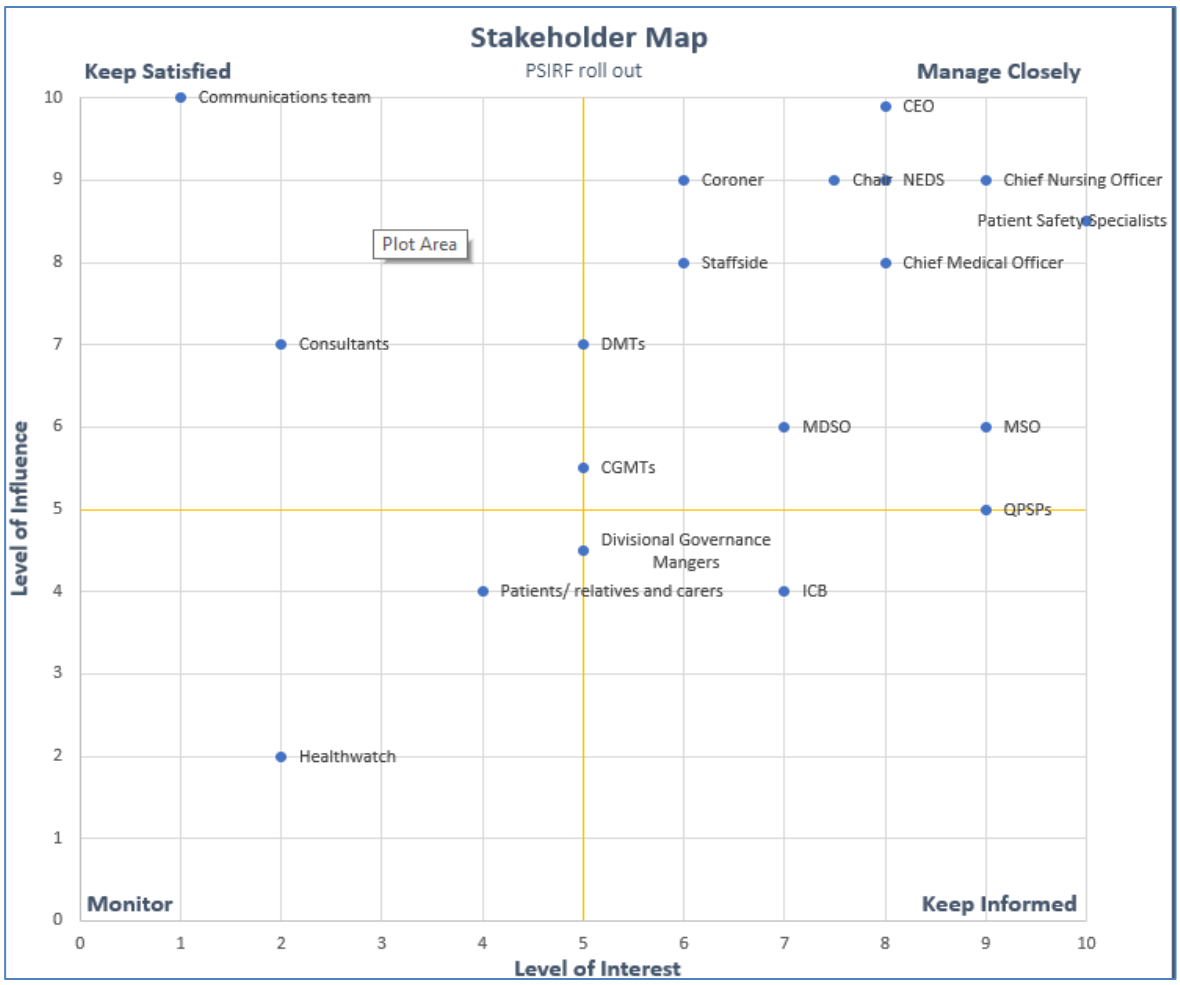
Stakeholder engagement:

To support the Plan's development with consulted with a range of stakeholders including Commissioners/ Hampshire and IOW Integrated Care Board (ICB)

- Members of staff through a number of workshops/ engagement events
- Trust Board executives and non-executives and delegated committees
- Trust governors
- Quality and patient safety partners
- Governance teams

[1] Failure or delay in recognizing and responding to a hospitalized patient experiencing complications from a disease process or medical intervention

- Medication Safety Officer
- Coroner
- Healthwatch



Defining our patient safety improvement profile

UHS have a centralised Transformation team, hosted in THQ, with staff embedded into subgroups working within each division. There are four corporate programmes of specific focus agreed for 2023/24, all of which will have an impact on elements of patient safety. These are:

- Outpatients
- Patient Flow
- Improving Operating Services
- Continuous Improvement (to include local and individual projects)

Progress against each of these is robustly monitored and reviewed by the Transformation Oversight group and owned jointly with care groups up to divisional board level.

We offer a variety of modular education opportunities in improvement science and techniques. These will be further developed to ensure all staff are equipped to solve the problems they see, empowered to be part of our improvement vision and inspired to develop their skills and learning within a culture of continuous improvement. Examples are:

- Induction seminars
- One day introduction to improvement
- Bite sized learning opportunities on specific tools and techniques
- 5-day Improvement Practitioner training (NHSE Improvement teaching programme)

We are working with teams to maximise engagement and further support learning in improvement tools and techniques and will be identifying local champions across the organisation.

The NHS Delivery and Continuous Improvement Review has just been published and offers guidance on ways to improve quality in the short, medium and longer term, with aims to support a whole system focus on improving healthcare outcomes. We are reviewing our Always Improving Strategy against these principles and ensuring it aligns with those from other UHS departments such as Patient Safety, Organisational Development, Research and Clinical Effectiveness.

Staff will have easy access to an online Always Improving hub, containing examples of successful projects, good practice and useful information to support improvement across UHS.

Our patient safety incident response plan: national requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event.

Incidents meeting the Never Events criteria (2018) and deaths thought more likely than not due to problems in care (i.e., incidents meeting the Learning from Deaths criteria for PSII) require a locally led PSII.

Table 1 below sets out the local or national mandated responses. As UHS does not directly provide mental health or custodial services it is more likely that the organisation will be a secondary participant rather than a lead for those incident types (8 to 11)

	Patient safety incident type	**Required response**
1	Incidents meeting the Never Events criteria or its replacement	UHS led Patient Safety Incident Investigation (PSII)
2	Death thought more likely than not due to problems in care	UHS led PSII
3	Maternity and neonatal incidents meeting the HSIB (or its replacement)	Referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation
4	Child deaths* * please see local priorities and PSIRF policy for greater detail	See local priorities for how we will decide level of investigation
5	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Local LeDeR panel review
6	Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence adults (over 18 years old) are in receipt of care and support needs from their local authority. • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.

	Patient safety incident type	Required response
7	Incidents in the NHS screening programme	Refer to local Screening Quality Assurance Service for consideration of locally led learning response. See: Managing safety incidents in NHS screening programmes
8	Deaths in custody (e.g. police custody, in prison etc) where health provision is delivered by the NHS	In prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations. Healthcare providers must fully support these investigations where required to do so.
9	Deaths of patients detained under Mental Health Act (1983) or where Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the Learning from Deaths criteria)	PSII – likely to include other organisations
10	Mental Health related homicides	Referred to the NHS England and NHS Improvement Regional Independent Investigation Team for consideration for an independent PSII Locally led PSII may be required with mental health provider as lead and UHS participation if required
11	Domestic Homicide	A Domestic Homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a Domestic Homicide Review (DHR) are met, they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, sets out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide review

Our patient safety incident response plan: local focus

- Following the review of our data and consultation UHS considers these our top incident types which have relevance to all our services including maternity
- These have been agreed with our local commissioning organisation, Hampshire and Isle of Wight Integrated Care Board
- These are the priorities set by UHS for 2nd October 2023 to 1st October 2024
- These apply to adults and children and both in and outpatients unless specified
- Each PSII will be conducted separately, in full and to a high standard by a team whose lead investigator is appropriately trained.
- Whilst communication was a reoccurring theme it was predominantly a secondary cause and hasn't been identified as a theme on its own.
- Decisions regarding type of response will be documented on the Safeguard System
- Guidance on management of cases not going through a full PSII is provided in the UHS PSIRF Policy.

Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Hospital acquired category 3/4 or unstageable pressure ulcer	After action review (AAR)	Local safety actions to be identified and quarterly thematic analysis through patient safety steering group and pressure ulcer steering group
Falls within hospital leading to an injury (consider if it is a non-accidental injury (NAI) e.g. infant or adult who is tetraplegic)	After action review (AAR) If NAI – consider safeguarding	Local safety actions to be identified and quarterly thematic analysis through patient safety steering group and Trust falls steering group
Child deaths that are unexplained with UHS paediatric involvement within 12 months <18 years (excluding neonates)	All reviewed by CDAD panel to determine investigation type for e.g. Concerns regarding care – PSII On a child protection plan or safeguarding concerns refer to local authority	Local safety actions to be identified. Learning shared through Children's hospital governance group To contribute to trust wide learning from deaths learning.

Patient safety incident type or issue	Planned response	Anticipated improvement route
	safeguarding lead via UHS safeguarding Other child deaths consider Local learning response e.g. M&M	
Interruptions to clinical services leading to temporary closure / service diverts lasting >24 hours	Has this service previously experienced this issue? Yes – review previous incident(s) if no new learning complete a harm review tool. PSII if new learning identified No - PSII	Local safety actions to be identified. Learning shared through divisional governance and Quality Governance Steering Group
Infections	Healthcare associated C/Difficile - Initial IPT case review followed by an AAR if there a concerns about practice Hospital associated MRSA and Gram negative blood stream infections - initial review with Senior IPN and Lead IP consultant to determine if more detailed IPT case review required followed by an AAR if there are concerns about practice Infection outbreaks/ incidents leading to bed closures. IPT/ Operational review of impact. Is there new learning? Yes – PSII No – Revisit previous actions	Local safety actions to be identified. Learning shared through divisional governance and Infection Prevention Committee.

Patient safety incident type or issue	Planned response	Anticipated improvement route
	Single infection incident e.g. Hospital acquired legionella or case of CJD – PSII	
Incidents relating to failure to rescue (Failure or delay in recognizing and responding to a hospitalized patient experiencing complications from a disease process or medical intervention).	Do we understand all the contributing factors? Yes – Review at M&M No - PSII	Local safety actions to be identified. Thematic reviews of incidents at Deteriorating Patient Group Learning shared via Patient Safety Steering Group
Maternal or neonatal death not meeting the HSIB criteria I.e. maternal suicide	PSII	Local safety actions to be identified.
Maternal/ Neonatal cases that are externally reportable i.e. PMRT/EMBRACE/ATTAIN	All cases would be triaged when externally reported. PSII will be completed if significant learning identified.	Local safety actions to be identified.
Interruptions to supply of medication or equipment leading to disruption to patient care	PSII – If within UHS sphere of control Consider MHRA yellow card (in discussion with MDSO or MSO) If not significant learning or has been seen previously – local learning response Outside UHS sphere of control - ensure Duty of Candour has been completed and consideration of any mitigations required and escalate appropriately.	

Patient safety incident type or issue	Planned response	Anticipated improvement route
Incidents where patients care has been impacted by delays to treatment and or appointments and or investigations	Are the reasons for the delay understood e.g. Covid – harm review tool If not understood - PSII	
Medication safety	Does the incident identify system based learning? – Yes PSII No use of appropriate tool to identify local learning e.g. AAR	Review of individual and thematic learning through the Medication Safety Group. Trust wide learning escalated via Quality Governance Steering Group
Incidents where patient care has been impacted on due to flow through the hospital E.g. ED long waits[2], ICU bed capacity, patients no longer meeting the criteria to reside	Is there significant systems based learning? Yes – PSII No – Local M&M / Case note review Align with improvement workstreams	Local safety actions to be identified.

[2] This is not defined by time but based on the clinical condition of the patient

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Register of Seals and Chair's Actions**			
Agenda item:	**6.1**			
Sponsor:	**Jenni Douglas-Todd, Trust Chair**			
Date:	**28 September 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. There have been no Chair's actions since the last report.			
Implications: (Clinical, Organisational, Governance, Legal?)	Compliance with The NHS Foundation Trust Code of Governance (probity, internal control) and UHS Standing Financial Instructions and Scheme of Delegation.			
Risks: (Top 3) of carrying out the change / or not:				
Summary: Conclusion and/or recommendation	The Board is asked to **ratify** the application of the seal.			

1 Signing and Sealing

1.1 **Deed of Variation** between University Hospital Southampton NHS Foundation Trust (Head Landlord), AKZO Novel CIF Nominees Limited (Superior Landlord), Compass Contract Services (UK) Limited (Landlord) and University Hospital Southampton NHS Foundation Trust (Tenant), relating to Lease of Unit 2, Main Entrance and Retail Area, Level C, Southampton General Hospital, Southampton (Charity offices). Seal number 262 on 25 July 2023.

1.2 **Licence for Alterations**, executed as a Deed, between University Hospital Southampton NHS Foundation Trust (Superior Landlord), AKZO Novel CIF Nominees Limited (Landlord), Compass Contract Services (UK) Limited (Tenant) and University Hospital Southampton NHS Foundation Trust (Undertenant), relating to Unit 2, Main Entrance and Retail Area, Level C, Southampton General Hospital (Charity offices). Sea number 263 on 25 July 2023.

1.3 **Supplemental Lease** executed as a Deed, for the Boiler House Energy Centre, between University Hospital NHS Foundation Trust (Landlord) and Veolia Energy & Utility Services UK PLC (Tenant) of Boiler House, Blowdown Pit, Chimney, Oil Separators, Hotwell and Fuel Oil Storage Tank on the land located Southampton General Hospital, Tremona Road, Southampton SO16 6YD. The supplemental lease incorporates the terms of the original lease dated 17 August 2020. The lease is granted for a term beginning on and including 1 April 2023 to and including 31 March 2024 (or earlier upon the parties entering the extension EVA framework agreement for the Energy Performance Centre). Seal number 264 on 19 September 2023.

2 Recommendation

The Board is asked to ratify the application of the seal.

Report to the Trust Board of Directors				
Title:	**Health and Safety Annual Report 2022-23**			
Agenda item:	**6.2**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Jane Fisher, Head of Health & Safety Services**			
Date:	**28 September 2023**			
Purpose:	**Assurance or reassurance** √	**Approval**	**Ratification**	**Information** √
Implications: (Clinical, Organisational, Governance, Legal?)	1. Staff may suffer injury or illness which could result in litigation (personal injury claims), staff may leave, and recruitment opportunities may be affected. 2. Regulatory enforcement action by the Health & Safety Executive (HSE) or Care Quality Commission (CQC) 3. Non-compliance with industry and national standards 4. Reputational damage to the Trust.			
Risks: (Top 3) of carrying out the change / or not:	As above.			
Summary: Conclusion and/or recommendation	The Health & Safety Services Department continues to provide advice, guidance and support to staff, managers, senior leaders, the Executive and the Trust Board to ensure that the Trust's statutory duties are met with regard to staff health and safety in the workplace; this supports the Trust values and that a positive health and safety culture is embedded into all of the Trust's activities. This report outlines the key activities carried out by the three teams within the Health & Safety Services Department (Health & Safety, Moving & Handling and FFP3 Resilience) from 1st April 2022 to 31st March 2023. Graphical summaries are provided of the top five causes of adverse events relating to staff health and safety, which include violence and aggression, moving and handling, slips, trips and falls, sharps and collision/contact with objects. Members of Trust Board are asked to continue to support and highlight the following key safety matters to their senior management and operational teams to improve the safety culture at UHS; • Appoint local, ward/departmental Health and Safety (H&S) Leads and Moving and Handling (M&H) Trainers with protected time to fulfil their roles. • Actively engage in the identification of hazards and assessment of risks, supporting the action planning process for the control and management of health and safety-related risks in their areas. • Continue to promote the "No Excuse for Abuse" approach and support staff to report any violence and aggression towards them. • Ensure staff attend appropriate practical moving and handling training to help reduce the risk of sustaining musculoskeletal injuries/disorders.			

	• Ensure that reviews of display screen equipment/workstation assessments are completed annually. • Ensure staff use and wear personal protective equipment/clothing to reduce exposure to hazardous substances. • Ensure safety sharp devices are used correctly, and safe systems of work are followed. • Ensure all staff exposed to infectious respiratory diseases and/or are involved in aerosol-generating procedures are fit tested to two models of FFP3 mask (including PeRSo respirators) where appropriate. • Ensure the careful and appropriate segregation of waste bags into carts for disposal (to help the Trust save unnecessary costs) • Actively encourage staff to report near miss incidents so that serious accidents can be prevented. • Record all work-related absences on HealthRoster (tick the "Industrial Injury" box) and report the case directly to the H&S Team within 24 hours of such absences being notified.

1. Introduction

This report provides a summary of the activities carried out by the Health & Safety Services Department, including health and safety (H&S), moving and handling (M&H) and FFP3 Resilience; key highlights are provided as a power point presentation, please see Appendix 1.

The Health & Safety Services Department continued to advise, guide and support staff at all levels to ensure that a positive health and safety culture is embedded into all of the Trust's activities.

The Corporate Health & Safety Committee (CHSC), chaired by the Chief Nursing Officer (CNO), met quarterly; it monitors the Trust's activities in relation to staff health and safety, moving and handling and FFP3 resilience, receiving quarterly reports from all three services. The committee also received quarterly reports from Divisional Risk and Governance Groups and key supporting departments (EFCD, Occupational Health, Claims and Insurance Services) on staff health and safety compliance.

Appendices are provided with summaries of the staff-related adverse event statistics and the FFP3 Resilience Service, from 1st April 2021 to 31st March 2022.

2. Summary of Activities

The teams transitioned back to "business as usual";

- Meetings with the Health & Safety Leads continued bi-monthly (133 active Leads and Links across the Trust).
- Advising managers and local H&S Leads on safety matters that concern them and their teams.
- Delivering training courses for staff at all levels; health and safety-related, practical moving and handling (Induction, Stat & Mand, Train-the-Trainer, Leads.
- Delivering an introduction to H&S at corporate and new manager induction sessions.
- Developing the FFP3 Resilience Service.
- Managing the central FFP3 mask fit testing service; 2264 fit tests carried out across the Trust, with 87.3% carried out in the central hub.
- Training mask fit testers to the national competence standards; 48 staff were assessed as being competent to deliver mask fit testing.
- Daily and weekly ward visits to support staff looking after complex patients, including plus-size patients.
- Ensuring that the pages of Staffnet are kept up to date and include the latest information to act as a "one-stop shop" for the latest information and guidance (for H&S, M&H and Fit Testing).

- Managing the programme of audits by the Dangerous Goods Safety Adviser (DGSA), ensuring reports and recommendations were communicated to the appropriate teams for action.
- Monitoring health and safety-related adverse event reports and supporting managers with investigations to ensure that lessons were learnt and implemented to prevent reoccurrence.
- Reporting accidents and incidents to the Health & Safety Executive under RIDDOR (the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations).
- Managing annual self-audits for H&S and M&H; using new Microsoft formats to make the process easier for staff to access and complete, resulting in more accurate and discernible data to analyse and report on.
- Providing reports to Corporate Groups;
  - Quarterly to the Corporate Health & Safety Committee (CHSC)
  - Mid-year and annually to the Staff Partnership Forum (SPF) and QGSG
- Attending corporate groups and advising as appropriate.
- Collaborating with and supporting the Infection Prevention team for outbreak reviews.
- Collaborating with the Occupational Health team for staff health and wellbeing; carrying out complex display screen equipment (DSE), workstation and workplace assessments (bridging the gap left at UHS as a result of the Disability Officer being seconded to the regional EDNA service).
- Liaising with the Claims and Insurance Service to support the management of claims.
- Liaising and co-operating with UHS subsidiaries (WPL, UEL, UPL) and non-Trust organisations including Serco and the University of Southampton (UoS).
- Supporting UoS with external agency inspections.

3. Summary of the FFP3 Resilience Service

The central fit testing service continued to be delivered by the external contractor (via the DHSC); most fit tests were carried out in the central hub rather than in wards/departments.
Mask fit testing appointment bookings continued to be available via the VLE.

The digital method of fit testing using portacount machines was used for most fit tests; this is quicker and less subjective. The introduction of digital record keeping allowed for the reduction in admin time and increased fit testing capacity during the reporting period.

Fit Tester training sessions continued to be delivered by the external accredited company (via the DHSC as part of the national FFP3 resilience strategy); 23 courses were delivered and 48 staff assessed as competent to fit test.

The PeRSo respirators were serviced and upgraded to the 3.2 model.

Sam Carter-Chappell, the Trust's FFP3 Resilience Lead, gained national Fit2Fit accreditation, which means the Trust is now compliant with its legal duty to have a competent trainer and adviser.

UHS was placed in the Top 5 for fit testing nationally throughout 2022-23 and was in the Top 3 for five months.

A summary and overview of the FFP3 Resilience Service is provided in Appendix 3.

4. Summary of the Moving & Handling Service

Two new specialists joined the team, M&H Officer (permanent post) and Lead M&H Trainer (18-month contract).
The new Lead M&H Trainer delivered over 100 M&H Statutory and Mandatory training sessions and trained over 600 clinical staff. Train-the-Trainer courses supported 56 staff to be competent to train others in their ward/department. The work of the team has improved training compliance for care groups, helped staff to keep themselves safe (reducing the potential for musculo-skeletal injuries/disorders) and supported the Trust to fulfil its legal duties.

The team successfully provided support, advice and guidance to teams working across the Trust;

- Operating Theatres and robotic equipment
- Education teams in improving VLE courses and the training matrix
- Single handed care projects in the Trust and providing regional support via a regional steering group and the Integrated Care Board
- Working with Ophthalmology staff to using different falls equipment for outpatients, e.g. trials with the “raizer chair” went well.
- Supporting ward staff and care groups with patients with complex M&H needs and being more visible on the wards via walk and chat visits
- Supporting teams with their MEP bids and working with suppliers to obtain the best contract arrangements for UHS.

Other collaborative work with IT/Workforce systems team has enabled significant progress in developing systems and processes for record keeping and evidencing of assessments and training;

- Development of a new workstation assessment and training course on VLE, which will benefit all staff using computers
- Recording and managing attendance records for training courses to be able to accurately report on the places taken up by staff, the places lost and completion.
- Recording M&H Trainer as an expirable skill onto Healthroster records. This recognises the valuable work these staff do to keep their colleagues in date with their training

Working with OH and leading on support and guidance for staff who need complex DSE assessments to help them remain and/or return to work safely.

5. Proactive Monitoring

Support visits to satellite sites and the programme of health and safety inspections/tours was significantly reduced due to capacity. Therefore there was limited formal monitoring of the management of health and safety within wards or departments;

- the H&S Team carried out a number of visits throughout the year (c30) in response to requests from H&S Leads and ward/dept managers,
- the M&H Team carried out wards visits to support the care of complex patients,
- the FFP3 Resilience Lead supported the PPE Operations Team and worked with local fit testers to ensure they were competent and confident to deliver fit testing in wards/departments.

The Trust maintains an honorary contract for biological safety advice via the University of Southampton.

The dangerous goods safety audit programme was completed by the contracted external company who act as the Trust’s Dangerous Goods Safety Adviser (DGSA). Recommendations were actioned by each department, with common themes being; poor security of waste in compounds and stores, poor segregation of different types of waste by wards/departments and incorrect labelling of packages being sent outside the Trust.

There was a very good level of engagement with the health and safety self-audit programme this year with 115 responses received (compared to 89 last year); a summary of returned data was presented to the CHSC in July.

6. Reactive Monitoring:

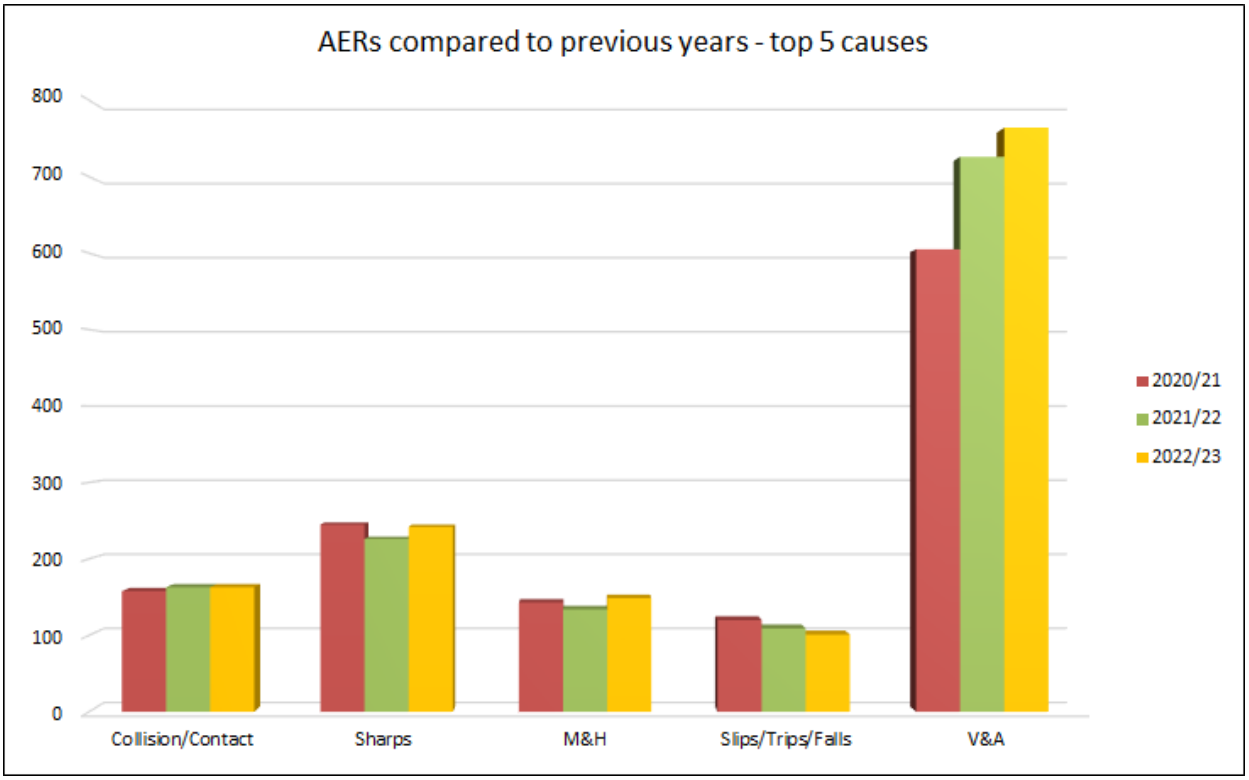
The H&S and M&H Teams continued to monitor the staff-related adverse event reports; a new data analysis tool was created to enable divisional governance teams to analyse AER data in more detail. Staff and managers were supported with accident investigations and validating reports in the Ulysses Safeguard Reporting system.

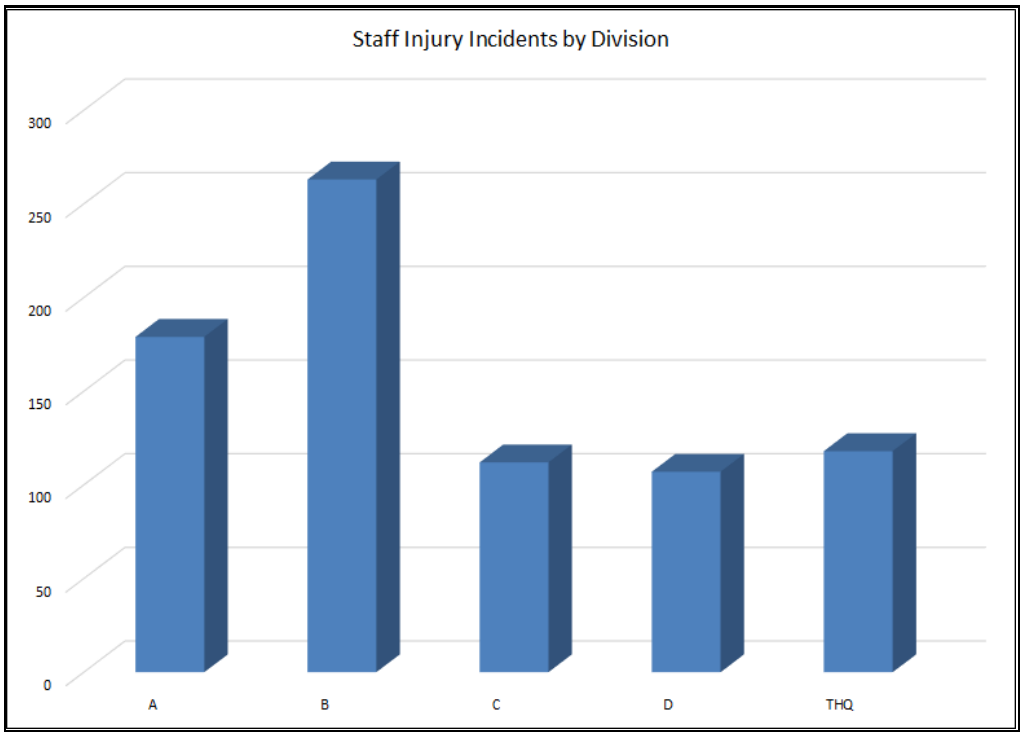
6.1 Adverse Events Involving Staff and Visitors

Compared to the previous year, "All Incidents" numbers rose by 17.6%, however we need to be cautious about comparisons with pandemic years; figures are similar to pre-pandemic years.

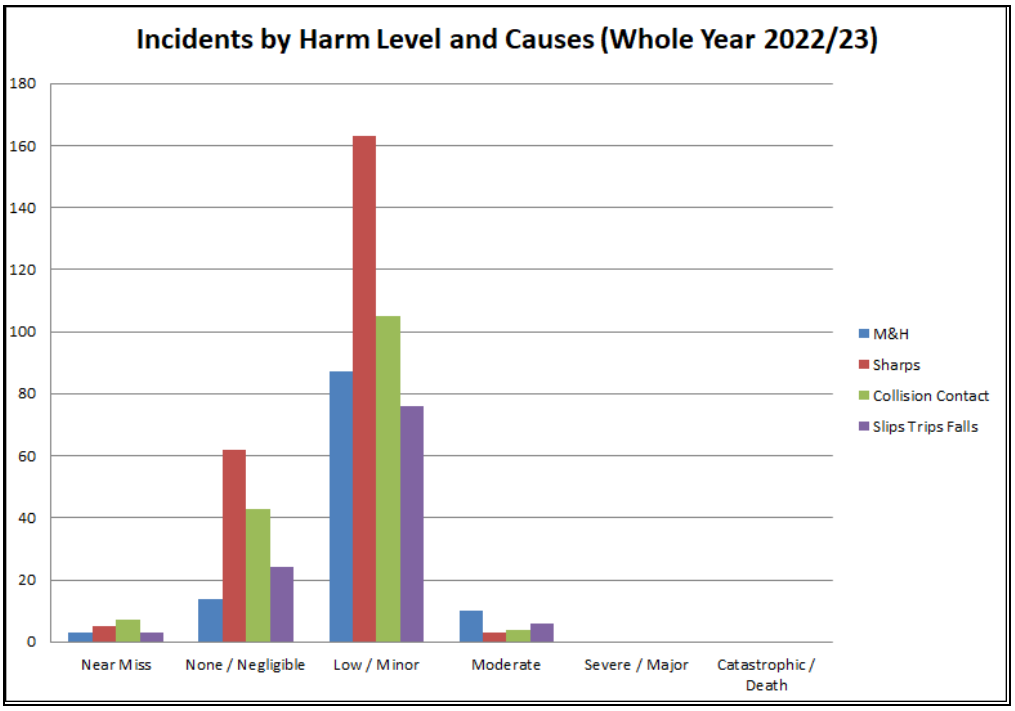
Violence and Aggression incidents can relate to either patients acting aggressively as a result of their clinical condition, or for no identifiable clinical reason. Although these categories are separated for RIDDOR incidents, unfortunately the way that the Ulysses Safeguard reporting system records violence and aggression means that they cannot be easily separated for "all incidents" (work has been carried out to review and update the reporting categories, so it is hoped that analysis will be more comprehensive going forward).

Year	H&S AERs	V&A AERs	Total
2018/19	1993	592	2585
2019/20	1902	687	2589
2020/21	1441	605	2046
2021/22	1455	733	2188
2022/23	1811	764	2575





The injury types used here are determined by the Ulysses Safeguard reporting system



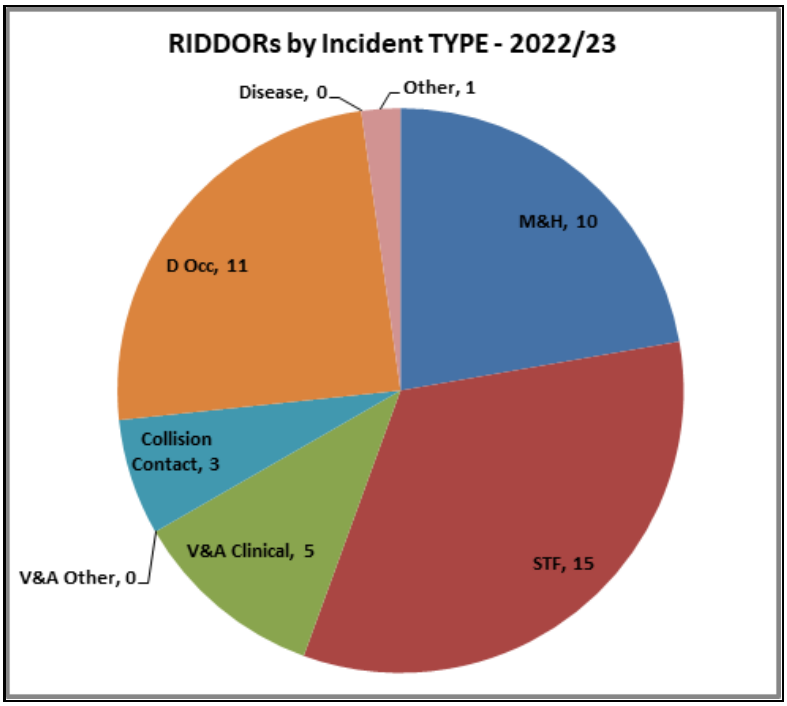
There have been no incidents rated “severe / major” in the Trust year 2022/23
Incidents graded “moderate” are generally regarded to have similar severity to a RIDDOR reportable incident, although not all of these shown here meet the RIDDOR criteria.
Reviewing incidents by actual harm caused closely mirrors the pattern seen in previous years, with the majority of incidents being in the “low/minor” category. This pattern suggests continued under-reporting of near misses and “none / negligible” incidents and encouraging the reporting of these must continue to be a priority.

A breakdown of the specific incident causes was presented to the CHSC in July and a summary of the health and safety related AERs is provided in Appendix 2

6.2 RIDDOR Reportable Incidents

The Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) is a statutory requirement; RIDDOR incidents are reported to the Health and Safety Executive by the Health and Safety Services Team, following investigations conducted locally in wards/departments and followed up by the H&S Adviser, M&H Adviser and/or the Head of H&S Services.

A total of forty-five (45) incidents were reported under RIDDOR in this reporting year, with the main causes remaining the same as previous years (slips, trips and falls, dangerous occurrences (sharps) and moving and handling).



The profile of staff types affected by RIDDOR incidents remains very similar to previous years, and broadly reflects the numbers of staff in each of the staff groups, so the proportions are generally what would be expected; nursing staff (30) and HCA staff (31).

Monthly RIDDOR Panel meetings continued to review cases and involved the Occupational Health and Litigation & Claims Teams as well as clinical teams as appropriate (union representation at the RIDDOR Panels will recommence in September 2023). The review panel ensures investigations have been carried out appropriately, any outstanding actions are followed-up and the lessons learnt to help prevent recurrence are shared.

7. Summary

A very positive and successful year, where the profile of the department and services was raised and the teams supported and collaborated with staff to enable them to work safely.

The approach of “Working Together” and “Always Improving” has delivered the following structure of assurance and reassurance for staff health and safety;

- comprehensive training programmes
- implementing systems of robust evidence
- a community of peer support through H&S Leads, M&H Trainers, and Fit Testers
- up-to-date information and guidance available to all staff
- proactive and reactive monitoring and analysis tools
- supportive governance; reviewing and updating Trust-wide policies and procedures
- advice, guidance, and contributions to specialist/corporate groups.

The training provision has significantly improved the skills, knowledge and understanding of clinical and non-clinical staff and their managers. The feedback from colleagues has been very positive with comments posted on Workplace recognising the teams and their hard work.

Appendix 1

Highlights from the Health & Safety Services Department 2022-23

Health & Safety Service

- ✓ Policy reviews and updates; H&S and COSHH
- ✓ Contributed to Trust-wide projects for Agile Working, Wellbeing at Work, new Appraisals
- ✓ Signposting H&S Services at Corporate and New Managers' Induction sessions
- ✓ Bespoke Hazardous Materials training for the Estates and Facilities teams
- ✓ Set up a specialist group for the monitoring of exposure to entonox (nitrous oxide)
- ✓ Set up the corporate PPE Management Group
- ✓ Maintained proactive monitoring with visits and training
- ✓ Supported managers with accident investigations and created a new data analysis tool for AERs

Moving & Handling Service

- **New roles: M&H Officer and dedicated Lead M&H Trainer** (temporary until Dec 2023)
- **Delivered 100 sessions of Stat & Mand training for 600 clinical staff**
- **Supported 115 Clinical M&H Trainers and 21 Non-Clinical M&H Trainers**
- **Bespoke training for falls champions and training for staff on how to use flat lifting equipment, so staff do not physically attempt to pick up patients who have fallen**
- **Supporting staff with complex DSE assessment requirements: 46 assessments in the last nine months** (fulfilling the gap left as a result of the Disability Officer being seconded to the EDNA Service)
- **Advising on equipment for new and refurbished wards, ensuring staff and patient safety (and saving the Trust significant amounts of money)**
- **Advised on the tendering process for the new bariatric equipment contract**
- **Supporting multi-disciplinary teams to look after plus-size patients safely; daily ward visits to see these patients and support the local staff**

FFP3 Resilience Service

- ✓ Dedicated Lead Fit Test Trainer/FFP3 Resilience Lead
- ✓ Two external fit testers staffed the central hub throughout the year
- ✓ 2264 mask fit tests carried out (compared to 2920 in 2021-22)
- ✓ 87.3% of mask fit tests were carried out in the central hub
- ✓ 2185 PeRSo Respirators upgraded to the new 3.2 model
- ✓ 48 staff trained as fit testers to use the portacount equipment for competent, accurate mask fit testing

Always Improving

The H&S Services staff have worked with the Workforce systems team to develop the use of VLE and Healthroster to record expirable skills for all staff at UHS

- ✓ **Key trainer skills such as Fit Test Trainer, Moving & Handling Trainer, H&S Lead**
- ✓ **Fit test information to show what FFP3 masks staff are fitted to**
- ✓ **Skills can easily be seen by senior staff/shift leaders**
- ✓ **Staff are notified of when the 'skill' needs to be refreshed/ renewed, e.g. when to go for their mask refit test.**

This valuable project will be applied to many other skills, so that easily accessible records of competence is made available across UHS

Always Improving

The H&S Services staff have developed a new e-learning course for training, guidance and assessment for the use of Display Screen Equipment (DSE)

- ✓ Comprehensive training and guidance
- ✓ Easy-to-complete assessment
- ✓ Referral process and guidance for managers when further/complex DSE assessments are required
- ✓ Evidence recorded on each person's VLE profile
- ✓ Annual review and renewal process

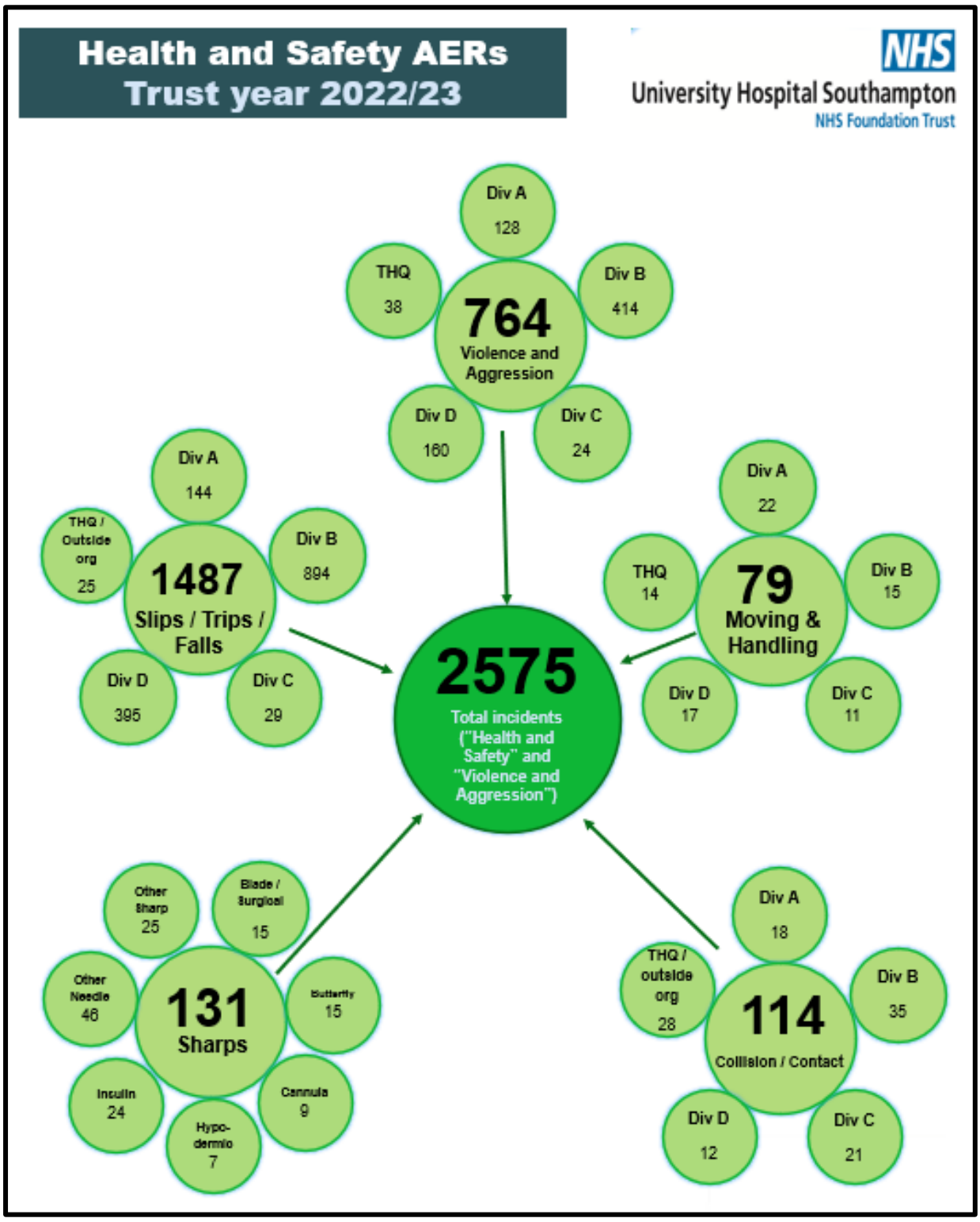
The Trust will now have robust evidence of compliance with the statutory requirements for managing the risks associated with DSE

HEALTH & SAFETY SERVICES supports our UHS family to be

“HAPPY, HEALTHY and HERE”!!

University Hospital Southampton NHS Foundation Trust

Statistical and Graphical Summaries of Staff Health & Safety-related Adverse Events and Work-related Sickness Absence 2022-23



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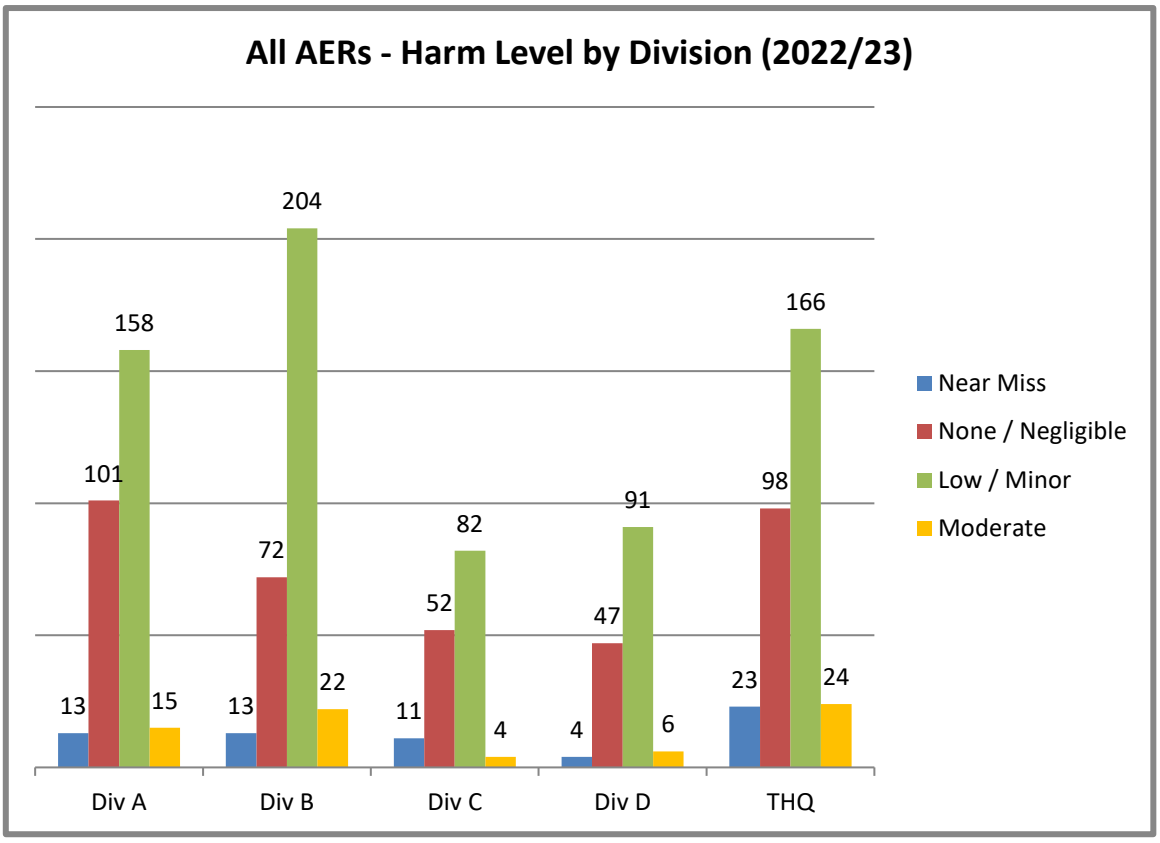
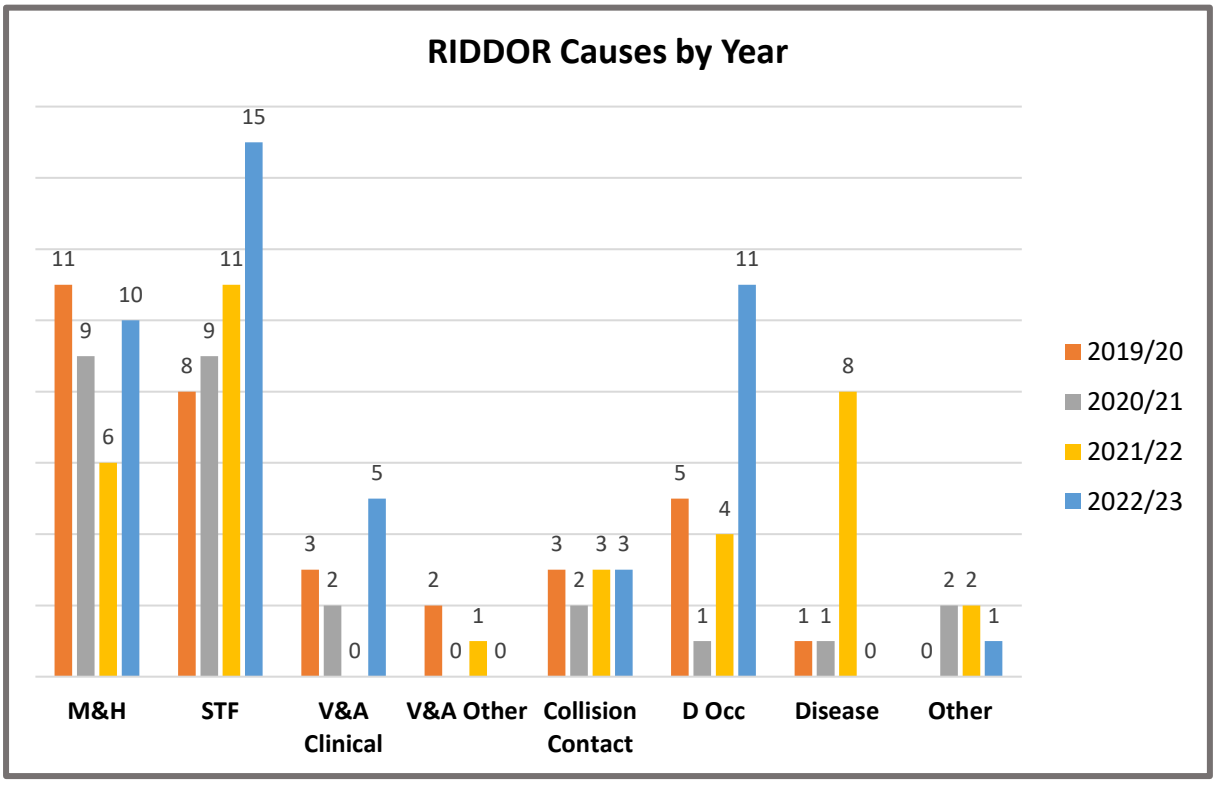
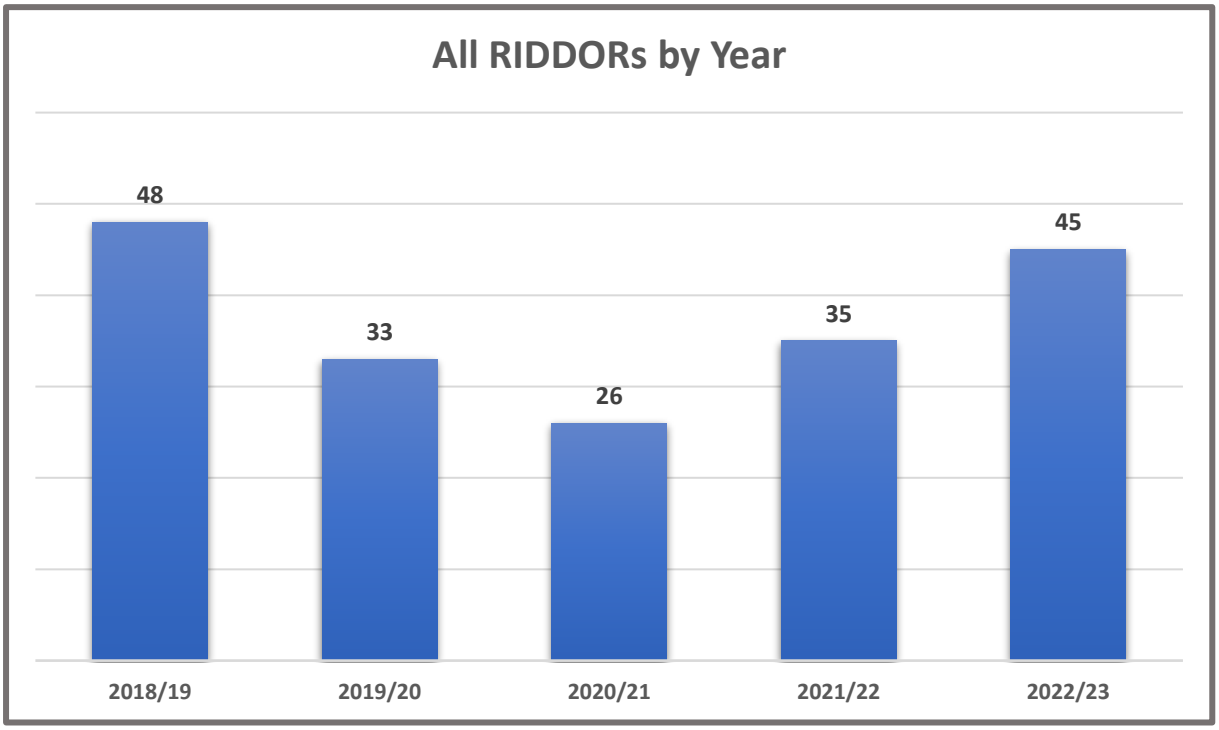
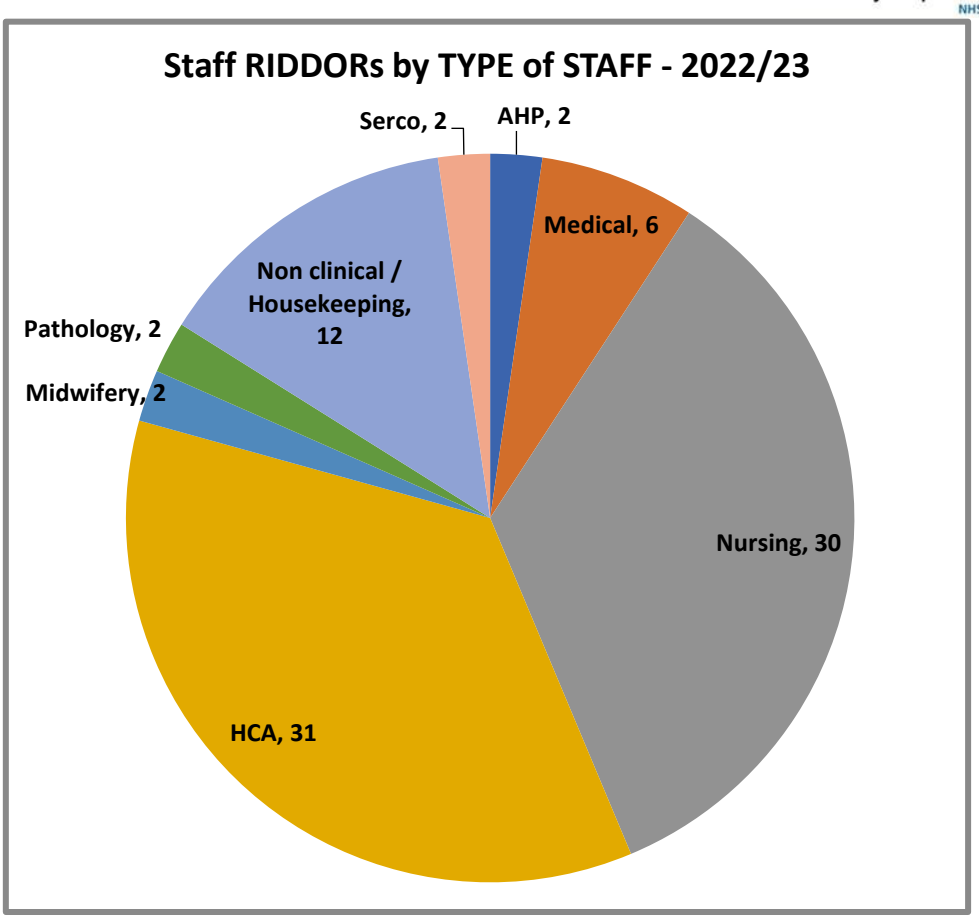
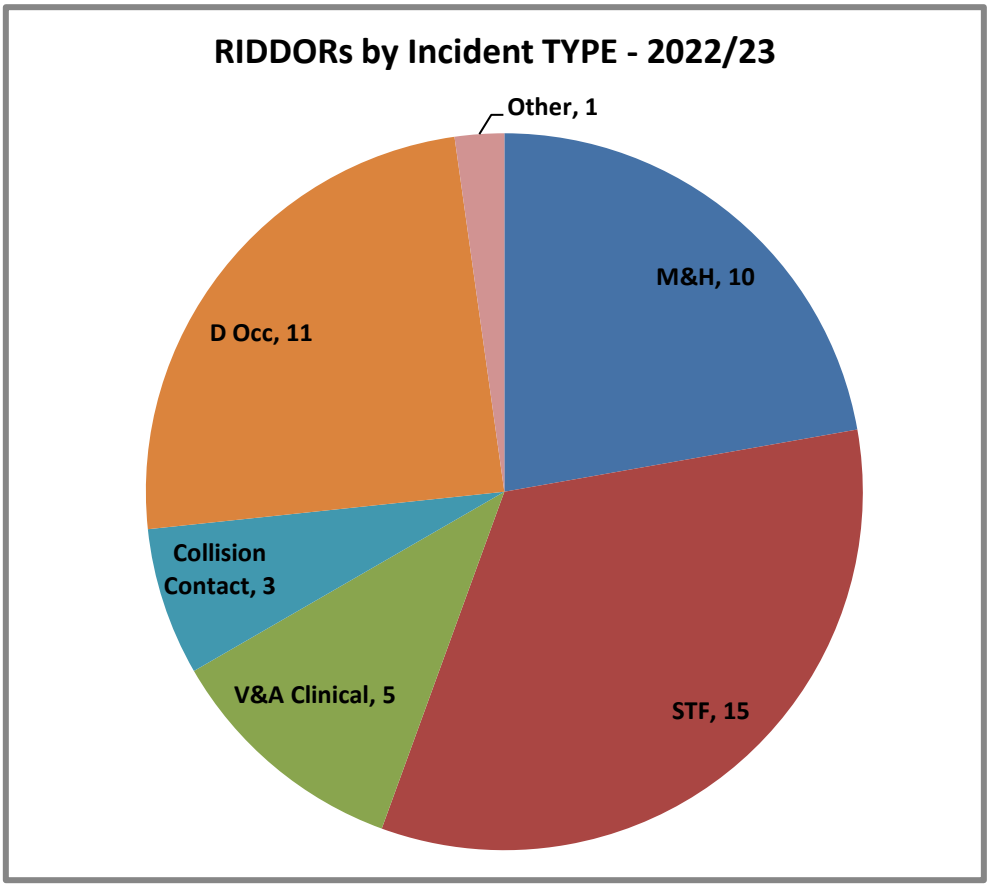
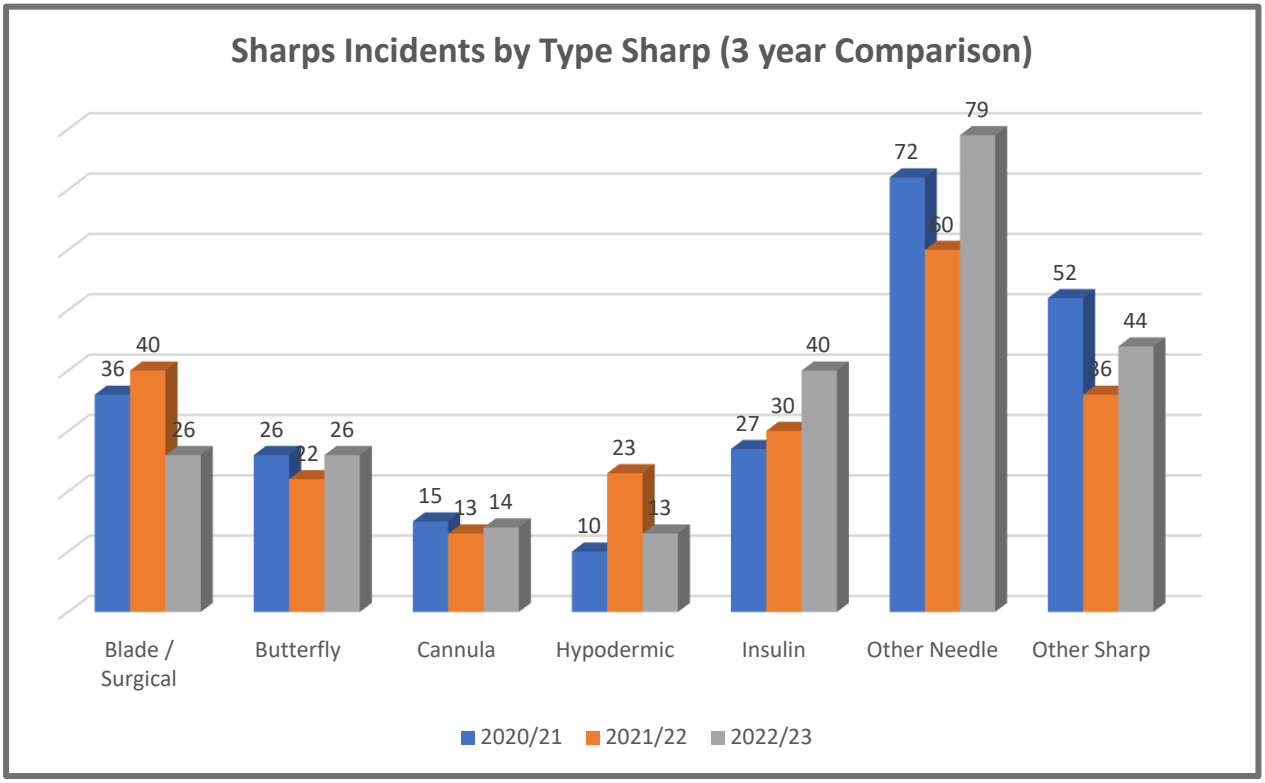


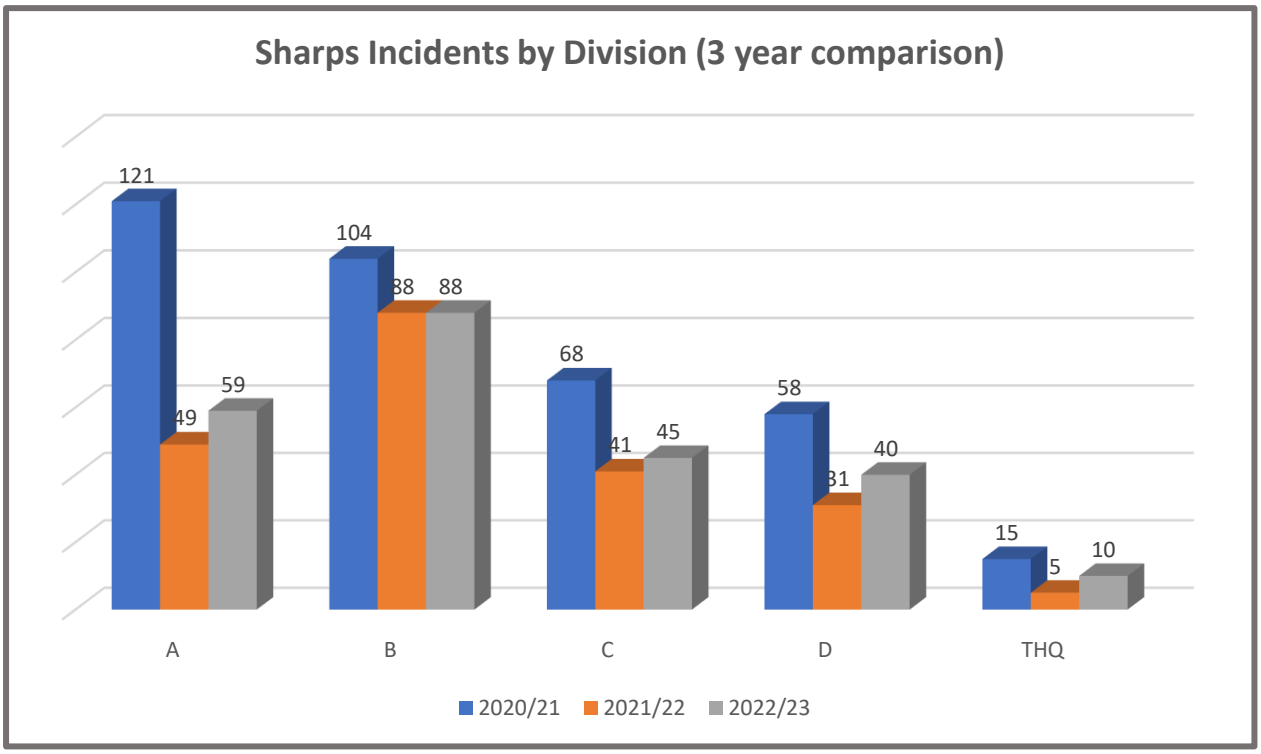

RIDDOR Causes by Year
11
9
6
10
8
9
11
15
3
2
0
5
2
0
1
0
3
2
3
3
5
1
4
11
1
1
8
0
0
2
2
1
M&H
STF
V&A Clinical
V&A Other
Collision Contact
D Occ
Disease
Other
2019/20
2020/21
2021/22
2022/23

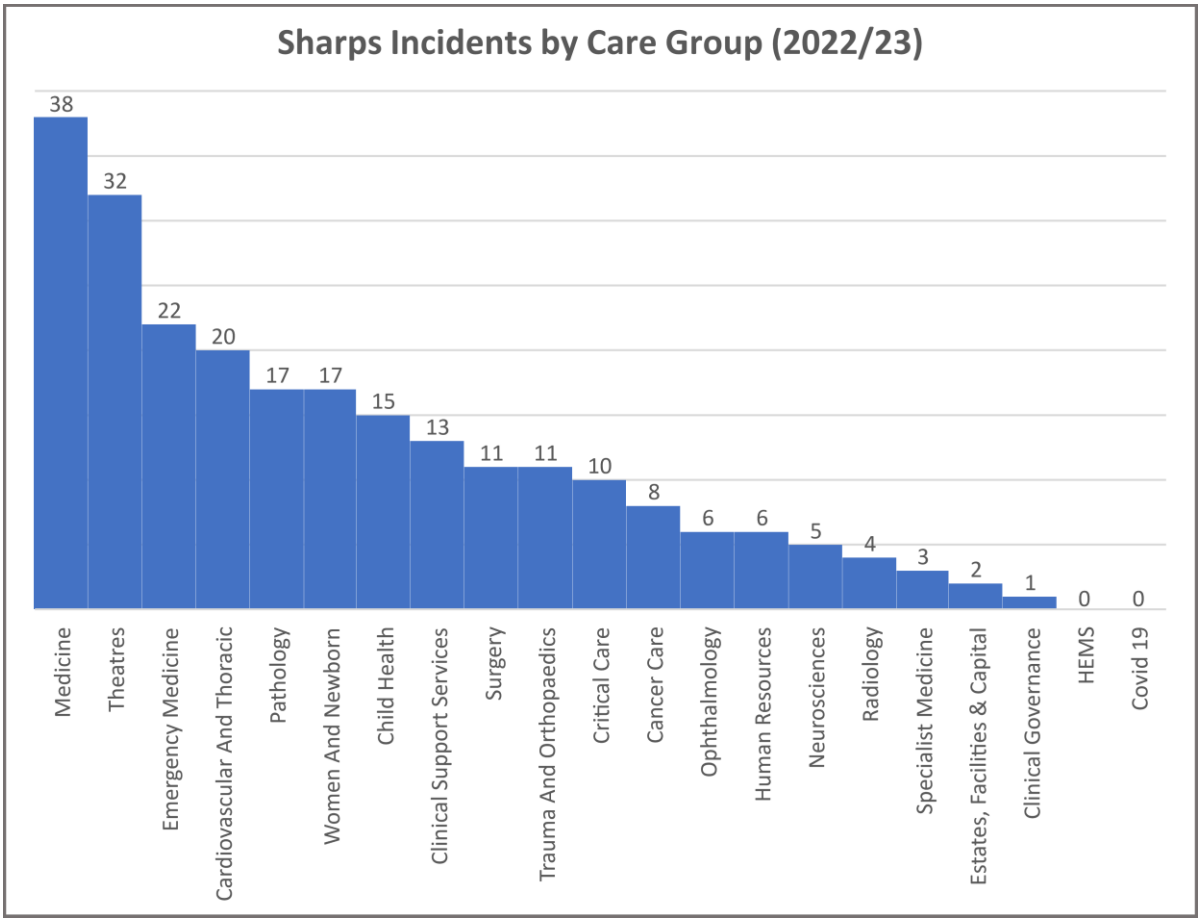

All RIDDORs by Year
48
33
26
35
45
2018/19
2019/20
2020/21
2021/22
2022/23

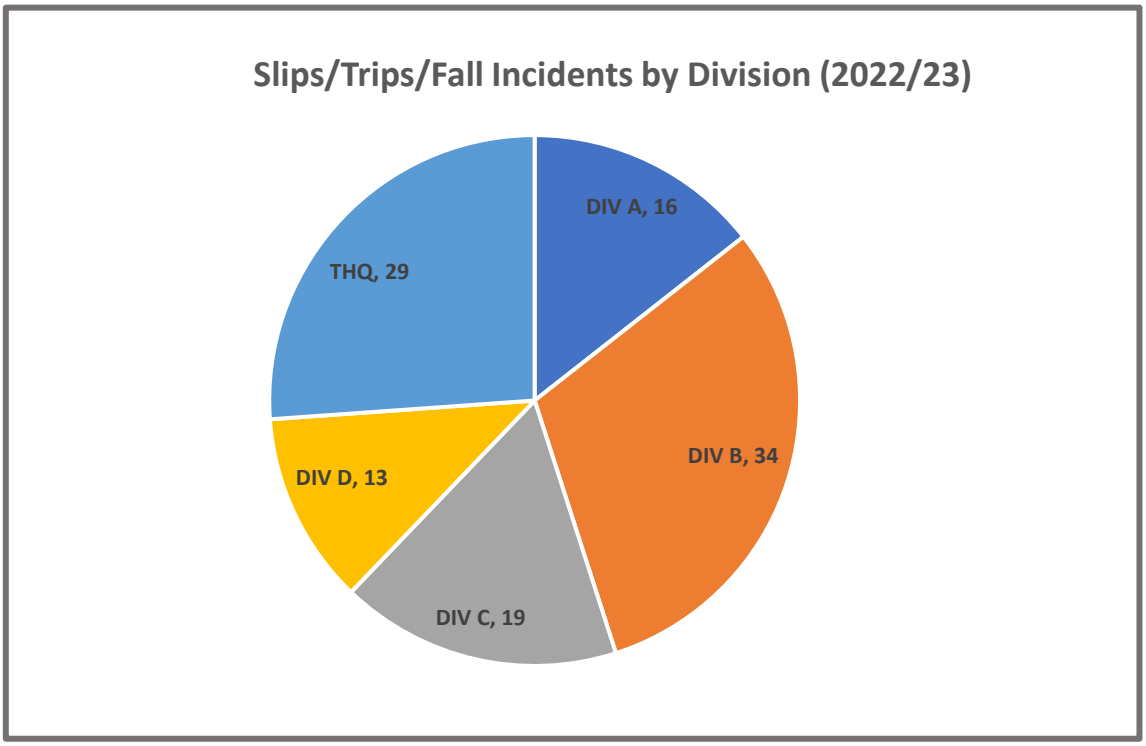

Staff RIDDORs by TYPE of STAFF - 2022/23
Serco, 2
AHP, 2
Medical, 6
Non clinical / Housekeeping, 12
Pathology, 2
Midwifery, 2
Nursing, 30
HCA, 31

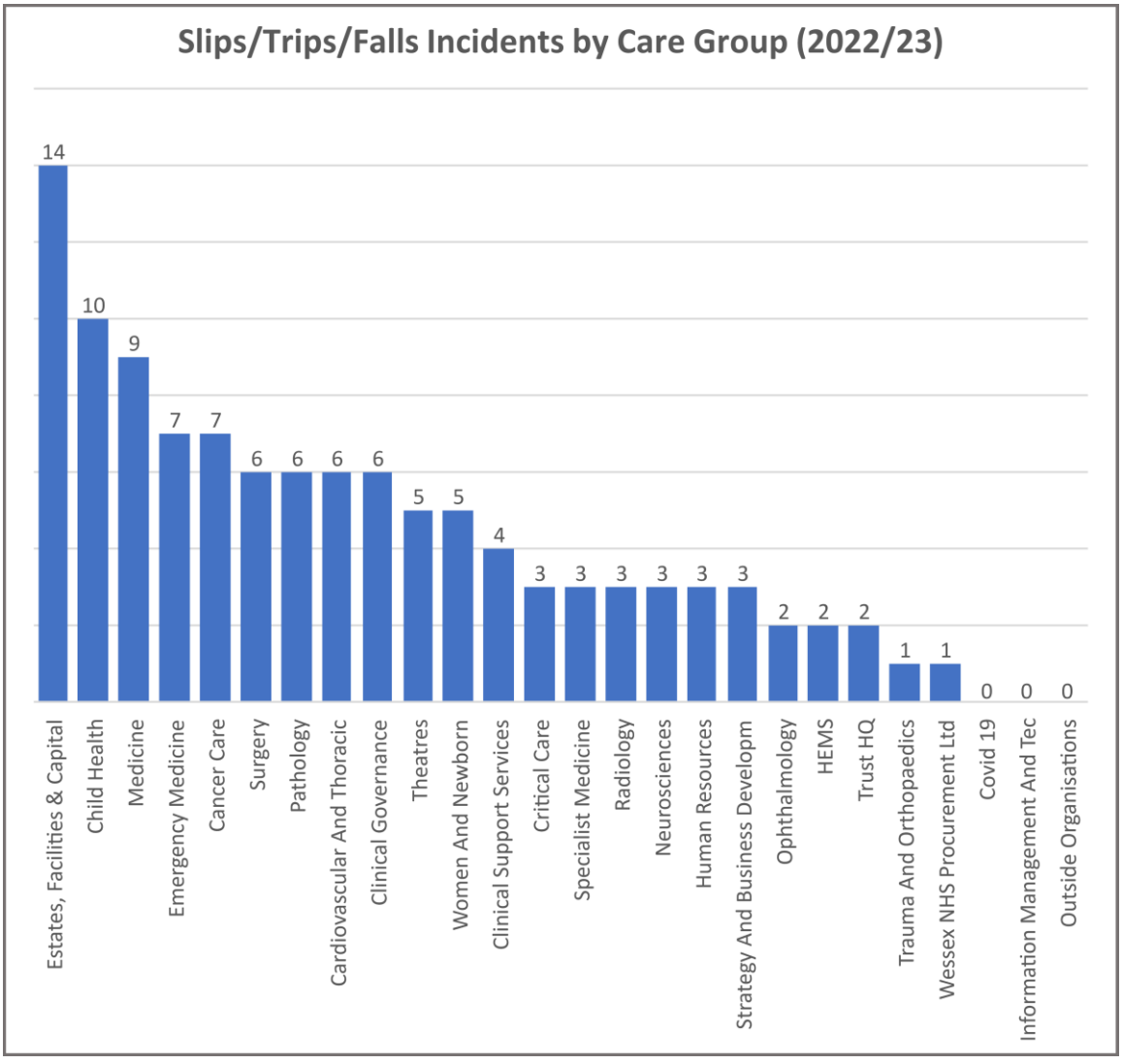

RIDDORs by Incident TYPE - 2022/23
Other, 1
M&H, 10
D Occ, 11
Collision Contact, 3
V&A Clinical, 5
STF, 15

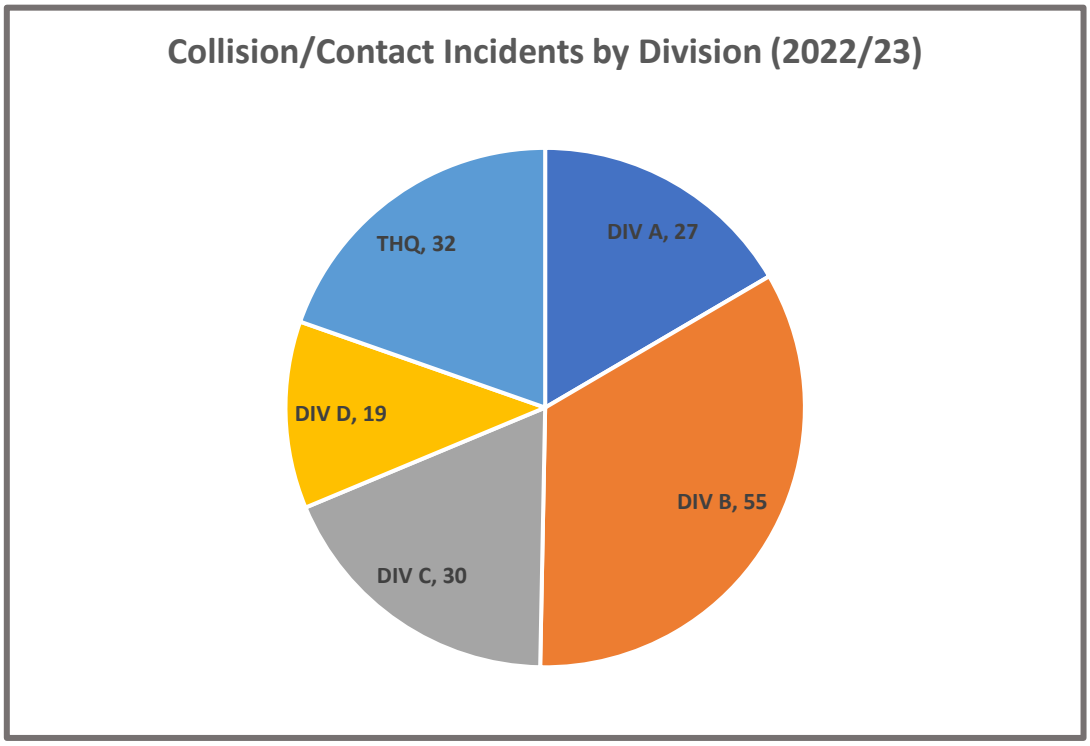

Sharps Incidents by Type Sharp (3 year Comparison)
36
40
26
26
22
26
15
13
14
10
23
13
27
30
40
72
60
79
52
36
44
Blade / Surgical
Butterfly
Cannula
Hypodermic
Insulin
Other Needle
Other Sharp
2020/21
2021/22
2022/23

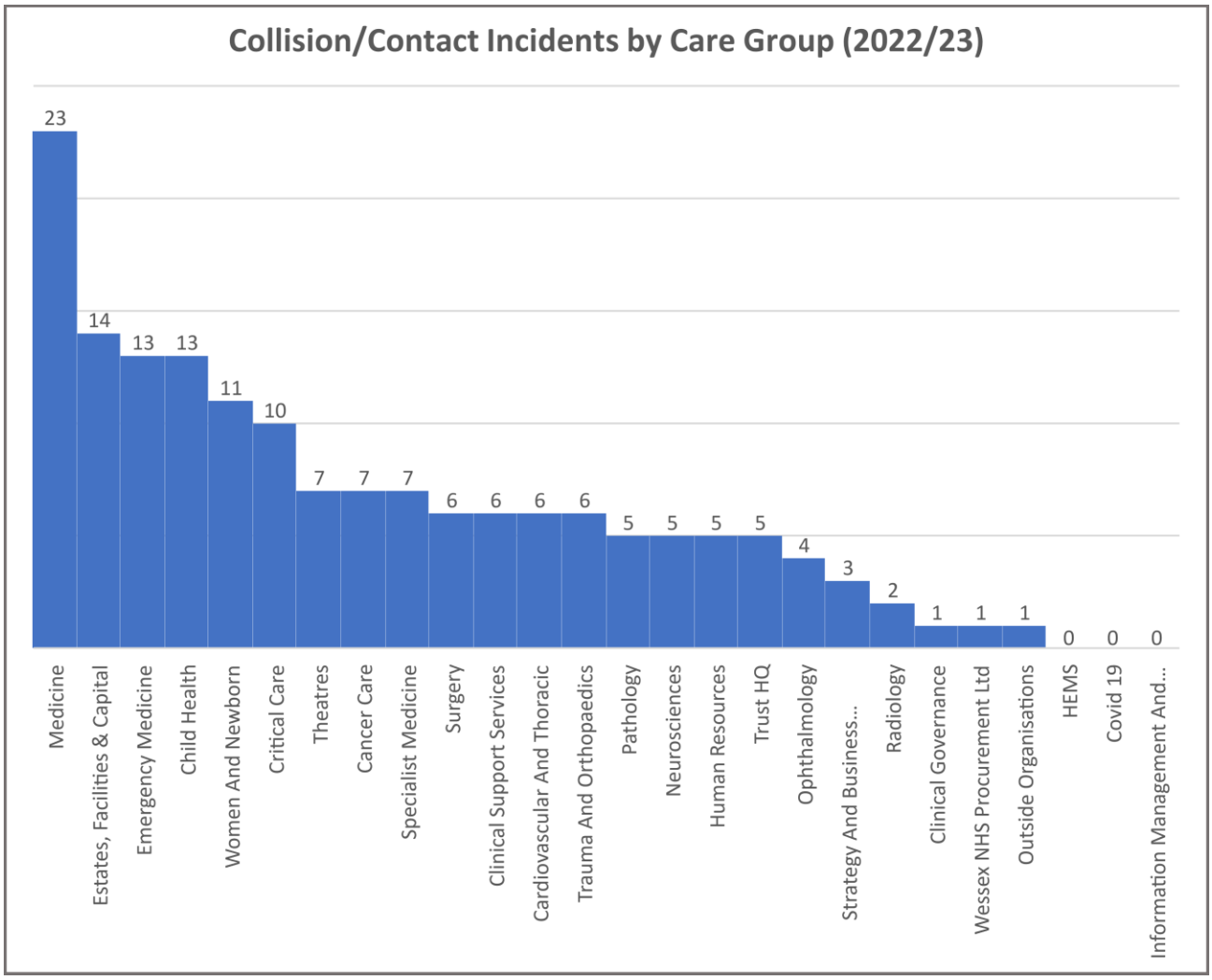

Sharps Incidents by Division (3 year comparison)
121
49
59
104
88
88
68
41
45
58
31
40
15
5
10
A
B
C
D
THQ
2020/21
2021/22
2022/23

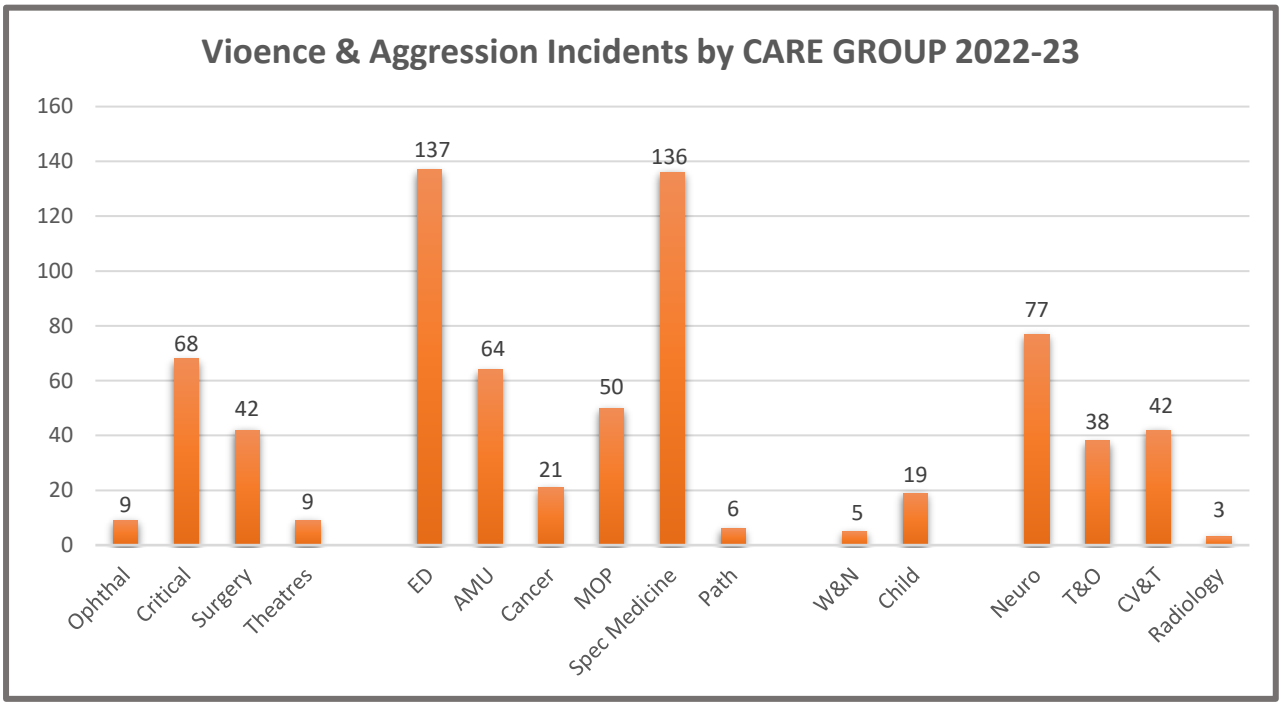

Sharps Incidents by Care Group (2022/23)
38
32
22
20
17
17
15
13
11
11
10
8
6
6
5
4
3
2
1
0
0
Medicine
Theatres
Emergency Medicine
Cardiovascular And Thoracic
Pathology
Women And Newborn
Child Health
Clinical Support Services
Surgery
Trauma And Orthopaedics
Critical Care
Cancer Care
Ophthalmology
Human Resources
Neurosciences
Radiology
Specialist Medicine
Estates, Facilities & Capital
Clinical Governance
HEMS
Covid 19

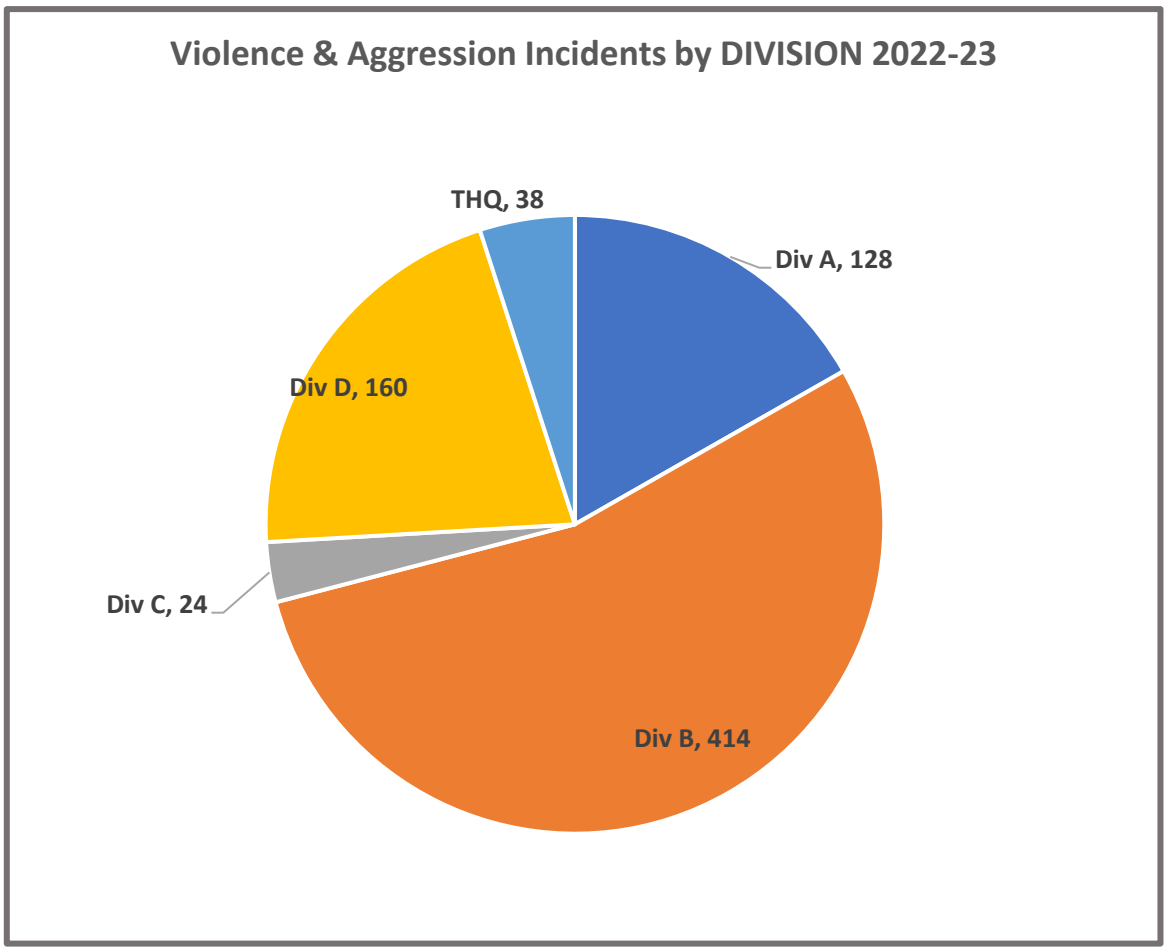

Slips/Trips/Fall Incidents by Division (2022/23)
DIV A, 16
DIV B, 34
DIV C, 19
DIV D, 13
THQ, 29

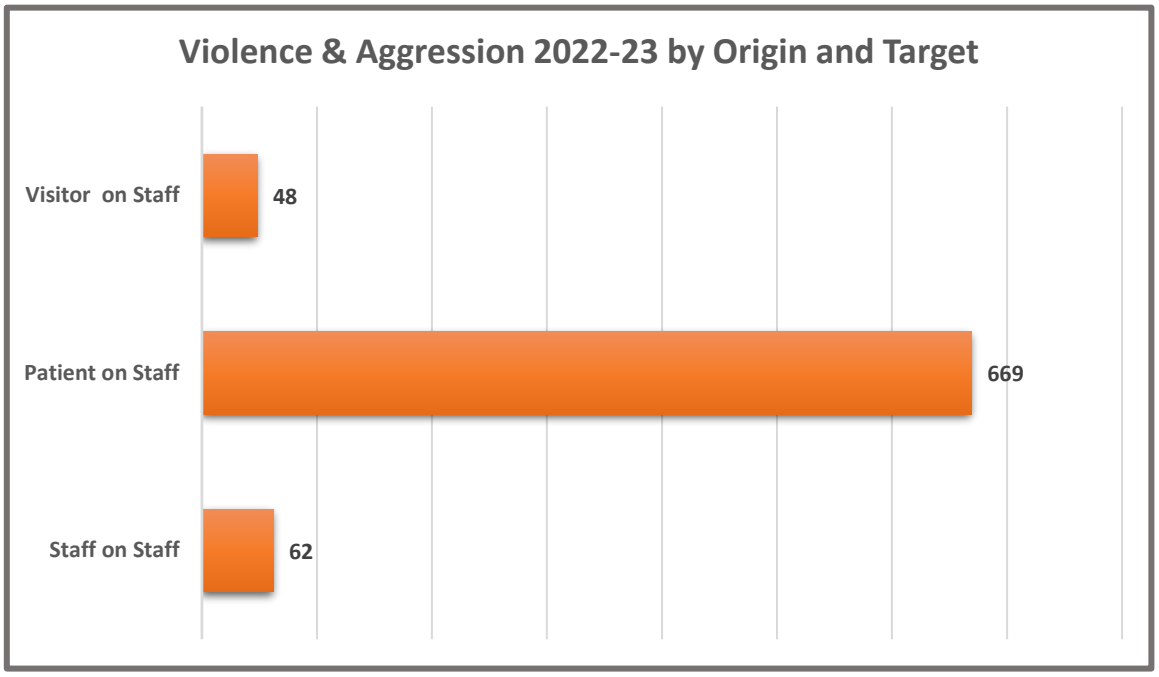

Slips/Trips/Falls Incidents by Care Group (2022/23)
14
10
9
7
7
6
6
6
6
5
5
4
3
3
3
3
3
3
2
2
2
1
1
0
0
0
Estates, Facilities & Capital
Child Health
Medicine
Emergency Medicine
Cancer Care
Surgery
Pathology
Cardiovascular And Thoracic
Clinical Governance
Theatres
Women And Newborn
Clinical Support Services
Critical Care
Specialist Medicine
Radiology
Neurosciences
Human Resources
Strategy And Business Developm
Ophthalmology
HEMS
Trust HQ
Trauma And Orthopaedics
Wessex NHS Procurement Ltd
Covid 19
Information Management And Tec
Outside Organisations

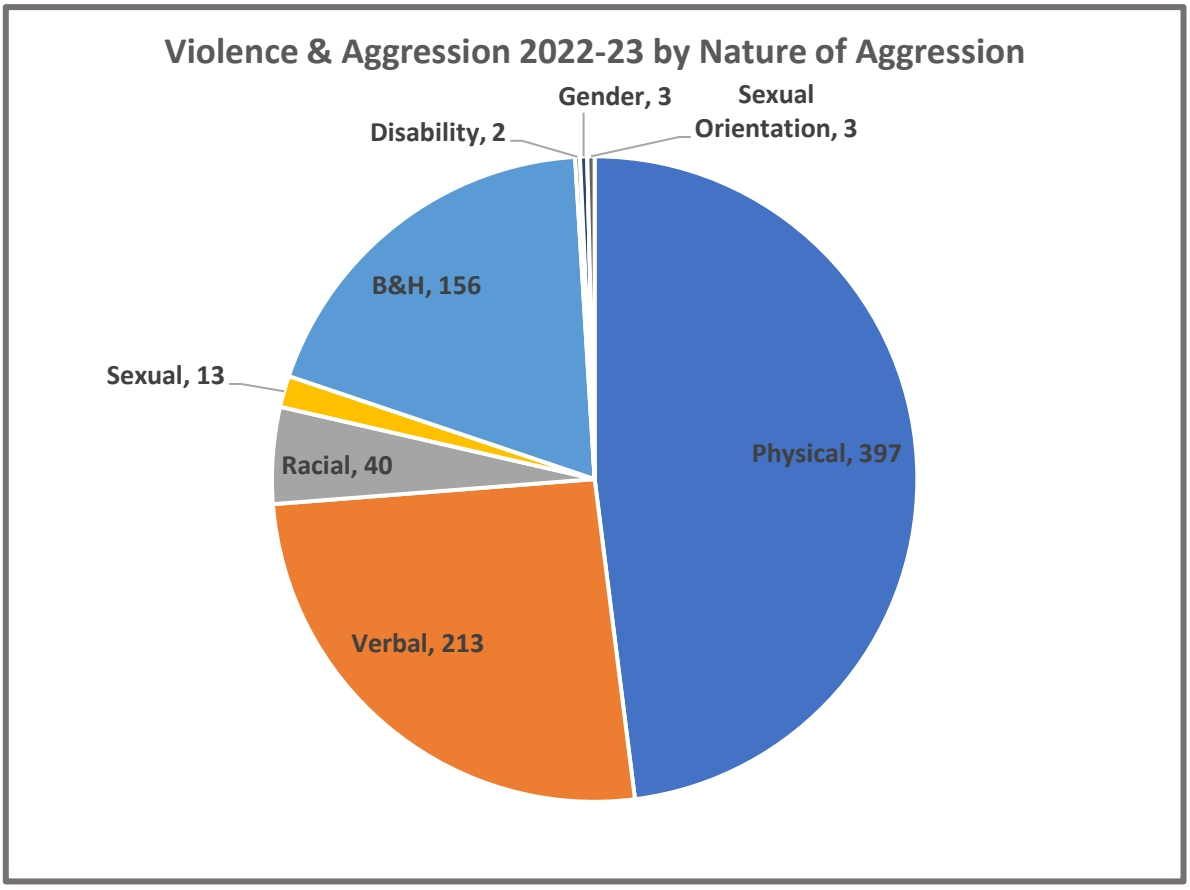

Collision/Contact Incidents by Division (2022/23)
THQ, 32
DIV A, 27
DIV D, 19
DIV B, 55
DIV C, 30

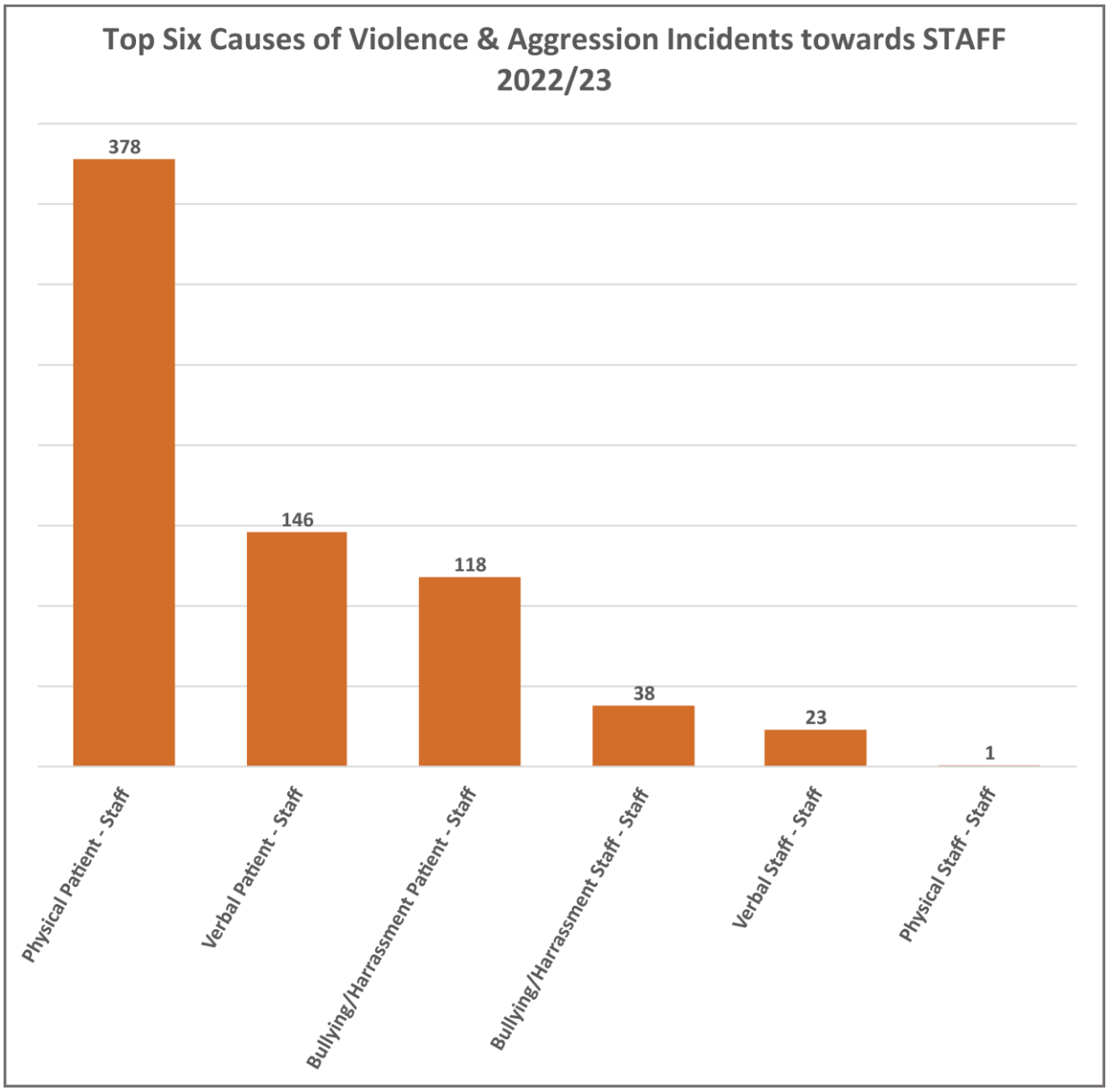

Collision/Contact Incidents by Care Group (2022/23)
23
14
13
13
11
10
7
7
7
6
6
6
6
5
5
5
5
4
3
2
1
1
1
0
0
0
Medicine
Estates, Facilities & Capital
Emergency Medicine
Child Health
Women And Newborn
Critical Care
Theatres
Cancer Care
Specialist Medicine
Surgery
Clinical Support Services
Cardiovascular And Thoracic
Trauma And Orthopaedics
Pathology
Neurosciences
Human Resources
Trust HQ
Ophthalmology
Strategy And Business...
Radiology
Clinical Governance
Wessex NHS Procurement Ltd
Outside Organisations
HEMS
Covid 19
Information Management And...

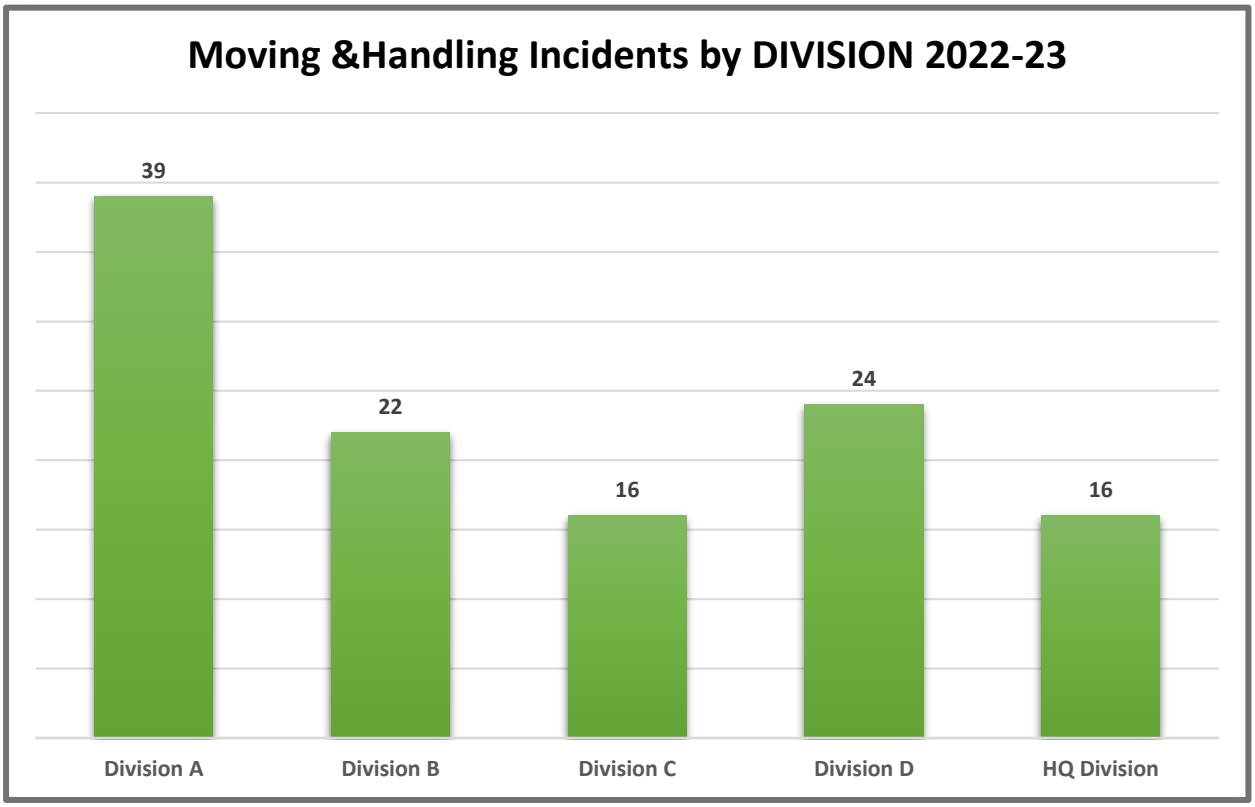

Vioence & Aggression Incidents by CARE GROUP 2022-23
160
140
120
100
80
60
40
20
0
9
68
42
9
137
64
21
50
136
6
5
19
77
38
42
3
Ophthal
Critical
Surgery
Theatres
ED
AMU
Cancer
MOP
Spec Medicine
Path
W&N
Child
Neuro
T&O
CV&T
Radiology

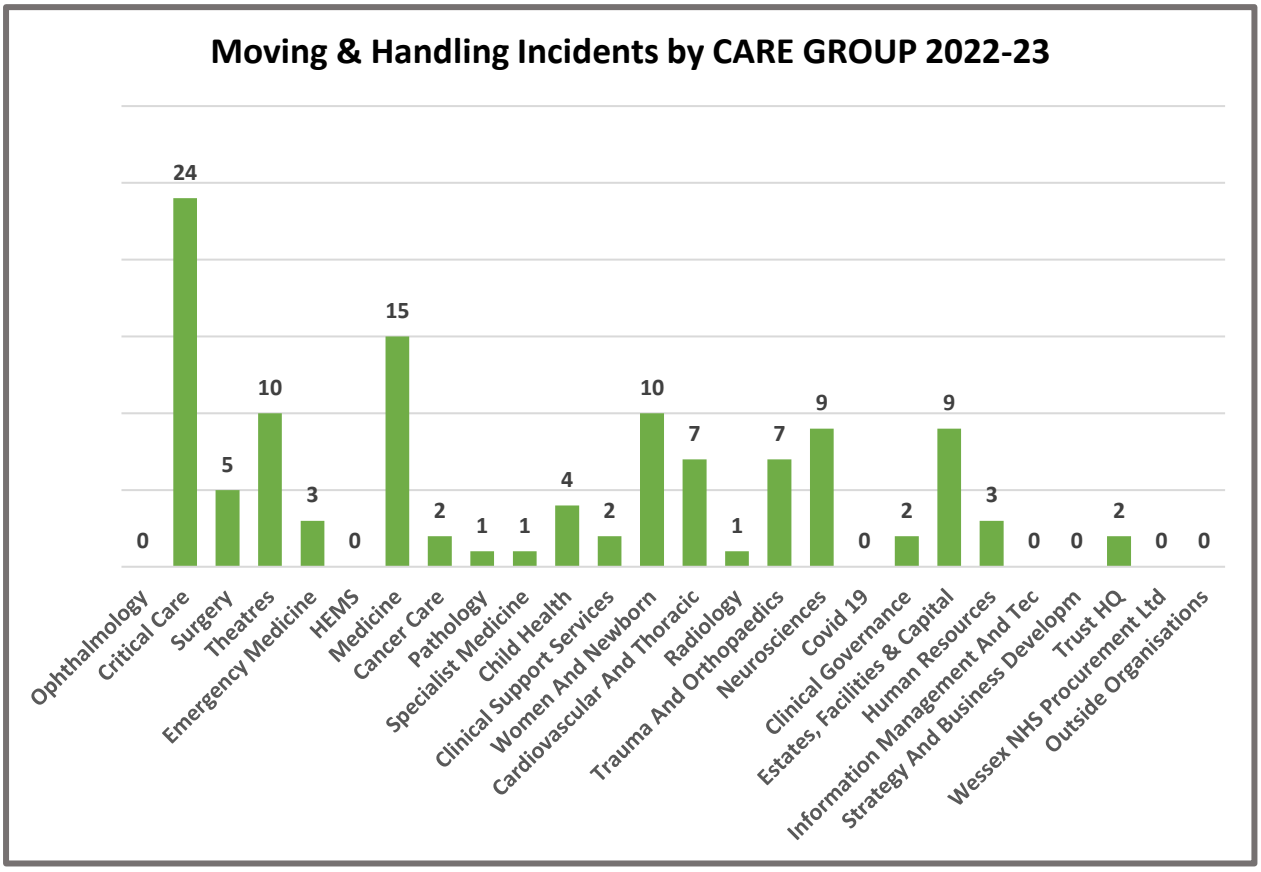

Violence & Aggression Incidents by DIVISION 2022-23
THQ, 38
Div A, 128
Div D, 160
Div C, 24
Div B, 414

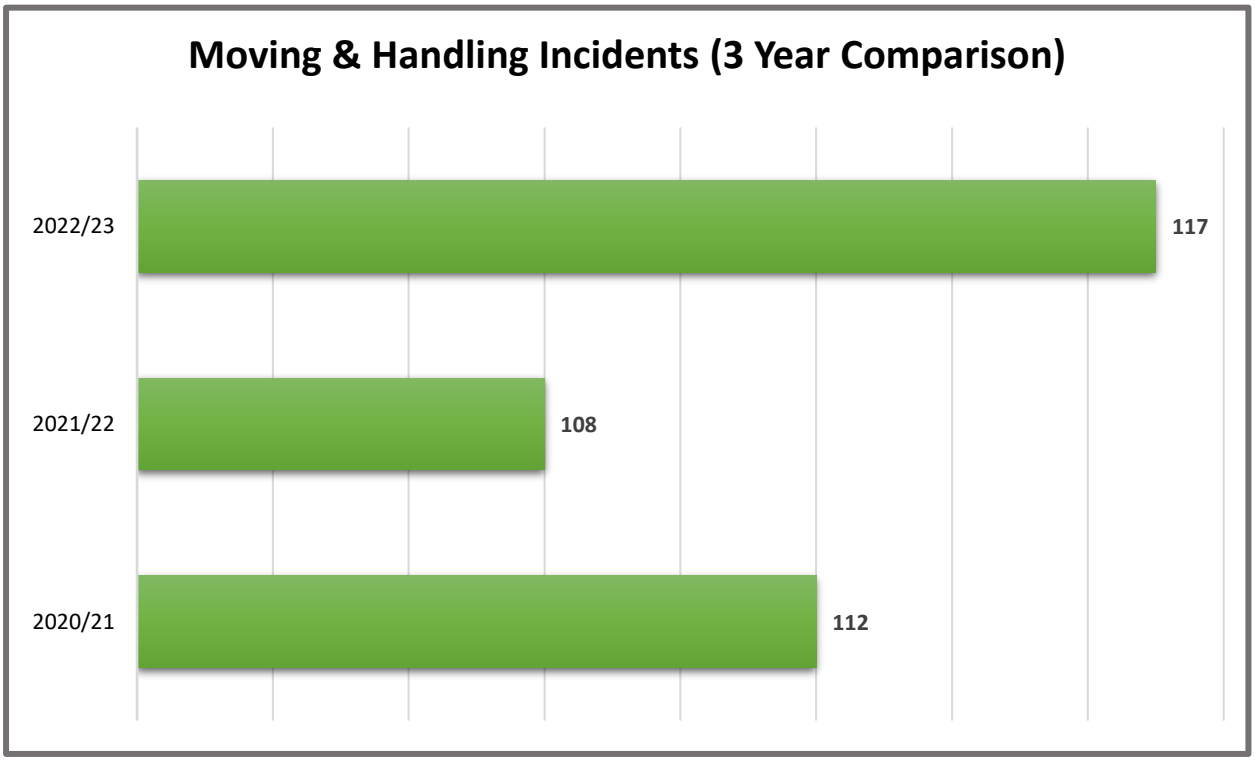

Violence & Aggression 2022-23 by Origin and Target
Visitor on Staff
48
Patient on Staff
669
Staff on Staff
62

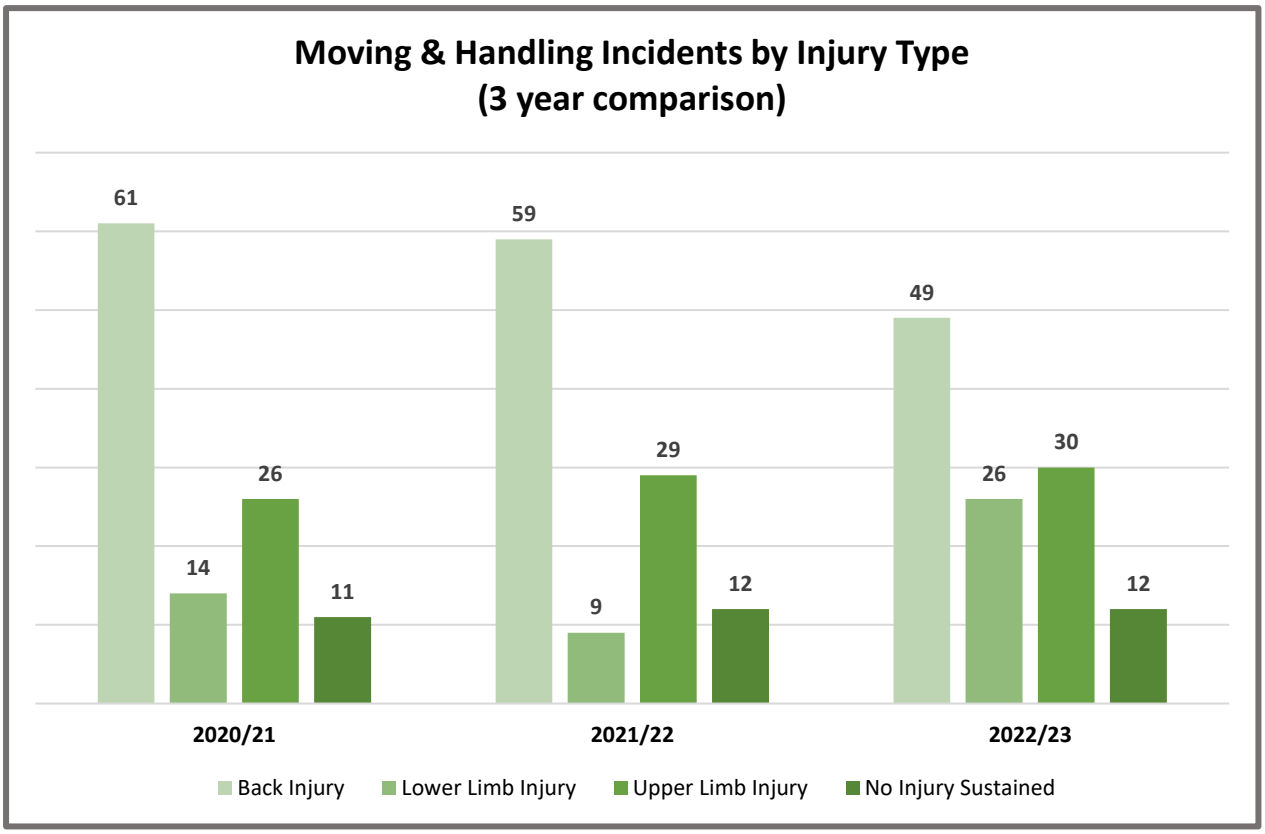

Violence & Aggression 2022-23 by Nature of Aggression
Gender, 3
Sexual Orientation, 3
Disability, 2
B&H, 156
Sexual, 13
Racial, 40
Physical, 397
Verbal, 213

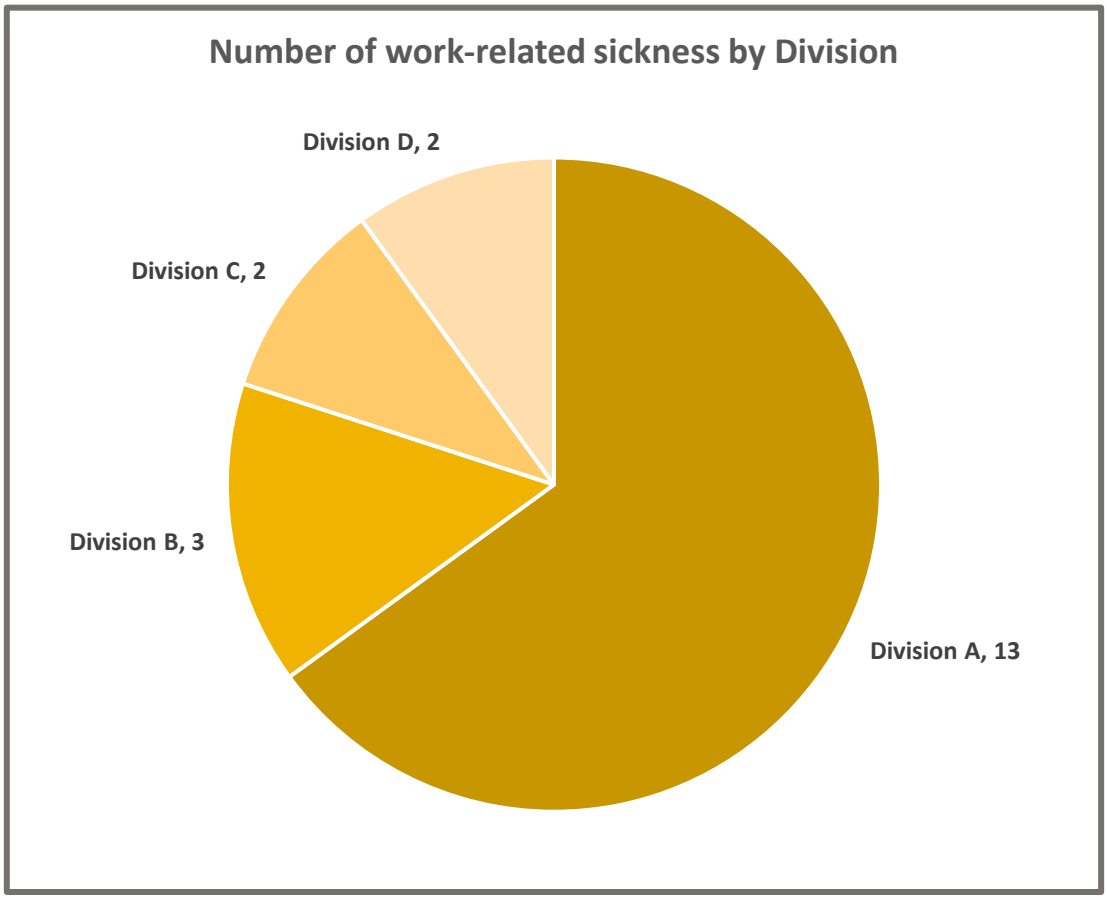

Top Six Causes of Violence & Aggression Incidents towards STAFF 2022/23
378
146
118
38
23
1
Physical Patient - Staff
Verbal Patient - Staff
Bullying/Harrassment Patient - Staff
Bullying/Harrassment Staff - Staff
Verbal Staff - Staff
Physical Staff - Staff

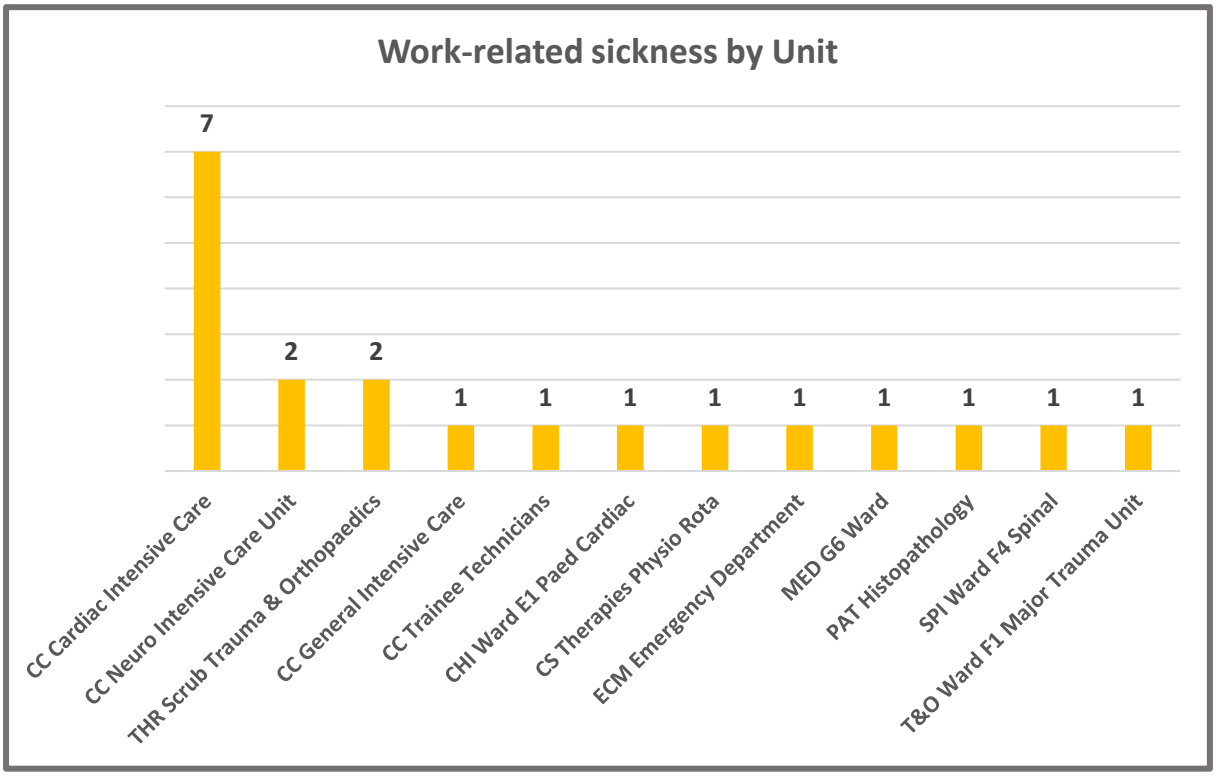

Moving &Handling Incidents by DIVISION 2022-23
39
22
16
24
16
Division A
Division B
Division C
Division D
HQ Division

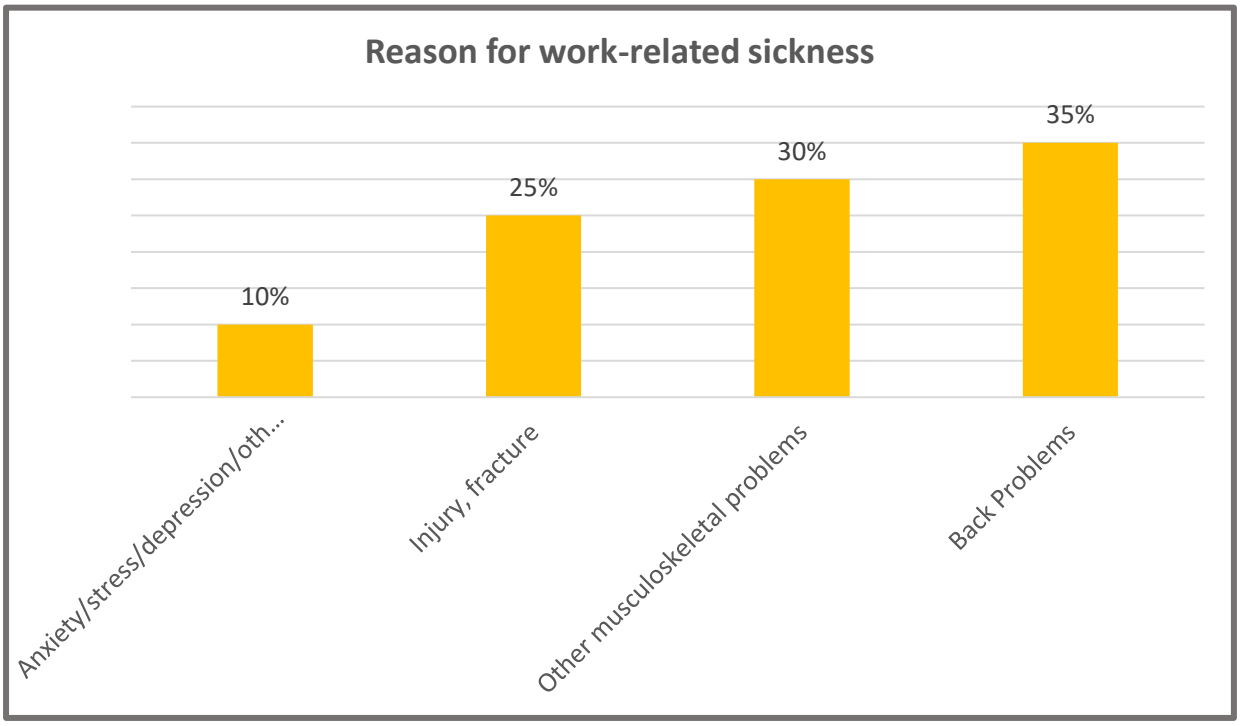

Moving & Handling Incidents by CARE GROUP 2022-23
0
24
5
10
3
0
15
2
1
1
4
2
10
7
1
7
9
0
2
9
3
0
0
2
0
0
Ophthalmology
Critical Care
Surgery
Theatres
Emergency Medicine
HEMS
Medicine
Cancer Care
Pathology
Specialist Medicine
Child Health
Clinical Support Services
Women And Newborn
Cardiovascular And Thoracic
Trauma And Orthopaedics
Radiology
Neurosciences
Covid 19
Clinical Governance
Estates, Facilities & Capital
Human Resources
Information Management And Tec
Strategy And Business Developm
Trust HQ
Wessex NHS Procurement Ltd
Outside Organisations


Moving & Handling Incidents (3 Year Comparison)
2022/23
117
2021/22
108
2020/21
112


Moving & Handling Incidents by Injury Type
(3 year comparison)
61
14
26
11
59
9
29
12
49
26
30
12
2020/21
2021/22
2022/23
Back Injury
Lower Limb Injury
Upper Limb Injury
No Injury Sustained


Number of work-related sickness by Division
Division D, 2
Division C, 2
Division B, 3
Division A, 13


Work-related sickness by Unit
7
2
2
1
1
1
1
1
1
1
1
1
CC Cardiac Intensive Care
CC Neuro Intensive Care Unit
THR Scrub Trauma & Orthopaedics
CC General Intensive Care
CC Trainee Technicians
CHI Ward E1 Paed Cardiac
CS Therapies Physio Rota
ECM Emergency Department
MED G6 Ward
PAT Histopathology
SPI Ward F4 Spinal
T&O Ward F1 Major Trauma Unit


Reason for work-related sickness
10%
25%
30%
35%
Anxiety/stress/depression/oth...
Injury, fracture
Other musculoskeletal problems
Back Problems

FFP3 Resilience Service

Annual Report 2022/2023

Central Fit Testing Hub

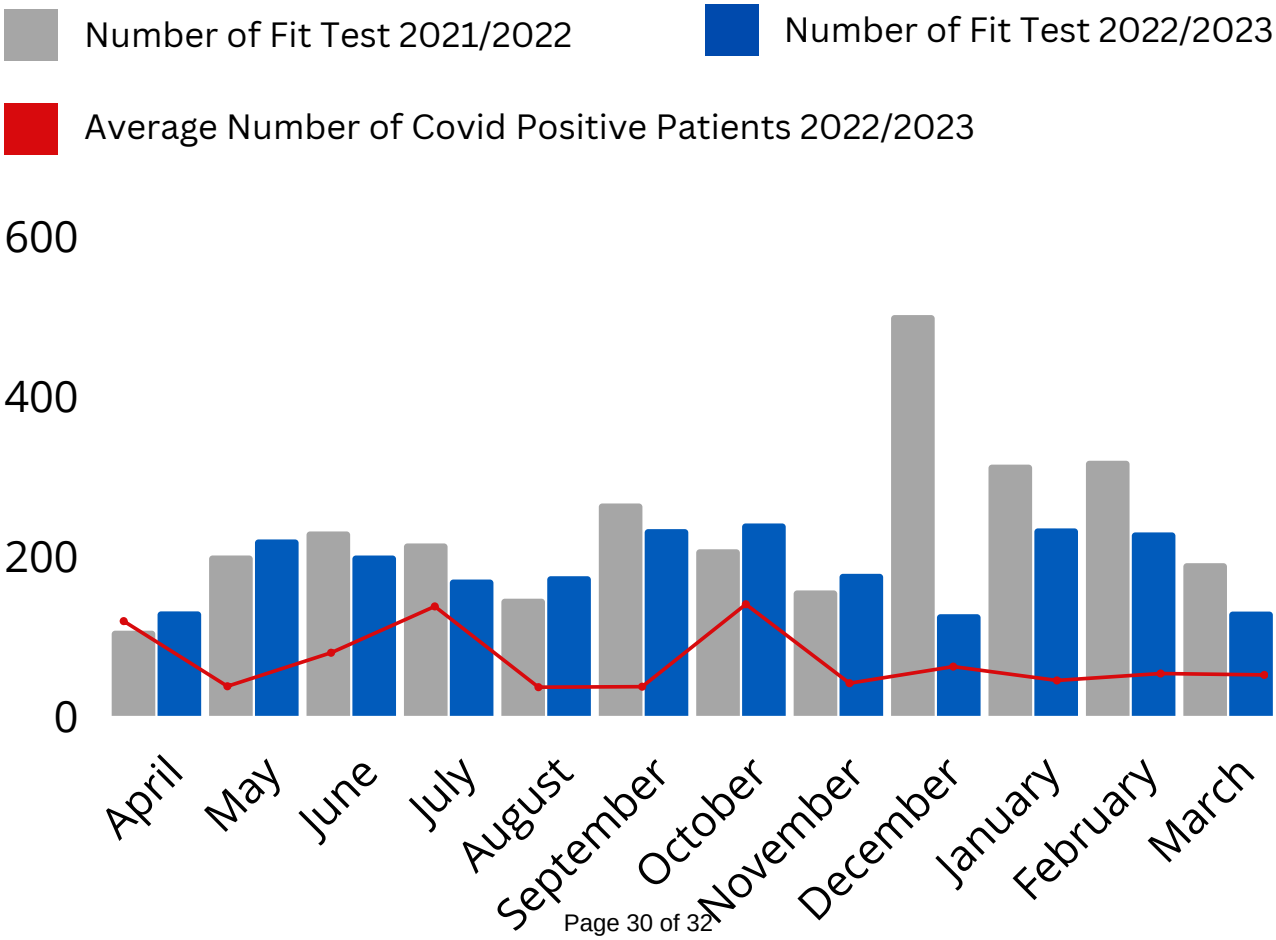
2264

Fit tests carried out across UHS

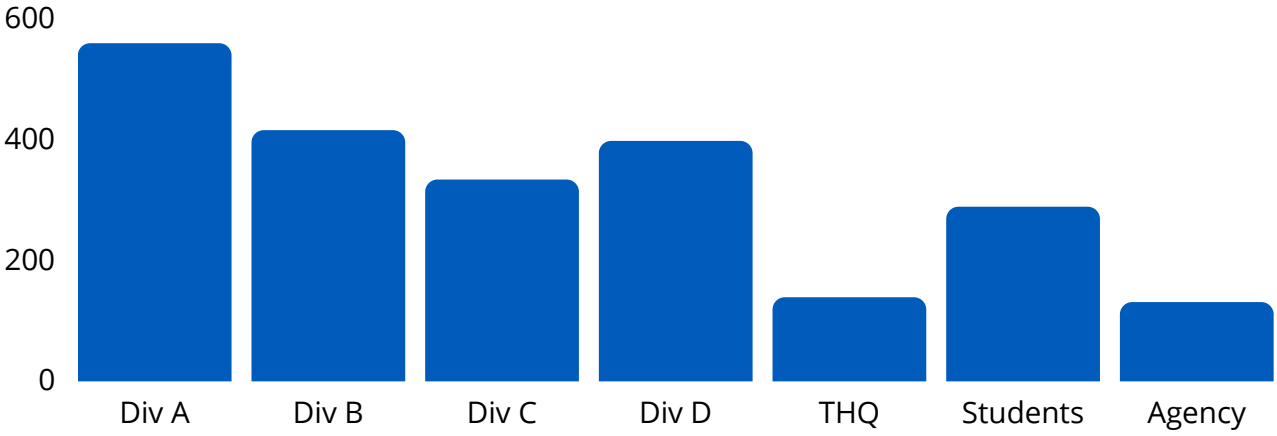
87.3%

Fit tests carried out in Central Fit Testing Hub

- Fit testing across University Hospital Southampton has remained high despite the drop in covid+ patients.
- The Central Fit Testing Hub has been supported by additional fit testing carried out by; Critical Care, Radiology, Ophthalmology and Child Health.
- Government fit testing contract has ended. UHS no longer has dedicated fit testing staff working in Central Fit Testing Hub.



The number of staff attending fit testing sessions is evenly spread across divisions. As expected Division A has required more staff to be fit tested due to the nature of their work.



Fit Testing Training

23

Fit Tester Training Courses

48

Staff trained to fit test

FFP3 Resilience Lead, Sam Carter-Chappell undertook Fit2Fit Accreditation. The Trust has never been accredited before for fit testing. Having an accredited fit test allows the Trust to be following best practice guidelines and ensure staff safety.
It will also allow the trust to run their own accredited training courses and advise on correct usage of respiratory protective equipment (RPE).

PeRSo Respirators

In Q3 we undertook a PeRSo Respirator usage survey to gain a detailed understanding of how staff are using PeRSo across the Trust.

PeRSo Respirator Survey Results

5.8%

of staff always use their PeRSo Respirator

17.3%

of staff often use their PeRSo Respirator

76.9%

of staff rarely or never use their PeRSo Respirator

44.6%

Of staff prefer to use a PeRSo over a tight fitting FFP3 mask (150 respondents)

85%

Of respondents to survey have been successfully fit tested to one or more FFP3 masks

All operational PeRSo respirators have now been upgraded to meet the BSIF standard as of March 2023.

FFP3 Resilience Service Achievements

- Introduced digital record keeping workflow, allowing for reduction in admin time and increased fit testing capacity.
- reduced amount of time staff are required to leave work to attend fit testing session.
- Increased Trust compliance and created systems that allow the Trust to measure itself against the EPRR framework.
- Enabled the Trust to be placed in the top five for fit testing nationally throughout 2022/20223 and spend five months in the top three.

FFP3 Resilience Service Year Ahead

- Central Fit Testing Hub Capacity Reduced to 40%
- Current wait time for fit test or PeRSo training appointment is seven working days.
- Centralised PeRSo servicing stopped.
- Moving of unused PeRSo respirators into long term storage also stopped.
- All FFP3 masks will no longer be free by March 2024.
- There is no capacity in the service for any increase in demand for fit testing.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**People and Organisational Development Committee Terms of Reference**			
Agenda item:	**6.3**			
Sponsor:	**Steve Harris, Chief People Officer**			
Author:	**Craig Machell, Associate Director of Corporate Affairs and Company Secretary**			
Date:	**28 September 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 People and Organisational Development Committee reviewed and approved its terms of reference at its meeting held on 20 September 2023. The terms of reference are to be approved by the Board of Directors.			
Response to the issue:	No changes are proposed to the current terms of reference.			
Implications: (Clinical, Organisational, Governance, Legal?)	The terms of reference ensure that the purpose and activities of the People and OD Committee are clear and support transparency and accountability in the performance of its role and comply with The NHS Foundation Trust Code of Governance.			
Risks: (Top 3) of carrying out the change / or not:	1. Non-compliance with the National Health Service Act 2006, The NHS Foundation Trust Code of Governance and the Trust's constitution relating to the composition of Board committees. 2. Non-compliance with the Trust's standing financial instructions and policies relating to the specific responsibilities of the Audit and Risk Committee. 3. The Board of Directors and the committee may not function as effectively without terms of reference in place.			
Summary: Conclusion and/or recommendation	The Board is asked to approve the terms of reference.			

University Hospital Southampton NHS
NHS Foundation Trust

People and Organisational Development Committee Terms of Reference

Version: 45

Date Issued:	~~20 December 2022~~28 September 2023
Review Date:	~~August~~ September 2023
Document Type:	Committee Terms of Reference

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Document Status

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1. Role and Purpose

1.1 The People and Organisational Development Committee (the **Committee**) is responsible for overseeing, monitoring and reviewing the development and implementation of the people and organisational development strategies and operational plans for University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**), including the three areas of culture, capacity and capability and skills and the Trust's response to specific workforce issues arising from the coronavirus pandemic and the recovery of the organisation.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of assurance regarding the Trust's culture, capacity and capability and skills in support of the provision of world-class care for all.

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 Executive;

3.1.3 the Chief Nursing Officer;

3.1.4 the Chief Medical Officer; and

3.1.5 the Chief People 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 director members present to chair the meeting.

3.3 Other individuals may be invited for one of more topics to be present depending on the nature of the agenda item.

3.4 Governors may be invited to attend meetings of the Committee.

4. Attendance and Quorum

4.1 Members should aim to attend every meeting and should attend a minimum of two-thirds 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 and either the Chief People Officer or the Chief Nursing Officer. A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4.3 When an executive director or manager is unable to attend a meeting they should appoint a deputy to attend on their behalf. A deputy for an executive director will not count towards quoracy.

5. Frequency of Meetings

5.1 The Committee will meet at least six 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 Chief People Officer. The agenda and supporting papers will be distributed to each member of the Committee and the regular attendees no later than four 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 whilst making reference to the People Strategy and in particular the three pillars of Thrive, Excel and Belong

7.1 ***Culture***

7.1.1 The Committee will ensure that there are robust policies, systems and procedures for the development and monitoring of an inclusive culture with the Trust.

7.1.2 The Committee may review and monitor the following ensuring these support the achievement of the Trust People Strategy and Trust's objectives. It will identify areas for action at a corporate and local level, ensuring follow up takes place:

7.1.2.1 staff and team engagement;

7.1.2.2 compassionate and inclusive leadership;

7.1.2.3 quality improvement;

7.1.2.4 equality, diversity and inclusivity;

7.1.2.5 bullying and harassment;

7.1.2.6 staff sickness and wellbeing

7.1.2.7 Freedom to Speak Up and raising concerns;

7.1.2.8 people aspects of the corporate and clinical strategy; and

7.2 ***Capacity***

7.2.1 The Committee will ensure that there are robust policies, systems and procedures to ensure delivery and monitoring of workforce planning and recruitment and retention of staff.

7.2.2 The Committee may review and monitor the following ensuring these support the achievement of the Trust People Strategy and Trust's objectives. It will identify areas for action at a corporate and local level, ensuring follow up takes place:

7.2.2.1 strategic workforce planning;

7.2.2.2 recruitment and retention;

7.2.2.3 staffing levels;

7.2.2.4 reports from the Guardian of Safe Working Hours;

7.2.2.5 talent management;

7.2.2.6 reward including pensions;

7.2.2.7 CQUINs;

7.2.2.8 bank and agency staff; and

7.2.2.9 volunteers.

7.3 ***Capability and Skills***

7.3.1 The Committee will ensure that there are robust policies, systems and procedures to ensure delivery and monitoring of staff appraisal and development.

7.3.2 The Committee will review and monitor the following ensuring these support the achievement of the Trust People Strategy and Trust's objectives. It willidentify areas for action at a corporate and local level, ensuring follow up takes place:

7.3.2.1 appraisals;

7.3.2.2 education and training;

7.3.2.3 mandatory training;

7.3.2.4 gaps to meet the long-term corporate and clinical strategy;

7.3.2.5 the annual staff survey;

7.3.2.6 the 'fit and proper persons' requirements;

7.3.2.7 the Staff Friends and Family Test; and

7.3.2.8 flu vaccinations and other national vaccination programmes.

7.4 ***Risk***

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

7.4.2 The Committee will establish and maintain an overview of the Trust's people risks and ensure the effectiveness and implementation of controls for people risks and actions to mitigate these risks.

7.4.3 The Committee will refer any potential risks to patient safety or quality identified by the Committee to the Quality Committee.

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

7.5 ***Reporting***

7.5.1 The Committee will advise the Trust Board on the appropriate key performance indicators, measures and benchmarks in the three areas of culture, capacity and capability and skills.

7.5.2 The Committee will ensure robust supporting data quality for any key performance indicators, measures and benchmarks within the areas of culture, capacity and capability and skills.

7.5.3 The Committee will review any submissions to national bodies before these are presented to the Board for approval.

8. Accountability and Reporting

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

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

8.3 Appendix A sets out the sub-committees that report to and support the Committee in fulfilling its duties and responsibilities. The Committee will receive the minutes of those meetings and at least an Annual Report of their work.

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 Employment Rights Act 1996

10.2 Equality Act 2010

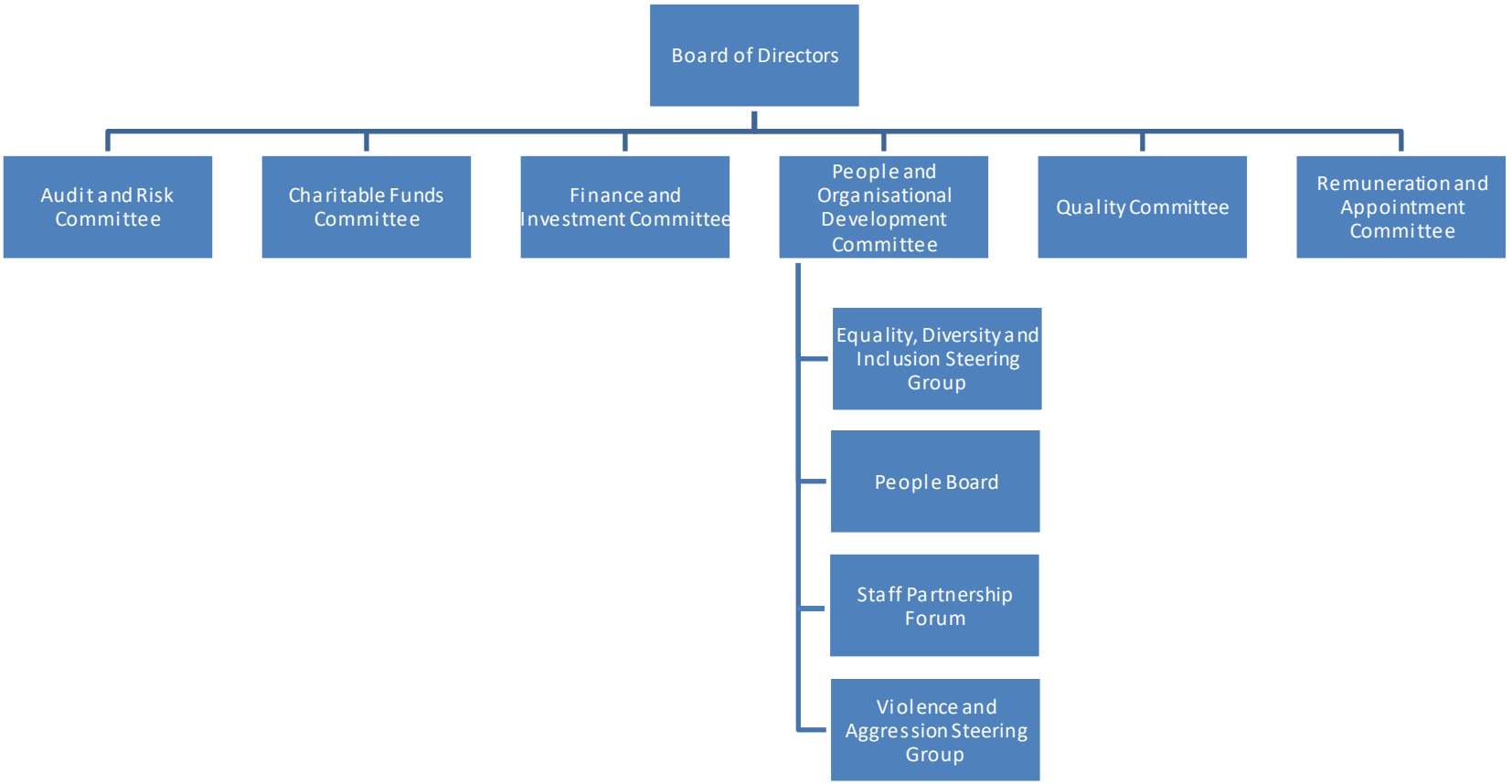
10.3 Public Interest Disclosure Act 1998

10.4 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

10.5 NHS Constitution

10.6 Terms and conditions of service for doctors and dentists in training (England) 2016 - December 2019

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
Equality, Diversity and Inclusion Steering Group
People Board
Staff Partnership Forum
Violence and Aggression Steering Group

People and Organisational Development Committee Terms of Reference	Version: ~~4~~5

Document Monitoring Information	
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Monitoring (Section 9) for Completion and Presentation to Approval Committee:	~~August 2023~~September 2024
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Consultation:	Chief People Officer
Number of pages:	8
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Does this document replace or revise an existing document?	Yes
Should this document be made available on the public website?	Yes
Is this document to be published in any other format?	No

Report to the Trust Board of Directors				
Title:	**CRN Wessex: 2023-24 Q1 Performance Report**			
Agenda item:	**9.1**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Author:	**Clare Rook, Chief Operating Officer, CRN Wessex** **Graham Halls, Business Intelligence Manager, CRN Wessex**			
Date:	**28 September 2023**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **x**
Issue to be addressed:	● This report covers Clinical Research Network (CRN) Wessex's performance in quarter one of the 2023/24 financial year (April to June 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 above or close to DHSC HLO ambitions to meet study sponsor recruitment expectations and ensure sufficient responses to the National Institute of Health and Care Research's (NIHR) Participant in Research Experience Survey (PRES). ● Recruitment is lower than in previous years; however, the region's strengths were demonstrated in the complexity and geographical scope of the activity that has taken place. One hundred and forty-nine GP practices, fifty-five secondary care sites and seven non-NHS sites have recruited during this period. ● Recruitment to commercially sponsored and funded studies, which offer novel tests or treatments to Wessex patients and generate income for research reinvestment, has been significant in quarter one.			
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 the funding is used effectively.			
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: ○ End of LCRN contract September 2024 ○ Winter pressures ○ Strike actions. *Please review the risk register in Appendix One for details of the already underway or planned responses.*			
Summary: Conclusion and/or recommendation	● Wessex has a robust research portfolio being delivered across all care settings. ● The CRN and its partner organisations recognise that recruitment has fallen compared to previous years and are reporting to the CRN Executive group monthly on the progress of local initiatives to remedy this position. This includes the identification of additional large interventional and observational studies, rapid setup, and investment in the workforce to increase recruitment from quarter two onwards. ● **The Board will continue to be updated on performance quarterly.**			

University Hospital Southampton
NHS Foundation Trust

NIHR | Clinical Research Network Wessex

CRN Wessex Q1 2023/24 Performance Report

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

September 2023

Introduction

This report informs the UHS Board of Directors of the clinical research activities within the Wessex region. The report covers the performance against the National Institute of Health and Care Research's (NIHR) high level objectives, as well as general research activity in Wessex. This report focuses on quarter one of the 2023/24 financial year (April 2023 to June 2023).

Key issues

National areas of strategic focus for health research

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.

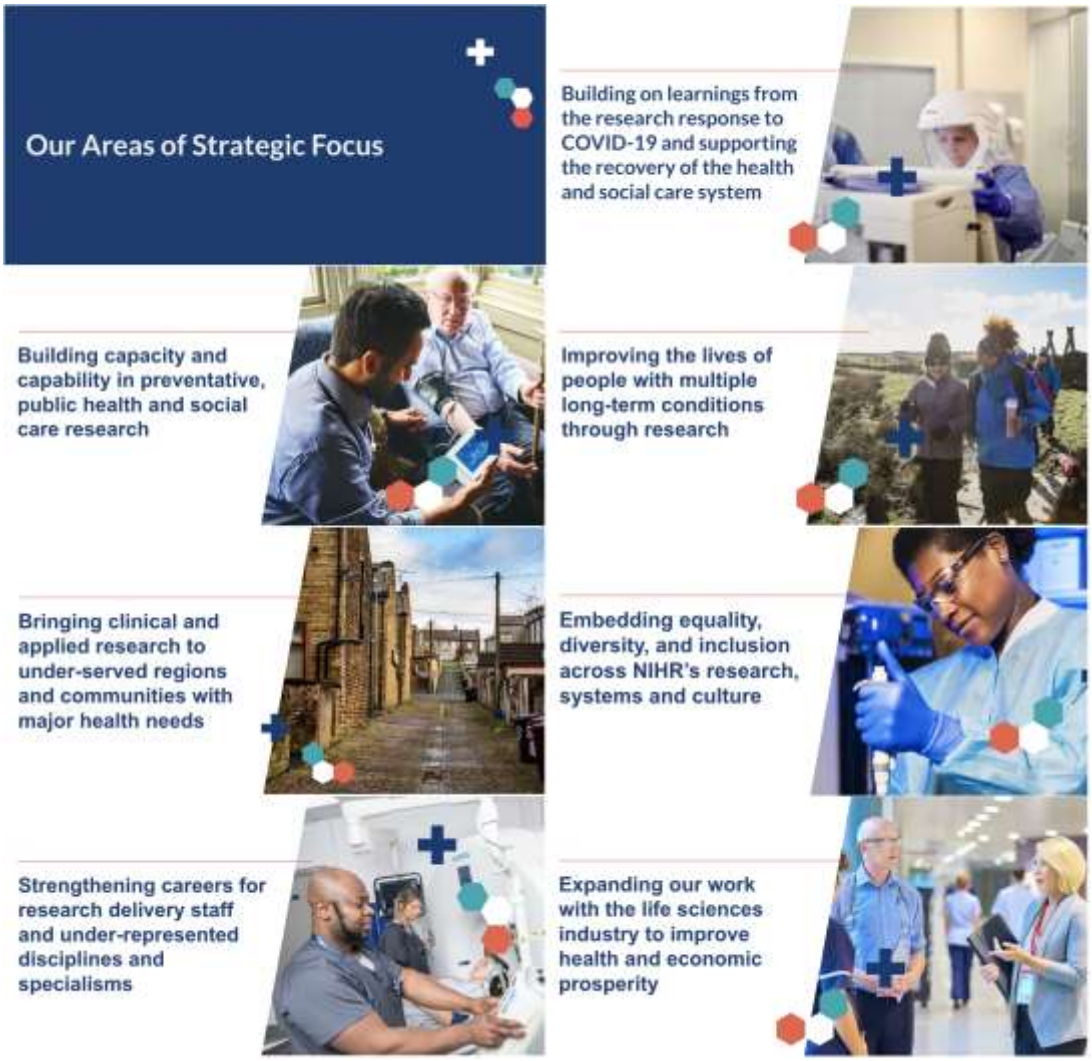

Figure 1 - NIHR Areas of strategic focus from Best Research for Best Health: The Next Chapter.

Recovery and growth of the research system following the COVID-19 pandemic

The Department of Health and Social Care's (DHSC) continued focus in quarter one of the 2023/24 financial year was on resetting and recovering health and care research. Local sponsors and CRN Wessex support the DHSC's 'Reset' programme (Research Recovery and Reset | NIHR). The programme aims to

make CRN research portfolio delivery achievable within planned timelines and sustainable within the resources 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.

The Reset programme has now become business as usual, with expectations from the DHSC of an ongoing monthly review of studies by sponsors and funders. Less than four per cent of studies led from the Wessex region are awaiting a response from the sponsor (Figure 2). The most recent guidance asked CRNs to review studies more than ninety days past their planned opening date and with no recorded activity. Wessex currently has no studies in this category.

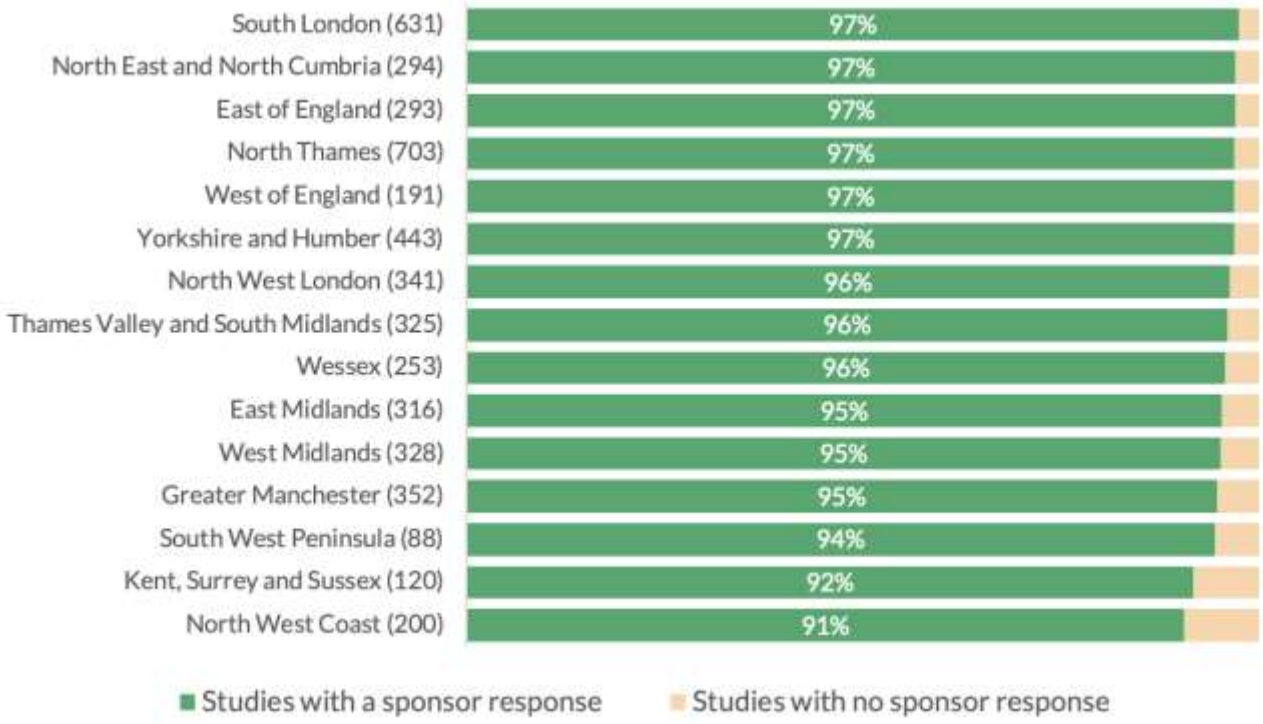

Figure 2 - Summary of DHSC Reset programme responses from study sponsors by local clinical research network region - updated 13 September 2023.

DHSC & NIHR Clinical Research Network high level objectives (HLOs) for 2023/24

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 3, with current Wessex and English (all local CRNs combined) performance linked to ambitions agreed with the DHSC.

During quarter one, the HLOs summarised in Figure 3, focused on two areas:

1. **Efficient study delivery:** recruitment meeting the targets and timelines agreed upon with sponsors.
2. **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%	100% (2/2 closed Wessex-led studies)	47%
		(2) Percentage of closed to recruitment non-commercial studies which have achieved their recruitment target	80%	86% (6/7 closed Wessex-led studies)	67%
		(3) Percentage of open to recruitment commercial contract studies which are predicted to achieve their recruitment target	80%	71% (24/34 open Wessex-led studies)	78%
		(4) Percentage of open to recruitment non-commercial studies which are predicted to achieve their recruitment target	80%	70% (106/151 open Wessex-led studies)	74%
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	296 (24%)	18,000 ambition (national response TBC)

Figure 3 – Local and national performance for the DHSC & NIHR CRN High Level Objectives for quarter one of the 2023-24 financial year.

For *Efficient study delivery* measures one and two, the region outperformed England for closed commercial and non-commercial studies led by Wessex organisations. Wessex-led open commercial and non-commercial studies were below the eighty per cent ambition for measures three and four. These measures have since improved after quarter one but remain below the ambition level and the England average. CRN Wessex is working with local chief investigators and sponsors, who will have greater influence over the sites participating in their study, to increase the performance on this HLO.

The *Participant Experience* objective has an ambition for Wessex of 1,237 completed surveys during 2023/24 (Figure 4). Nearly three hundred responses had been received at a quarter of the way through the financial year. If enrolment is linear throughout the year, this is one per cent behind the anticipated responses. A PRES working group operates in Wessex and contributes ideas to increase enrolment in this survey. Figure 5 demonstrates the predominantly positive results received in quarter one, with the two areas requiring improvement related to communications with research participants about the study they are supporting. The PRES results for the 2022/23 financial year are available at this link: https://local.nihr.ac.uk/lcrn/wessex/patients-carers-and-the-public/participant-in-research-experience-survey-crn-wessex.htm.

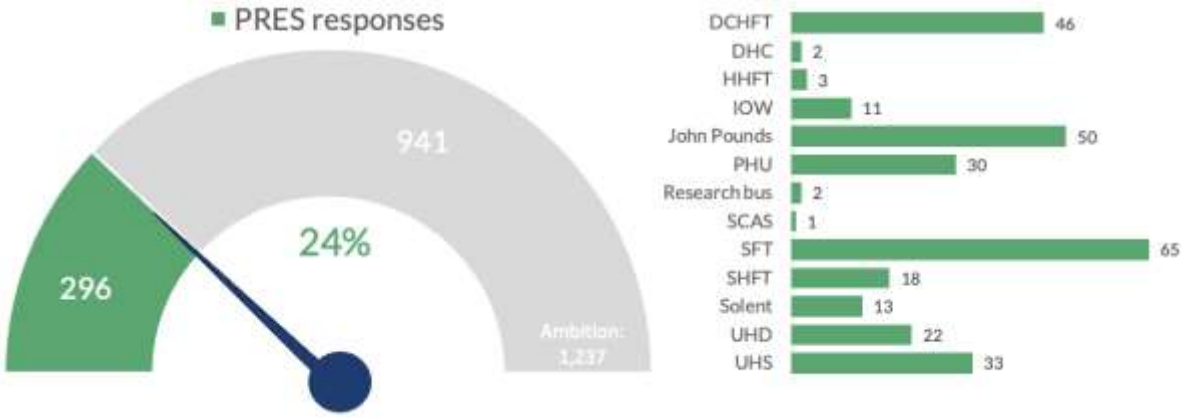

Figure 4 - Participant in research experience survey responses in Wessex during quarter one of the 2023/24 financial year.

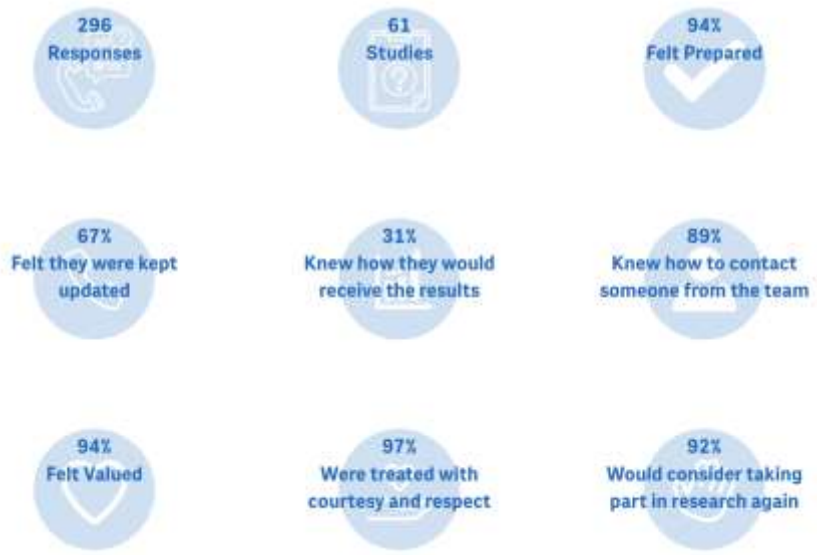

Figure 5 - Summary of the Participant in research experience survey results in Wessex during quarter one of the 2023/24 financial year.

Research activity in Wessex

All research activity in Wessex

Recruitment has been benchmarked against England's activity over the eighteen months leading to the end of quarter one (Figure 6). Over eight thousand three hundred participants supported 402 studies during this period. Recruitment in the Wessex region has recruited an average of 2,800 participants each month since quarter two of the 2022/23 financial year. In 2019/20, before the COVID-19 pandemic, the Wessex monthly average was around 3,000 participants. By contrast, England's overall monthly recruitment is now stable around pre-pandemic levels, indicating that the national portfolio has recovered.

Figure 6 - Wessex research recruitment benchmarked against England for the eighteen months leading to the end of quarter one of the 2023/24 financial year.

Recruitment is not an NIHR CRN high level objective, but it is considered a measure of access to research. For Wessex to meet the 'Efficient study delivery' HLO, sites across the country on Wessex-led studies must recruit sufficiently to achieve their respective study sample sizes. Since quarter one, the NIHR CRN Coordinating Centre, following steer from the Department of Health and Social Care, has chosen to remove HLOs related to closed studies, as well as clarified that sponsors, rather than local CRNs, remain responsible for the performance of their studies.

Wessex has an estimated five per cent of England's population, which is the value CRN Wessex uses to benchmark the region's share of recruitment. Wessex's proportion of English recruitment was 4.1 per cent in the 2022/23 financial year. In quarter one of 2023/24, the proportion was 3.3 per cent. Wessex's proportion of recruitment by study design has been compared to England in Figure 7. Wessex has delivered fewer, smaller, and more complex research studies than England, therefore affecting the total recruitment.

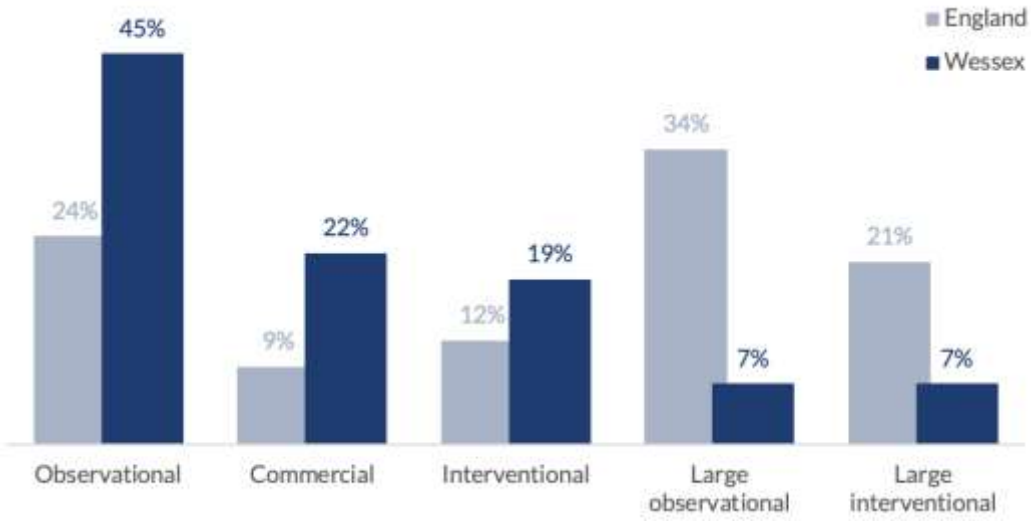

Figure 7 - Proportion of Wessex and English recruitment in quarter one of the 2023/24 financial year by study design.

The most significant differences between Wessex and England are in the proportion of large observational, observational and large interventional studies (non-commercial). Conversely, the proportion of non-commercial interventional recruitment has been increasing since the middle of the COVID-19 pandemic. Wessex is also an LCRN outlier for the amount and proportion of commercial recruitment delivered.

In quarter one, research activity has already been demonstrated across the region and in all care settings (Figure 8). One hundred and forty-nine GP practices, fifty-five secondary care sites and seven non-NHS sites have recruited during this period.

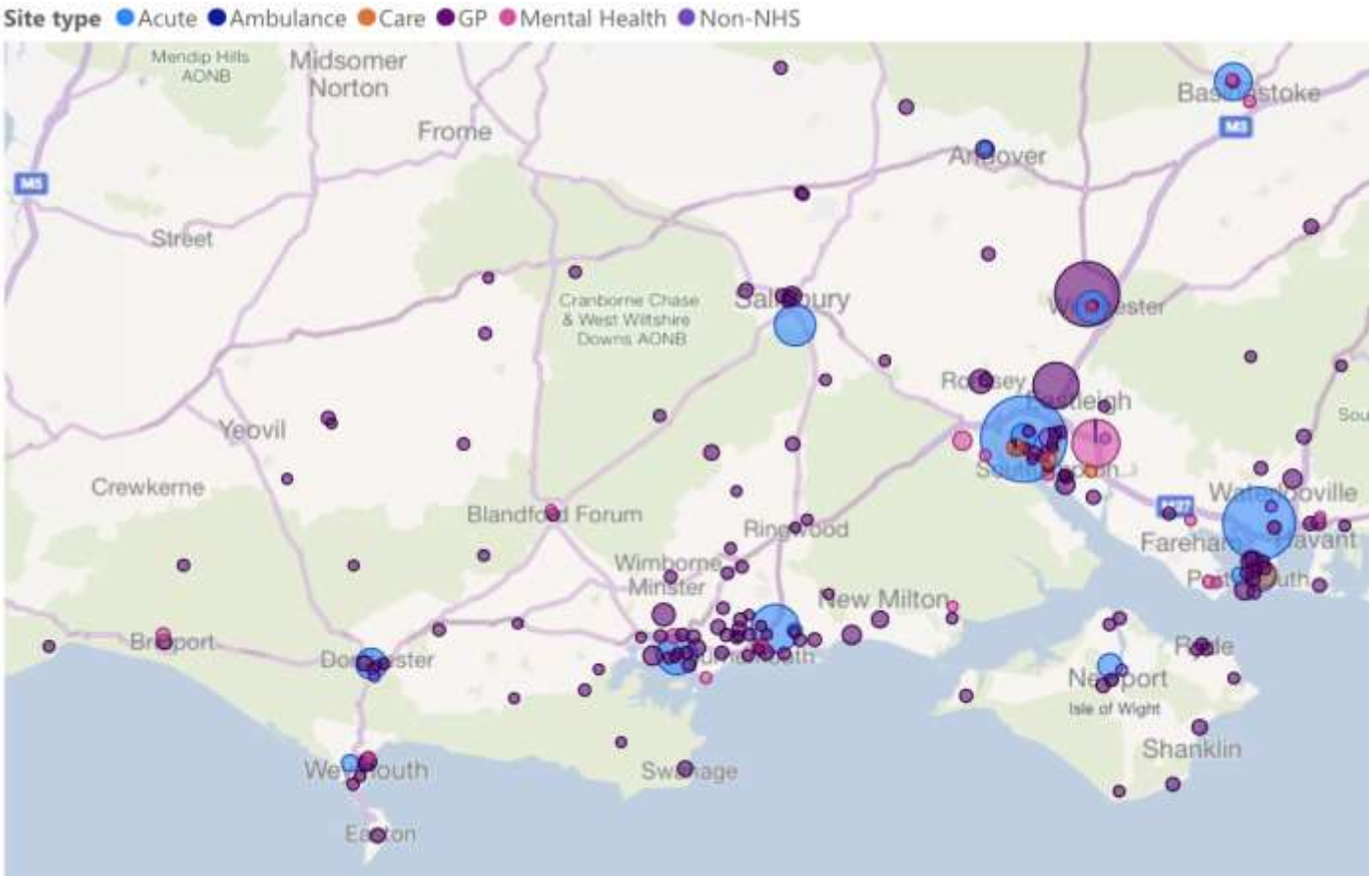

Figure 8 – Recruiting research sites in Wessex in Q1 of the 2023/24 financial year by organisation type.

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. CRN Wessex funds small-grant projects, working with community charities and other local organisations to increase research activity, 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). This successful programme is underway with a ringfenced budget of £200,000.

The proportion of Wessex recruitment by care setting has changed over time since the 2017/18 financial year (Figure 9). Of note is that primary care's contribution to the Wessex portfolio is well above the historical average and that the contribution from acute trusts has fallen over time. For further information, Wessex organisation's quarterly recruitment since April 2022 is provided in Figure 10.

Care setting	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24 (Q1)	Wessex total
Acute	73.8%	80.4%	79.9%	26.0%	33.8%	68.4%	65.8%	49.4%
Ambulance	1.6%	0.3%	1.6%	1.2%	1.9%	1.4%	2.1%	1.4%
Care	5.2%	6.3%	5.6%	0.7%	1.1%	3.8%	1.4%	2.7%
Mental Health	6.5%	4.3%	6.8%	30.2%	24.6%	6.3%	7.0%	18.2%
Non-NHS	0.3%	1.9%	1.7%	40.2%	33.1%	3.5%	0.4%	21.7%
Primary care	12.5%	6.8%	4.4%	1.7%	5.5%	16.6%	23.2%	6.5%

Figure 9 - Recruitment contribution by care setting in Wessex since April 2017.

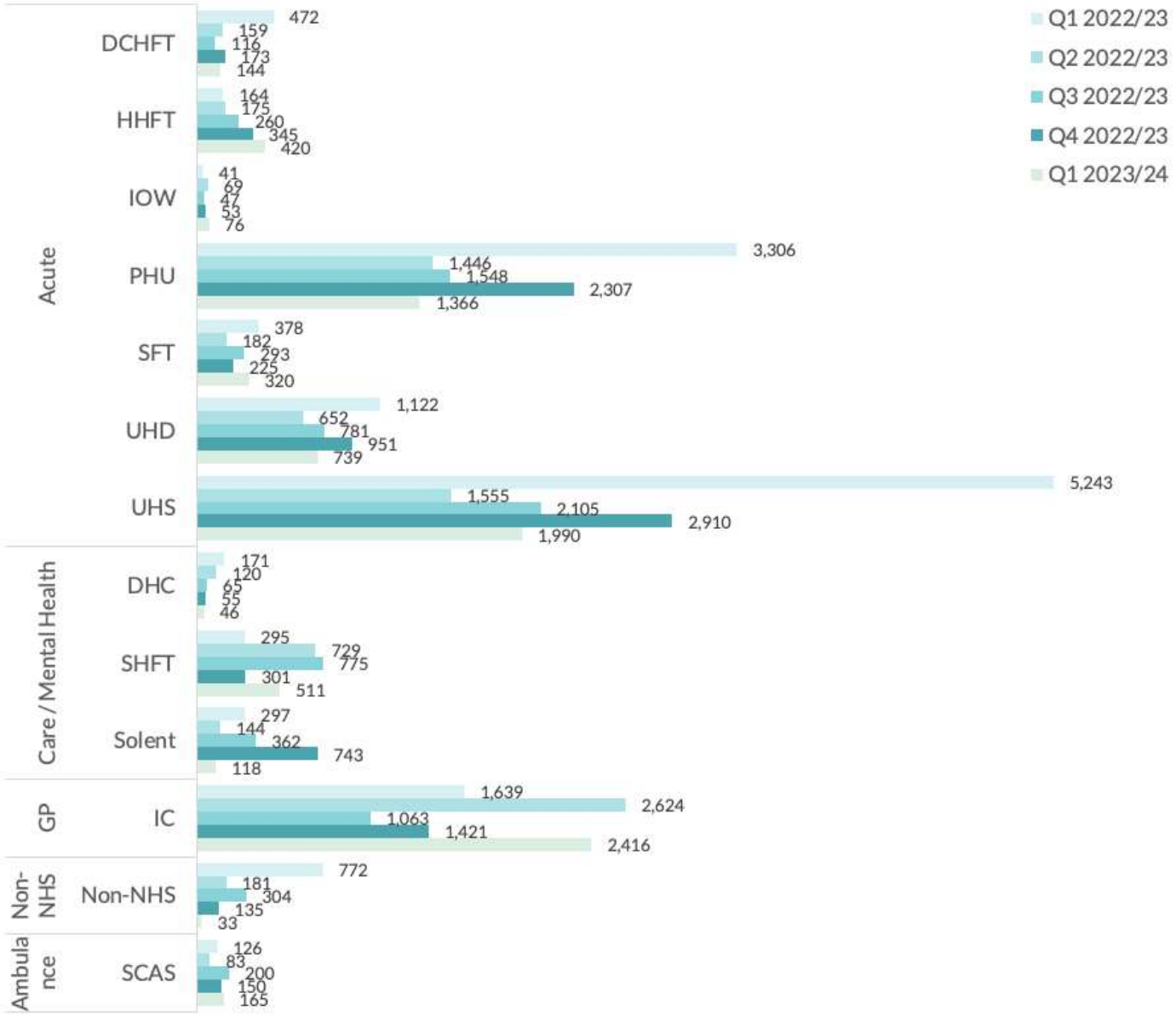

Figure 10 – Quarterly CRN Portfolio study recruitment by organisation type in Wessex since April 2022.

The number of studies that have recruited in Wessex each quarter since April 2018 is shown in Figure 11. This appears to have settled at a new level of around four hundred recruiting studies since the COVID-19 pandemic. A primary 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, and this was achieved in Wessex.

Figure 11 - Recruiting studies in Wessex by funding type in the last five financial years.

The average sample size, affected by very large studies, has been decreasing in steps as COVID-19 studies have closed to recruitment. This has since levelled out above the Wessex average seen before the pandemic. The Wessex average is towards the lower end of the other LCRN regions, again indicating fewer, lower recruiting studies are being delivered.

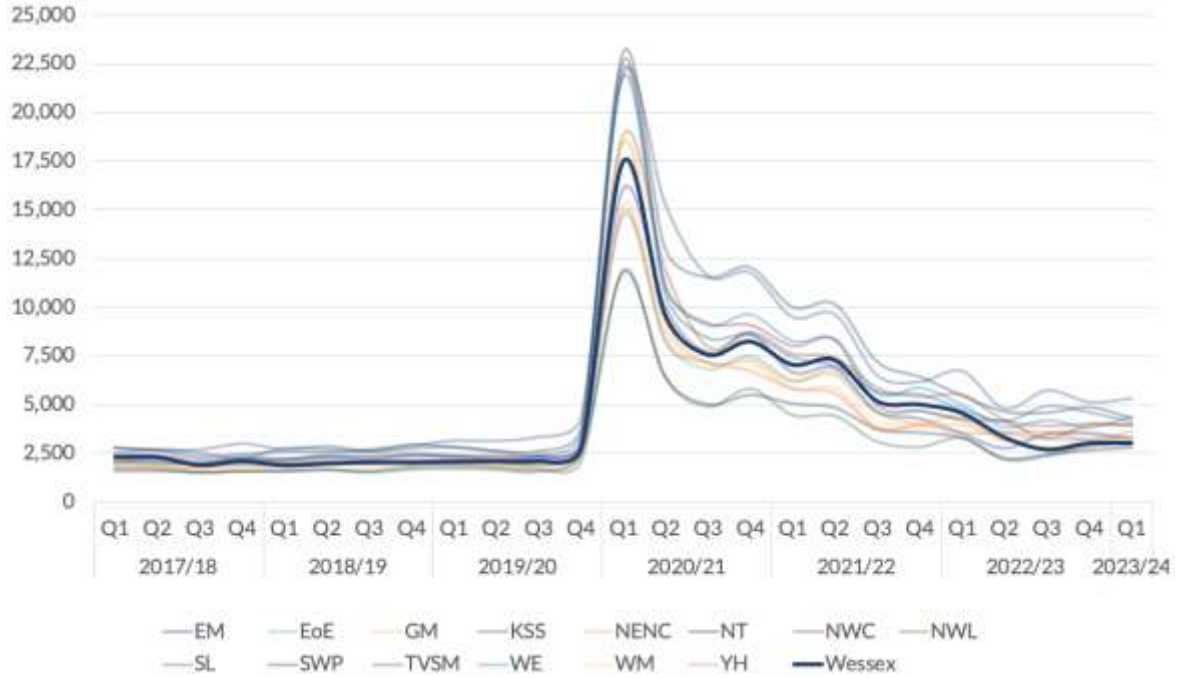

Figure 12 - Average sample size of recruiting studies by local CRN region since April 2017.

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.

Wessex's contribution to the national commercial portfolio has been significant in quarter one, with 1,612 participants recruited in quarter one on forty-four studies. This represents 8.2 per cent of England's commercial recruitment in the same period, with five per cent of the population.

The high level objectives focus on studies led by each region, but site performance on commercial studies led from any region is monitored (Figure 13). Wessex is just below the eighty per cent ambition that the region aims for; however, this is not an externally set figure.

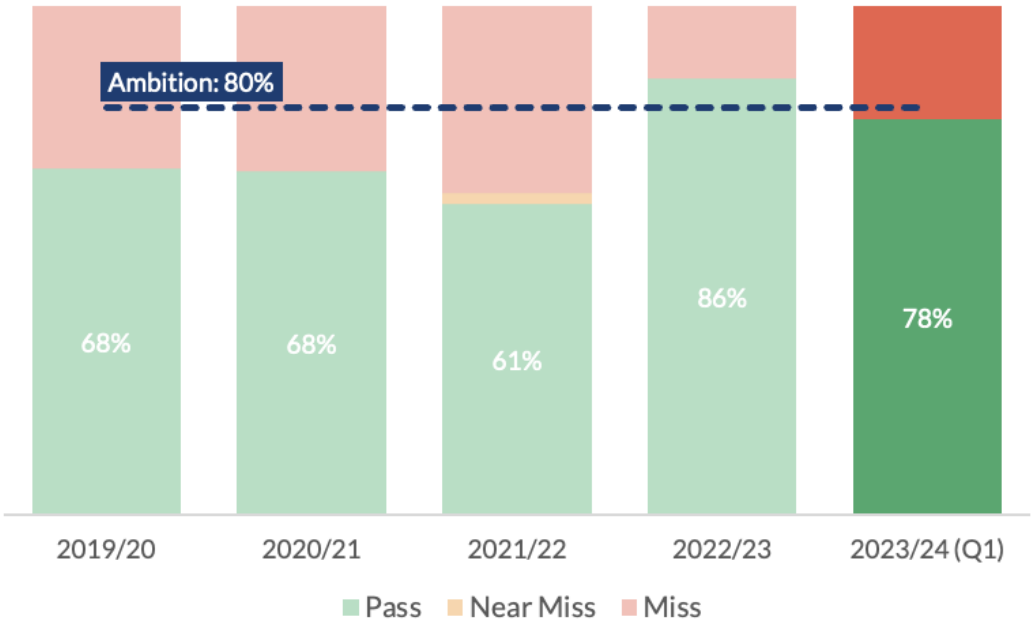

Figure 13 - Percentage of Wessex sites on commercial studies that closed each financial year meeting their recruitment target assigned by the sponsor.

At the end of 2022/23, Wessex was ranked eleventh for commercial recruitment among the fifteen local clinical research network regions. In quarter one of 2023/24, the Discover Me genetics study (mainly delivered in primary care), mRNA Moderna trial (delivered by UHS) and other regional activity resulted in commercial recruitment that is already close to exceeding the whole of 2022/23. In quarter one, Wessex was ranked sixth for commercial recruitment among the fifteen local CRN regions. For further information, Wessex organisation's quarterly commercial recruitment since April 2022 is provided in Figure 14.

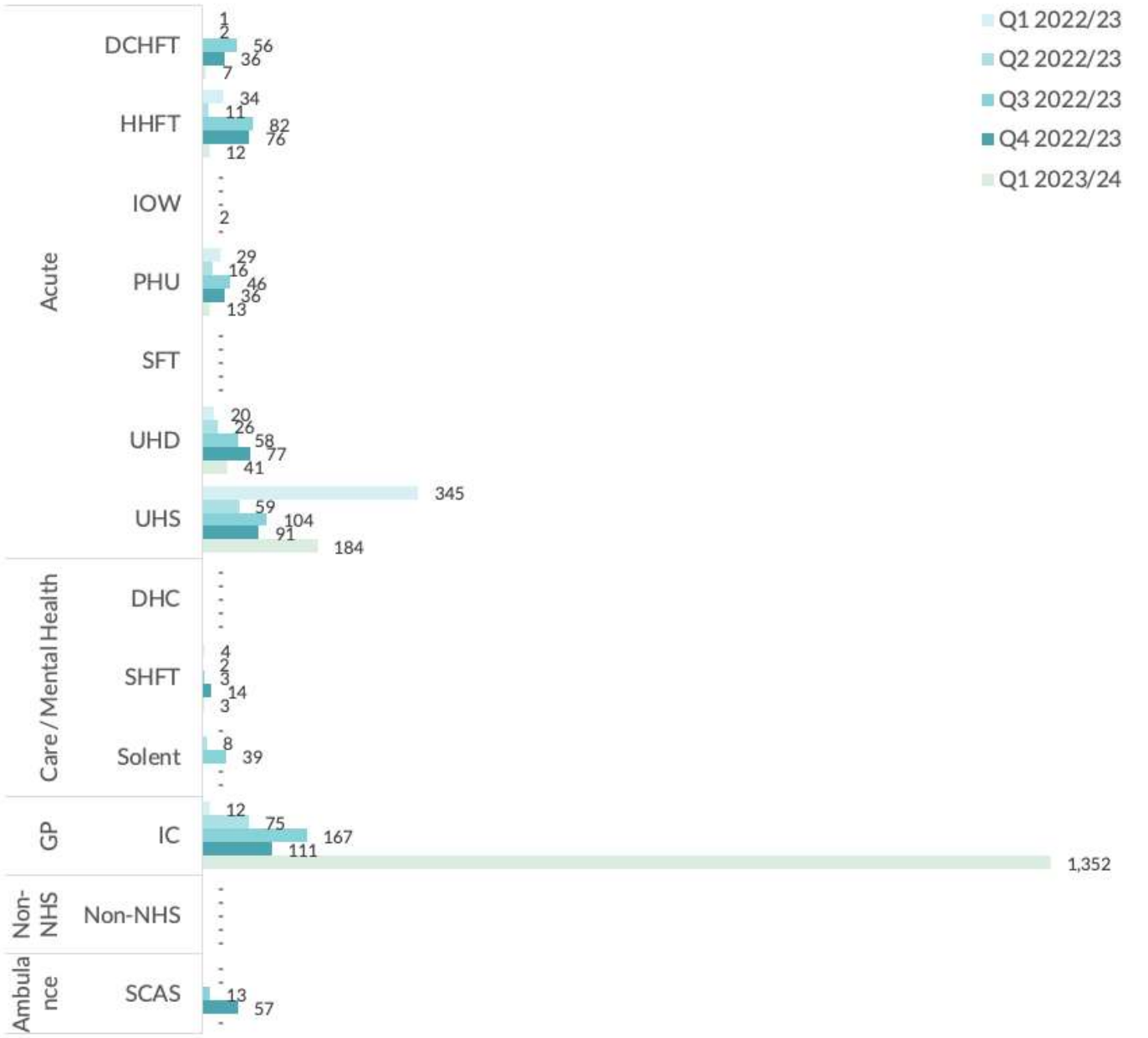

Figure 14 – Quarterly commercial CRN Portfolio study recruitment by organisation type in Wessex for the 2022/23 financial year and quarter one of the 2023/24 financial year.

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 (Pxl)	Proximity	Response Actions	Action owner(s)	Action status	Probability	Impact	Value (Pxl)	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	3	9	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	2	6	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**	3	4	12	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	3	6	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**	2	3	6	Current	1. DDT based nearer hub locations could pick up some work 2. Look for opportunities for remote trial delivery	COO/DCOO	All - ongoing	2	2	4	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	3	6	Current	1. Raise locally and nationally for advice on prioritisation of key activities/studies	COO/DCOO	All - ongoing	2	3	6	Open	Decreased
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**	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 15	Performance	March	CDs/COO	**Cause: Consultant strike action** **Event: Redeployment of clinical staff to cover emergency care leading to lack of staff to deliver clinical trials**	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

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 2023/24 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