University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	31/01/2023
Time	9:00 – 13:00
Location	Conference Room, Heartbeat/Microsoft Teams
Chair	Jenni Douglas-Todd
Apologies	Diana Eccles

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		**Staff 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	9:20	**Minutes of Previous Meeting held on 29 November 2022** Approve the minutes of the previous meeting held on 29 November 2022
4		**Matters Arising and Summary of Agreed Actions** To discuss any matters arising from the minutes, and to agree on the status of any actions assigned at the previous meeting.
5		**QUALITY, PERFORMANCE and FINANCE** Quality includes: clinical effectiveness, patient safety, and patient experience
5.1	9:30	**Briefing from the Chair of the Audit and Risk Committee (Oral)** Keith Evans, Chair
5.2	9:35	**Briefing from the Chair of the Finance and Investment Committee (Oral)** Jane Bailey, Chair
5.3	9:40	**Briefing from the Chair of the People and Organisational Development Committee (Oral)** Jane Harwood, Chair
5.4	9:45	**Briefing from the Chair of the Quality Committee (Oral)** Tim Peachey, Chair
5.5	9:50	**Chief Executive Officer's Report** Receive and note the report Sponsor: David French, Chief Executive Officer

5.6 **Integrated Performance Report for Month 9**

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

5.7 **Finance Report for Month 9**

10:40 Review and discuss the finance report
Sponsor: Ian Howard, Chief Financial Officer

5.8 **People Report for Month 9**

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

5.9 **Break**

11:00

5.10 **Maternity Safety 2022-23 Quarter 3 Report**

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

6 **STRATEGY and BUSINESS PLANNING**

6.1 **Inclusion and Belonging Strategy**

11:25 Review and approve the Strategy
Sponsor: Steve Harris, Chief People Officer
Attendee: Ceri Connor, Director of OD and Inclusion

6.2 **Corporate Objectives 2022-23 Quarter 3 Review**

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

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

11:50 Review and discuss the update
Sponsor: Gail Byrne, Chief Nursing Officer
Attendees: Craig Machell, Associate Director of Corporate Affairs and Company Secretary/Kyle Lacoste, Trust Documents Manager

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

7.1 **Feedback from the Council of Governors' (CoG) meeting on 25 January 2023 (Oral)**

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

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

12:05 Receive and ratify
In compliance with the Trust Standing Orders, Financial Instructions, and the Scheme of Reservation and Delegation.
Sponsor: Jenni Douglas-Todd, Trust Chair

7.3 **Audit and Risk Committee Terms of Reference**

12:10 Review and approve the Terms of Reference
Sponsor: Ian Howard, Chief Financial Officer
Attendee: Craig Machell, Associate Director of Corporate Affairs and Company Secretary

7.4 **Finance and Investment Committee Terms of Reference**

12:15 Review and approve the Terms of Reference
Sponsor: Ian Howard, Chief Financial Officer
Attendee: Craig Machell, Associate Director of Corporate Affairs and Company Secretary

7.5 **Quality Committee Terms of Reference**

12:20 Review and approve the Terms of Reference
Sponsors: Gail Byrne, Chief Nursing Officer/Paul Grundy, Chief Medical Officer
Attendee: Craig Machell, Associate Director of Corporate Affairs and Company Secretary

8 **Any other business**

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

9 **Note the date of the next meeting: 30 March 2023**

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

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

11 **Follow-up discussion with governors**

12:35

University Hospital Southampton
NHS Foundation Trust

Minutes Trust Board – Open Session

Date	29/11/2022
Time	9:00 – 13:20
Location	Microsoft Teams
Chair	Jenni Douglas-Todd (JD-T)
Present	Jane Bailey, Non-Executive Director (NED) (JB) Dave Bennett, NED (DB) Gail Byrne, Chief Nursing Officer (GB) Jenni Douglas-Todd, Chair (JD-T) Keith Evans, Deputy Chair and NED (KE) David French, Chief Executive Officer (DAF) Paul Grundy, Chief Medical Officer (PG) Steve Harris, Chief People Officer (SH) Jane Harwood, NED (JH) Ian Howard, Chief Financial Officer (IH) Tim Peachey, NED (TP) Joe Teape, Chief Operating Officer (JT)
In attendance	James Allen, Chief Pharmacist (JA) (item 8) Ellis Banfield, Associate Director of Patient Experience (EB) (item 12) Julie Brooks, Head of Infection Prevention Unit (JBr) (item 7) Phil Bunting, Director of Operational Finance (PB) (item 16.2) Rosemary Chable, Head of Nursing for Education, Practice and Staffing (RC) (item 10) Ceri Connor, Director of OD and Inclusion (CCo) (item 9) Diana Hulbert, Guardian of Safe Working Hours and Emergency Department Consultant (DH) (item 11) Femi Macaulay, Associate NED (FM) Christine Mbabazi, Equality & Inclusion Advisor/Freedom to Speak Up Guardian (CMb) (item 13) John Mcgonigle, Emergency Planning & Resilience Manager (JMc) (item 14) Christine McGrath, Director of Strategy and Partnerships (CMcG) Craig Machell, Associate Director of Corporate Affairs and Company Secretary (CM) Helen Potton, Associate Director of Corporate Affairs and Company Secretary (Interim) (HP) Julian Sutton, Interim Lead Infection Control Director (JS) (item 7) Tracey Burt (Minutes) One member of staff (for item 2) 3 governors (observing) 1 member of staff (observing) 1 member of the public (observing)
Apologies	Cyrus Cooper (CC), NED

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

JD-T welcomed all those attending the meeting in person or by Microsoft Teams and noted apologies from CC. There were no declarations of interest.

2. Staff Story

The member of staff had Covid-19 and was therefore unable to present her story.

3. Minutes of the Previous Meeting held on 29 September 2022

The minutes of the meeting held on the 29 September 2022 were confirmed as an accurate record of that meeting.

4. Matters Arising and Summary of Agreed Actions

It was noted that action 704 was due in May 2023.

5. QUALITY, PERFORMANCE and FINANCE

5.1 Briefing from the Chair of the Charitable Funds Committee

DB advised that the committee had met on the 1 November 2022 and he highlighted the following:-

- income generation was a challenge and fundraising against the forecast budget was down. The charity had seen a downturn in fundraising across all income streams apart from grants and foundations and ways to diversify were being considered.
- the strategy on legacies continued to improve with over £1.1m identified and £250k already received in the current year.
- at the next committee meeting on 7.12.22 a lottery and a business case for a retail offering for the charity would be considered.
- a benchmarking group had been formed with other large NHS charities with the intention of having more detailed information sharing.
- general money received was often sat in small funds, waiting to be spent and the charity was working with divisions to encourage them to consolidate their funds, to have nominated fund holders and more effective spending plans. IH noted that the charity should consider a cap and collar fee that rewarded consolidation.
    - **ACTION: IH**
- charity friendly campaigns in the hospital, around children and cancer, were being targeted. A large Christmas campaign for children had been planned, working with an external agency, but had been withdrawn as the banner statement had not been considered appropriate. GB noted that the agency had not invited the care group to participate in the planning for the campaign.
- there would be a major campaign for the Children's Hospital in the New Year.
- the charity section of the Financial Standing Instructions had been approved.
- his concern that the charity had recruited a part-time curator of art for the hospital. The Board agreed that the charity may wish to consider alternative investments.

The Board noted that fundraising for Great Ormond Street Hospital was taking place locally. DAF advised that he had been in contact with their CEO, who had agreed that they would, in future, be more considerate of neighbouring children's hospitals fundraising campaigns.

CMcG queried whether it would be possible to register with the Association of Medical Research Charities (AMRC) and DB agreed to consider the possibility.

- **ACTION: DB**

5.2 Briefing from the Chair of the Finance and Investment Committee

JB noted that the Finance and Investment Committee had met on 28.11.22 and that several of the items discussed would be presented at the Closed Board.

She advised that the Trust's current financial position had been reviewed and that there had been an update on UHS Pharmacy Ltd. There had been some concerns regarding the latter, related to performance and the safety of prescribing but good progress had been made against their four strategic pillars and they were beginning to offer a better service to patients.

5.3 Briefing from the Chair of the Quality Committee

TP advised that there were multiple indicators that the hospital was under a degree of stress, e.g. high harm falls, medication errors, increased C. difficile rates, notifiable radiation incidents and category 3 and 4 pressure ulcers. There had, however, been rapid progress in all the quality improvement priorities and on delivery of the Mental Health Strategy and the Always Improving programme.

Various reports had been reviewed which included:-

- the Patient Pathways report. A new software package had been installed which provided greater visibility of pathways that were not linked to RTT or cancer standards.
- the Clinical Assurance Framework update. It had been noted that the highest risks in Ophthalmology had finally reduced.
- the Clinical Effectiveness Outcomes report. A new clinical lead was now in post and future enhancements to the function had been discussed.

DAF advised that he had seen a change in the tone of the complaints he saw coming into the Trust. The Board acknowledged that it was a challenging time and many staff were under pressure both at work and at home. SH noted that due to the operational pressures there had been challenges in releasing staff to undertake statutory and mandatory training.

The Board discussed transformational priorities and the importance of an Always Improving culture, where all staff were empowered to improve. The Trust was looking at how it could embed that culture and education, in order that UHS could authentically become outstanding.

JT suggested that the transformation programme had tried to deliver too many things and he advised that work was underway to establish a single integrated programme that brought together operational, clinical, digital and transformation workstreams.

The Board acknowledged that it was not possible for staff to work any harder, so different ways of working needed to be found. It was noted that the programmes had delivered some outstanding improvements and it was agreed that it was important to share that information more broadly across the organisation so that staff felt encouraged to invest in the programmes.

5.4 Chief Executive Officer's Report

The Chief Executive's report was noted and he highlighted the following:-

- there were currently only a handful of patients with Covid-19 and staff sickness associated with Covid-19, was down to 0.3%.
- criteria to reside remained the most significant operational challenge to flow.

- ED attendances were consistently 400+ Type 1 and on some days Type 1 and Type 2 were well above 500 which was a challenge.
- the nursing strike dates had been announced but the Trust did not know any details. The Trust planned to deal with the strike days as late announced public holidays (in the same way that it had dealt with the State funeral).
- a discharge funding programme of £500m had been announced for this year by the government. Some would go directly to local authorities and some would be administered through the NHS. Detailed plans were ongoing to agree how the money would be used locally.
- the Wessex Genomics Laboratory service was now live and around 90 people from Salisbury had TUPE transferred to UHS.
- the Trust had received a couple of Nursing Times awards for quality and diabetes, an HSJ award for the Children's Hospital Alliance and The Sun award for the Best Team (PICU) in their Who Cares Wins awards.
- the Trust had recently held a successful Inclusion and Belonging Conference.
- an extra £3.3b for the NHS had been announced in the government's budget statement for next year.
- 42% of staff had been vaccinated (making it third in the South-East region) and the Trust was having a further drive to try to increase that number.
- an increasing shortage of products from major international suppliers was being seen and substitutes were creating stress in the Procurement Team and on the ground.

5.5 Integrated Performance Report for Month 7

The Integrated Performance Report (IRP) for Month 7 was noted. The Spotlight section contained reports on Emergency Department (ED) performance and red flag staffing incidents at the Trust.

The overall ED situation remained very challenging with an average of c400 Type 1 attendances a day, when the team were staffed for c330 attendances. Performance on 4 hours had reduced significantly over the period and whilst the Trust remained in the top quartile with its teaching hospital comparators, it was struggling. The Trust was, however, performing well on ambulance handovers and was one of the best in the country in terms of releasing ambulances back into the community. It was also doing well on 12 hour waits in the department.

Analysis had shown that UHS was an outlier in the number of walk-ins it received and Dan Bowden, one of the national leads for emergency care, would be visiting the Trust. A bid had been submitted to the national £500m fund to trial GP streaming in ED for the winter period and a local GP consortium had offered its services. Growing violence and aggression in ED and staffing vacancies within certain staff groups, particularly at registrar level, were all contributing to the challenges in the department.

The Urgent Care Village trial, when a large number of senior decision makers had been put at the front door of ED, had transformed the department. However, the long-term plan for the Urgent Care Village was a challenge as it would require significant investment and recruitment to achieve it.

The Board made the following observations/comments:-

- whilst the number of ED attendances had reduced last year, performance had been worse. JT advised that there had been greater acuity, which had led to more staff being pulled into resus, leaving other parts of the department struggling.

- UHS considered it safer to queue patients on trolleys, in corridors, than leave them collapsed at home, which meant that its data around 4 hour performance looked worse than many other hospitals.
- whether walk-ins were returning home relatively quickly or whether they were being admitted? JT advised that the number of admissions was low and that clinical prioritisation meant that many waited for long periods to be seen. A co-located Urgent Treatment Centre, on site, would mean that those patients could easily be redirected to a GP or nurse led facility.
- whether the Trust could determine if the number of walk-ins was due to a lack of access to primary care.
- ED was seeing a significant increase in people attending in mental health crisis. JT advised that there was a monthly report on mental health presentations to ED that could be circulated to Board members for information.

- **ACTION: JT**

Spotlight: Staffing incidents and red flags

- there had been a significant increase in red flag incidents in October and it was hoped that the number would decrease as Covid-19 receded. There could, however, be challenges with winter approaching.

NHS Constitution

- there had been challenges in meeting the cancer standards and whilst a lot of improvement work was taking place regarding pathways, the metrics would be relatively poor for the next few months, while recovery took place.
- the Board discussed ways in which specific areas of concern, within cancer, could be highlighted and it was agreed that the Quality Committee would keep a general oversight on areas of particular concern.

- **ACTION: TP/JT**

- JT highlighted challenges within diagnostics around neurophysiology which was at 49% and cystoscopy waits which were only achieving 64%.

Patient outcomes, safety and experience

- JD-T highlighted the declines in UT21 and UT23.
- JH queried whether there was any breakdown within UT22 of patients with a disability. PG advised that the breakdown did not go into that level of detail.
- DB highlighted UT1. PG advised that the issue was likely to relate to co-morbidities and palliative care input and work was being done with the clinical and coding teams.

World class people

- WR7 and WR11. DB noted that the number of staff recommending UHS as a place to work had dropped slightly. SH advised that it was a trend that was being seen nationally as the pandemic and operational pressures impacted on staff.

5.6 Finance Report for Month 7

IH advised that the Trust had reported a £2.5m deficit in October which was consistent with reporting in Months 1 to 6. In Month 7 the underlying position was £3.8m deficit which was a deterioration on the range seen throughout the year. The primary drivers had been the move into winter, which meant that energy consumption had increased and pressures in early October with Covid-19, surge capacity being opened and temporary staffing.

The ERF position remained broadly consistent at 106% which was above the target, while the national average was around 94%.

The Cost Improvement Programme for the winter remained above target. There was still money to spend in the last five months of the capital programme and various schemes would be coming online shortly.

The ICS remained under pressure and the South-East region was a national outlier. The Trust was therefore coming under increased pressure to improve its immediate financial position.

5.7 People Report for Month 7

SH advised that the workforce had continued to grow and there had been a TUPE transfer of staff from Salisbury, which had increased the numbers. A mid- year review of the workforce plan, in line with the financial position, was being conducted to understand where there had been growth, where there had been expansion in unfunded activity and whether there was correlation with a reduction in agency use.

A package of support had been put in place to support leaders across the organisation in recognition of the pressure they were likely to face during the winter and some had taken up specific packages of coaching support.

The cost-of-living packages had been well received and there had been around 24,000 transactions in Feast, which had saved staff around £48k in total. The discount to the AMT café in PAH had been extended, just before it had been taken over by another provider who could not accommodate the 60% discount but that issue had now been resolved. Ways to broaden the offerings for staff at the Royal South Hants continued to be explored with NHS Property Services.

The Staff Survey had closed on 25.11.22 and the response rate currently stood at 50% which was lower than the Trust's target but better than the national average of 41%.

A positive action programme would be launched in the New Year as part of the Trust's Equality, Diversity and Inclusion focus and applications (for the 25 places) were being received.

The Board discussed staffing and noted that the report showed around 700 more WTE staff compared to the plan. SH advised that whilst substantive WTE's had increased, there had not been a subsequent reduction in the use of bank and agency and work was being underway to understand why that had not happened.

DAF noted that the Trust's recruitment success had meant that its substantive workforce was above plan and the total headcount (which included substantive, bank and agency) was due to the Trust having hundreds of extra surge beds open and increased activity. The challenge moving forward would be whether the Trust continued to convert bank and agency into substantive posts.

JB suggested that if the Trust wanted to drive transformation it would need substantive staff in post.

SH noted that the Trust continued to see a difficult recruitment market on entry level jobs and it struggled to fill certain vacancies. GB said that her greatest concern, moving forward, was the loss of registered nurses.

DAF noted that the Board had previously agreed that the Trust would continue to recruit until it had clarification of the payment mechanism and architecture for

2023/24. He was, however, becoming more concerned with that approach whilst the Trust's deficit continued to rise, pressure on the ICS increased and UHS received no credit for the extra work it was doing.

Decision: The Board agreed that the Trust would continue to recruit and that long-term workforce planning, which was due to be discussed at a Trust Board Study Session, would be critical.

6. Break

7. Infection Prevention and Control 2022-23 Quarter 2 Report

GB introduced JS and JBr who presented the above report. JS advised that he had taken over from Dr. Nitin Mahobia as the lead infection control doctor for UHS and he thanked his predecessor for his work, particularly during the pandemic.

JBr advised that the Trust's C. difficile threshold for the year was 61 cases. At the end of Q2 there had been 39 cases and by 25.11.22 there had been 56. There had been a 25% increase in C. difficile rates nationally and UHS had made changes to the way it reviewed cases. A considerable amount of work was also being done in the community to understand the increase in C. difficile rates. JS advised that the majority of cases at UHS were unavoidable.

The national threshold for Gram negative bacteraemia was 127 in the year and the Trust was just over 50% with 78 at the end of Q2. A small proportion were urinary catheter related and whilst most were unavoidable, there were learning points which were being shared.

He advised that UHS was an exemplar hospital for nosocomial Covid-19 rates, despite the Trust doing a great deal more testing than Trusts nationally. He advised, however, that once emergency admissions had come into UHS, the Trust was no longer doing any further asymptomatic testing, which included Covid-19 contacts.

The Trust did, however, have cases of adult and paediatric flu, RSV and Norovirus and the Infection Prevention Team was piloting rapid, in-lab GI testing, which had helped to close (and open) bays very quickly.

JBr noted that Norovirus had always been a challenge and following the pandemic a lot of the population had no applied immunity. IH advised that the Trust Investment Group had considered an excellent business case around permanent 24/7 pathology and point of care testing but had paused on making a decision until information was available regarding national funding for next year.

Decision: The Board supported (1) the proposed actions/measures to facilitate improvements in practice related to reduction of C. difficile and Gram negative bacteraemia. (2) It noted the actions required over the winter period to minimise the risk of in-hospital transmission and outbreaks associated with COVID-19, other respiratory viruses and Norovirus. (3) It also noted the ongoing concerns in relation to the environment (e.g. ventilation and lack of toilet/bathroom facilities) and the impact on preventing and controlling infection.

8. Medicines Management Annual Report 2021-22

JA advised that the team had been pleased to start recovering many of the functions it had paused during the pandemic and there was a good post pandemic regional medicines optimisation programme in place. The Trust's plans for the

aseptic unit at Adanac Park were progressing well and it was already well established on the national agenda.

Workforce continued to be a challenge, particularly in relation to highly specialist oncology pharmacy and competitiveness with juniors who joined the Trust, undertook apprenticeships programmes and then found alternative pathways in Southampton. Medicine shortages also remained a problem for primary and secondary care. Previous difficulties with digital progress, particularly around the Trust's ward based prescribing systems, were beginning to move forward.

PG thanked JA for his local and regional leadership and for the support he had given to UPL Ltd.

JD-T asked whether the Trust did anything different in terms of prescribing for people with visual impairments. JA advised that the Trust had access to recording labels but work was needed to make medicines more accessible.

The Board noted and discussed the impact on the environment of metered dose inhalers mentioned in the Sustainability and UHS Green Plan section of the paper.

KE requested timescales for the actions at the back of the report and JA agreed that they would be added.

- **ACTION: JA**

9. Equality, Diversity and Inclusivity (EDI) Update including Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Results 2022

SH introduced the report and data which had been discussed at TEC and the People and Organisational Development Committee in October.

DB noted that BAME staff reported that they were more likely to experience bullying and harassment. They also perceived that they had poorer progression but were very positive about working for the Trust.

He queried whether staff-on- staff violence continued to be an issue and CC advised that it was, although formal complaints were rarely raised. The Trust was trying to obtain greater clarity from the data and was working with Sarah Herbert, Deputy Chief Nursing Officer and the Violence and Aggression Group.

JH queried progress around a gender equality measure and potentially around LBGTQ+. CC advised that there had been unsuccessful attempts to create a gender metric but work was continuing.

The Board agreed that if staff felt the Trust listened to them and responded to their needs, the number of people who declared they had a disability would increase (as it had done during the pandemic). It was also suggested that rather than talking about disability in terms of the need to make reasonable adjustments, consideration should be given to the value that a disabled member of staff might bring to the organisation.

Board members were encouraged to be visible, to listen to staff they would not normally engage with and to support a zero tolerance approach when necessary.

Action: The Board asked SH/CC to update the language used in the presentation of the WRES/WDES data to reflect the messages to be given to staff and to make the data more understandable.

- **ACTION: SH/CC**

10. Annual Ward Staffing Nursing Establishment Review

RC presented the above review and invited questions from the Board. CMcG queried whether the staffing hub was unique to UHS and RC advised that the way it was run was unique.

RC advised that the hub had evolved in the way it had, due to the staffing challenges the Trust had faced. JT noted that some of the work being done by the staffing hub was delivered in different ways by other Trusts but he acknowledged that the hub was extremely effective and well led.

GB commended the engagement of nurses in the staffing hub, particularly at challenging times and she also thanked RC for her input into workforce and ward staffing. She highlighted that the Corporate Nursing team considered that, in certain areas of the Trust, nurse staffing levels were low and the skill mix (in terms of experience) was not ideal.

The Board was asked to continue to see the importance of a Trust-wide commitment, focus and momentum on actions to fill nursing vacancies.

11. Guardian of Safe Working Hours Quarterly Report

PG noted that it was a difficult time for junior doctors nationally with challenges around pay, conditions and workforce and he introduced DH who was working with them to make improvements.

There were issues with a lack of office and rest spaces and discussions were taking place to make the Mess facilities available to all junior doctors. DH advised that some of the basic expectations were a hook to hang a coat on, a locker, a free cup of tea or coffee and the availability of a meal after 10 p.m. It was also noted that many junior doctors are often miles away from home, were transient and from a different country.

The Junior Doctors' Forum was active and DH advised that much of her role was in providing pastoral support. SH suggested that with the continued level of vacancies the Board may, in the future, need to consider how the Trust utilised its junior doctor workforce and how it reduced its reliance and expenditure on locum bank juniors.

DH acknowledged the sensitivities around having junior doctors from other countries. JD-T noted that many international doctors had been displaced from Ukraine and a group had been set up to consider whether any could join UHS.

The changes in the provision of self-development time, outlined in the Executive Summary, were highlighted and DH advised that a day each month (instead of 2 hours a week) was likely to take effect from February 2023.

JD-T thanked DH for the report and for her work with the junior doctors.

12. Learning from Deaths 2022-23 Quarter 2 Report

EB presented the above report and advised that there had been an increase in deaths being reviewed by the Medical Examiners due to the time of year and the roll out of the service to the community, which would be fully implemented in 2023.

Four of the deaths reviewed had been found to be either probably or possibly avoidable. The details had not been included in the report as the inquest outcomes were awaited.

There had been a slight increase in HSMR and issues around coding and the inclusion of palliative care contact were being explored.

An appointment to the Lead Medical Examiner role had been made and the offer of an appointment had been made to a GP for the lead role for community deaths, which would help to build contacts with primary care.

13. Freedom to Speak Up Report

CMb introduced the Freedom to Speak Up report which updated the Board on the actions taken to deliver the Trust's Vision and provided assurance on how cases were managed at UHS.

JD-T noted that many of the issues raised related to individual experiences, rather than concerns regarding patient safety and care. She queried how the latter were being picked up and GB said that they were often raised with the Freedom to Speak Up Champions.

CMb advised that research from the national guardian office in 2019 had indicated that concerns around patient safety and care were often raised through other channels, e.g. incident reports/near misses. There was, however, concern that an increasing number of people felt unable to raise concerns regarding patient safety and care. It was also noted that the WRES data suggested there were more concerns than were being raised through the formal process.

The importance of being visible around the Trust and listening to staff was noted and it was suggested that it may be helpful for the Board to meet with the Freedom to Speak Up Champions.

Action: It was agreed that GB would contact CMb as there had been some technical issues with the Teams link.

- **ACTION: GB/CMb**

14. Annual Assurance Process and Self-assessment against the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)

JT introduced JMc who had recently joined the Trust. He advised that a review of the NHSE core standards for EPRR had been undertaken and a programme of work was in place to ensure that UHS was fully compliant.

The Board was advised that there were a number of standing risks to be dealt with in relation to major/critical incidents but the most immediate threat the Trust faced would be a power outage. There was a risk from the national grid of a potential power outage in January 2023 and work was underway to ensure that the Trust was appropriately prepared.

JMc confirmed that risks were noted in the Risk Register and that the Board Assurance Framework had been updated.

15. STRATEGY and BUSINESS PLANNING

15.1 Board Assurance Framework (BAF) Update

DB highlighted Risk 3a and said that he considered the critical risk to be the unavailability of qualified staff to fulfil key roles.

JH noted that the People and OD Committee had asked for various risks to be separated. JB proposed that failure to innovate should be considered as a risk and included in the BAF.

Action: The Board agreed that CM/HP/GB would consider the above comments.

- **ACTION: CM/HP/GB**

16. CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

16.1 Register of Seals and Chair's Actions Report

Decision: The Board ratified the application of the Trust seal as set out in the report.

16.2 Review of Standing Financial Instructions 2022-23

Decision: The Board approved the proposed changes to the Standing Financial Instructions 2022-23.

16.3 Corporate Governance Update

CM advised the Board that three new documents had been published by NHSE which would modify the current NHS Foundation Trust Code of Governance (issued in 2014) and would apply from April 2023.

The most significant changes were to the formalisation of the ICS framework. It was also highlighted that:-

- the Code of Governance now applied to both NHS and Foundation Trusts.
- there were a number of technical changes, e.g. changes in governance practice.
- there were additional expectations on Boards, particularly around diversity.
- guidance had been published on governance collaboration.
- a provider licence consultation was under way.

JB highlighted the implications within pages 2 to 4 and suggested that they required further discussion.

Decision: The Board noted that it would meet the basic requirements outlined and agreed that it would use a Trust Board Study Session to consider how, and whether, it wanted to expand beyond those.

17. Any other business

There was no other business.

18. Note the date of the next meeting: 31 January 2023

19. Resolution regarding the Press, Public and Others

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

The meeting was adjourned.

University Hospital Southampton NHS Foundation Trust

List of action items

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 26/05/2022 5.6 Freedom to Speak Up Report				
704.	Comparative information	Byrne, Gail	25/05/2023	Pending
	Explanation action item It was requested that future FTSU reports included comparative information from previous years in order to identify trends and also identified cases from previous reporting periods that had not yet been closed. Update: This will be included in the May 2023 report.			
Trust Board – Open Session 29/09/2022 5.6 People Report for Month 5				
824.	Updated People Report	Harris, Steve	13/12/2022	Completed
	Explanation action item The People and OD Committee should review and discuss the most appropriate format for the People Report for the Trust Board. Update: Discussion to take place in December.			
Trust Board – Open Session 29/09/2022 5.4 Integrated Performance Report for Month 5				
826.	My medical record	Teape, Joe	28/02/2023	Pending
	Explanation action item JT noted that there was a business case that was overdue for my medical record around how we industrialised it across the Trust which should provide some huge benefits and would bring a timeline back as to when this would happen. Update: In progress and not yet due.			

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 29/09/2022 5.4 Integrated Performance Report for Month 5				
827.	Digital change and indicators	Teape, Joe	31/03/2023	Pending
	Explanation action item JT noted that there was some big digital change happening with the rolling out of speech recognition and some E tools. In addition it would be helpful to look at the indicators to understand whether they were the right ones and review them as part of the digital updates which could be discussed at F&IC. Update: In progress and not yet due.			
Trust Board – Open Session 29/09/2022 5.4 Integrated Performance Report for Month 5				
828.	Harm falls - deep dive	Byrne, Gail	31/01/2023	Completed
	Explanation action item A deep dive into the falls would be included in the IPR and presented to a future meeting. Update: This will be included in the January 2023 report.			
Trust Board – Open Session 29/09/2022 7.4 People and Organisational Development Committee Terms of Reference				
829.	Reporting	Harris, Steve Harwood, Jane	31/01/2023	Pending
	Explanation action item JB suggested that reporting was out of sync and it was important that the Committee were able to have those bigger conversations. SH confirmed that scheduling had been raised but because of the concerns around workforce at least a summary report should be coming to Board and was a work in progress. JD-T asked for JH and SH to review prior to the next Board. Update: Discussions have taken place and changes were being discussed.			

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 29/11/2022 5.1 Briefing from the Chair of the Charitable Funds Committee (Oral)				
872.	Cap and collar fee	Howard, Ian	28/02/2023	Pending
	Explanation action item General money received was often sat in small funds, waiting to be spent and the charity was working with divisions to encourage them to consolidate their funds, to have nominated fund holders and more effective spending plans. IH noted that the charity should consider a cap and collar fee that rewarded consolidation. Update: The charity is working through an options appraisal process which will be considered at the next Charitable Funds Committee scheduled for 21/02/2023.			
873.	Association of Medical Research Charities	Bennett, Dave	31/01/2023	Pending
	Explanation action item CMcG queried whether it would be possible to register with the Association of Medical Research Charities (AMRC) and DB agreed to consider the possibility.			
Trust Board – Open Session 29/11/2022 5.5 Integrated Performance Report for Month 7				
874.	Mental health presentations to ED	Teape, Joe	31/01/2023	Completed
	Explanation action item ED was seeing a significant increase in people attending in mental health crisis. JT advised that there was a monthly report on mental health presentations to ED that could be circulated to Board members for information. Update: The Mental Health monthly report circulated 25/01/2023.			
875.	Cancer areas of concern	Peachey, Tim Teape, Joe	31/01/2023	Completed
	Explanation action item The Board discussed ways in which specific areas of concern, within cancer, could be highlighted and it was agreed that the Quality Committee would keep a general oversight on areas of particular concern. Update: This is an ongoing part of the quality indicators report.			

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 29/11/2022 8 Medicines Management Annual Report 2021-22				
876.	Action timescales	Allen, James Grundy, Paul	31/01/2023	Completed
	Explanation action item KE requested timescales for the actions at the back of the report and JA agreed that they would be added.			
Trust Board – Open Session 29/11/2022 9 Equality, Diversity and Inclusivity (EDI) Update including Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Results 2022				
877.	Language	Harris, Steve Connor, Ceri	31/01/2023	Pending
	Explanation action item The Board asked SH/CC to update the language used in the presentation of the WRES/WDES data to reflect the messages to be given to staff and to make the data more understandable.			
Trust Board – Open Session 29/11/2022 13 Freedom to Speak Up Report				
878.	FTSU Champions	Byrne, Gail Mbabazi, Christine	31/01/2023	Pending
	Explanation action item The importance of being visible around the Trust and listening to staff was noted and it was suggested that it may be helpful for the Board to meet with the Freedom to Speak Up Champions. It was agreed that GB would contact CMb as there had been some technical issues with the Teams link.			

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 29/11/2022 15.1 Board Assurance Framework (BAF) Update				
879.	Comments	• Byrne, Gail • Machell, Craig	31/01/2023	Pending
	Explanation action item DB highlighted Risk 3a and said that he considered the critical risk to be the unavailability of qualified staff to fulfil key roles. JH noted that the People and OD Committee had asked for various risks to be separated. JB proposed that failure to innovate should be considered as a risk and included in the BAF. The Board agreed that CM/HP/GB would consider the above comments.			

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Chief Executive Officer's Report**			
Agenda item:	**5.5**			
Sponsor:	**David French, Chief Executive Officer**			
Date:	**31 January 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 • Foundation Trust Capital Resource Limits • Southampton Clinical Trials Unit • Southampton's Experimental Cancer Medicine Centre			
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

Industrial action by the Royal College of Nursing (RCN) took place on 18 and 19 January 2023. The overall planning for this by the Trust was led by the Chief Nurse and supported by the Deputy Chief Nurse, Deputy Chief Operating Officer and colleagues from the People directorate.

The Trust focussed on the following objectives:

1. Safe delivery of NHS services – ensuring minimum staffing levels are available to deliver emergency, immediate life-, limb-, or organ-saving intervention
2. Safety of staff being protected
3. Safety of the public being maintained – ensuring relevant staffing levels are available to deliver care to the public in case of a major incident at national or local level
4. Ensuring professional regulatory advice is provided and followed
5. Life preserving services continuing
6. Derogations agreed to reflect local population and service needs

The RCN has been clear that this is not a dispute with the Trust, and we have worked positively with the local RCN strike committee on arrangements and derogations. The RCN national process for derogations has been followed (a service-by-service, ward-by-ward approach). In total over 100 derogations were agreed for inpatients with night time staffing cover and, for assessments areas, with bank holiday-level staffing cover. This is bare minimum staffing levels.

Most of the derogations submitted were agreed by the RCN. Based on the urgency of so many of our elective lists – particularly cancer and cardiac – we sought and received derogation for 13 elective operating lists for ENT, HPB, Prostate, Neuro-oncology, Colorectal, Breast, Cancer and Thoracic (cancer activity) across the two days. We also sought and received derogation for emergency lists for CEPOD (emergency surgery), trauma, paediatric CEPOD, paediatric trauma lists, neurosurgery, adult cardiac, paediatric cardiac, gynaecology, obstetrics and for eye emergencies if needed. In addition to the above, we also sought and received derogation for interventional neuro radiology, interventional radiology labs and emergency endoscopy rooms.

The RCN was clear it would not consider derogations for outpatient areas. However, where safe and possible, we tried to continue running outpatients, and ran approximately 75% of a normal day's outpatient activity. Clinics went ahead except where a nurse was essential to support the clinic or where it was a nurse-led clinic and the individual had indicated that they will or might strike.

Chemotherapy was granted a derogation so continued at normal levels, while radiotherapy was unaffected by the strike.

On the strike days, the staffing hub ensured oversight of safe staffing to the derogated levels. This did result in staff moving to cover areas but only where they felt competent to do so and with mutual agreement. Hospital Incident Management Team (HIMT) meetings with tactical strategic command were run on both days of the strike. The RCN strike committee was based on site and worked closely with us on any urgent derogations.

In relation to patient communications, we messaged patients where their appointment had been cancelled and developed a leaflet for informing our inpatients.

The Chief Nurse with colleagues led three staff briefing sessions with over 850 attending in all. A detailed FAQ and strike webpage was provided for staff information and the Communications team have provided great support.

The aim throughout the strike has been to set a tone that we are one nursing family and that we should respect the fact that staff have a right to strike and also that staff may choose not to do so – we have received very positive feedback from staff on these sessions.

During the strike, 200 boost boxes were delivered by the People team to staff working across the organisation and to the picket lines. These were received positively by our staff. We held a further listening/debriefing event, with psychologists present, on 20 January 2023 to hear experiences, capture any learning and ensure we come together as one UHS nursing family. An online form has been developed to capture feedback from staff which we will ensure is used to capture learning for future strike days.

The RCN has announced a further strike on 6 and 7 February 2023, which will involve 73 Trusts (as opposed to 44 this time), including UHS. The Chartered Society of Physiotherapists has also announced a strike on the 9 February 2023 which will impact UHS.

On the actual days of the strike, picketing took place on Coxford Road and we were required to provide SITREPS to NHS England on numbers and how the strike was impacting the Trust. The final details are as follows:

- Total staff members on strike action over both days = 1,091
- Total staff members on strike action on 18 January 2023 = 695
- Total staff members on strike action on 19 January 2023 = 703
- Over 300 staff members were on strike on both days
- A number of derogated areas were not supported, which resulted in the cancellation of some additional activity
- Although activity was reduced, we did maintain the majority of high complexity urgent work.
- Total activity lost and reported to NHS England over the two days was 37 inpatient operations, 182 day cases (including infusions, endoscopy etc.) and 1,650 outpatient appointments.

Lastly, I must place on record my immense thanks to everyone who worked so hard to plan for the strike, manage the arrangements on the day, and, importantly, to the many staff members who worked differently and went over and above to support our colleagues who chose to strike.

Foundation trust capital resource limits

The Health and Care Act 2022 includes a new discretionary power allowing NHS England to make an order imposing a limit on the capital expenditure by a NHS Foundation Trust. NHS England has published statutory guidance regarding the circumstances in which such an order would be made and the method used to determine the limit.

The guidance is clear that the power will be used as a last resort where a foundation trust is actively pursuing capital expenditure which is not affordance within integrated care system envelopes or allocated spending through capital programmes. It is expected that other mechanisms at system, regional and national levels should mitigate this risk and that the power under the Act will only be used where all other options have been exhausted.

The guidance provides the following example scenarios where NHS England might consider exercising its powers to impose a capital limit:

- A foundation trust submits a capital plan that is not aligned with and/or exceeds the level of capital notionally allocated to the organisation through the ICS process of prioritising capital envelopes;

- Data submitted through the monthly reporting process indicates the year-to-date expenditure or forecast outturn by a foundation trust is above the affordable plan;
- Capital spending on unplanned projects in-year is without prior notification and discussion with NHS England.

Where NHS England identifies a foundation trust the actions of which create a risk to its ICS managing spend, the Trust Board would be notified via a formal letter. The Trust will have ten working days to respond.

In the event that such an order is imposed, it will be published, together with a report containing details of the circumstances, representations made by the Trust and the limit itself. Any limit imposed would be for a single financial year.

Southampton Clinical Trials Unit (SCTU)
Southampton Clinical Trials Unit (SCTU) have been awarded £5.5m over the next five years (2023-2028) from Cancer Research UK (CRUK) to run world-leading trials testing new cancer treatments and to help diagnose the disease at an earlier stage. Southampton is one of eight Clinical Trials Units (CTUs) currently funded by the CRUK. This award represents an increase of 37.5% in funding from the previous award (£4m), set against a background of two of the eight CTUs having their funding totally cut and two further CTUs receiving reduced funding.

Below is a summary of CRUK Feedback on our application:

- We are pan-cancer, early phase, early detection
- We share learnings more with network (e.g. PPI, digital tools)
- We need to increase methodology leadership
- We should increase external CIs
- We need to develop our international profile

Southampton's Experimental Cancer Medicine Centre
Southampton's Experimental Cancer Medicine Centre (ECMC) Partnership has been awarded over £1.75m in funding over the next five years (2023-2028) by Cancer Research UK, the National Institute for Health and Care Research (NIHR) and the Little Princess Trust. This award represents an increase of 20% in funding from the previous award (£1.36m). The Southampton ECMC is part of network of 17 ECMCs across the UK focused on the development of new cancer treatments for both adults and children and the delivery of early phase clinical trials of promising new treatments.

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Integrated Performance Report 2022/23 Month 9**			
Agenda item:	**5.6**			
Sponsor:	**David French, Chief Executive Officer**			
Author	**Jason Teoh, Director of Data and Analytics**			
Date:	**31 January 2023**			
Purpose	**Assurance or reassurance** **Y**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	The report aims to provide assurance: • Regarding the successful implementation of our strategy • That the care we provide is safe, caring, effective, responsive, and well led			
Response to the issue:	The Integrated Performance Report reflects the current operating environment and is aligned with our strategy.			
Implications: (Clinical, Organisational, Governance, Legal?)	This report covers a broad range of trust services and activities. It is intended to assist the Board in assuring that the Trust meets regulatory requirements and corporate objectives.			
Risks: (Top 3) of carrying out the change / or not:	This report is provided for the purpose of assurance.			
Summary: Conclusion and/or recommendation	This report is provided for the purpose of assurance.			

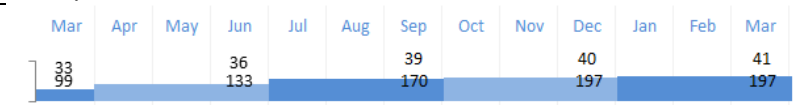
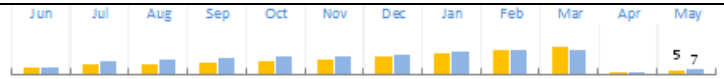
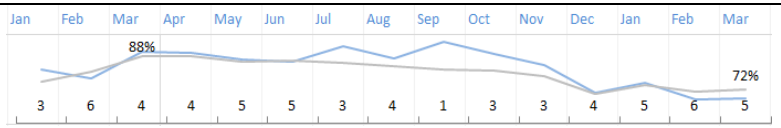
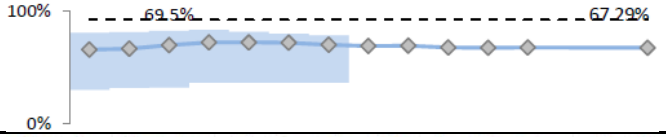
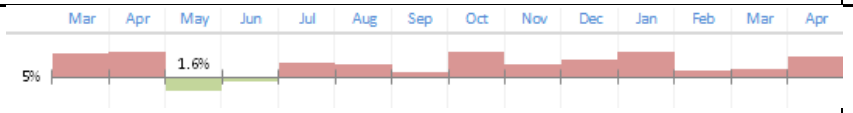
University Hospital Southampton NHS
NHS Foundation Trust

Integrated KPI Board Report

Covering up to
December 2022

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

Report guide

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

Introduction

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

The report aims to provide assurance:

- regarding the successful implementation of our strategy; and
- that the care we provide is safe, caring, effective, responsive, and well led.

The content of the report includes the following:

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

This month the following changes have been made to format of the report.

- Data source change: We are moving the ambulance handover data source from the South Coast Ambulance Service (SCAS) Board Report to utilise the NHS England published data instead because the SCAS data will include data for other hospitals while the NHS England data is specific for UHS.

Please note, due to the earlier timing of the December 2022 Board, at the time of publishing last month's report, some of the IPR data points were not yet available. Therefore, two months of data have been added for this report for the following metrics.

- UT28 - % Patients on an open 18 week pathway
- UT29 - Total number of patients on a waiting list
- UT30 - % Patients on an open 18 week pathway (waiting 52+ weeks)
- UT31 - % Patients on an open 18 week pathway (waiting 104+ weeks)
- UT31a - % Patients on an open 18 week pathway (waiting 78+ weeks)
- UT32 - Patients waiting for diagnostics
- UT33 - % of Patients waiting over 6 weeks for diagnostics

Summary

This month the 'Spotlight' section contains an update on Falls and Research & Innovation.

The Falls spotlight highlights that:

- Falls remain one of the highest patient safety incidents at UHS. Most cases are deemed as appropriate care following review, and the volume of falls are reflective of the Trust's workload and the patient acuity.
- There has been a significant amount of quality improvement work over the last 12 months which has predominantly focused on education and raising awareness. This includes a successful "falls education week" in September 2022.
- The team will continue to explore quality improvement initiatives alongside engagement under the new national Patient Safety Incident Response Framework (PSIRF). This includes the implementation of after action reviews for falls that is designed to reduce the administrative burden on the clinical teams and instead focusing on identifying good practice and opportunities for learning.

The Research and Innovation (R&I) spotlight highlights that:

- The Trust Board KPIs for research activity have focused on national ranking as a measure of UHS research activity in comparison to our peer NHS Acute Trusts. UHS national performance was declining due to capacity constraints across the research system, which was highlighted in the successful R&I investment case to Trust Board.
- In 2021/22 Trust Board KPIs were met, reflecting the pivot to vaccine studies, detailed work on our portfolio and the rapid restart of our research portfolio after the height of the pandemic had passed.
- Over 2022/23 we have seen a gradual decline in our national performance recruitment ranking. The KPIs highlight a few concerns with the current performance of UHS in comparison to other acute trusts, including staffing, capacity constraints in pharmacy, imaging, clinical pressure on clinical time and access to patients.
- We have action plan to address in short and longer term.

Areas of note in the appendix of performance metrics include:

1. Cancer performance to November 2022 (the latest available month) has deteriorated on an absolute basis, and relative to our peers.
    a. Two week wait (2WW) performance dropped to 73.1% mainly driven by performance within the Breast tumour site (performance at 25%) due to staffing challenges. In November 2022, the Skin tumour site also saw performance challenges due to higher referrals, although the new tele-dermatology pathway being introduced from January 2023 will help to address this.
    b. 31 day performance reduced to 87.7%, mainly driven by the increase of the number of Skin patients, with performance in the Skin tumour site in the 50% range. The Care Group have worked with the Wessex Cancer Alliance to review the pathway, and the Alliance has also

provided additional funding for new insourcing capacity. There is a challenge with a growing waiting list for urology patients awaiting robotic prostatectomy for which additional sessions are planned.

c. There was a small improvement in 62 day performance which stands at 58%, although we remain in the second quartile compared to other teaching hospitals, with performance impacted by our 2WW and 31 day performance. There is considerable improvement effort across our cancer sites including dedicated improvement resource to review current pathways, additional funding for targeted improvements from the Wessex Cancer Alliance, and implementation of new pathways to improve higher volume tumour sites.

2. Emergency Department (ED) four hour performance reduced to 52.1% in December 2022. There were challenges in the month due to the critical incident at the Trust, and challenges with flow, alongside relatively high attendances during the Christmas period. This is also reflected in the mean time in department statistics. Our benchmarked performance compared to acute teaching hospitals remains in the upper quartile.
3. The number of diagnostic breaches (patients waiting over 6 weeks) has increased to 29.6% of the diagnostic waiting list. This is partly linked to the Christmas period as diagnostic activity was 12% lower than previous periods, as well as ongoing inpatient demand for diagnostic tests.
4. There was a 10% decrease in the average number of patients not meeting the Criteria to Reside in hospital to an average of 181 patients for December. This was partly due to an additional focus applied to discharges during the December critical incident, as well as lower volumes of patients being admitted over the Christmas period (which is an annualised trend).
5. Clostridium difficile cases remain above target; this is in line with infection rates that continue to be seen nationally. We continue to work with our teams to remind and reinforce on best case infection prevention.
6. Staff sickness continues to be higher than target, with a small increase seen in December to 4.9%. This is partly seasonal variation due to colds and flu, but has a continued proportion of mental health sickness linked to the challenging environment staff are working in.

Ambulance response time performance

NHS England published ambulance handover data has been removed, and so we have reverted to the unvalidated weekly data which is provided to UHS by the South Coast Ambulance Service (SCAS).

UHS continues to ensure that it does not significantly contribute to ambulance handover delays. In the week commencing 9 January 2023, our average handover time was approximately 16 minutes and 50 seconds across 693 emergency handovers, and 19 minutes and 13 seconds across 46 urgent handovers. There were 46 handovers which took longer than 30 minutes within the unvalidated data. This is in line with historic performance.

Spotlight: Falls

Inpatient falls remain one of the highest reported patient safety incidents within UHS. Falls will always occur in hospitals due to the multifactorial causes of falls and the nature of patients requiring treatment. Currently, deconditioning (whether this be hospital associated or pre-admission), acute illness, history of falls and cognitive impairment are significant contributing factors seen in patients falling and sustaining harm at UHS. Further thematic review is underway exploring causes of falls to enable improvement initiatives focused on these.

In Quarters 1 and 2 (April – September 2022) there were 19 falls with significant harm in each quarter. In Quarter 3 (October – December) there were 13. In terms of falls per 1,000 bed days, we remain within the upper and lower control limits (Figures 1 and 2). In summary:

- 37 of 51 patients who fell sustained serious harm on their first inpatient fall (72.5%). Nationally around 80% of patients who sustain inpatient hip fractures do so on their first inpatient fall. This highlights that we have one opportunity to get it right.
- 20 of 51 patients were medically optimised for discharge when they fell sustaining harm (39% overall). This has varied by quarter – quarter 1: 47% were MOFD, quarter 2: 42% MOFD and in quarter 3: 23% were MOFD.
- In quarter 1-3 of 2022/2023 there were 15 inpatient fractured neck of femur, 15 head injuries, ten upper limb fractures and 13 other significant injuries.
- At the time of writing, 35 cases were closed as incidental learning (learning that did not directly contribute to the harm sustained); seven closed as omissions in care; two closed as appropriate care; and seven have ongoing investigations.

Figure 1

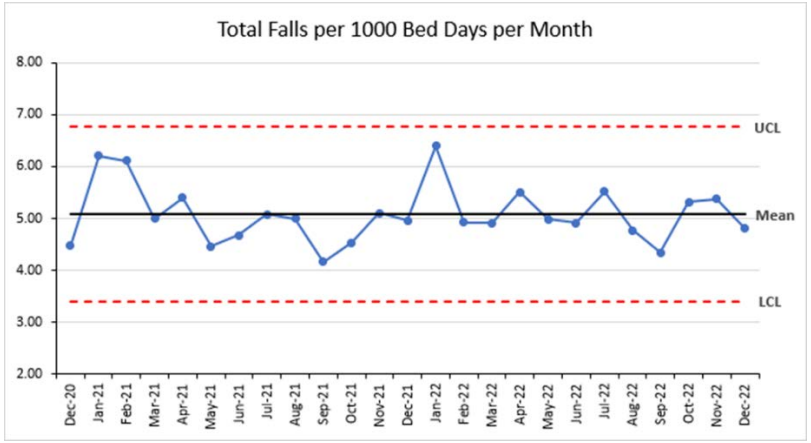
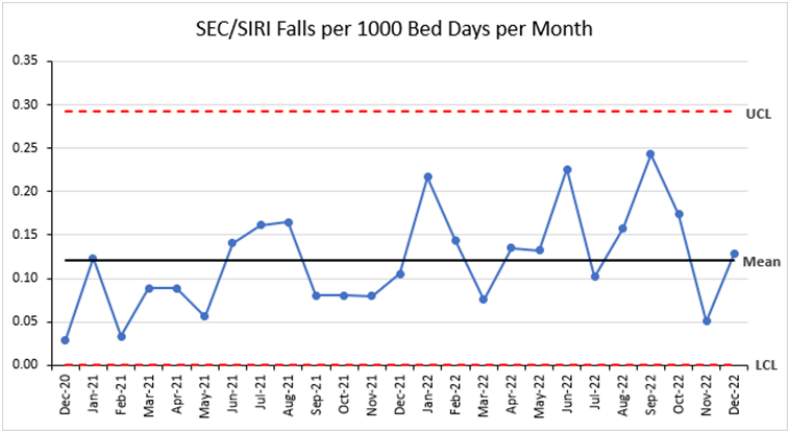


Figure 2



At present an increased number of falls with significant harm are occurring requiring investigation. This is all falls known to have caused a significant fracture, intracranial head injury or other injury leading to a marked increased length of stay. Further work is required to develop greater understanding of the data; and we are working on increasing Trust wide engagement in falls prevention and management which will further benefit our falls work.

Themes requiring learning regarding falls management across UHS have highlighted missed opportunities for comprehensive assessment and personalised care planning, provision of desired level of supervision, lack of assessment for injury before moving a fallen patient from the floor, and monitoring after a fall with neurological observations amongst others. Local action plans are developed to support learning, but further work is required enabling this to be more widely shared. Currently a large proportion of falls with harm, particularly hip fractures, occur outside of core hours.

A recently published systematic review and new world falls guidelines highlights the importance of education for falls management in hospitals. This will be an area of focus moving forwards alongside quality improvement workstreams. The national audit of inpatient falls is now providing real-time data enabling us to focus areas of quality improvement work.

Some actions that have been implemented in the last 12 months include:

- Falls awareness week completed 20-23rd September with a focus on staff engagement in prevention strategies, personalised care, and education. Over 50 areas visited, Trust-wide communications shared and external communications video via social media.
- Falls mapping across some division B areas to better understand environmental themes at ward level.
- New medical lead for falls engaging in falls management, investigations, and quality improvement initiatives.
- Falls multifactorial risk assessment and care plan updated for use with electronic noting. This includes reminder prompts for completion.
- Additional flat-lifting equipment in departments, with staff trained on these by PST, moving and handling team, and education teams.
- Integrated working with various teams such as dementia and delirium, education and moving and handling.
- Local quality improvement initiatives undertaken (e.g. implementation of Baywatch on E-neuro, enhanced education on Medicine for Older People, and purchase of a staff notes table for each bay on G8.)

Information shared with staff in the Q3 Falls Infographic briefing

The following actions are in process:

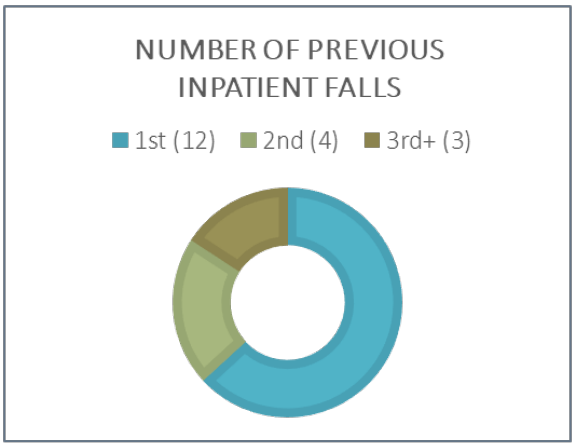
- Implementation of after-action reviews for falls with harm – these support patient safety developments, involving the patient (when able) and engage a wider MDT in inpatient falls management processes and enhance understanding of causes of falls at UHS. This will form part of the national requirements of the new Patient Safety Incident Response Framework (PSIRF). Clinical teams are needed to be involved in this developmental process. Development of hot debriefs following all inpatient falls will also be beneficial as part of this process to better understand causes for falls in the hospital.
- Falls becoming part of mandatory training for several patient facing clinician groups. The aim is to have approximately 50% of staff completed this in the first 12 months of going live. Consideration of the number of high harm falls pre / post VLE mandatory live date will be completed. Currently awaiting "go live" date for mandatory component.
- Ward based practical / simulation training – these have commenced in conjunction with the division B education team on MOP, AMU and cancer care. The aim is to facilitate this hospital wide and requires engagement from all divisions. Outcomes could be measured through analysis of falls incident management.
- Relaunching the falls champion programme and upskilling dedicated staff in January 2023.
- An audit project is commencing with pharmacy colleagues to understand whether medications are impacting inpatient falls.
- Collaboration with local acute falls leads regarding falls management processes.

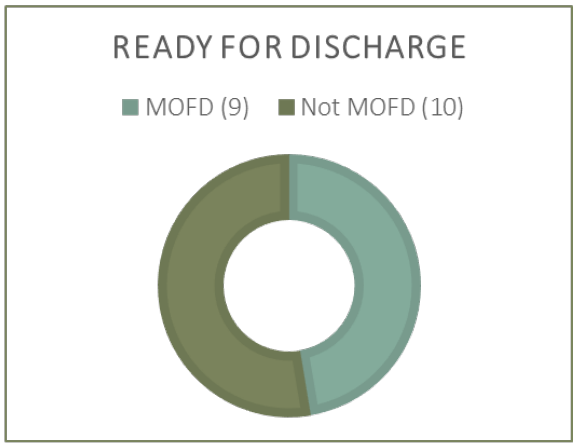
In 2023, we will reinvigorate of the Trust falls steering group (TFSG) with senior leadership from a Divisional Head of Nursing. We will ask for support and attendance from all clinical areas, with the aim of facilitating wider learning and practice improvements by engaging with a wider range of staff and ownership at departmental level. This will be supported through improved data and, enabling further thematic analysis of contributing factors to falls with harm. This will set further developmental workstreams in place over the next 12 months.

Appendix – quarterly infographics with falls analysis

19 inpatient falls with significant harm April – June 2022 in UHS

Inpatient Falls Q1 2022

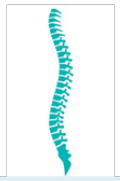




5 # NOF

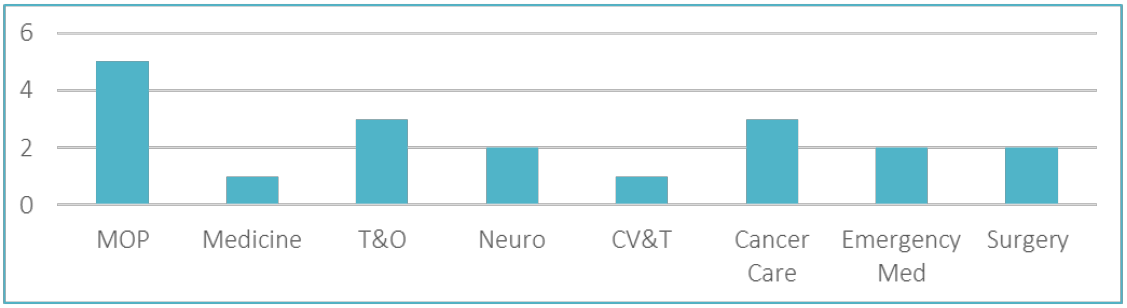
4 head injuries

4 upper limbs #'s



3 spinal #'s

3 other injuries

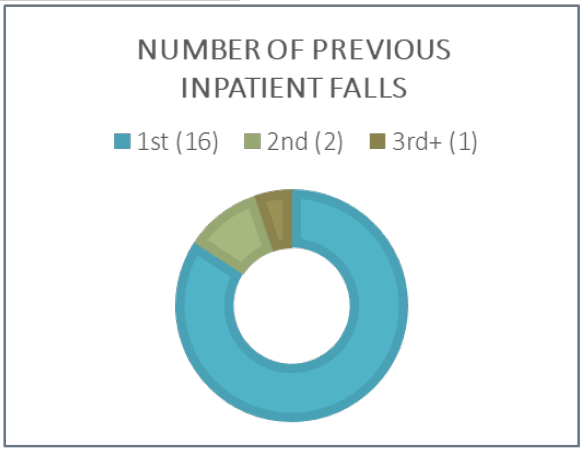


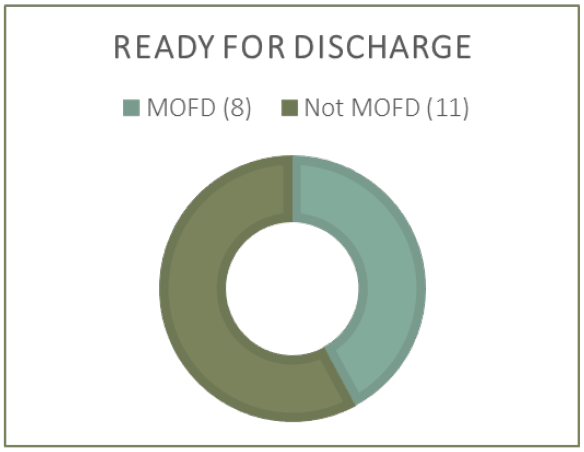
There are hundreds of causes of falls. Each fall will usually have multifactorial causes. Below are some of the key cause themes seen in the high harm falls in Q1 2022. All patients had at least one potential cause.

Toileting	3	Environmental	5
Cognition – acute or chronic confusion	6	Acute medical condition (inc covid)	7
Gait and / or balance disorder	8	Deconditioning and / or weakness	6
History of falls	12	Postural hypotension	2
Medications	1		

19 inpatient falls with significant harm July – September 2022 in UHS

Inpatient Falls Q2 2022



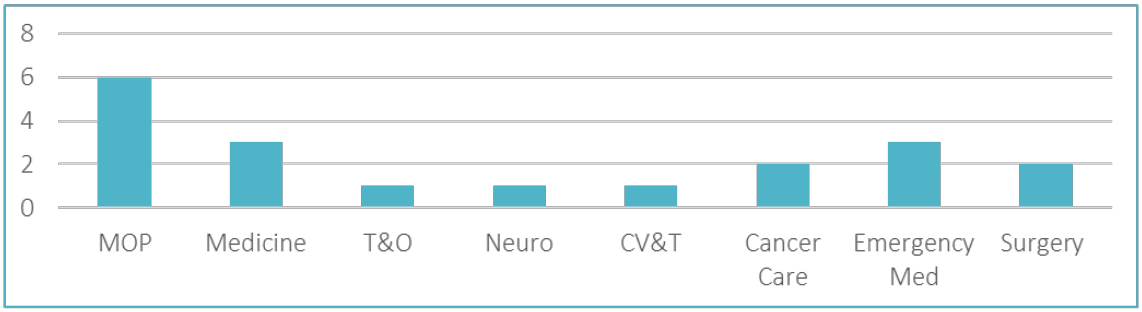


5 # NOF

8 head injuries

3 upper limbs #'s

4 other injuries

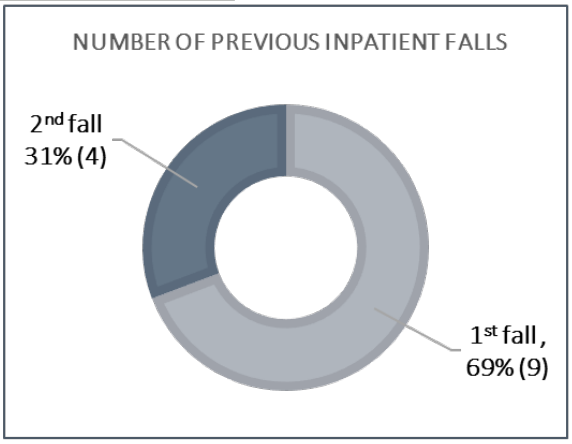


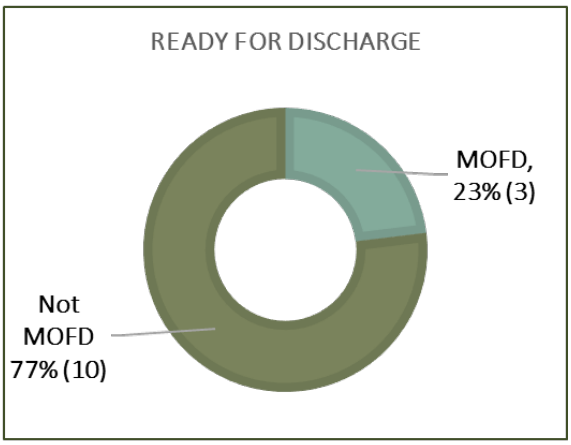
There are hundreds of causes of falls. Each fall will usually have multifactorial causes. Below are some of the key cause themes seen in the high harm falls in Q2 2022. All patients had at least one potential cause. (quarter 1 causes shown in brackets)

Toileting	2 (3)	Environmental	3 (5)
Cognition – acute or chronic confusion	8 (6)	Acute medical condition (inc covid)	6 (7)
Gait and / or balance disorder	9 (8)	Deconditioning and / or weakness	2 (6)
History of falls	11 (12)	Postural hypotension	1 (2)
Medications	1 (1)	Other – vision / behaviour	3

13 inpatient falls with significant harm October – December 2022 in UHS

Inpatient Falls Q3 2022



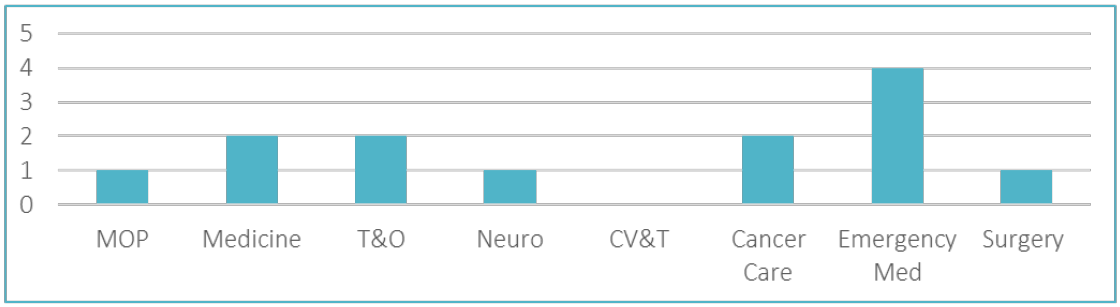


5 # NOF

3 head injuries

3 upper limbs #'s

3 other injuries



There are hundreds of causes of falls. Each fall will usually have multifactorial causes. Below are some of the key cause themes seen in the high harm falls in Q3 2022. All patients had at least one potential cause. (quarter 2 causes shown in brackets)

Toileting	0 (2)	Environmental	3 (3)
Cognition – acute or chronic confusion	6 (8)	Acute medical condition (inc covid)	5 (6)
Gait and / or balance disorder	5 (9)	Deconditioning and / or weakness	1 (2)
History of falls	7 (11)	Postural hypotension	0 (1)
Medications	2 (1)	Other – vision / behaviour / pt choice against staff advice	6 (3)

Spotlight: Research & Innovation

Background

Trust Board KPIs for research activity have focused on national ranking as a measure of UHS research activity in comparison to our peer NHS Acute Trusts. These performance metrics have been monitored as High-Level Objectives (HLOs) by the National Institute for Health & Care Research Clinical Research Network Co-ordinating Centre (NIHR CRN CC) and have been linked historically to future funding allocations. At present the NIHR CRN CC are not monitoring these recruitment metrics as a HLO and no future allocation of funding is currently dependent upon them, although that may change in the future.

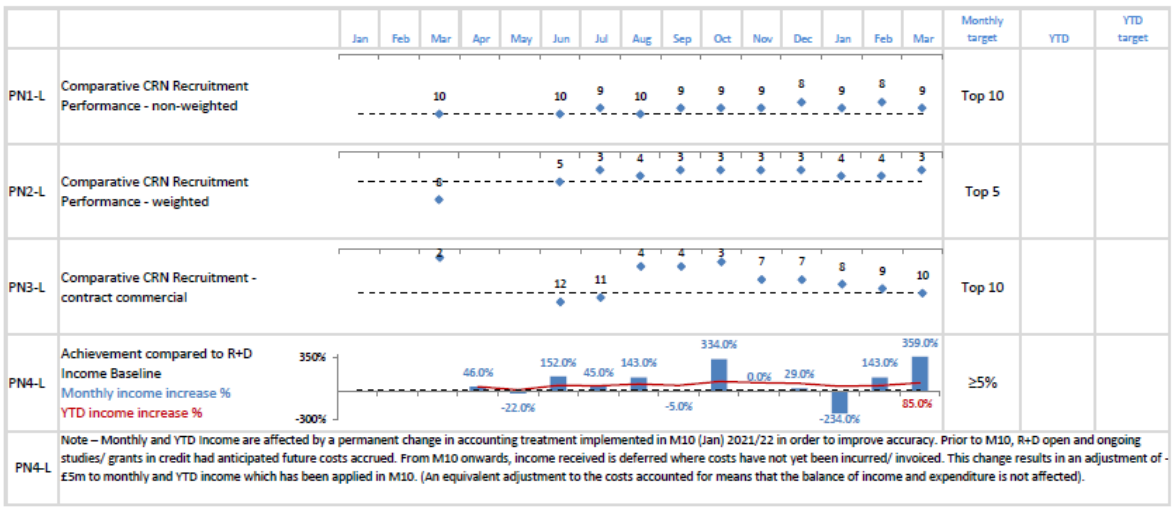
Historically UHS had consistently met the Trust Board KPIs for Comparative CRN Recruitment Performance Non- Weighted Ranking (top 10), Comparative CRN Recruitment Performance Weighted Ranking (top 5) but we had not met the Comparative CRN Recruitment Performance – Contract Commercial Ranking (top 10) for several years. In 2020/21 UHS national performance was declining due to capacity constraints across the research system, which was highlighted in the successful Research & Innovation (R&I) investment case to Trust Board.

Table 1. Historical UHS Research Performance Trends

	Comparative CRN Recruitment Performance							
Year	Non-Weighted Ranking	Non-Weighted Number	Weighted Ranking	Weighted Number	Contract Commercial Ranking	Contract Commercial Number	No Studies Ranking	No. Studies
20/21	11	12,670	8	49,709	2	1289	7	507
19/20	9	16,154	4	86,516	13	488	2	726
18/19	8	18,369	2	96,275	16	607	3	512
17/18	5	18,170	1	87,796	15	562	9/10	450

In 2021/22 Trust Board KPIs were met – reflecting the pivot to vaccine studies, detailed work on our portfolio and the rapid restart of our research portfolio after the height of the pandemic had passed.

Table 2. Trust KPIs Pioneering Research & Innovation 2021/22

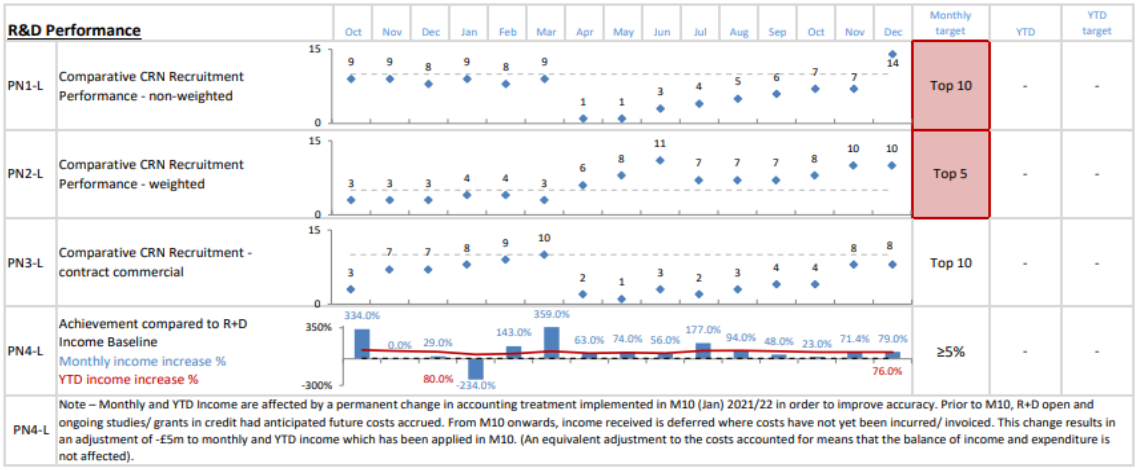


Research Activity 2022/23

Over 2022/23 we have seen a gradual decline in our national performance recruitment ranking (Table 3) – and whilst we were still meeting until recently the Trust Board KPIs we had significant concerns that the underlying recruitment figures were significantly lower than we would have expected, our ranking lifted by several large recruiting studies at the beginning of the year (RoAR 1,600 and NEWBIE 1091), which along with some other large recruiting studies have now closed to recruitment at UHS. The KPIs highlight a few concerns

with the current performance of UHS in comparison to other acute trusts. There is no one reason, but rather a multiplicity of factors impacting on current performance which we are seeking to address. Our financial KPIs around return on investment of the investment case are still being met despite our poor performance, which provides confidence that if we can address issues identified below that we would be able to generate a greater return on investment.

Table 3. Trust KPIs Pioneering Research & Innovation 2022/23



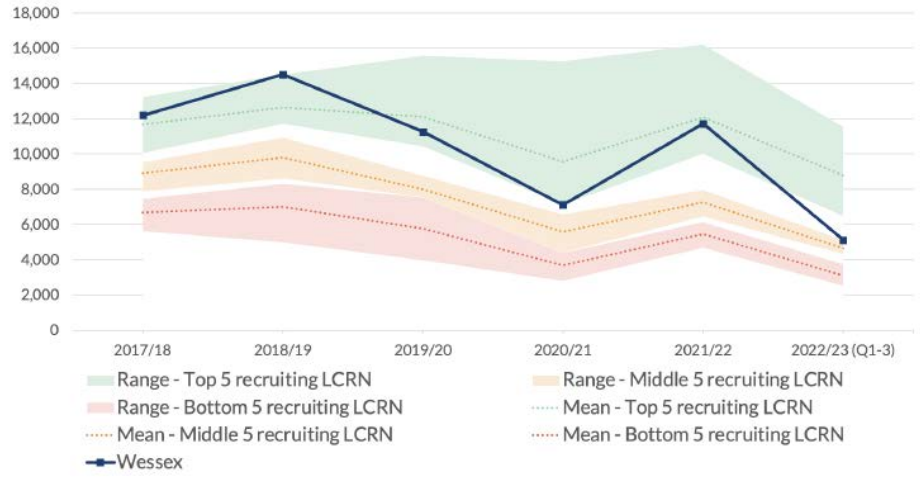
We would expect to be within the top 10 for recruitment activity, with our performance comparable to a number of the other large acute teaching hospitals. Table 4 provides a snapshot of current recruitment activity and how UHS performance compares. Lower recruitment activity is not unusual for quarters one and two of the year as recruitment upload or confirmation often lags behind activity. We would normally expect to see our ranking fluctuate over the year, as recruitment is added to the national system at different rates.

The number of open studies which have recruited participants has been relatively stable over the last few years (with only a significant uplift in 2019/20). However, to be in the top 10 currently we would need at least additional 1,000 patients recruited to our studies, at this stage of the year. Trusts currently ranked in top five all have several large recruiting observational or large interventional studies, recruiting thousands of participants, which are considered simpler to deliver.

Table 4. Recruitment in Acute Hospitals in England January 2022/23

Trust	Trust type	Recruitment Rank	Total Recruitment	CWR Rank	Complexity Weighted Recruitment	No. of studies	No. of studies rank
	-	-	**404,165**	-	**1,440,817**	**4915**	-
King's College Hospital NHS Foundation Trust	Acute - Acute teaching trust	1	20,777	4	52,642	503	12
Oxford University Hospitals NHS Foundation Trust	Acute - Acute teaching trust	2	17,652	3	55,398	710	2
Leeds Teaching Hospitals NHS Trust	Acute - Acute teaching trust	3	15,591	2	57,020	564	8
Manchester University NHS Foundation Trust	Acute - Acute teaching trust	4	13,966	5	51,075	513	11
Guy's and St Thomas' NHS Foundation Trust	Acute - Acute teaching trust	5	12,139	1	57,825	800	1
North Bristol NHS Trust	Acute - Large acute trust	6	9,971	23	20,092	223	27
Imperial College Healthcare NHS Trust	Acute - Acute teaching trust	7	9,235	6	49,086	568	7
Barts Health NHS Trust	Acute - Acute teaching trust	8	9,136	12	31,078	527	9
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	Acute - Acute teaching trust	9	9,113	11	31,527	670	3
Nottingham University Hospitals NHS Trust	Acute - Acute teaching trust	10	8,984	8	37,633	586	5
Bradford Teaching Hospitals NHS Foundation Trust	Acute - Acute teaching trust	11	8,946	17	25,676	180	35
Cambridge University Hospitals NHS Foundation Trust	Acute - Acute teaching trust	12	8,535	7	39,333	579	6
Royal Free London NHS Foundation Trust	Acute - Acute teaching trust	13	8,343	25	18,426	373	17
University Hospital Southampton NHS Foundation Trust	Acute - Acute teaching trust	14	8,052	10	31,895	526	10
Northern Care Alliance NHS Foundation Trust	Acute - Acute teaching trust	15	7,969	19	25,428	291	20
St George's University Hospitals NHS Foundation Trust	Acute - Acute teaching trust	16	7,372	15	28,861	362	18
Alder Hey Children's NHS Foundation Trust	Acute - Acute specialist trus...	17	7,165	37	11,571	97	57
University College London Hospitals NHS Foundation Trust	Acute - Acute teaching trust	18	7,005	9	34,754	659	4
University Hospitals Bristol And Weston NHS Foundation Trust	Acute - Acute teaching trust	19	6,532	30	16,000	295	19
Portsmouth Hospitals University National Health Service Trust	Acute - Large acute trust	20	6,204	22	22,236	167	36

Table 5. LCRN rank for recruitment per million population excluding large interventional or observational studies since April 2017



Analysis of the overall Wessex portfolio at the end of quarter three shows that Wessex recruitment is only slightly below the average of previous years, when excluding large scale studies (Table 5). UHS is the largest recruiting site in Wessex so UHS portfolio will be reflected in the Wessex portfolio more generally.

Table 6 illustrates how recruitment to the UHS portfolio across care groups fluctuates from year to year, dependent generally upon the studies being delivered within clinical speciality in year. UHS have certain specialities where we generally expect higher levels of research activity (e.g., cancer, critical care, ophthalmology, respiratory, cardiovascular disease). Recruitment activity is generally lower in 2022/23 across all specialities once the high recruiting studies mentioned earlier – NEWBIE (1,091) in children, and RoAR (1,600) in neurological disorders) are removed.

Table 6. Recruitment to UHS Care Groups & Specialties 2021/21 – 2022/23

UHS Division	UHS Care Group	Specialty	FY2021 Recruitment	%	FY2122 Recruitment	%	FY2122 Target	FY2223 Recruitment	%
A	Cancer Care	Cancer	637	5.0%	1982	13.4%	0	935	11.5%
	Critical Care and Theatres	Anaesthesia, Perioperativ...	528	4.2%	955	6.5%	0	92	1.1%
		Critical Care	239	1.9%	190	1.3%	0	155	1.9%
	Surgery	Surgery	28	0.2%	297	2.0%	0	149	1.8%
B	Emergency Medicine	Trauma and Emergency C...	20	0.2%	70	0.5%	0	118	1.5%
	Medicine for Older People	Ageing	12	0.1%	390	2.6%	0	34	0.4%
		Stroke	130	1.0%	254	1.7%	0	186	2.3%
	Specialist Medicine/Ophthalmology	Dermatology	100	0.8%	74	0.5%	0	73	0.9%
		Diabetes	0	0.0%	9	0.1%	0	82	1.0%
		Ear, Nose and Throat	1	0.0%	7	0.0%	0	4	0.0%
		Gastroenterology	259	2.0%	329	2.2%	0	87	1.1%
		Genetics	223	1.8%	170	1.1%	0	343	4.2%
		Haematology	5	0.0%	19	0.1%	0	7	0.1%
		Hepatology	9	0.1%	87	0.6%	0	94	1.2%
		Infection	4,605	36.3%	2403	16.2%	0	511	6.3%
		Metabolic and Endocrine ...	3	0.0%	13	0.1%	0	3	0.0%
		Ophthalmology	1,613	12.7%	158	1.1%	0	94	1.2%
		Renal Disorders	39	0.3%	74	0.5%	0	1	0.0%
		Respiratory Disorders	201	1.6%	212	1.4%	0	245	3.0%
C	Child Health	Children	2,623	20.7%	3934	26.6%	0	1590	19.6%
	Women and Newborn	Reproductive Health and ...	275	2.2%	292	2.0%	0	112	1.4%
D	Cardiovascular	Cardiovascular Disease	367	2.9%	682	4.6%	0	451	5.6%
	Neurosciences	Neurological Disorders	159	1.3%	220	1.5%	0	1784	22.0%
	Trauma and Orthopaedics	Musculoskeletal Disorders	364	2.9%	659	4.5%	0	195	2.4%
Other	Other	Dementias and Neurodeg...	17	0.1%	78	0.5%	0	138	1.7%
		Health Services Research	39	0.3%	71	0.5%	0	100	1.2%
		Mental Health	70	0.6%	5	0.0%	0	0	0.0%
		NonSpecified	0	0.0%	0	0.0%	0	0	0.0%

Analysis of Reasons for low recruitment in 22/23

Staffing: During the pandemic we lost many senior and highly experienced research delivery clinical staff, who have been difficult to replace. Most staff leaving the Trust were making significant life decisions (e.g., returning to EU country, relocating with family) following the pandemic, followed by subsequent rounds of recruitment as staff have been promoted into vacant posts. This has led to significant gaps in expertise, and

whilst we have recruited actively, there is a significant training burden, with new staff not working at full capacity. Some posts remain difficult to fill despite repeated attempts. Currently we have 28.7 posts vacant (of those 10.48 appointed but pending a start date) including some new posts.

Table 7. Research Delivery team - Clincial Staff. Vacant posts arising in 2022/23

Research Delivery Team – Clincial Staffing	Staff Vacancies During 2022/23	% Vacancy Rate Expereinced in 22/23
246.36 wte	62.7 WTE	25.45%

Research Delivery Team – Clincial Staffing	Staff in post 6 months	Staff in post 3 months
246.36 wte	40.41 WTE	13.32 WTE

Bottlenecks: Pharmacy has experienced particular constraints, especially in oncology pharmacy. A detailed action plan is in place, but repeated changes to the NHS environment and requirements for staffing have impacted on this.

For research imaging, there is direct competition with clinical imaging requirements. We have actively negotiated imaging capacity and tried to minimise the burden of research scans where possible. External resources are used where possible, but this is not feasible for many trials. Clinical reporting pressures further impact the ability to successfully utilise our imaging resource.

The ability of principal investigators (PI) to devote time to studies has been constrained due to clinical pressures. We know that locally developed studies recruit best, but this requires significant input on behalf of PIs to deliver. The Research Leaders Programme (RLP) is one attempt to address this, but there is a lead time between appointment to this programme and the generation of successful grants whilst individuals develop the necessary skills, and in turn studies, which then generate recruitment.

Multiple simultaneous set up: Phasing of the setup of new trials has been particularly challenging. During the pandemic there was a strong focus on setting-up vaccine related trials and maintaining trials that were already running. Much of our recruitment is dependent on clinical service activity, and as this was constrained, feasibility for many studies was impacted. External sponsors frequently delayed starting trials as a result of the national situation. As the pandemic eased, multiple trial opportunities became available simultaneously. Under normal circumstances, we would phase these, but this has not been possible, and we have attempted to open as many trials as we could to recover the portfolio. This pressure is easing but will continue to have an impact for some time.

Access to patients: During the pandemic, we maintained clinical trial activity where possible and worked within COVID 19 clinical guidance for patients on site. This allowed us to maintain recruitment and trial activity many cases, but where clinical activity has moved onto virtual platforms, there are fewer access points to clinical trials. The impact of changes to elective care provision as similarly had an impact on patient recruitment to particular trials, and in particular settings (e.g., surgical studies).

Specific portfolios: The cancer portfolio is normally a significant part of our recruitment performance. We placed a strategic focus on early phase trials that would help support the successful Experimental Cancer Medicine Centre (ECMC) submission. These early phase trials are typically complex and recruit small numbers of patients. Larger recruiting trials (phase 3) have been more difficult to do, and there have been staffing vacancies for the delivery team alongside the pressures on pharmacy and imaging.

National context: The research restart process is a national acknowledgement that clinical trials portfolio recovery has been slow, and difficult. The CRN focus has been on delivery of pandemic studies, then RRG (recovery) studies and then commercial trials. The normal recruitment metrics have not used in ranking for the purposes of future income as would normally be the case. The priority has been to recruit to time and target instead.

ACTION PLAN

Short / Medium Term

- Ensure we continue to fill vacant posts in delivery teams, train staff and seek to address staff retention issues identified though the staff survey, feedback from teams and individuals.
- Pharmacy Oncology Action Plan to address capacity constraints.
- Actively reviewing the pipeline in order to bring forward any strategically important studies with a focus on those that have high recruitment numbers or are commercially sponsored.
- R&D Ops groups (fortnightly review of staffing, pipeline and recruitment)
- Ongoing review of capacity to ensure an agile response to areas of high need – ensuring capacity to deliver studies that will have the most impact on recruitment
- Several large recruiting studies which have over-recruited will be allowed to continue to recruit.
- Working with delivery teams to assess if further recruitment on studies possible over existing forecast with additional targeted resource.
- Looking at cohort studies to see what recruitment might be possible – some usually only delivered when resources are available.
- Wessex CRN created a list of championed studies including studies ranking in the top 50 highest recruiting studies on the portfolio – assessing feasibility / studies in set up including Newborn Screening for SMA, ELSA, PETS.

Long Term

- Research Leaders Programme (RLP) to create capacity within our research leaders.
- Create new types of delivery posts to create development opportunities and diversify the workforce to create more resilience (e.g., Clinical Research Practitioners, Advanced Clinicals Practitioners)
- Develop and grow teams of Clinical Research Co-ordinators and Project Managers to support researchers and clinical delivery teams to set up and deliver clinical research studies.
- Develop better forecasting and portfolio management tools to enable more effective oversight of the UHS portfolio (e.g., commercial vs. non-commercial portfolio balance, complexity – simple observational vs. complex early phase).
- Ensure all studies which can go onto portfolio are on the portfolio.
- Look at support required for Southampton cohort studies where sustainable, long-term recruitment will provide consistent, sustainable baseline level of recruitment to maintain UHS ranking.
- Adopt new digital and data solutions to identify and recruit participants.

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

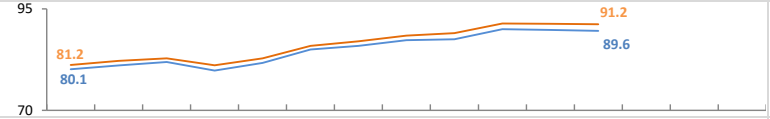
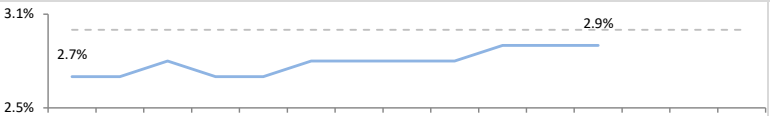
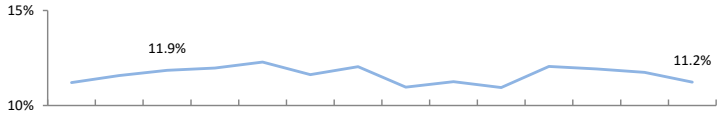
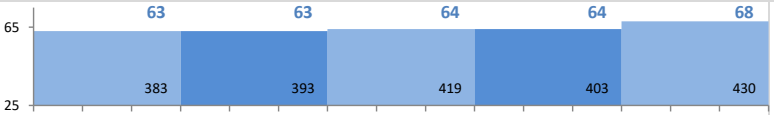
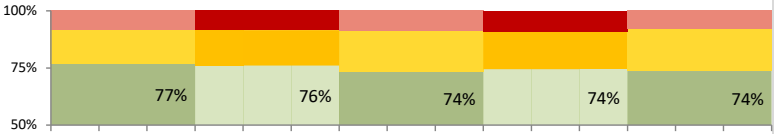
- All patients should receive high-quality care without any unnecessary delay
- Patients can expect to be treated at the right time and according to their clinical priority. Patients with urgent conditions, such as cancer, will be able to be seen and receive treatment more quickly

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.

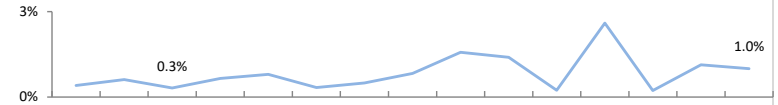
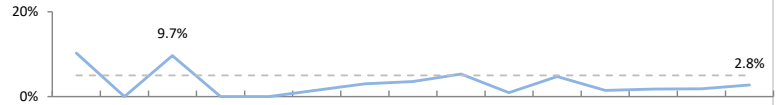
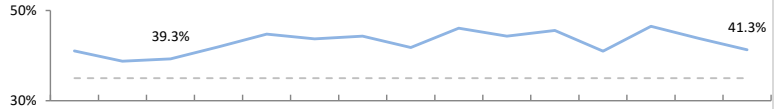
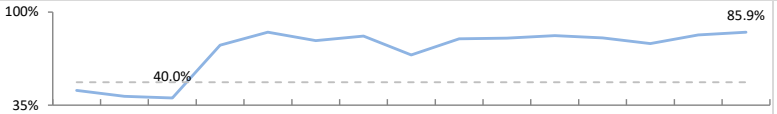
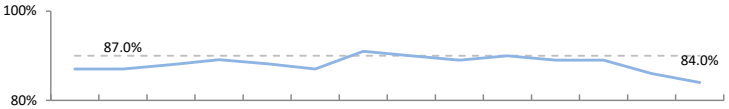
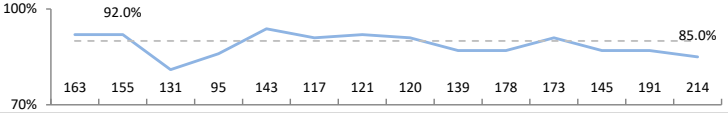
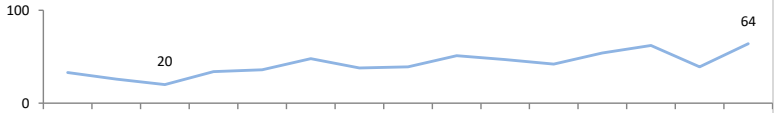
* https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england
** https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD
UT28-N	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	10	10	67.4%	8	6	5	5	3	4	4	5	6	5	5	63.3%	≥92%	65.5%
		9	8	9	8	8	8	7	7	7	6	6	6	6	5	5		
CN1-N	% Patients following a GP referral for suspected cancer seen by a specialist within 2 weeks (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	17	14	16	12	13	13	13	15	14	8	9	9	13	17	73.1%	≥93%	83.3%
		14	76.7%	9	10	7	5	4	4	5	7	4	4	8	11	13		
UT34-N	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	12	69.6%	13	13	11	12	7	11	14	10	10	16	14	58.0%	14	≥85%	64.6%
		4	5	3	4	4	2	3	4	6	3	4	10	11	7			
UT25-N	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 16) South East average (& rank of 16)	6	4	70.1%	8	10	6	4	8	7	7	4	5	7	6	52.1%	≥95%	61.5%
		4	3	3	4	4	4	4	4	3	4	3	4	4	4	4		
UT33-N	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching Hospital average (& rank of 20) South East Average (& rank of 18)	7	7	22.1%	7	8	9	8	9	9	9	9	11	11	8	29.6%	≤1%	24.3%
		14	13	12	13	12	13	13	11	8	8	7	9	8	11			

Outcomes		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
UT1-N	HSMR - **UHS** HSMR - **SGH**																≤100	94.3	≤100
UT2	HSMR - Crude Mortality Rate																<3%	2.7%	<3%
UT1-N / UT2: At time of IPR publication, the latest information available in Doctor Foster was from Sept 2022. Metrics are 12 month rolling. YTD target is for UHS for financial year																			
UT3	Percentage non-elective readmissions within 28 days of discharge from hospital																-	11.5%	
				Q3 21-22			Q4 21-22			Q1 22-23			Q2 22-23			Q3 22-23	Quarterly target		
UT4-L	**Cumulative Specialties** with Outcome Measures Developed (Quarterly)																+1 Specialty per quarter		
UT5	Developed Outcomes RAG ratings (Quarterly) Red Amber Green																		
UT5 -	Red : below the national standard or 10% lower than the local target Amber : below the national standard or 5% lower than the local target Green : within the national standard or local target																		

Safety		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
UT6-N	Cumulative Clostridium difficile Most recent 12 Months vs. Previous 12 Months	52/56	55/64	57/71	63/74	7/9	16/11	21/18	25/24	33/28	39/35	44/47	49/55	56/65			≤5	65	≤45
UT7	**Healthcare-acquired COVID infection**: COVID-positive sample taken >14days after admission (validated)	6	11	21	20	14	42	36	23	45	45	2	29	87	2	34	-	303	-
UT8	**Probable hospital-associated COVID infection**: COVID-positive sample taken >7 days and <=14 days after admission (validated)	9	11	14	17	10	31	35	12	32	37	4	15	49	6	14	-	204	-
UT9	Pressure ulcers category 2 per 1000 bed days	0.27														0.23	<0.3	0.32	<0.3
UT10	Pressure ulcers category 3 and above per 1000 bed days	0.32														0.38	<0.3	0.38	<0.3
UT11-N	Medication Errors (severe/moderate)	2														4	≤3	23	≤27

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
UT12	Watch & Reserve antibiotics, usage per 1,000 adms Most recent months vs. 2018*95.5%	2,571	2,739											2,571	2,825		2,571	19,498	18,698
UT12 - For 2022/23, a new requirement is applied: Reduction of 4.5% from calendar year 2018 usage in combined WHO/NHSE AWaRE subgroups for "watch" and "reserve" agents. The performance data relate to successive FINANCIAL years, however the comparator denominator remains CALENDAR year 2018 (we are not using 2020 or 2021 due to the disruptive effect of COVID on both usage and admissions). Data is reported 3 months in arrears.																			
UT13	Serious Incidents Requiring Investigation (SIRI) (based upon month reported as SIRI, excluding Maternity)			8												3	-	91	-
UT14	Serious Incidents Requiring Investigation - Maternity			0												1	-	8	-
UT15	Number of falls investigated per 1000 bed days			0.11												0.13	-	0.15	-
UT16	% patients with a nutrition plan in place (total checks conducted included at chart base)			97.0%												94.0%	≥90%	94%	≥90%
				787	444	397				53	742	572	750	719	676	669	711		
UT16 - monthly audit was paused due to pressure on all ward areas between Dec 2021 to May 2022. The audit was partially restarted in some ward areas in May 2022, and fully restarted in June 2022.																			
UT17	Red Flag staffing incidents			45												30	-	324	-

Patient Experience		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
UT18-N	FFT Negative Score - Inpatients																≤5%	1.0%	≤5%
UT19-N	FFT Negative Score - Maternity (postnatal ward)																≤5%	2.8%	≤5%
UT20	Total UHS women booked onto a continuity of carer pathway																≥35%	43.9%	≥35%
UT21	Total BAME women booked onto a continuity of carer pathway																≥51%	81.1%	≥51%
UT22	% Patients reporting being involved in decisions about care and treatment																≥90%	88.5%	≥90%
UT23	% Patients with a disability/ additional needs reporting those needs/adjustments were met (total number questioned included at chart base)																≥90%	88.4%	≥90%
UT23 - Performance is a scored metric with a "Yes" response scoring 1, "Yes, to some extent" receiving 0.5 score and other responses scoring 0.																			
UT24	Overnight ward moves with a reason marked as non-clinical (excludes moves from admitting wards with LOS<12hrs)																-	436	-

Access Standards		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
UT25-N	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 16) South East average (& rank of 16)	6 4 4	4 3	5 70.1% 3	8 4	10 4	6 4	4 4	8 4	7 3	7 4	4 3	5 4	7 4	6 4	52.1% 4	≥95%	61.5%	≥95%
UT26	Average (Mean) time in Dept - non-admitted patients	02:58														03:19	≤04:00	03:21	≤04:00
UT27	Average (Mean) time in Dept - admitted patients	05:01														07:05	≤04:00	05:55	≤04:00
UT28-N	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	10 9 9	10 8	67.4% 9 8	8 8	6 8	5 7	5 7	3 7	4 6	4 6	5 6	6 6	5 5	5 5	63.3% 5	≥92%	65.5%	≥92%
UT29	Total number of patients on a waiting list (18 week referral to treatment pathway)	44,737														53,941	-	53,941	-
UT30	% Patients on an open 18 week pathway (waiting 52 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	7 2,299 15	7 15	7 14	7 14	7 14	7 14	7 14	7 12	5 12	5 13	5 13	5 13	5 12	5 12	5 2,254	2,011	2,254	2,011

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
UT31	Patients on an open 18 week pathway (waiting 104 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	600 0 8 171 17	8 17	8 17	8 17	8 17	6 17	8 17	5 13	6 13	6 13	6 14	7 14	5 10	1 1	0	0	0	0
UT31a	Patients on an open 18 week pathway (waiting 78 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	3,000 0 7 656 15	7 15	7 15	8 15	8 15	7 15	7 15	7 13	7 13	7 14	7 15	7 15	7 15	7 15	327		327	
UT32	Patients waiting for diagnostics	12,500 8,500 10,056														10,634	-	10,634	-
UT33-N	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	40% 0% 7 7 14	7 13	6 22.1% 12	7 13	8 12	9 13	8 13	9 11	9 8	9 8	9 7	11 9	11 8	8 11	29.6%	≤1%	24.3%	≤1%
UT34-N	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	100% 40% 12 69.6% 4	15 5	13 3	13 4	11 4	12 2	7 3	11 4	14 6	10 3	10 4	16 10	14 11	14 7	58.0%	≥85%	64.6%	≥85%
UT35-N	31 day cancer wait performance - decision to treat to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	100% 80% 9 96.3% 3	9 11 3	2	12 5	14 6	16 14	14 9	16 12	15 8	15 10	17 16	16 12	16 13	13 87.7%		≥96%	90.1%	≥96%
UT36-N	31 day cancer wait performance - Subsequent Treatments of Cancer (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	100% 85% 14 13 88.8%	16 16	15 11	11 8	14 11	15 8	13 15	9 10	12 10	13 13	13 13	13 9	14 13	14 89.8%		≥96.0%	90.5%	≥96.0%

R&D Performance		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
PN1-L	Comparative CRN Recruitment Performance - non-weighted	9	9	8	9	8	9	1	1	3	4	5	6	7	7	14	Top 10	-	-
PN2-L	Comparative CRN Recruitment Performance - weighted	3	3	3	4	4	3	6	8	11	7	7	7	8	10	10	Top 5	-	-
PN3-L	Comparative CRN Recruitment - contract commercial	3	7	7	8	9	10	2	1	3	2	3	4	4	8	8	Top 10	-	-
PN4-L	Achievement compared to R+D Income Baseline Monthly income increase % YTD income increase %	334.0%	0.0%	29.0%	-234.0%	143.0%	359.0%	63.0%	74.0%	56.0%	177.0%	94.0%	48.0%	23.0%	71.4%	79.0%	≥5%	-	-
PN4-L	Note – Monthly and YTD Income are affected by a permanent change in accounting treatment implemented in M10 (Jan) 2021/22 in order to improve accuracy. Prior to M10, R+D open and ongoing studies/ grants in credit had anticipated future costs accrued. From M10 onwards, income received is deferred where costs have not yet been incurred/ invoiced. This change results in an adjustment of -£5m to monthly and YTD income which has been applied in M10. (An equivalent adjustment to the costs accounted for means that the balance of income and expenditure is not affected).																		

Thrive		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
WR1-L	Substantive Staff - Turnover **-R12M turnover %** **-Leavers in month (FTE)**	16% 10%		13.4% 103												14.3% 89	200 0	R12M <= 12.0%	14.8%	-
WR2-L	Staff Vacancies **-Nursing vacancies** (registered nurses only in clinical wards) **-All Staff vacancies**	20% 0%		13.5% 7.7%												12.4% 7.4%		-	-	-
WR3-L	Workforce Numbers **-Planned substantive WTE** **-Actual substantive WTE** *-Including - Month-end contracted staff in post (ESR), Consultant APAs, Junior doctors Extra Rostered Hrs* *-Excluding - Bank and agency; honorary contracts; career breaks; secondments; hosted services; WPL; Chilworth; Vaccination Hub*	13,000 11,000							11,570 11,570							12,034 11,785		11,900 WTE by March 2023	-	-
WR4-L	Staff - Sickness absence **-R12M sickness %** **-Sickness in month %**	7% 0%		5.5% 4.3%												4.7% 4.9%		R12M <= 3.4%	4.8%	-
Excel		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
WR5-L	Non-medical appraisals completed **-R12M appraisal %** **-Appraisals in month**	100% 50%		74.5% 343												74.5% 366	725 325	R12M >= 92.0%	73.2%	-
WR6-L	Medical staff appraisals completed - Rolling 12-months	90% 50%		64.8%												83.2%		-	-	-

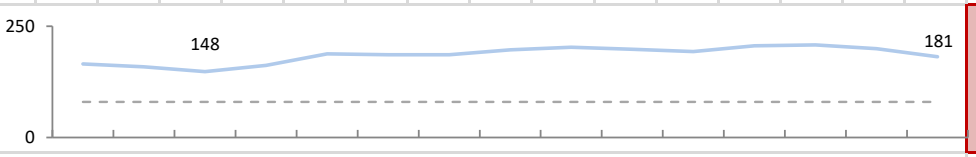
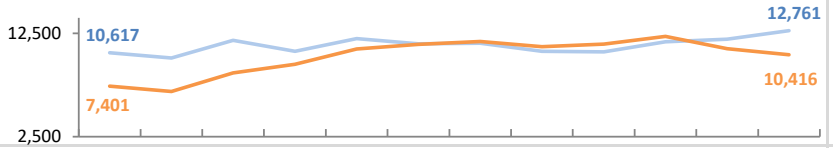
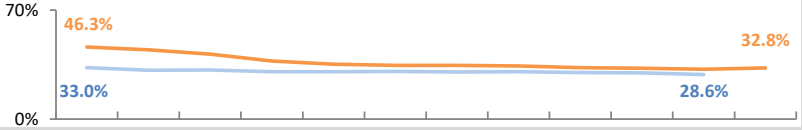
		Q3 21-22	Q4 21-22	Q1 22-23	Q2 22-23	Q3 22-23	Quarterly target		
WR7-L	Staff recommend UHS as a place to work score: National Quarterly Pulse Survey (NQPS) **National NHS Staff Survey**	7.1	7.24	7.05	6.96		-	-	-
WR7-L - Metric has changed from The Friends and Family Test (%, Q4 2020) to the Pulse Survey (out of 10).									
WR8-L	Staff survey engagement score National Quarterly Pulse Survey (NQPS) **National NHS Staff Survey**	7.2	7.17	7.08	7.03		-	-	-
WR7-L , WR8-L: National NHS Staff Survey results under **embargo** until late Feb 2023.									

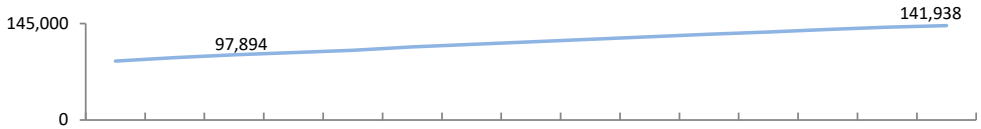
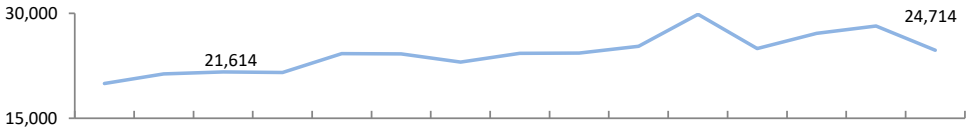
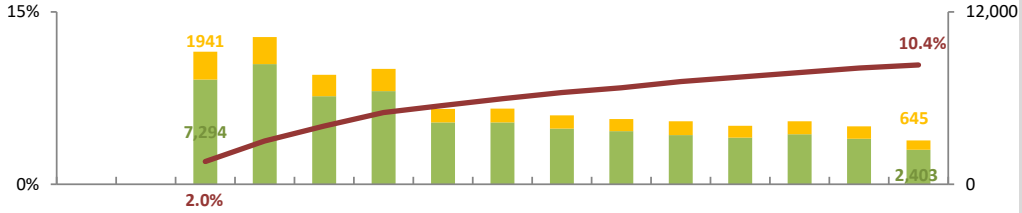
Belong		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
WR9-L	% of Band 7+ staff who are Black and Minority Ethnic	10.3%														10.8%	19% by 2026	10.6%	-
WR10	% of Band 7+ Staff who have declared a disability or long term health condition	13.4%														13.1%	-	-	-

		Q3 21-22	Q4 21-22	Q1 22-23	Q2 22-23	Q3 22-23	Quarterly target		
WR11	Staff recommending UHS as a place to work: White British staff compared with all other ethnic groups combined -White British -All other ethnic groups combined	7.36 / 7.14	7.44 / 7.12	7.3 / 7.02	7.14 / 6.97		-	-	-
WR12	Staff recommending UHS as a place to work: Non disabled /prefer not to answer compared with Disabled -Non disabled /prefer not to answer -Disabled	6.9 / 7.3	7.02 / 7.18	6.9 / 7.09	6.91 / 7.06		-	-	-
WR13	Staff recommending UHS as a place to work: Sexuality = Heterosexual compared with all other groups combined -Sexuality = Heterosexual -All other groups combined	7.00 / 7.20	6.87 / 7.19	6.81 / 7.08	6.62 / 7.05		-	-	-

WR11, WR12,WR13: National NHS Staff Survey results under **embargo** until late Feb 2023.

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
FN6	Percentage of staff living locally (inside the Southampton City boundaries)	52.9%														53.8%	-	-	-
FN7	Percentage of staff residing in deprived areas (lowest 30% - national Index of Multiple Deprivation)	23.3%														24.9%	-	-	-

Local Integration		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
NT1	Number of inpatients that were medically optimised for discharge (monthly average)																≤80	181	-
NT2	Emergency Department activity - type 1 This year vs. last year																-	103,659	-
NT3	Percentage of virtual appointments as a proportion of all outpatient consultations This year vs. last year																≥25%	30.0%	≥25%

Digital		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
FN1	My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month)																-	141,938	
FN2	My Medical Record - UHS patient logins (number of logins made within each month)																-	208,808	
FN3	Patients choosing digital correspondence - Total choosing paperless in the month - Total offered but not yet choosing paperless in the month - % of total My Medical Record service users who have chosen paperless (cumulative)																-		

Report notes - Nursing and midwifery staffing hours - December 2022

Our staffing levels are continuously monitored through our staffing hub and we will risk assess and manage our available staff to ensure that safe staffing levels are always maintained

The total hours planned is our planned staffing levels to deliver care across all of our areas but does not represent a baseline safe staffing level. We plan for an average of one registered nurse to every five or seven patients in most of our areas but this can change as we regularly review the care requirements of our patients and adjust our staffing accordingly.

Staffing on intensive care and high dependency units is always adjusted depending on the number of patients being cared for and the level of support they require. Therefore the numbers will fluctuate considerably across the month when compared against our planned numbers.

Enhanced Care (also known as Specialling)
Occurs when patients in an area require more focused care than we would normally expect. In these cases extra, unplanned staff are assigned to support a ward. If enhanced care is required the ward may show as being over filled.
If a ward has an unplanned increase or decrease in bed availability the ward may show as being under or over filled, even though it remains safely and appropriately staffed.

CHPPD (Care Hours Per Patient Day)
This is a measure which shows on average how many hours of care time each patient receives on a ward /department during a 24 hour period from registered nurses and support staff - this will vary across wards and departments based on the specialty, interventions, acuity and dependency levels of the patients being cared for. In acute assessment units, where patients are admitted , assessed and moved to wards or theatre very swiftly, the CHPPD figures are not appropriate to compare.

The maternity workforce consists of teams of midwives who work both within the hospital and in the community offering an integrated service and are able to respond to women wherever they choose to give birth. This means that our ward staffing and hospital birth environments have a core group of staff but the numbers of actual midwives caring for women increases responsively during a 24 hour period depending on the number of women requiring care. For the first time we have included both mothers and babies in our occupancy levels which will have impacted the care hours per patient day for comparison in previous months.

Throughout COVID-19, a growing number of our clinical areas started to move and change specialty and size to respond to the changing situation (e.g. G5-G9, Critical Care and C5). With the evolving COVID-19 position, these wards had in the main returned to their normal size and purpose. Over the last few months COVID-19 numbers as well as flu increased so wards and departments have been required to change focus and form to respond to changing circumstances. These decisions are sometimes swift in nature and the data in some cases therefore may not be fully reflective of all of these changes. September, October, November and December have again seen a rise in the number of beds required to support COVID-19 and other infections and therefore ward changes have occured and additional beds have been staffed.

Ward		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered staff	CHPPD Care Staff	CHPPD Overall	Comments
CC Neuro Intensive Care Unit	Day	5220	4541	715	641	87.0%	89.8%	29.0	4.0	33.1	Safe staffing levels maintained; Staffing appropriate for number of patients; Staff moved to support other wards.
CC Neuro Intensive Care Unit	Night	5053	4607	684	621	91.2%	90.8%				Safe staffing levels maintained; Staffing appropriate for number of patients; Staff moved to support other wards.
CC - Surgical HDU	Day	2123	1769	717	466	83.3%	65.0%	16.7	4.2	20.9	Safe staffing levels maintained; Staffing appropriate for number of patients; Staff moved to support other wards.
CC - Surgical HDU	Night	2025	1716	688	420	84.8%	61.0%				Safe staffing levels maintained; Staffing appropriate for number of patients; Staff moved to support other wards.
CC General Intensive Care	Day	11048	10549	1882	1159	95.5%	61.6%	27.5	3.3	30.8	Safe staffing levels maintained; Staffing appropriate for number of patients; Staff moved to support other wards.
CC General Intensive Care	Night	10717	10139	1758	1308	94.6%	74.4%				Safe staffing levels maintained; Staffing appropriate for number of patients; Staff moved to support other wards.
CC Cardiac Intensive Care	Day	5958	4876	1423	1025	81.8%	72.1%	26.9	4.8	31.7	Safe staffing levels maintained; Staffing appropriate for number of patients; Staff moved to support other wards.
CC Cardiac Intensive Care	Night	6010	5253	873	763	87.4%	87.4%				Safe staffing levels maintained; Staffing appropriate for number of patients; Staff moved to support other wards.
SUR E5 Lower GI	Day	1511	1315	718	1025	87.0%	142.8%	4.1	3.5	7.6	Band 4 staff working to support registered nurse numbers; Staff moved to support other wards; Additional staff used for enhanced care - Support workers.
SUR E5 Lower GI	Night	713	807	495	783	113.2%	158.2%				Band 4 staff working to support registered nurse numbers; Staff moved to support other wards; Additional staff used for enhanced care - Support workers.
SUR E5 Upper GI	Day	1534	1452	1174	979	94.7%	83.4%	4.3	3.1	7.4	Staff moved to support other wards; Band 4 staff working to support registered nurse numbers.
SUR E5 Upper GI	Night	772	785	345	631	101.7%	183.2%				Additional staff used for enhanced care - Support workers; Safe staffing levels maintained.
SUR E8 Ward	Day	2594	2014	1416	1423	77.7%	100.5%	4.4	3.6	8.0	Staff moved to support other wards; Band 4 staff working to support registered nurse numbers.
SUR E8 Ward	Night	1724	1232	1057	1276	71.5%	120.8%				Staff moved to support other wards; Additional staff used for enhanced care - Support workers; Band 4 staff working to support registered nurse numbers.
SUR F11 IF	Day	1936	1800	821	661	93.0%	80.6%	4.9	2.6	7.5	Safe staffing levels maintained; Staff moved to support other wards; Skill mix swaps undertaken to support safe staffing across the Unit.
SUR F11 IF	Night	713	749	699	678	105.0%	96.9%				Safe staffing levels maintained.
SUR Acute Surgical Unit	Day	1468	1045	744	680	71.2%	91.4%	7.4	4.7	12.0	Staff moved to support other wards; Band 4 staff working to support registered nurse numbers.
SUR Acute Surgical Unit	Night	702	750	703	461	106.8%	65.6%				Staff moved to support other wards; Safe staffing levels maintained.
SUR Acute Surgical Admissions	Day	2151	2079	894	1115	96.7%	124.8%	4.0	2.9	6.9	Additional staff used for enhanced care - Support workers; Increased night staffing to support raised acuity.
SUR Acute Surgical Admissions	Night	1069	1087	1055	1139	101.7%	108.0%				Safe staffing levels maintained; Increased night staffing to support raised acuity.

Ward		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered staff	CHPPD Care Staff	CHPPD Overall	Comments
SUR F5 Ward	Day	1986	1564	954	1264	78.7%	132.4%	3.3	2.6	5.9	Band 4 staff working to support registered nurse numbers; Staff moved to support other wards.
SUR F5 Ward	Night	1173	1058	697	794	90.2%	113.8%				Additional staff used for enhanced care - Support workers; Safe staffing levels maintained.
OPH Eye Short Stay Unit	Day	1164	1042	830	951	89.6%	114.6%	15.3	14.3	29.6	Safe staffing levels maintained.
OPH Eye Short Stay Unit	Night	341	352	324	352	103.2%	108.6%				Safe staffing levels maintained.
THR F10 Surgical Day Unit	Day	1887	1727	3031	2287	91.5%	75.5%	5.2	6.3	11.5	Safe staffing levels maintained; run as an inpatient ward during the month
THR F10 Surgical Day Unit	Night	692	682	642	619	98.7%	96.4%				Safe staffing levels maintained; run as an inpatient ward during the month
CAN Acute Onc Services	Day	1025	902	713	798	88.1%	111.9%	10.1	9.8	19.8	Safe staffing levels maintained; Support workers used to maintain staffing numbers.
CAN Acute Onc Services	Night	357	565	356	632	158.6%	177.5%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers; Increased night staffing to support raised acuity.
CAN C4 Solent Ward Clinical Oncology	Day	1778	1566	1031	1105	88.1%	107.2%	4.5	3.7	8.2	Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAN C4 Solent Ward Clinical Oncology	Night	1070	967	735	1007	90.4%	136.9%				Additional staff used for enhanced care - Support workers.
CAN C6 Leukaemia/BMT Unit	Day	2859	2512	321	650	87.8%	202.8%	7.2	1.6	8.9	Additional staff used for enhanced care - Support workers.
CAN C6 Leukaemia/BMT Unit	Night	2089	1869	144	349	89.5%	241.9%				Additional staff used for enhanced care - Support workers; This ward has a high number of siderooms and if acuity/dependency of patients is raised Registered nurse or support workers are required to special on night duty.
CAN C6 TYA Unit	Day	1235	859	428	112	69.6%	26.1%	8.4	0.7	9.1	Safe staffing levels maintained.
CAN C6 TYA Unit	Night	656	618	0	10	94.2%	Shift N/A				Safe staffing levels maintained.
CAN C2 Haematology	Day	2388	2206	1137	986	92.4%	86.7%	5.9	3.2	9.1	Safe staffing levels maintained.
CAN C2 Haematology	Night	1776	1591	1053	1079	89.6%	102.5%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAN D3 Ward	Day	1789	1685	799	1123	94.2%	140.6%	4.4	3.4	7.8	Additional staff used for enhanced care - Support workers; Safe staffing levels maintained.
CAN D3 Ward	Night	1070	1037	696	1010	96.9%	145.1%				Additional staff used for enhanced care - Support workers; Safe staffing levels maintained.
ECM Acute Medical Unit	Day	4178	4606	3831	3454	110.2%	90.2%	5.9	4.6	10.4	Skill mix swaps undertaken to support safe staffing across the Unit; Additional surge capacity open, plus boarding; Safe staffing levels maintained by sharing staff resource.
ECM Acute Medical Unit	Night	4050	4581	3395	3710	113.1%	109.3%				Increased night staffing to support raised acuity; Additional staff used for enhanced care - Support workers; RMN and specialling high demand at night plus additional capacity still remains open; Additional staff used for enhanced care - Support workers.
MED D5 Ward	Day	1311	1408	1703	1184	107.4%	69.5%	3.4	2.7	6.0	Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
MED D5 Ward	Night	1070	1088	928	801	101.7%	86.3%				Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
MED D6 Ward	Day	1070	1528	1567	1204	142.8%	76.8%	4.6	3.0	7.6	Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
MED D6 Ward	Night	1071	1510	920	745	141.0%	81.0%				Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
MED D7 Ward	Day	689	905	1200	681	131.3%	56.7%	3.5	2.7	6.2	Safe staffing levels maintained; Staff moved to support other wards.
MED D7 Ward	Night	713	656	685	546	91.9%	79.7%				Safe staffing levels maintained; Staff moved to support other wards.
MED D8 Ward	Day	1076	1036	1640	1396	96.3%	85.1%	3.0	3.4	6.5	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
MED D8 Ward	Night	1066	1036	948	935	97.1%	98.6%				Safe staffing levels maintained
MED D9 Ward	Day	1274	1505	1692	1476	118.1%	87.2%	3.0	3.4	6.4	Safe staffing levels maintained; Support workers used to maintain staffing numbers.
MED D9 Ward	Night	1082	829	923	1162	76.6%	125.8%				Safe staffing levels maintained

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MED E7 Ward	Day	1133	1411	1657	1834	124.5%	110.7%	3.6	4.4	7.9	Safe staffing levels maintained; Additional staff used for enhanced care - RNs; Band 4 staff working to support registered nurse numbers.
MED E7 Ward	Night	702	1274	796	1463	181.5%	183.9%				Safe staffing levels maintained; Additional staff used for enhanced care - RNs.
MED F7 Ward	Day	681	1088	1535	1257	159.7%	81.9%	3.1	3.4	6.5	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
MED F7 Ward	Night	713	725	687	702	101.6%	102.2%				Safe staffing levels maintained.
MED Respiratory HDU	Day	2338	1508	447	420	64.5%	94.0%	13.5	3.5	17.0	Staffing appropriate for number of patients.
MED Respiratory HDU	Night	2144	1454	330	346	67.8%	105.0%				Staffing appropriate for number of patients.
MED C5 Isolation Ward	Day	1171	943	1191	764	80.6%	64.2%	5.0	3.3	8.3	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
MED C5 Isolation Ward	Night	1070	911	317	449	85.1%	141.5%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
MED D10 Isolation Unit	Day	1103	950	1319	1166	86.2%	88.4%	3.3	3.6	6.9	Safe staffing levels maintained; Staff moved to support other wards.
MED D10 Isolation Unit	Night	713	726	684	678	101.8%	99.0%				Safe staffing levels maintained; Staff moved to support other wards.
MED G5 Ward	Day	1442	1358	1500	1313	94.2%	87.5%	3.0	2.6	5.6	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
MED G5 Ward	Night	1070	1000	683	771	93.5%	112.9%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
MED G6 Ward	Day	1450	1253	1498	1188	86.4%	79.4%	3.2	2.9	6.1	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
MED G6 Ward	Night	1058	909	682	767	85.9%	112.4%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
MED G7 Ward	Day	710	684	915	740	96.3%	80.8%	3.6	2.8	6.4	Safe staffing levels maintained by sharing staff resource; Increase in acuity/dependency of patients in the month.
MED G7 Ward	Night	713	727	325	345	101.9%	106.3%				Safe staffing levels maintained by sharing staff resource; Increase in acuity/dependency of patients in the month.
MED G8 Ward	Day	1450	1310	1492	1354	90.4%	90.7%	3.0	2.9	5.9	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
MED G8 Ward	Night	1070	909	680	782	84.9%	115.0%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
MED G9 Ward	Day	1422	1299	1489	1268	91.3%	85.2%	3.2	2.6	5.8	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
MED G9 Ward	Night	1070	1116	667	736	104.3%	110.3%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
MED Bassett Ward	Day	1305	888	2478	2014	68.1%	81.3%	2.3	4.1	6.4	Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month.
MED Bassett Ward	Night	1070	886	1035	1242	82.8%	120.1%				Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month.
CHI High Dependency Unit	Day	1617	1218	0	164	75.3%	Shift N/A	15.0	1.1	16.1	Non-ward based staff supporting areas; Safe staffing levels maintained; Beds flexed to match staffing.
CHI High Dependency Unit	Night	1071	1098	0	0	102.6%	Shift N/A				Safe staffing levels maintained.
CHI Paed Medical Unit	Day	1956	1662	789	811	85.0%	102.8%	7.2	3.9	11.1	Non-ward based staff supporting areas; Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
CHI Paed Medical Unit	Night	1705	1486	645	917	87.1%	142.2%				Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained.
CHI Paediatric Intensive Care	Day	6539	5642	979	408	86.3%	41.6%	26.8	2.4	29.2	Non-ward based staff supporting areas; Safe staffing levels maintained.
CHI Paediatric Intensive Care	Night	5704	5171	800	551	90.7%	68.9%				Safe staffing levels maintained.
CHI Piam Brown Unit	Day	4032	2465	1041	571	61.1%	54.9%	12.8	3.3	16.0	Beds flexed to match staffing; Safe staffing levels maintained.
CHI Piam Brown Unit	Night	1415	945	674	301	66.7%	44.7%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.

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CHI Ward E1 Paed Cardiac	Day	2228	1279	601	899	57.4%	149.6%	6.1	3.4	9.5	Non-ward based staff supporting areas; Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
CHI Ward E1 Paed Cardiac	Night	1406	1282	317	540	91.2%	170.6%				Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month.
CHI Bursledon House	Day	518	290	302	255	55.9%	84.6%	3.8	3.4	7.2	Non-ward based staff supporting areas; Safe staffing levels maintained; Beds flexed to match staffing.
CHI Bursledon House	Night	110	99	69	99	90.0%	143.5%				Safe staffing levels maintained.
CHI Ward G2 Neuro	Day	768	709	902	152	92.3%	16.9%	8.2	1.1	9.3	Safe staffing levels maintained.
CHI Ward G2 Neuro	Night	743	721	702	47	97.0%	6.7%				Safe staffing levels maintained.
CHI Ward G3	Day	2436	1757	1731	703	72.1%	40.6%	6.0	2.3	8.3	Non-ward based staff supporting areas; Beds flexed to match staffing; Safe staffing maintained; Band 4 staff working to support registered nurse numbers.
CHI Ward G3	Night	1707	1336	981	466	78.3%	47.5%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
CHI Ward G4 Surgery	Day	2461	2116	1269	532	86.0%	41.9%	7.1	2.0	9.1	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Safe staffing maintained; Band 4 staff working to support registered nurse numbers.
CHI Ward G4 Surgery	Night	1706	1451	639	455	85.0%	71.1%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
W&N Bramshaw Womens Unit	Day	1166	904	709	516	77.5%	72.8%	5.9	3.6	9.5	Non-ward based staff supporting areas; Safe staffing levels maintained.
W&N Bramshaw Womens Unit	Night	748	714	622	479	95.6%	77.0%				Safe staffing levels maintained.
W&N Neonatal Unit	Day	6476	5002	2083	1545	77.2%	74.2%	10.1	3.4	13.5	Safe staffing levels maintained.
W&N Neonatal Unit	Night	5121	4116	1670	1514	80.4%	90.7%				Safe staffing levels maintained.
W&N PAH Maternity Service combined	Day	10826	8728	3777	3160	80.6%	83.7%	9.0	2.8	11.8	Safe staffing levels maintained.
W&N PAH Maternity Service combined	Night	6891	5466	1609	1295	79.3%	80.5%				Safe staffing levels maintained.
CAR CHDU	Day	4858	4572	1854	1330	94.1%	71.8%	15.0	4.2	19.2	Safe staffing levels maintained; Skill mix swaps undertaken to support safe staffing across the Unit.
CAR CHDU	Night	3892	4066	1005	1059	104.5%	105.3%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAR Coronary Care Unit	Day	2729	2733	1069	831	100.2%	77.7%	8.7	3.6	12.3	Safe staffing levels maintained; Skill mix swaps undertaken to support safe staffing across the Unit.
CAR Coronary Care Unit	Night	2412	2069	893	1145	85.8%	128.2%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
CAR Ward D4 Vascular	Day	1822	1782	1214	999	97.8%	82.3%	4.9	3.2	8.1	Safe staffing levels maintained; Skill mix swaps undertaken to support safe staffing across the Unit.
CAR Ward D4 Vascular	Night	1034	1298	969	1041	125.5%	107.4%				Increased night staffing to support raised acuity; Additional staff used for enhanced care - Support workers.
CAR Ward E2 YACU	Day	1584	1421	873	849	89.7%	97.3%	4.4	3.3	7.8	Staff moved to support other wards; Safe staffing levels maintained.
CAR Ward E2 YACU	Night	715	786	615	808	109.9%	131.3%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAR Ward E3 Green	Day	1636	1379	1439	1241	84.3%	86.2%	3.1	3.1	6.2	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
CAR Ward E3 Green	Night	704	760	966	916	108.0%	94.8%				Safe staffing levels maintained; Safe staffing levels maintained.
CAR Ward E3 Blue	Day	1630	1358	951	904	83.3%	95.1%	4.2	3.2	7.5	Staff moved to support other wards; Safe staffing levels maintained.
CAR Ward E3 Blue	Night	699	732	602	700	104.8%	116.3%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAR Ward E4 Thoracics	Day	1561	1592	1429	1467	102.0%	102.6%	4.4	4.0	8.3	Safe staffing levels maintained; Safe staffing levels maintained.
CAR Ward E4 Thoracics	Night	1023	991	436	875	96.9%	200.6%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers; Safe staffing levels maintained.
CAR Ward D2 Cardiology	Day	1402	902	706	1170	64.3%	165.7%	3.6	4.8	8.3	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
CAR Ward D2 Cardiology	Night	704	689	628	963	97.8%	153.3%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.

Ward		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered staff	CHPPD Care Staff	CHPPD Overall	Comments
NEU Acute Stroke Unit	Day	1403	1794	2645	2134	127.8%	80.7%	3.4	4.3	7.7	Additional staff used for enhanced care - RNs; Increase in acuity/dependency of patients in the month.
NEU Acute Stroke Unit	Night	1024	1113	1634	1562	108.6%	95.6%				Additional staff used for enhanced care - RNs.
NEU Regional Transfer Unit	Day	1160	965	408	234	83.2%	57.5%	8.3	4.0	12.2	Staff moved to support other wards; Skill mix swaps undertaken to support safe staffing across the Unit.
NEU Regional Transfer Unit	Night	671	583	621	506	86.9%	81.5%				Staff moved to support other wards; Skill mix swaps undertaken to support safe staffing across the Unit.
NEU Ward E Neuro	Day	1863	1861	1334	1297	99.9%	97.2%	3.9	3.4	7.3	Safe staffing levels maintained.
NEU Ward E Neuro	Night	1364	1134	1060	1323	83.1%	124.8%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
NEU HASU	Day	1551	1365	400	369	88.0%	92.2%	7.5	2.3	9.8	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
NEU HASU	Night	1364	1180	278	401	86.5%	144.1%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
NEU Ward D Neuro	Day	1881	1780	1916	1559	94.6%	81.4%	4.1	4.0	8.1	Safe staffing levels maintained; Staff moved to support other wards.
NEU Ward D Neuro	Night	1345	1302	1641	1481	96.8%	90.2%				Safe staffing levels maintained.
SPI Ward F4 Spinal	Day	1591	1599	1123	1446	100.5%	128.7%	4.0	4.0	8.0	Additional staff used for enhanced care - RNs; Band 4 staff working to support registered nurse numbers.
SPI Ward F4 Spinal	Night	1012	1039	958	1210	102.6%	126.3%				Additional staff used for enhanced care - RNs; Band 4 staff working to support registered nurse numbers.
T&O Ward Brooke	Day	1044	1224	1102	940	117.3%	85.3%	3.6	3.5	7.1	Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained by sharing staff resource; Additional RNs to support enhanced care; Staff moved to support other wards.
T&O Ward Brooke	Night	713	714	1004	977	100.1%	97.3%				Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained.
T&O Trauma Admissions Unit	Day	913	771	747	646	84.4%	86.6%	8.8	8.1	16.9	Safe staffing levels maintained; Staff moved to support other wards; Safe staffing levels maintained by sharing staff resource.
T&O Trauma Admissions Unit	Night	682	583	616	606	85.5%	98.4%				Safe staffing levels maintained; Staff moved to support other wards; Safe staffing levels maintained by sharing staff resource.
T&O Ward F1 Major Trauma Unit	Day	2310	2556	1965	2034	110.6%	103.5%	4.7	4.4	9.1	Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards; Additional staff used for enhanced care - RNs; Skill mix swaps undertaken to support safe staffing across the Unit.
T&O Ward F1 Major Trauma Unit	Night	1783	1822	1711	2054	102.2%	120.1%				Patient requiring 24 hour 1:1 nursing in the month; Additional staff used for enhanced care - HCAs; Staff moved to support other wards.
T&O Ward F2 Trauma	Day	1651	1611	1998	2037	97.6%	102.0%	3.4	5.1	8.5	Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained.
T&O Ward F2 Trauma	Night	1023	872	1294	1687	85.2%	130.4%				Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained by sharing staff resource.
T&O Ward F3 Trauma	Day	1603	1669	2141	1900	104.1%	88.8%	3.8	5.0	8.9	Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained by sharing staff resource.
T&O Ward F3 Trauma	Night	1023	1069	1635	1684	104.4%	103.0%				Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained.
T&O Ward F4 Elective	Day	1380	1272	847	827	92.1%	97.6%	3.8	3.3	7.2	Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit.
T&O Ward F4 Elective	Night	683	707	953	882	103.6%	92.5%				Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Finance Report 2022-23 Month 9**			
Agenda item:	**5.7**			
Sponsor:	**Ian Howard – Chief Financial Officer**			
Author:	**Philip Bunting – Director of Operational Finance**			
Date:	**31 January 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:	**M9 Financial Position** UHS reported a deficit of £0.2m in December 2022, which is now a £17.9m deficit YTD. A 'flight path' has been developed for months 8 - 12 and the in-month position was reported as expected as per the forecasting process. A revised forecast position of **£20.2m (1.7%) deficit** has been discussed with HIOW ICB and conversations are ongoing over the final landing forecast position which may move due to some areas of additional income still under discussion i.e., discharge funding and ERF funding. These will only seek to improve the position. **Underlying Position** The underlying position for December is £4.1m deficit which is marginally better than that of November (which has been updated from £3.6m to £4.3m following the application of backdated costs). This position has stepped out slightly in winter months due firstly to significant operational pressures requiring further spend on unfunded capacity and secondly due to increased energy costs (up £0.5m per month from the previous months). **Key drivers** The key drivers for the underlying position remain consistent with previous monthly reports and are listed in the table below. Most of these are classed as uncontrollable with UHS having limited ability to directly influence the level of cost pressure being experienced. These have been partly offset by planned CIP and further to that additional CIP being achieved. This has helped UHS report a lower deficit number than the underlying position of £31.4m deficit YTD.			

Cost Driver	Rationale	Controllable / Uncontrollable	Underlying Variance to Breakeven (YTD £m)
Covid Costs	Covid volumes in excess of 'low covid environment' assumed within plan	Uncontrollable	5.1
Pay Inflation	Pay award funding does not cover costs in full	Uncontrollable	1.9
Non Pay Inflation	Rates of inflation are in excess of planned expectations	Uncontrollable	8.9
Energy Costs	Energy costs have increased beyond that expected.	Uncontrollable	9.0
Criteria to Reside	Medically optimised patients still residing leading to flex bed costs.	Uncontrollable	2.3
Additional Bank Holiday	One off costs were incurred relating to bank holiday enhancements	Uncontrollable	0.2
Drugs and devices expenditure in excess of block funding	Drugs and devices costs have been in excess of the block funded level due to additional NICE approvals and new treatments approved.	Uncontrollable	7.8
Emergency Department	ED costs are in excess of planned levels due to activity and workforce pressures.	Controllable	4.0
CIP	Planned CIP Offset	Controllable	(7.9)
Underlying Deficit YTD			**31.4**
Additional CIP Achievement / Additional Income / Other One Offs			(13.5)
Reported Deficit YTD			**17.9**

ERF Position

UHS achieved 105% in December which is slightly down from November but still above the national target. December was also a month of significant operational pressure and a critical incident being called within the HIOW ICS. UHS is reporting achievement of 106% YTD ahead of the national 104% target and consistent with that planned. Indicatively UHS has achieved £5.3m of income relating to ERF. This is part of the fixed settlement with Specialised Commissioning for their element of income. Discussions remain ongoing at regional and national levels about the availability of additional funding to support the HIOW ICS element.

CIP

The Trust has achieved delivery of £29.5 YTD, £0.4m above the target of £29.1m.

Identification of CIP schemes remains at £42.4m of the £45.4m target (93%) and equates to an overall achievement of 3.5% of income. We are looking to commit to achievement of the full target and close the remaining gap within the Financial Recovery Plan.

This achievement level is beyond what has previously been achieved by the Trust, particularly given the operational challenges faced and the financial framework meaning inability to achieve CIP through additional activity.

HIOW ICB Position

A revised forecast position is still in discussion with HIOW ICS. A verbal update on the latest external position will be provided.

Financial Recovery

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

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

Capital

The Trust has reported capital expenditure of £16.9m YTD against Internal CDEL, which is £6.8m behind plan. The Trust has £30.8m of internally funded programmes for delivery in Q4, including wards and theatres. Although this represents a significant step change in the pace of delivery there is confidence in the forecast numbers and that it can be achieved.

The Trust is also forecasting expenditure of £27.5m on externally funded schemes, predominantly for delivery in M9-12 with £10.5m spent YTD. This includes £10m of wards funded linked to the internal scheme for which £8.1m has been spent YTD. Funding for an MRI and CT Scanner has also recently been confirmed.

Due to the risk of slippage, we have identified a number of schemes to bring forward expenditure from 2023/24, including increasing the profile of wards expenditure. This is mitigating the risk at the end of the year. We are therefore over-committed, off-set by an assumed level of slippage. The amount left to spend has been circulated to responsible owners in month to ensure clarity, with progress and risks reported regularly.

Capital Prioritisation Process for 2023/24 onwards

A process is underway to prioritise capital projects proposed for 2023/24 and onwards. This involves starting with the previous three-year rolling capital plan and reviewing for any changes required to reflect either additional projects, the removal of non-viable projects, changes in timings/phasing or changes to estimated project values.

This will then generate a long list of schemes for prioritisation. At present it is unknown how much internal CDEL will be allocated to UHS from the HIOW ICS allocation. It is however likely that this will be a reduced amount from 22/23 due to firstly the underlying system deficit which forms part of the CDEL calculation for the following year and secondly due to UHS having greater than its fair share apportionment and being under challenge to reduce this.

As the internal allocation quantum is currently unknown the long list will be prioritised in order and then can be mapped across to the affordable level once this is confirmed.

	The process of prioritisation is one that is being progressed over the next month with operational and clinical colleagues via subgroups of the Trust Investment Group. The scoring matrix will take account of the following domains: • Feasibility to deliver • Costs and Benefits (Financial Evaluation) • Clinical Impact / Patient Benefits • Link to the trust risk register and mitigation / elimination of risk • Strategic fit Once a prioritised list has been formed this will be shared with the Finance and Investment Committee and Board for discussion and approval. **Cash** The cash position has deteriorated £7.7m from M8 reducing to £100m. This was predominantly due to capital expenditure increases in month. The underlying trend remains consistent with the previous forecast, however. Cash is therefore anticipated to reduce further in the remainder of 2022/23 as capital expenditure increases and with it an underlying deficit prevails. There is also a significant amount of cash drawdown for external CDEL schemes anticipated in Q4. We are therefore anticipating short-term volatility in the cash position. We are continuing to have a current-account deficit, which is being funded by our capital investment savings account. Should the current run-rate continue, UHS will approach the set Minimum Cash Holding position in mid-2023/24. This continues to be monitored closely.
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 2023/24 due to the forecast deficit for 2022/23.
Summary: Conclusion and/or recommendation	Trust Board is asked to: • Note the update to the financial position.

Finance Report Month 9

Report to:	**Board of Directors and Finance & Investment Committee** **December 2022**
Title:	**Finance Report for Period ending 31/12/2022**
Author:	**Philip Bunting, Director of Operational Finance**
Sponsoring Director:	**Ian Howard, Chief Financial Officer**
Purpose:	**Standing Item**
	The Board is asked to note the report

Executive Summary:

In Month and Year to date Highlights:

1. In Month 9, UHS reported a deficit position of £0.2m which was £0.5m adverse to the planned £0.3m surplus. The YTD position is £17.9m deficit which is £13.5m adverse to the planned deficit target of £4.4m.

2. The underlying position is however £31m deficit YTD with one off benefits helping improve the in year reported position. Estimates of the forecast indicate an intermediate projection of £20.2m after accounting for non recurrent costs and benefits. This is heavily influenced by largely uncontrollable costs relating to covid, inflation, MOFD numbers and energy expenditure.

3. CIP YTD delivery is £29.5m, an increase from the £27m achieved at M8. This exceeds the planned YTD delivery of £29.1m by £0.4m. Of the £29.5m delivered YTD £13.2m has been transacted by Divisions and Directorates and £16.3m has been transacted through Central Schemes.

4. The main income and activity themes seen in M9 were:
    1. UHS has delivered 105% of Elective Recovery activity in M9.
    2. Indicative ERF income totals £5.3m year to date.
    3. At M9 the unfunded pressure for ICB block funded drugs and devices is £7.8m of which £5.5m is from drugs.

5. The underlying deficit of £4.1m in month is driven by:
    1. Drugs & Devices (£0.9m per month) – partly offset with CIP
    2. Energy costs – (£0.9m per month) – Inflationary pressure increasing – partly offset by CIP
    3. Covid related staff costs – (£0.6m per month) – continued sickness absence costs and covid spend which has not reduced as per planning assumptions
    4. Inflationary and pay award pressures (£1.3m per month) – costs are unfunded
    5. Activity and MOFD related pressures (£0.5m per month) – ED costs above plan as a result of significant operational pressure.

Finance: I&E Summary

A deficit position of £0.2m was reported in December adverse to the planned position of £0.3m surplus. The YTD position of £17.9m deficit is £13.5m adverse to the planned £4.4m deficit target.

Underlying trends continue as per previous months with the exception of clinical supplies and other non pay that spiked in month showing an overspend of £6.0m due to energy and clinical supplies increases. All categories of expenditure are reporting an overspend which is offset in part with the overachievement of income such as pay award funding and pass through income. Other income is significantly over plan YTD (£20.0m) relating to two significant covid R&D studies. These do however have offsetting costs within Other non pay. The Trust continues to formally report a breakeven annual forecast for 2022/23 whilst flagging the risks of delivery.

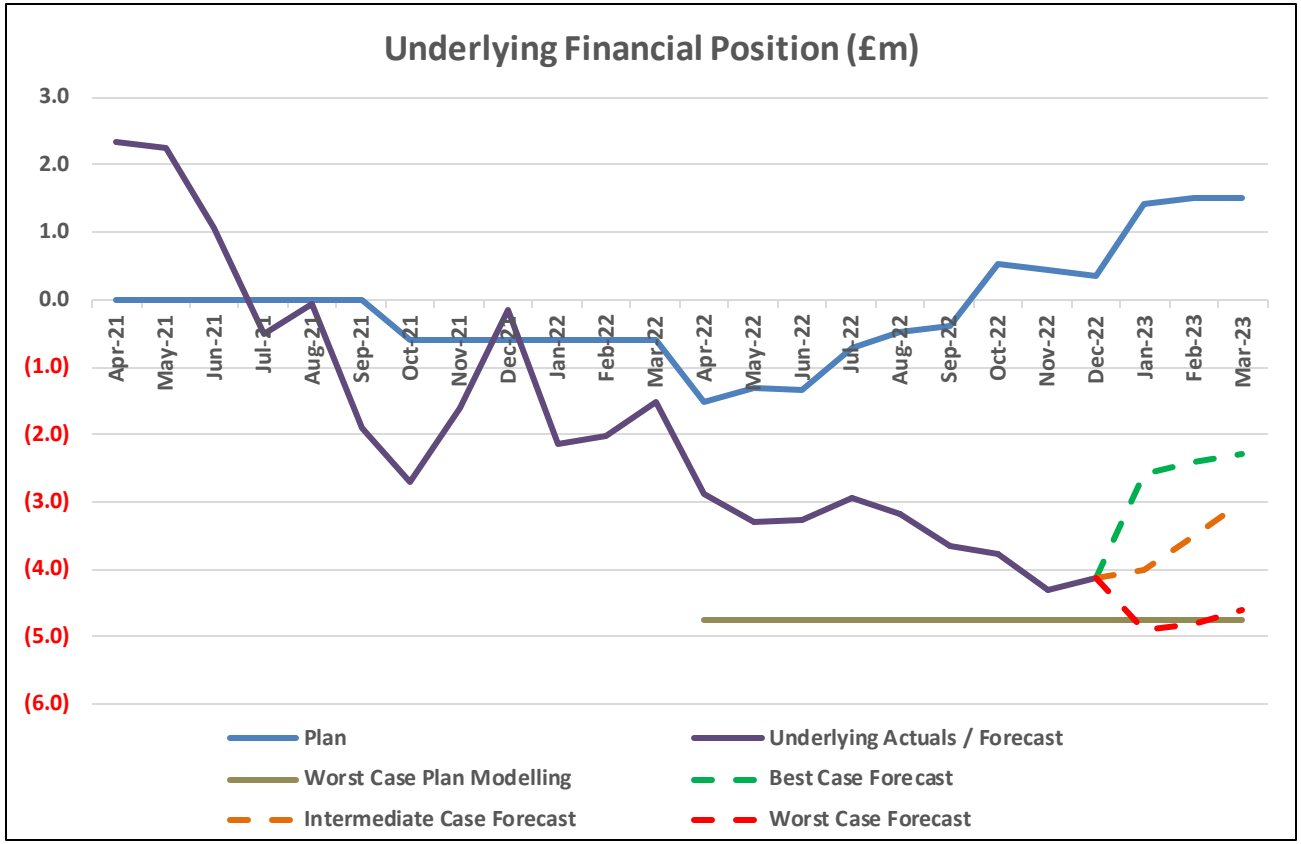
		Current Month			Cumulative			Plan		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
NHS Income:	Clinical	69.8	73.0	(3.3)	627.8	639.4	(11.6)	837.0	852.5	(15.5)
	Pass-through Drugs & Devices	11.2	12.8	(1.6)	100.9	114.8	(13.8)	134.6	153.0	(18.4)
Other income	Other Income excl. PSF	10.6	15.3	(4.8)	94.9	114.9	(20.0)	126.6	133.3	(6.7)
	Top Up Income	0.6	0.6	0.0	6.6	6.1	0.5	8.3	8.2	0.2
Total income		**92.1**	**101.7**	**(9.6)**	**830.3**	**875.2**	**(44.9)**	**1,106.6**	**1,146.9**	**(40.4)**
Costs	Pay-Substantive	49.7	50.7	1.0	441.5	454.3	12.7	591.6	605.7	14.1
	Pay-Bank	2.4	3.0	0.6	26.6	34.8	8.2	33.2	41.4	8.3
	Pay-Agency	0.9	1.5	0.6	9.7	11.1	1.3	12.0	12.8	0.7
	Drugs	4.9	4.9	0.0	45.5	47.0	1.5	59.7	65.2	5.5
	Pass-through Drugs & Devices	11.2	12.8	1.6	100.9	114.8	13.8	134.6	153.0	18.4
	Clinical supplies	5.9	7.9	2.0	59.2	62.2	3.0	74.6	80.4	5.7
	Other non pay	15.9	19.8	4.0	142.8	161.4	18.7	189.6	177.0	(12.6)
Total expenditure		**90.8**	**100.5**	9.7	**826.3**	**885.5**	**59.3**	**1,095.3**	**1,135.5**	40.2
EBITDA		**1.3**	**1.2**	**0.1**	**4.0**	**(10.3)**	**14.4**	**11.2**	**11.4**	(0.2)
EBITDA %		1.4%	1.2%	0.2%	0.5%	-1.2%	1.7%	1.0%	1.0%	0.0%
	Non operating expenditure/income	(0.9)	(0.7)	0.2	(8.4)	(7.5)	0.9	(11.1)	(11.1)	0.0
Surplus / (Deficit)		**0.4**	**0.5**	**(0.2)**	**(4.3)**	**(17.8)**	**13.5**	**0.1**	**0.3**	**(0.2)**
Less	Donated income	(0.1)	(0.5)	0.4	(1.0)	(1.2)	0.2	(1.4)	(1.4)	0.0
	Profit on disposals	-	-	0.0	-	-	0.0	-	-	0.0
	Gain/ Loss on absorption		(0.4)	0.4		(0.4)	0.4		(0.9)	0.9
Add Back	Donated depreciation	0.1	0.2	0.1	1.0	1.5	0.5	1.3	2.0	0.7
	Impairments	-	-	0.0	-	-	0.0	-	-	0.0
Net Surplus / (Deficit)		**0.3**	**(0.2)**	**0.5**	**(4.4)**	**(17.9)**	**13.5**	**0.0**	**0.0**	**(0.0)**

Monthly Underlying Position

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

This differs from the reported financial position as it has been adjusted for non recurrent items (one offs) and also had any necessary costs or income rephased by month to get a true picture of the run rate. The underlying position is £4.1m deficit in M9 down from £4.3m in M8 (this has been adjusted from previously reported).

The run rate from month 1 to month 9 is on average £3.5m deficit per month due mainly to energy cost pressures (seasonality impact also), continuing covid pressures, inflationary pressures and the unfunded pay award pressures. This is in addition to activity related operational pressures especially within ED and related to delayed discharges. A range of deficit scenarios have been modelled which are shown on the graph and are shown within the table overleaf.



Financial Risks

The table illustrates the key variables driving the underlying deficit position.

It is acknowledged that this generates a wide ranging underlying forecast between £39m deficit and £46m deficit with an intermediate forecast assessment of £42m deficit before non recurrent CIP is added and any stretch applied. This has marginally increased from the previous month however has been offset with increased non recurrent CIP achievement.

Additionally Elective Recovery Fund income risk has now been removed as this has now been agreed with Specialised Commissioning. Further income is in discussion with the national team.

			Forecast Assessment		
Risk Variable	**Controllable / Uncontrollable**	**Original Worst Case Assessment (£m)**	**Best Case (£m)**	**Intermediate Case (£m)**	**Worst Case (£m)**
Cost Improvement Plans not fully delivered	Controllable	(28.9)	0.0	0.0	0.0
Covid 19 remains at above 'background' levels meaning costs don't reduce	Uncontrollable	(17.0)	(8.0)	(8.4)	(8.8)
Inflationary pressures impacting the price of goods and services (including stockouts)	Uncontrollable	(11.3)	(11.6)	(11.9)	(12.8)
Energy Cost prices continue to rise	Uncontrollable		(8.9)	(9.9)	(10.9)
Depreciation / PDC Pressure from Central Capital Schemes	Uncontrollable	0.0	(1.4)	(1.4)	(1.4)
Block drugs and devices costs continue to overspend	Uncontrollable	0.0	(8.8)	(9.3)	(9.8)
Medically optimised for discharge numbers do not reduce and flex beds remain open	Controllable	0.0	(1.8)	(2.3)	(2.8)
Emergency Department	Controllable	0.0	(3.2)	(3.7)	(4.2)
Pay Award Funding Gap	Uncontrollable	0.0	(2.7)	(2.7)	(2.7)
Additional Bank Holiday Costs	Uncontrollable	0.0	(2.9)	(2.9)	(2.9)
Cost Improvement Plans Offsetting (Within Plan)	Controllable	0.0	10.6	10.6	10.6
Underlying Deficit Subtotal		**(57.2)**	**(38.7)**	**(41.9)**	**(45.7)**
Non Recurrent CIP (Within Plan)			5.0	5.0	5.0
Additional CIPs / Stretch Achievement			28.7	16.7	12.5
Reported Deficit Total		**(57.2)**	**(5.0)**	**(20.2)**	**(28.2)**

University Hospital Southampton NHS
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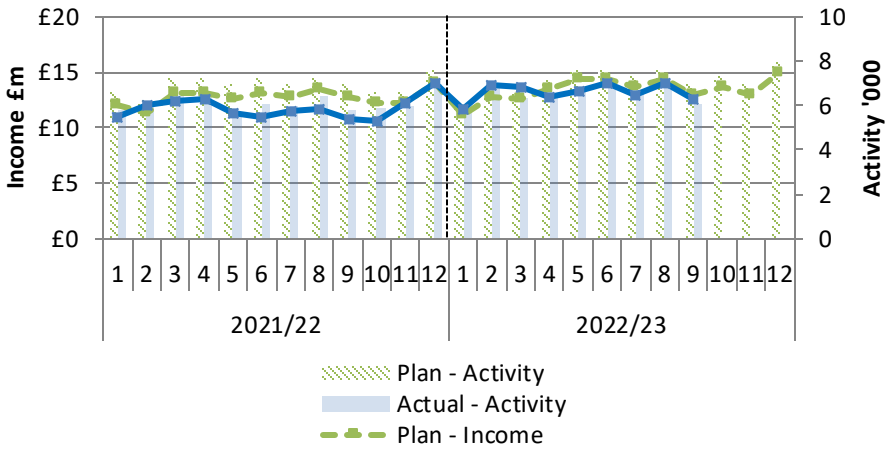
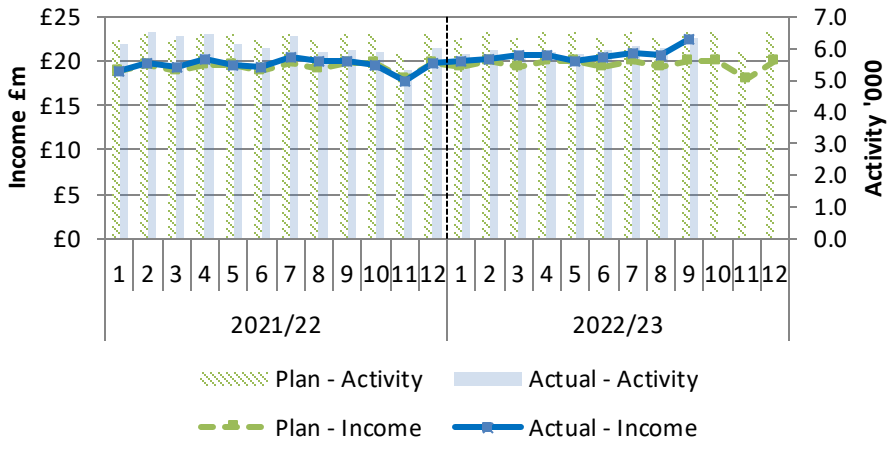
Clinical Income

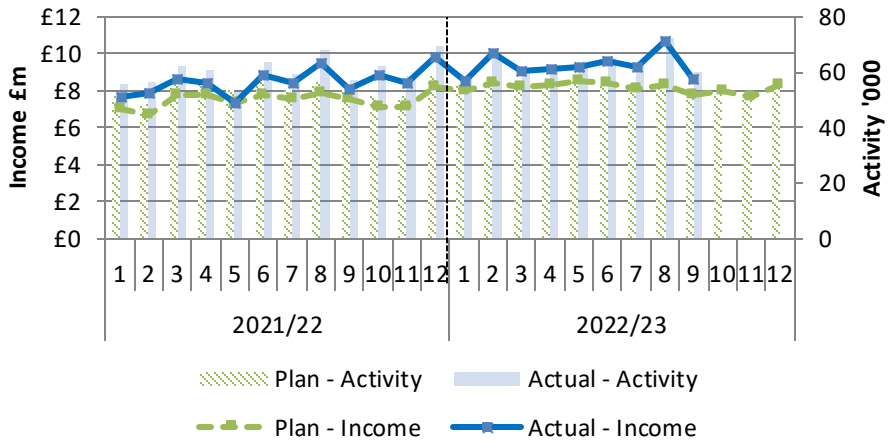
Elective spells



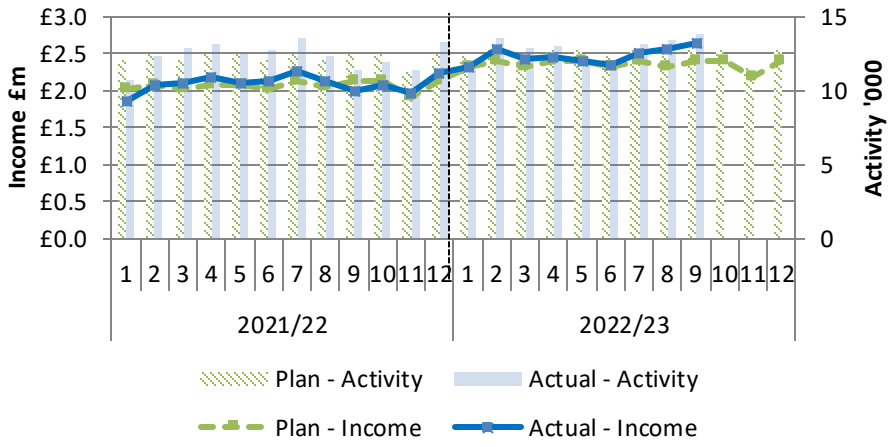
Non elective spells



Outpatients Total



A&E



University Hospital Southampton NHS
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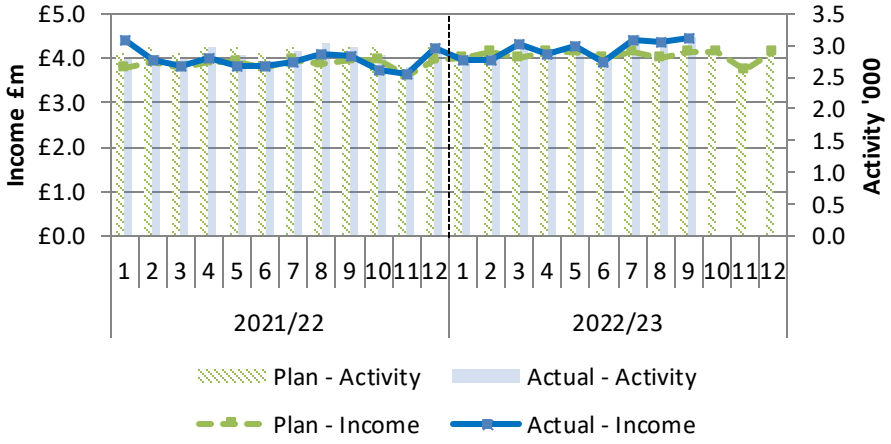
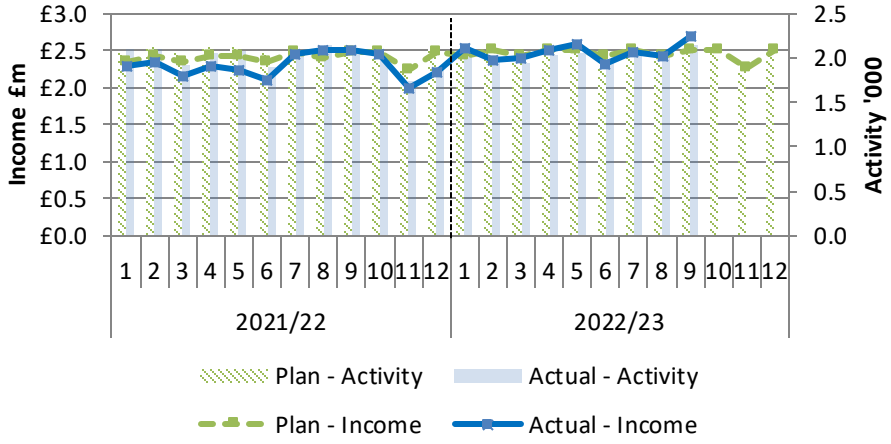
Clinical Income

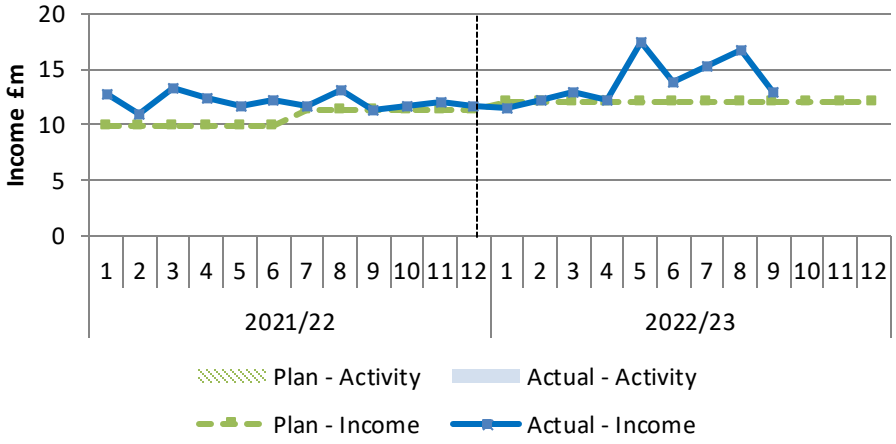
Adult critical care



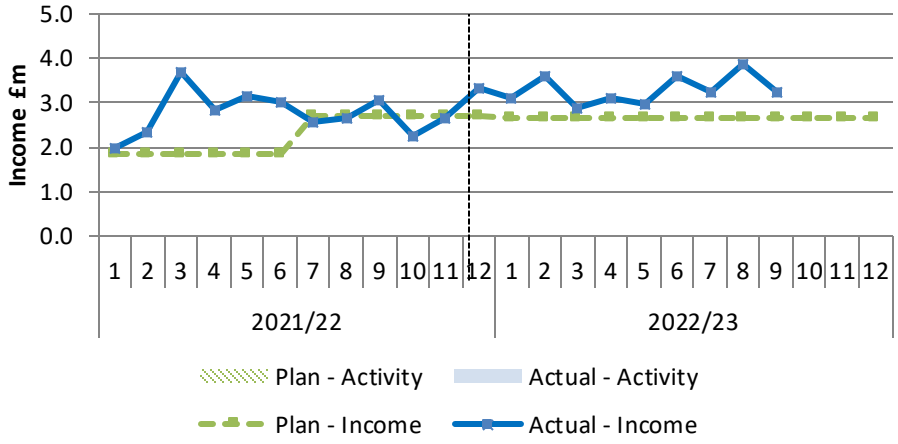
Neonatal & paediatric critical care



Tariff excluded drugs



Tariff excluded devices



Finance Report Month 9

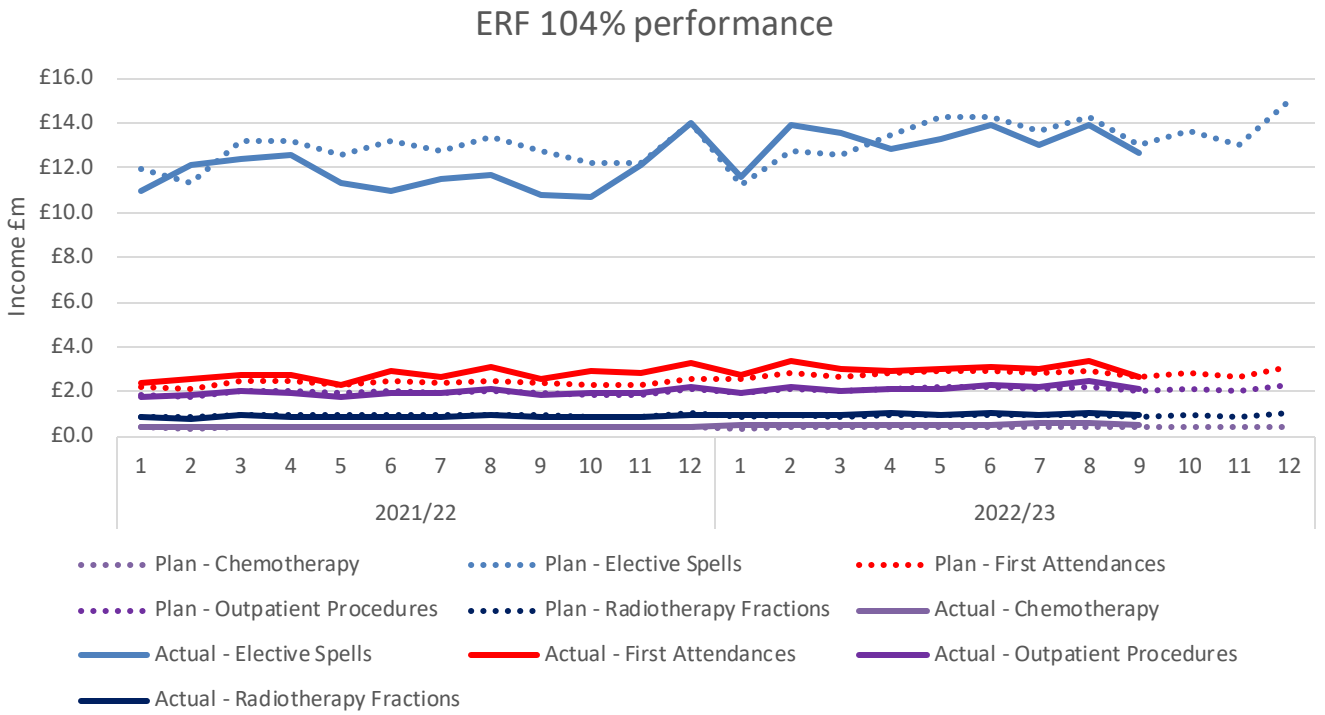
Elective Recovery Fund 22/23

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

In 22/23 the Trust has a plan to achieve 106% of 19/20 activity for elective inpatients, outpatient first attendances and outpatient procedures, above the 104% national target. This stretch was applied as part of the plan resubmission.

The table highlights overall performance against the 19/20 pre-Covid baseline, highlighting M9 performance of 105% and 106% YTD. Indicatively this has generated £5.3m in ERF income YTD.

Most of this relates to Specialised Commissioning activity and discussions with them have generated a favourable outcome with regards to funding in year costs on a fixed arrangement. Income will continue to be monitored in shadow form in year however.



Elective Recovery Framework Performance	M1	M2	M3	M4	M5	M6	M7	M8	M9	YTD
Elective performance	99%	107%	110%	99%	98%	103%	101%	103%	103%	103%
Outpatient first and procedures performance	109%	117%	112%	108%	104%	109%	111%	120%	107%	111%
Chemotherapy performance	146%	127%	142%	127%	128%	133%	142%	140%	135%	135%
Radiotherapy performance	119%	112%	114%	116%	104%	113%	112%	117%	113%	113%
Overall ERF performance	**104%**	**111%**	**112%**	**103%**	**101%**	**106%**	**104%**	**109%**	**105%**	**106%**
Anticipated ERF payment (incl. A&G)	**£826**	**£1,673**	**£1,502**	**£125**	**-£409**	**£337**	**£172**	**£812**	**£271**	**£5,310**
Outpatient follow up performance	130%	137%	130%	125%	120%	125%	126%	138%	124%	129%

Finance Report Month 9

Cost Pressures 2022/23

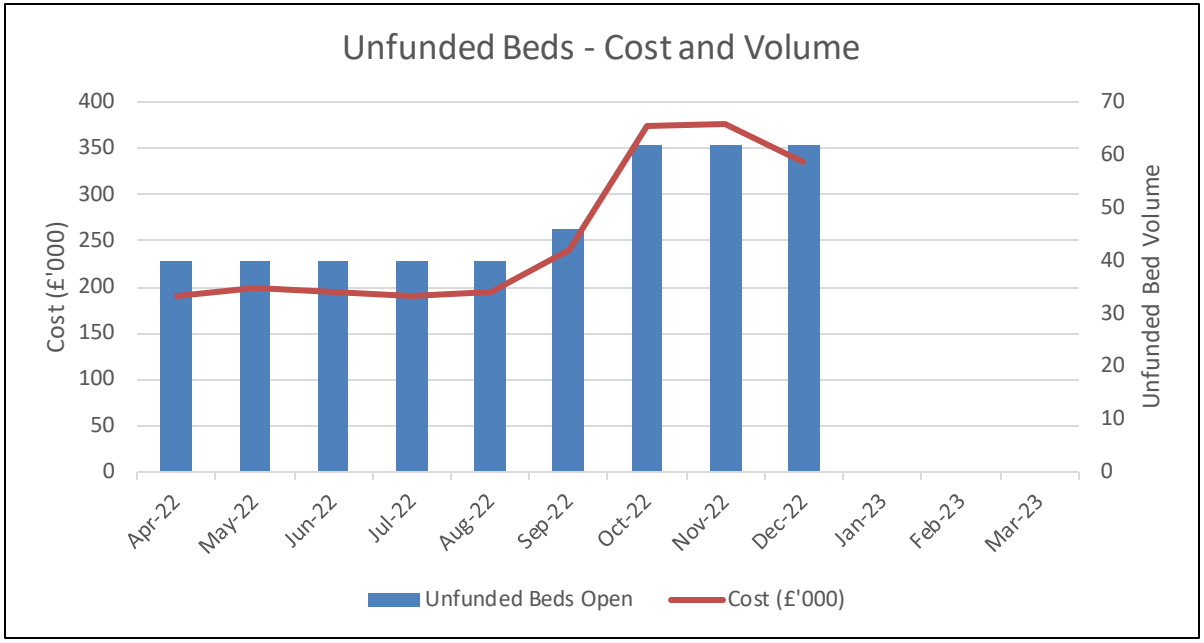
The top tables show the performance for block funded and pass-through drugs in 22/23. The majority of NHS England Specialised Commissioned drugs and devices are being funded on a cost and volume (C&V) basis but all those which are ICB commissioned are subject to a fixed block payment.

At M9 the unfunded pressure for these block funded drugs and devices is £7.8m of which £5.5m is from drugs. Long term conditions form one of the key areas of cost growth particularly within gastroenterology, rheumatology and ophthalmology. These services are seeing disproportionate growth in patient numbers and significant impact from NICE technical appraisals particularly around biologics.

The graph shows the costs of 'unfunded beds' open within UHS. These are required due to increasing numbers of patients (c200) not meeting the criteria to reside. Flex bed pressures have increased over the last two months with costs increasing to £370k per month (£2m YTD).

Block	YTD Plan	YTD Actual	Unfunded performance
Drugs	£27,604,704	£33,138,200	£5,533,496
Devices	£4,402,878	£6,650,285	£2,247,407
Total	**£32,007,582**	**£39,788,485**	**£7,780,903**

C&V	YTD Plan	YTD Actual	Funded performance
Drugs	£81,458,498	£91,783,946	£10,325,448
Devices	£19,510,180	£22,978,257	£3,468,077
Total	**£100,968,678**	**£114,762,202**	**£13,793,525**

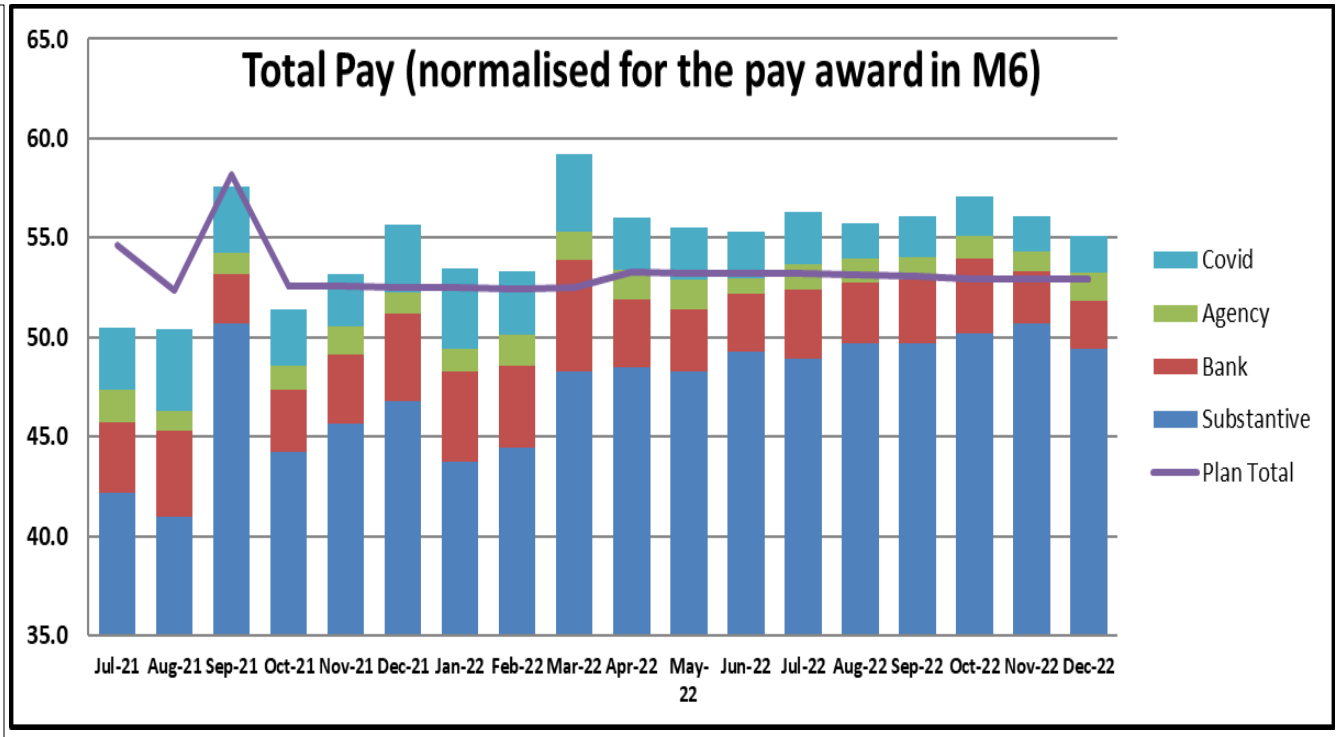


Finance Report Month 9

Substantive Pay Costs

Total pay expenditure in December was £55.1m, down from November's £56.1m. Substantive staff costs decreased by £0.9m from November to December, Bank costs were also reduced over the period by £0.2m, this was partially offset by an increase in Agency staff spend of £0.5m. Reduced elective scheduling of patients over the Christmas period has contributed to this in month position. Costs are likely to increase slightly in winter months as extra spend is required to alleviate operational pressures particularly within ED.

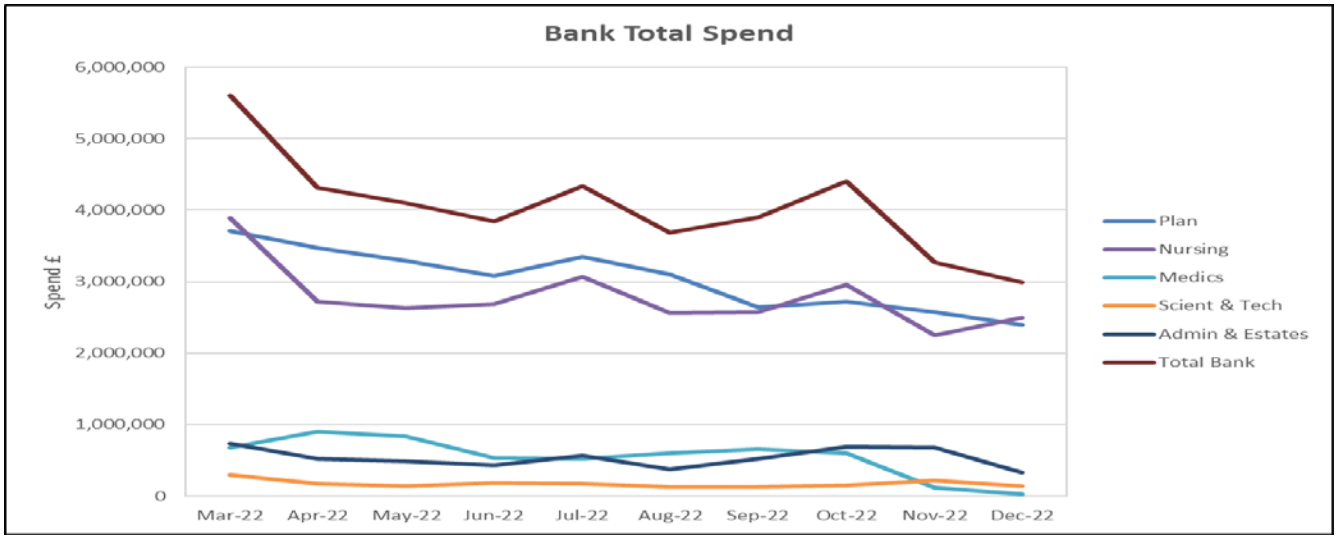
Staff costs are over plan £25m YTD for which £16m relates to pay award costs not within plan and largely funded. The residual £9m is due mainly to operational and covid related pressures meaning temporary staffing costs have remained even though substantive costs have increased.

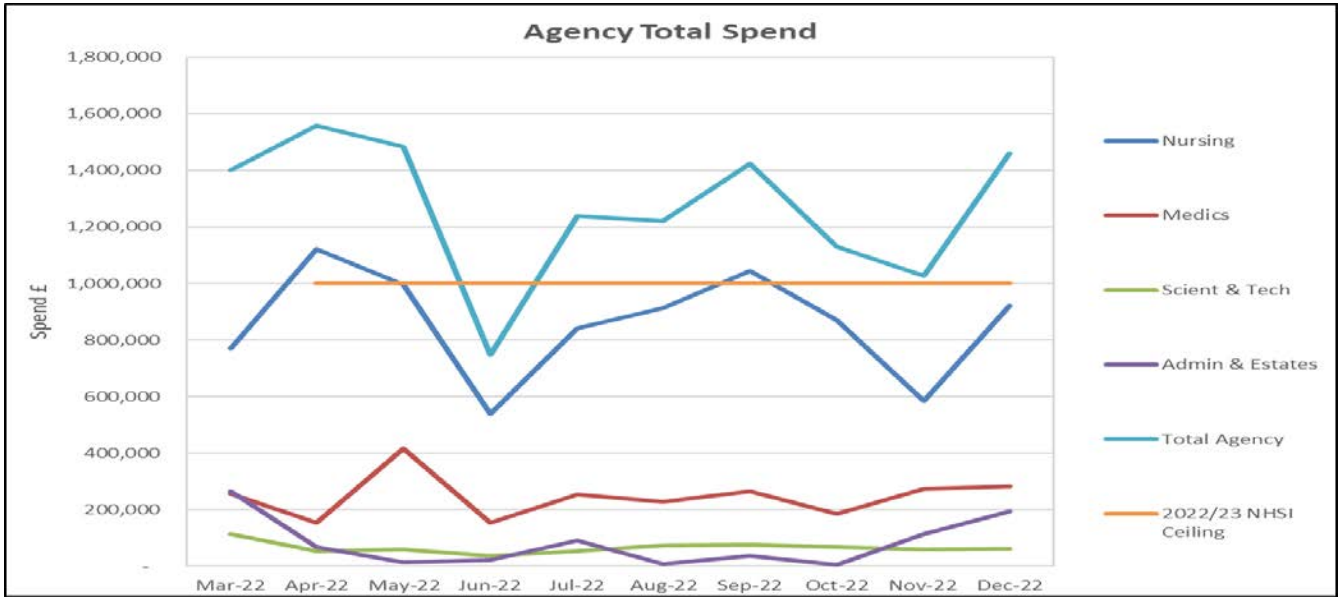


Temporary Staff Costs

Expenditure on Bank staff decreased by £0.2m from November to £3.0m in month. The majority of this decrease was in administrative and estates staffing over the festive period.

Agency spend increased by £0.5m. Increases were experienced across the majority of staff groups with nursing staffing being the largest user with increased spend of £0.3m.
Spend is above the 22/23 agency ceiling, however remains comparably lower than other similar sized trusts. Reducing agency spend remains a focus area for the Trust Savings Group (TSG).
Thornbury spend increased slightly to £70k in month however remained below the average of previous months spend to date (£120k per month).





University Hospital Southampton NHS
NHS Foundation Trust

Covid Costs 22/23

The table illustrates Covid costs incurred YTD versus 22/23 plan.

YTD costs are £20.7m which is £5.1m ahead of plan. This is due to Critical Care and ED additional capacity and costs which are reporting £6.4m of costs in excess of plan.

All areas of spend are under continuous review especially those associated with national guidance changes.
Alternatively for some areas where an ongoing need has been identified discussions with commissioners have taken place to explore recurrent funding sources. Critical care is the main example of this with NHSE supporting £1.5m in recurrent funding increase from 22/23.

ED remains a particular concern as demand remains much higher than pre-Covid levels.

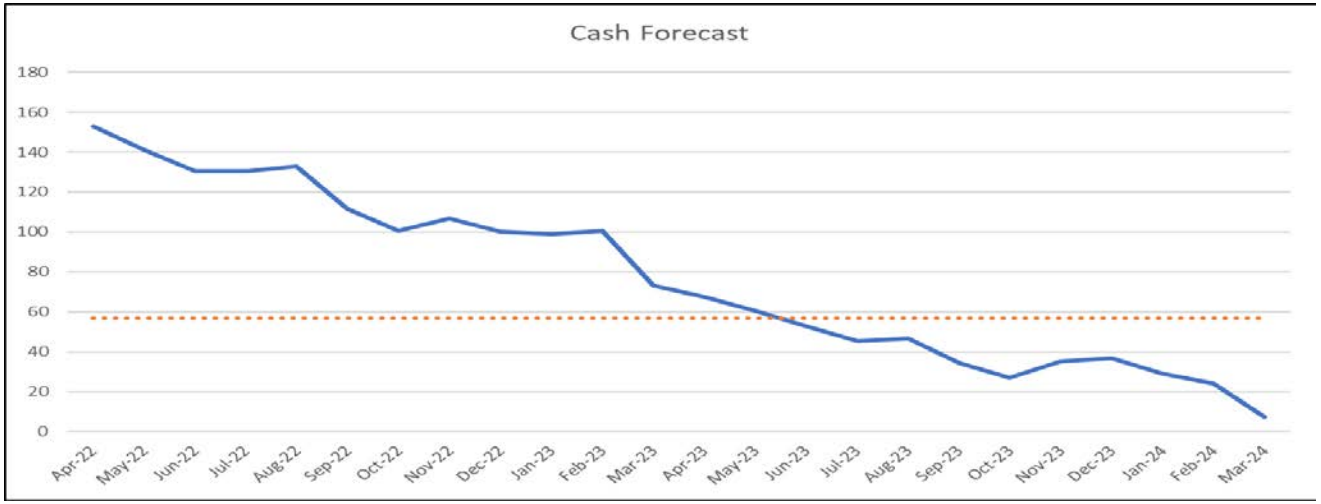
Description	2022/23 Annual Plan (£'000)	2022/23 YTD Plan (£'000)	2022/23 YTD Actual (£'000)	2022/23 YTD Variance (£'000)
Covid Related Staff Sickness / Absence	9,123	6,842	6,433	409
Critical Care Additional Capacity	4,914	3,686	6,831	(3,146)
Emergency Department Additional Costs	1,800	1,350	4,579	(3,229)
Car Parking Income - Patients / Visitors	1,320	990	990	0
Additional Cleaning / Decontamination	812	609	640	(31)
C5 uplift to L2 facility for 12 beds for Covid	480	360	360	0
Staff / High Risk Patient Covid Testing	500	375	210	165
PPE / Perso Hoods and Consumables	320	240	12	228
Staff Psychology Support	200	150	39	111
Car Parking Income - Staff	183	137	137	0
Clinical Engineering	138	104	0	104
Covid Medical Model (Div B)	115	86	86	0
PAH Theatres social distancing	108	81	0	81
Infection Control Team	107	80	18	62
Other (sub £100k plans)	694	521	358	163
TOTAL	**20,813**	**15,610**	**20,693**	**(5,083)**

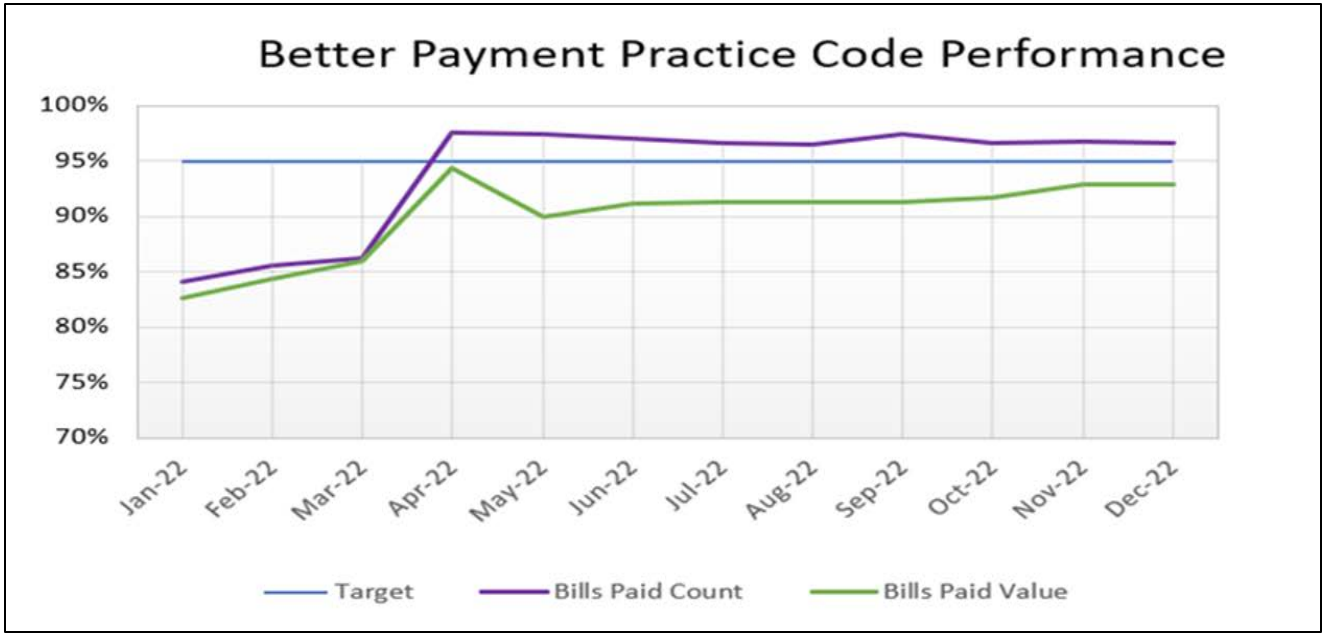
Cash

The cash balance decreased by £7.7m in December to £99.9m and is analysed in the movements on the Statement of Financial Position.

A cash forecast has been completed for the next 18 months projecting a material decline in cash driven by an underlying deficit and sizeable internally funded capital programme of £49m per annum. It is however difficult to predict beyond 22/23 as the financial regime has yet to be confirmed for future years.

BPPC in month for December is just over the 95% target at 95.75%, (November 97.46%) for count of invoices and now below target for value at 93.34% (December 95.76%). Despite the small decline in December our YTD position still shows a similar stable position with improvement needed to reach the 95% target for value.





University Hospital Southampton NHS
NHS Foundation Trust

Capital Expenditure

(Fav Variance) / Adv Variance

Expenditure on capital schemes was £41.8 for the year to Month 9. The total expenditure in the month was £7.4m; a significant increase on the average for months 1 to 8 (£4.3m). The main areas of expenditure were on the wards above oncology scheme (£3.9m) and medical equipment (£1.1m).

The trust is forecasting to spend £89.8m by the end of the year, following further successful bids for external capital funding. To achieve this, expenditure on the wards above oncology, the fit out of C level of the vertical extension, strategic maintenance and IT is forecast to be very high in the fourth quarter of the financial year. A total of £48.1m is forecast to be spent in January to March.

	Month			Year to Date			Full Year Forecast		
	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var
Scheme	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Internally Funded Schemes									
Strategic Maintenance (excl. Neuro Ventilation)	842	325	517	4,728	2,473	2,255	7,185	7,300	(115)
Refurbish of neuro theatres 2 & 3 (incl. Ventilation)	0	381	(381)	730	3,332	(2,602)	1,800	3,412	(1,612)
Decorative Improvments/Small Projects/Fire/DDA	95	0	95	454	107	347	950	348	602
General Refurbishment Fund	124	60	64	149	160	(11)	1,097	2,000	(903)
Theatres 10 & 11/F level Fit Out	965	476	489	2,105	1,344	761	5,000	5,000	0
Oncology Centre Ward Expansion Levels D&E	1,439	0	1,439	2,325	0	2,325	8,000	10,219	(2,219)
Fit out of C Level VE (MRI) Capacity	0	100	(100)	6,592	391	6,201	6,592	5,145	1,447
Donated Estates Schemes	549	488	61	3,535	965	2,570	5,327	4,704	623
Other Estares Schemes	53	16	37	1,731	2,024	(293)	1,731	1,973	(242)
Information Technology Programme	400	852	(452)	3,600	3,072	528	5,000	5,000	0
Pathology Digitisation	42	36	6	309	276	33	448	448	0
IMRI	0	0	0	1,300	323	977	1,300	400	900
Medical Equipment panel (MEP)	250	1,016	(766)	1,125	1,784	(659)	2,500	3,260	(760)
Other Equipment	161	39	122	1,004	387	617	1,550	2,561	(1,011)
Other	0	15	(15)	691	984	(293)	691	1,673	(982)
Slippage	0	0	0	(3,000)	0	(3,000)	(4,681)	0	(4,681)
Donated Income	(676)	(524)	(152)	(4,603)	(1,241)	(3,362)	(6,760)	(5,518)	(1,242)
Total Trust Funded Capital excl Finance Leases	**4,244**	**3,281**	**963**	**22,775**	**16,382**	**6,393**	**37,730**	**47,925**	**(10,195)**
Leases									
Medical Equipment Panel (MEP) - Leases	54	60	(6)	346	309	37	700	390	310
Equipment leases	70	0	70	315	187	128	500	400	100
IISS	0	0	0	285	0	285	3,115	1,435	1,680
Fit out of C Level VE (MRI) Capacity	0	0	0	0	0	0	5,619	2,969	2,650
Total Trust Funded Capital Expenditure	**4,368**	**3,341**	**1,027**	**23,721**	**16,878**	**6,843**	**47,664**	**53,119**	**(5,455)**
Capital to Revenue Adjustment	0	0	0	0	0	0	0	(2,734)	2,734
Top Up to external Schemes	0	0	0	0	0	0	0	(2,721)	2,721
Total Including Technical Adjustments	**4,368**	**3,341**	**1,027**	**23,721**	**16,878**	**6,843**	**47,664**	**47,664**	**0**

University Hospital Southampton NHS
NHS Foundation Trust

(Fav Variance) / Adv Variance

Capital Expenditure

The £89.8m forecast includes £27.5m of additional funding awards from national funding streams. As well as being successful with large bids for wards, the neonates expansion and the community diagnostic centre, the trust expects to get confirmation of awards for imaging equipment, an endoscopy system and frontline digitisation funding.

	Month			Year to Date			Full Year Forecast		
	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var
Scheme	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Externally Funded Schemes									
Maternity Care System (Wave 3 STP)	0	0	0	89	89	0	89	89	0
Digital Outpatients (Wave 3 STP)	50	17	33	442	160	282	592	592	0
Oncology Centre Ward Expansion Levels D&E	0	3,930	(3,930)	8,117	9,912	(1,795)	0	10,000	(10,000)
Neonatal Expansion	0	15	(15)	0	144	(144)	0	198	(198)
Targeted Lung Health Checks CT Scanner	0	0	0	0	0	0	0	1,364	(1,364)
Pathology Digitisation / LIMS	0	78	(78)	0	153	(153)	0	250	(250)
Community Diagnostic Centre Phase 2	0	0	0	0	0	0	0	3,200	(3,200)
Asceptic Pharmacy Building	0	0	0	0	0	0	0	761	(761)
Minimal Data Foundation Funding	0	0	0	0	0	0	0	1,070	(1,070)
P1P2 Additional IT Funding	0	0	0	0	0	0	0	2,875	(2,875)
Cyber Security	0	0	0	0	0	0	0	118	(118)
MRI Scanner	0	0	0	0	0	0	0	2,000	(2,000)
Nasendoscopy system for Cancer ENT/Head & Neck	0	0	0	0	0	0	0	75	(75)
Endoscopy IT - New Scheduling / Referral system	0	0	0	0	0	0	0	700	(700)
CT Scanner	0	0	0	0	0	0	0	1,460	(1,460)
Transfer from schemes within CDEL	0	0	0	0	0	0	0	2,721	(2,721)
Total CDEL Expenditure	**4,418**	**7,382**	**(2,964)**	**32,369**	**27,335**	**5,034**	**48,345**	**75,137**	**(26,792)**
Outside CDEL Limit									
Adanac Park Car Park	0	0	0	3,000	14,400	(11,400)	0	14,400	(14,400)
Surgical Robot Lease Element	0	0	0	0	0	0	0	265	(265)
Total Capital Expenditure	**4,418**	**7,382**	**(2,964)**	**35,369**	**41,735**	**(6,366)**	**48,345**	**89,802**	**(41,457)**

University Hospital Southampton NHS
NHS Foundation Trust

Statement of Financial Position

(Fav Variance) / Adv Variance

The December statement of financial position illustrates net assets of £464.9m.

Although there are movements with receivables and payables, receivables itself is virtually unchanged from November and payables has only reduced by £1.2m.

The most significant movement is an increase in fixed assets of £6.0m, of which £7.4m relates to fixed asset purchased additions. This is then the main driver of the reduction in cash of £7.7m.

Statement of Financial Position	2021/22	2022/23		
	YE Actuals	M8 Act	M9 Act	MoM Movement
	£m	£m	£m	£m
Fixed Assets	471.9	479.3	485.2	6.0
Inventories	17.0	16.9	17.0	0.1
Receivables	53.1	61.5	61.6	0.1
Cash	148.1	107.6	99.9	(7.7)
Payables	(204.2)	(190.4)	(189.2)	1.2
Current Loan	(1.7)	(1.7)	(1.7)	0.0
Current PFI and Leases	(9.1)	(7.9)	(7.8)	0.1
Net Assets	**475.0**	**465.1**	**464.9**	**(0.2)**
Non Current Liabilities	(23.0)	(20.3)	(20.6)	(0.3)
Non Current Loan	(6.8)	(6.1)	(5.6)	0.5
Non Current PFI and Leases	(33.6)	(41.9)	(41.3)	0.6
Total Assets Employed	**411.6**	**396.9**	**397.4**	**0.5**
Public Dividend Capital	261.9	265.6	265.6	0.0
Retained Earnings	115.6	97.2	97.7	0.5
Revaluation Reserve	34.1	34.1	34.1	0.0
Other Reserves				
Total Taxpayers' Equity	**411.6**	**396.9**	**397.4**	**0.5**

Efficiency and Cost Improvement Programme 22/23 – M9

University Hospital Southampton NHS
NHS Foundation Trust

UHS Total - £42.2m identified, 93% of the total 22/23 requirement which = £45.4m

Divisions and Directorates - £18.2m of CIP schemes identified. This represents 91% of it's 22/23 target which = £20m

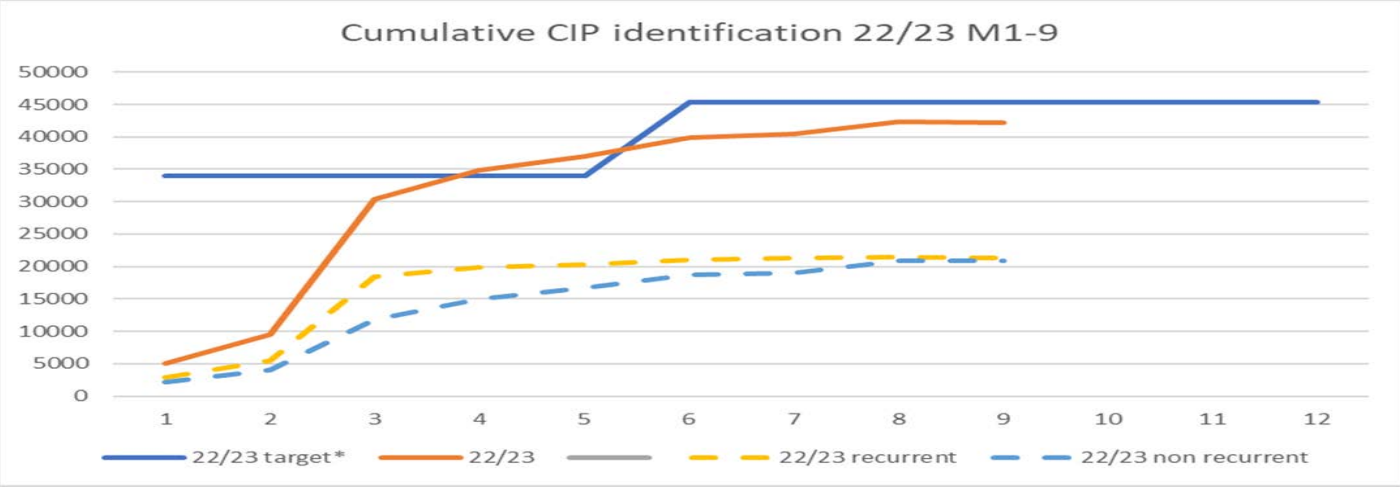
Central Schemes - £24m of CIP schemes identified. This represents 94% of the 22/23 target which = £25.4m

Of the identified UHS total, £8.3m is Pay, £25.6m is Non-Pay, and £8.3m is Income

Divisional identification varies from 76% to 95%, a detailed breakdown by Care Group can also be found in Appendix 1

Month 9 CIP Identification	Non Recurrent ('000s)	Recurrent ('000s)	Total ('000s)	Target ('000s)	% Identified
Division A	£2,679	£1,387	£4,066	£4,260	95%
Division B	£2,265	£2,456	£4,722	£5,535	85%
Division C	£2,432	£657	£3,089	£3,938	76%
Division D	£1,275	£1,989	£3,264	£3,573	91%
THQ	£849	£1,692	£2,541	£2,695	94%
Unallocated Procurement Schemes	£0	£574	£574		
Central Schemes	£11,422	£12,542	£23,964	£25,400	94%
Grand Total	**£20,922**	**£21,297**	**£42,220**	**£45,400**	**93%**

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



**based on 75% identification by the end of Q1 and 100% identification by the end of Q2*

Efficiency and Cost Improvement Programme 22/23 – M9

University Hospital Southampton NHS
NHS Foundation Trust

M9 Trust YTD delivery is £29.5m, an increase from the £27m achieved at M8.

Our £29.5m delivery YTD exceeds our planned YTD activity of £29.1m.

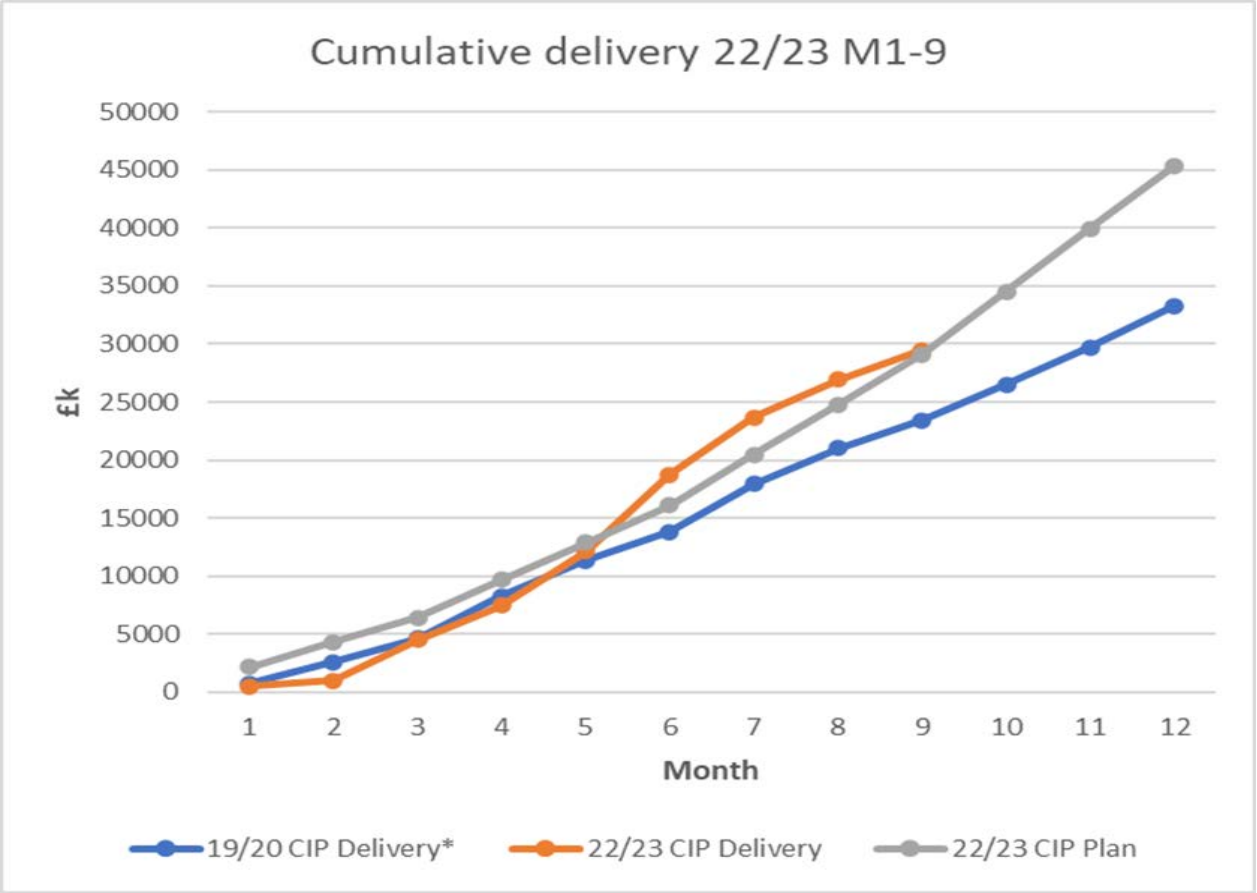
Of the £29.5m delivered YTD:

- £13.2m has been transacted by Divisions and Directorates

- £16.3m has been transacted through Central Schemes.

Of the trust YTD achievement, £17m is non-recurrent.

This includes £9.1m of non-recurrent Central Schemes.



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

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Monthly People Report 2022-23 for Month 9**			
Agenda item:	**5.8**			
Sponsor:	**Steve Harris, Chief People Officer**			
Author:	**Workforce Team**			
Date:	**31 January 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 key metrics in the strategy. It is provided monthly to Trust Executive Committee. The report is based on December 2022 data.			
Response to the issue:	December was an extremely challenging month for UHS including emergency demand pushing the Trust into a critical incident. Sickness was high during December reflecting the general health of the population (COVID, FLU, Strep A). It continues to be a very difficult time for our people, now compounded by periods of industrial action. The Chief People Officer can report the following to the Board: **THRIVE (Our workforce supply)** For the first time in a number of months, our overall WTE (Perm and Temp) fell slightly during December by -144 WTE since November. The total and substantive workforce is still above plan by +595 WTE at Month 9. Specifically • **Substantive staff fell slightly by -16 WTE to 12,034 WTE.** This is underpinned by less starters during the Christmas period which is a normal trend for this time of year • **Turnover** was broadly the same as last month at 14.3% 12-month rolling average.			

- Despite consistent operational pressures, temp staffing usage fell slightly during the period. Less availability of temp staff working due to Christmas, coupled with robust controls on leave during the holiday period accounted for this change.
- **The staffing hub continues to work closely with the temporary resourcing team** to manage our contingent workforce utilisation and expenditure, particularly focusing on reducing very high-cost agency where able to substitute bank.
- During the critical incident a variety **of HQ staff provided direct support to operational areas** such as ED. UHS continues to **build an internal reservist pool** under the leadership of the Chief Nurses team with support from Transformation and HR.

In December People and OD undertook a review of growth WF growth over the first 6 months of the year. Key messages from this month 8 (Oct) review were as follows:

- Overall total workforce: **the total workforce had grown by +473 WTE** YTD**.** This **is +738 over plan** at Month 8.
- Underpinning this **substantive workforce had grown by +480 WTE YTD**. This is as a result of successful recruitment to vacancies (existing gaps and funded capacity growth) and the TUPE transfer of Salisbury Genomics.
- **However temporary staffing had not fallen in line with plan**. Overall temporary staffing usage has remained broadly static.
- Our temporary workforce demands have been driven by:
  - **COVID** impact beyond planned activity.
  - **Higher levels of absence** (4.8% rolling 12 month) than anticipated and still above pre-covid levels
  - **Significant unfunded capacity demands** from staffing surge areas and from the 200 MOFD patients we are unable to discharge.
  - Consistent **higher emergency demand** during the year.
  - Other operational pressures to deliver reductions in our **weight times for elective patients.**

EXCEL (Career growth, reward, well-being)

- In the month recorded **appraisal completion has decreased in December due to operational pressures and staff availability during Christmas.** The overall rate is at 74.5% (rolling 12 months).

- Overall **availability to participate in training, education, development and other culture / OD and transformation activities** continue to be affected by the overwhelming operational patient demands.

	• **Inflation is** still a key issue for our people. The Trust continues to promote its popular **cost-of-living packages**. PAH will also be continuing its 60% discount offering with extended operating hours. More food options are being made available at RSH through work with NHS Property Services. **BELONG (Equality, Diversity, Inclusion)** • **The 2022 National Staff Survey closed in late 2022.** First look staff survey results have been received but these remain under embargo from publication until March. At this point full national comparison becomes available. • The new **Inclusion and Belonging strategy** was approved by TEC, EDI committee, People Board and Supported by People and OD committee. This is due to be presented to Trust Board in January 2023. • Recruitment continues for the **positive action leadership programme** which is due to start in April. • The **Trust Actionable Allyship programme** continues to be popular for those who attend. The speed of rollout is linked to people's ability to be released.
Implications: (Clinical, Organisational, Governance, Legal?)	Implications are for good governance, meeting legal requirements, and the provision of safe clinical and organisational delivery (as this report provides intelligence on current and future workforce challenges).
Risks: (Top 3) of carrying out the change / or not:	There is a risk that we fail to meet our strategic objectives as set out in the business assurance framework for UHS. Specifically: a) We fail to increase 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

January
2023

THRIVE
EXCEL
BELONG

View from Chief People Officer

"

It has been an extremely challenging month during December for our People. We have seen significant demands on our service driven by community illness (COVID, Flu, Strep A) which tipped the Trust into a critical incident on 20 December. The health of the community was reflected in the health of our people, with sickness absence rising during the month.

The operational pressures resulted in lower levels of appraisals completed during the month, in addition to staff being deployed differently to support the critical incident. Our overall substantive staffing fell slightly during December (by -144 WTE) compared with November due to lower levels of new starters over the Christmas period and reduced bank staff availability. Our turnover remained stable with continued small gains being made in retention of HCAs. Our controls on leave during the holiday period resulted in lower demands for bank staffing which saw a seasonable reduction in demand in this group. 122 fewer WTEs were used in temporary staffing during December compared with November.

"

Steve Harris
Chief People Officer

Purpose and Executive Summary

Purpose: The purpose of this report is to provide a monthly retrospective update on UHS workforce, linked with the UHS People Strategy, and to highlight any current or future areas of risk or concern.

Executive Summary:

The report highlights the following:

(1) **Covid absence (p.5)** increased in December with an average of 79 headcount off sick with Covid compared with 49 in November

(2) **Workforce Plan (p.9):** The December (M9) position shows that substantive, bank and agency workforce remains above plan. There was a decrease in temporary resourcing due to decreased availability of staff during December

(3) **HCA supply (p.14):** The vacancy rate is 21% in December, an increase from 20% in November; this is due to a decrease in staff in post by -12 WTE and budget increase of +3 WTE

(4) **Turnover (p.19):** There were fewer leavers (87) in December compared to November (97) with a reduction of leavers in all staffing groups compared to the previous month. The rolling 12 month average is 14.3%.

(5) **Sickness (p.20):** Rates are at 4.7% (rolling 12 month), considerably higher than our trust target of <3.4%. December high sickness is due to a increased prevalence of flu and respiratory conditions

Workforce Summary

HCA Supply
Currently at 21% vacancy. HCA SIP decreased slightly in December

Turnover
Fewer leavers in December (87) compared with November (97)

Sickness
Sickness remains at 4.7% (r12M); a significant increase in flu in December

Covid-19
Over 6500 boosters have been delivered; avg. daily absences due to Covid increased by 30 to 78 in Dec 23

THRIVE
In December we had a substantive SIP growth of +464 WTE
(Compared with Dec-21 baseline)

EXCEL
366 appraisals were completed in December, an improvement on last year (343)

BELONG
Proportion of our staff of BAME backgrounds at B7+ has increased in Dec

Levels of attainment
Job plan sign off has reduced to 14%
Medic eJP is LoA 1; close to 2

Patient Safety
117 incident reports cited staffing in December 2022. A significant increase from November (64), reflecting the increased staffing and capacity challenges experienced in December

Other contextual updates
An update on 2023/24 operational planning will be taken to the January People Board

NHS England and Improvement Operational Planning Update
Planning guidance and templates for 2023/24 have been published; work is ongoing to produce the plan

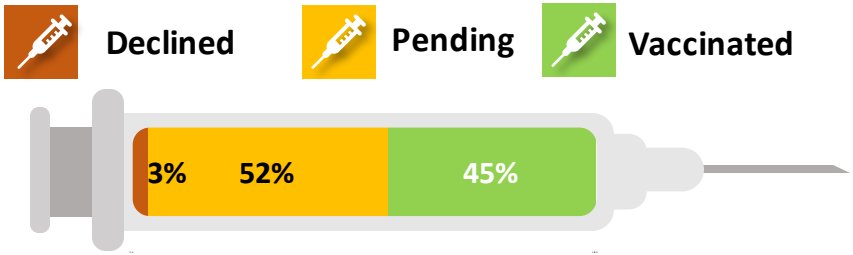
People Report - Covid

COVID UPDATE

Covid-related absences
The average staffing absence in the month of December for Covid reasons was **78** (0.5%) headcount; this is an increase from November where the average was **49** (0.3%).

Covid vaccine boosters
UHS has delivered over 6500 boosters to its staff since September 2022

Total Substantive Staff Booster uptake



Source: HealthRoster - Unavailability
Source: APEX & ESR - Booster programme

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.

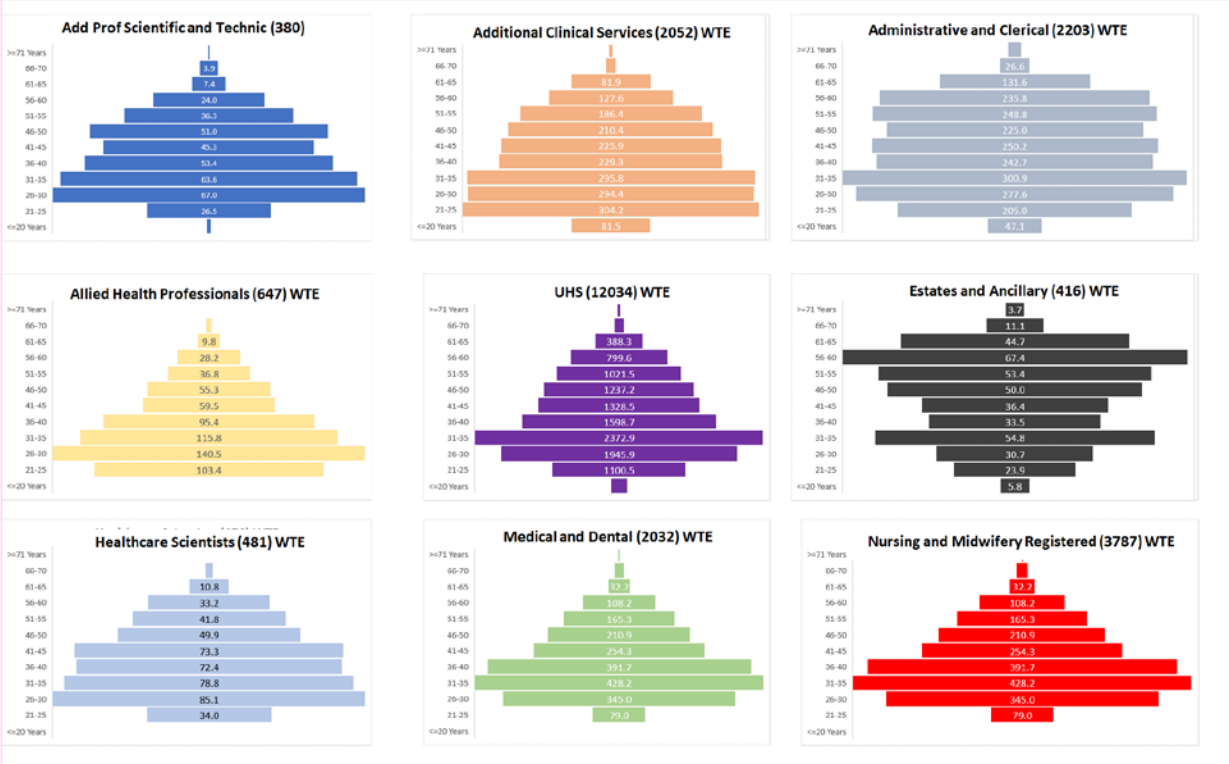
Relevant information:

Staff in Post | Workforce Plan 2022/23 | Temporary resourcing | Turnover | Sickness absence | New investments | HCA Supply

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

STAFF IN POST (n = 12,034 WTE) – 31 Dec 2022



Source: ESR substantive staff as of 31 Dec 2022; includes consultant APAs and junior doctors' extra rostered hours

THRIVE | EXCEL | BELONG | PATIENT SAFETY

Staff in Post Commentary

Month 8 to 9 (November to December) 2022/23 saw a marginal decrease in substantive employed staff, as well as reduced bank and agency usage.

The substantive staffing complement was because fewer starters joined in December, as well as the totals including those who were already substantively employed and adjusting their hours. For example, the medical and dental shows an increase YTD of +69 WTE, and this is because we recruited more medics over the year, but also substantive staff are working more rostered hours and doing more PAs.

Reduced bank usage was due to bank staff availability which was limited throughout December. Agency usage also marginally dropped in December.

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

Monthly Staff in Post (WTE) for 2022/23

	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	392	395	377	372	369	380	384	385	380				-12	
Additional Clinical Services	2009	2029	2055	2047	2053	2042	2052	2066	2052				42	
Administrative and Clerical	2119	2149	2164	2156	2152	2175	2182	2194	2203				84	
Allied Health Professionals	622	624	624	617	622	643	640	649	647				25	
Estates and Ancillary	394	391	394	399	401	406	416	416	416				22	
Healthcare Scientists	392	397	400	403	408	420	481	478	481				89	
Medical and Dental	1963	1969	1966	1961	2030	2052	2046	2043	2032				69	
Nursing and Midwifery Registered	3649	3682	3676	3667	3693	3762	3769	3781	3787				139	
Students	30	29	29	29	29	29	35	37	37				7	
Grand Total	**11570**	**11664**	**11684**	**11651**	**11757**	**11907**	**12006**	**12050**	**12034**				464	

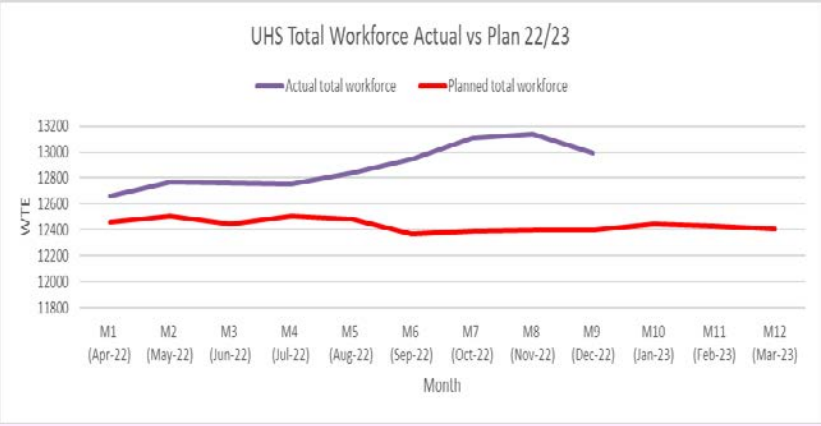
Source: ESR substantive staff as of 31 Dec 2022; includes consultant APAs and junior doctors' extra rostered hours, excludes hosted services. Numbers relate to WTE, not headcount

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

Total Workforce – performance to date (substantive, bank and agency)

	M1 Apr-22)	M2 (May-22)	M3 (Jun-22)	M4 (Jul-22)	M5 (Aug-22)	M6 (Sep-22)	M7 (Oct-22)	M8 (Nov-22)	M9 (Dec-22)	M10 (Jan-23)	M11 (Feb-23)	M12 (Mar-23)
Actual WTE	12664	12770	12764	12757	12819	12944	13105	13137	12993			
Planned WTE	12458	12506	12445	12510	12485	12371	12391	12399	12398	12446	12427	12409
Deviation from Plan	+206	+264	+319	+247	+356	+573	+714	+738	+595			



Inclusions:

Month-end contracted staff in post (ESR)
Consultant APAs
Junior doctors Extra Rostered Hrs
Bank and Agency usage including Overtime, Excess Hours and WLI

Exclusions:

Honorary contracts; career breaks; secondments; hosted services; WPL; Chilworth; Vaccination Hub

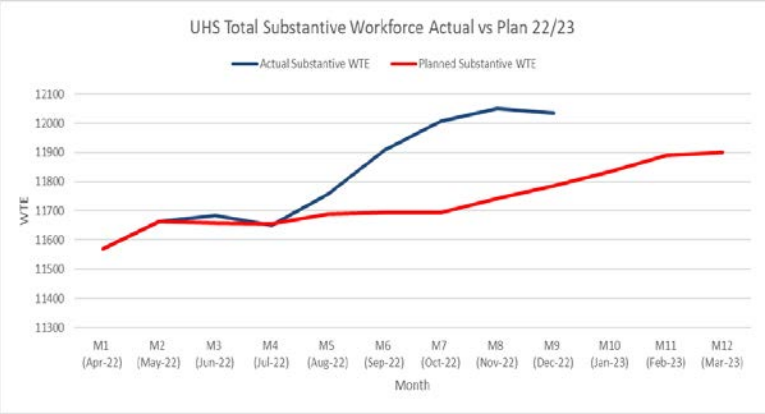
Source: ESR substantive staff as of 31 December 2022; ESR (Overtime & Excess Hours, WLI); NHS Professionals (bank and non-medical agency); 247 Time; HealthRoster MedicOnline (medical bank)

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

Total substantive Workforce – performance to date

	M1 (Apr-22)	M2 (May-22)	M3 (Jun-22)	M4 (Jul-22)	M5 (Aug-22)	M6 (Sep-22)	M7 (Oct-22)	M8 (Nov-22)	M9 (Dec-22)	M10 (Jan-23)	M11 (Feb-23)	M12 (Mar-23)
Actual WTE	11570	11664	11684	11651	11757	11907	12006	12050	12034			
Planned WTE	11570	11664	11659	11657	11688	11693	11695	11741	11785	11834	11890	11900
Deviation from Plan	+0	+0	+25	-5	+69	+214	+311	+309	+249			



Inclusions:

Month-end contracted staff in post (ESR)
Consultant APAs
Junior doctors Extra Rostered Hrs

Exclusions:

Bank and agency; honorary contracts; career breaks; secondments; hosted services; WPL; Chilworth; Vaccination Hub

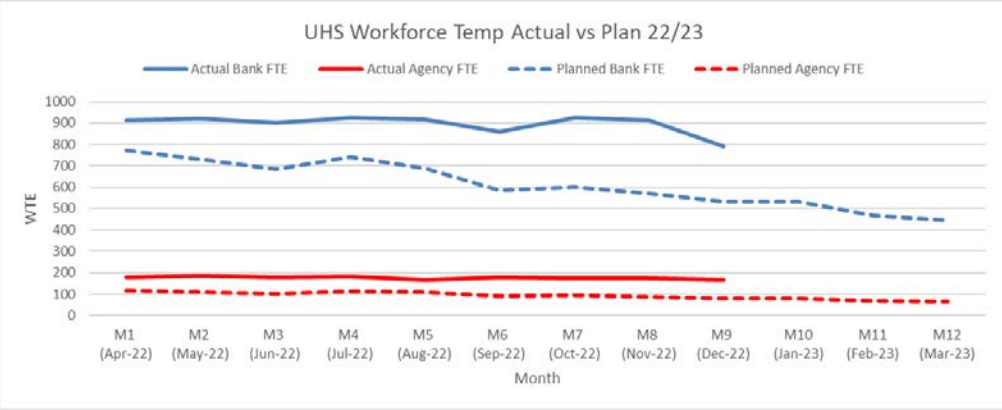
Source: ESR substantive staff as of 31 December 2022; consultant APAs and junior doctors' extra rostered hours

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

Temporary Staffing – performance to date (bank and agency)

	M1 (Apr-22)	M2 (May-22)	M3 (Jun-22)	M4 (Jul-22)	M5 (Aug-22)	M6 (Sep-22)	M7 (Oct-22)	M8 Nov-22)	M9 Dec-22)	M10 Jan-23)	M11 Feb-23)	M12 Mar-23)
Actual Bank WTE	914	920	902	924	917	859	924	913	791			
Planned Bank WTE	770	731	684	741	688	587	602	570	532	532	467	444
Deviation from Plan	+144	+189	+219	+184	+229	+273	+322	+343	+259			
Actual Agency WTE	179	187	178	182	167	177	174	174	168			
Planned Agency WTE	118	111	103	112	109	91	93	88	81	80	69	65
Deviation from Plan	+61	+76	+75	+70	+58	+86	+81	+86	+87			



Inclusions:

Bank and Agency usage including Overtime, Excess Hours and Waiting List Initiative (WLI)

Source: ESR (Overtime & Excess Hours, WLI); NHS Professionals (bank and non-medical agency); 247 Time; HealthRoster_MedicOnline (medical bank) as of 31 December 2022

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

Developments for 2023/24 and beyond

No	Investment	Approved by Finance & Investment Committee?	Approved by Trust Board or TEC?	Workforce Implication	Other Comments
1	Chimeric Antigen Receptor T-cell (CAR-T) Cellular Therapy service for blood cancer patients	Yes	Yes	+95.28 WTE over three years	All posts are new posts; there is no plan to transfer staff from other departments
2	UHS Adanac Aseptic Hub	Yes	Yes	+32 WTE over three years	
3	Cath Lab 6	Yes	Yes	+14.94 WTE	
4	All other business cases	Yes	Yes	+ 9.5 WTE	

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TRUST-WIDE VACANCIES (December 2022)

Staffing group	Vacancy %	
Add Prof Scientific and Technic	21.0%	↑
Additional Clinical Services	16.0%	↑
Administrative and Clerical	5.2%	↓
Allied Health Professionals	11.2%	↓
Estates and Ancillary	17.3%	↓
Healthcare Scientists	8.2%	↑
Medical and Dental	1.7%	↑
Nursing and Midwifery Registered	8.7%	↑
UHS total	**9.2%**	↑

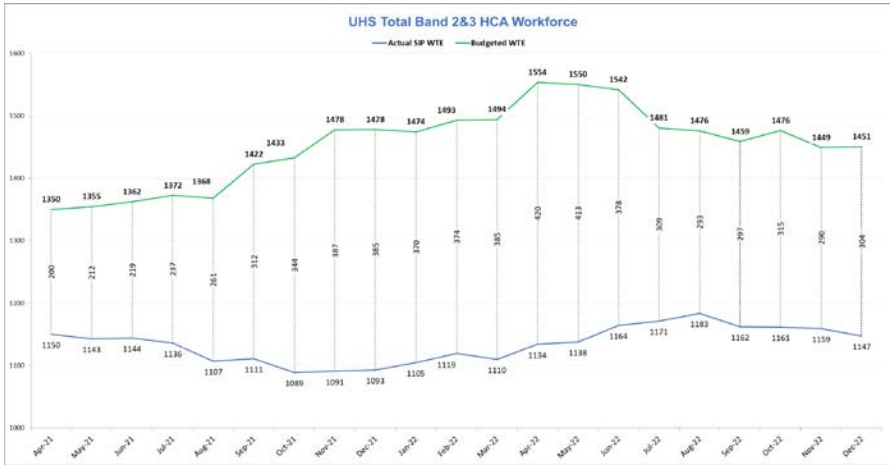
Source: ESR Staff in Post & Finance Budget Dec 2022 – Excludes APAs & extra rostered hours, includes hosted services

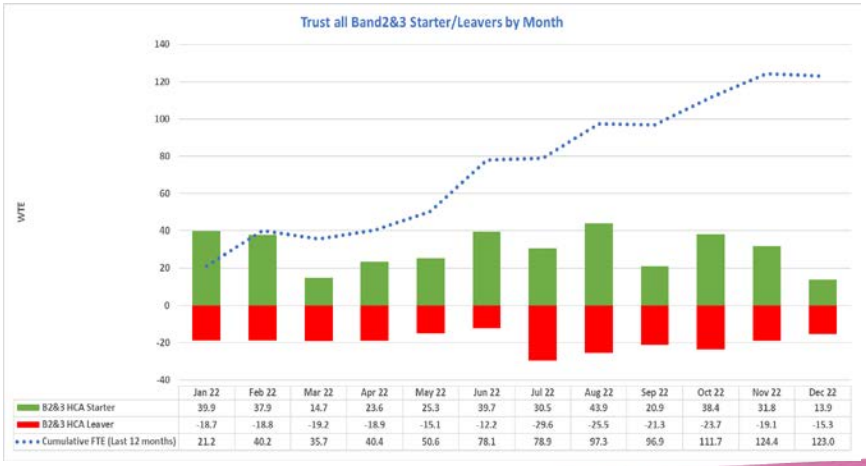
People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

HCA SUPPLY

- UHS continue to be involved in the national NHS England & Improvement HCA recruitment and retention programme. There are a number of successful initiatives, including extended two-week inductions, a HCA hub, Welcome Wards, and a HCA Project Lead; approval to continue the initiatives beyond 2023/24 is being sought
- Vacancies have decreased significantly from the peak in April 2022 (420 WTE; 27%) to December 2022 (304 WTE; 20.9%)
- The budget, linked to safe staffing and additional capacity and service delivery, has decreased in 12 months from 1478 WTE to 1451 WTE
- The last 12 months have seen a net increase of +54 WTE HCAs
- During the last 12 months 237 WTE HCAs left UHS, of which 45% left with less than one year service at UHS and 26% had less than six months' service
- Additional the HCAs workforce reduced by 136 WTE due to reduced contract hours, moving to non-HCA posts or taking nursing degree or Training Nursing Associate courses). These staff were retained in the UHS workforce



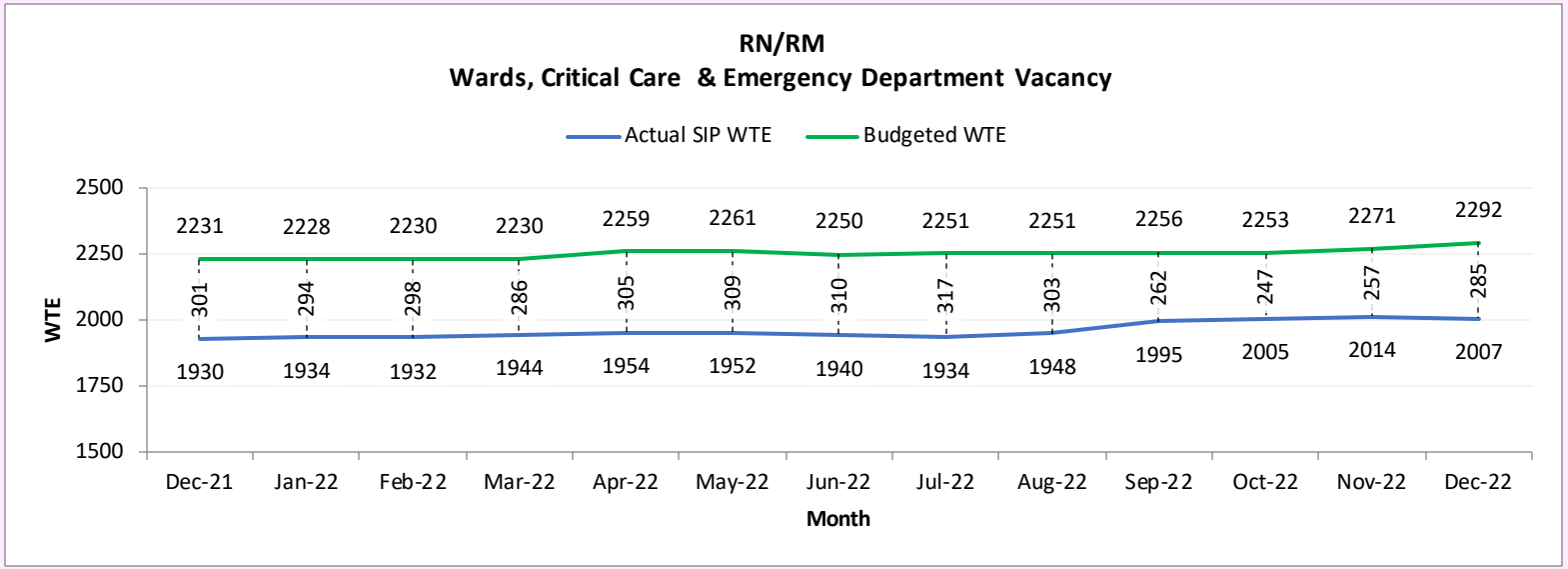


Source: ESR Staff in Post & Finance Budget Dec 2022

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

REGISTERED NURSING (WARD-BASED) VACANCIES (Dec-22)

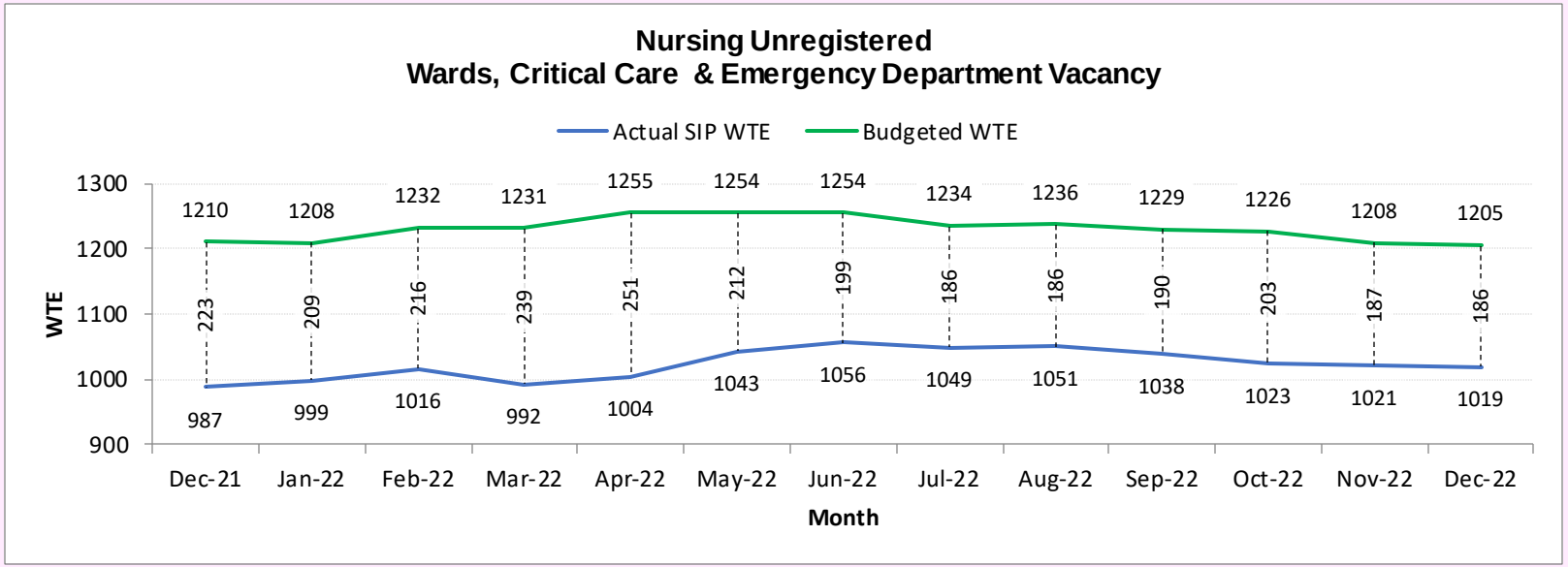


Source: ESR Staff in Post & Finance Budget Dec 2022

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

UNREGISTERED NURSING (WARD-BASED) VACANCIES (Dec-22)

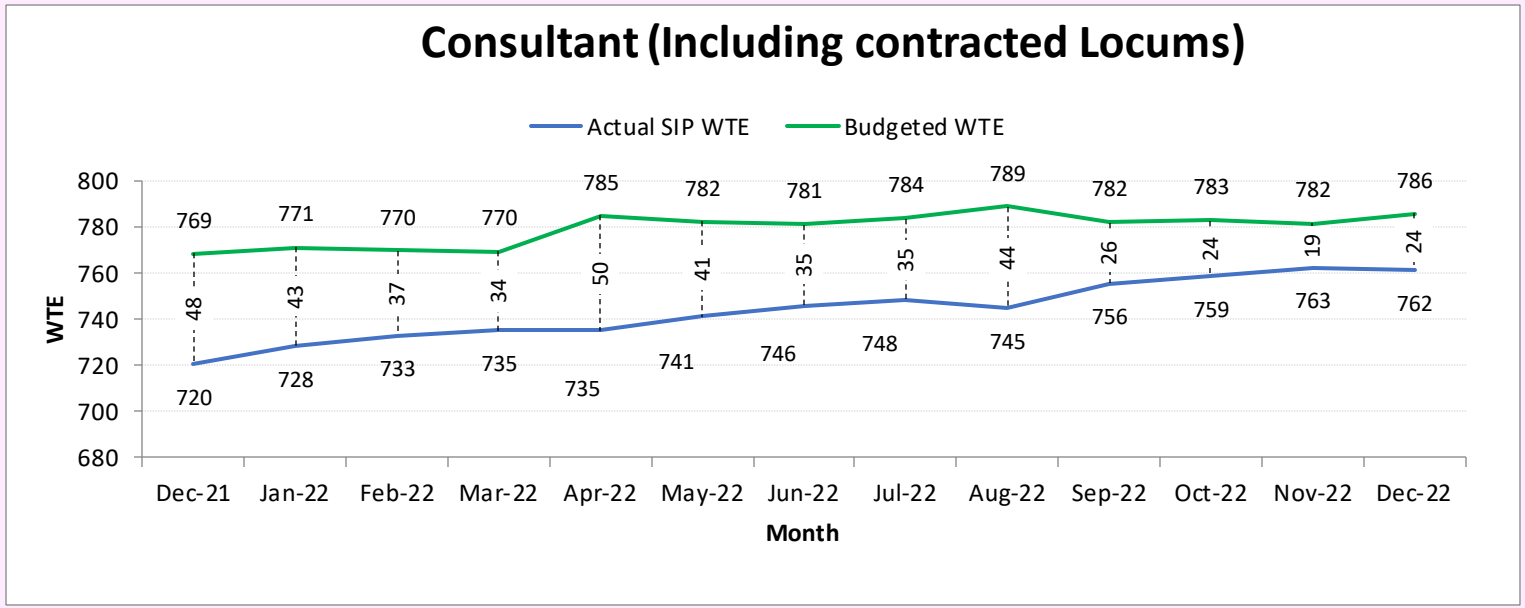


Source: ESR Staff in Post & Finance Budget Dec 2022

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

CONSULTANT VACANCIES (Dec-22)



Source: ESR Staff in Post & Finance Budget Dec 2022

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

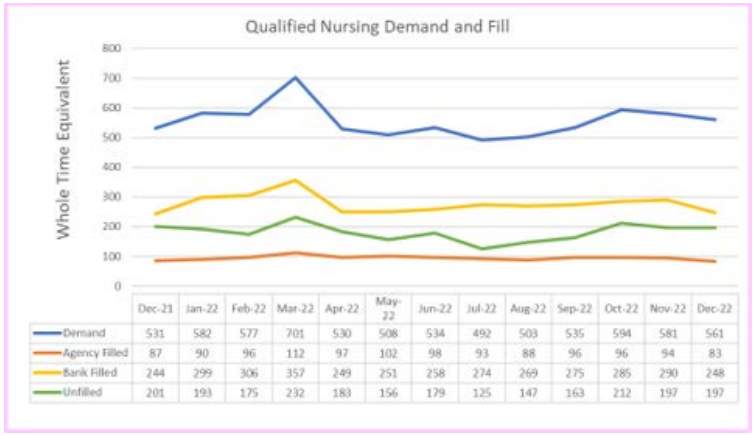
TEMPORARY RESOURCING

Status

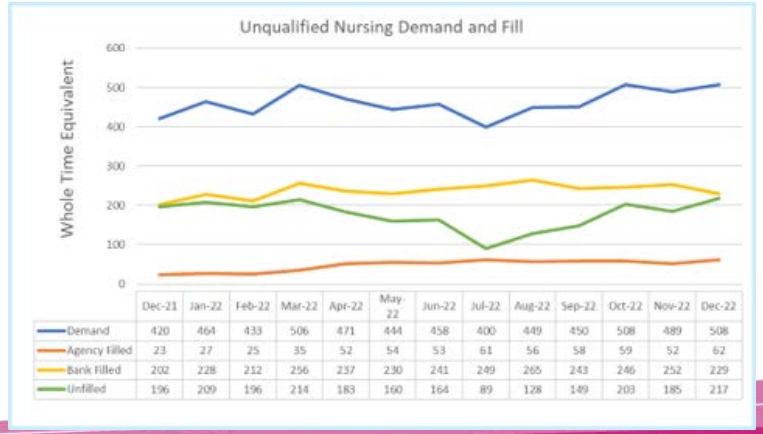
- Qualified nursing demand/fill (WTE): Demand decreased from 581 WTE in November to 561 WTE in December, of which, bank filled 248 (42 down on last month), agency filled 83 and 197 remained unfilled
- Bank fill for qualified nursing decreased from 49.93% in November to 44.16% in December.
- Demand for December 2022 is 30 WTE higher than December 2021
- HCA demand/fill (WTE): Demand increased to 508 WTE in December, of which, bank filled 229, agency filled 62 and 217 remained unfilled
- Bank fill decreased from 51.62% in November to 45.12% In December
- Demand for HCAs 88 WTE higher than in December 2021

Actions

- NHSP continue to migrate agency HCAs
- Incentive proposal being considered for January and February
- Further work to be actioned on mental health requirements



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



	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Demand	420	464	433	506	471	444	458	400	449	450	508	489	508
Agency Filled	23	27	25	35	52	54	53	61	56	58	59	52	62
Bank Filled	202	228	212	256	237	230	241	249	265	243	246	252	229
Unfilled	196	209	196	214	183	160	164	89	128	149	203	185	217

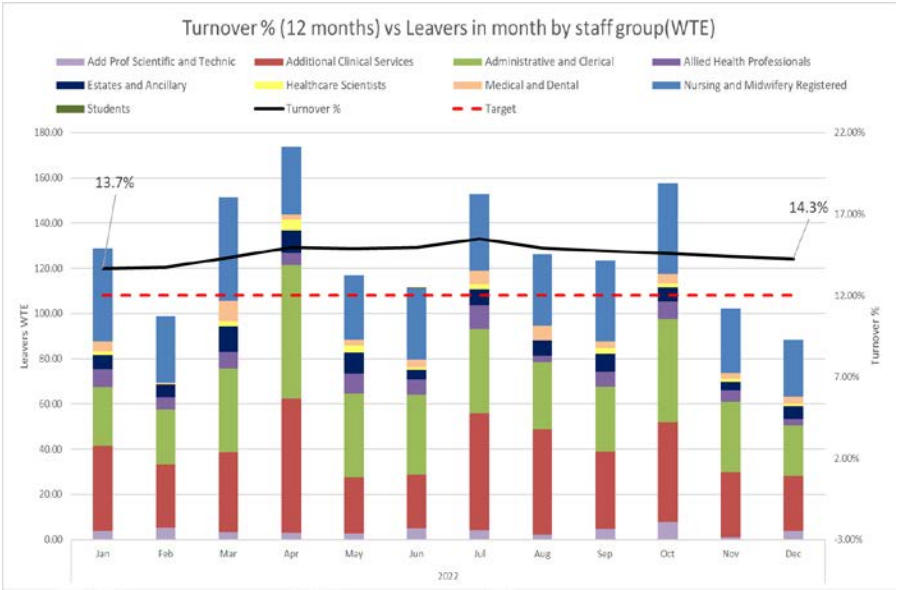
Source: NHSP December 2022

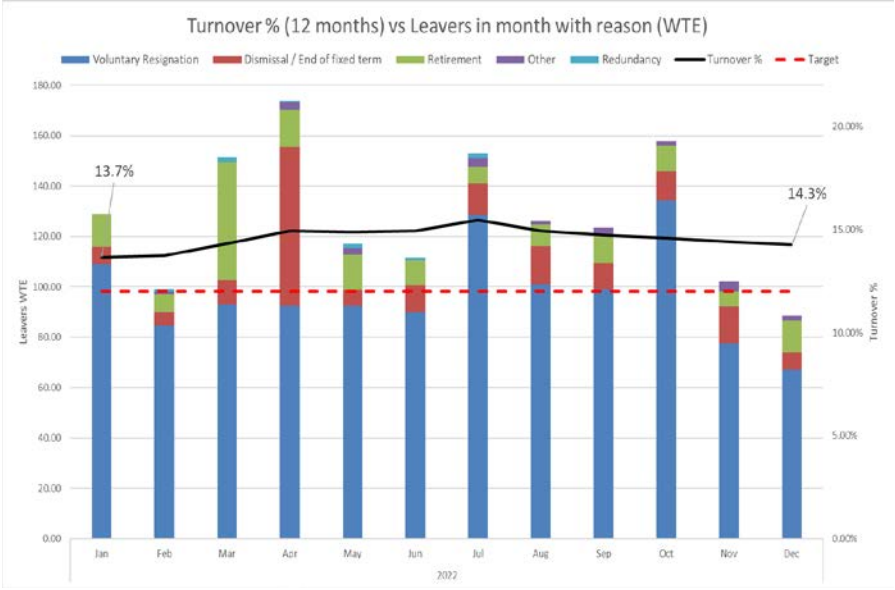
People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TURNOVER

Turnover has been decreasing since July 2022; in December there were 88.5 WTE leavers, which is 15 fewer than December 2021. Turnover is currently 14.3% which remains higher than the trust-wide target of <12%.





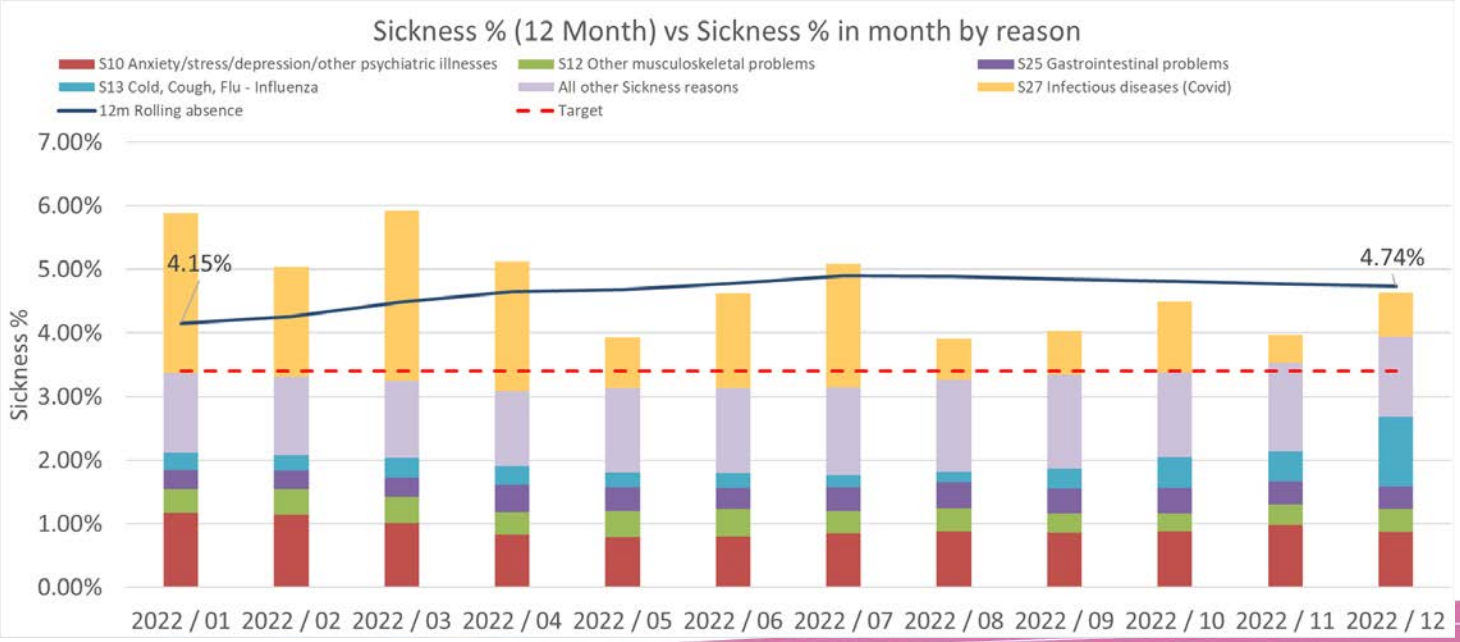
Source: ESR – Leavers Turnover WTE

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

SICKNESS

The rolling sickness rate (4.74%) is higher than 12 months ago; however this has been reducing gradually since September 2022. The reasons for this include COVID-related sickness, flu, mental health, gastrointestinal and MSK. Flu has seen a significant increase in December, accounting for 1.1% of the organisation being absent. Employee Relations and Occupation Health are setting up working groups to review sickness with a focus on mental health and long-term absence, alongside continued work with managers to support staff suffering from work-related stress to improve wellbeing and decrease absence levels



Source: ESR – Absence data

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:

NHS Staff Survey | NHS Pulse Survey | Apprenticeships | Appraisals | Statutory and Mandatory Training compliance

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

APPRENTICESHIPS

A total of 363 staff are currently partaking in an apprenticeship programme.

There are a total of 45 different apprenticeships with 45 different training providers. These include staff working in clinical apprenticeships in nursing, ODP, Occupational Therapy and Diagnostic Radiology. Two new apprenticeship have been added to the UHS apprenticeship portfolio in December; mortuary technician and early years educator.

The 3 remaining RNDAs are to be interviewed shortly for NQN posts, and a further 28 nursing apprentices start in February.

The apprentice ship levy remains at £5M, with average monthly spend of £120K, and monthly contributions of £220K. We transfer some of our levy to four different small businesses to support the local community apprentices.

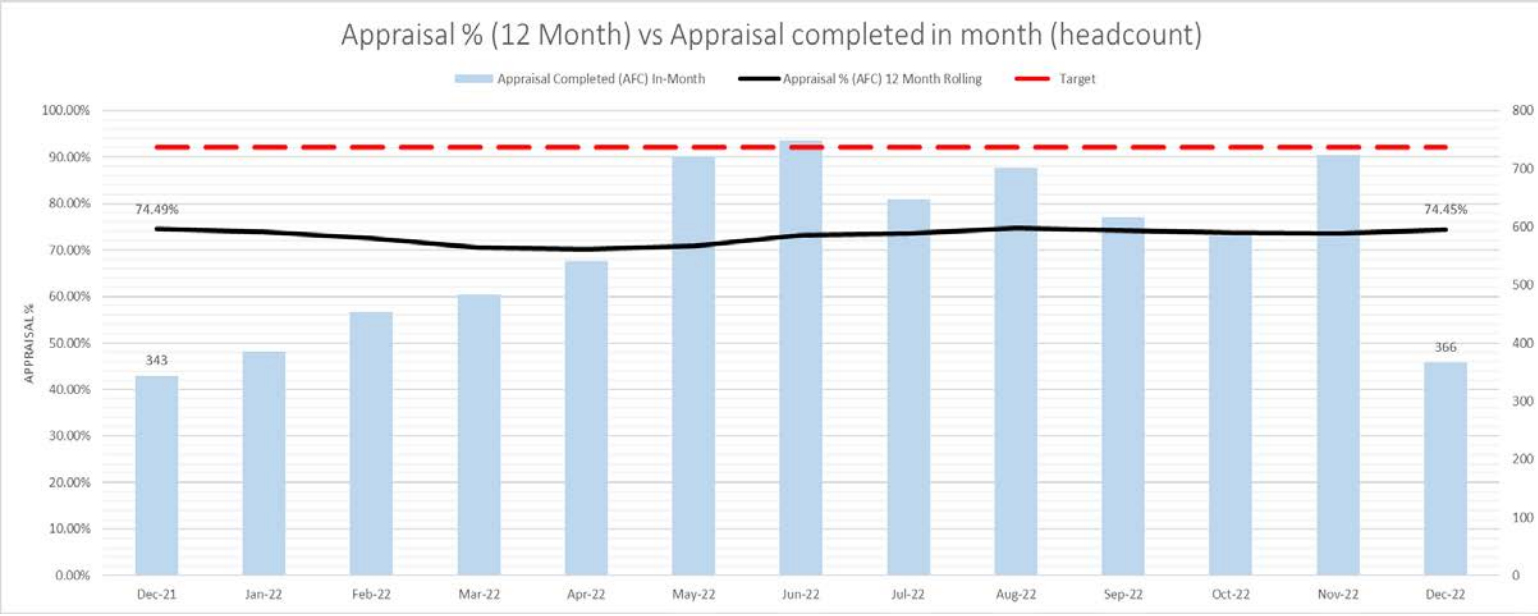
Division	Headcount
Division A	64
Division B	89
Division C	72
Division D	70
THQ	66
CLRN	2
Grand Total	**363**

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

APPRAISALS

In December 2022, 366 appraisals were completed, which, whilst being higher than December 2021, is considerably lower than November (700). Lower appraisal completion is likely due to a combination of factors including winter pressures, annual leave, and increased sickness absence



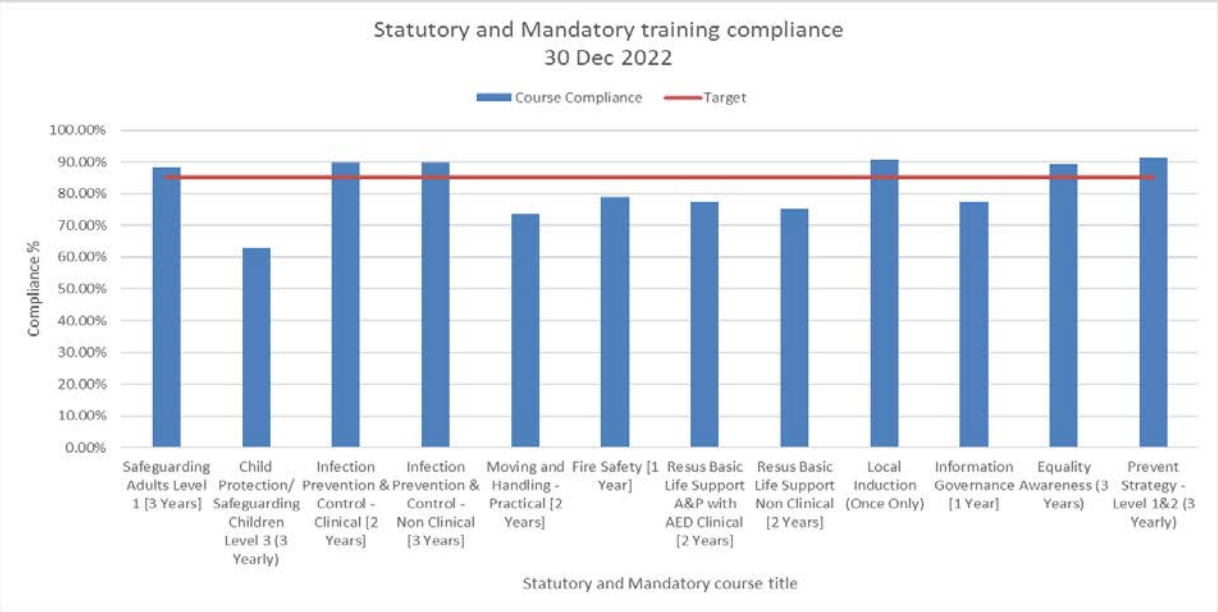
Source: ESR – Appraisal data

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

STATUTORY AND MANDATORY TRAINING

Statutory and Mandatory training and compliance is devolved to the clinical divisions with oversight being held by divisional education leads and flagged at the divisional governance meetings. Benchmarking statutory and mandatory training compliance with other NHS organisations is being carried out, and we are monitoring against the National Core Skills Training Framework



Source: 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.

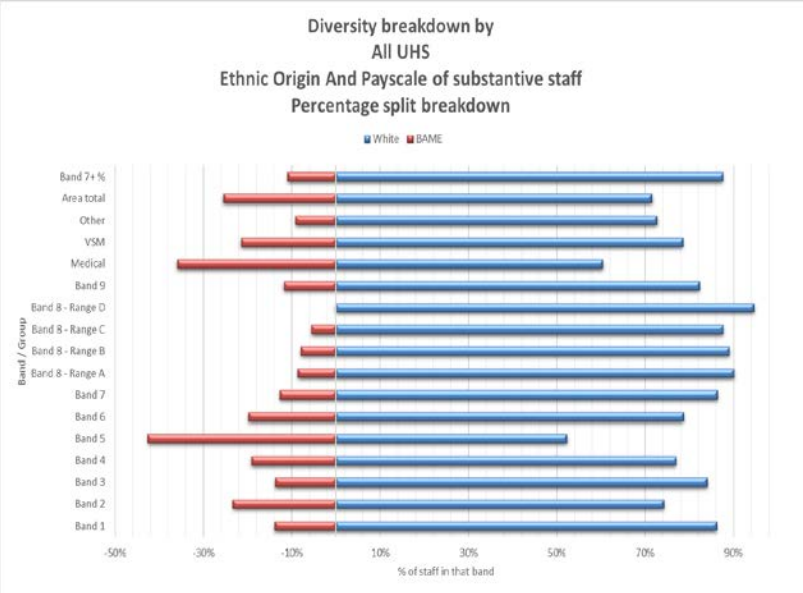
Relevant information:

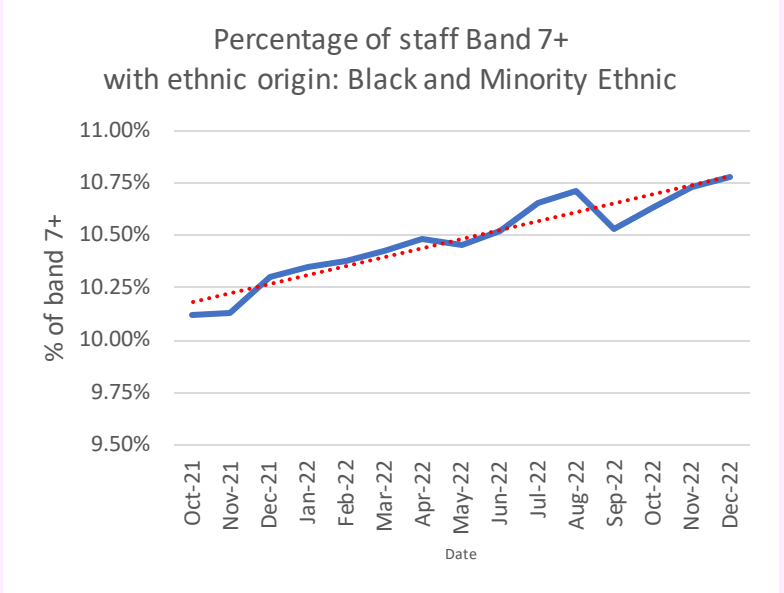
Percentage of staff employed at AfC B7+ from non-white backgrounds | Percentage of staff employed at AfC B7+ with a disability or long-term condition

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

STAFF IN POST - ETHNICITY



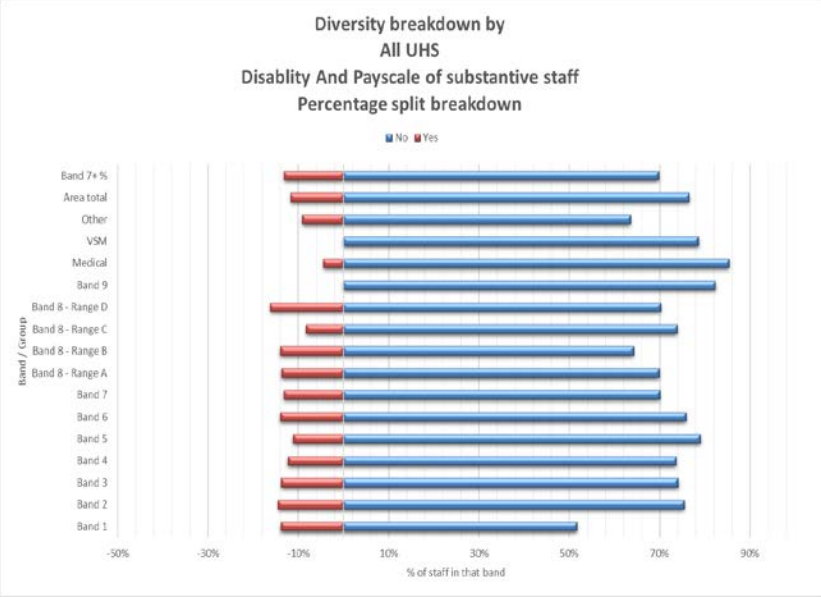


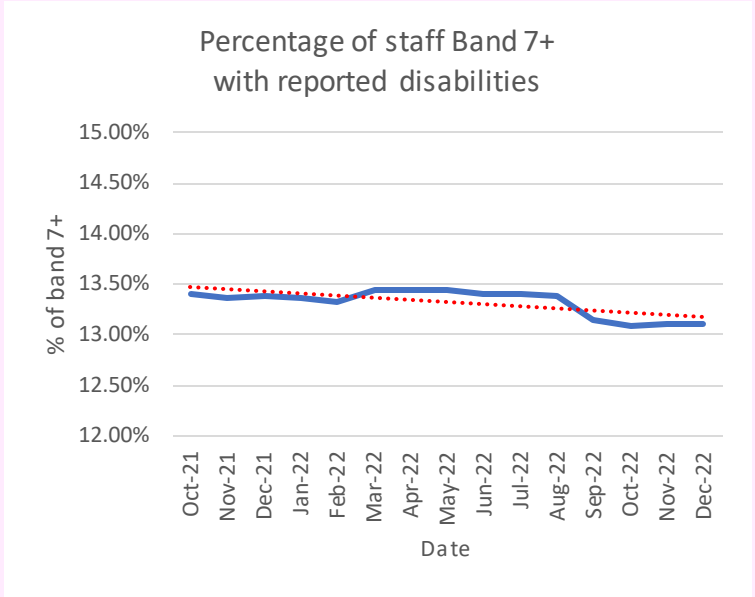
Source: ESR

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

STAFF IN POST – DISABILITY STATUS





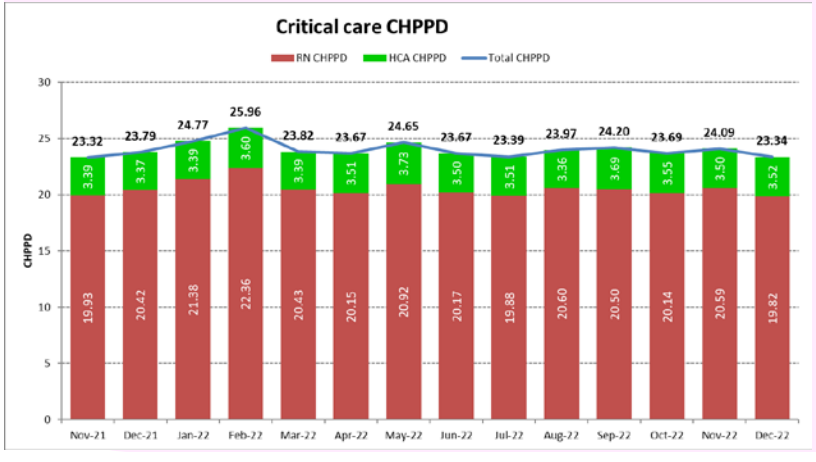
Source: ESR

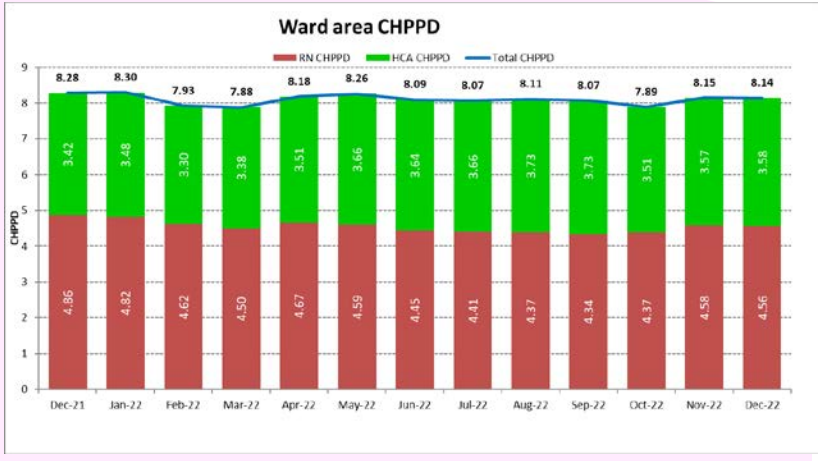
People Report

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

CARE HOURS PER PATIENT DAY

The Ward areas CHPPD rate in the Trust has decreased from last month to RN 4.56 (previously 4.58), HCA 3.58 (previously 3.57) overall 8.14 (previously 8.15). The decrease in CHPPD is linked to increasing patient numbers and the budgets of additional winter pressure areas available to include in the report this month (THR F10, Eye SSU, Bursledon House)





The CHPPD rate in Critical care has decreased overall from last month. RN 19.82 (previously 20.59), HCA 3.52 (previously 3.50) overall 23.34 (previously 24.09). Staffing on intensive care and high dependency units is always adjusted depending on the number of patients being cared for and the level of support they require. Therefore, the numbers will fluctuate considerably across the month when compared against our planned numbers. Plans are in place to restart the redeployment to support the critical care teams over winter.

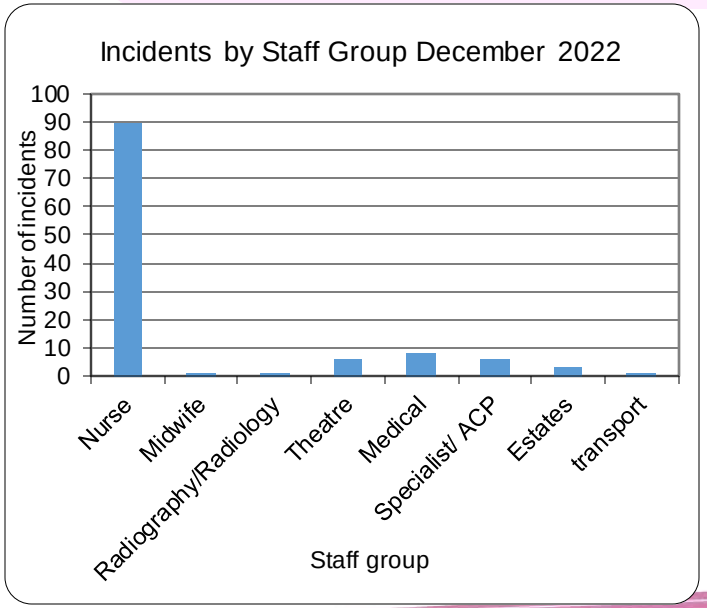
Source: HealthRoster & eCamis

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

OVERVIEW OF PATIENT SAFETY INCIDENTS AND RED FLAGS

- In total 117 incident reports were received in December 2022 which cited staffing. This is a significant increase on the 64 in the previous month and reflects the increased staffing and capacity challenges experienced in December.
- These incidents were rated from near miss to moderate (17) impact. A significant increase in the severity of incident reported with only 2 reported in November. Several the moderate incidents related to the overcrowding and queuing in the different sections of the emergency department.
- Red flags total reported via the AER system increased slightly this month with a significant increase in Division B and reduction in Division C.



Month Incident occurred	Division A	Division B	Division C	Division D	THQ	Trust total
December 2022	30 ↑ (14)	45 ↑ (16)	16 ↓ (26)	23 ↑ (5)	3 ↔ (3)	117 ↑ (64)

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

DIVISIONAL BREAKDOWN:

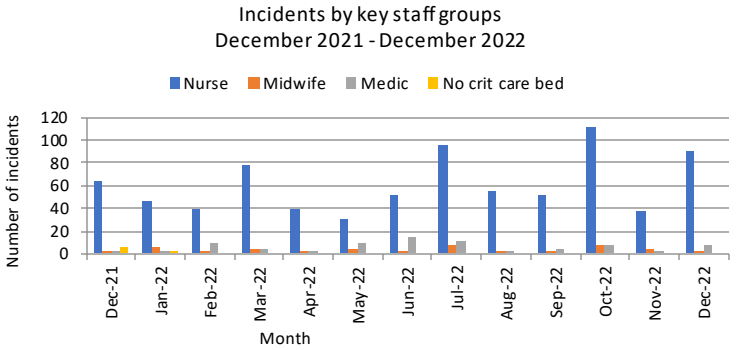
Div A: Thirty incidents reported in December, up on the 14 reported in November but not at the level of the peak in October. There were again no red flags reported in the month, this is the 3rd month and is an unusual position for the Division, and they are asked to review whether there has been a change in approach to completing the red flags on AER.

Div B: Forty-five incidents reported in December 2022, up significantly on the 16 in November and back at October levels. There were 23 red flags reported in the month, again a rise on the previous month but at a more normal level for the division.

Div C: Sixteen incidents reported in December, a reduction on the 26 in the previous month.

Div D: Twenty-three incidents reported in December, a significant rise on the 5 in November and back to levels noted in October.

THQ: Three incidents reported in December, the same level as the previous month. All 3 incidents reported shortfalls in the maintenance on-call roster



	Red flag category	Number of reports	Div A	Div B	Div C	Div D
December 2022	Delay in medication	5	0	4	0	1
	Delay in pain relief	10	0	5	1	4
	Delay in observations	10	0	7	1	2
	Less than 2 registered	10	0	7	1	2
	Total	**35**	**0**	**23**	**3**	**9**

	Red flag category	Number of reports	Div A	Div B	Div C	Div D
November 2022	Delay in medication	6	0	0	5	1
	Delay in pain relief	6	0	0	5	1
	Delay in observations	9	0	1	8	0
	Less than 2 registered	9	0	1	8	0
	Total	**30**	**0**	**2**	**26**	**2**

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Maternity Safety 2022-23 Quarter 3 Report**			
Agenda item:	**5.10**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Emma Northover, Director of Midwifery and Professional Lead for Neonatal Services** **Marie Cann, Interim Senior Midwifery Manager** **Alison Millman, Interim Quality Assurance and Safety Matron**			
Date:	**31 January 2023**			
Purpose	**Assurance or reassurance** **x**	**Approval**	**Ratification**	**Information** **x**
Issue to be addressed:	This report constitutes the agreed Maternity Services safety report for the Trust Board. The timeframe for this report is Quarter 3 2022/2023. This report provides assurance to the Board members that the appropriate reporting is in place to provide assurance on the following: **1.** Provider Board Level Measures – UHS Maternity dashboard **2.** Ockenden and Kirkup (East Kent) reports **3.** Avoiding Term Admissions into Neonatal Units (ATAIN) **4.** Maternity Survey **5.** Listening to women and their families (feedback and complaints) **6.** NHSR Maternity Incentive Scheme – ICB response **7.** Maternity Claims Scorecard **8.** Healthcare Safety Investigation Branch (HSIB) cases, Serious Incidents (SI) and Moderate Incidents **9.** Prolonged Opel 4 escalations by the NNU – Root Cause Analysis reports **10.** Perinatal Mortality Report Tool **11.** Root Cause Analyses for both prolonged Opel 4 escalations by the NNU **12.** Maternity Workforce and Birthrate Plus **13.** Antenatal and Newborn Screening Annual Report			
Response to the issue:	**1. Provider Board Measures** Our maternity service intends to streamline our reporting of these measures and we are now utilising the UHS Maternity dashboard which can be viewed as **Appendix 1**.			

2. Ockenden and East Kent update

Ockenden:
Our maternity service welcomed the Ockenden insight visit team in November 2022. The informal feedback was positive, and we are hoping that we will have received the formal report back prior to submitting this report. A key discussion point during the visit related to our maternity information system – Badgernet. This paperless and interactive system relies on women owning a smart phone and is also very orientated towards women with English as a first or functional language. The maternity service plans to seek to engage the experience of users of the service regarding any barriers to using this system.

East Kent:
Our maternity service has performed a provisional gap analysis around the key themes from the Kirkup report into maternity services in East Kent. The areas we identified as a focus include:

- Clinical behaviours
- Team working
- Professional culture

The maternity services in Southampton have previously received positive feedback around our collegiate ways of working and the recent recruitment of 8 Freedom to Speak Up Champions across all disciplines for the PAH site has also given a positive boost to providing obvious and open support to staff who wish to raise concerns. The key message however is that there is significant risk in exercising any complacency around these areas, and civility and high expectations of professional behaviour is a key focus across all staff groups.

3. Avoiding Term Admissions into the Neonatal Unit (ATAIN)

Please see the Q3 ATAIN report as **Appendix 2.** Our maternity dashboard records the ATAIN data under 2 headings. The first is admissions of babies with antenatally identified issues where an admission to NNU would be expected and the second figures are with this group excluded. The target to stay below 5% for this group continues to be met.

A key theme for this report is a substantial increase in the numbers of babies admitted to the NNU with hypoglycaemia. All cases of ATAIN have a clinical events review and the team will be looking for any key themes to understand why this has occurred and to inform practice advice to the relevant teams. There is an early assessment of this issue in the narrative of the report highlighted in Standard C of the report.

4. CQC Maternity Survey

The results from the maternity survey for women who gave birth between 1st and 28th February 2022 were published this month. Nationally the themes make difficult reading around women's experiences of maternity care. As a service we are scrutinising the results and will include a full response in our Quarter 4 report.

5. Listening to women and their families

Our service continues to exceed the trust target for feedback of 20%. December saw the service under severe pressure with several periods of the maternity service declaring Opel 4 and significant periods in Opel 3. Combined with high levels of staff sickness absence and the need to maintain one-to-one care for women in labour and women who are unwell antenatally or postnatally this has, inevitably, impacted on some of our user's experience. Staffing and sickness levels have improved significantly in January and we would expect to see this reflected in our user feedback.

Maternity FFT Results					
2022		October	November	December	Q3
Response rate - Trust Target 20%	Total response rate	26.5%	28.7%	27.3%	27.3%
	Antenatal	30.7%	30.2%	30.2%	30.4%
	LW and birthing unit	24.3%	26.6%	24.8%	25.2%
	Postnatal ward	24.4%	27.0%	25.1%	25.4%
	Postnatal community	26.5%	31.1%	29.2%	28.0%
% of women who would recommend	Average score	93.3%	87.6%	84.7%	88.5%
	Antenatal	94.6%	94.5%	89.9%	93.0%
	LW and birthing unit	97.3%	97.2%	94.5%	96.4%
	Postnatal ward	90.1%	80.0%	78.0%	82.7%
	Postnatal community	91.2%	78.6%	76.4%	82.0%
% of women who would NOT recommend	Average score	2.0%	2.8%	6.5%	3.7%
	Antenatal	1.8%	1.8%	5.5%	3.0%
	LW and birthing unit	1.8%	1.8%	2.8%	2.1%
	Postnatal ward	4.5%	6.4%	12.8%	7.9%
	Postnatal community	0.0%	1.0%	4.7%	1.9%
Number of responses		n 111	n110	n109	

Complaints

Please see **Appendix 3** for a summary of complaints for Q3. The general themes lie around communication around labour and induction of labour, with one complaint focusing on advice given by our Maternity Antenatal Triage Line colleagues. Our maternity service continues to work closely with the complaints team to enable us to have a clearer overview of negative feedback and complaints from our service users.

6. NHSR Maternity Incentive Scheme – ICB response

The maternity service met with the designated representatives of the Accountable Office (AO) for the ICB on 4 January 2023. The team had undertaken a comprehensive review of the evidence for the 10 safety actions and the representative of the AO has contacted the Trust to declare that they deem all 10 of the safety actions to have been met. It is anticipated that the AO sign off will occur after 18 January 2023 following this a submission with both the CEO and AO declarations can be submitted to NHSR prior to the deadline of midday on 2 February 2023.

7. Maternity Claims Scorecard

Please see this as **Appendix 4**.

8. Healthcare Safety Investigation Branch (HSIB) cases, Serious Incidents (SI) and Moderate Incidents

There are currently 4 open HSIB cases and one completed HSIB case which is awaiting a local action plan. The 4 cases include 3 maternal deaths and one cooled baby where the MRI was normal but the family requested HSIB involvement. These cases are at report panel stage currently, and any learning will be shared when the cases close. A further HSIB case relating to a cooled baby was closed in Q3, and an action plan is awaited. An overview of the HSIB cases is included in the Moderate and Above Incidents grid and can be viewed in **Appendix 5.**

9.
Two Root Cause Analysis reports relating to the extended Opel 4 status for the NNU are available to share with this report and can be viewed as **Appendix 6a and 6b.**

For an overview of our stillbirths, neonatal deaths, HSIB severe brain injury and maternal deaths please see **Appendix 7.**

10. Perinatal Mortality Review Tool (PMRT)

This information is to provide assurance around the maternity service's compliance with the reporting requirements of Perinatal Mortality to MBRRACE. This is a NHSR Maternity Incentive Scheme requirement. Please see **Appendix 8**. The key themes are:

- Clearer evidence of documentation regarding taking baby home
- CO monitoring for booking
- Asking about domestic violence
- Estates issues within NNU /PICU
- Use of interpreter services

Actions to resolve these are detailed in **Appendix 8**.

11. Maternity Service Workforce

Q3 saw an increasing level of pressure with sickness absence combined with unfilled vacancies creating substantial challenge to the maternity service. An overview of our midwifery workforce can be seen in **Appendix 9a.** Further challenges around filling the middle grade medical rota have also been escalated and remain under careful review.

	The maternity service uses the Birthrate Plus Tool to assess acuity versus staffing in our intrapartum, antenatal and postnatal wards. At times of high acuity staff are redeployed internally to ensure safe care and one-to-one ratios for HDU patients and women in labour and to ensure that the Labour Ward Coordinator remains supernumerary which is an NHSR requirement. Whilst this will protect these ratios it may substantially deplete ward areas during periods when staffing levels are challenged. Please see **Appendix 9b**. **12. Antenatal and Newborn Screening Annual report 21-22** The sharing of the antenatal and newborn screening report has not previously occurred within the maternity safety report. Moving forwards, it is expected that this will be shared with the Quality Committee and Trust Board in Quarter 3 annually. Please see **Appendix 10**.
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.
Summary: Conclusion and/or recommendation	Our maternity service continues to be mindful of all the safety drivers for maternity and neonatal services and will continue to provide safety information on a quarterly basis unless otherwise required. Achieving the 10 safety actions for the NHSR Maternity Incentive Scheme is very positive for the maternity and neonatal service and the service will continue to focus on maintaining the required standards moving forward.

Appendix 1

Working UHS Maternity Quarterly Dashboard							
	Q1 = April - June		*Q2 = July - September*		*Q3 = October - December*	*Q4 = January - March*	
Indicator	**Q4 21/22**	**Q1 22/23**	**Q2 22/23**	**Q3 22/23**	**Green**	**Red**	**Comments**
Outcomes - mothers							
Total number of Births (women/people)	**1202**	**1261**	**1316**	**1315**	1375 or fewer	More than 1375	Total number of births for 2021 - 5355. 2022 - 5094
Predicted birth rate	**1243**	**1219**	**1299**	**1287**	1375 or fewer	More than 1375	**Predictions as of 09/01/2023 - Q4 - 1178. Q1 - 1215**
Sets of Multiples	**20**	**19**	**13**	**22**	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)
IOL	**30.8%**	**28.3%**	**31.2%**	**30.5%**	Less than 33%	More than 33%	Total number of inductions 2022 - 1540. UHS total induction rate - 2021 - 28.0%. 2022 - 30.2%
Elective Caesarean section capacity	**152**	**157**	**188**	**191**	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	**28**	**29**	**32**	**34**			New measure added to show the number of elective slots cancelled due to complexity of the lists
PPH 500ml or more - NMPA	**36.3%**	**34.6%**	**35.7%**	**36.0%**	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	**3.1%**	**3.0%**	**3.5%**	**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%

Appendix 1

3rd/4th degree tears - NMPA	2.9%	3.3%	3.0%	3.0%	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%**
HDU	Data currently not collected in BadgerNet, work ongoing to explore how we could collect this data				Less than 75	75 or more	2020- Average 62 admissions per quarter
ITU Transfers	1	2	5	0	1	2 or more	ITU data obtained via Trust BI team from Camis data
Hysterectomy	1	0	1	0	0	1+	
Outcomes - Babies							
Babies Born	1223	1280	1329	1337	1375 or fewer	More than 1375	Total number of babies born during - 2021 - 5441. 2022 - 5169
Normal Birth Rate (babies)	51.0%	47.4%	47.5%	47.4%	Rag rating removed Nov 2021		
Apgar's <7 at 5 minutes - NMPA	2.4%	1.9%	1.9%	2.2%	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%**
Low Birth Weight at Term (<2500g)	2.3%	2.4%	2.0%	3.3%	Less than 2.8%	More than 2.8%	Source Public Health England 2017 National average 2.82% of live term births.
Term Admission to NNU -All babies	3.8%	4.6%	4.9%	5.9%	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	2.8%	2.9%	3.5%	4.0%	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
Antenatal Booking							
% Bookings < 10 weeks	3.5%	4.8%	5.8%	5.5%	Performance threshold of bookings by 10 weeks Acceptable level >50% Achievable level >75%		Dashboard update July 2022 - figures relate to current pregnancy bookings, not delivered women/pregnant people. Using BadgerNet HOM report
% Bookings < 12 weeks	13.6%	21.1%	22.7%	43.8%			
Public Health Outcomes							

Appendix 1

Breast Feeding Initiation	75.5%	77.9%	80.6%	79.3%	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
Breast Feeding at Discharge to community	77.4%	73.3%	71.5%	71.8%	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 during pregnancy of delivered women/people	13.6%	13.5%	15.2%	13.9%	n/a	n/a	SBLs BadgerNet outcome report
Smoking at Delivery	10.6%	10.2%	8.8%	9.4%	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
Southampton City Smoke Free Pregnancy Monitoring	6.25%	26.7%	21.8%	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.
Continuity of Carer							
Booked - total women/pregnancy people booked onto a CoC pathway	43.4%	44.1%	43.6%	43.9%	Greater than 35%	Less than 35%	Prioritise those most likely to experience poorer outcomes first, including ensuring most (51%) women from Black, Asian and mixed ethnicity backgrounds and also from the most deprived areas are placed by on a continuity of carer pathway by March 2022. (Target updated on the dashboard Q1 2021/22)
Booked - total BAME women / pregnant people booked onto a CoC pathway	81.2%	78.2%	82.5%	82.7%	Greater than 51%	Less than 51%	
Booked - total women living within an IMD-1 area booked onto a CoC pathway	82.5%	82.7%	55.1%	79.0%	Greater than 51%	Less than 51%	
Risk and Patient Safety							
Number of Stillbirths	3	6	3	5	5 or less	6 or above	Actual number of Stillbirths each quarter

Appendix 1

Stillbirth rate per 1000 births	2.45	4.69	2.32	3.75	4.1 or less	4.2 or above	National rate 2021 4.2 per 1000 births
Total HSIB reportable cases	1	5	2	6	n/a	n/a	Q2 – Maternal death was a patient transferred from Salisbury.
Term Intrapartum Stillbirths	0	0	0	0	n/a	n/a	
Early neonatal death	0	1	0	6	n/a	n/a	
Severe brain injury	1	2	1	0	n/a	n/a	
Maternal death	0	2	1	0	n/a	n/a	
The number of incidents logged graded as moderate or above and what actions are being taken	9	10	12	17	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. Out of the 17 incidents, 2 are SIs, 2 are SEC.
Number of SIs reported and under investigation	3	2	2	4	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 don't include cases under HSIB investigation.
Number of major complaints received for Maternity Services	1	0	2	2	n/a	n/a	The number of major complaints and themes received for Maternity Services are reported to the LMNS on a monthly basis.
Provider Board Level Measure - Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training							
	Apr-22	**Jul-22**	**Sep-22**	**Dec-22**	**Month**		
Fetal Monitoring Training (SBL2 & NHSR)	79.4%	88.2%	94.2%	94.0%	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).
	70.6%	72.2%	95.0%	81.0%	Consultant Obstetricians		
	38.5%	69.2%	92.0%	56.3%	Obstetric trainees		

Appendix 1

Friends and Family Test	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23			
Responders as % of eligible populations	12.4%	28.1%	29.0%	27.3%	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	84.6%	86.7%	85.7%	88.5%	90% or more	Less than 90%	
NOT recommending as % of responders	3.0%	4.4%	4.3%	3.7%	Less than 5%	5% or more	
HR							
Black Alerts / OPEL 4	8	9	5	9	0	1 or more	2020/21 - Average 0.75 a quarter 2021/22 - Average 7.5 a quarter

Appendix 2.

UHS Maternity Services Report – for NHS Resolution Maternity Incentive Scheme (MIS) Q3 – October, November, December - 2022

Title	ATAIN quarterly update
Report to: (Quarterly report unless stated otherwise)	W&N Governance Neonatal Governance Maternity, Neonatal and Board level safety champions LMNS ICS Quarterly surveillance meeting
Report from:	Matthew Davies – Data Manager Hayley Taylor – Lead for Neonatal Outreach and Transitional Care Wendy Marsh – Consultant Midwife ATAIN team – Victoria Puddy (Neonatal Consultant), Kelly Brown (Neonatal Consultant), Donna Winderbank-Scott (Neonatal Consultant)
Maternity Sponsor:	Emma Northover – Director of Midwifery & Professional Lead for Neonatal Services Sarah Walker - Care Group Clinical Lead Women & Newborn
Purpose of Report:	The purpose of this report is to provide ongoing assurance that the requirements for NHS Resolution Safety Action 3 have been met
Assurance relating to the following NHSR actions:	Standard A – Transitional Care operational policy Standard B – Quarterly audit of pathways of care into TCU Standard C – Summary of all unexpected term admissions Standard D – Possible TC future admissions Standard E – Commissioner returns Standard F – Quarterly review of all term admissions to NNU irrespective of length of stay. To include babies who met criteria for TCU but went to NNU due to capacity/staffing/unable to implement phase 2 (NG tube feeding) Standard G – Evidence of local action plan addressing standards B&F Standard H – Progress with the action plan has been shared as required
Escalation Required or What Further Action Required:	N/A
Considerations:	

Recommendation(s):	

Summary

This paper provides a report regarding term admissions to neonatal unit and transitional care services at University Hospital Southampton. This is line with NHSR Safety Action 3 requirements

It is a quarterly report shared with the following:

- W&N Governance
- Neonatal Governance
- Maternity and Neonatal Safety Champions
- LMNS Board
- Commissioner and ICS quality surveillance meeting

Standard A:

Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.

Evidence: An operational policy has been developed for transitional care outlining criteria, staffing, and escalation pathways. (Accessible on staffnet). New criteria developed for review of SOP (including Nasogastric tube feeding).

Action Plan: Operational pathway currently being updated by TC neonatal lead due to changes in TC staff management. Revised Standard of Practice (SOP) currently going through governance.

Standard B:

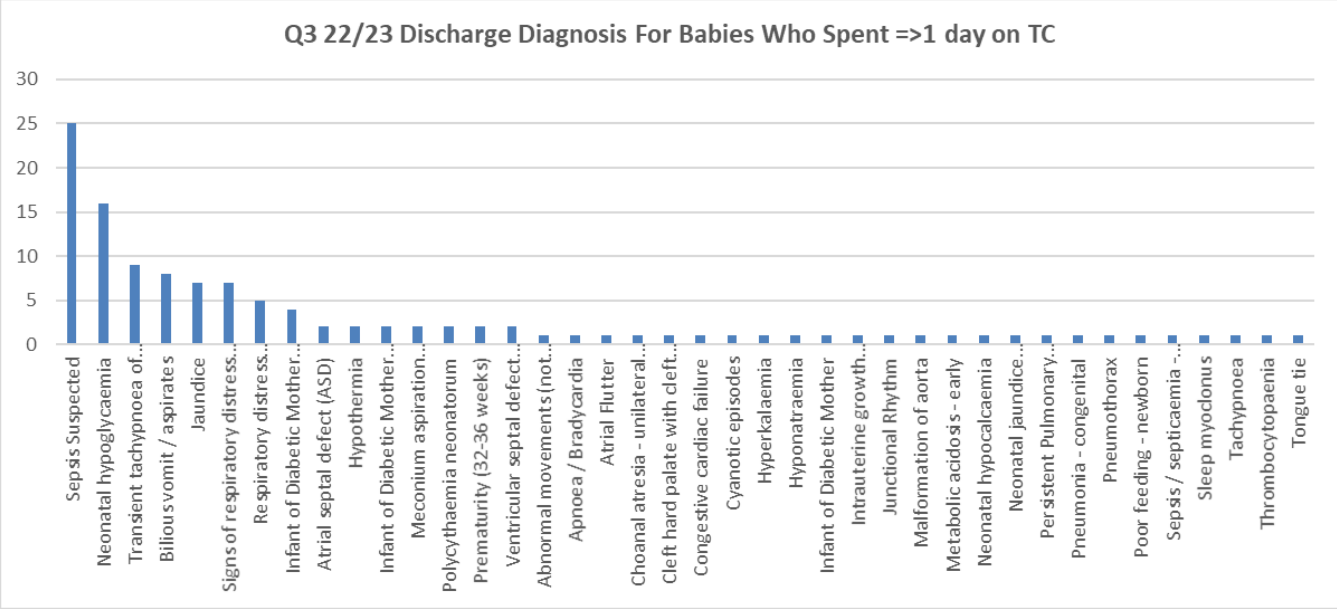
The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.

Evidence: TC Admissions, reasons for admissions, and staffing are reviewed monthly by lead clinician and data analyst. Key themes are reported monthly via NNU governance dashboard and escalated through W&N governance.

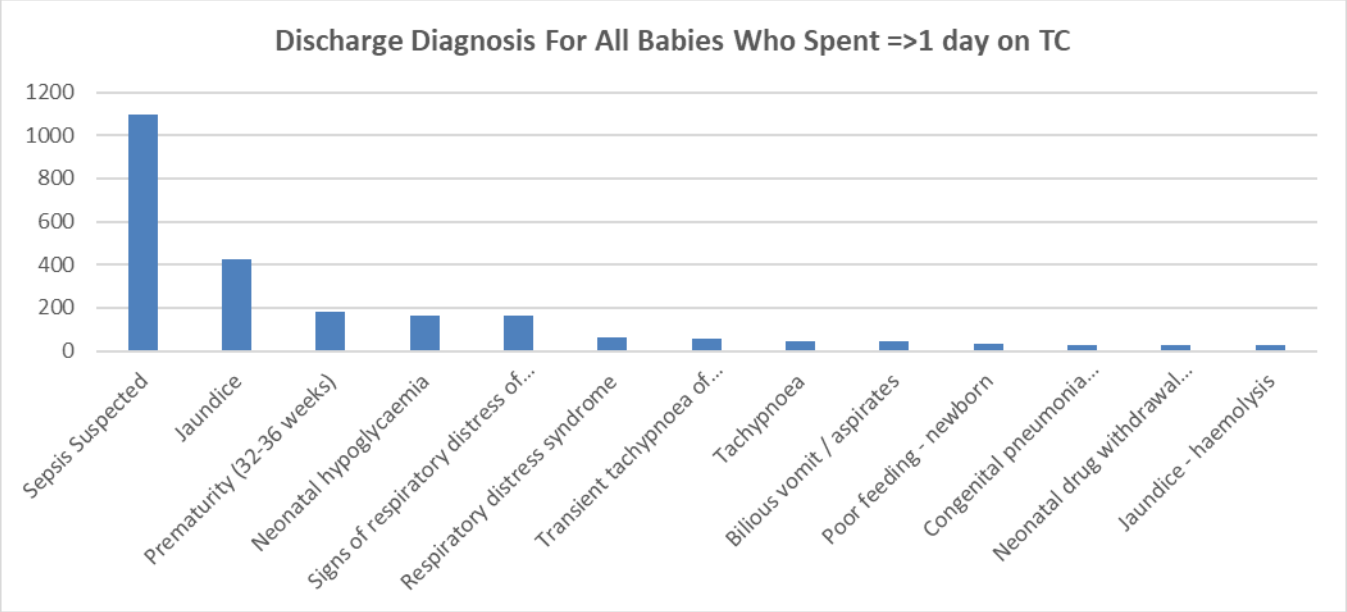
Number of admissions to Transitional Care

Q1 2022/2023	Q2 2022/2023	Q3 2022/2023
136	133	153

Discharge diagnosis for babies admitted to transitional care

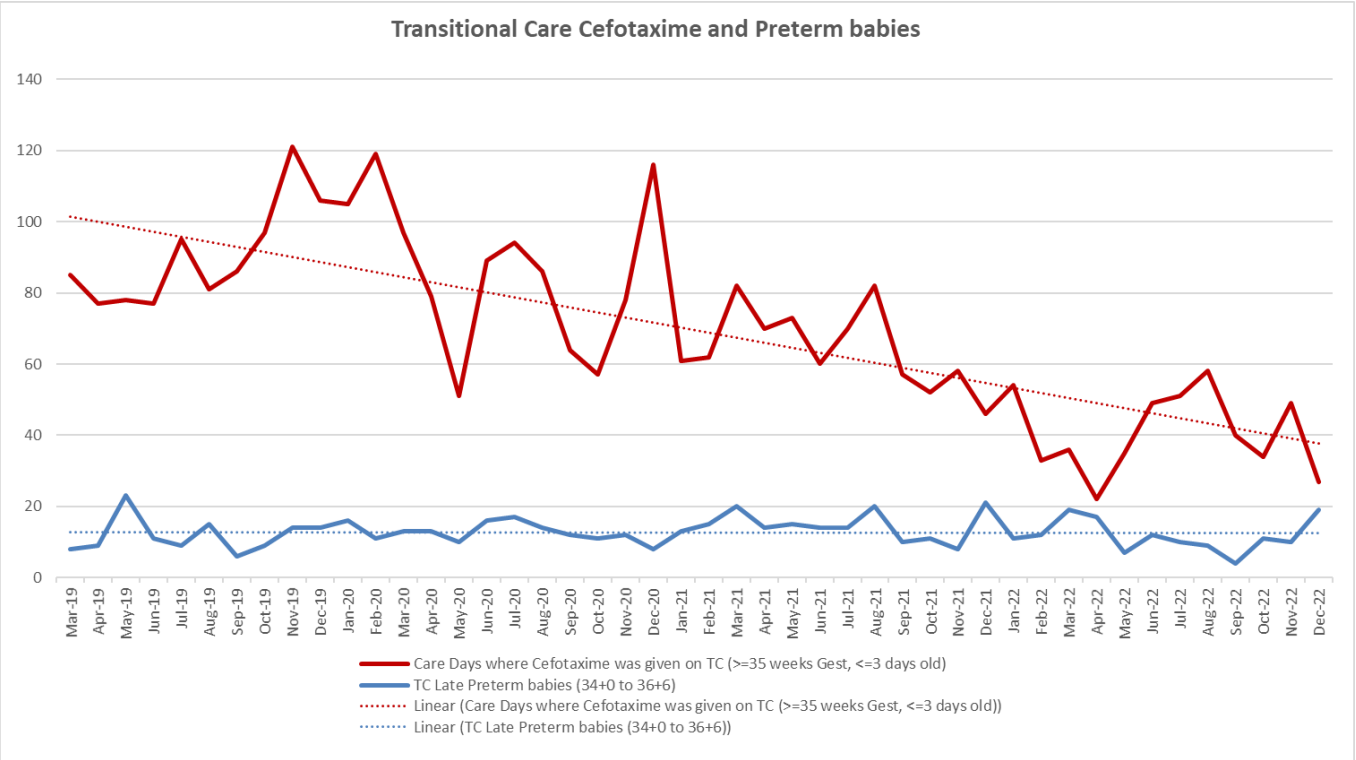


NB: Some babies diagnosis from the neonatal unit before admission to TC

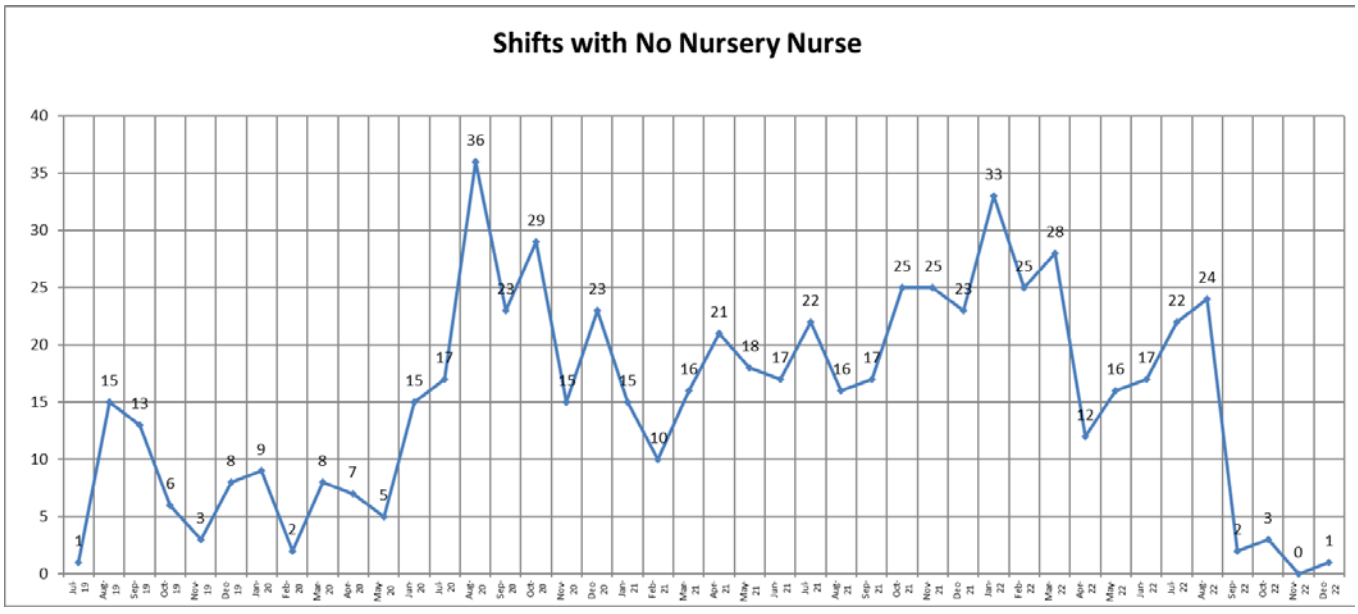


Figures show all TC admissions during Q1 – Q3

In view of sepsis being the main reason for admission to transitional care, the team have been focussing on safely reducing the amount of antibiotics being given when not clinically indicated. During this quarter the antibiotic trend continues to trend downwards, and we have an increased number of late preterm babies being cared for on transitional care with their mothers.



Action Plan: Nursery Nurse staffing has moved to neonatal management as from 4th July 2022. Since this time, the NNU coordinator is responsible for ensure TC is always staffed. TC band 4 vacancies were advertised and filled. Three new nursery nurses have joined the TC team and have received their training (including NGT feeding) and supernumerary time on the NNU. The graph below demonstrates improved TC staffing this quarter.



Standard C:

*A data recording process (electronic and/or paper based) for capturing **all** term babies transferred to the neonatal unit, regardless of the length of stay, is in place.*

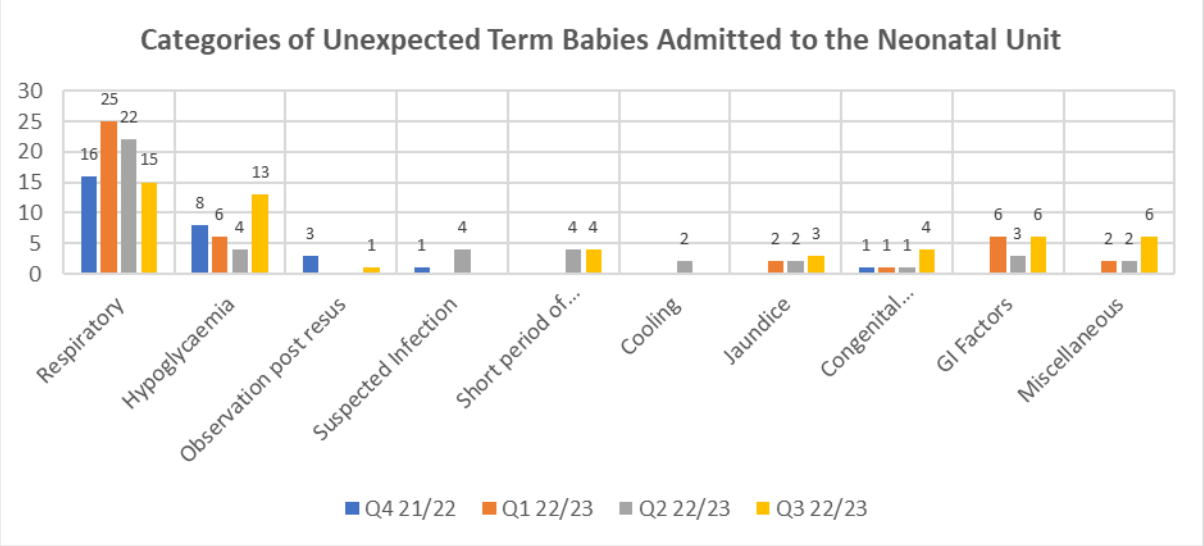
Evidence: ATAIN database developed by ATAIN neonatal nursing lead capturing all term admissions to the neonatal unit.

Date	*Birth Rate (>37 weeks)*	*Total term admissions to the NNU*	*Unexpected term admissions to NNU*	*Unexpected term admissions as a percentage of birth rate*	*Unexpected term admissions excluding known chromosomal or congenital anomalies*	*Term admissions to NNU (all inborn babies)*	Avoidable Term Admission to NNU -Excluding surgical/cardiac/ congenital babies
Q1 22/23	*1269*	*47*	*34*	*2.7%*	*2.6%*	*4.6%*	*2.9%*
Q2 22/23	*1228*	*68*	*44*	*3.5%*	*3.5%*	*4.9%*	*3.5%*
Q3 22/23	*1220*	*75*	*53*	*4.3%*	*4%*	*5.9%*	*4.0%*

Category of unexpected term babies admitted to the neonatal unit

	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23
Respiratory	16	25	22	15
Hypothermia				
Hypoglycaemia	8	6	4	**13**
Observation post resus	3			1
Suspected Infection	1		4	
IVAB – No additional requirement				
Short period of observation			4	4
Single procedure				
Cooling			2	
Jaundice		2	2	3
Congenital Abnormality	1	1	1	**4**
NAS				
GI Factors		6	3	**6**
Social				
Miscellaneous		2 (1-born with ascites – RIP, 1-17.4% wt loss)	2 (1-accident – baby fall from bed, 1-Reduced Tone)	6 (2 – birth trauma, 2 – abnormal movements (neuro obs

				required), 1 – covid +ve, 1 - ?seizures
TOTAL	29	42	44	52



This quarter we have seen a rise in total term admissions to the NNU, with a significant increase in those admitted for hypoglycaemia and GI factors. Admission for those with congenital abnormalities has also risen.

Twelve of those admitted due to hypoglycaemia, were done so appropriately according to the protocol: admission to the neonatal unit following 2 doses of Dextrogel or three BG values 1.5-2.5 mmol/L.
In Ten cases, IV dextrose was required at admission. In one case, bottle feeds along with monitoring was enough to resolve the hypoglycaemia. In two other cases, the patient recovered with the insertion of an NGT with top ups. With the introduction of NGT feeding on TC in the next few weeks, we would expect this number to reduce.

Regarding the rise in admissions due to Gi factors. All were appropriately admitted as per protocol for bilious vomiting.

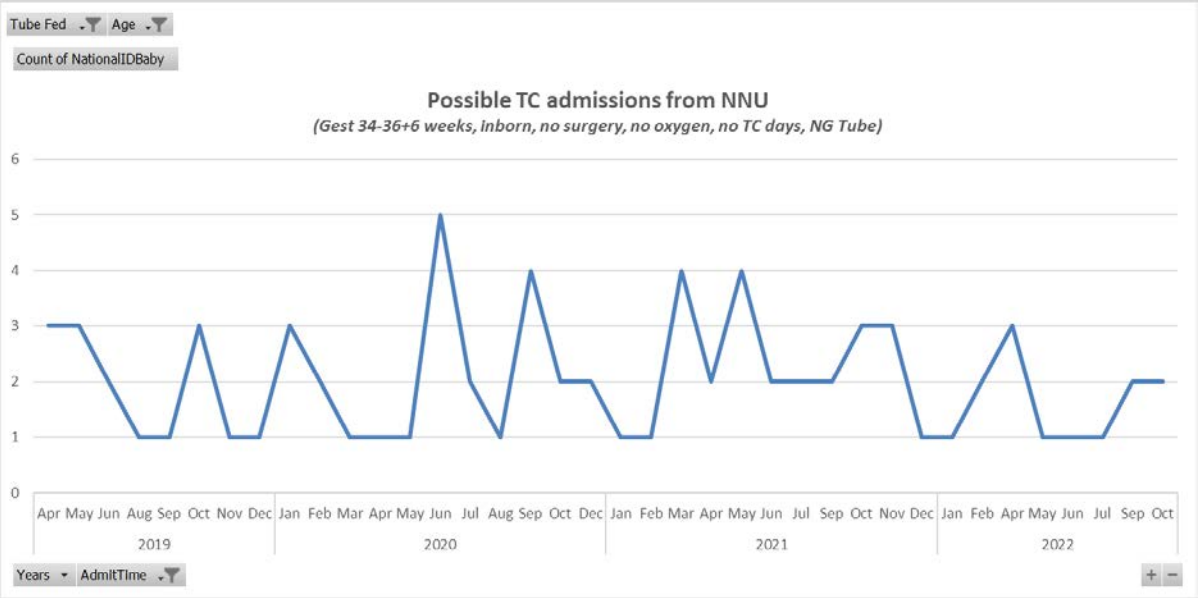
Action Plan: To continue collecting expected and non-expected term admission data into next quarterly report. To review categories of admission. Maternity to discuss at clinical events meetings to explore the increase in these categories further. NGT to be launched on TC as planned by the end of the month.

Standard D:

A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future

capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered

Evidence: In addition to data collected for standard B. Data on future potential admissions now also collected.



None recorded in Nov-Dec

Standard E:

Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.

Data download request

04 Jan 23 10:07
(unknown user)

Request time	04 Jan 23 at 10:07
Care locations	University Hospital Southampton NHS Foundation Trust, Princess Anne Hospital
Units	
Type	NCCMDS
Date Range Type	Admitted within time period
Date range	Last year From 01 Jan 22 to 31 Dec 22
Build request status	Ready. Click here to download...

Evidence to show this that downloads of the data are available.

Standard F:

Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. Reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.

Evidence:

Transitional Care criteria is being revised to include Nasogastric Tube Feeding:

- Preterm 34+0-35+6 weeks gestation >1.6kg and assessed as suitable for TC by the neonatal team **(NG)**
- >36 weeks with birth weight 1.6-2.0kg **(NG)**
- Persistent *asymptomatic* hypoglycaemia which could be managed with NG feeds **(NG)**
- Suspected infection requiring antibiotics but clinically stable
- Haemolytic disease/early onset jaundice and/or double phototherapy
- At risk of neonatal abstinence syndrome requiring observations for >48hrs
- Weight loss >12.5% for feeding support **(NG)**
- >36 weeks with poor suck feeding requiring NG feeding support (NG)
- Congenital anomaly with likely impact on establishing feeding or requiring intermittent observations additional to standard NEWS **(NG)**
- Cleft lip/palate
- Trisomy 21

Action Plan: Training is almost complete along with an escalation policy. We hope to launch NGT feeding on TC within the next 2-3 weeks. Date TBC.

Standard G:

An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions Into Neonatal units (ATAIN) reviews (point f) has been agreed with the maternity and neonatal safety champions and Board level champion.

Evidence: Atain Action Plan available to share. Multidisciplinary atain meetings running bimonthly (3rd Tuesday every month). Atain reviews discussed at Clinical Events Meeting Weekly.
Action Plan: For results of atain clinical event reviews to be added onto ATAIN database by maternity risk team, and further actions/QI plans made. Database to be shared and accessible to all.

Standard H:

Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting.

Evidence: Atain Database and action plan available to maternity and neonatal Trust Atain leads on Shared Drive.

Appendix

NHSR Safety Action 3:

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?
MIS-year-4-relaunch-guidance-May-2022.docx (live.com)

Standard A:

Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.

Standard B:

The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.

Standard C:

A data recording process (electronic and/or paper based for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place.

Standard D:

A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.

Standard E:

Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.

Standard F:

Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.

Standard G:

An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions into Neonatal units (ATAIN) reviews (point f) has been agreed with the maternity and neonatal safety champions and Board level champion.

Standard H:

Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting.

University Hospital Southampton
NHS Foundation Trust

Appendix 3.

Quarter 3 Complaints

Raised	Seriousness	Complaint Grade	Main Theme	Second Theme	Ward	CLOSED
Q3	Moderate	Moderate	Mismanagement of labour	Inadequate Pain Management	Labour	21/11/2022
Q3	Major	Moderate	Mismanagement of labour		L & B	21/12/2022
Q3	Major	Moderate	Mismanagement of labour	Inadequate Pain Management	Labour	29/12/2022
Q3	Moderate	Moderate	Mismanagement of labour	Delay in induction of labour	Labour	22/12/2022
Q3	Moderate	Moderate	Delay/ Failure to Diagnose		Labour	
Q3	Moderate	Moderate	Mismanagement of labour	Delay in induction of labour	Labour	
Q3	Major	Moderate	Mismanagement of labour		L & B	

Key

Closed
Complaint Plan w/lead
Complaint Resolution Meeting
Draft w/ contributors

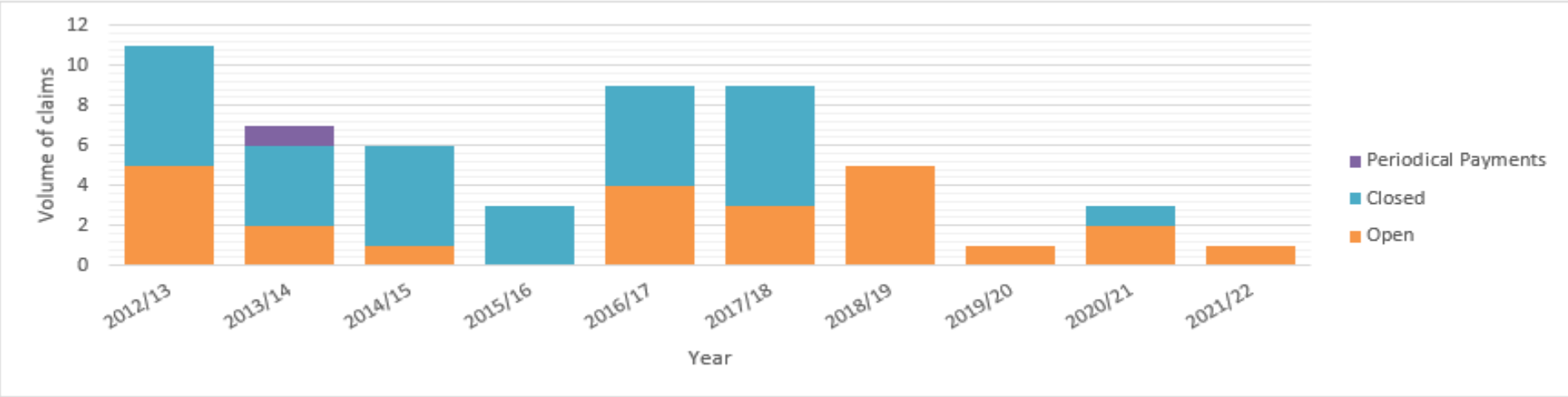
Appendix 4

Maternity Claims Scorecard Dec 2022

% of Trust Clinical Claims - Volume
Obstetrics accounts for 10% of claims

% of Trust Clinical Claims - Value
Obstetrics accounts for 57% of the value of claims

Volume of claims by year



Current status for obstetric claims

	Volume
Open	24
Closed	30
Periodical Payments	1
Total	**55**

Top 5 injuries by value for obstetrics

Top 5 injuries by volume for Obstetrics

	Injury	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Brain Damage	11	107,135,201	9,739,564	18%	49%
2	Adtnl/unnecessary Operation(s)	7	19,485	31,355	12%	0%
3	Fatality	6	1,544,855	257,476	10%	1%
4	Cerebral Palsy	5	70,990,017	14,198,003	8%	32%
5	Unnecessary Pain	4	263,660	65,915	7%	0%
Total Top 5 injuries by Volume for Obstetrics		**33**	**180,153,218**	**5,459,188**	**55%**	**82%**

Top 5 injuries by value for Obstetrics

	Injury	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Brain Damage	11	107,135,201	9,739,564	18%	49%
2	Cerebral Palsy	5	70,990,017	14,198,003	8%	32%
3	Multiple Disabilities	1	13,560,000	13,560,000	2%	6%
4	Not Specified	2	13,162,000	6,581,000	3%	6%
5	Developmental Delay	1	10,550,050	10,550,050	2%	5%
Total Top 5 injuries by Volume for Obstetrics		**20**	**215,397,268**	**10,769,863**	**33%**	**98%**

Top 5 causes by volume for Obstetrics

	Causes	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Failure/Delay Diagnosis	10	26,462,811	2,646,281	17%	12%
2	Fail To Monitor 2nd Stg Labour	10	62,694,814	6,269,481	17%	29%
3	Fail / Delay Treatment	7	39,769,910	5,681,416	12%	18%
4	Inappropriate Treatment	6	409,150	68,192	10%	0%
5	Not Specified	3	13,830,050	4,610,017	5%	6%

Top 5 causes by value for Obstetrics

	Causes	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Fail To Monitor 2nd Stg Labour	10	62,694,814	6,269,481	17%	29%
2	Fail / Delay Treatment	7	39,769,910	5,681,416	12%	18%
3	Fail To Make Resp To Abnrm FHR	2	32,954,967	16,477,484	3%	15%
4	Failure/Delay Diagnosis	10	26,462,811	2,646,281	17%	12%
5	Not Specified	3	13,830,050	4,610,017	5%	6%

Total Top 5 causes by Volume for Obstetrics	**36**	**143,166,734**	**3,976,854**	**60%**	**65%**

Total Top 5 causes by Volume for Obstetrics	**32**	**175,712,551**	**5,491,017**	**53%**	**80%**

Summary of Open Moderate and Severe Incidents and Closed Incidents
UHSFT Maternity Quarter 3 2022-23 Appendix 5

Incident Date by month	Incident Trigger	Summary of Incident	Outcome of Incident	Current Actions and Progress	Any current shared learning
April 22	Therapeutic Cooling	Term baby admitted to the neonatal unit for >24 hours. Cat 1 C-section, term 38+4wks. No RF sepsis, IOL for obstetric cholestasis. Mother had been awaiting ARM. Reduced fetal movements - CTG commenced - pathological --> cat 1 C-section. Mother also required ITU admission	Remained an inpatient on NNU for approx 18 days.	Under investigation by HSIB. November 22: ongoing Jan 2023. Awaiting final comments prior to 5 day review	None at present
May 22	Maternal Death HSIB case	30 yr old. 9th pregnancy (7 liveborn, 1 miscarriage). Complex social history (all 7 children in care/adopted/special guardianship). Self referred to maternity and liaised to NEST team. Presented to ED 16/05/22 (8weeks) feeling unwell with vomiting and dizziness. Noted to have had a headache 2 days previously. Treated with IV fluids and antiemetics. Discharged home with safety netting and referral to hyperemesis (HG) clinic the following day. Attended HG clinic 17/05/22 - TTO metoclopramide given and discharged. Presented 21/05/22 (9 weeks) with dropped GCS. CT scan showed extensive cerebral venous sinus thrombosis with cerebral oedema.	Maternal Death	Under investigation by HSIB. Report in fact accuracy checking until 23/1/23	None at present

		Transferred to Neuro ITU. Fixed and dilated pupils 22/05/22. Certified as being brain stem dead 25/05/22. No FH found on scan 26/05/22. Underwent organ donation 26/05/22.			
June 22	Maternal Death HSIB case	Patient in their 2nd pregnancy (previous termination). She had a past medical history of mild idiopathic intracranial hypertension and a previous MRI brain scan in keeping with old left transverse sinus and sigmoid sinus thrombosis (i.e., clots in the brain). She self-referred to the UHS Maternity services at 5 weeks gestation and was added to the list for triage. She presented to the Emergency Department (ED) at UHS with vomiting and complaining of a severe headache at 7 weeks gestation. She underwent a CT scan which showed cerebral venous thrombus and was started on treatment dose enoxaparin. She was admitted to the neurology ward for observation. She had stable symptoms and visual function and self-discharged against medical advice 2 days after admission. She returned to ED the following morning after experiencing an episode of visual loss and was admitted to the neurology ward where she underwent a lumbar puncture. She suffered a cardiac arrest later that day with alteplase given on presumptive diagnosis of massive pulmonary	This case has been referred to the coroner for a coroners PM.	Under investigation by HSIB and at report panel stage 8/2/23 November 22: ongoing Jan 2023 With HSIB	Review process for informing the appropriate team of a maternal death

		embolism. There was no return of spontaneous circulation and resuscitation was stopped.			
June 22	Neonatal Death	Admitted to UHD following delivery at home of 26+3 baby. Transferred to UHS with working diagnosis of PPHN, sepsis, pneumothorax with IVH	RIP at 9 days of age	Joint PMRT UHS/Dorset ongoing November 22: ongoing	None at present
June 22	Neonatal Death	Born at DCH, transferred to UHS PAH. CoD: 1a Pulmonary haemorrhage b Extreme Prematurity 24 weeks gestation c Gram negative septicaemia e Maternal sepsis , chorioamnionitis	RIP at 2 days of age	Joint PMRT UHS/Dorset ongoing November 22: ongoing	None at present
July 2022	Term post neonatal death	Baby born in Portsmouth and transfer to UHS PICU due to need for emergency tracheostomy at 4 days of age. Diagnosis of Wieacker-Wolff syndrome following genetic testing. He was on long term ventilation and mostly cared for on PHDU. He had concerns with abnormal neurology and EEG showed epileptic spasms. MRI demonstrated brain atrophy. MDT took place and the palliative care team became involved. A ReSPECT form (DNACPR form) was filled out and a symptom management place put in place. He passed away peacefully on PHDU.	RIP at 4 months of age	For review in PICU CDRM. Date TBC. No immediate patient safety concerns identified. November 22: ongoing	None at present
August 22	Therapeutic Cooling	1st pregnancy. BMI 22.49. Under MLC. Called MDAU at 37+1 with reduced fetal movements for 3.5 hours (1st episode). Advised to monitor and call back.	Baby was cooled following	Discussed at CER on 16/08/22. Does not meet HSIB criteria as	To ensure that all local guidance and practice around reduced fetal

		Attended MDAU at 37+2 with history of reduced FMs since the night before. CTG commenced - abnormal CTG. Transferred to theatre for Cat 2 C section. Baby girl born in poor condition. Neurology review planned for 1 hour of age as met criteria A for cooling. Borderline neurology, not meeting criteria B at 1 hour review. Baby admitted to NNU at 3 hours of age and commenced on CFAM. Seizure identified and cooling commenced.	seizure activity. She was started on anticonvulsants and d/c to the postnatal ward.	the mother did not labour. The recording of the call will be reviewed to determine whether the advice given was correct and in line with national guidance. On review, it was felt that a full RCA investigation was required. Reviewed at SISG 27/10/22 and agreed grading as SEC. Investigation ongoing	movements is reflecting national guidance.
August 22	Maternal Death HSIB case	29 yr old. Admitted to Salisbury with abdo pain?PET. Baby delivered by C section at 33/40. At delivery she was found to have ischaemic bowel. She had a CT scan at Salisbury which confirmed aortic dissection and was transferred to UHS for surgical management. She underwent two laparotomies, resection of ischaemic bowel and an infarcted liver. She had fasciotomies for compartment syndrome.	This case has been referred to the coroner for a coroners PM.	Referred to HSIB and MBRRACE (some confusion as Salisbury also completed referrals). Patient safety case review (joint with Salisbury) held on	Clear communication with other hospitals if there is a poor outcome to determine who will be completing relevant reporting.

		She had a further laparotomy which showed no viable bowel, her stomach and uterus were necrotic. This was not survivable, and she died that evening.		13/09/22. No immediate learning identified. November 22: ongoing	

University Hospital Southampton
NHS Foundation Trust

Summary of Open Moderate and Severe Incidents and Closed Incidents
UHSFT Maternity Quarter 3 2022-23 Appendix 5

August 22	Neonatal Unit (NNU) on Opel 4 alert for greater than 24 hours RCA included in this report Appendix 6a	The Neonatal Unit (NICU) at the Princess Anne Hospital (PAH) escalated to Opel14 alert status2 at 1340 hours on 13/08/2022 due to the levels of acuity and reduced staffing. They remained on Opel 4 alert until they de-escalated at 1800 hours on 18/08/2022.	To identify if there was any harm to mothers or babies because of the alerts.	RCA completed to ensure correct processes were followed and to ascertain if any harm came to babies as a result. Reported to the CQC as per requirements and as a SIRI. To combine with other RCA from August. Closed at internal Trust safety meeting (SISG) mid November.	Review the processes within adult critical care to see if there is any shared learning. Write a guideline (or appendix to the Neonatal Unit Operational Policy) which includes a clear process for escalation when there are bed capacity concerns. To also include if there are opportunities to request mutual aid within the region. Once clear process for escalation is in place, ensure that this is communicated to the NICU co-ordinators.
August 22	Neonatal Unit (NNU) on Opel 4 alert for greater than 24 hours RCA included in this report	The Neonatal unit (NNU) at Princess Anne Hospital (PAH) escalated to Opel 4 alert at 1515 hours on 20th August 2022 due to staffing. They de-escalated to Opel 3 at 1600 hours on 21st August 2022. There was a total of 10 nurses available, including the transport nurse and nurse in charge (not usually included in the numbers or given a patient load). The	To identify if there was any harm to mothers or babies because of the alerts.	RCA completed to ensure correct processes were followed and to ascertain if any harm came to babies as a result. Reported to	Review the processes within adult critical care to see if there is any shared learning. Write a guideline (or appendix to the Neonatal Unit Operational Policy) which includes a clear

	Appendix 6b	unit was unable to allocate staff safely. A nurse from PICU was allocated from the staffing hub however this was withdrawn an hour prior to the shift starting without consultation with the unit.		the CQC as per requirements and as a SIRI. To combine with other RCA from August. Closed at internal Trust safety meeting (SISG) mid November.	process for escalation when there are bed capacity concerns. To also include if there are opportunities to request mutual aid within the region. Once clear process for escalation is in place, ensure that this is communicated to the NICU co-ordinators.
September 22	Neonatal Death	Baby born in Portsmouth at 28+6 weeks gestation. Transferred to UHS at 3 days of age for a surgical review. He was found to have had a spontaneous bowel perforation and underwent a laparotomy. He was found to have candida albicans sepsis. He developed seizures and on MRI found ot have extensive damage consistent with disseminated fungal sepsis and a large posterior abscess. Following discussions with the family and the medical teams, care moved to comfort palliative care.	RIP at 18 days of age.	For review in CDRM. Date TBC. No immediate patient safety concerns identified. November 22: ongoing	None at present
September 22	Neonatal Death	Born at 29+6. Caesarean section for reduced fetal movements and abnormal CTG	RIP at 11 weeks from HIE	Joint PMRT UHS/Dorset ongoing November 22: ongoing	None at present

September 22	Therapeutic Cooling HSIB case at parental request although MRI normal	Baby born at 41+3 gestation. Baby was 4.8kg at birth, and it was noted that there were no risk factors for a bigger baby. Mother had a normal BMI, and no gestational diabetes screening. Her previous baby was a normal weight. Baby: Shoulder dystocia, full resuscitation and successful CPR. Had 72 hours of cooling as initial concerns were having seizure activity, cooling was tolerated. Bloods were slightly deranged with deranged LFT and ALT with some evidence of hypoxia. MRI ashowed no definite evidence of HIE injury and baby is doing neurologically well. Mother: Placenta was not able to be delivered in the labour room and there was an ongoing postpartum haemorrhage, so taken to theatre and placenta was delivered under a general anaesthetic. Estimated blood loss (EBL) 1.5L.	Baby and mother discharged home	November 22: ongoing Jan 2023 HISB initial report for Fac Acc in progress.	None at present
September 22	Missed Breech presentation at Term	Baby was identified as being breech on an ultrasound scan at 36 weeks. There were multiple opportunities for this to be escalated appropriately and for the mother's birth options to be discussed. The likelihood is that she would have required a CS, but it was a late first stage of labour CS rather than a planned CS which holds a greater element of risk and most likely contributed to the PPH for which she then needed HDU care.	Mother and Baby discharged home	case reviewed at CER 20/10/22 and taken forward to SISG for grading. Agreed SEC. RCA investigation ongoing November 22: ongoing	Missed opportunity to refer patient down to MDAU after the 36week scan diagnosed breech Formal process needed on referring patients down to MDAU Missed opportunity to have expedited birth by inviting mother in when she first called labour line.

				Jan 2023 RCA for 5 day review end of Jan	
October 22	Neonatal Unit (NNU) on Opel 4 alert for greater than 24 hours (case 6 in 2022)	The Neonatal unit (NNU) at Princess Anne Hospital (PAH) escalated to Opel 4 alert at 0430hours on 24/10/2022 due to acuity and capacity. They remained on Opel 4 alert until 1930 hours on 25/10/2022.	No harm identified	Case logged on STEIS on 28/10/22. RCA investigation ongoing November 22: ongoing	None at present RCA currently in 5 day review to be closed at SISG in late Jan/Feb.
October 22	Antepartum stillbirth	Road Traffic Accident at 27+2. Decision to deliver baby via Cat 1 LSCS for maternal and fetal compromise following a significant placental abruption at RTC.	IUD 27+2	PMRT ongoing November 22: ongoing	None at present Care to be closed PMRG on 24th Jan
October 22	Neonatal Death	Premature labour and had a category 1 LSCS at 33 weeks gestation.	RIP on day of birth	PMRT ongoing November 22: ongoing	None at present
October 22	Neonatal Death	Pre-labour rupture of membranes at 21 weeks	RIP at 1 day of age. Cause of death was extreme prematurity	PMRT ongoing November 22: ongoing Jan 2023 -PMRT with UHD for completion	None at present
October 22	Neonatal death	Antenatal diagnosis of Trisomy 18.	RIP on day of birth	PMRT ongoing	None at present

				November 22: ongoing	
November 22	Neonatal death	Pulmonary Hypoplasia/ Prematurity /Anhydramnious/PPROM at 21weeks Pre-labour LSCS at 31+3 for fetal concerns Cat 3 LSCS	Baby RIP at 1 day of age	November 22: PMRT ongoing For CDRM December 22	None at present
November 22	Maternity Unit on Opel 4 alert for greater than 24 hours	Maternity Services at Princess Anne Hospital (PAH) escalated to Opel 4 alert at 18.20hrs hours on 4/11/2022 due to capacity and acuity. They remained on Opel 4 alert until 02.30hrs hours on 06/11/2022.	No harm Identified	Case logged on STEIS on 28/10/22. RCA investigation ongoing November 22: ongoing	None at present RCA currently in 5- day review to be closed at SISG in late Jan/Feb.
November 22	Neonatal death	Heptoblastoma, CLD, Extreme prematurity at 22 weeks	No harm Identified	Case discussed at NNU CDRM with QAH/Kings/Oncology teams in Dec2022	None at present for UHS
November 22	Neonatal Death	Born at 36+2 at Frimley. Consanguinity. CoD 1a Cardiomegaly. 1b Prematurity	Baby RIP at 1 day of age	November 22: PMRT ongoing For CDRM December 22 Jan 2023 -Awaiting NNU aspects of PMRT to be completed prior to closure	None at present

Summary of Open Moderate and Severe Incidents and Closed Incidents
UHSFT Maternity Quarter 3 2022-23 Appendix 5

November 22	Ureteric injury Serious Event Clinical (SEC)	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.		SISG Panel 20/02/2023	RCA currently being written
November 22	Baby skull fracture – Serious Event Clinical (SEC)	Baby born via LSCS following several attempts at instrumental delivery. Bruising noted post birth CVT scan showed an occipital skull fracture with subgaleal haemorrhage and right sided haematoma which could be consistent with birth injury.	NAI excluded Baby admitted with mum for investigations	SISG Panel 20/02/2023	RCA is ongoing 30 day review next week
December 2022	Baby skull fracture – Moderate incident	UNEXPECTED TERM ADMISSION TO NNU: Readmission from community Forceps delivery, NIPE done by midwife On D2 of life noticed a lump on left side of head Noticed by community team today so sent in Breastfeeding, regained birthweight, otherwise well. Skull XR done - ? fracture from forceps delivery Low index of suspicion for safeguarding- picture of baby seen on D2, lump clearly visible there, parents state seen on D1 by midwife just not documented on NIPE. Boggy, fluctuant swelling over left parietal area with ridge of bone underneath suspicious for depressed fracture. Admitted to SCBU for neuro obs.	NAI excluded Baby admitted with mum for investigations	Case closed	Awaiting DOC to be completed

December 22	Neonatal death	IOL at 39 weeks for fetal reasons	Cause of death was congenital diaphragmatic hernia	PMRT completed by UHS, awaiting Leicester to publish. Jan 2023- No further Action reqd form UHS November 22: ongoing	None at present
December 22	Antepartum Stillbirth	Attended MDAU at 32+2 weeks with absent FM's IUD confirmed 07/12/2022	Intra-uterine death 32+2. Case to be discussed at PMRG and PMRT to be completed	Jan 2023 Case to be discussed at PMRG and PMRT to be completed	None at present
December 22	Moderate Incident	Patient tachycardia worsening from start of night shift, brisk PV loss noted, significant hb drop from 122 to 105 for noted delivery EBL 300ml. Escalated to Obstetric Team, subsequently patient required EUA under GA with 500ml clots removed and total EBL 1500ml PPH. Noted a few episodes of care in the day leading to this event differed from usual care/ guidelines. - Indwelling catheter removed at delivery (1338) with epidural/ forceps- later re-inserted at 1600.	Incident closed	Had Clinical events review. Case closed with some follow up actions including DOC	None at present

		- epidural catheter removed 1600, clexane given 2 hours later at 1800. - Oxytocin 40 IU- 250ml of bag given only. - Group + save not sent in labour. Sample required when attending theatre for EUA. G+S clotted sample found later when patient vacated room, found under delivery bed in corner of room- taken 15/12 at 0320?			
December 22	Moderate Incident	Long term middle grade gaps in Obs and gynae rota Consultant had to act down to cover night as resident Hence day time duties - 2 fetal med lists and preterm clinic had no cover To mitigate risks to women and babies - fetal medicine list needed to be staffed by another consultant (extra contractual) to scan a fetal arrhythmia and another urgent cardiac referral Potential harm - certain fetal arrhythmias could potentially cause fetal hydrops and death We had to request another consultant to run the preterm clinic, further sickness meant a third consultant had to cover the preterm clinic Preterm clinic - if women needed intervention (1 did) and not picked up or performed could lead to second trimester miscarriage or extremely preterm birth These activities cannot be postponed due to the nature of the care we provide	Incident closed	Ongoing workstream to improve this situation	None at present

December 22	Moderate Incident	Neonatal unit on opel 3 alert on: 5.12.22 8.12.22 9.12.22 10.12.22 11.12.22	Incident closed	No further action required at present	None at present
December 22	Moderate Incident	Neonatal unit on Opel 3 alert: 29.11.22 3.12.22 4.12.22	Incident closed	No further action required at present	None at present
December 22	Moderate Incident	Neonatal unit on opel 3 alert: 12.12.22 14.12.22 15.12.22 16.12.22 18.12.22	Incident closed	No further action required at present	None at present

Closed Incidents in Quarter 2 2022-23

November 22	Neonatal Death	Born at 38+1 gestational weeks via elective C-section on a background of antenatal diagnosis of bilateral renal dysplasia, anhdyramnios, severe pulmonary hypoplasia and biventricular hypertrophy with decreased cardiac function and pericardial effusion.	RIP at 1 day of age Transferred to Naomi house		PMRT completed. No learning identified
November 22	Antepartum stillbirth	Referred to UHS for fetal medicine input re bronchogenic cyst. Attended for drainage of the cyst and insertion of chest drain 18/08/2022. Seen in FMU on 26/08/2022 when scan showed cyst to have decreased significantly in size and mediastinal shift had	IUD 27+0	Joint PMRT UHS/Dorset	No

		also improved greatly. Scans following this were within acceptable limits until attendance at scan on the 12/9/22 when sadly the baby had died. Condolences were expressed with forward planning for IOL.			
November 22	Antepartum stillbirth	Patient in her 4th pregnancy with history of previous miscarriages and a late neonatal death (at 6 weeks of age). Referred to Fetal Medicine due to concerns re. fetal growth at the anomaly scan. Confirmed intrauterine growth restriction. Prognosis for the baby explained and agreed to scan 2 weekly. Referred to MDAU as community midwife unable to auscultate fetal heart. IUD confirmed.	IUD at 23+4 weeks gestation.		No learning identified
December 22	Neonatal death	PROM at 21 weeks. CoD: extreme prematurity	RIP 1 day of age		No learning currently identified.

Patient initials or Case Name	Neonatal Unit Opel 4 alert August	**Patient's date of birth**	N/A
UHS hospital number	N/A	**Patient's age**	N/A
AER number	9931668	**Case Log date**	19/08/2022
Investigating officer (s)	LBS	**Investigating officer (s) job title**	Risk & Patient Safety Co-ordinator
Incident date	13-18/08/2022	**Incident type**	SIRI
Division	C	**Care Group**	Women & Newborn
Version History	V1.6 Final Post SISG	**Report Date**	October 2022
STEIS No (for PST use)	2022-17979		

Brief summary of the incident

The Neonatal Unit (NICU) at the Princess Anne Hospital (PAH) escalated to Opel[1] 4 alert status[2] at 1340 hours on 13/08/2022 due to the levels of acuity and reduced staffing. They remained on Opel 4 alert until they de-escalated at 1800 hours on 18/08/2022.

During this period of time, there was 1 referral into our service that was declined:

- 32+4 week gestation woman in utero transfer from Portsmouth

There were a number of in-utero transfers out of our service which took place:

- 34 week gestation woman with premature pre-labour rupture of membranes (PPRoM)
- 34 week gestation woman who had had an antepartum haemorrhage (APH)
- 40+4 week gestation woman who had spontaneous rupture of membranes which were meconium[3] stained

There were a total of 2 women diverted to Salisbury Hospital via the labour line service.

[1] Opel – Operational Pressures Escalation Levels
[2] Opel 4 alert status– the highest level of alert
[3]

Maternity services at PAH escalated to Opel 4 at 1430 hours on 17/08/2022 due to the critical Opel 4 status of NICU. A Divisional emergency meeting was held at 0800 hours and 1500 hours on 18/08/2022 to review the situation. The Maternity services de-escalated to Opel 3 alert at 1430 hours on 18/08/2022 due to some movement of babies in neonates.

Terms of reference for investigation (from case review/ SISG)

- What was the acuity for this period of time?
- What was the staffing for this period of time?
- What is the escalation process for escalating to Opel 4 alert and was this followed?
- Was there appropriate leadership prior to and during this time?
- Did any babies or women come to harm as a result of the Opel 4 alert?
- Is there support for UHS neonatal services in the wider system?
- Have we implemented immediate actions from the previous Opel 4 alerts?
- Were any other babies refused?
- How many women were diverted?
- What was the impact on maternity services?

Root cause/s and major contributory factors of the incident being investigated

Root cause

- The Neonatal Unit experienced extreme pressure due to a lack of available bed capacity.

Main recommendations linked to Action Plan in relation to the root cause/s and contributory factors of the incident being investigated

- Review the bed escalation processes within NICU.

Immediate actions identified and completed

- Adapt the Opel 4 checklist paperwork which is used within Maternity services to improve documentation of the Opel 4 alerts.

How will any specific learning required to achieve the main recommendations outlined above be delivered

- Write a guideline (or appendix to the Neonatal Unit Operational Policy) which includes a clear process for escalation when there are bed capacity concerns. To also include if there are opportunities to request mutual aid within the region.

Any incidental findings not directly related to the incident being investigated, which were not contributory to the outcome of the incident being investigated, but which can lead to additional lessons being learnt
None

Brief details of any support given to the patient and/or relatives relating to the incident and planned investigation. Have they raised any specific issues/questions?	
There is no evidence that any women or babies have come to harm, therefore no duty of candour has been completed.	
Identified patient and/or relatives contact	N/A
Name and designation of staff member acting as contact	N/A

Support provided for Staff involved in the incident
Staff have been supported by the Neonatal Matron AA and the Neonatal Clinical Lead MJ.

	Name	**Designation**
Investigating Officer	LBS	Maternity and Neonatal Risk & Patient Safety Co-ordinator
Clinical lead for investigation	N/A	
Other Team Members	AA	Neonatal Matron
	HM	Divisional Governance Manager
External or internal independent clinical advice provided by (*if none enter Not Applicable*)	N/A	

Resources used for investigation	Incident forms Staffing roster Unit diary Regional huddle information

Chronology (timeline) of significant events

Date & Time	Event	Comments and significant contributory factors
13/08/2022 1340 hours	The Neonatal Unit (NICU) at Princess Anne Hospital (PAH) escalated to Opel 4 alert at 13.40hrs on 13/08/2022 due to acuity of babies on the NICU. There were a total of 28 patients on the NICU. Across the early and late shifts there were 5 members of staff off sick (due to a variety of long-term and short- term sickness – all notified in line with Trust policy for absence). The unit escalated to the site/staffing hub and the site team released keys (i.e., the golden key) to request further staffing via the agency. There were no available staff to be moved to support the unit. Shifts were released on NHS Professionals (NHSP) (agency) but only 1 was filled for both the day and night shift. At this point the Maternity service was on Opel 2 alert. The following referral in to the UHS NICU was declined due to capacity: • 32+4 week in utero from Portsmouth	The neonatal service has 37 bed spaces (12 IC, 11 HC and 14 SC). It is one of three tertiary centres part of the Thames Valley and Wessex Operational Delivery Network (ODN). It is the designated level 3 neonatal unit within Wessex ODN providing integrated neonatal medical care alongside surgical and cardiac care. The service provides care to neonates requiring subspecialist care services within the Southampton Children's Hospital including neonatal surgery, cardiac, clinical genetics, endocrinology, nephrology, neurology, neurosurgery and orthopaedics. In addition, it provides care to the local population. The neonatal service also works closely with Obstetric and Fetal Medicine teams to ensure the right care is delivered in the right place. Southampton Children's Hospital is also a specialist (level 1) cardiac centre which means that surgical cardiothoracic services are provided for patients within the region. The neonatal unit also hosts a specialist neonatal transfer service in collaboration with the neonatal intensive care unit in Oxford (SONeT) and provides emergency neonatal retrievals, planned transfers and repatriations in Thames Valley and Wessex Neonatal Network. The neonatal service aim to meet the optimal nurse staffing as outlined by the British Association of Perinatal Medicine (BAPM)

NICU Intensive Care and High Dependency Care (ICU & HDU) staffing and baby numbers

Late				
	Babies	**Staff Required**	**Actual Staff**	**Unit status**
IC[4]	12	12	7	Opel 4 @ 13:40
HDU[5]	5	3	4	
SC[6]	0	0	0	

NICU Special Care (SC) staffing and baby numbers

Late

2010[7] / 2019[8]. The guidance states that the minimum nurse to baby ratio should be 1:1 for babies receiving intensive care (IC), 1:2 for high dependency care (HC) and 1:4 for special care (SC). The neonatal service use the BAPM 2011[9] categories of care guidance to define intensive care, high dependency care and special care.

There is a daily regional maternity safety huddle call at 1000 hours every day to review the alert status across the Region. This is a Wessex Maternity services huddle for support and mutual aid. A representative from each maternity and neonatal unit within the region are invited to attend (this includes UHS, Hampshire Hospitals NHS Foundation Trust (HHFT), Portsmouth Hospitals NHS Trust (PHU), University Hospitals Dorset NHS Foundation Trust (UHD / Poole), Isle of Wight NHS Trust (IOW) and Labour Line). The staffing and acuity for the maternity services is discussed as well as the neonatal intensive care unit (NICU) & neonatal unit (NNU) staffing.

The TVWODN currently have no role when one or more of the network neonatal providers have challenges with staffing or capacity.

The table below reflects the alert status as of 1000 hours 13/08/22.

	HHFT[10]	UHS[11]	PHU[12]	Poole[13]	IOW[14]	Labour line[15]

[4] IC – intensive care
[5] HDU – high dependency care
[6] SC – special care
[7] BAPM 2010 – Service standards for hospitals providing neonatal care (https://hubble-live-assets.s3.amazonaws.com/bapm/file_asset/file/75/Service_Standards_for_Hospitals_Final_Aug2010.pdf)
[8] BAPM 2019 – Calculating unit cot numbers and nurse staffing establishment and determining cot capacity (https://hubble-live-assets.s3.amazonaws.com/bapm/file_asset/file/101/BAPM_Guidance_on_Cot_Capacity_and_use_of_Nurse_Staffing_Standards_24-10-19.pdf)
[9] BAPM 2011 – categories of care (https://hubble-live-assets.s3.amazonaws.com/bapm/file_asset/file/38/CatsofcarereportAug11.pdf)
[10] HHFT -Hampshire Hospitals Foundation Trust
[11] UHS -University Hospitals Southampton
[12] PHU -Portsmouth Hospitals
[13] Poole -Poole Hospital/University Hospitals od Dorset
[14] IOW -Isle of Wight Hospital.
[15] Labourline -Triage Service dedicated to giving women advice re pregnancy and appropriate referral when they suspect they are in labour.

	Babies	Staff Required	Actual Staff	Unit status
HC	1	0.5	1	Opel 4 @ 13:40
SC	10	2.5	1	

Maternity Staffing & acuity	Opel 2	Opel 2	Opel 3	Opel 2	Not on call [16]	Opel 1
NICU & NNU	Opel 2	Opel 3	Opel 3	Opel 3		SCAS 3

No mutual aid required today.

To note that there was an admission to the UHS NICU at 1220 hours of a term baby (Baby MU) who subsequently underwent therapeutic hypothermia[17] around 1400 hours. (This case has been logged as an SEC[18] (it did not meet HSIB[19] criteria) and will be investigated).

Within the NICU, the staffing for ICU, HDU and SC was split into ICU & HDU (Rooms 2, 3, 4, 5 and 6) and SC (Room 1), therefore the tables containing babies and staff required have been split. There are occasionally SC babies being cared for in ICU & HDU and occasionally HDU babies being cared for in SC.

Information from NNU Data Analyst

HD ratio is supposed to be 1 Staff :2 babies
SC ratio is : 1:4
So if there is 1 High Dependency baby technically we should have 0.5 staff. Which obviously is impossible.
If there were 2 high dependency babies there should be 1 member of staff.

[16] IOW were not on the call as part of the Wessex regional LMNS however they are unable to help with capacity as we would not consider transferrin patients there for ongoing care

[17] Therapeutic Hypothermia Mild total body hypothermia, induced by cooling a baby to 33-34°C for three days after birth, is nowadays a standardized treatment after moderate to severe hypoxic ischemic encephalopathy in full-term and near to full-term neonates.

[18] SEC-Serious Event Clinical - are defined as any untoward medical occurrence(s) that at any dose results in death, hospitalisation or prolongation of existing hospitalisation, persistent or significant disability/incapacity or a congenital anomaly or birth defect.

[19] HSIB – (Healthcare Safety Investigation Branch) are an independent body who conduct safety investigations into care in which patients may have been harmed or may harm the NHS. They provide high quality reports which do not attribute blame or liability .

1436 hours	As part of the escalation process a text alert was sent to key staff to inform of the Opel 4 alert and ask if any staff were able to pick up shifts.	The ALERT text goes to site, maternity services, Neonatal Matron, Care Group Manager and Operations Manager.
1630 hours	Baby girl (Baby C) admitted from PAH theatres (36+1 weeks gestation, twin 2).	This was an unexpected admission of a baby born in good condition following a category 2[20] caesarean section with difficult extraction, who developed breathing difficulties and required respiratory support.
1644 hours	As part of the escalation process a text message was sent to NICU staff to ask if anyone was able to support on the night shift or the following day shift. It should be noted that the NICU had 12 Intensive care beds with 13 Intensive Care babies, and another expected to be admitted.	This was carried out and a text message was sent out to the nursing staff to asked anyone who could help to work a shift.
1909 hours	Baby boy (Baby RL) admitted from PAH theatres with known antenatal diagnosis of transposition of great arteries[21].	This was a planned admission of a baby whose mother was under the care of the Fetal Medicine team at UHS. He was intubated in preparation for atrial septostomy[22] and had an uneventful planned transfer to the Paediatric Intensive Care Unit (PICU) at Southampton General Hospital (SGH) at 22.45 hours for ongoing care.
1945 hours	As part of the escalation process a text message was sent to NICU staff to ask if anyone was able to support on the night shift or the following day shift. It should be noted that the NICU had 12 ICU beds with 14 ICU babies and no emergency space[23].	No adverse outcomes resulted from the issue of overcapacity
2000 hours	NICU remained on Opel 4 status at the beginning of the night shift. There were a total of 29 babies on the unit. The staffing for the night shift is as below.	

[20]

[21] Transposition of the great arteries- is a birth defect of the heart in which the two main arteries carrying blood out of the heart – the main pulmonary artery and the aorta – are switched in position, or "transposed.

[22] Atrial septostomy - is a surgical procedure in which a small hole is created between the upper two chambers of the heart, the atria. This procedure is primarily used to palliate dextro-Transposition of the great arteries or d-TGA, a life-threatening cyanotic congenital heart defect seen in infants.

[23] This space is to ensure that any unexpected emergency that occurred would have a cot to be placed into.

<table>
<tr>
<td></td>
<td>IC & HDU
<table>
<tr><th colspan="5">Night</th></tr>
<tr><th></th><th>Babies</th><th>Staff Required</th><th>Actual Staff</th><th>Unit status</th></tr>
<tr><td>IC</td><td>14</td><td>14</td><td>6</td><td rowspan="3">Opel 4</td></tr>
<tr><td>HDU</td><td>5</td><td>3</td><td>5</td></tr>
<tr><td>SC</td><td>0</td><td>0</td><td>0</td></tr>
</table>
SC
<table>
<tr><th colspan="5">Night</th></tr>
<tr><th></th><th>Babies</th><th>Staff Required</th><th>Actual Staff</th><th>Unit status</th></tr>
<tr><td>HC</td><td>1</td><td>0.5</td><td>1</td><td rowspan="2">Opel 4</td></tr>
<tr><td>SC</td><td>9</td><td>2.25</td><td>1</td></tr>
</table>
</td>
<td>To note that the NICU nurse co-ordinating the night shift should have been supernumerary but was included in the numbers and was required to take a patient load as well as managing the shift coordination. There was no direct impact on the coordination of the shift but it should be recognised that in times of staffing pressures all staff are required to work within the numbers providing direct patient care. This is challenging for the shift coordinator but necessary in the circumstances. It should, however, be the exception in very ad hoc situations due to the impact of the pressure on the wellbeing of the coordinator.</td>
</tr>
<tr>
<td>2245 hours</td>
<td>Baby boy (Baby RL) was transferred uneventfully to PICU for ongoing care. There were now 13 babies in NICU ICU.</td>
<td></td>
</tr>
<tr>
<td>14/08/2022
0644 hours</td>
<td>Baby boy (Baby TC) currently being cared for in room 1 (SC) needed to be transferred to NICU ICU due to requiring central intravenous access to aid with glycaemic control[24]. This meant that there were now 14 babies in ICU.</td>
<td>Baby TC was diagnosed with congenital hyperinsulinism during his admission and initially required a continuous dextrose infusion.</td>
</tr>
<tr>
<td>0815 hours</td>
<td>NICU remained on Opel 4 alert. Text message was sent to NICU staff asking if they were able to work on the day shift. There were 3 members of staff off sick out of 19 staff required to cover the shift.

The ICU staffing for the day shift is as below.

IC & HDU</td>
<td>UHS Maternity were now on Opel 3 alert</td>
</tr>
</table>

[24] Glycaemic control is a medical term referring to the typical levels of blood sugar (glucose) in a person with diabetes mellitus.

	Early & Late **Babies** / **Staff Required** / **Actual Staff** / **Unit status** **IC** 14 / 14 / 6 / Opel 4 **HDU** 5 / 2.5 / 5 **SC** 0 / 0 / 0 SC **Early & Late** **Babies** / **Staff Required** / **Actual Staff** / **Unit status** **HC** 1 / 0.5 / 1 / Opel 4 **SC** 8 / 2 / 1	
0915 hours	The daily PAH Huddle was held as normal. It was noted that NICU were on Opel 4 alert. There were no actions identified.	This is a verbal discussion regarding staff movement and any keys that are released are documented on the Neonatal ward diary pages. Pending patients for admission through maternity services are discussed. At the PAH morning huddle, a discussion is had on staffing and acuity to highlight alert status. Maternity services will then deliver, delay, or try and transfer out what has been agreed. Staffing gaps are highlighted at this meeting and can also escalate unit need to the child health bleep holder and the Neonatal Matron lets the child health Matrons know at their morning huddles. The team decide which registered nurses who are in support roles the unit need to ask to work clinically to maintain patient safety as this is part of our escalation policy. Teams which include the education team, surgical team, family support roles, breast feeding team, risk lead and transport team to consider. The unit try not to do this from the same team as there is then impact on that service but ultimately adhere to the trust values of patient's first and working together.

<table>
<tr><td>1000 hours</td><td>The daily regional maternity safety huddle was held.

It was noted that PHU (Portsmouth) Maternity services were on Opel 3 and needed assistance from within the Region to support with patients in labour.

UHS also needed support with intrauterine transfers. It was noted that NICU at UHS had no capacity and were currently making plans for managing the capacity issues.</td><td><table>
<tr><td></td><td>HHFT</td><td>UHS</td><td>PHU</td><td>Poole</td><td>IOW</td><td>Labourline</td></tr>
<tr><td>Maternity Staffing & acuity</td><td>Opel 1</td><td>Opel 3</td><td>Opel 3</td><td>Opel 1</td><td>Not on call</td><td>Opel 1</td></tr>
<tr><td>NICU & NNU</td><td>Opel 2</td><td>Opel 4</td><td>Opel 3</td><td>Opel 2</td><td></td><td>SCAS 1</td></tr>
</table>
It was incorrectly recorded that NICU at UHS was on Opel 3 status as they were on Opel 4. However, on further discussion with the Manager on call, this was an administrative error.

To note the table above does not contain NICU staffing levels only midwifery staffing.</td></tr>
<tr><td>1100 hours</td><td>The NICU huddle including unit coordinator and Consultant to re-evaluate the unit status.</td><td>On review, the team have been unable to locate the paperwork used which would state the outcome from this discussion.</td></tr>
<tr><td>1500 hours</td><td>The NICU unit huddle including NICU coordinator and Consultant to re-evaluate the unit status. Plan to transfer 1 baby to G2 ward.</td><td>On review, the team have been unable to locate the paperwork used which would state the outcome from this discussion.</td></tr>
<tr><td>Time unknown</td><td>It was noted on the NICU diary page that there was a patient who was pregnant with twins at 30/40 week gestation contracting on labour ward and a 36/40 weeks gestation patient with multiple anomalies also contracting on labour ward.

It was also noted on the NICU diary page that the paediatric bleep holder was aware of need for late or night staff.</td><td>The patient (Ms MM) who was contracting and pregnant with twins at 30/40 weeks gestation stopped contracting that evening and was transferred to the antenatal ward on 15/08/22 and subsequently discharged home.

The woman (Ms LLB) who was on labour ward contracting at 36/40 weeks gestation with multiple anomalies was discussed with the NICU team. It was noted that NICU was on Opel 4 alert and there was a possibility that she would require an in utero or ex utero transfer. However, the Fetal Medicine Consultant stated that she should remain at PAH due to the extensive anomalies.</td></tr>
<tr><td>2000 hours</td><td>Baby boy (Baby FB) was transferred from NICU to G2 ward (within the Children’s Hospital) for ongoing care.</td><td>This was an appropriate transfer.</td></tr>
</table>

<table>
<tr><td></td><td></td><td></td></tr>
<tr><td>2000 hours</td><td>The NICU remained on Opel 4 alert for the night shift. The NICU staffing across the unit was as below. The NICU also had support from a nurse from the Children's Hospital.

IC & HDU
<table>
<tr><th colspan="5">Night</th></tr>
<tr><th></th><th>Babies</th><th>Staff Required</th><th>Actual Staff</th><th>Unit status</th></tr>
<tr><td>IC</td><td>14</td><td>14</td><td>6</td><td rowspan="3">Opel 4</td></tr>
<tr><td>HDU</td><td>4</td><td>2</td><td>5</td></tr>
<tr><td>SC</td><td>0</td><td>0</td><td>0</td></tr>
</table>
SC
<table>
<tr><th colspan="5">Early & Late</th></tr>
<tr><th></th><th>Babies</th><th>Staff Required</th><th>Actual Staff</th><th>Unit status</th></tr>
<tr><td>HC</td><td>1</td><td>0.5</td><td>1</td><td rowspan="2">Opel 4</td></tr>
<tr><td>SC</td><td>8</td><td>2</td><td>1</td></tr>
</table></td><td></td></tr>
<tr><td>2353 hours</td><td>Baby girl (Baby FT) in NICU room 2 was transferred to room 1 (SC). This meant that there were now 4 babies receiving HC in the IC & HDU section of the unit.</td><td>This was an appropriate transfer of care.</td></tr>
<tr><td>15/08/2022
0520 hours</td><td>Baby boy (Baby ALB) born with multiple congenital anomalies and was admitted in to NICU.</td><td>This was a planned admission of a baby with multiple congenital anomalies.</td></tr>
<tr><td>0800 hours</td><td>The NICU remained on Opel 4 alert. There were 4 staff members off sick. Staff were redeployed from non-clinical</td><td></td></tr>
</table>

<table>
<tr>
<td></td>
<td>roles to support the unit. Text message alerts were sent throughout the day to ask for support.

The staffing for the day shift is as below.

IC & HDU
<table>
<tr><th colspan="5">Early & Late</th></tr>
<tr><th></th><th>Babies</th><th>Staff Required</th><th>Actual Staff</th><th>Unit status</th></tr>
<tr><td>IC</td><td>15</td><td>15</td><td>7</td><td rowspan="3">Opel 4</td></tr>
<tr><td>HDU</td><td>3</td><td>2</td><td>3</td></tr>
<tr><td>SC</td><td>0</td><td>0</td><td>1</td></tr>
</table>
SC
<table>
<tr><th colspan="5">Early & Late</th></tr>
<tr><th></th><th>Babies</th><th>Staff Required</th><th>Actual Staff</th><th>Unit status</th></tr>
<tr><td>HC</td><td>1</td><td>0.5</td><td>1</td><td rowspan="2">Opel 4</td></tr>
<tr><td>SC</td><td>9</td><td>2.25</td><td>2</td></tr>
</table>
</td>
<td></td>
</tr>
<tr>
<td>0915 hours</td>
<td>The daily PAH Huddle was held. It was noted that UHS NICU was on Opel 4 and UHS Maternity were on Opel 3. There were no actions identified.</td>
<td></td>
</tr>
<tr>
<td>1000 hours</td>
<td>The daily regional maternity safety huddle was held.

It was noted that UHS NICU were on Opel 4 and PHU NICU were on Opel 3. The plan for the next 24 hours was not yet confirmed at the time of this huddle. It was noted that NICU capacity was minimal due to the workforce which was driving the increased potential for IUT[25] and EUT[26].</td>
<td>
<table>
<tr><td></td><td>HHFT</td><td>UHS</td><td>PHU</td><td>Poole</td><td>IOW</td><td>Labourline</td></tr>
<tr><td>Maternity Staffing & acuity</td><td>Opel 1</td><td>Opel 3</td><td>Opel 2</td><td>Not on call</td><td>Not on call</td><td>Opel 1 - Opel 2 then Opel 3 at 02.00</td></tr>
<tr><td>NICU & NNU</td><td>Opel 1</td><td>Opel 4</td><td>Opel 3</td><td></td><td></td><td>SCAS 3 Portsmouth area (Opel 4)</td></tr>
</table>
</td>
</tr>
</table>

[25] IUT In utero transfer -Transfer of baby whilst mother is still pregnant
[26] EUT- Ex Utero transfer-Transfer of baby following birth.

<table>
<tr><td></td><td></td><td></td></tr>
<tr><td>1100 hours</td><td>A NICU huddle including unit coordinator and Consultant to re-evaluate the unit status was held.</td><td>On review, the team have been unable to locate the paperwork used which would state the outcome from this discussion.</td></tr>
<tr><td>1250 hours</td><td>Baby girl (twin 2) (Baby HW) admitted from PAH Theatres. This meant that there were now 16 IC babies.</td><td>This was an unplanned admission of a baby born at 23+4 weeks gestation. Her mother had presented to PAH with tightenings and severe maternal sepsis. Twin 1 had sadly been stillborn. Twin 1’s care has been reviewed locally and no further action was required as his mother attended acutely unwell and was managed appropriately</td></tr>
<tr><td>1500 hours</td><td>A NICU huddle including unit coordinator and Consultant to re-evaluate the unit status was held.</td><td>On review, the team have been unable to locate the paperwork used which would state the outcome from this discussion.</td></tr>
<tr><td>2000 hours</td><td>At the start of the night shift the NICU remained on Opel 4 alert.

The staffing for the night shift is as below.

IC & HDU
<table>
<tr><th colspan="5">Night</th></tr>
<tr><th></th><th>Babies</th><th>Staff Required</th><th>Actual Staff</th><th>Unit status</th></tr>
<tr><td>IC</td><td>16</td><td>16</td><td>5</td><td rowspan="3">Opel 4</td></tr>
<tr><td>HDU</td><td>3</td><td>2.5</td><td>4</td></tr>
<tr><td>SC</td><td>0</td><td>0</td><td>1</td></tr>
</table>
SC
<table>
<tr><th colspan="5">Night</th></tr>
<tr><th></th><th>Babies</th><th>Staff Required</th><th>Actual Staff</th><th>Unit status</th></tr>
<tr><td>HC</td><td>1</td><td>0.5</td><td>1</td><td rowspan="2">Opel 4</td></tr>
<tr><td>SC</td><td>9</td><td>2.25</td><td>2</td></tr>
</table></td><td></td></tr>
</table>

<table>
<tr>
<td>16/08/2022
0800 hours</td>
<td>The NICU remained on Opel 4 alert. There were 6 staff members off sick. Staff were redeployed from non-clinical roles to support the unit. Shifts were put onto NHSP. Text message alerts were sent throughout the day to ask for support.
The staffing for the day shift is as below.

IC & HDU
<table>
<tr><th colspan="5">Early & Late</th></tr>
<tr><th></th><th>Babies</th><th>Staff Required</th><th>Actual Staff</th><th>Unit status</th></tr>
<tr><td>IC</td><td>16</td><td>16</td><td>6</td><td rowspan="3">Opel 4</td></tr>
<tr><td>HDU</td><td>3</td><td>2</td><td>4</td></tr>
<tr><td>SC</td><td>0</td><td>0</td><td>1</td></tr>
</table>
SC
<table>
<tr><th colspan="5">Early & Late</th></tr>
<tr><th></th><th>Babies</th><th>Staff Required</th><th>Actual Staff</th><th>Unit status</th></tr>
<tr><td>HC</td><td>2</td><td>1</td><td>1</td><td rowspan="2">Opel 4</td></tr>
<tr><td>SC</td><td>8</td><td>2</td><td>2</td></tr>
</table>
</td>
<td></td>
</tr>
<tr>
<td>0915 hours</td>
<td>The daily PAH Huddle was held. It was noted that UHS NICU was on Opel 4 and UHS Maternity were on Opel 3. There were no actions identified.</td>
<td></td>
</tr>
<tr>
<td>1000 hours</td>
<td>The daily regional maternity safety huddle held.

It was noted that UHS NICU had been on Opel 4 alerts for greater than 72 hours due to staffing and acuity.

It also noted that UHS were organising inter uterine transfers (IUTs) due to NICU capacity.</td>
<td>
<table>
<tr><th></th><th>UHS</th><th>HHFT</th><th>PHUT</th><th>UHD</th><th>SCAS</th><th>Labour Line</th></tr>
<tr><td>Maternity Staffing & acuity</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>NICU & NNU</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>
</td>
</tr>
</table>

1100 hours	A NICU huddle including unit coordinator and Consultant to re-evaluate the unit status.	On review, the team have been unable to locate the paperwork used which would state the outcome from this discussion.
1129 hours	An incident form was completed regarding the Opel 4 alert status of greater than 24 hours. The UHS Patient Safety Team were informed. It was planned that the commissioners would be informed, and the case logged on STEIS.	The case was logged on STEIS[27] on 19/08/2022. The Care Quality Commission (CQC) were informed on 18/08/2022 by the UHS Head of Quality Assurance.
1147 hours	Baby boy (Baby AA) admitted to room 2 requiring HC care from postnatal ward.	This was an unplanned admission of a term baby who was admitted requiring respiratory support due to having low oxygen saturations. There were no adverse consequences to this admission
Time unknown	It is documented in the NICU diary pages that there was a 34/40 week gestation woman in the Maternity Day Assessment Unit (MDAU) with premature pre-labour rupture of membranes (PPRoM) who was going to be transferred to Winchester. There was also a 34/40 week gestation woman on MDAU who had had an antepartum haemorrhage (APH) who would be required to be transferred out. There was also a 28/40 week gestation woman with ?spontaneous rupture of membranes (SROM).	Appropriate in utero transfers to other units as the neonatal unit were unable to provide any capacity.
1500 hours	A NICU huddle including unit coordinator and Consultant to re-evaluate the unit status was held.	On review, the team have been unable to locate the paperwork used which would state the outcome from this discussion.
2000 hours	At the start of the night shift the NICU remained on Opel 4 alert. The staffing for the night shift is as below. IC & HDU	

27

	Night **Babies** / **Staff Required** / **Actual Staff** / **Unit status** **IC** 16 / 16 / 5 / Opel 4 **HDU** 4 / 2 / 4 **SC** 0 / 0 / 2 SC **Night** **Babies** / **Staff Required** / **Actual Staff** / **Unit status** **HC** 2 / 1 / 1 / Opel 4 **SC** 8 / 2 / 2	
17/08/2022 0800 hours	The NICU remained on Opel 4 alert. There were 8 staff members off sick. Staff were redeployed from non-clinical roles to support the unit. Shifts were put onto NHSP. Text message alerts were sent throughout the day to ask for support. The staffing for the day shift is as below. IC & HDU **Early & Late** **Babies** / **Staff Required** / **Actual Staff** / **Unit status** **IC** 16 / 16 / 7 / Opel 4 **HC** 4 / 2 / 3 **SC** 0 / 0 / 1 SC **Early & Late**	

<table>
<tr><td></td><td><table>
<tr><th></th><th>Babies</th><th>Staff Required</th><th>Actual Staff</th><th>Unit status</th></tr>
<tr><td>HC</td><td>2</td><td>1</td><td>1</td><td rowspan="2">Opel 4</td></tr>
<tr><td>SC</td><td>8</td><td>2</td><td>2</td></tr>
</table></td><td></td></tr>
<tr><td>0915 hours</td><td>The daily PAH Huddle was held. It was noted that UHS NICU was on Opel 4 and UHS Maternity were on Opel 3. There were no actions identified.</td><td></td></tr>
<tr><td>1000 hours</td><td>The daily Regional maternity safety huddle held.

It was noted that NICU capacity at UHS had remained on Opel 4 for more than 72 hours. The team were attempting to transfer any patient requiring NICU care for their baby out as in utero transfers.

It was also noted that there were no in utero transfer cots available within the Thames Valley and Wessex region for babies who required NICU care (i.e., level 3 care).</td><td><table>
<tr><td></td><td>HHFT</td><td>UHS</td><td>PHU</td><td>Poole</td><td>IOW</td><td>Labourline</td></tr>
<tr><td>Maternity Staffing & acuity</td><td>Opel 2</td><td>Opel 3</td><td>Opel 4</td><td>Opel 2</td><td>Not on call</td><td>Opel 1 N Opel 3</td></tr>
<tr><td>NICU & NNU</td><td>Opel 1</td><td>Opel 4</td><td>Opel 4</td><td>Opel 2</td><td></td><td>SCAS 3 /4 P’mouth</td></tr>
</table></td></tr>
<tr><td>1100 hours</td><td>NICU huddle including unit coordinator and Consultant to re-evaluate the unit status.</td><td>On review, the team have been unable to locate the paperwork used which would state the outcome from this discussion.</td></tr>
<tr><td>1430 hours</td><td>UHS Maternity Services escalated to Opel 4 alert due to the NICU capacity.</td><td>The escalation process was followed as per guidance.</td></tr>
<tr><td>Time unknown</td><td>38+6 woman (Ms MAB) diverted to Salisbury in labour via labour line. She delivered at 2258 hours on 17/08/22.</td><td>The maternity service writes to women as standard if they are diverted or transferred out due to maternity capacity, however they only write to women as standard due to NICU capacity if they are over 36 weeks gestation. There is an operational maternity lead now in post who is supporting with improvements in collation of women’s information so that there is assurance that any woman transferred out is written to.</td></tr>
</table>

<table>
<tr><td>1500 hours</td><td>A Divisional emergency meeting was held to discuss the pressures facing UHS Maternity and Neonatal Services.</td><td>There was no formal documentation from this review meeting.</td></tr>
<tr><td>1700 hours</td><td>Baby girl (Baby BD) from room 1 discharged into foster care.</td><td>This was an appropriate discharge.</td></tr>
<tr><td>1730 hours</td><td>40+4 woman (Ms KC) presented to Broadlands for a SROM[28] check. She was referred to MDAU for a CTG as there was light meconium-stained liquor seen on her pad.</td><td>She was transferred to Salisbury at 2145 hours and delivered at 0259 on 18/08/22. The patient was followed up by the service following the transfer and apologies offered.</td></tr>
<tr><td>1839 hours</td><td>38+0 woman (Ms EE) diverted to Salisbury in labour via labour line. She delivered at 2101 hours on 17/08/22.</td><td>The patient was followed up by the service following the transfer and apologies offered.</td></tr>
<tr><td>1900 hours</td><td>Baby boy (Baby AA) transferred from NICU room 2 to room 1.</td><td>This was an appropriate transfer to support with capacity within the IC & HDU section of the Neonatal Unit.</td></tr>
<tr><td>2000 hours</td><td>Baby boy (Baby LG) transferred to Portsmouth.</td><td>This was an appropriate transfer of a baby so that he could be cared for at the same hospital as his twin.</td></tr>
<tr><td>2000 hours</td><td>At the start of the night shift both NICU and Maternity Services remained on Opel 4 alert.

The NICU staffing for the night shift is as below.

IC & HDU
<table>
<tr><th colspan="5">Night</th></tr>
<tr><th></th><th>Babies</th><th>Staff Required</th><th>Actual Staff</th><th>Unit status</th></tr>
<tr><td>IC</td><td>15</td><td>15</td><td>7</td><td rowspan="3">Opel 4</td></tr>
<tr><td>HDU</td><td>3</td><td>1.5</td><td>5</td></tr>
<tr><td>SC</td><td>0</td><td>0</td><td>0</td></tr>
</table>
SC
<table>
<tr><th>Night</th></tr>
</table></td><td></td></tr>
</table>

		Babies	**Staff Required**	**Actual Staff**	**Unit status**	
	HC	2	1	1	Opel 4	
	SC	8	2	2		
18/08/2022 0800 hours	The NICU remained on Opel 4 alert. There were 9 staff members off sick. Staff were pulled from non-clinical roles to support the unit. Shifts were put onto NHSP. Text message alerts were sent throughout the day to ask for support. Maternity services continued on Opel 4 alert. To note that a baby (Baby FT) from room 1 was transferred to NICU room 6 to have laser surgery for retinopathy of prematurity. She was transferred back to room 1 the following day. The staffing for the day shift is as below. IC & HDU					
	Early					
		Babies	**Staff Required**	**Actual Staff**	**Unit status**	
	IC	16	16	7	Opel 4	
	HDU	3	1.5	3		
	SC	0	0	1		
	SC					
	Early & Late					
		Babies	**Staff Required**	**Actual Staff**	**Unit status**	
	HC	2	1	1	Opel 4	
	SC	7	2	2		

<table>
<tr><td>0800 hours</td><td>A Divisional emergency meeting was held to discuss the pressures facing UHS Maternity and Neonatal Services.</td><td>There was no formal documentation from this review meeting.</td></tr>
<tr><td>0915 hours</td><td>The daily PAH Huddle was held. It was noted that UHS NICU was on Opel 4 and UHS Maternity were on Opel 4. There were no actions identified.</td><td></td></tr>
<tr><td>1000 hours</td><td>Regional maternity safety huddle was held.

It was noted that both UHS were on Opel 4 for both maternity and neonates. NICU have requested all high-risk women for IUT where clinically stable to do so. Labour Ward was closed to labouring women (on full divert) and labour line were aware. The NICU leads from Salisbury, Dorchester, IOW, TV&W ODN and Specialist Commissioning also joined the call. There was a plan to support NICU capacity at UHS.

Those on the call agreed and supported the plan. It was noted that there would be up to 5 IUT transfers across Wessex would potentially need accommodating. UHS confirmed that they could possibility provide maternity escort for IUT.

It was identified that the risk was that there may not be transport available for IUT due to volume. There was a risk that women would decline to be moved. There was also a patient experience risk as women may not be able to have care in their chosen place of birth.

It was also noted that there was an open invite to the maternity safety huddle for NICU staff.</td><td><table><tr><td></td><td>HHFT</td><td>UHS</td><td>PHU</td><td>Poole</td><td>IOW</td><td>Salisbury</td><td>Dorchester</td><td>Labourline</td></tr><tr><td>Maternity Staffing & acuity</td><td>Opel 2</td><td>Opel 4</td><td>Opel 3</td><td>Opel 2</td><td>Not on call</td><td>Not on call</td><td>Not on call</td><td>Opel 1</td></tr><tr><td>NICU & NNU</td><td>Opel 1</td><td>Opel 4</td><td>Opel 2</td><td>Opel 1</td><td>Opel 1</td><td>Opel 1</td><td>Opel 1</td><td>SCAS Opel 1</td></tr></table>
To note that an action from a previous Opel 4 investigation was for NICU staff to be invited to attend the regional maternity safety huddle.</td></tr>
<tr><td>1100 hours</td><td>NICU huddle including unit coordinator and Consultant to re-evaluate the unit status.</td><td>On review, the team have been unable to locate the paperwork used which would state the outcome from this discussion.</td></tr>
</table>

<table>
<tr><td>1235 hours</td><td>Baby girl (Baby EB) born and admitted to Room 1.</td><td>This was an unplanned admission of a baby born at 32+3 weeks gestation whose mother required a caesarean section due to pre-eclampsia[29].</td></tr>
<tr><td>1350 hours</td><td>Maternity Services were able to de-escalate to Opel 3 alert.</td><td></td></tr>
<tr><td>1430 hours</td><td>Baby AA was discharged from the Neonatal Unit to Transitional Care (TC).</td><td>Appropriate transfer.</td></tr>
<tr><td>1500 hours</td><td>NICU huddle including unit coordinator and Consultant to re-evaluate the unit status.

The bed and NICU staffing status within IC&HDU are as below.

IC & HDU
<table>
<tr><th colspan="5">Early</th></tr>
<tr><th></th><th>Babies</th><th>Staff Required</th><th>Actual Staff</th><th>Unit status</th></tr>
<tr><td>IC</td><td>15</td><td>15</td><td>6</td><td rowspan="3">Opel 4</td></tr>
<tr><td>HDU</td><td>3</td><td>1.5</td><td>3</td></tr>
<tr><td>SC</td><td>1</td><td>0.25</td><td>1</td></tr>
</table></td><td></td></tr>
<tr><td>1800 hours</td><td>The neonatal unit de-escalated to Opel 3 alert.</td><td></td></tr>
<tr><td>1900 hours</td><td>Twin girls (Baby AH and Baby AH) were repatriated back to Winchester.</td><td>This was an appropriate transfer.</td></tr>
</table>

29

PST Case number: 9927361 / 9928952 / 9930821

Action plan relating to the root cause/s or contributory factors of the incident being investigated

	Recommendation (as a result of the investigation)	Action required	Impact of action	Designated Lead	Completion date	Group to oversee delivery of this Action Plan
1	Review the escalation processes within NICU when there are bed capacity concerns.	Review the processes within adult critical care to see if there is any shared learning. Write a guideline (or appendix to the Neonatal Unit Operational Policy) which includes a clear process for escalation when there are bed capacity concerns. To also include if there are opportunities to request mutual aid within the region. Once clear process for escalation is in place, ensure that this is communicated to the NICU co-ordinators.	Clearer escalation processes	Neonatal Matron AA Neonatal Matron AA / Director of Midwifery EN / Division C Head of Nursing LG Neonatal Matron AA	Dec 2022 Dec 2022 Dec 2022	Women & Newborn Governance Steering Group

PST Case number:

Action Plan related to any incidental findings not directly related to the incident being investigated, which were not contributory to the outcome of the incident being investigated, but which can lead to additional lessons being learnt

	Recommendation (as a result of the investigation)	Action required	Impact of action	Designated Lead	Completion date	Group to oversee delivery of this Action Plan
	None					

RCA report sign off by divisional teams

Which Committee/s, Group/s or Individual/s approved the Final Draft Report and on what date		
	Date	**Name and designation if appropriate**
Individual/s – specify	21/10/2022	DMT/CGM
	10/11/22	RB DGM
Divisional governance group		
Other Committees/Groups - specify		

RCA report sign off by SISG

Action Plan			
Was the Action Plan agreed by SISG	Yes		
Did the Action Plan mitigate the main risks	Yes		
When are the main components Action Plan due for review	December 2022		
Which Divisional/Care Group Committee/Group will review the Action Plan	Div C		
Are the impact of the Recommendations noted in the Action Plan	Yes		

Final sign off by SISG	
Signed on behalf of SISG by	R. Wheeler
Date	24/11/2022

Patient initials or Case Name	Neonatal Unit (NNU) OPEL 4 alert 20th-21st August	**Patient's date of birth**	N/A
UHS hospital number	N/A	**Patient's age**	N/A
AER number	9932073	**Case Log date**	02/09/2022
Investigating officer (s)	LBS	**Investigating officer (s) job title**	Risk & Patient Safety Co-ordinator
Incident date	20-21/08/2022	**Incident type**	SIRI
Division	C	**Care Group**	Women & Newborn
Version History	V1.3	**Report Date**	October 2022
STEIS No (for PST use)	2022-18967		

Brief summary of the incident

NNU at Princess Anne Hospital (PAH) escalated to OPEL 4[1] alert at 1515 hours on 20th August 2022 due to staffing. They de-escalated to OPEL 3 at 1600 hours on 21st August 2022.

There was 1 patient whose referral was declined admission to University Hospitals Southampton (UHS) (25+1 week gestation woman from Poole).

Terms of reference for investigation (from case review/ SISG)

- What was the acuity for this period of time?
- What was the staffing for this period of time?
- What is the escalation process for escalating to OPEL 4 alert and was this followed?
- Was there appropriate leadership prior to and during this time?
- Did any babies or women come to harm as a result of the OPEL 4 alert?
- Is there support for UHS neonatal services in the wider system?

[1] OPEL 4 – Operational Pressures Escalation Level, which is the hospital's highest alert level.

Root cause/s and major contributory factors of the incident being investigated

Root cause

- The Neonatal Unit experienced extreme pressure due to staffing shortages, largely due to short term staff sickness and also a lack of available bed capacity.

Main recommendations linked to Action Plan in relation to the root cause/s and contributory factors of the incident being investigated

- Review the staffing escalation processes within NICU.
- Review the NICU recruitment and retention plans.

Immediate actions identified and completed

- Adapt the OPEL 4 checklist paperwork which is used within Maternity services to improve documentation of the OPEL 4 alerts.

How will any specific learning required to achieve the main recommendations outlined above be delivered

- Write a guideline (or appendix to the Neonatal Unit Operational Policy) which includes a clear process for escalation of unsafe nursing levels. Once clear process for escalation is in place, ensure that this is communicated to the NICU co-ordinators.

Any incidental findings not directly related to the incident being investigated, which were not contributory to the outcome of the incident being investigated, but which can lead to additional lessons being learnt

None

Brief details of any support given to the patient and/or relatives relating to the incident and planned investigation. Have they raised any specific issues/questions?

There is no evidence that any women or babies have come to harm, therefore no duty of candour has been completed.

Identified patient and/or relatives contact	N/A
Name and designation of staff member acting as contact	N/A

Support provided for Staff involved in the incident
Staff have been supported by the Neonatal Matron AA and the Neonatal Clinical Lead MJ.

	Name	**Designation**
Investigating Officer	LBS	Maternity and Neonatal Risk & Patient Safety Co-ordinator
Clinical lead for investigation	N/A	
Other Team Members	AA	Neonatal Matron
	HM	Divisional Governance Manager
	RB	DGM
External or internal independent clinical advice provided by (*if none enter Not Applicable*)	N/A	
Resources used for investigation	Incident forms Staffing roster Unit diary Regional huddle information	

Chronology (timeline) of significant events

<table>
<tr><th>Date & Time</th><th>Event</th><th>Comments and significant contributory factors</th></tr>
<tr><td>20/08/2022
0800 hours</td><td>The Neonatal Unit (NICU) at Princess Anne Hospital (PAH) were on OPEL 3 status at the beginning of the day shift.

NICU Intensive Care and High Dependency Care (ICU & HDU) staffing and baby numbers

<table>
<tr><th colspan="5">Early</th></tr>
<tr><th></th><th>Babies</th><th>Staff Required</th><th>Actual Staff</th><th>Unit status</th></tr>
<tr><td>IC[2]</td><td>12</td><td>12</td><td>6</td><td rowspan="3">OPEL 3</td></tr>
<tr><td>HDU[3]</td><td>3</td><td>1.5</td><td>4</td></tr>
<tr><td>SC[4]</td><td>3</td><td>0.75</td><td>1</td></tr>
</table>

NICU Special Care (SC) staffing and baby numbers

<table>
<tr><th colspan="5">Early</th></tr>
<tr><th></th><th>Babies</th><th>Staff Required</th><th>Actual Staff</th><th>Unit status</th></tr>
<tr><td>HC</td><td>2</td><td>1</td><td>1</td><td rowspan="2">OPEL 3</td></tr>
<tr><td>SC</td><td>8</td><td>2</td><td>2</td></tr>
</table>
</td><td>The neonatal service has 37 bed spaces (12 IC, 11 HC and 14 SC). It is one of three tertiary centres part of the Thames Valley and Wessex Operational Delivery Network (ODN). It is the designated level 3 neonatal unit within Wessex ODN providing integrated neonatal medical care alongside surgical and cardiac care. The service provides care to neonates requiring subspecialist care services within the Southampton Children's Hospital including neonatal surgery, cardiac, clinical genetics, endocrinology, nephrology, neurology, neurosurgery and orthopaedics. In addition, it provides care to the local population. The neonatal service also works closely with Obstetric and Fetal Medicine teams to ensure the right care is delivered in the right place.

Southampton Children's Hospital is also a specialist (level 1) cardiac centre which means that surgical cardiothoracic services are provided for patients within the region.

The neonatal unit also hosts a specialist neonatal transfer service in collaboration with the neonatal intensive care unit in Oxford (SONeT) and provides emergency neonatal retrievals, planned transfers and repatriations in Thames Valley and Wessex Neonatal Network.

The neonatal service aim to meet the optimal nurse staffing as outlined by the British Association of Perinatal Medicine (BAPM) 2010[5] / 2019[6]. The guidance states that the minimum nurse to baby ratio should be 1:1 for babies receiving intensive care (IC), 1:2 for high dependency care (HC) and 1:4 for special care (SC). The neonatal service use the BAPM 2011[7] categories of care guidance to define intensive care, high dependency care and special care.</td></tr>
</table>

[2] IC – intensive care
[3] HDU – high dependency care
[4] SC – special care
[5] BAPM 2010 – Service standards for hospitals providing neonatal care (https://hubble-live-assets.s3.amazonaws.com/bapm/file_asset/file/75/Service_Standards_for_Hospitals_Final_Aug2010.pdf)
[6] BAPM 2019 – Calculating unit cot numbers and nurse staffing establishment and determining cot capacity (https://hubble-live-assets.s3.amazonaws.com/bapm/file_asset/file/101/BAPM_Guidance_on_Cot_Capacity_and_use_of_Nurse_Staffing_Standards_24-10-19.pdf)
[7] BAPM 2011 – categories of care (https://hubble-live-assets.s3.amazonaws.com/bapm/file_asset/file/38/CatsofcarereportAug11.pdf)

		Within the NICU, the staffing for ICU, HDU and SC was split into ICU & HDU (Rooms 2, 3, 4, 5 and 6) and SC (Room 1), therefore the tables containing babies and staff required have been split. There are occasionally SC babies being cared for in ICU & HDU and occasionally HDU babies being cared for in SC.
0915 hours	The daily Wessex Maternity Safety Huddle which includes all Units within the Region was held as normal. It was noted that NICU were on OPEL 3 alert. There were no actions identified.	This is a verbal discussion regarding staff movement and any keys that are released are documented on the Neonatal ward diary pages. Pending patients for admission through maternity services are discussed. At the PAH morning huddle, a discussion is had on staffing and acuity to highlight alert status. Maternity services will then deliver, delay, or try and transfer out what has been agreed. Staffing gaps are highlighted at this meeting and can also escalate unit need to the child health bleep holder and the Neonatal Matron lets the child health Matrons know at their morning huddles. The team decide which registered nurses who are in support roles the unit need to ask to work clinically to maintain patient safety as this is part of our escalation policy. Teams which include the education team, surgical team, family support roles, breast feeding team, risk lead and transport team to consider. The unit try not to do this from the same team as there is then impact on that service but ultimately adhere to the trust values of patient's first and working together.
1000 hours	The daily regional maternity safety huddle was held. It was note that UHS NICU was on OPEL 3. There was reduced night and weekend staff within Maternity services across the region. No support was requested.	There is a daily regional maternity safety huddle call at 1000 hours every day to review the alert status across the Region. This is a Wessex Maternity services huddle for support and mutual aid. A representative from each maternity and neonatal unit within the region are invited to attend (this includes UHS, Hampshire Hospitals NHS Foundation Trust (HHFT), Portsmouth Hospitals NHS Trust (PHU), University Hospitals Dorset NHS Foundation Trust (UHD / Poole), Isle of Wight NHS Trust (IOW) and Labour Line). The staffing and acuity for the maternity services is discussed as well as the neonatal intensive care unit (NICU) & neonatal unit (NNU) staffing. The status at this meeting is below

		<table><tr><td></td><td>HHFT</td><td>UHS</td><td>PHU</td><td>UHD</td><td>IOW</td><td>Labourline</td></tr><tr><td>Staffing & acuity</td><td>OPEL 2</td><td>OPEL 2</td><td>OPEL 3</td><td>OPEL 2</td><td>Not on call</td><td>Opel 1</td></tr><tr><td>NICU & NNU</td><td>Win OPEL 3 – Basing 4</td><td>OPEL 3</td><td>OPEL 3</td><td>OPEL 3</td><td></td><td>SCAS 1</td></tr></table>
1040 hours	Baby boy (Baby HW) admitted from PAH Theatres to Room 3 (requiring special care).	This was an unplanned admission of a baby born at 33+3 weeks gestation via Category 3 caesarean section for pre-eclampsia. He was initially born in condition but starting grunting and therefore was started on non-invasive respiratory support and admitted to the Neonatal Unit.
1045 hours	Baby boy (Baby M-IT) admitted from the postnatal ward to Room 1 due to persistent hypoglycaemia.	This was an unplanned admission of a baby born at 37+4 weeks gestation who had persistent hypoglycaemia and therefore needed neonatal support. As this was a term unplanned admission, his care was reviewed through the Maternity Clinical Events Review process as is the case for any term unplanned admission. On review, there was a learning point identified regarding temperature control and use of incubators, but it was not felt that changes in antenatal, intrapartum, or postnatal management would have prevented the admission.
Time unknown	It was noted in the NICU diary pages that there was a woman (Ms NL) who was 35/40 weeks gestation contracting on Labour Ward. It was also noted in the NICU diary pages that a referral was declined. This referral was for a 25+1 weeks gestation woman (Ms EB) from Poole. The reason for the referral being declined was lack of beds/staff.	Ms NL continued to labour and gave birth to a baby boy at 1804 hours on 20/10/22. Both mum and baby were admitted to the Transitional Care Unit on F Level at PAH and Baby DL did not require admission to the Neonatal Unit. Ms EB was admitted to Queen Alexandra Hospital (QAH) Portsmouth. Her baby boy was born at 25+5 weeks gestation on 24/08/2022. He has since transferred to NICU PAH on 04/09/2022 for surgical review and is currently still on the unit (preterm babies often remain on the neonatal unit until their corrected gestational age is around term).

<table>
<tr>
<td>Approx 1400 hours</td>
<td>It was noted in the NICU diary pages that there was a woman (Ms PM) who was 35+1 weeks gestation.</td>
<td>On review, Ms PM was in threatened pre-term labour. It was discussed that the neonatal unit were closed and therefore if she continued to labour, she would need an in-utero transfer and Salisbury were prepared to accept her if required. She was transferred to Salisbury at 1839 hours on 20/08/22.</td>
</tr>
<tr>
<td>Time unknown</td>
<td>It was noted in the NICU diary pages that there was a woman (Ms CN) with twins who was 36+2 weeks gestation.</td>
<td>On review, Ms CN was admitted due to tightenings and ?pre-term labour. She was admitted to the antenatal ward on 19/08/22. Her tightenings decreased in pain and it was confirmed that she was not in labour. She was discharged home at 2045 hours on 20/08/2022.</td>
</tr>
<tr>
<td>1515 hours</td>
<td>The Neonatal Unit escalated into OPEL 4 status. It was noted that the unit was down 5 nurses on the late and down 6 nurses on the night shift. The staffing hub and child health were informed. Text alerts were sent as per the escalation process.

There were 5 members of staff off sick on NICU on this day. It appears from the NICU diary pages that 4 nursing staff were doing NHSP agency shifts to cover the Unit.

NICU Intensive Care and High Dependency Care (ICU & HDU) staffing and baby numbers

<table>
<tr><th colspan="5">Late</th></tr>
<tr><th></th><th>Babies</th><th>Staff Required</th><th>Actual Staff</th><th>Unit status</th></tr>
<tr><td>IC</td><td>12</td><td>12</td><td>5</td><td rowspan="3">OPEL 4 @15.15</td></tr>
<tr><td>HDU</td><td>3</td><td>1.5</td><td>4</td></tr>
<tr><td>SC</td><td>4</td><td>1</td><td>1</td></tr>
</table>

NICU Special Care (SC) staffing and baby numbers

<table>
<tr><th colspan="5">Late</th></tr>
<tr><th></th><th>Babies</th><th>Staff Required</th><th>Actual Staff</th><th>Unit status</th></tr>
<tr><td>HC</td><td>2</td><td>1</td><td>1</td><td rowspan="2">OPEL 4 @15.15</td></tr>
<tr><td>SC</td><td>9</td><td>2.25</td><td>2</td></tr>
</table>
</td>
<td></td>
</tr>
</table>

<table>
<tr>
<td></td>
<td>It was also noted that a baby (Baby SC) was transferred from Room 4 to Room 1.</td>
<td>Appropriate transfer.</td>
</tr>
<tr>
<td>2000 hours</td>
<td>The Maternity Services at UHS escalated to OPEL 4 alert due to NICU capacity. NICU at UHS remain on OPEL 4. It was noted that there was a nurse from PICU to support on the night shift.

ICU&HDU

<table>
<tr><th colspan="5">Night</th></tr>
<tr><th></th><th>Babies</th><th>Staff Required</th><th>Actual Staff</th><th>Unit status</th></tr>
<tr><td>ICU</td><td>12</td><td>12</td><td>7</td><td rowspan="3">OPEL 4</td></tr>
<tr><td>HDU</td><td>3</td><td>1.5</td><td>2</td></tr>
<tr><td>SC</td><td>4</td><td>1</td><td>0</td></tr>
</table>

SC

<table>
<tr><th colspan="5">Night</th></tr>
<tr><th></th><th>Babies</th><th>Staff Required</th><th>Actual Staff</th><th>Unit status</th></tr>
<tr><td>HC</td><td>2</td><td>1</td><td>2</td><td rowspan="2">OPEL 4</td></tr>
<tr><td>SC</td><td>9</td><td>2.25</td><td>0</td></tr>
</table>
</td>
<td>The escalation process was followed as per guidance.

To note that the NICU nurse co-ordinating the night shift should have been supernumerary but was included in the numbers and was required to take a patient load as well as managing the shift coordination. There was no direct impact on the coordination of the shift but it should be recognised that in times of staffing pressures all staff are required to work within the numbers providing direct patient care. This is challenging for the shift coordinator but necessary in the circumstances. It should, however, be the exception in very ad hoc situations due to the impact of the pressure on the wellbeing of the coordinator.

Unfortunately, the support by the nurse from PICU was withdrawn an hour before the shift started due to two members of PICU staff phoning in sick.</td>
</tr>
<tr>
<td>21/08/2022
0800 hours</td>
<td>NICU and Maternity Services at UHS remain on OPEL 4 alert.
The staffing on NICU was as below:

ICU&HDU
<table>
<tr><th colspan="5">Early</th></tr>
<tr><th></th><th>Babies</th><th>Staff Required</th><th>Actual Staff</th><th>Unit status</th></tr>
<tr><td>IC</td><td>11</td><td>11</td><td>8</td><td>OPEL 4</td></tr>
</table>
</td>
<td></td>
</tr>
</table>

	<table><tr><td>**HDU**</td><td>4</td><td>2</td><td>3</td></tr><tr><td>**SC**</td><td>3</td><td>0.75</td><td>0</td></tr></table> SC <table><tr><th colspan="5">Early</th></tr><tr><th></th><th>Babies</th><th>Staff Required</th><th>Actual Staff</th><th>Unit status</th></tr><tr><td>**HC**</td><td>2</td><td>1</td><td>2</td><td rowspan="2">OPEL 4</td></tr><tr><td>**SC**</td><td>9</td><td>2.25</td><td>0</td></tr></table>	
1000 hours	The daily regional maternity safety huddle was held. It was noted that UHS Maternity and NICU were on OPEL 4 status. Though NICU were hoping to step down by lunchtime. It was also noted that PHU Maternity and NICU were on OPEL 4 (they went onto divert at 1030 hours). PHU had 16 IOL[8] booked, their postnatal ward was closed as was their birth centre. It was planned that there would be a further regional call at 1300 hours to review the status across the region.	<table><tr><td></td><td>HHFT</td><td>UHS</td><td>PHU</td><td>UHD</td><td>IOW</td><td>Labourline</td></tr><tr><td>Staffing & acuity</td><td>OPEL 2</td><td>OPEL 4</td><td>OPEL 4</td><td>OPEL 2</td><td>Not on call</td><td>Opel 1</td></tr><tr><td>NICU & NNU</td><td>Win OPEL 3 – Basing 4</td><td>OPEL 4</td><td>OPEL 4</td><td>OPEL 3</td><td></td><td>SCAS 1</td></tr></table>
Time unknown	It was noted on the NICU diary pages that there was a 28+1 weeks gestation woman (Ms SI) on labour ward who was ?septic and requiring antibiotics. It was noted that Poole could potentially take ex-utero.	On review, Ms SI was diagnosed as being covid positive. She remained an inpatient until 2130 hours on 22/08/22 where she was discharged home.
1300 hours	The daily regional maternity safety huddle was reconvened due to capacity within the region. There was representation from maternity and neonates across the region. Salisbury was also on the call to support. It was noted that at UHS:	<table><tr><td></td><td>HHFT</td><td>UHS</td><td>PHU</td><td>UHD</td><td>IOW</td><td>Labourline</td></tr><tr><td>Staffing & acuity</td><td>OPEL 2</td><td>OPEL 4</td><td>OPEL 4</td><td>OPEL 2</td><td>Not on call</td><td>Opel 1</td></tr><tr><td>NICU & NNU</td><td>Win OPEL 3 – Basing 4</td><td>OPEL 4</td><td>OPEL 4</td><td>OPEL I 3</td><td></td><td>SCAS 1</td></tr></table>

8

<table>
<tr>
<td></td>
<td>

UHS maternity services de-escalating to OPEL 3 and able to take term labourers but still needing to divert pre-term activity
Maternity staffing appropriate at present however concerns regarding the night shift
NICU have 1 emergency cot at present, with 1 further cot later though staffing reduces overnight (improves the following morning).
NICU discussing further staffing overnight with aim to support IC babies

It was also noted that there was significant ongoing high acuity and activity with Maternity at PHU, including reduced staffing overnight and tomorrow.
It was also noted that there were limited options to support the neonatal staff across units as although Salisbury and Poole were able to support it would compromise their ability to function. Oxford NICU (Level 3) were also closed.
There were a few IUT transfers due to take place which would support with capacity across the region. The plan was to reconvene at 1830 hours.
</td>
<td></td>
</tr>
<tr>
<td>1530 hours</td>
<td>UHS Maternity services de-escalated to 3.</td>
<td></td>
</tr>
<tr>
<td>1600 hours</td>
<td>
UHS NICU de-escalated to O 3. Support was offered from Child Health for the night shift.
The staffing on NICU was as below:
ICU&HDU
<table>
<tr><th colspan="5">Late</th></tr>
<tr><th></th><th>Babies</th><th>Staff Required</th><th>Actual Staff</th><th>Unit status</th></tr>
<tr><td>IC</td><td>9</td><td>9</td><td>7</td><td rowspan="2">OPEL 3</td></tr>
<tr><td>HDU</td><td>4</td><td>2</td><td>3</td></tr>
</table>
</td>
<td></td>
</tr>
</table>

SC	4	1	1	

SC

Early				
	Babies	**Staff Required**	**Actual Staff**	**Unit status**
HC	2	1	2	OPEL 3
SC	9	2.25	0	

PST Case number: 9932073

Action plan relating to the root cause/s or contributory factors of the incident being investigated

	Recommendation (as a result of the investigation)	Action required	Impact of action	Designated Lead	Completion date	Group to oversee delivery of this Action Plan
1	Review the staffing escalation processes within NNU.	Review the processes within adult critical care to see if there is any shared learning. Write a guideline (or appendix to the Neonatal Unit Operational Policy) which includes a clear process for escalation of unsafe nursing levels. To also include if there are opportunities to request mutual aid within the region. Once clear process for escalation is in place, ensure that this is communicated to the NNU co-ordinators.	Clearer escalation processes	Neonatal Matron AA Neonatal Matron AA / Director of Midwifery EN / Division C Head of Nursing LG Neonatal Matron AA	Dec 2022 Dec 2022 Dec 2022	Women & Newborn Governance Steering Group
2	Review the NNU recruitment and retention plans	Review the NNU recruitment and retention plans to determine if there are any other strategies to aid in recruitment and retention. Include the Thames Valley & Wessex Operational Delivery Network Neonatal Nursing Workforce Report May 2022 as part of this review.	Potential for increased staff recruitment and retention	Neonatal Matron AA / Divisional lead for Education, Recruitment and Retention SN	Dec 2022	Women & Newborn Governance Steering Group

PST Case number: 9932073

Action Plan related to any incidental findings not directly related to the incident being investigated, which were not contributory to the outcome of the incident being investigated, but which can lead to additional lessons being learnt

	Recommendation (as a result of the investigation)	Action required	Impact of action	Designated Lead	Completion date	Group to oversee delivery of this Action Plan
1	None					

RCA report sign off by divisional teams

Which Committee/s, Group/s or Individual/s approved the Final Draft Report and on what date		
	Date	**Name and designation if appropriate**
Individual/s – specify	21/10/2022	DMT/CGM/DGM
	21/10/2022	AA NNU Matron
Divisional governance group	21/10/2022	DGM
Other Committees/Groups - specify		

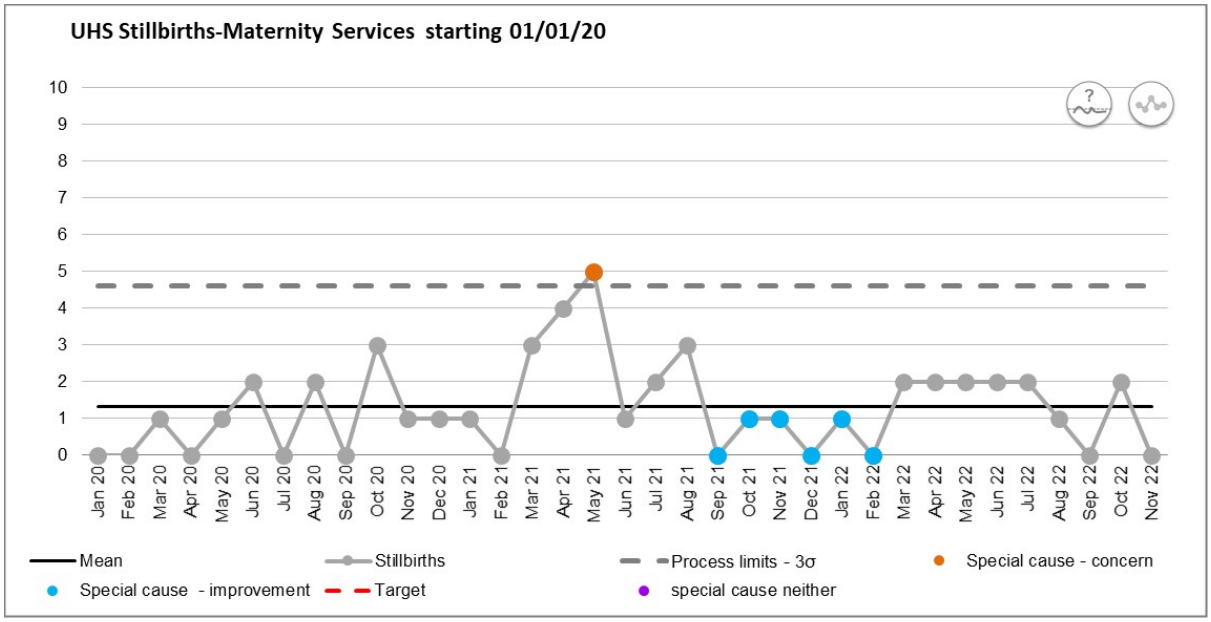
RCA report sign off by SISG

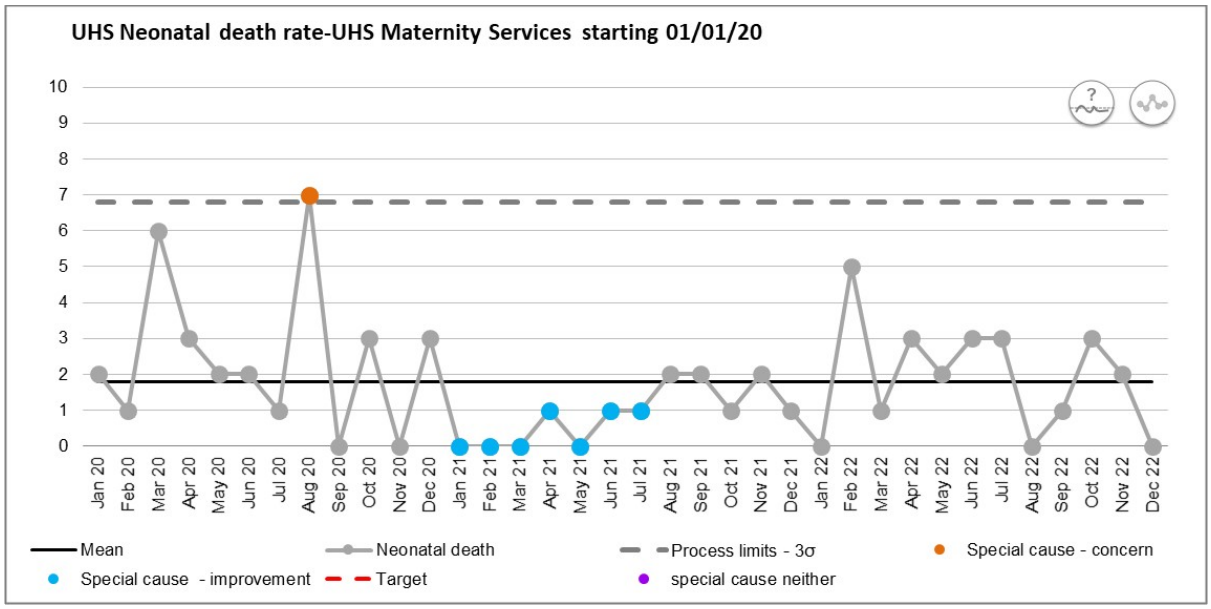
Action Plan			
Was the Action Plan agreed by SISG	Yes		
Did the Action Plan mitigate the main risks	Yes		
When are the main components Action Plan due for review	December 2022		
Which Divisional/Care Group Committee/Group will review the Action Plan	Div C		
Are the impact of the Recommendations noted in the Action Plan	Yes		

Final sign off by SISG	
Signed on behalf of SISG by	R. Wheeler
Date	24/11/2022

Appendix 7

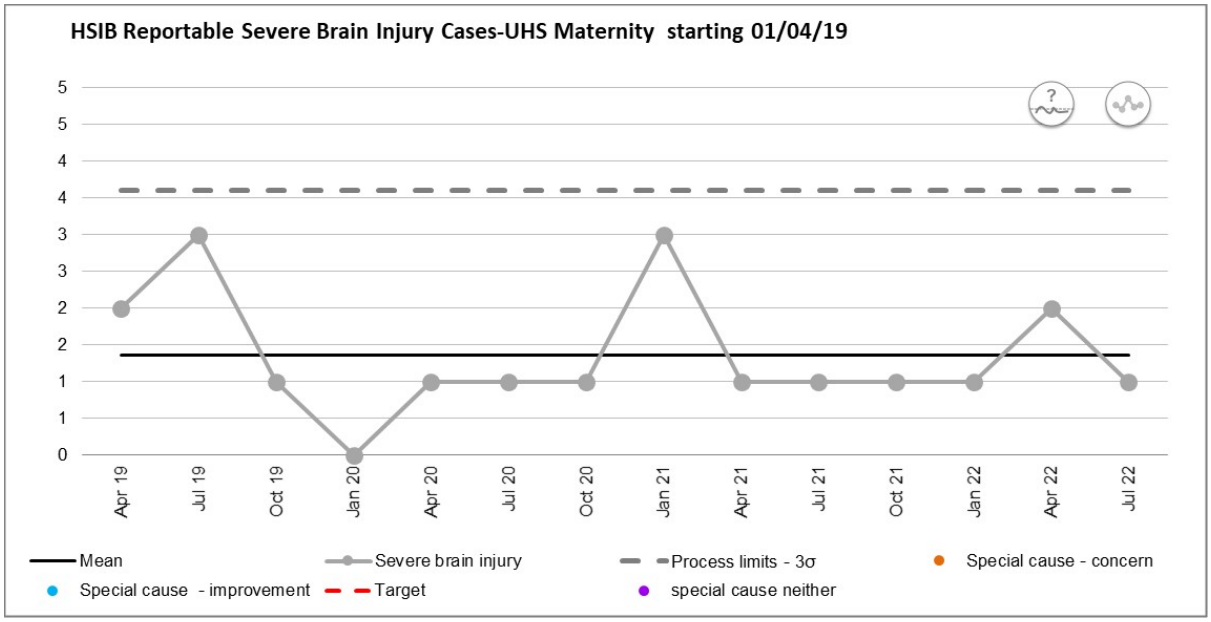
Overview of UHS Stillbirths, Neonatal Deaths, HSIB severe brain injury and Maternal Deaths

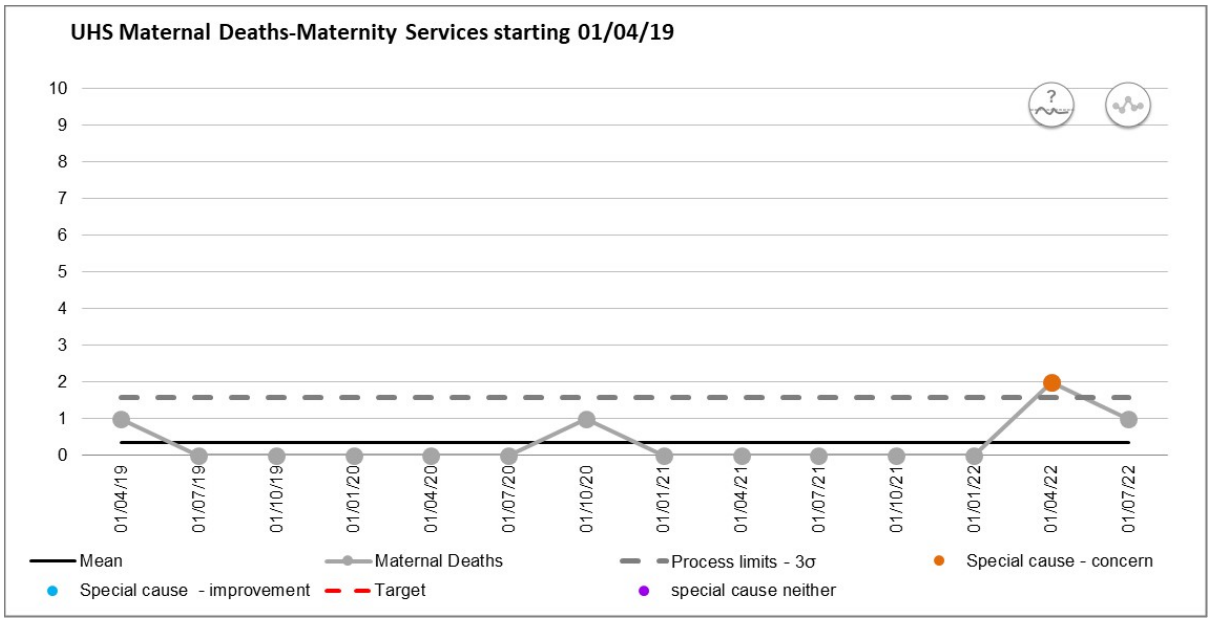




Appendix 7

Overview of UHS Stillbirths, Neonatal Deaths, HSIB severe brain injury and Maternal Deaths





Appendix 8

Maternity and Newborn Clinical Governance Risk Report
January 2023
NHSR PMRT REPORTING

Report to:	Women and Newborn Governance Steering Group / Quality Governance Steering Group
Aim of Report:	To provide the Governance group with assurance and escalate areas of concern and non-compliance
Reports Received from:	Maternity & Neonatal Risk Group
Background:	This information is to provide assurance to **Women and Newborn Governance Steering Group / Quality Governance Steering Group** on the requirement for the maternity services Perinatal Mortality to MBRRACE as required by NHS Resolution Maternity Incentive Scheme (MIS). The year 4 scheme was paused on 05/01/2022 and restarted in May 2022. The updated year 4 requirements are: a) i. All perinatal deaths eligible to be notified to MBRRACEUK from **6th May 2022** onwards must be notified to MBRRACE-UK within **seven working days** and the surveillance information where required must be completed within **one month** of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter. ii. A review using the Perinatal Mortality Review Tool (PMRT) of **95% of all deaths of babies (of the quarter being reviewed),** suitable for review using the PMRT, from **6th May 2022** will have been started within **two months** of each death. This includes deaths after home births where care was provided by your Trust. b) **At least 50% of all deaths of babies** (suitable for review using the PMRT) who were born and died in your Trust, including home births, from **6th May 2022** will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within **four months** of each death and the report **published within six months** of each death. c) **For at least 95% of all deaths** of babies who died in your Trust from **6th May 2022**, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. d) Quarterly reports will have been submitted to the Trust Board from **6th May 2022** onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.
Reporting requirements:	**Quarter 1 – 2022/23 – 1st April – 30th June** **Standard ai)** • **22 babies** eligible for notification (including babies that died within the Children's Hospital). • All cases were notified within 7 working days. • **19 babies** eligible for notification and surveillance, of which all have had surveillance completed. **Standard aii)** • **19 babies** suitable for review • All reviews started within 2 months of the death **Standard b)** • **13 babies** suitable for review who were born and died at UHS. All reviews completed.

Standard c)

- **95% of deaths of babies,** the parents have been told that a review of their baby's death will take place. This will be reviewed with the bereavement teams to ensure that this aspect of the PMRT is completed.

Quarter 2 22022/23 1st July -30th September 2022
Standard ai)

- **13 babies** eligible for notification (including **2** babies that died within the Children's Hospital).
- All cases were notified within 7 working days.
- **11 babies** eligible for notification and surveillance, of which all have had surveillance completed, are still within the timescale.

Standard aii)

- **11 babies** suitable for review
- All reviews started within 2 months of the death

Standard b)

- **11 babies** suitable for review who were born and died at UHS
- **6** reviews completed, the other **5** reviews are still within timescale

Standard c)

- **86% of deaths of babies,** the parents have been told that a review of their baby's death will take place. This will be reviewed with the bereavement teams to ensure that this aspect of the PMRT is completed. 1 case is yet to be reviewed however is within the timescale and will be updated.

Key points of the reviews from Q2:

- Clearer evidence of documentation regarding taking baby home
- CO monitoring for booking
- Asking about domestic violence
- Estates issues within NNU /PICU
- Use of interpreters

Quarter 3 22022/23 1st October- 5th December 2022
Standard ai)

- **9 babies** eligible for notification (including 0 babies that died within the Children's Hospital).
- All cases were notified within 7 working days.
- **5 babies** eligible for notification and surveillance, of which all have had surveillance completed, are still within the timescale.

Standard aii)

9 babies suitable for review

- All reviews started within 2 months of the death

Standard b)

- **9 babies** suitable for review who were born and died at UHS

4 reviews completed, the other reviews are still within timescale

Standard c)

- **100% of deaths of babies,** the parents have been told that a review of their baby's death will take place. This will be reviewed with the bereavement teams to ensure that this aspect of the PMRT is completed

.

Key points of the reviews from Q3:

- Clearer evidence of documentation regarding taking baby home
- CO monitoring for booking
- Asking about domestic violence
- Estates issues within NNU /PICU
- Use of interpreter services

Actions to address the above:

	• Improve documentation to reflect conversations taking place in the bereavement period (including use of cold cot, discussions re. taking baby home and use of cubicles on PICU for end-of-life care) • Community Matron to address why CO monitoring was not undertaken and ensure that all staff have access to appropriate equipment • Community Matron to discuss with staff involved re the importance of asking DV questions and how to manage this if the partner is present with different approaches. • Estates issues are ongoing which will only be resolved in NNU with the proposed expansion plan • Usage of interpreters reminder to staff in all areas, including SGH
	A formal action tracker is in development using the Safeguard system. To note the ongoing actions. Parental involvement to be improved /increased within the process so that parents are more involved in the reviews
Requires Urgent Escalation to Divisional Board	Nil.

MBRRACE No	Type of death	Date of death	Initial date of review	Cause of death	Themes / actions	Status
Quarter 4 – 21/22						
80477	IUD	15/03/2022	Apr 22 PMRG	Awaiting PM findings	None at present	Published – awaiting review of PM at Jan 2023 Meeting
Quarter 1 – 22/23						
81042	NND	10/04/2022	June 22 NNU CDRM	1a Severe Hypoxic ischaemic encephalopathy Stage 3 B Multiorgan dysfunction c Fetal atrial flutter secondary to myocardial dysfunction d Maternal Type 1 Diabetes Mellitus (Infant of diabetic mother)	None	Published – awaiting PM results Ask Sam/Jackie
81286	IUD	26/04/2022	May 22 PMRG	Awaiting PM findings	None	Published
81474	NND	07/05/2022	June 22 PMRG	Coroners PM	CO monitoring Asking about DV	Awaiting Coroner PM
81679	IUD	19/05/2022	June 22 PMRG	Awaiting PM findings	None	Completed - Pending PM results Ask Sam/Jackie
81861	NND	03/06/2022	June 22 CER	1a) severely dysplastic tricuspid valve 1b) dilated right atrium / prenatal closure of ductus arteriosus	None – to note referred to HSIB as term neonatal death	Published – awaiting review of PM at Jan 2023 Meeting
81863	NND	04/06/2022	July 22 NNU CDRM	Severe hypoxic ischaemic encephalopathy Extreme prematurity	None at present	Published – awaiting review of PM at Jan 2023 Meeting
81934	IUD	08/06/2022	July 22 PMRG	Awaiting PM findings	None at present	To Add PM
82070	NND	18/06/2022	July 22 NNU CDRM	Awaiting PM findings	Late booking /AN steroids info/Estates issues with no appropriate room provision	Completed pending PM Ask Sam/Jackie
82103	NND	21/06/2022	July 22 NNU CDRM	Ia Pulmonary Hemorrhage. Extreme prematurity 24 weeks gestation. Gram -ve septicemia. Maternal sepsis Chorioamnionitis	Estates issues only for UHS however many issues for DCH	Awaiting SONET to complete information prior to closing
82203	NND	25/06/2022	July 22 CER Aug 22 PMRG	Undetermined -Awaiting PM	CO monitoring	To Add PM
Quarter 2 – 22/23						
82463	NND	11/07/2022	Sept 22 NNU CDRM	1a Complex congenital heart disease (not operated)	None at present	Completed
82470	IUD	11/07/2022	Aug 22 CER Sept 22 PMRG	Unexplained	Unbooked/Interr preter issues Offered to take baby home Inappropriate as well as against mothers wishes	Completed pending PM Ask Sam/Jackie

82708	IUD	26/07/2022	Aug 22 CER Sept 22 PMRG	Unexplained	Partogram use	Published – awaiting review of PM at Jan 2023 Meeting
83052/1	IUD	15/08/2022	Sept PMRG	Sepsis	Opportunity not to take baby home -However this was not possible as rooming in with 2nd Twin	Published
83052/2	NND	/09/2022	October NNU CDRM	Extreme prematurity	No sound-proofed room Opportunity not to take baby home	Published
83118	IUD	21/08/2022	Aug 2022 PMRG	Undetermined awaiting full PM	No blood tests were taken post delivery	Completed pending PM Ask Sam/Jackie
83459	NND	07/09/2022	For Oct 22 NNU CDRM	? Fungal Sepsis	None at present	Awaiting return from QAH
83516	IUD	09/09/2022	Sept 22 PMRG	Awaiting PM	None at present	Completed pending PM Ask Sam/Jackie
83839	IUD	04/10/2022	Dec PMRG	Antepartum placental Abruption	None at present	In progress- Awaiting further Scoping meeting
83960	NND	11/10/2022	Nov NNU CDRM	Fetal Macrosomia <95th centile =ve NIPT T21 Anhydramnious dilated heart with heart block ,hydrops	Co monitoring, Resus notes	In progress Awaiting completion of NNU aspects
84181	NND	23/10/2022	Nov NNU CDRM	Extreme prematurity	Parental information n post death	Published
84248	NND	28/10/2022	Nov NNU CDRM	Cyanotic Heart disease /T21	None at present	With UHD Awaiting CDRM notes/ prior to closure
84424	NND	08/11/2022	Dec NNU CDRM	Pulmonary Hypoplasia/ Prematurity /Anhydramnious/PPROM at 21weeks	Estates issues on NNU.Post death communication with parents	Awaiting Update re Lletz info prior to closure
84492	NND	13/11/2022	Dec NNU CDRM	Heptoblastoma, CLD ,Extreme prematurity at 22 weeks	Estates issues on NNU.Post death communication with parents	Awaiting completion by QAH and CDRM notes prior to closure
84505	NND	14/11/2022	Dec NNU CDRM	1a.Cardiomyopathy 1b.Prematurity(36 weeks).	Use of Interpreters - FPH. Estates issues at UHS. - Skin care	Awaiting FPH dats/CDRM notes prior to closure
84915	IUD	09/12/2022	For Jan 2023 PMRG	Unknown	Unknown	In progress
Child Health Cases						
MBRRACE No	**Type of death**	**Date of death**	**Initial date of review**	**Cause of death**	**Themes / actions**	**Current status**

76066	NND	04/07/2021	Oct 2021 PICU CDRM	Undetermined – waiting PM report	None for UHS	To Add PM details in +Review at CDRM
81588	NND	13/05/2022	Sept 22 PICU CDRM	Pulmonary hypertension suspected secondary to alveolar capillary dysplasia Malrotation (operated 08/05/22), anal stenosis, undescended testes	CO monitoring throughout pregnancy	Completed
81866	NND	31/05/2022	Sept 22 PICU CDRM	Group B streptococcal meningitis	Documentation re. use of cold cot and offering parents to take their baby home	Completed
82474	NND	12/07/2022	Not yet reviewed	1a: Hypoplastic left heart syndrome (Palliation operation 27/06/2022).	None at present	Completed
82690	NND	24/07/2022	Not yet reviewed	1a. Wieacker-Wolff Syndrome 1b. Respiratory failure requiring tracheostomy-dependent ventilation 2. Seizure Activity	None at present	In progress- Awaiting CDRM in Jan 2023 to complete

Appendix 9a.

Midwifery Workforce Q3 2022-2023 UHSFT

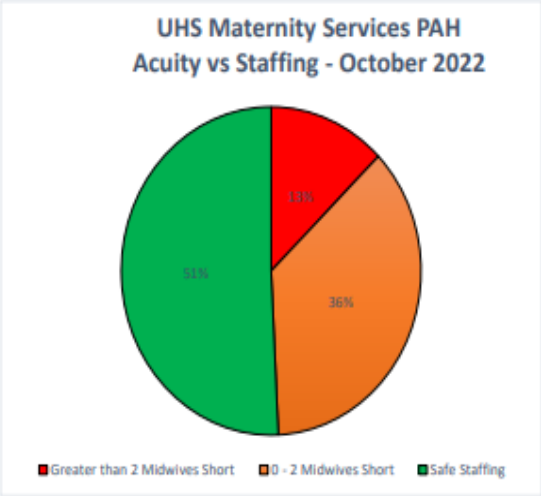
Snapshot Date	Overall Funded - WTE	Total WTE	Starters - WTE	Starters - Head Count	Leavers - WTE	Leavers - Head Count	Turnover - %	Vacancy = (-) Overspent = (+) - WTE	Study Leave WTE	Study Leave %	Mat in WTE	Mat as % of WTE	Sickness in WTE	Sickness As a %	Covid Sickness in WTE	Covid Sickness as a %	Vacancy as a %
Snapshot 1 Oct	206.92	188.68	1.80		2.43		1.29%	-18.24					10.45	5.54%			8.81%
Snapshot 1 Nov	206.92	196.11	10.59	12.00	3.13	3.00	1.60%	-10.81	4.47	2.28%	10.07	5.14%	11.54	5.88%	2.20	1.12%	5.22%
Snapshot 1 Dec	206.92	192.64	0.57	0.00	4.04	4.00	2.10%	-14.28	13.39	6.95%	10.58	5.49%	13.55	7.04%	1.06	0.55%	6.90%
Snapshot 1 Jan	206.92	191.67	0.00	0.00	0.97	2.00	0.51%	-15.25	5.14	2.68%	10.58	5.52%	17.24	8.99%	3.16	1.65%	7.37%

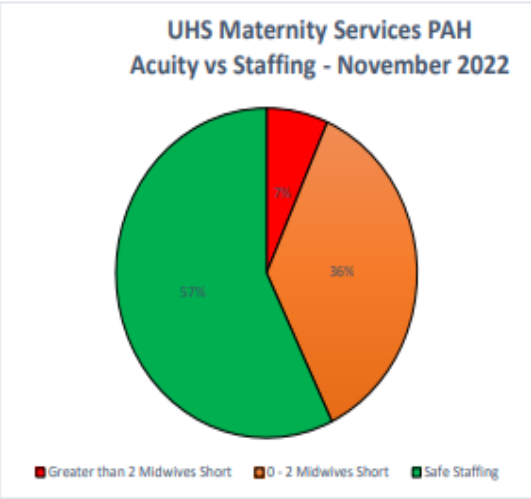
Midwifery Staffing Ratios Q3 2022-2023 – Reports 1 month in arrears – based on midwives in post

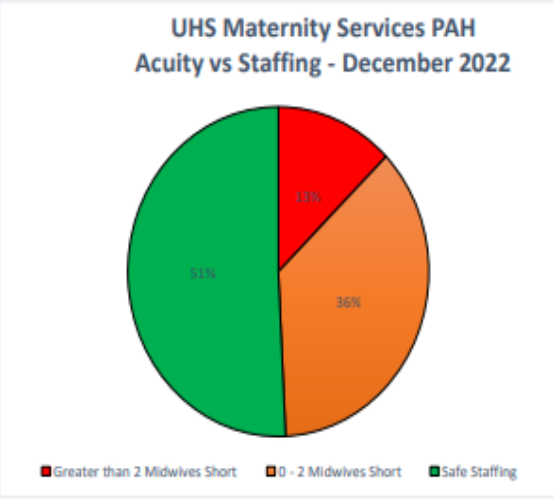
Date	Midwifery to Birth Ration
November 2022	1:26.5
November 2022	1:26.9
December 2022	1.27.1

University Hospital Southampton NHS
NHS Foundation Trust

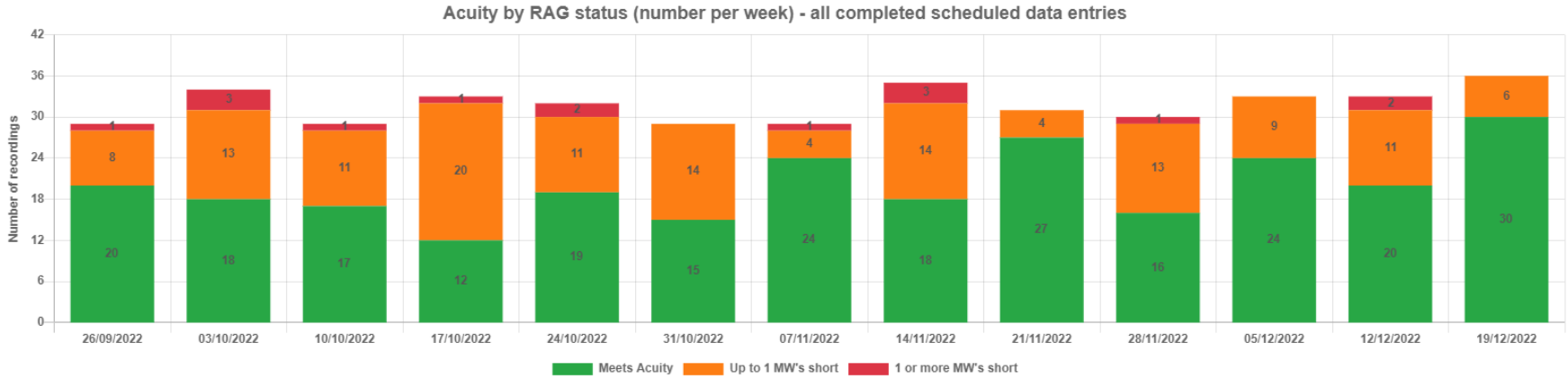
Maternity Service Overview of Birthrate Plus Data Q3 2022-2023- Acuity vs Staffing





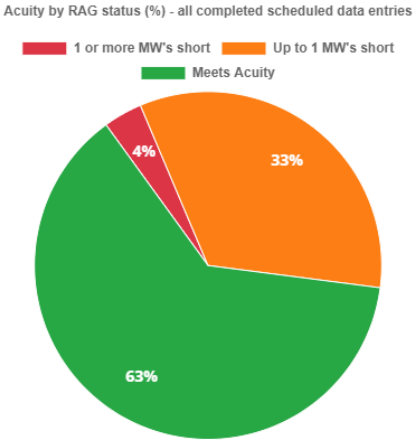


University Hospital Southampton NHS FT - Princess Anne Hospital - Broadlands BC

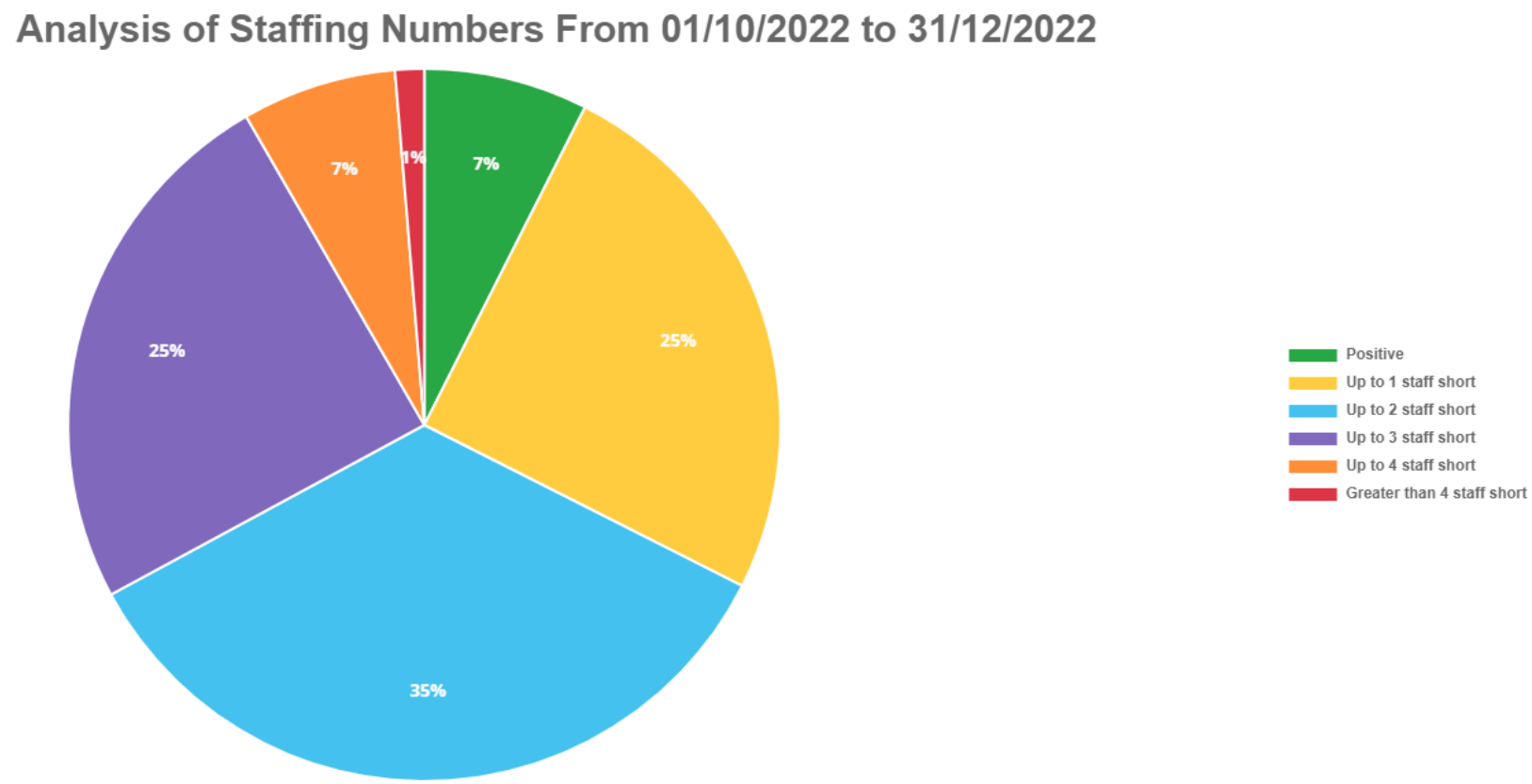


Overall compliance during the data period for weeks commencing 26/09/2022

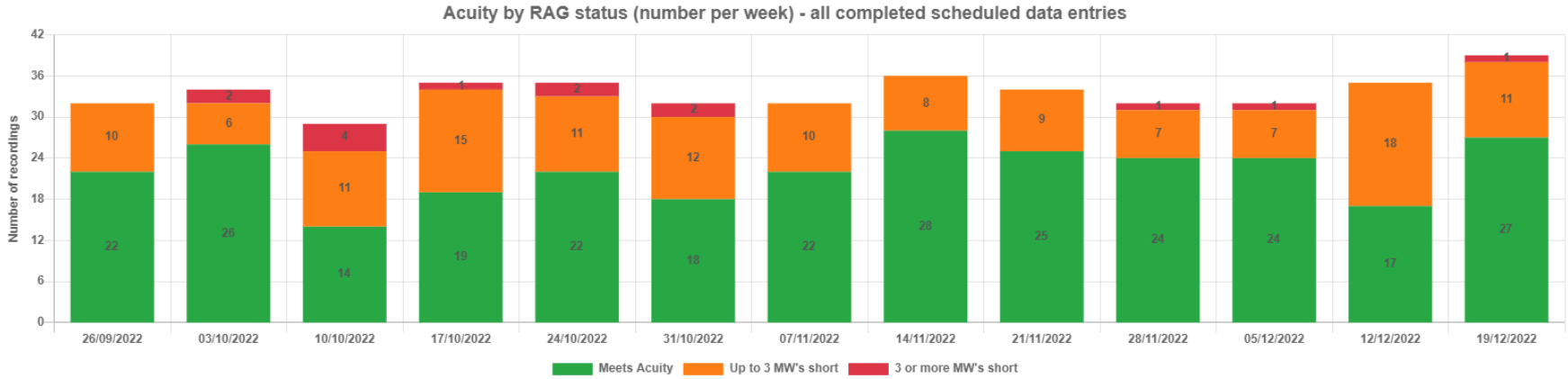
Completed scheduled data entry	75.6%
Missed scheduled data entries	24.4%



University Hospital Southampton NHS FT - Princess Anne Hospital - Burley Ward

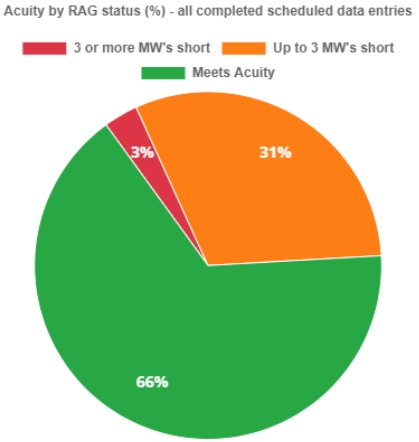


University Hospital Southampton NHS FT - Princess Anne Hospital - Labour Ward 1

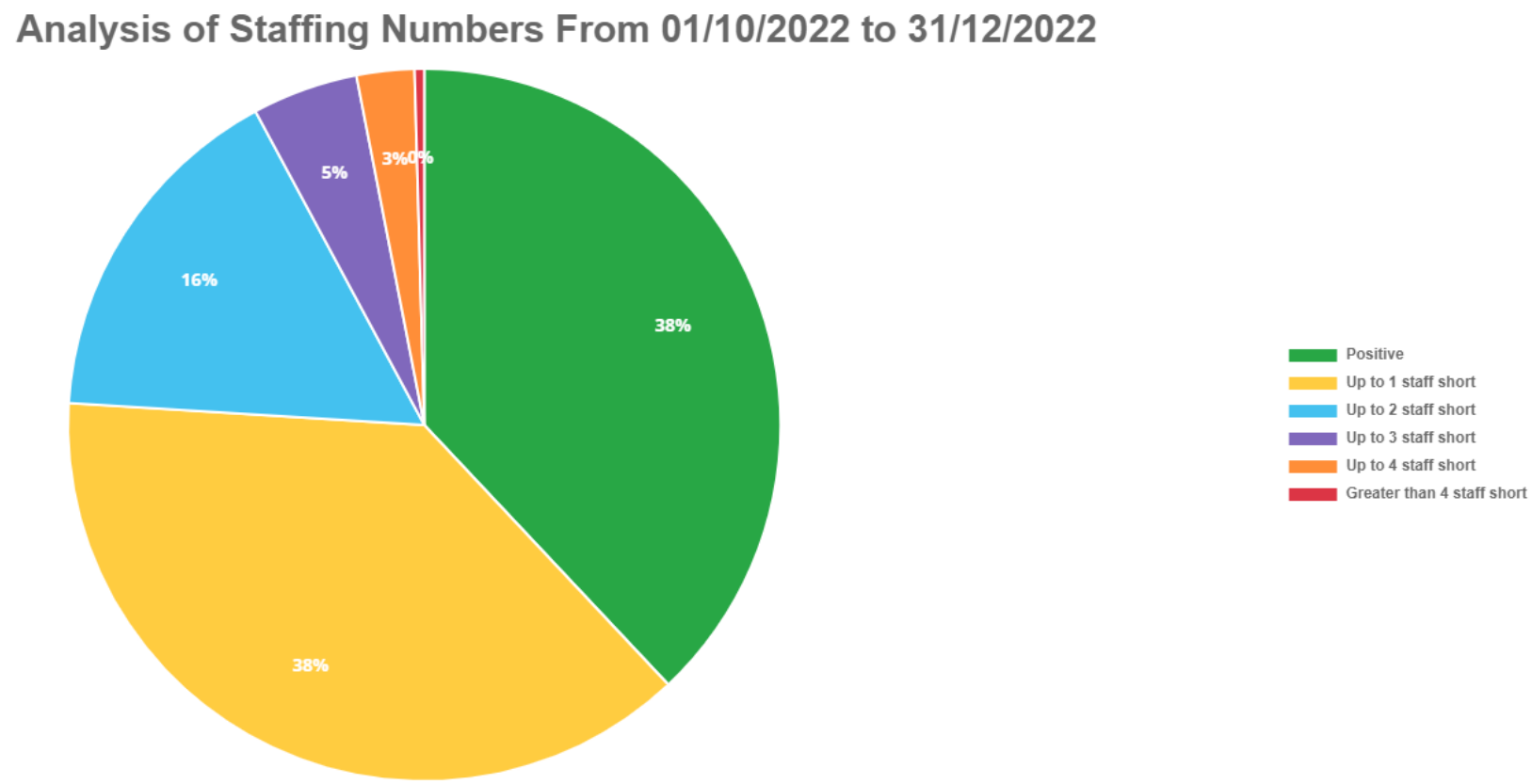


Overall compliance during the data period for weeks commencing 26/09/2022

Completed scheduled data entry	80%
Missed scheduled data entries	20%



University Hospital Southampton NHS FT - Princess Anne Hospital - Lyndhurst Ward



Annual Report 2021 – 2022 for Antenatal and Newborn Screening at University Hospital Southampton NHS Foundation Trust

Author Francesca Finch – Antenatal and Newborn Screening Specialist Midwife

The purpose of the annual report is to give assurance up to Trust Board level that the commissioned antenatal and newborn screening programmes are performing in line with national standards. Our commissioners consider it imperative that there is an awareness of the successes, quality, and challenges within antenatal and newborn screening at UHSFT at this level.

This report will be distributed to the following people and organisations after review by the Director of Midwifery and Neonatal Services.

Internally:

- The CEO at UHSFT
- The Medical director at UHSFT who has oversight of screening programmes within the trust
- The DCD and DDO of Division C (Woman and Newborn)
- The CGM for Women and Newborn
- The Midwifery Business manager
- The QA matron who also line manages the screening team
- The contracting manager at UHSFT
- The Ultrasound Lead
- The clinical lead for the Virology laboratory
- The laboratory manager and clinical lead for Sickle Cell and thalassaemia screening

Externally:

- The clinical lead for trisomy 13,18 and 21 screening at Portsmouth Hospital Trust
- The clinical lead for Newborn Bloodspot Screening at Portsmouth Hospital Trust
- The Screening and Immunisation Manager at NHS England Wessex area team
- The Screening and Quality Assurance team at NHS England

The content of this report will be discussed at the Screening Steering Board Meeting which provides trust oversight of screening and is attended by both the DCD for Division C (delegated attendance from the Trust's Medical Director) and the Director of Midwifery and Neonatal Services who is designated as the responsible officer for screening at UHSFT.

There are six antenatal and neonatal screening programmes. The standards for these are set by each programme team at a national level. The programmes are commissioned by Public Health England/NHS England. The programmes include:

Introduction

This report relates to the operations and performance of antenatal and newborn screening programmes from April 2021 to the end of March 2022. It is important to acknowledge the impact that Covid 19 still had across maternity services within this time frame.

Antenatal

- **Infectious Diseases in Pregnancy Screening (IDPS)**
- **Sickle Cell and Thalassaemia screening (SC&T)**
- **Fetal Anomaly Screening Programme (FASP)**

Newborn

- **Newborn Bloodspot screening (NBBS)**
- **Neonatal and Infant Physical Examination (NIPE)**
- **Newborn Hearing Screening Programme (NHSP)**

There are KPIs attached to all the screening programmes which are submitted quarterly and there is an annual data submission against the standards for the antenatal screening programmes.

Antenatal screening programmes

Infectious Diseases in pregnancy screening (IDPS). Screening for HIV, Hepatitis B and syphilis

Despite the continued demand on our virology laboratory, we continue to receive a robust, high level of service from our virology laboratory colleagues. Overall, our turn-around- times are met and our multi-disciplinary team meetings with a risk of vertical transmission to babies remains virtual. The monthly meeting over 'Teams' is still working well, and we continue to enjoy a very solid multidisciplinary relations with our Hepatology and Sexual Health colleagues.

The annual antenatal data submission for IDPS measured against the following standards submitted June 2021 for this reporting period:

Standard 4 Test Turnaround Time
Standard 5 Timely discussion of screen Results with women
Standard 7 timely immunisation of babies whose mothers are Hep B positive

The standards were met and exceeded for all of these during the period of this report.

In addition, quarterly data is submitted against the following standards:
Standards 1,2 and 3 – these are coverage KPI's where the achievable standard for coverage of tests for these 3 conditions is 99%. We exceed 99% and have a very low decline rate for these tests.

Standard 6 Timely review by Heptology of new and high infectivity Hepatitis B positive mothers within 6 weeks. Our trust exceeds this standard and offers all hepatitis B positive women a review within 6 weeks.

Sickle Cell and Thalassaemia Screening

Historically, UHSFT has struggled to achieve the timeliness of testing for sickle cell and thalassaemia by 10 weeks and 0 days. %. It is important to note that the rationale behind timely testing is to ensure that women can access prenatal diagnostic testing at a stage in their pregnancy which

enables them to have 'reproductive choice'. At UHSFT we have rapid referral into a CVS and amniocentesis service which overcomes any earlier delay but, in line with other trusts regionally, we experience some variation in the length of time it takes to receive results. The samples must travel to the regional laboratory for preparation and are then sent to the national reference laboratory in Oxford.

The introduction of Badgernet with direct self-referral has assisted in reducing timescales for entry into the maternity service and, as we restored from the one stop model, we were able to see a direction of improvement. However, the introduction of Badgernet meant we lost the ability to pull exception reports that consistently gave the gestation at testing. This meant that we were still unable to pull meaningful reports in Q4. A workaround report has been created but was complex to create and was only in use from April 2022. Significant resources have been mobilised to speed up the timely triage of women and recruitment has occurred to reintroduce additional venesection services into the maternity pathway to improve this. All our staff have worked very hard to ensure that women have been bled as soon as possible, that high risk couples have been fast-tracked where evident and the turnaround for father testing has been managed very proactively.
A SDIP for timeliness of testing was submitted to our commissioners in August 2022 which is still in progress but will be reviewed in the light of Q2's date which showed performance around 6%. The service continued to see further waves of covid related staff absence and absence due to staff's reaction to high workload and the effects of the pandemic. Five venesection clinics a week are set to be in place from January 2023 which will improve screening timescales even though the face-to-face bookings will be conducted afterwards.

Fetal Anomaly Screening Programme

Down's syndrome, Edwards' and Patau's syndrome screening

During this reporting period, we saw the return of partners attending scans which has made a huge difference to women's experiences especially if there are concerns about the pregnancy identified at scan.

Our relationship with the laboratory remains strong with turnaround times and national standards being met. As with most of the NHS in response to Covid, virtual adaptations have been sought, and our service users screening results are now emailed directly to the screening team which has greatly reduced the waiting time for women to receive their screening results.

The 18+0 to 20+6 anomaly scan

Capacity in the Ultrasound Department has been pressured at times during this reporting period due to continued covid staff absences, introduction of additional growth scanning requirements following the launch of Saving Babies Lives initiative and implementation of a new triage referral system for women. This has been managed efficiently due to strong leadership in the ultrasound department with additional lists added and outsourcing of growth scans locally. Nonetheless, the coverage KPI for anomaly scanning was met throughout this reporting year with few issues. The national reporting system for fetal anomalies known as NCARDRs reports a year in arrears but there were no concerns raised in the most recently published report and no concern that key conditions had been missed.

As part of the annual data submission for the Fetal Anomaly scan part of FASP we report against Standard 8 which is the time to referral of 3 working from ultrasound to our Fetal Medicine service. This data showed that of 28 women referred for one of the 11 key conditions 28 women were seen by 3 days. In total 238 women were referred within this time period for other reasons at the anomaly scan. The working relationships with the Fetal Medicine service are strong and effective. This has been further strengthened by the current acting band 7 having completed a year's secondment in Fetal Medicine. This has introduced more transferable skills across 2 small specialist teams and has proved to be an excellent fit.

Newborn Screening Programmes

Newborn Bloodspot Screening (NBBS)

This newborn screening programme is, currently, the only newborn programme coordinated by the screening team. All newborn screening programmes benefit from national fail-safes which flag babies who have not completed screening. The nature of our service, alongside the Children's Hospital mean that newborn screening programmes can be complex.

The KPI we report against for NBBS is for samples requiring a repeat for avoidable reasons. Our performance slipped in Q4 to 2.9% however, this was expected following a blip around the beginning of January with the incorrect year being documented which caused most of the rejections. Also following this data, a QI project has been identified for the Neonatal Unit (NNU). This is in the initial stages of being launched due to the recent pressures on NNU and the changes in leadership. Over the last two quarter data submissions our avoidable repeat rate has now returned to 1.2% which is well within the acceptable threshold and very close to the achievable threshold of 1%.

Neonatal and Infant Physical Examination

This screening programme is complex due to the nature of our service which offers regional services for neonatal intensive care and is a specialist centre for cardiac and other paediatric surgery. The programme lead is a consultant neonatologist with no other coordinator currently. However, an advert for a band 7 NIPE screening coordinator is currently advertised. The fail-safes for the screening programme are monitored by the consultant neonatologist, the antenatal and newborn failsafe officer, and the IT lead on the NNU for unwell babies. This rather fragmented model provided further challenge to the NIPE lead's ability to consistently ensure that outcomes to referrals and timeliness of review occurred consistently.
The failsafe officer was appointed to cover 5 of the 6 screening programmes at the end of 2021 which has greatly improved the management of outcomes. However, due to the challenges of trying to unify the fail-safes for this screening programme, it became clear that this distracted the failsafe officer away from the other screening programmes. In view of this, the Matron with oversight was able to negotiate more support for this screening programme and the specific NIPE coordinator role was approved. We await the positive impact of this appointment.

Newborn Hearing Screening

The Newborn Hearing Screening Service came under new management in January 2022 when Carole Woodhead retired after more than 28 years of service to the PAH. The succeeding service manager is Christina Crouchman who now oversees a team of 11 hearing screeners and administrators.

Staffing levels due to Covid-19 has been an issue like most teams this past year. Since Christina's tenure, many changes have been implemented into the service to improve efficiency and ensure the

delivery of a family-friendly service. We have reviewed our outpatient clinics and improved communication of appointments with families via text messages and the Badger App. Sarah Cross (Senior Screener) and the rest of the team have been instrumental in driving these changes forward.

While we aim to screen most babies before they're discharged from hospital, those born over a weekend or those discharged quickly from hospital will require the hearing screen at a community outpatient appointment. We have started to look at the bigger picture and aim to align our clinics with midwifery lead postnatal checks and NIPE clinics to catch more babies. The launch of Appointment Books has been a huge driver in this way of working. As a result, we have strengthened our relationship with the midwifery team on the wards and they know we are always happy to come up to screen a baby who is being seen for an outpatient PN or NIPE check at the PAH. We have screened an additional 70 babies coming into the PAH as outpatients since August which has saved the families a separate appointment in the community. We are managing to complete the hearing screening process in hospital on 5% more babies than the same time last year.

Our patient satisfaction survey launched in April 2022 which has reflected the hard work and dedication that the hearing screening service provides. We utilise a running survey which has proven a useful tool to monitor and address local issues at our community clinics, such a parking.

From April 2022, we began offering targeted testing for congenital CMV for all babies who refer to Audiology from the hearing screen. The aim is for early identification of babies who are positive for cCMV and to enable timely treatment before the recommended 4 weeks of age. cCMV testing has previously been performed at the initial Audiology appointment in Southampton, however, babies are usually ~4 weeks of age at the point of audiological assessment which is too late for those requiring treatment. The pilot study is being led by Dr Chrissie Jones (Consultant for Paediatric infectious Diseases) and the plan is for this pilot to be made a permanent process. Neighbouring hospital Trusts are looking at following suit.

Our KPIs for the past four quarters are as follows:

Q2 01/07/2021 – 30/09/2021 KPI 1 **98.2%** (Acceptable 98%) KPI 2 **93.8%** (Acceptable 90%)
Q3 01/10/2021 – 31/12/2021 KPI 1 **97.9%** (Acceptable 98%) KPI 2 **85.7%** (Acceptable 90%)
Q4 01/01/2022 – 30/03/2022 KPI 1 **98.9%** (Acceptable 98%) KPI 2 **100%** (Acceptable 90%)
Q1 01/04/2022 – 30/06/2022 KPI 1 **99.4%** (Acceptable 98%) KPI 2 **100%** (Acceptable 90%)

(KPI 1 = The proportion of babies eligible for newborn hearing screening for whom the screening process is complete by 4 weeks corrected age. KPI 2 = The proportion of babies with a no clear response result in one or both ears or other result that require an immediate onward referral for audiological assessment who receive audiological assessment within the required timescale).

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Inclusion and Belonging Strategy**			
Agenda item:	**6.1**			
Sponsor:	**Steve Harris, Chief People Officer**			
Author:	**Ceri Connor, Director of OD and Inclusion**			
Date:	**31 January 2023**			
Purpose:	**Assurance or reassurance**	**Approval** x	**Ratification**	**Information**
Issue to be addressed:	Inclusion and belonging is a fundamental goal for the UHS family, as set out in our Corporate and People Strategy. This paper sets out our new inclusion and belonging strategy for Trust Board approval. The strategy has been approved at EDI Committee, People and OD Committee and Trust Executive Committee (TEC). **Increasing Diversity in the populations we serve** Our local population is changing. The 2021 Census Southampton reports the population in Southampton has increased by 5.1% since the 2011 census. Those aged 20 to 24 make up the largest group (10.5%), and Southampton has seen a large increase in migrants since 2011.The number of people living in the City but born outside the UK has increased by **44.3%** since the 2011 census. In Southampton 15.4% of residents do not speak English as their main language, and of these 14.6% cannot speak English well. 68.1% of the population of Southampton are white British, 12.6% White Other, 10.6% are Asian or Asian British, 4% are Polish, 3.7% Indian or British Indian, and 1.7% are Chinese. 43.4% declared they had no religion, 40.1% were Christian, 5.6% Muslim. 86% of people over 16 years identified as straight or heterosexual, 4.93% as lesbian, gay, bisexual, or all other sexual orientations. **Recruiting, retaining and developing our people** Why does this matter? It matters because we are in the midst of a workforce crisis in the NHS, the labour market is highly competitive, and we are challenged to recruit and retain people to deliver our services. We must be able to attract from all people in our populations and retain them in safe working environment which understands the needs of all people. Our population nationally and locally is diverse, people with diverse backgrounds, beliefs, experiences, and needs. People who access our services are therefore diverse and we must ensure that our workforce represents the communities we live in, to ensure a safe and positive experience for all those who interact with us.			

	Improving the experience of our diverse UHS family We must also ensure that the people that work for UHS and those that represent us, treat others with respect, dignity, understanding, and there should be no disparity of experience at UHS based on race, sex, sexual orientation, gender identity, belief, religion, age, status, or any other characteristic. Our Board Assurance Framework has a risk **recorded** that "We fail to recruit, retain, and develop a diverse, compassionate, and inclusive workforce to meet our corporate strategy aims." Therefore, it is a strategic imperative to focus on creating a place to work, learn, and place to be treated where people feel that they belong, feel included, welcomed and safe, and there are opportunities for growth, support and equity of experience for all. At UHS our People Strategy 22-26, under the 'belong' pillar states that we have an ambition to: "Create a compassionate, inclusive and welcoming environment that values and supports every individual, both personally and professionally. To help us understand our diversity and the experiences of people we have looked deep into our data, listened to insights and feedback from people, and specifically we have looked at data relating to experiences of those with protected characteristics as under the Equality Act 2010. Our data isn't complete in terms of some protected characteristics but the data and supporting information we do have, tells us there is disparity of experience between people that work at UHS. We know the experiences worsen for those from Black, Asian, and ethnic minority backgrounds, those who identify as lesbian, gay, bisexual, transgender, queer, intersex or asexual, those who have a disability or long-term illness. In relation to ethnicity, our existing UHS workforce *is* very diverse at mid pay levels (Band 4/5/6) and medical staffing. Much of this can be attributed to our successful overseas recruitment programme. Whilst there has been increases (a growth from 7% to 10%) there is still underrepresentation of diverse ethnicities at bands 7 and above. Under the Equality Act 2010, where there is clear evidence of under representation we can take "Positive Action" to address it. Positive action is a specific definition under legislation. We know from our Workforce Race Equality Standard, and our Workforce Disability Equality Standard, our Staff Survey, and from significant engagement with our staff network members that the disparity of experience is slowly improving. However, there is still a significant way to go for UHS to be able to evidence there is no disparity in terms of being subject to bullying, harassment, aggression, racism and discrimination due to ethnicity, race, sexual orientation, religion, disability, personal circumstances, age, sex, and that all people have equal access to opportunities and support.
Response to the issue:	In December 2021, UHS Trust Board agreed to the development of a strategy explaining our intentions at UHS in relation to Inclusion and Belonging over the next four years. This strategy aims to clearly articulate how equality, diversity, inclusion and belonging is at the heart of our values. The strategy

	aims to describe bold intentions which will improve experiences for all people. Over 2022 engagement has taken place to design the priorities of the strategy, including a thematic analysis to group the priorities into themes. The strategy describes **five themes** which will be driven operationally through the organisation and act as a vehicle to bring us together, maximise efforts, and see impact at greater pace: 1. Workforce reflecting our communities, at all roles, at all levels. 2. Safe and healthy working environments, free from racism, aggression, hate and discrimination. 3. Recruitment processes which are free from bias and are inclusive. 4. Inclusive leadership and management. 5. Networks that thrive and support creation of an inclusive and safe place to work. The strategy will provide a framework that enables us to work towards a set of agreed priorities. It incorporates legal duties under the Equalities Act 2010, incorporates national and regional priorities and enables UHS to act as a leader in this subject area across Hampshire and IOW and nationally. It is important with this strategy that people know it exists, understand it, understand their role in it, and can explore concepts, discuss any concerns, ask questions, in a safe environment. Therefore, once approved, the launch and engagement will commence immediately with the following actions: 1. Socialisation, comms plan, and engagement with staff – "big conversations" to talk about the strategy, the concepts such as *anti-racist and anti-discriminatory,* and what proactive and personal action means, impact for teams and managers. 2. Provide team briefings and ensure divisional EDI steering groups are supported. 3. Establish working groups (as appropriate) with representation from divisions and THQ, staff networks, to steer and implement specific workstreams. 4. Share the strategy with Governors, Members, UHS partners and ICB. 5. Complete the full implementation plan for Years 1, 2 and 3. 6. Establish process for monitoring and reporting progress/risks to delivery of the strategy through People Board/ People and OD Committee/EDI Committee. NB: Page 12 of the strategy will be updated in the digital version, annually on 31 March.
Implications: (Clinical, Organisational, Governance, Legal?)	The following implications should be noted: • **Culture** – The requirement to ensure inclusivity and belonging becomes a central focus of the implementation of the UHS 5-year strategy and response to the NHS People Plan. • **Diverse voice** - UHS will ensure diverse thought is included in decision-making. • **CQC** - To note that the CQC well led domain, and achieving outstanding, requires excellence to be demonstrated in this field. It is

	likely the CQC will increase their scrutiny of Diversity and Inclusion activities when conducting inspections. Organisations who are rated Outstanding have embedded strategies and demonstrable outcomes in this area which positively impacts on staff and patient experience. • **Governance** - Ensuring inclusivity becomes core in our organisational governance will be key. The strategy's implementation plan and measurable outcomes will be reviewed as part of our performance management processes within Divisions, Care Groups and through Divisional Governance. To the People Board and People and OD Committee and to the Equality, Diversity and Inclusion Committee. Provision and analysis of data at local level will be important to achieve this. • **Legal framework** - UHS must continue to ensure it complies with its legal duties under the Equalities Act (2010).
Risks: (Top 3) of carrying out the change / or not:	BAF risk 3b) We fail to recruit, retain, and develop a diverse, compassionate, and inclusive workforce to meet our corporate strategy aims.
Summary: Conclusion and/or recommendation	Equality, diversity, inclusion and belonging has many complexities and the challenges within UHS are part of a much wider external, often volatile environment. There are multiple moral, ethical, historical and cultural complexities and sensitivities around the subject area and hence takes time to support growth in thinking, perception, change behaviour. There is no quick fix. However, this strategy aims to provide a clear direction for the organisation over the next three years in line with the People Strategy. Also provide a collective, organisational wide focus on the priorities that will make the biggest difference. The EDI team or wider People team cannot deliver this strategy in isolation, we all are responsible owning and implementing this strategy throughout the Trust Board members are asked to: • Approve this strategy for an immediate move to launch and socialise as per the engagement plan and then to implementation. • Take a proactive approach to positively support the content and ethos of the strategy as Trust Board members.

University Hospital Southampton
NHS Foundation Trust

THE UHS WAY

INCLUSION AND BELONGING STRATEGY

2023 to 2026

CONTENTS

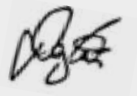
"AS THE CHAIR OF UHS, I AM COMMITTED TO EVOLVING OUR BOARD AND LEADERSHIP SO WE DELIVER WHAT IS REQUIRED FOR ALL OUR WORKFORCE TO FEEL THEY BELONG AND CAN THRIVE AT UHS."

FOREWORD BY
JENNI DOUGLAS-TODD – CHAIR OF THE TRUST BOARD

Over the last few years there has been significant engagement, listening and sharing of experiences from our workforce at UHS, and specifically those who have protected characteristics and those who were disproportionately impacted by the Covid Pandemic. This brought about a real understanding of what inclusion and belonging needs to "look like" at UHS. The Inclusion and Belonging Strategy now provides the mandate for us to move to action and enable everyone to know what inclusion and belonging "feels like" at UHS.
The themes in the strategy have been developed with staff, across a diverse range of groups, also including the outputs from engagement during the pandemic. This strategy sets out a clear intent to move UHS to an organisation beyond just being content to acknowledge racism and discrimination exists and should not be tolerated, to a place where we take pro-active action to eliminate it.

This strategy cannot be delivered by one team, a select group of leaders, or those who have faced racism or discrimination themselves, it must be owned and delivered by all of us, by our everyday actions and behaviours aligned to our UHS Values. What we accept for our staff, we accept for our patients. We should only accept a place where we can **all** belong.

As the Chair of UHS, I am committed to evolving our board and leadership so we deliver what is required for all our workforce to feel they belong and can thrive at UHS.



Jenni Douglas-Todd
Chair of the Trust Board, UHS

WORLD CLASS PEOPLE

"NO MATTER WHO YOU ARE, WHERE YOU ARE FROM, WHATEVER YOUR RELIGION OR SEXUAL ORIENTATION, I AM COMMITTED TO BUILDING A CULTURE AT UHS WHERE YOU CAN BE YOURSELF AND BE YOUR VERY BEST."

FOREWORD BY
DAVID FRENCH – CHIEF EXECUTIVE OFFICER

University Hospital Southampton is a leading university teaching hospital, together just under 13,000 staff provide a range of secondary care services to our local population and specialist services for nearly 4 million people across the south of England and beyond. We are proud of the care we provide and the outcomes we achieve. We are also proud of our hugely diverse workforce, that do amazing work every day, over 116 nationalities working together to deliver our vision of *World class people delivering world class care.*

Our People Strategy 2022-2026 sets our ambition to support and nurture our people through a culture that values diversity and builds knowledge and skills, to provide rewarding career pathways in compassionate and motivated teams. The three components of *"Thrive, Excel and Belong"* describe the work programmes over the next five years to enable us to reach those ambitions.

Our Belonging and Inclusion Strategy is critical to the "Belong" element of our People Strategy. It sets out clear actions we will take to make UHS a place where every person feels they belong and feels safe to carry out their work free from violence, bullying, harassment and abuse.

In an organisation where *everyone* feels respected, included and involved, we will collectively deliver the best care for our patients and communities.

No matter who you are, where you are from, whatever your religion or sexual orientation, I am committed to building a culture at UHS where you can be yourself and be your very best.

David French
Chief Executive Officer

WORLD CLASS PEOPLE

SECTION 1:

THE NATIONAL NHS PEOPLE AGENDA

The National NHS People Plan 2021-23 sets out the following 4 strategic aims across the whole NHS:

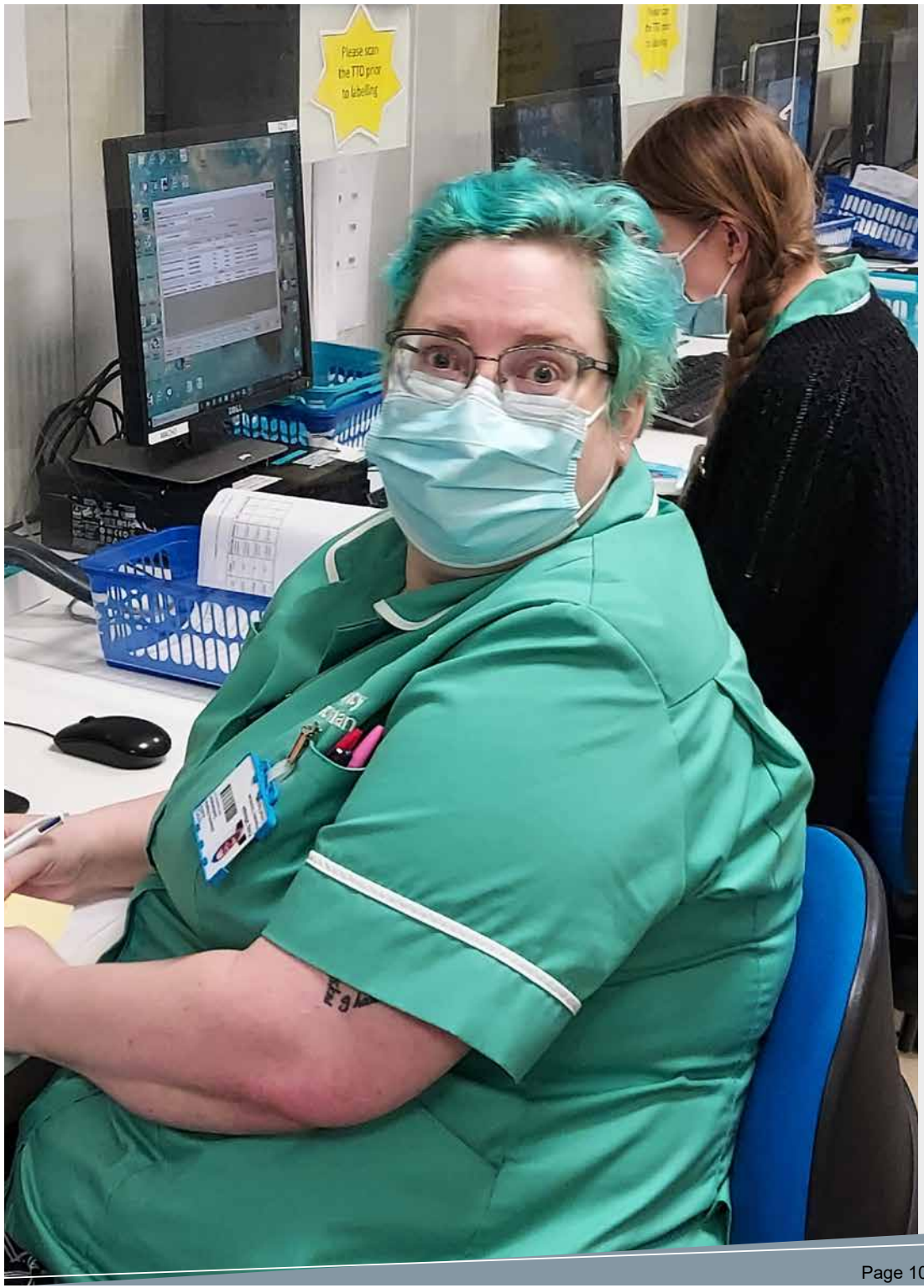
1. Looking after our people
2. Belonging in the NHS
3. New ways of working and delivering care
4. Growing for the future

Under the strategic aim of *Belonging in the NHS* the plan states:

"the NHS must welcome all, with a culture of belonging and trust. We must understand, encourage and celebrate diversity in all its forms. Discrimination, violence and bullying have no place."

To deliver the objectives of the People Plan the national 6 High Impact Actions firmly places the ownership of creating inclusive and compassionate workplaces with executive senior managers of NHS trusts.

It describes specific action and improvement to be taken across the NHS in a number of areas including recruitment, leadership representation, governance, accountability and staff voice.



THE UHS STRATEGY

Our **UHS strategic plan** provides a framework based on the **vision and values** of UHS, organised around **five themes** which set out the ambitions for UHS.

The world class people pillar describes our ambitions to develop a supporting and nurturing culture that values diversity and builds knowledge and skills to provide rewarding career paths within empowered, compassionate, and motivated teams.

OUR PEOPLE STRATEGY

To deliver the ambitions of the ***World Class People***, our People Strategy was developed based on feedback and insights gathered from our UHS family, it sets out **three key areas** of focus over the next four years, with ambitious programmes of delivery under each area.

[1] NHS England » NHS People Plan
[2] UHS Way - University Hospital Southampton

WHY AN INCLUSION AND BELONGING STRATEGY?

Prior to the Covid-19 pandemic UHS had made good progress developing a workforce more reflective of the community we serve and in that is supporting and valuing our staff with their diverse attributes and needs. The impact of the Covid-19 pandemic and the George Floyd murder created a new momentum. As the impact of Covid on Black, Asian and ethnic communities became clear the UHS family came together to talk and listen, and the Race Equality Improvement Plan was created and the imperative to broaden the agenda to enable inclusion and belonging for all came to the forefront.

It has been widely acknowledged that the use of the term Black, Asian and Minority Ethnic, and specifically the use of acronyms BAME or BME are unhelpful and it groups many ethnicities into one term. It disguises huge differences in outcomes between ethnic groups and does not help identify or meet the needs of diverse groups of people who have been collectively described. Recommendation 24 of the ***Inclusive Britain: government responses to the Commission in Race and Ethnic Disparities*** (March 2022) states the term BAME should be disaggregated, and the ***NHS Race & Health Observatory report Power of Language*** (November 2021) also recommends single collective terms should not be used unless specific context is provided, also use of the word "minority" reinforces inequity and should not be used.

As part of the launch and implementation of this strategy, we will engage with UHS staff about language, and we will collaborate with partners across Hampshire and Isle of Wight Integrated Care System as part of the Race Inequality workstream. We will await the outcome of the governments consultation to determine appropriate language, we will stop using acronyms BAME and BME, and we will never use collective terms when referring to an individual. We have used Black, Asian and Ethnic group in this strategy to differentiate between experiences and disparity between workforce groups as per the NHS Workforce Race Equality Standard. We will update this digital strategy when there is agreed and widely accepted language which can be used in the broader workforce context.

We want to go further. We want to make a clear statement about our intent, underpinned by a set of stretching objectives to drive change, reduce disparity and create the culture described in our strategic plans. We have committed to significant investment in time and resources to achieve this.

In line with the NHS Improvement and NHS England WRES leadership strategy document *A Model Employer: Increasing black and ethnic minority representation at senior levels across the NHS*, we must take action to improve race inequality and ensure that the leadership at senior levels across the organisation matches that across the rest of the UHS workforce and NHS more broadly.

Being an inclusive organisation isn't just about race inequality, it is about creating an environment where all people feel that they belong, are included, respected and free from harassment, bullying and abuse. Alongside our intent to become an **anti-racist** organisation, we also want UHS to be an **anti-discriminatory** organisation.

[3] Our vision, mission and values - our people - University Hospital Southampton (uhs.nhs.uk)

[4] https://www.uhs.nhs.uk/Media/UHS-website-2019/Docs/About-the-trust/Plans-and-strategies/Our-race-equality-improvement-plan.pdf

[5] wres-leadership-strategy.pdf (england.nhs.uk)

The Official Statistics report on Hate crime in England and Wales, 2021 to 2022 reported that hate crimes, defined as "hostility or prejudice towards someone based on a personal characteristic" increased by 26% from 2020. The report states that hate crimes increased across all five strands (appendix 2), race crimes increased by 19%, 43% against people with disabilities, 41% against lesbian, gay and bisexual people, and 56% increase against transgender people, and religious hate crimes increased by 37% the highest number of religious hate crimes recorded since the time series began in 2012.

This strategy is focused on the delivery of an inclusive culture for our staff, recognising the overwhelming body of evidence that engaged staff who feel valued and safe, deliver better healthcare. The NHS providers with high levels of staff engagement (as measured in the annual NHS Staff Survey) tend to have lower levels of patient mortality, make better use of resources and deliver stronger financial performance.

We are also building our strategy and programme of work to tackle health inequalities; this will help us to remove avoidable variations in quality and experience of care by engaging with our communities. Both strategies will run in parallel and align to reduce disparity and improve experiences at UHS.

”

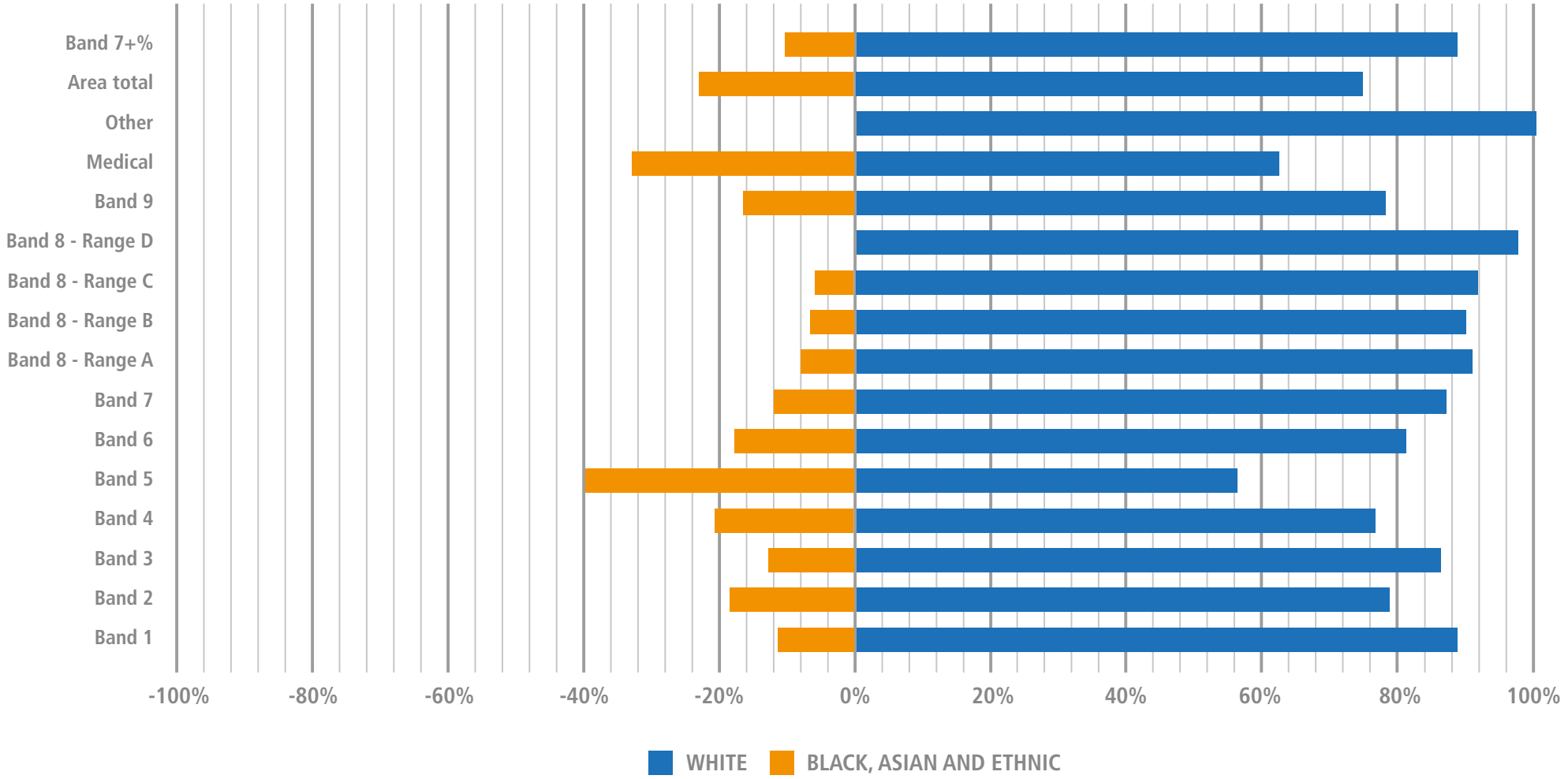
“WE AIM TO TAKE MORE RADICAL POSITIVE ACTIONS, NO ONE IN SOCIETY SHOULD EXPERIENCE RACISM OR DISCRIMINATION. AS A WORKPLACE UHS STRIVES TO LIVE BY OUR VALUES AND CREATE A PLACE WHERE EVERYONE CAN FEEL SAFE AND FEEL THAT THEY BELONG.”

SECTION 2:

WHAT WE KNOW ABOUT INCLUSION AND BELONGING AT UHS IN 2022

Diversity breakdown

Ethnic Origin and Payscale of substantive staff
Percentage split breakdown



[6] Hate crime, England and Wales, 2021 to 2022 - GOV.UK (www.gov.uk)

People from Black, Asian and ethnic backgrounds represent 25% of the workforce at UHS, in roles within Agenda for Change (AfC) bands 2 to 6, meeting or exceeding the national target of 19%. Total workforce at AfC B7 or above make up 11%, however roles above band 8a are below the national target, with less than 10% in roles 8a-8d and 12% at band 9. There is 35% representation from people of Black, Asian and ethnic backgrounds in the Medical professional group. In Nursing and Midwifery, 11% of the workforce in roles B7 or above are represented by people from black and ethnic backgrounds.

The data in our WRES/WDES for 2022 report shows there is still disparity between the experiences of people from Black, Asian and ethnic backgrounds and those from white backgrounds, those with disability and long term illness and those without. We can evidence we have progressed in many areas over the last five years, but we still have a long way to go to substantially reduce or eliminate this disparity.

In the 2021 national staff survey, 14.7% of people from Black, Asian and ethnic backgrounds reported experience of discrimination at work from a manager compared to 5.9% from white backgrounds. 11.9% of people with a long term illness or disability experienced discrimination from a manager/team leader or colleagues in the same period, compared to 7% without a disability or long term illness.

Black, Asian and Ethnic background

14.7% of our staff from Black, Asian and Ethnic backgrounds reported experience of discrimination at work from a manager between 2020 and 2021 compared to **5.9%** from white backgrounds.

White background

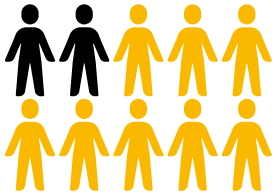
People with a disability or long term illness'

People without a disability or long term illness

11.9% of people with a long term illness or disability experiencing discrimination from a manager/team leader or colleagues in the same period, compared to **7%** without a disability or long term illness.

UHS WORKFORCE PROFILE AS AT 31st MARCH 2022

UHS is one of the **largest employers** in Southampton, with **12,972 staff** working across a diverse range of healthcare fields as well as nonclinical career pathways. Our profile is as follows:

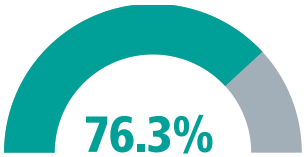


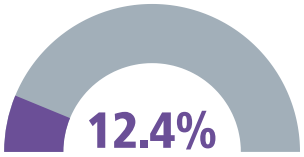
ETHNICITY

The UHS workforce is comprised of **25%** of people from **Black, Asian and Ethnic** backgrounds, which is in line with the local population. The largest ethnic minority groups outside of White other are, **Indian** (**4.9%**), **Filipino** (**4.8%**), Other Asian backgrounds (**3.2%**) and **Black/Black British - African** (**3.03%**).

GENDER

UHS has a predominantly **female workforce** (**9716** employees), Females, are, however, under represented at the **most senior levels** in the organisation.



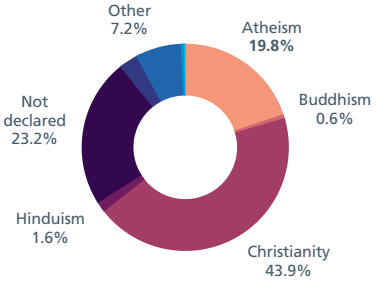


DISABILITY

UHS has **increased** its disability declarations by **9.3%** since March 2019.

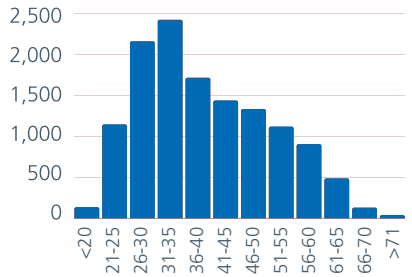
FAITH & RELIGION

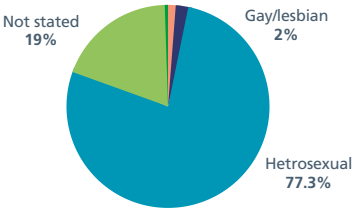
Christianity is the predominant religion amongst UHS staff.



AGE

The majority of UHS staff fall within the **31-35** and **26-30** age brackets.



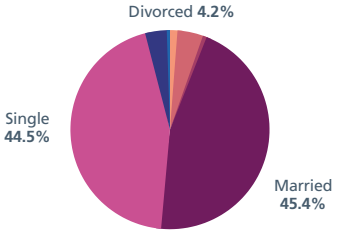


SEXUAL ORIENTATION

3.23% (419 employees) of the UHS workforce have declared their sexual orientation as **lesbian, gay or bisexual**. **18.79%** (2,438 staff) have not stated their sexual orientation.

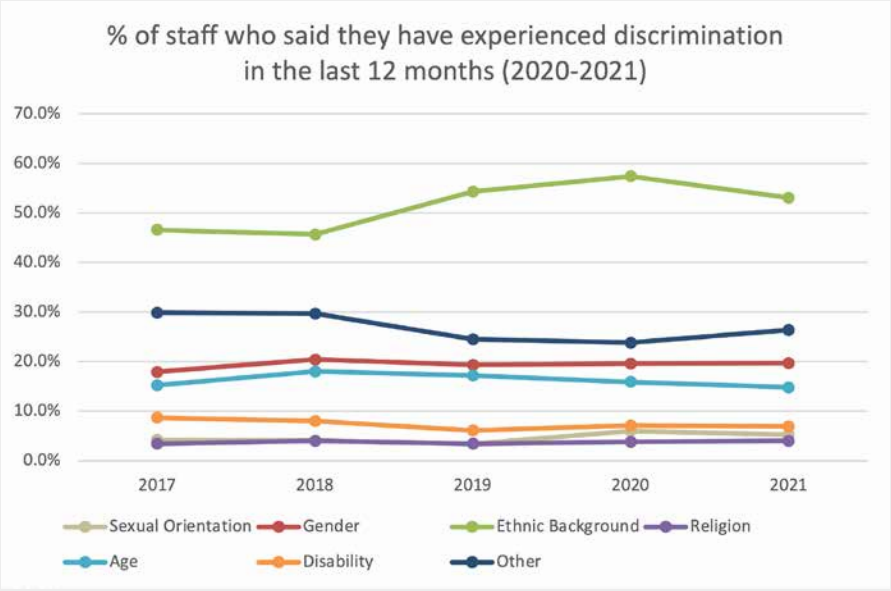
MARRIAGE & CIVIL PARTNERSHIP

UHS staff tend to fall into either married or single categories. **1.21%** are in civil partnerships, **4.2%** divorced and **0.52%** widowed.

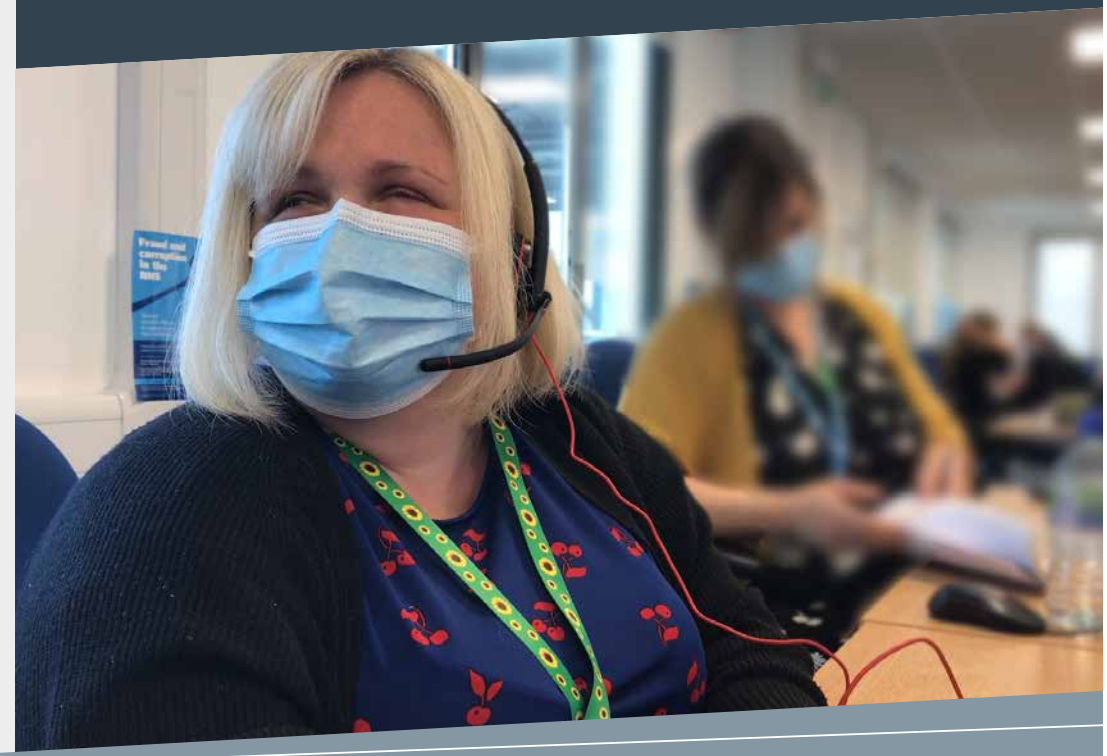


Our data shows overall we have a predominantly female workforce, however this changes at more senior roles; Agenda for Change (AfC) roles at 8d shows 54%-46% male to female ratio, at AfC roles at B9 this shifts to 65% males to 35% females, and Trust Board whereby 70% male to 30% female (October 2022). Our 2022 gender pay gap report showed there was disparity between the average male and female pay across the total workforce, per hour of 24% in favour of males.

Obtaining a clear picture of people who identify as Lesbian, Gay, Bi-sexual, Transgender, Queer, (Questioning), Intersex, Asexual in our workforce, having reliable data on whether this group is represented across all roles, and identifying whether their experiences in UHS is positive or negative is more difficult and restricted by declaration rates. The categories available on the NHS Electronic Staff Record (ESR) are not representative of the broad range of Lesbian, Gay, Bi-sexual, Transgender Queer, (Questioning), Intersex, Asexual identity which in turn impacts on declaration, and our ability to take informed action to improve. This is being nationally considered but we are unable to change this locally.



"It is important that we consider and acknowledge intersectionality when seeking to understand and overcome inequality. No person has one single characteristic or issue that impacts their experience. In order to move forward we must look at the complexity surrounding discrimination and marginalisation and understand the ways in which multiple forms of discrimination, such as racism, sexism and classism combine and overlap or intersect and impact on people's quality of life and their ability to be their best at work."



SECTION 3:

CHANGE FOR THE FUTURE

By fully utilising the provisions within the Equality Act 2010, we want to be clear about our intentions to reduce disparity of experiences and create an inclusive culture.

We have heard from a large number of our UHS family both at specific engagement events and over the period of the Covid pandemic. From these insights we have developed this strategy and work programme over the next three years. We want to set out a clear ambition to become an anti-racist and anti-discriminatory organisation, celebrating our diverse workforce as one of our key strengths.

We will draw from the review of evidence on how to make recruitment and career progression fairer from NHS East of England and Roger Kline research paper ***"No More Tick Boxes"*** and specifically the shift to the new paradigm (appendix 2). We will align our programme of work to the **Model Employer WRES leadership strategy 2019** model for improving Black, Asian and Ethnic representation across the workforce (appendix 3).

We want to take action to **make change happen, quicker**. We believe that the actions described in these five themes will enable us to achieve this:

1. Workforce **reflecting our communities**, at all roles, at all levels.
2. Safe and healthy working environments, free from all **racism, aggression, hate** and **discrimination**.
3. Recruitment processes which are **free from bias** and are **inclusive**.
4. **Inclusive** leadership and management.
5. Networks that thrive and support creation of an **inclusive and safe** place to work.

[7] NHSE-Recruitment-Research-Document-FINAL-2.2.pdf (england.nhs.uk)

There are full work programmes under each of these themes, and some are in development. We will be working alongside the **Hampshire and IOW Integrated Care Board**. Examples of action that will be taken are listed below, full work programmes are available on request:

Workforce **reflecting our communities**, at all roles, at all levels.

- Positive Action Programmes both UHS and HIOW wide; for those who have protected characteristics and may experience barriers to promotion, development and career progression.
- Partnership with the Florence Nightingale Foundation; Nurse leadership programme aimed at aspiring nurses from backgrounds that are under represented in our nursing workforce.
- Partnership with Black History Month South outreach into schools with high Black, Asian and Ethnic pupil populations to inspire young people from Black, Asian and Ethnic backgrounds into NHS careers.
- Talent development programme for all, supporting career development, pathways, training and development.

Safe and healthy working environments, free from all **racism, aggression, hate** and **discrimination**.

- Creation of a behaviour framework to bring to life our Trust Values and more clearly describe the expected behaviours relating to equality, diversity and inclusion.
- Fully establish divisional EDI Steering Groups to drive actions and improvements throughout each division.
- Creation of EDI data and information dashboard to evidence improvements and scrutinise themes, determine actions required.
- Developing a culture of Allyship: All staff to participate in Actionable Allyship training by 2024.
- Hate crime and violence and aggression; improve mechanisms for data collection and scrutiny, identifying hate crime, incidences of violence and aggression themes to determine action and /or improvement.
- Digital inclusion work programme
- Revise existing and implement new Equality Impact Assessment process, governance and learning package with a view to making improvements in the embeddedness of EIA as a decision making tool by March 2023.

Recruitment processes which are **free from bias** and are **inclusive**.

- Implement work programme to review and improve recruitment processes and practices. Working group to include Staff Network leads. Aligning to the NHS People Plan England/Improvement High Impact Actions and Inclusive Recruitment Programme.
- Inclusive training, learning and development for all people involved in recruitment and attraction.

Inclusive leadership and management.

- Inclusive Leadership content in all UHS leadership & management programmes to include personal learning, personal action and accountability.
- Board and Senior leadership programmes to include the element for all leaders plus strategic and cultural responsibilities for equality, diversity inclusion.
- Inclusive leadership and management as part of the UHS Managers Induction Programme.
- Implementation of ongoing learning and development opportunities to enable leaders and managers to role model inclusive behaviours every day. For example:
  - Inclusive meetings
  - Agile working
  - Equality impact assessment
  - Adjustments required to enable people to thrive and be at their best at work.

Networks that thrive and support creation of an **inclusive and safe** place to work.

- Development programmes for Network Chairs to enable leadership of highly active networks.
- Implement the Equality, Diversity and Inclusion Council
- Establish and support new staff networks, as per requested:
  - Women's Network
  - Carers Network
  - Veterans Network

HOW WILL WE MEASURE PROGRESS? WHAT ARE THE TARGETS?

Our targets reflect our ambitions and the national requirements where they exist. We have also agreed local targets where it is meaningful for UHS over the lifetime of this strategy unless otherwise stated:

- **Reduce disparity across all WRES and WDES indicators by 5% by 2026.**
- **Increase percentage of people declaring they have a disability or long term illness in the UHS workforce by 8%, reaching 20% in the total workforce by 2024.**
- **Increase representation of people from Black, Asian and Ethnic backgrounds at Band 7 and above by 10% by 2024**
- **Meet or exceed the national target of representation at all levels in the organisation of 19% in 2022/23 increasing to 23% by 2024/25.**
- **80% of all UHS staff to participate in UHS Allyship training programme by 2024.**
- **Increase all staff participation in the annual NHS staff survey to 70% by 2026.**
- **Increase participation in the staff survey questions related to WRES and WDES by 10% by 2026.**
- **In addition to the WRES and WDES questions in the annual staff survey, increase staff experience measured by the annual NHS staff survey to be "the best" in the acute and acute community trust benchmark group by 2026, for questions:**

  21C – I would recommend my organisation as a place to work

  9G – My immediate manager is interested in listening to me when I describe challenges I face

  15 – Does your organisation act fairly with regard career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?

  18 – I think my organisation respects individual differences (e.g cultures, working styles, backgrounds, ideas, etc)

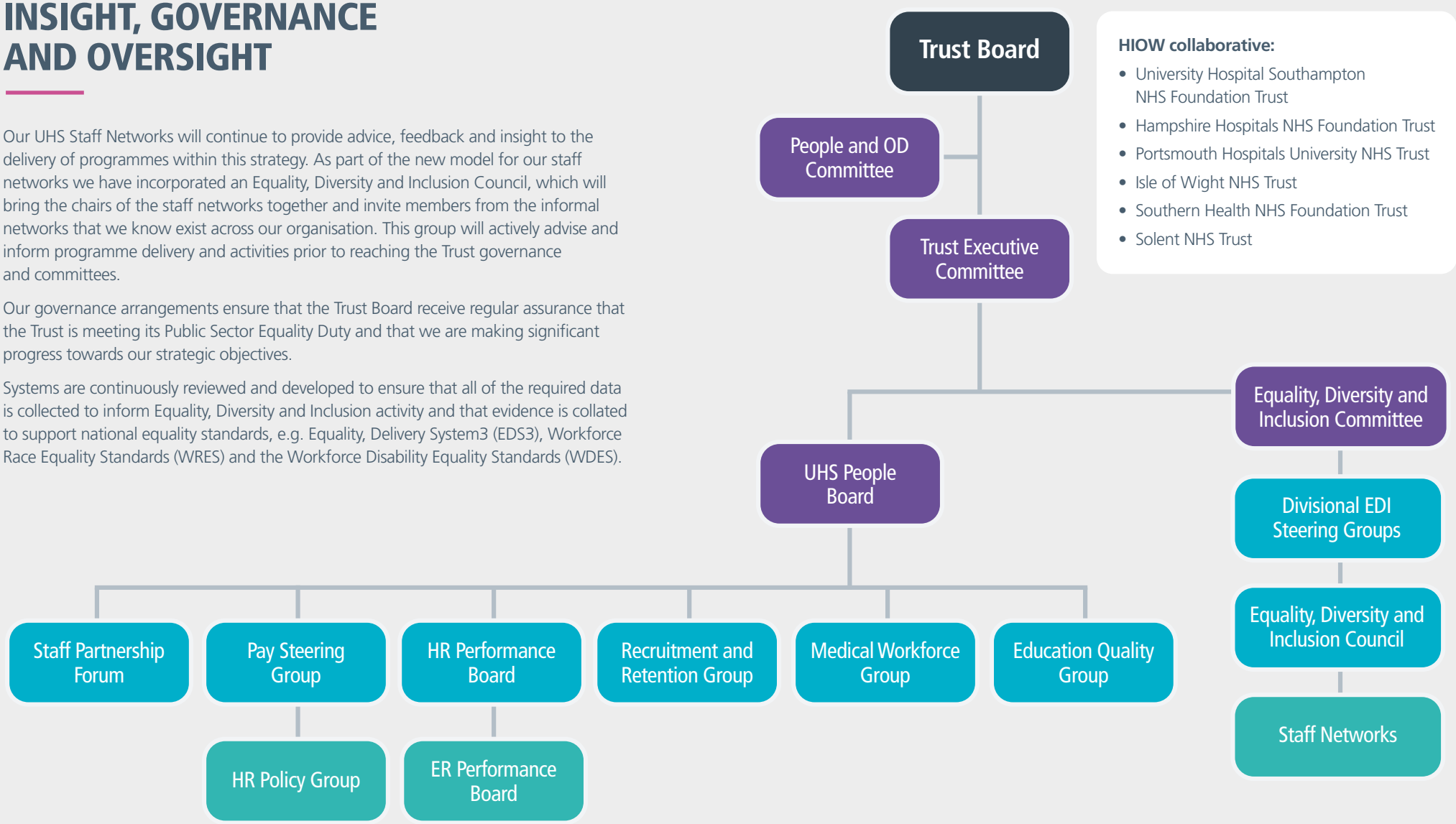
SECTION 4:

INSIGHT, GOVERNANCE AND OVERSIGHT

Our UHS Staff Networks will continue to provide advice, feedback and insight to the delivery of programmes within this strategy. As part of the new model for our staff networks we have incorporated an Equality, Diversity and Inclusion Council, which will bring the chairs of the staff networks together and invite members from the informal networks that we know exist across our organisation. This group will actively advise and inform programme delivery and activities prior to reaching the Trust governance and committees.

Our governance arrangements ensure that the Trust Board receive regular assurance that the Trust is meeting its Public Sector Equality Duty and that we are making significant progress towards our strategic objectives.

Systems are continuously reviewed and developed to ensure that all of the required data is collected to inform Equality, Diversity and Inclusion activity and that evidence is collated to support national equality standards, e.g. Equality, Delivery System3 (EDS3), Workforce Race Equality Standards (WRES) and the Workforce Disability Equality Standards (WDES).



HIOW collaborative:

- University Hospital Southampton NHS Foundation Trust
- Hampshire Hospitals NHS Foundation Trust
- Portsmouth Hospitals University NHS Trust
- Isle of Wight NHS Trust
- Southern Health NHS Foundation Trust
- Solent NHS Trust

APPENDIX 1 – HATE CRIME DEFINITION

Hate crime is defined by the Police, Crown Prosecution Service, Prison Service (now the National Offender Management Service) and other agencies who make up the criminal justice system as 'any criminal offence which is perceived, by the victim or any other person, to be motivated by hostility or prejudice towards someone based on a personal characteristic.' There are five centrally monitored strands of hate crime:

- **race or ethnicity**
- **religion or beliefs**
- **sexual orientation**
- **disability, and**
- **transgender identity**

A hate crime is any criminal offence which is perceived by the victim or any other person to be motivated by a hostility or prejudice based on:

- a person's race or perceived race, or any racial group or ethnic background including countries within the UK and Gypsy and Traveller groups; this includes asylum seekers and migrants
- a person's religion or perceived religion, or any religious group including those who have no faith
- a person's sexual orientation or perceived sexual orientation, or any person's sexual orientation
- a person's disability or perceived disability, or any disability including physical disability, learning disability and mental health or developmental disorders
- a person who is transgender or perceived to be transgender, including people who are transsexual, transgender, cross dressers and those who hold a Gender Recognition Certificate under the Gender Recognition Act 2004.

APPENDIX 2

Roger Kline, Research Fellow at Middlesex University, brings together a wealth of evidence in the NHS East of England document ***"No More Tick Boxes"*** and the practitioner guide ***"If your face fits – Exploring common mistakes to addressing equality and equity in recruitment"***. It suggests practical steps NHS employers can do to improve staff recruitment and career progression and in particular the shift needed from the old model to the new. It focuses on the treatment of **women, disabled staff**, and staff of **Black, Asian and ethnic origin**.

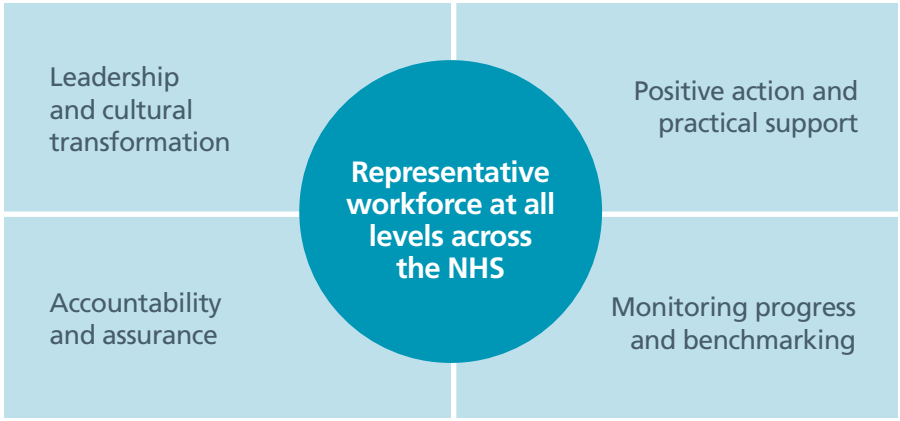
Fig.1 – The old and the new paradigm for recruitment and career progression.

OLD MODEL	NEW MODEL
Emphasises importance of policies, procedures and training thus setting standards and enabling individuals to raise concerns safely.	Emphasises importance of accountability and transparency. Adopts a "**public health**" approach to improving outcomes, triangulating data to be proactive and preventative. Intervenes to encourage staff, seeing fair and effective career progression as a key management function.
Substantial emphasis on diversity training and unconscious bias training.	Understanding the biases, stereotypes and assumptions that distort decision making in recruitment career progression is important but training alone will not significantly change decision making.
Encouragement and support to individuals to take advantage of development opportunities through mentoring and positive action. Training for panels and managers on ensuring processes are followed and are fair and free of bias.	Granular attention to primarily removing bias from processes, not through training individuals at each stage of the career lifecycle by understanding how bias and stereotypes affect decision making and how to mitigate it. Emphasises tracking all individual's development proactively, linked to effective appraisals, transparent access to stretch opportunities.
Delegated to HR and often under-resourced.	Key Board issue led by CEO and Chair.

Source reference: NHS East of England, No More Tick Boxes: A review of the evidence on how to make recruitment and career progression fairer. Roger Kline 2021.

APPENDIX 3

Model Employer: Increasing Black, Asian and ethnic background representation at senior levels across the NHS. Evidence based model for improving Black, Asian and Ethnic representation across the NHS workforce.



[8] NHS-Practitioners-Guide-If-Your-Face-Fits_FINAL-2.pdf (england.nhs.uk)

CLOSING THOUGHTS

STEVE HARRIS – CHIEF PEOPLE OFFICER

Thank you for reading our Inclusion and Belonging Strategy.

The intentions and priorities within this document are important to us and we are firmly committed to delivering them. We know that in order to achieve our ambitions we all must come together and collectively we must be accountable for the behaviours we live, and actions we take. We must be willing to challenge what we think we know, and to at times, feel uncomfortable as we stretch our learning and understanding. We want UHS to be a place where there is no disparity of experience between individuals, and there is equality of opportunity for everyone in the UHS family. Rightly, we will be held to account for what we do, and I am committed to supporting the delivery of this strategy.

Steve Harris
Chief People Officer

NHS
University Hospital Southampton
NHS Foundation Trust

"A WORLD CLASS ORGANISATION IS MADE UP OF WORLD CLASS PEOPLE. THEY ARE OUR GREATEST ASSET"

THE UHS WAY

University Hospital Southampton
NHS Foundation Trust
Trust Management Offices, Mailpoint 18
Tremona Road, Southampton
Hampshire SO16 6YD

www.uhs.nhs.uk

Report to the Trust Board of Directors				
Title:	**Corporate Objectives 2022/23 – Quarter 3 review**			
Agenda item:	**6.2**			
Sponsor:	**David French, CEO**			
Author:	**Christine McGrath, Director of Strategy and Partnerships**			
Date:	**31 January 2023**			
Purpose	**Assurance or reassurance** X	**Approval**	**Ratification**	**Information**
Issue to be addressed:	The 2022/23 Corporate Objectives were approved by the UHS Board in April 2022 and were noted by the Board to be deliberately stretching.			
Response to the issue:	This paper provides an update regarding achievement of the Quarter 1,2 and 3 objectives and a forward look at Q3. During Q3, 64% of the Q3 objectives were achieved in full and 30% are currently delayed. Cumulatively, for Q1, 2 and 3, 80% of the objectives have been fully achieved and 14% partly achieved/delayed. Looking forward, of the Q4 objectives, 71% are on target to be achieved, 18% have been rated as likely to be partially achieved and 12% rated as likely to be significantly delayed or not achieved. Summary tables for Q3 only objectives and Q1, 2 and 3 combined are provided below. Separate summaries of the objectives RAG rated as red and amber at the end of Q3 are provided in appendix 1 and 2. A full collated report is provided in appendix 3. The agreed objectives have been colour coded: Green = Achieved Amber = Partially achieved / full achievement delayed Red = Not achieved / achievement significantly delayed and unlikely to be achieved in a reasonable time.			

Q3	Planned	Green	Amber	Red
Outstanding patient outcomes, safety and experience	13	12	0	1
Pioneering research and innovation	6	4	2	0
World Class people	6	2	4	0
Integrated networks and collaboration	7	5	1	1
Foundations for the future	12	5	6	1
Total	**44**	**28**	**13**	**3**

Quarter 1, 2 and 3 cumulative progress	Plan	Green	Amber	Red
Outstanding patient outcomes, safety and experience	39	35	3	1
Pioneering research and innovation	21	19	2	0
World Class people	12	7	5	0
Integrated networks and collaboration	27	23	2	2
Foundations for the future	34	23	7	4
Total	**133**	**107**	**19**	**7**

	The two areas of greatest concern are: • Integrated Networks and Collaboration • Foundations of the Future *Integrated Networks and Collaboration:* Whilst the networks programme of work is complex and thus challenging, particularly in light of current clinical pressures, progress has improved with the targeted support from a small THQ team that came into post in Q2 and Q3. This has been further helped by securing support from partners organisations at executive level, particularly with HHFT and UHD. Externally, NHS England have changed the timelines for the Southern Counties Pathology Network (SCPN) at least in part due to complexity. Work will continue to the new SCPN timelines. *Foundations of the Future:* The NHS/Trust financial position presents the greatest challenge within this strategic ambition.
Implications: (Clinical, Organisational, Governance, Legal?)	Achieving appropriate corporate objectives which are aligned to our Values, Strategic Ambitions, Legal and Regulatory requirements will have positive impacts.
Risks: (Top 3) of carrying out the change / or not:	In the absence of this process, we would risk: • failing to take the right steps, over the next year, in order to support achievement our longer-term strategic ambitions • not being able to appropriately monitor progress and make corrective adjustments when required
Summary: Conclusion and/or recommendation	The Board is asked to note the progress made delivering the corporate objectives in the context of the agreed objectives being deliberately stretching and the ongoing significant clinical pressures

Appendix 1: Corporate objectives Q1 and 2 remaining RAG rated RED at end of Q2.	
Outstanding patient outcomes, safety and experience	
1(b)	**Introducing a robust and proactive safety culture**
	Q3: Initiate roll-out of national patient safety syllabus levels 3&4
	Q3: Level 3 and 4 not yet released by NHSE
Integrated networks and collaboration (CEO/CMO/Dir. of S&P)	
4(b)	**Integrated Networks and Collaboration**
	Q1: Move fully to collaborative arrangements with partners for pharmacy procurement and distribution
	Q1: Not achieved - consolidation & move to PUH procurement hub has been extensively delayed & now under review. Since the approval of the case in 2019 several of the strategic drivers have diminished & the necessary IT infrastructure is not yet available. A review of the case is planned for the trust investment group in August 22.
	Q2 update: Paper presented to TIG in September setting out revised timelines and new considerations for use of resource including engagement required with partners. Proposals approved in principle by TIG. Conversations with partners being progressed.
	Q3 Update – While the strategic drivers have shifted, UHS still expects to realise benefits from the regional procurement hub hosted by PUH. Approximately 65% of the medicines purchased for UHS patients are purchased using the hub. In addition, the rapidly accessible, sizable stockholding provides consistent protection from ever increasingly frequent medicines shortages. However, it should be noted that the digital architecture to deliver the complete range of strategic objectives in the original case has been further delayed until Autumn 2023. As a result, there is a significant degree of uncertainty regarding the finalised model presented in the original case. Nevertheless, UHS remains committed to working with its strategic partners to ensure the maximal benefits of the regional procurement hub are realised for UHS and the wider healthcare system.
4(b)	**Southern Counties Pathology Network**
	Q3: Submission of SCP network full business case to NHS as approved by the Pathology Network Board.
	Q3 update: NHS England have revised timelines for all pathology networks to get to maturity nationally. Final FBC now programmed to be developed in 23/24 and thus will not be presented to 22/23.
Foundations for the future	
5(a)	**Create a sustainable financial infrastructure (CFO)**
	Q1: Deliver finances to plan or better than plan in Q1. Support delivery of the ICS financial plan.
	Q1: Not achieved - off-plan to date
	Q2: Deliver finances to plan or better than plan in Q2, whilst targeting an improvement in the underlying financial position. Support delivery of the ICS
	Q2: Not achieved - off-plan to date. Improvements in underlying position off-set by additional risks e.g., energy
	Q3: Deliver finances to plan or better than plan in Q3, whilst targeting an improvement in the underlying financial position. Support delivery of the ICS
	Q3: Not achieved - off-plan to date. Improvements in underlying position off-set by additional risks e.g., energy
5(b)	**Making our corporate infrastructure (estates and digital) fit for the future to support a leading university teaching hospital in the 21st century**
	Q2: Estate masterplan published widely
	Q3: Due to current financial pressure on HIOW ICB and SE region decision taken by Trust executive to not publish plan at the current time. Alternate approach being scoped.

Appendix 2: Corporate objectives Q1, 2 and 3 remaining RAG rated AMBER at end of Q3.	
Outstanding patient outcomes, safety and experience	
1(a)	**Recovery, restoration and improvement of clinical services (COO/CMO/CNO)**
	Q1: Sign off Trust road map for patient communications
	Q1: Process commenced to contact a cohort of patients on waiting list on a systematic basis to check their status & offer access to a clinician if needed. Starting with current waiters, exercise will also extend to outpatients & patients still on pathway. Additionally, we have developed a patient communications roadmap for the year setting out our proposed actions with timescales. This is draft and will be signed off in quarter 2.
	Q2 update: A rolling process of texting patients is now in place for inpatients and outpatients on RTT pathways. A wider programme of work to substantially review and change patient communications approach remains a work in progress and at scoping stage.
	Q3 update: Small project group established . We don't know what we don't know re: ALL pt comms in UHS . Agreed TORs and scope . Trust wide base line current comms assessment completed 6/1/23 . Results for review to : flag risks, inform priorites for change , focus resources - digital & transformation .
1(e)	**Delivering a high-quality experience of care for all (CNO/CMO)**
	New Experience of Care Strategy and associated charity programmes
	Q2: Experience of care strategy to be informed by output data and insight from health inequalities work and further engagement with patients and staff. Engagement piece delayed by pressures on clinical teams.
	Q3 update: No change- likely to resume developing the strategy in the Spring.
	Q2: Constitute new Learning from Deaths committee as part of overall integrated strategy for improved end of life care, learning from deaths and expanded medical examiner service.
	New mortality governance analyst started August, and is currently revising reporting and data collection ahead of launching learning from deaths committee beginning Q4
	Q3 update: We have been waiting for the appointment of lead medical examiners – the process has been completed Jan 23 with two lead MEs in post. The immediate priority is to meet the national targets for medical examiner service rollout. Medical Examiners have been invited to join the end of life programme board, with the aim of working towards establishing the Learning from Deaths committee in Q1.
Pioneering research and innovation	
2(b)	**Strategy and Partnership working**
	Q3: Implement regional clinical trial hub model Clinical Research Network ((CRN) Wessex led)
	Q3: Delayed due to clinical pressure - working groups established and will finalise hub model in Q4 22/23
	Q3: Present proposed areas of strategic growth to Senior Operations Group for review and incorporate ambition for growth / development into UHS Research Strategy
	Q3: Senior Operational Group meeting and presentation scheduled for Q4.

World Class people	
3(a)	**Thrive: Growing developing, innovating our workforce**
	Establish a strategic five-year outline workforce and education plan for UHS, including demand and supply opportunities.
	Q3 update: National planning guidance requiring 5 year workforce projection. Considering in light of new financial architecture. TBSS planned for March.
3(b)	**Excel:** A great place to work, develop and achieve
	Q3: Completion of a new roof garden
	Q2 Forecast: Following a redesign of the roof space, tenders have now been sent out for the roof garden and associated link bridge. Works are scheduled to commence in December 2022 and completed in March 2023
	Q3 update: Work has commenced on Wellbeing Hub, roof garden to commence WC 24 Jan. Rooms identified and work beginning.
	Increase the participation rate in the national NHS staff survey from 55% to 60% in 2022
	Delivered 55% (same as last year). This benchmarks well against other acute NHS trusts. Did not achieve 60%.
3(c)	**Belong : Compassionate and inclusive workplace for all**
	Q2: Refresh and re-launch equality, diversity and inclusion (EDI) strategy
	Q3: New EDI strategy has been drafted following consultation with our People. To be taken through Governance routes for launch in Q4.
	Through engagement with our people, refresh the underpinning behaviours of our Trust values and produce a new behaviours framework. This will underpin future leadership development and organisational development (OD) interventions.
	Q3 update: delay in sign off to Q4. Engagement process with staff extended due to operational pressures limiting availability.
Integrated networks and collaboration (CEO/CMO/Dir. of S&P)	
4(a)	**Work in partnership with ICS and PCNs**
	Q2: Secure TB approval for elective hub outline business case (OBC) and submit to NHSE
	Q2: Elective hub OBC submission delayed due to costs being higher than funding available. Further value engineering work and identification of alternate funding in progress. HIOW acute provider collaborative remains committed to the project, Current funding gap is approx. £7.5m.
	Q3: Due to further additional costs arising from electrical support to proposed build for elective hub, cost of original plan prohibitive. Alternate option identified providing reduced capacity from 4 to 2 theatres at reduced costs. Programme for revised approvals agreed.
	Q3: Submit elective hub full business case (FBC) to TB and NHS England.
	Q3: Short Form Business Case for revised design will be submitted to NHSE/I DHSC Q1 23/24.

Foundations for the future	
5(a)	**Create a sustainable financial infrastructure**
	Q2: Develop a medium-term financial plan for 2023/24 to 2024/25.
	Work underway but incomplete, noting link to in-year financial uncertainty.
	Q3: Approve a medium-term financial plan for 2023/24 to 2024/25.
	Underway but completion moved to Q4 in line with ICB and NHSE process.
5(b)	**Making our corporate infrastructure (estates and digital) fit for the future to support a leading university teaching hospital in the 21st century (COO)**
	Q3: Business case for the future of the Chilworth LAMP facility developed
	Q3: Awaiting final confirmation from the Unversity as to the future of Chilworth
	Q3: Have a generic PROMs standard (equivalent to EQ5D)
	Q3 update:Technical design work is now underway for implementation of Phase 1 - Generic HR-QOL EQ-5D-5L for all new MyMR referrals. This includes a review of specialties currently excluded from MyMR, design of the data flows to pick up referrals and to define what happens when referrals are rejected at clinical review where applicable, along with supporting trust integration engine and administrative requirements. Design changes to the MyMR clinical site to support the ability of clinicians to review the EQ-5D-5L responses are also underway. The PROMS steering group meeting has been delayed due to operational pressures – this is a key dependency for sign off of the technical and process design work and to ensure clinical governance. Business intelligence resources are also being requested to support the development of the required reporting and dashboard solutions. The risks around digital exclusion are also being defined for addition to the Trusts risk register. Note: The delivery date for phase 1 has now slipped to February/March due to operational pressures, the complexity of the referral messaging process and the delay in the provision of the required clinical governance.
	Q3: Register 200k active accounts with My Medical Record ready for digital virtual outpatients roll out
	Q3: As of 1st October 2022 there were 132k patients with active MyMR accounts at UHS. We now send automatic invites to register to patients when they are referred, attend ED or attend an OP clinic. We have a team on three in place to support patient registration. We have identified over 15 different initiatives to encourage registration by patients and are working through these. We will need to extend further into wider citizen registration to reach the 200k target e.g. work with GP practices. Therefore this target will slip to Q4
	Q3: Voice recognition. Migrate from Alden OKS service to Fluency Flex 3M service complete
	Q3 update: The migration did not complete by end of December due to decision not to place a hard stop on the old contract (OKS) by the steering group. However the progress is good with some care groups at 100% - plan is to review progress at end of Jan
	MS 365 shared drive (G: O: V: Z: etc) migrations [to SharePoint] completed for all general use
	Q3 update (AB): Operational pressure and staff recruitment issues have meant that this project is slipping

Appendix 3:						
Outstanding patient outcomes, safety and experience						
Ref	**Short title**	**Lead**	**Q1**	**Q2**	**Q3**	**Q4**
1(a)	Recovery, restoration and improvement of clinical services	COO/ CMO/ CNO	Recovery, operational and activity plans for H1 and winter 2022/23	Based on Urgent Care Village (UCV) pilot agree next steps including options appraisal to Trust Executive Committee (TEC) / Trust Board (TB), whichever is more suitable.	Open 25% of allocated cardiac capacity in new cardiac theatre	Commission new MRI x 3 C level vertical extension
			Operational plan complete for H1. Winter Plan via TEC and Board for October	Q2 update: Pilot completed in September 2022, Options appraisal scheduled for November 2022 with early actions where possible being implemented. Q3 update: Next steps agreed. Plan to trial GP streaming at front door to evaluate impact and cost of that vs. full UCV model. Trial to start for 6 weeks from 30th Jan 2023	Complete	Q3 forecast: orders have been placed with the preferred contractor for enabling works. MRIs selected. Developing a design programme with the contractor. Establishing project team , arranging meetings on site for surveys etc. We have allowed 12 weeks for this – taken from 3rd Jan 2023 (mid-March) so we can integrate mechanical design to the completed duct works terminating in the C Level suite. Reviewing potential impact of long lead items Spending time well now on ensuring the proposed plan / design is sufficiently worked up – in order to mitigate programme slippage later on . Occupation of site Feb / March 2023 followed by set up and early works . Major works from April.

						Replacement MR's operational end of Qtr. 2 2023.
			Submit business case to Trust Investment Group (TIG) for development of Transcatheter Aortic Valve Implantation (TAVI) lab 6	Secure TIG/TB agreement for CAR-T plan TIG/TB	Genomics – implementation of two site one service model	Commission Cath Lab 6 (TAVI)
			Case approved by Trust Investment Group on 14th July 2022	Complete	Complete	Q3 forecast: Awaiting affordable design for new air handling solution . Options appraisal completed for discussion at February TIG .
			Sign off Trust Strategy for Advice & Guidance (A&G) and plans to reduce follow-ups and initiate			Achieve national targets for: -A&G (16 per 100 First Out-Patient Appointment (OPFA)) and -Patient Initiated Follow Up (PIFU) (5% of all Outpatient Appointments (OPAs) discharged with PIFU)

			Complete			Q3 forecast: Exceeding A&G target with 25.9 A&G responses per 100 OPFA provided in November, expect this to be maintained. Currently performing at 3.6% PIFU (Nov 22') ranking 27th out of 142 Trusts in the country – top 20%. We have confidence in our trajectory to meet 5% by March 23 with early cut of December figures at 4.3%
			Launch of Theatre pathway improvement programme	Phase 2 of the theatre improvement programme initiated and second theatre pathway enabler transformation identified and initiated.		Phase 2 of the theatre improvement programme completed and Phase 3 initiated.

			Complete	Complete - Third improvement phase of 6-4-2 focused on in session utilisation - Trust wide review of theatre backfill led by Roger Lightfoot - Theatre pathway enabler: Delivery of Women and Newborn improvements in the average start time with the number of lists that start within the 30 minute window improved by 21.27%.		Q3 forecast: on track. Phase 2 of the theatre improvement programme will be completed, with the following successes (Jan): -Continued Improvement in theatre start times by expanding initial pilots -Improvement of theatre estate utilisation to 89% with the 95% target being hit in November for the first time compared with a baseline of 77%. -Touch time scheduling has continued to improve with the trust delivering over 80% in 5/8 months in elective care. -Increased emergency operating hours available due to CEPOD improvements. Forecast -Exceed 92% theatre estate utilisation as BAU -Exceed 82% theatre utilisation as BAU
					Initiate phased implementation CAR-T plan	
			Sign off Trust road map for patient communications		Q2 forecast: On track – CAR-T plan approved by Trust Investment Group	

			Q1: Process commenced to contact a cohort of patients on waiting list on a systematic basis to check their status & offer access to a clinician if needed. Starting with current waiters, exercise will also extend to outpatients & patients still on pathway. Additionally, we have developed a patient communications roadmap for the year setting out our proposed actions with timescales. This is draft and will be signed off in quarter 2.		Q3 update: Complete. Plan initiated. First case planned for end of Jan23. Ambulatory pilot to commence end of Jan23 also.	-Continued improvement in theatre start times beyond 19/20 levels.
			Q2 update: A rolling process of texting patients is now in place for inpatients and outpatients on RTT pathways. A wider programme of work to substantially review and change patient communications approach remains a work in progress and at scoping stage.			

			Q3 update: Small project group established . We don't know what we don't know re: ALL pt comms in UHS . Agreed TORs and scope . Trust wide base line current comms assessment completed 6/1/23 . Results for review to flag risks, inform priorities for change , focus resources - digital & transformation .			
		CNO/ COO	Sign off detailed project plan for inpatient flow programme.	Embed use of electronic bed states, map 7 day services, focus with wards on embedding criteria to reside and discharge planning / time for tomorrow, embed review of length of stay in performance meetings, new Onward care referral (OCR) form live on APEX, agree priorities based on scoping for first 12 hours, first 10 days and 10+ days and have first virtual wards running.	Focus on next six priorities and embed pathway changes agreed in Q2	Deliver final six priorities and ensure work is embedded as BAU. Agree either continuation of the project in some form or wind-down plan.

			Complete	Elements of this have been completed, we haven't embedded electronic bed states but we have mapped 7 day services, progressing the work with wards, embedded LoS stay reviews, implemented new OCR form, and have refocussed priorities for the rest of the year.	Q2: We have only recorded patient choice 104ww so far this year. ERF performance YTD is 106%	Q3 forecast: Ensure final priorities embedded. Plan for 2023/24 patient flow programme including proposal to TIG and F&I
				Q3 update. Refocused priorities are delivering.	Q3: Patient flow project progressing with 7% reduction in NEL Pathway 0 LOS delivered.	
			Ensure no patient waits longer than 104 weeks at the end of Q1 and ensure delivery of elective target of 104% of activity baseline.	Ensure no patient waits longer than 104 weeks throughout Q2 and ensure delivery of elective target of 104% of activity baseline.	Ensure no patient waits longer than 104 weeks throughout Q3 and ensure delivery of elective target of 104% of activity baseline.	Ensure no patient waits longer than 78 weeks at the end of Q4 and ensure delivery of elective target of 104% of activity baseline.
			Complete (other than a few patients who chose to wait)	6 at end of Sept, all patient choice	Complete	Q3 forecast - We are currently continuing to forecast elective activity at 104% (subject to industrial action caveat) but it is now unlikely we will achieve the 78ww target with between 100 and 200 patients projected at the end of the year. Plan B to seek aid including via DMAS
1(b)	Introducing a robust and proactive	CMO/ CNO	Initiate roll-out of national patient safety syllabus levels 1&2	Initiate roll-out of national patient safety incident response framework	Initiate roll-out of national patient safety syllabus levels 3&4	Initiate roll-out of national patient safety syllabus level 5

	safety culture		Levels 1,2 & 3 available via VLE or E LFH. Currently over 100 staff have completed. We continue to promote via governance and education teams.	Plan progressing to achieve full roll-out by September 2023	Level 3 and 4 not yet released by NHSE	Q3 forecast: No release date from NHSE
			Initiate work to develop UHS Human Factors strategy	Recruitment and training of quality and patient safety partners and supporting them to become active members of patient safety steering group and serious incident scrutiny group	Identify quality and patient safety partner (QPSP) to sit as an active member of patient safety steering group and serious Incident Scrutiny Group, which must be completed by September 22 (national objective)	Launch Human Factors Strategy
			Workstream continues. A framework of behaviours has been developed linked to the trust values. Work ongoing about standardising HF language across Trust.	Complete - 2 QPSP recruited	Complete - 2 QPSP now sit as core members of SISG and PSSG	Q3 forecast - currently on track
						Review progress against national expectation of roll-out of national patient safety incident response framework and plan for 2023/24
						Q3 forecast - On track: Orientation phase complete and currently working through phase 2 diagnostic and discovery
1(c)	Empowering and developing staff to	CMO	Plan for further shared decision making (SDM) roll-out and delivery against CQUIN	Deliver SDM CQUIN		

	improve services for patients		In progress and on target: The SDM CQUIN specialities have been agreed with the ICS and baseline assessments have been undertaken for all target areas.	In progress and on target: Q2 actions have been achieved and reported to NHSE. After further discussion with NHSE, slight amendments to the CQUIN requirements have been agreed for Q3 and Q4		
1(d)	Always Improving strategy	CNO/ COO	Launch ward based coaching programme	Establish governance structure for organisational change programme established trust-wide	Quality and patient safety partners embedded into first workstreams	Comprehensive improvement educational offering available to staff at a level appropriate to their needs/roles.
			Complete - programme launched	Complete. Established Organisational Change Steering Group in August	Complete: QPSPs all recruited and aligned to workstreams bringing valuable patient perspective	Q3 forecast: On track: Education & training programme developed for launch in March 23' following agreement at Organisational Change Steering Group
			Commence co-produced quality and patient safety partners programme	Design 3 year plan for organisational change to support Always Improving strategy	Evidenced benefits delivered through local change projects supported	Staff survey indicates increase in ability to make improvement at UHS (questions 3d,e,f)
			Complete - programme commenced	Complete. Drafted to be reviewed in Org Change steering group in Q3	Q3 update: All local change projects have benefits tracking in place with outcomes being delivered	Q3 forecast: On track: Staff survey results are not yet released. Expecting a modest UHS improvement in the context of national regression of overall engagement scores, will scrutinise absolute and relative results upon release
					Host Always Improving conference	

					Complete: Virtual conference took place virtually on 18th Oct with over 100 staff attending. New projects received charity funding and awards presented against all poster categories	
1(e)	Delivering a high-quality experience of care for all	CNO/ CMO	Recruit to health inequalities posts and establish health inequalities programme focusing on access, experience, and outcomes	New Experience of Care Strategy and associated charity programmes	Initial pilot of medical examiner service into the community with selected primary care networks (PCNs) to develop and test new referral processes	Full-roll out of medical examiner service to cover all non-coronial deaths in Southampton and the surrounding areas
			Post appointed to and start date 15th August. Initial areas of focus defined and will commence when postholder starts.	Q2: Experience of care strategy to be informed by output data and insight from health inequalities work and further engagement with patients and staff. Engagement piece delayed by pressures on clinical teams.	Complete: New lead medical examiners appointed, and pilots with GPs started.	Q3 forecast: Some staff turnover has impacted the service, but lead medical examiners now started and primary care roll out and launch is progressing to plan.
				Q3 update: No change- likely to resume developing the strategy in the Spring.	Launch of Patient Support Hub 'waiting well' initiative to support patients and carers facing long waits.	Health Inequalities report and provisional Trust strategy / action plan submitted to Trust Board
			Progress Patient Support Hub strategic programme including diabetes support initiative	Constitute new Learning from Deaths committee as part of overall integrated strategy for improved end of life care, learning from deaths and expanded medical examiner service.	Patient Support Hub initiatives are all live, although we've not seen much activity around waiting well. It's currently mostly pre-admission and post-discharge support at this stage.	Q3 forecast: A big engagement event is being planned for Q4/Q1, and this will be accompanied by new patient survey questions around health inequalities. Report and strategy likely to be delivered Q2

			Diabetes support initiative near launch - recruitment to specialist volunteer roles underway and in progress. Goes live 18th July	Q2 update: New mortality governance analyst started August, and is currently revising reporting and data collection ahead of launching learning from deaths committee beginning Q4	FFT SMS surveys fully operational and embedded, driving increased response rates across emergency and urgent care departments	
				Q3 update: We have been waiting for the appointment of lead medical examiners – the process has been completed Jan 23 with two lead MEs in post. The immediate priority is to meet the national targets for medical examiner service rollout. Medical Examiners have been invited to join the end of life programme board, with the aim of working towards establishing the Learning from Deaths committee in Q1.	Q3 update: Testing and coding checks completed. Final systems integration in progress and go live date due to be set Q4.	

Pioneering research and innovation						
Ref	**Short title**	**Lead**	**Q1**	**Q2**	**Q3**	**Q4**
2(a)	Deliver year 2 of the research and innovation investment plan including the Southampton Emerging Therapies and Technologies Centre (SETT), Research Leaders programme (RLP) and delivery infrastructure	CMO/Dir. of S&P	Formal launch of SETT Innovation Centre (MedTech trials component)	Review Advanced Therapy Treatment Centre (ATTC) Midland and Wales network portfolio and identify expanded study pipeline for development.	SETT Board established and governance for workstreams in place	Commence delivery (TRE) and ATTC studies
			SETT launched during UHS/UoS 50th Anniversary research event	Complete	Q3 update: SETT Board ToRs finalised and workstreams governance established. 1st SETT Board meeting in Q4.	On track. ATTC:Polarise study is planned to set up in 2023. TRE established and research data studies underway.
			Establish refreshed Research Leaders Programme (RLP) oversight and operational boards	Regional NHSx TRE business case submitted in response to call	Initiate RLP cohort 2 and launch call for cohort 3	Plan evaluation of RLP cohort 1 to be conducted in Q1 2022/23
			Governance structure established	Q2 update. National call was delayed by 1 month. Application will be submitted by 21st October.	Complete. Cohort 3 appointed.	On track. End of year review scheduled for January to be followed by evaluation.
			Initiate RLP cohort 1 and launch call for cohort 2	Q3 update: Complete. Funding awarded and confirmed.		Pilot new digital solutions for patient identification, patient recruitment and data capture

			Complete			On Track. NHS Digitrials used for Orion 4 and UMED for Harmonie study. No recruits yet for Harmonie but open to referrals. The Sponsor for the Orion 4 Study accesses NHS Digital to identify patients, they then send the details to delivery team to book the patients into clinic. We have currently recruited 67/75 and potential to go above the 75.
			Implement strategy to address oncology pharmacy capacity			SCREI formal launch
			Complete: monitoring impact			Launch has been amended to align with NIHR PPI/E and EDI strategy releases. Launch expected in Q3 of 23/24.
			Implement National Institute for Health and Care Research (NIHR) portfolio research reset process			
			Complete			
			Consider implications of DHSC Future of Clinical Research Delivery report, agree response and initiate			
			Complete. Immediate actions initiated. Longer term response will form part of strategy.			

2(b)	Strategy and Partnership working	CMO/Dir. of S&P	Deliver 50th Anniversary UHS/UoS Partnership celebration event. Delivered	Submit CRUK Southampton Clinical Trials Unit (SCTU) full application	Secure CRUK/NIHR Experimental Cancer Medicine Centre (ECMC) award	Secure TB approval of Research Strategy and launch.
			Commence review for UHS research strategy 2023-2025	Application submitted in September 2022.	Award secured	On track - Strategy will be submitted by March.
			Strategic review for UHS research strategy 2023-2025 commenced		Establish, with system partners, WHP in line with business case	Secure CRUK SCTU Award
			Joint University of Southampton (UHS/UoS) external review of cancer sciences research.		Q3 deliverables achieved. WHP Chair Appointed, MD post to be appointed in Q4 22/23.	Complete: Award secured with increased funding.
			Review complete. UHS Director of Strategy and Partnerships participated on the external review panel.		Implement regional clinical trial hub model Clinical Research Network ((CRN) Wessex led)	Launch WHP
			Submit Cancer Research UK (CRUK)/NIHR Experimental Cancer Medicine Centre renewal Application June 2022		Delayed due to clinical pressure - working groups established and will finalise hub model in Q4 22/23	Forecast: On track
			CRUK/NIHR renewal application submitted		Present proposed areas of strategic growth to Senior Operations Group for review and incorporate ambition for growth / development into UHS Research Strategy	Create strategic research growth plans across UHS/UoS partnership and identify potential funding opportunities as they arise
			Secure NIHR Biomedical Research Centre (BRC) and NIHR Patient Safety Research Collaboration (PSRC) funding		Senior Operational Group meeting and presentation scheduled for Q4.	Forecast: On track

			Complete. BRC awarded and funding confirmed. PRSC submitted, not awarded.			
			Present Wessex Health Partners (WHP) BC to TB.			
			WHP BC finalised and approved. Level of investment does not require TB approval.			

World Class people						
Ref	**Short title**	**Lead**	**Q1**	**Q2**	**Q3**	**Q4**
3(a)	Thrive: Growing developing, innovating our workforce	CPO	Develop and initiate 2022/23 operational workforce plan	Refresh Trust volunteer strategy to incorporate all voluntary partners, align objectives, and ensure ambitious plans for UHS volunteering	Establish a strategic five-year outline workforce and education plan for UHS, including demand and supply opportunities.	Deliver a plan to increase apprenticeships by 20% compared to the number of starters 2021-22.
			Workforce plan for 22/23 signed off as part of operating plan for UHS.	Regular onsite charities meeting established, with volunteers as an agenda item to identify needs and objectives across all partners. Trust volunteer strategy still in development as the service continues to rebuild numbers and reintroduce roles to clinical areas.	Q2 Forecast: Strategy in draft to be shared at Trust Board Study Session	Q3 forecast: Delivery of increased apprentice numbers on track
			Design and initiate plan to reduce reliance on temporary staffing.		Q3 update: National planning guidance requiring 5 year workforce projection. Considering in light of new financial architecture. TBSS planned for March.	Deliver a reduction in healthcare assistant (HCA) vacancy and turnover. Reduce current vacancy level from 21% to 10% Build a greater sense of belonging in HCAs to improve retention.
			Action plan created and being implemented for agency control for all staff groups. Continuing with substantive recruitment and retention actions to improve perm staff position.			Q3 forecast: Highly unlikely to deliver objective due to significant market pressures. Retention has improved with interventions but overall target remains a challenge.
						Hit key milestone of 250 new volunteers recruited into Trust volunteer roles.

						391 new applications received to date in the year, with 344 total active volunteers across the Trust. Ambition to reach 500 by end of 23/24 is on track. Numbers plummeted from 800 to less than a 100 during the first wave of the pandemic so it is rebuilding the volunteer workforce.
3(b)	Excel: A great place to work, develop and achieve		Launch a refreshed appraisal framework, including a focus on our corporate strategy.	Refresh and launch our forward wellbeing offer post-COVID. Ensure a range of well-being measures to support physical and mental health.	Agree refreshed approach to talent management and succession planning, including launching the UHS careers conversation.	Recover our focus on people development post-COVID, increasing appraisal coverage to 90% by 31 March 2023.
			Refresh complete and new process launched. Increases in uptake in appraisal during April and May.	Cost of Living plan for winter implemented to support employee Wellbeing.	Complete: Talent management steering group established and Talent lead appointed. Talent discussions included in revised appraisal process.	Q4 forecast: Appraisal have remained stable but significant operational pressures are preventing increased levels.
				Existing wellbeing offers reviewed against NHSE Framework. OH launching range of Live Well Offers to support healthy living.		Completion of a new wellbeing centre
					Completion of a new roof garden	New wellbeing hub has started building. On track for completion

					Q2 Forecast: Following a redesign of the roof space, tenders have now been sent out for the roof garden and associated link bridge. Works are scheduled to commence in December 2022 and completed in March 2023	Launch the refreshed Hospital Heroes Awards aligned to our values with a new 'We are UHS' Awards.
					Q3 update: Work has commenced on Wellbeing Hub, roof garden to commence WC 24 Jan. Rooms identified and work beginning.	New UHS champions awards approach agreed with clinical and non clinical award based on our values. Have agreed to move awards to September to align with new we are UHS week and to avoid continued industrial action.
					Increase the participation rate in the national NHS staff survey from 55% to 60% in 2022	Protect our UHS family through the delivery of the 2022/23 vaccination campaign (flu and COVID TBC) against national targets
					Delivered 55% (same as last year). This benchmarks well against other acute NHS trusts. Did not achieve 60%.	Forecast: Campaign being delivered as planned, however behind target for vaccinations. COVID uptake lower than previous years. Flu currently at 60% uptake of frontline staff.
3(c)	Belong : Compassionate and inclusive workplace for all	CPO		Refresh and re-launch equality, diversity and inclusion (EDI) strategy	To support the Chief Nursing Officer in a staff engagement programme, 'We Are UHS' to drive pride across the UHS family	Deliver annual EDI objectives showing improvements in WRES, WDES and gender experience

				New EDI strategy has been drafted following consultation with our People. To be taken through Governance routes for launch in Q4	We are UHS launched. Departments are encouraged to share their stories. We Are UHS awards launched in monthly connect meeting.	New EDI strategy (UHS Inclusion and Belonging Strategy) to be signed off at Trust Board in January.
					Through engagement with our people, refresh the underpinning behaviours of our Trust values and produce a new behaviours framework. This will underpin future leadership development and organisational development (OD) interventions.	
					Q3 update: delay in sign off to Q4. Engagement process with staff extended due to operational pressures limiting availability	

Integrated networks and collaboration						
Ref	**Short title**	**Lead**	**Q1**	**Q2**	**Q3**	**Q4**
4(a)	Work in partnership with ICS and PCNs	CEO/ CMO/ Dir. of S&P	UHS strategic intent for Southampton and SW Local delivery system (LDS) determined and partners engaged. Secure TB steer on MOFD/CTR approach.	LDS plans agreed and initiated. Scope fully new options to address MOFD/CTR subject to TB steer and agree business cases.	UHS leadership mapped and connected to ICS new leadership structure ensuring UHS strongly represented, gaps identified and action to remedy initiated.	S&SW LDS governance strengthened, plans for 2022/23 delivered and 2023/24 agreed.
			UHS strategic intent for Southampton and SW Local delivery system (LDS) determined and partners engaged. MOFD/CTR TB paper presented July 2022.	Complete.	Mapping exercise with UHS executive team complete and key meetings and contacts identified and connections made. It is anticipated that this will evolve as the ICS structure continue to evolve.	Forecast: S&SW LDS governance in process of being strengthened with UHS COO taking a greater lead.
			Agree with partners, future role of Acute Provider Collaborative (APC) Board and initiate plans to realise	Agree approach to Specialised commissioning with Hampshire and Isle of Wight (HIOW)integrated care system (ICS) partners		APC 2022/23 plans delivered and 2023/24 priorities agreed.
			Role agreed with partners and paper submitted to ICB for consideration. Of four themes, two are progressing and ICB resource to support has been requested for remaining themes.	SE Region/HIOW ICB have agreed a post and appointed a programme lead to work with organisations. ICB has not yet commenced more detailed work with organisations but contact with ICB programme lead has been made.		On track
				Q3 update: Arrangements for 23/24 agreed.		

4(b)	Integrated Networks and Collaboration	CEO/ CMO/ Dir. of S&P	Complete intelligence gathering for prioritised networks and assess maturity. Agree and initiate 'next steps' for each prioritised network.	Establish governance arrangements structures for remaining prioritised networks and agree project plans.	Top UAN priorities identified and plans to address commenced including draft pathways guided by GIRFT report	Review progress and agree 2023/24 plans for networks and system infrastructure.
			Complete.	Q2 update: Delayed: Of the 10 prioritised networks, 3 have an established governance structure (Eye Care Alliance, UAN and ENT), 1 (upper GI) has draft TORs for a steering groups under consideration by HHFT, UHS and UHD. Having completed baseline assessments on all of the networks it is evident that the remining 6 networks (lower GI, gastro/endoscopy, head and neck/OMF, gynae, plastics and breast surgery) are too early in their development for formal governance structures. However, the overarching scrutiny and support of the Integrated Networks and Collaboration Board is resulting in identification and delivery of 'next steps' for each network. progress is however slow due to the complexity of the programme and ongoing clinical pressures.	Complete: workstreams agreed. • Prostate pathway workstream. Aim is to equalise wait times across the region and to minimise inefficiency. Sub-group created to look at logistics. • Bladder Cancer workstream to look at creating efficiencies in the Haematuria pathway. Sub-group created to look at logistics. • Consultant on-call between the three Trusts to reduce PA allocation for each Consultant, look into potential of a 'hot stone list' and reviewing how a referral pathway might look like between Trusts. • Workforce planning for nursing /ACP. Sub-group created to look at career progression for staff, the equity of banding in the region. The workstream aims to attract staff to train and stay in the region • Theatre utilisation/allocation – aim to utilise theatre space in each Trust with 'regional patients'. Also aims to share staff and equipment to make lists more efficient.	On track

				Q3 update: Progress made. Breast and Gynae scoping work progressing. Plastics being discussed at January INC Board to agree next steps. Decision not to proceed with Head and neck/OMF network with UHD as not needed at this time. Lower GI will build on upper GI network in due course.	• Elective hub. The aim is to have equal representation for all three Trusts at the Elective hub, under the banner of the UAN.	
			For urology area network (UAN) , constitute cross-system steering group.	Constitute UAN workstreams and working groups & agree performance management arrangements	HIOW elective hub development of clinical ways of working	
			Achieved. UAN Steering Group constituted: UHS: HHFT :SDH Clinical Leads & UAN Trust management representation, with Senior CCG Commissioner participant	Q2 update: UAN development day held Oct 2022. Workstreams scoped and next steps agreed. Performance metrics and management arrangements not yet agreed.	Ongoing work on track aligning with revised timelines of elective hub programme.	
			Secure TB, ICS and SE Region support for SSWHS CDC year 2 - 4 business case	Updated in Q3 objective.	Submit elective hub full business case (FBC) to TB and NHS England.	
			Complete. Funding secured.	Secure TB approval for elective hub outline business case (OBC) and submit to NHSE	Short Form Business Case for revised design will be submitted to NHSE/I DHSC Q1 23/24.	

			Establish UHS oversight group for system infrastructure (elective hub and community diagnostic centres (CDCs).	Elective hub OBC submission delayed due to costs being higher than funding available. Further value engineering work and identification of alternate funding in progress. HIOW acute provider collaborative remains committed to the project, Current funding gap is approx. £7.5m.	Genomics – implementation of two site one service model	
			Complete. Oversight structure established.	Q3: Due to further additional costs arising from electrical support to proposed build for elective hub, cost of original plan prohibitive. Alternate option identified providing reduced capacity from 4 to 2 theatres at reduced costs. Programme for revised approvals agreed.	Complete	
			Move fully to collaborative arrangements with partners for pharmacy procurement and distribution			

			Not achieved - consolidation & move to PUH procurement hub has been extensively delayed & now under review. Since the approval of the case in 2019 several of the strategic drivers have diminished & the necessary IT infrastructure is not yet available. A review of the case is planned for the trust investment group in August 22.			
			Q2: Paper presented to TIG in September setting out revised timelines and new considerations for use of resource including engagement required with partners. Proposals approved in principle by TIG. Conversations with partners being progressed.			

			Q3 – Update – While the strategic drivers have shifted, UHS still expects to realise benefits from the regional procurement hub hosted by PUH. Approximately 65% of the medicines purchased for UHS patients are purchased using the hub. In addition, the rapidly accessible, sizable stockholding provides consistent protection from ever increasingly frequent medicines shortages. However, it should be noted that the digital architecture to deliver the complete range of strategic objectives in the original case has been further delayed until Autumn 2023. As a result, there is a significant degree of uncertainty regarding the finalised model presented in the original case. Nevertheless, UHS remains committed to working with its strategic partners to ensure the maximal benefits of the regional procurement hub are realised for UHS and the wider healthcare system.			

4(b)	Southern Counties Pathology Network	CEO/ CMO/ Dir. of S&P	Appoint Southern counties pathology network (SCPN) clinical lead and establish a next steps matrix to show how the network will move from current emerging status to mature by 2024 including options for redistribution of pathology work across SCP network.		Submission of SCP network full business case to NHS as approved by the Pathology Network Board.	Go live of LIMS for all trusts in the network
			Next steps matrix complete and submitted to NHSE. Business case being presented July TB. Interviews for Clinical Lead 8th July.		Q2 forecast: OBC now presented to all Boards in SCPC. FBC expected to be finalised by end of October and available for presentation to Boards during Q3.	Q3 forecast: The go live date for LIMS in all Trusts delayed due to complexity. Unlikely to be delivered across the whole network in 22/23.
			Establish SCP network Digital Pathology Clinical Group and submit three year digital roadmap bid for NHSE funding for laboratory information management system (LIMS) and DP.		Q3 update: NHS England have revised timelines for all pathology networks to get to maturity nationally. Final FBC now programmed to be developed in 23/24 and thus will not be presented to 22/23.	
			Digital Pathology Clinical Group established, 1st meeting June and now monthly since. Digital roadmap bid submitted (UHS share - £550k for DP and £300k for LIMS). Result due by end of July. We are reasonably confident the we will be successful.			

4(b)	Wessex Imaging Network (WIN)	CEO/ CMO/ Dir. of S&P	Submit business case and secure national funding (£30m) for WIN digital strategy, primarily for HHFT to join SWASH system.	Secure NHSE funding for SSWHS CDC years 2-4 business case.		HHFT join SWASH (might be next year)
			Business case submitted and funding requested by network has been confirmed.	Complete		On track
				Commission year 1 RSH U/S and Hythe CDC and scope use of CDC with Cancer Alliance		
				Year 1 RSH U/S and 1 CT commissioned. WCA has joined CDC Board and embedded in decision making.		
				Options for WIN network arrangements considered		Option for WIN network arrangements agreed
				Potential options for WIN networks arrangements have been developed and dates to brief Boards of the WIN NHS partners are currently being secured.		On track: Draft currently being discussed.
4(c)	Collaborations	CFO/Dir. of S&P	Approach to develop wider strategic partnerships agreed and initiated	Agree UHS/UoS priorities to increase joint working in research, estates, education and enterprise.	Agree UHS/UoS joint influencing strategy	Agree list of master plan major capital developments requiring collaborative financial approach

			Complete - Agreed as part of role of Interim Commercial Director and work initiated.	Q2 update: Research and estates agreed. Shared priorities in enterprise and education explored . Enterprise being finalised. Education under review. Clinical team unable to progress due to leave and pressures.	UHS/UoS are partnering with the Southern Policy Centre and developing a life sciences advocacy strategy and engaged in Anchor organisation Initiative through Southampton Connect. Work explored in Q4 and commence in 23/24	Masterplan phase II programme group and workstreams being established including workstream for this objective.
				Q3 update: Areas scoped and priority areas for joint working agreed.		Secure TB approval of private patient collaboration strategy
						On track

Foundations for the future						
Ref	**Short title**	**Lead**	**Q1**	**Q2**	**Q3**	**Q4**
5(a)	Create a sustainable financial infrastructure	CFO	Finalise 2022/23 operating plan, including financial, activity, workforce and performance.	Develop a medium-term financial plan for 2023/24 to 2024/25.	Approve a medium-term financial plan for 2023/24 to 2024/25.	Finalise 2023/24 operating plan, including financial, activity, workforce and performance.
			Plan finalised.	Work underway but incomplete, noting link to in-year financial uncertainty.	Underway but completion moved to Q4 in line with ICB and NHSE process.	Forecast on track: Operating plan finalised and approved in Q4
			Deliver finances to plan or better than plan in Q1. Support delivery of the ICS financial plan.	Deliver finances to plan or better than plan in Q2, whilst targeting an improvement in the underlying financial position. Support delivery of the ICS financial plan.	Deliver finances to plan or better than plan in Q3, whilst targeting an improvement in the underlying financial position. Support delivery of the ICS financial plan.	Deliver finances to plan or better than plan for 2022/23, whilst targeting an improvement in the underlying financial position. Support delivery of the ICS financial plan.
			Not achieved - off-plan to date	Not achieved - off-plan to date. Improvements in underlying position off-set by additional risks e.g., energy	Not achieved - off-plan to date. Improvements in underlying position off-set by additional risks e.g., energy	Not achieved - £20.2m deficit forecast
			Develop a £33m savings programme - with at least 75% identification. Deliver savings to the profiled savings programme (15% by Q1)	Develop a £33m savings programme - with 100% identification. Deliver savings to the profiled savings programme (35% by Q2)	Develop a £33m savings programme - with 100% identification. Deliver savings to the profiled savings programme (65% by Q3)	Develop a savings programme for 2023/24. Deliver savings to the profiled savings programme for 2022/23 (100% by Q4)
			Not achieved in Q1. Achieved in Q2.	£39m identified at M6, 88% of revised plan value. 41% delivered by Q2.	£42m identified, 93% of revised stretch plan. 65% delivered by Q3.	Forecast: Delivery of 100% of stretch CIP target of £45.4m Noting under-delivery of recurrent schemes.
			Finalise capital plan for 2022/23. Implementation of investments including an on-track capital programme and successful bids for national funding.	Implementation of investments including an on-track capital programme and successful bids for national funding.	Implementation of investments including an on-track capital programme and successful bids for national funding.	Implementation of investments including an on-track capital programme and successful bids for national funding.

			Achieved and on-plan to date, with successful national funding bids	Capital programme broadly on-plan, noting high level of H2 spend programmed.	Capital programme forecast to deliver, noting risk of £50m spend required in Q4.	Forecast: Capital programme forecast to deliver, noting risk of £50m spend required in Q4.
				Successful bids for wards, Aseptic, Neonates, targeted lung CT, CDC and Digital funding.	Successful bids for additional in-year and future year capital: CT scanner, MRI scanner, Endoscopy suite, Endoscopy IT, Digital funding	
5(b)	Making our corporate infrastructure (estates and digital) fit for the future to support a leading university teaching hospital in the 21st century	COO	Estate masterplan finalised	Estate masterplan published widely		Trust Executive Committee review of draft estates strategy
		PM/DJ	Estates Masterplan Finalised: The estates masterplan went to Trust Board on 30th June, with broad sign off. The next step is to finalise the external comms pack and publish.	Q2: Estates masterplan published widely. Masterplan currently sitting with Executives for review and confirmation of wording		Q3 forecast: On track to deliver draft Estates Strategy by end of Q4
		PM/DJ	Adanac Park and Ride opened	Q3: Due to current financial pressure on HIOW ICB and SE region decision taken by Trust executive to not publish plan at the current time. Alternate approach being scoped.		Masterplan for remainder of the Adanac Park site agreed and business cases initiated
			Completed and handed over to the Trust, scheduled to open 3rd week in July	Successful bids for wards, Aseptic, Neonates, targeted lung CT, CDC and Digital funding.		forecast: Masterplan for plots 3,5 & 6 to be presented to TIG in February 2023. Business case to follow thereafter.
				Construction of aseptic and sterile services facilities commenced		
		PM/DJ		Commenced and on target for Dec 2022	Complete paediatric intensive care unit (PICU) side rooms	Complete design works and tendering for the retained ICU refurbishment

				Neuro Intensive Care Unit pendant replacement delivered	update: Project Complete	forecast: Retained GICU design works complete. GMP due in March 2023
		PM/DJ		Complete		Complete the refurbishment of Theatres 10 and 11
						Q3 forecast: On track
		JM			18 month security work plan developed covering all key aspects of security within UHS.	
					Q3 update: Work plan has been developed and due to go to EFCD Divisional Board by end Jan 23, and then to exec for review and approval.	
		PB	Exit LAMP testing facility, whilst retaining skilled staff and protecting UHS and UoS commercial interests.		Business case for the future of the Chilworth LAMP facility developed	
			Complete - whilst continuing to explore future opportunities		Awaiting final confirmation from the University as to the future of Chilworth	
		PM/DJ				Deliver £9m of critical infrastructure backlog maintenance programme
						forecast: On target to deliver the full budget in 2022/23.
		PM/DJ				List of master plan major capital developments requiring collaborative approach to funding agreed.

						forecast: Main capital plans (Adanac park/PPU/SouthSide/Energy Centre/ University) already in discussion with prospective partners on suitable delivery vehicles. Each project being taken forward on a case by case basis.
		JW/AB	(MS 365) plan for future use of SharePoint in place	Ophthalmology new EPR system "Open Eyes" implemented	Have a generic PROMs standard (equivalent to EQ5D)	
			Q1 The project for office 365 has now been wound up with a proposal to initiate a new project for the SharePoint element (new membership and terms). The steering group has not yet met but is being scheduled in.	Q2 update: Contract is undergoing legal review. Expected to be ready for signature by December 2022. Once contract signed, the implementation period will be 6 months therefore looking at a go-live of around April 2023	Q2 forecast: UHS now has an active free of charge license agreement for non-commercial implementation of the EQ-5D-5L standardised, validated, internationally recognised health related quality of life measure (HR-QOL) for use in	

			Q2 Draft Outline Business Case (OBC) developed and circulated to senior stakeholders for review and confirmation of the aims, objectives, scope etc. Once agreed a new project to define, create and deploy the use of SharePoint will be established.	Q3 update: Contract signed December 2022. The implementation period will be 6 months therefore looking at a go-live of around April 2023	the MyMR patient portal for 100K+ patients currently valid until 05-10-2025. We are now moving to implement stage 1 (baseline measure of HR-QOL) of the project to add the EQ-5D-5L (which has already been developed in MyMR) to each new referral where the patient has consented to MyMR registration. This will provide the clinician with a structured view of the patients perception of their mobility, ability to self-care, ability to perform their usual activities, their level of pain and discomfort, their levels of anxiety & depression, and an overall score of their perceived level of health, which will be accessed & by the clinician during the primary patient encounters via the MyMR clinical view (click through from charts with patient context). We are currently on track to deliver phase 1 by the end of Dec.	

					Q3 update:Technical design work is now underway for implementation of Phase 1 - Generic HR-QOL EQ-5D-5L for all new MyMR referrals. This includes a review of specialties currently excluded from MyMR, design of the data flows to pick up referrals and to define what happens when referrals are rejected at clinical review where applicable, along with supporting trust integration engine and administrative requirements. Design changes to the MyMR clinical site to support the ability of clinicians to review the EQ-5D-5L responses are also underway. The PROMS steering group meeting has been delayed due to operational pressures – this is a key dependency for sign off of the technical and process design work and to ensure clinical governance. Business intelligence resources are also being requested to support the development of the required reporting and dashboard	

					solutions. The risks around digital exclusion are also being defined for addition to the Trusts risk register. Note: The delivery date for phase 1 has now slipped to February/March due to operational pressures, the complexity of the referral messaging process and the delay in the provision of the required clinical governance.	
		JW/AB		Progress to HIMSS 5. Clinical noting app ready to/start roll out	Register 200k active accounts with My Medical Record ready for digital virtual outpatients roll out	Clinical Noting App: 25% rolled out

				Complete	As of 1st October 2022 there were 132k patients with active MyMR accounts at UHS. We now send automatic invites to register to patients when they are referred, attend ED or attend an OP clinic. We have a team on three in place to support patient registration. We have identified over 15 different initiatives to encourage registration by patients and are working through these. We will need to extend further into wider citizen registration to reach the 200k target e.g. work with GP practices. Therefore this target will slip to Q4	Q3 forecast: Hospital pressures have pushed some of the go-live dates but broadly on track for a 25% live by end of Q4
		JT	PowerBI usage increased compared to previous quarter	PowerBI usage increased compared to previous quarter	PowerBI usage increased compared to previous quarter	PowerBI usage increased every quarter
			Complete	Complete 29 Users, 164 Views per day	Q3: In December 2022 we had 185 unique users, generating an average of 124 views on a week day. Views per day are reduced due to Christmas holiday period.	Forecast: To review at end of January with a view to being almost complete
		JW/AB			Voice recognition. Migrate from Alden OKS service to Fluency Flex 3M service complete	

					Q2 forecast: The deployment is underway and we are aiming to complete migration by December 2022.	
					Q3 update: The migration did not complete by end of December due to decision not to place a hard stop on the old contract (OKS) by the steering group. However the progress is good with some care groups at 100% - plan is to review progress at end of Jan	
		JW/AB			MS 365 shared drive (G: O: V: Z: etc) migrations [to SharePoint] completed for all general use	Digital outpatients PIFU for five sites already live with MyMR developed
					Forecast: On target for migration of shared drives to One Drive by end of Q3 2022-23	Forecast on track: The plan is to be worked through in the outpatient group but is a priority in that programme
					Q3 update (AB): Operational pressure and staff recruitment issues have meant that this project is slipping	
		JT	New Trust Validation Tool (LUNA) deployed across UHS providing visibility of Follow Up Pathways in the Trust			Reduced the number of aged Follow Up Pathways across UHS delivered

			Complete			Q4 forecast: On track to have delivered a reduction in follow up pathways – although this is partly dependent on agreement to implement the ROVA letter reading solution
5(c)	Recognising our responsibility as a major employer in the community of Southampton and our role in delivering a greener NHS	COO/CMO	Agree funding requirements to commence the delivery of the sustainability strategy	Tender returns for energy procurement contract with full report to Board on outcomes	Tender returns for energy procurement contract with full report to Board on outcomes	
			Paper reviewed and approved at TIG August 2022	Tendering process due to close on the 18th November.	Agreed revised date on target	

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Board Assurance Framework (BAF)**			
Agenda Item:	**6.3**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Date:	**31 January 2022**			
Purpose:	**Assurance or reassurance** ✓	**Approval** ✓	**Ratification**	**Information**
Issue to be addressed:	The Board Assurance Framework (BAF) provides assurance against the achievement of our strategic objectives; highlighting those that are at risk of not being delivered. The BAF provides evidence to support the annual governance statement, and is a focus of CQC and audit scrutiny. This report sets out the strategic risks, control framework, sources of assurance and action plans. The BAF is a dynamic document that will reflect the Trust's changing strategic position.			
Response to the issue:	The BAF has been developed with input from responsible executives and relevant stakeholders. It satisfies good governance requirements on information and scoring. This report reflects recent discussion at the Audit & Risk Committee, incorporating challenges around risk titles.			
Risks: (Top 3) of carrying out the change / or not:	The ability of the Board to effectively manage strategic risk is fundamental to the delivery of the Trust's strategic objectives, and is a core element of the CQC's 'well led' inspection process. An organisation that does not monitor its strategic risk through a Board Assurance Framework or similar document may not be aware of key risks, or may not understand failures in the control environment and actions planned to address these failures.			
Summary: Conclusion and/or recommendation	The Board Assurance Framework has been refreshed to reflect the updated corporate action plan for 2022/23, as well as increases in risk relating to finance, staffing, and capacity. Scores and dates have been reviewed and updated with pragmatic targets.			

1. Purpose

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

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

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

Following discussion at Board sub committees the Board Assurance Framework has been updated to reflect key gaps in both controls and assurances, and to reflect the updated corporate action plan. The Trust strategic risk relating to outcomes and patient experience has increased to reflect the negative impact of long waiting times. The full BAF is provided as ***appendix 1***.

The Board is asked to consider:

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

Appendix 1

Trust Status

Trust status

Executive summary:

The key strategic risks for the Trust are:

- capacity (1a);
- staffing (3a); and
- the financial position (5a),

all of which are interrelated. As of June 2022 the financial pressures on the Trust have been escalated, as each depends on funding to mitigate. The capacity and staffing risks has also increased in score.

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

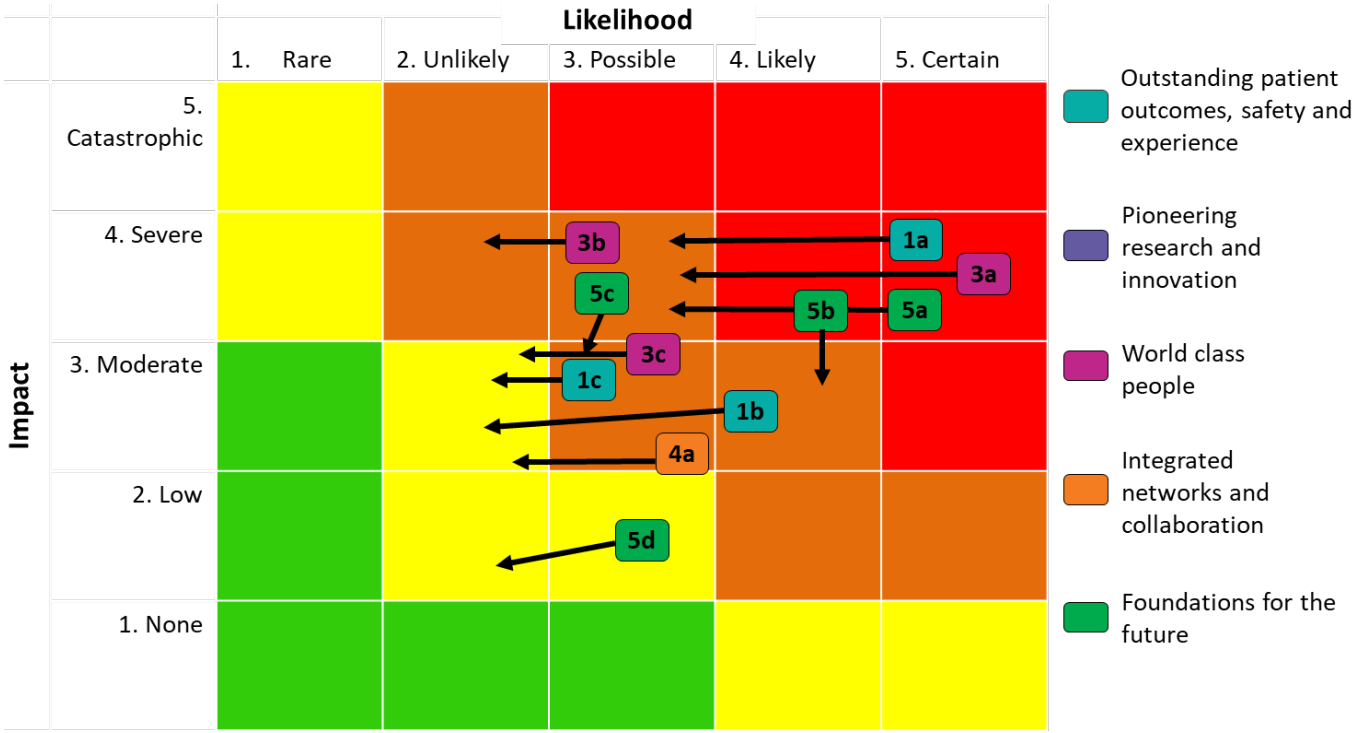
Patients who are waiting a long time for treatment are an increasing concern. This is impacting on outcomes and experience of care. Risk 1b) has increased to reflect this.

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

Trajectory:

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

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



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

1a) Lack of capacity to appropriately respond to emergency demand, manage the increasing waiting lists for elective demand, and provide timely diagnostics, that results in avoidable harm to patients.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Use of independent sector to increase capacity Triage of patient lists based on risk of harm Consultant-led flagging of patients of concern Clinical Prioritisation Framework Capacity and demand planning including trajectories, surge capacity and continuity arrangements Specific operational plans for urgent care and cancer care Business continuity arrangements in place to provide continuity of care Outpatient, theatres and inpatient improvement programmes Successful staff and patient vaccination and testing programmes and dispensing of neutralising monoclonal antibody therapies (nMAD) to eligible patients in the community to reduce COVID-19 related hospitalisations	Excess demand on primary care and social care, employment market for domiciliary/home care and care homes Limited funding, workforce and estate to address capacity mismatch in a timely way Lack of local delivery system response and local strategy to manage demand in our emergency department as well as to address delays in discharge from the acute sector Staff capacity to engage in quality improvement projects due to focus on managing operational pressures Challenges in staffing ED department during periods of extreme pressure	4 x 5 20	Clinical Assurance Framework, reported monthly to executive Live monitoring of bed occupancy and capacity data Monitoring of urgent care and cancer care pathways Monitoring and reporting of waiting times Harm reviews identifying cases where delays have caused harm.	Limited capacity within the Local Authority to support for patients without a criteria to reside Data suggests waiting lists and ED performance are not likely to improve	Outpatient theatres and inpatient flow transformation programmes Review of ED workforce model Development of final plans for urgent care village Review of local delivery system plan for reducing delays throughout the hospital. Deliver target of 106% of 19/20 baseline activity to secure additional funding and address waiting lists. Review plans to deliver no 78 week waiters by end of 22/23. Review the robustness of system winter planning.	4 x 3 12 Apr-25

Outstanding patient outcomes, safety and experience					Monitoring Committee: Quality Committee Executive Leads: CNO, CMO	
1b) Due to the current challenges, we fail to provide patients and their families / carers with a high quality experience of care and positive patient outcomes.						
Key Controls	**Gaps in Controls**	**Current Risk Score (I x L)**	**Key Assurances**	**Gaps in Assurance**	**Key Actions**	**Target Risk Score* (I x L)**
Trust Patient Safety Strategy and Experience of care strategy Organisational learning embedded into incident management, complaints and claims Learning from deaths and mortality reviews Mandatory, high quality training Health and safety framework Robust safety alert, NICE and faculty guidance processes Integrated Governance Framework Trust policies, procedures, pathways and guidance Recruitment processes and regular bank staff cohort Culture of safety, honesty and candour Clear and supportive clinical leadership Always Improving	No agreed funding for the quality of outcomes programme to go forward beyond this year Staff capacity to engage in quality improvement projects due to focus on managing operational pressures	3 x 4 12	Monitoring of patient outcomes CQC inspection reporting: Good overall Feedback from Royal College visits Getting it right first time (GIRFT) reporting to Quality Committee External accreditations: endoscopy, pathology, etc. Kitemarks and agreed information standards Clinical accreditation scheme (with patient involvement) Internal reviews into specialties, based on CQC inspection criteria Current and previous performance against NHS Constitution and other standards Matron walkabouts and executive led back to the floor Quality dashboard, KPIs, quality priorities, clinical audits and involvement in national audits Integrated performance reporting Patient Safety Strategy Oversight Committee	Negative outlier on follow-ups for outpatients.	**Introducing a robust and proactive safety culture:** Implement plan to enable launch of PSIRF in Q2 2022/23 Embed learning from deaths lead & lead medical examiner roles (primary and secondary care) and develop objectives and strategy Introduce thematic reviews for pressure ulcers and falls. Implement the second round of Ockenden recommendations. **Empowering and developing staff to improve services for patients** Completion of SDM project, data analysis and formulate plan for ongoing roll-out, predominantly focussed on specialist services. To embed as business as usual from April 2023. Baseline assessments and two quarters' submissions have completed and this will form part of the CQINN this year **Always Improving strategy** Delivery of year 1 outpatients and theatres agreed quality, operational and financial benefits Increase specialties contributing to	3 x 2 6 Mar-24

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

1a) Lack of capacity to appropriately respond to emergency demand, manage the increasing waiting lists for elective demand, and provide timely diagnostics, that results in avoidable harm to patients.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Programme					CAMEO There is currently no clinical lead for this project. We expect to recruit within three months, and will develop a new strategy linking outcomes, transformation, and safety. Actively managing waiting list through points of contact, escalating patients where changes are identified. Ongoing harm reviews for p2s and recurring contact for p3 and p4 patients.	

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

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

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

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
New 5 year People Strategy and clear objectives for Year 1 monitored through POD. Recruitment and resourcing processes Workforce plan and overseas recruitment plan General HR policies and practices, supported by appropriately resourced HR team Temporary resourcing team to control agency and bank usage Overseas recruitment Recruitment campaign Apprenticeships New recruitment branding and successful targeted campaigns in critical are, ED, Ophthalmology and theatres. Bank and agency cost project – Joint finance and HR controls	Multi-year workforce and education plan to be developed in cooperation with the wider ICS Implementation of talent management and development programme Appropriate resourcing of people directorate commensurate with ongoing recruitment and retention activity Workforce plan is a risk due to current recruitment market challenges, rising pay in private sector, and buoyancy of job market. Inflation of 11% against national pay awarded of 3% is resulting in cost of living outstripping pay Differential pay grading across the ICS leading to retention difficulties	4 x 5 20	Fill rates, vacancies, sickness, turnover and rota compliance NHSI levels of attainment criteria for workforce deployment Annual post-graduate doctors GMC report WRES and WDES annual reports - annual audits on BAME successes Gender pay gap reporting NHS Staff Survey results and pulse surveys	Robust board reporting on wellbeing, belonging and morale	Approval of Year 1 objectives supporting delivery of the Trust's People Strategy Deliver workforce plan for 22/23 including increasing substantive staff and reducing temporary agency spend. Targeted campaigns in key areas. Refresh talent management and succession planning processes Deliver an increase in apprenticeships starters by 20% To deliver improved workforce deployment through continued expansion of the use of e-rostering, including for medical staff To meet the national requirements of the NHS England and NHS Improvement levels of attainment rostering maturity assessment Review of KPIs via IPR in light of new strategy to address identified gaps in assurance Agree long-term workforce education plan, including building relationships across the ICS and with education providers. Introduce measures to support staff during cost of living increases.	4 x 3 12 Mar-25

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

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

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

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

3c) We fail to create a sustainable and innovative education and development programme to create future leaders, and develop skills and competencies needed for healthcare of the future, aligning with our strategic ambitions.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Education Policy Leadership and development opportunities, apprenticeships, secondments In-house, accredited training programmes Provision of high quality clinical supervision and education Access to apprenticeship levy for funding Access to CPD funding from HEE and other sources Leadership development talent plan 2023-2024 Executive succession planning	Quality of appraisals Limitations of the current estate and access to offsite provision Access to high-quality education technology Estate provision for simulation training Staff providing education being released to deliver education, and undertake own development Releasing staff to attend core training, due to capacity and demand Releasing staff to engage in personal development and training opportunities Limited succession planning framework, consistently applied across the Trust	4 x 3 12	Annual Trust training needs analysis reported to executive Trust appraisal process GMC Survey Education review process with Health Education Wessex Utilisation of apprenticeship levy Talent development steering group People Board reporting on leadership and talent, quarterly	Need to develop quantitive and qualitative measures for the success of the leadership development programme	To have recovered development and education of our people post pandemic (this includes improving appraisals carried out to 92% and appraisal quality as measured through the staff survey) Wellbeing programme Further develop education offer and formal launch of improvement education strategy/ five year education plan Approval of Year 1 objectives supporting delivery of the Trust's People Strategy Relaunch/refresh of the VLE need to be put down as a key action in terms of supporting people to access more self directed learning opportunities? Implement the leadership development and talent plan throughout 2023 and 2024 Strategic leadership programme and positive action programmes Succession planning for executive 1st and 2nd line reports, and hard-to-recruit to senior posts	3 x 2 6 Mar-25

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

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

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

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

Foundations for the future					Monitoring Committee: Finance and Investment Committee Executive Lead: COO	
5b) We do not adequately maintain, improve and develop our estate to deliver our clinical services and increase capacity.						
Key Controls	**Gaps in Controls**	**Current Risk Score (I x L)**	**Key Assurances**	**Gaps in Assurance**	**Key Actions**	**Target Risk Score* (I x L)**
Multi-year estates planning, informed by clinical priorities and risk analysis Up-to-date computer aided facility management (CAFM) system Asset register Maintenance schedules Trained, accredited experts and technicians Replacement programme Construction Standards (e.g. BREEM/Dementia Friendly Wards etc.) Six Facet survey of estate informing funding and development priorities Estates masterplan 22-32 approved.	Missing funding solution to address identified gaps in the critical infrastructure Timescales to address risks, after funding approval Operational constraints and difficulty accessing parts of the site affecting pace of investment including refurbishment	4 x 4 16	Compliance with Health Technical Memoranda monitored by estates and reported for executive oversight Patient-Led Assessments of the Care Environment Statutory compliance audit and risk tool for estates assets Monitoring at Finance and Investment Committee, including progress of capital investment and review of critical infrastructure risk and updates to Six Facet survey Quarterly updates on capital plan and prioritisation to the Board of Directors	Funding streams to be identified to fully deliver capacity and infrastructure improvements	Continue work on the estates strategy following the finalisation and agreement of the estates masterplan, including engagement with all clinical and non-clinical divisions Identify future funding options for additional capacity in line with the site development plan Delivery of 2022/23 capital plan Implement the HOIW elective hub. Deliver £9m of critical infrastructure backlog maintenance Agree plan for remainder of Adanac Park site Site development plan for Princess Anne hospital.	3 x 4 12 Apr-25

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

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

5c) We fail to introduce and implement new technology and expand the use of existing technology to transform our delivery of care through the funding and delivery of the digital strategy.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
					Department patient flow and vital signs systems via Alcidion.	

Foundations for the future	Monitoring Committee: Trust Executive Committee
	Executive Lead: CMO

5d) We fail to prioritise green initiatives to deliver a trajectory that will reduce our direct and indirect carbon footprint by 80% by 2028-2032 (compared with a 1990 baseline) and reach net zero direct carbon emissions by 2040 and net zero indirect carbon emissions by 2045.

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

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Register of Seals and Chair's Actions**			
Agenda item:	**7.2**			
Sponsor:	**Jenni Douglas-Todd, Trust Chair**			
Date:	**31 January 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 **Agreement**, executed as a Deed, between University Hospital Southampton NHS Foundation Trust (the Employer) and P T Contractors Limited (the Contractor) relating to the building contract for the Centre West HV/LV Substation Replacement. Seal number 241 on 10 January 2023.

2 Recommendation

The Board is asked to ratify the application of the seal.

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Audit and Risk Committee Terms of Reference**			
Agenda item:	**7.3**			
Sponsor:	**Keith Evans, Chair of Audit and Risk Committee**			
Author:	**Craig Machell, Associate Director of Corporate Affairs and Company Secretary**			
Date:	**31 January 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 NHS Foundation Trust Code of Governance requires that Council of Governors is consulted on the terms of reference. The terms of reference are then approved by the Board of Directors.			
Response to the issue:	It is proposed to amend paragraph 3.2 to permit the deputy chair of the Board to act as Chair of the Audit and Risk Committee, noting that, should the deputy chair have to act as Chair of the Board for an extended period of time, they will resign as Chair of the Audit and Risk Committee in order to ensure that the Committee Chair remains independent. The Council of Governors has been consulted on this change.			
Implications: (Clinical, Organisational, Governance, Legal?)	The terms of reference ensure that the purpose and activities of the Audit and Risk Committee are clear and support transparency and accountability in the performance of its role and comply with The NHS Foundation Trust Code of Governance. The Code of Governance for NHS Provider Trusts, applicable from April 2023, includes provisions (B.2.5 and D.2.1), which state that the deputy chair should not be chair of the audit committee. However, the key concern is that the audit committee chair should be independent, and where the deputy chair is expected to act as chair of the board, there is potential for the director's independence to become compromised over time. Hence, it is proposed to include the proviso in the Audit and Risk Committee terms of reference, that should the deputy chair have to act as Chair of the Board for an extended period of time, they will resign as Committee Chair in order to preserve the independence of the Committee Chair. Given the current Committee Chair's experience and qualifications, it was considered appropriate that he should remain as Committee Chair, the non-compliance with the new Code of Governance notwithstanding. It was considered that the non-compliance can be justified under the 'comply or explain' principle and that the underlying concern in respect of independence will be mitigated through the proviso referred to above.			

	An additional consideration is that, as part of succession-planning and Board composition discussions, the Board should consider the need for an additional suitably (financially) qualified individual to be a member of the Committee, who can replace the Committee Chair should he have to resign due to his Deputy Chair commitments.
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.

Audit and Risk Committee Terms of Reference

Version: 54

Date Issued:	~~27 January 2022~~TBC
Review Date:	January ~~2023~~2024
Document Type:	Committee Terms of Reference

Contents

Document Status

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1. Role and Purpose

1.1 The Audit and Risk Committee (the **Committee**) is responsible for overseeing, monitoring and reviewing corporate reporting, the adequacy and effectiveness of the governance, risk management and internal control framework and systems and areas of legal and regulatory compliance at University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**) and the external and internal audit functions.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities both generally and in support of the annual governance statement.

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

2. Constitution

2.1 The Committee has been established by the Board. The Committee has no executive powers other than those set out in these terms of reference. It is supported in its work by other committees established by the Board 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 will primarily utilise the work of internal audit, external audit and other assurance functions. It is also 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 independent non-executive directors of the Trust (other than the chair of the Board). The Committee will consist of not less than three members, at least one of whom will have recent and relevant financial experience, ideally with a qualification from one of the professional accountancy bodies.

3.2 The Board will appoint the chair of the Committee from among its members (the **Committee Chair**). ~~The Committee Chair will not be the senior independent director or deputy chair of the Board~~The Committee Chair may be the deputy chair of the Board. However, in the event that the deputy chair must act as chair of the Board for an extended period of time, the deputy chair will resign as Committee Chair. In the absence of the Committee Chair and/or an appointed deputy, the remaining members present will elect one of themselves to chair the meeting.

3.3 Only members of the Committee have the right to attend and vote at Committee meetings. However, the following will be invited to attend meetings of the Committee on a regular basis:

3.3.1 representative(s) from the external auditor;

3.3.2 representative(s) from the internal auditor;

3.3.3 representative(s) from the local counter fraud service;

3.3.4 Chief Financial Officer;

3.3.5 Chief Nursing Officer; and

3.3.6 Associate Director of Corporate Affairs/Company Secretary.

3.4 The Chief Executive Officer will be invited to attend meetings of the Committee, at least annually, to discuss with the Committee the process for assurance that supports the annual governance statement.

3.5 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas of risk or operation that are the responsibility of a particular executive director or manager.

3.6 Governors may be invited to attend meetings of the Committee.

4. Attendance and Quorum

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

4.2 The quorum for a meeting will be two members. A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4.3 When an executive director or manager is unable to attend a meeting they should appoint a deputy to attend on their behalf.

5. Frequency of Meetings

5.1 The Committee will meet at least four times each year and otherwise as required.

5.2 At least once each financial year the Committee will meet with representatives of the external and internal auditors without management being present to discuss their remit and any issues arising from their audits.

5.3 Outside of the formal meeting programme, the Committee Chair will maintain a dialogue with key individuals involved in the Trust's governance, including the chair of the Board, the Chief Executive Officer, the Chief Financial Officer, the Chief Nursing Officer, the external audit lead partner and the head of internal audit.

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, or at the request of external or internal auditors if they consider it necessary.

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

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

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

the Committee, minutes will be circulated to all other members of the Board unless it would be inappropriate to do so in the opinion of the Committee Chair.

7. Duties and Responsibilities

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

7.1 ***Integrated Governance, Risk Management and Internal Control***

7.1.1 The Committee will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (clinical and non-clinical), that supports the achievement of the Trust's objectives. In particular, the Committee will review the adequacy and effectiveness of:

7.1.1.1 all risk and control related disclosure statements (in particular the annual governance statement), together with the head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board;

7.1.1.2 the underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of annual disclosure statements; and

7.1.1.3 the policies and arrangements for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reviews, reporting and self-certifications, including the NHS Constitution, the Trust's NHS provider licence, registration with the Care Quality Commission and the Trust's constitution, standing orders and standing financial instructions and management of conflicts of interest.

7.2 ***Internal Audit***

7.2.1 The Committee will ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Accounting Officer and Board. This will be achieved by:

7.2.1.1 considering the provision of the internal audit service and the costs involved;

7.2.1.2 reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in any risk assessment;

7.2.1.3 considering the major findings of internal audit work (and the appropriateness and implementation of management responses) and ensuring coordination between the internal and external auditors to optimise audit resources;

7.2.1.4 ensuring the internal audit function is adequately resourced and has appropriate standing within the Trust; and

7.2.1.5 monitoring the effectiveness of internal audit and carrying out an annual review.

7.3 ***External Audit***

7.3.1 The Committee will review and monitor the external auditors' integrity, independence and objectivity and the effectiveness of the external audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's response to their work. This will be achieved by:

7.3.1.1 considering the appointment and performance of the external auditors, including providing information and recommendations to the council of governors in connection with the appointment, reappointment and removal of the external auditors in line with criteria agreed by the council of governors and the Committee;

7.3.1.2 discussing and agreeing with the external auditors, before the external audit commences, the nature and scope of the audit as set out in the annual external audit plan;

7.3.1.3 discussing with the external auditors their evaluation of audit risks and assessment of the Trust and the impact on the audit fee;

7.3.1.4 reviewing all external audit reports, including reports addressed to the Board and the council of governors, and any work undertaken outside the annual external audit plan, together with any significant findings and the appropriateness and implementation of management responses; and

7.3.1.5 ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services taking into account relevant ethical guidance.

7.4 ***Financial Reporting***

7.4.1 The Committee will monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

7.4.2 The Committee will ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board.

7.4.3 The Committee will review the annual report and financial statements before these are presented to the Board in order to determine their completeness, objectivity, integrity and accuracy and the letter of representation addressed to the external auditors from the Board. This review will cover but is not limited to:

7.4.3.1 the annual governance statement and other disclosures relevant to the work of the Committee;

7.4.3.2 areas where judgment has been exercised;

7.4.3.3 appropriateness and adherence to accounting policies and practices;

7.4.3.4 explanation of estimates or provisions having material effect and significant variances;

7.4.3.5 the schedule of losses and special payments, which will also be reported on separately during the financial year;

7.4.3.6 any significant adjustments resulting from the audit and unadjusted audit differences; and

7.4.3.7 any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

7.5 ***Counter Fraud***

7.5.1 The Committee will review the effectiveness of arrangements in place for counter fraud, anti-bribery and corruption to ensure that these meet the NHS Counter Fraud Authority's standards and the outcomes of work in these areas, including reports and updates on the investigation of cases from the local counter fraud service.

7.6 ***Raising Concerns/Freedom to Speak Up***

7.6.1 The Committee will review the effectiveness of the arrangements in place for allowing staff and contractors to raise (in confidence) concerns and possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently with appropriate follow-up action and safeguards in place for those who raise concerns.

7.6.2 The Committee will ensure that the Trust's policy reflects the minimum standards for raising concerns set out by NHS Improvement and that the arrangements in place are regularly audited.

8. Accountability and Reporting

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

8.2 The Committee will report to the Board at least annually on its work in support of the annual governance statement, specifically commenting on:

8.2.1 the fitness for purpose of the board assurance framework;

8.2.2 the completeness and maturity of risk management in the Trust;

8.2.3 the integration of governance arrangements;

8.2.4 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 The Trust's annual report will include a section describing the work of the Committee in discharging its responsibilities including:

8.3.1 the significant issues that the Committee considered in relation to financial statements, operations and compliance, and how these issues were addressed;

8.3.2 an explanation of how the Committee has assessed the effectiveness of the external audit process and the approach taken to the appointment or reappointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and

8.3.3 if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.

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 in consultation with the council of governors.

10. References

10.1 National Health Service Act 2006

10.2 NHS Foundation Trust Code of Governance

10.3 NHS Foundation Trust Annual Reporting Manual

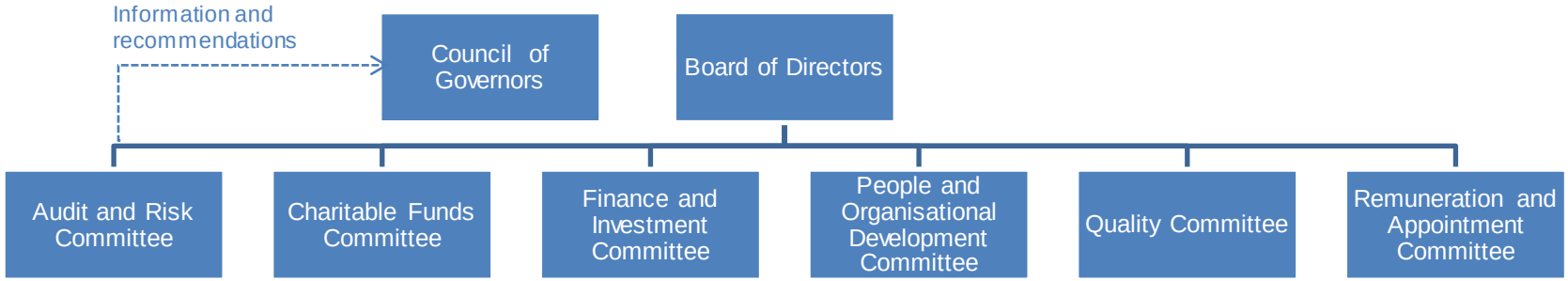
10.4 National Audit Office Code of Audit Practice

10.5 Public Sector Internal Audit Standards

10.6 NHS Counter Fraud Authority's counter fraud standards

10.7 NHS Improvement guidance on Freedom to Speak Up

Appendix A


Information and recommendations
Council of Governors
Board of Directors
Audit and Risk Committee
Charitable Funds Committee
Finance and Investment Committee
People and Organisational Development Committee
Quality Committee
Remuneration and Appointment Committee

Document Monitoring Information	
Approval Committee:	Board of Directors
Date of Approval:	~~27 January 2022~~TBC
Responsible Committee:	Audit and Risk Committee
Monitoring (Section 9) for Completion and Presentation to Approval Committee:	January 202~~43~~
Target audience:	Board of Directors, Audit and Risk Committee, NHS Regulators, Staff and Public
Key words:	Audit, Risk, Committee, Board, Terms of Reference
Main areas affected:	Trust-wide
Summary of most recent changes if applicable:	~~Minor changes of a typographical nature.~~Amendment to para 3.2.
Consultation:	Council of Governors, Internal Audit, External Audit, Counter Fraud
Number of pages:	8
Type of document:	Committee Terms of Reference
Does this document replace or revise an existing document?	Yes
Should this document be made available on the public website?	Yes
Is this document to be published in any other format?	No

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Finance and Investment Committee Terms of Reference**			
Agenda item:	**7.4**			
Sponsor:	**Jane Bailey, Chair of Finance & Investment Committee**			
Author:	**Craig Machell, Associate Director of Corporate Affairs and Company Secretary**			
Date:	**31 January 2023**			
Purpose	**Assurance or reassurance**	**Approval** X	**Ratification**	**Information**
Issue to be addressed:	The terms of reference for all Board committees should be reviewed regularly, and at least once annually, to ensure that these reflect the purpose and activities of each committee. The terms of reference are approved by the Board of Directors.			
Response to the issue:	No changes are proposed to the current terms of reference. However, it should be noted that the introduction of the new Code of Governance for NHS Provider Trusts in April 2023 may necessitate a further review of the terms of reference.			
Implications: (Clinical, Organisational, Governance, Legal?)	The terms of reference ensure that the purpose and activities of the Finance & Investment 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.			

Finance and Investment Committee Terms of Reference

Version: 7

Date Issued:	1 April 2022
Review Date:	November 2022
Document Type:	Committee Terms of Reference

Contents

Document Status

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1. Role and Purpose

1.1 The Finance and Investment Committee (the **Committee**) is responsible for overseeing, monitoring and reviewing the stewardship of the Trust's finances, investments and sustainability of University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**), including planning, financial performance, capital expenditure and the delivery of the informatics and estates, facilities and capital development annual plans.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of assurance regarding the Trust's financial position and capital and revenue investments to enable world-class people to deliver world-class care.

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

2. Constitution

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

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

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

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

3. Membership

3.1 The members of the Committee will be appointed by the Board and will be:

3.1.1 three non-executive directors of the Trust, at least two of whom should be independent, including the chair of the Audit and Risk Committee;

3.1.2 the Chief Executive Officer;

3.1.3 the Chief Financial Officer; and

3.1.4 the Chief Operating Officer.

3.2 The Board will appoint the chair of the Committee from among its non-executive director members (the **Committee Chair**). The Committee Chair will not be the chair of the Audit and Risk Committee. In the absence of the Committee Chair and/or an appointed deputy, the remaining members present will elect one of themselves to chair the meeting.

3.3 To ensure that non-executive directors hold the majority of votes on the Committee, only the Chief Financial Officer and Chief Operating Officer shall be invited to vote on any matter. The Committee Chair will have a second and casting vote in the event of a tie.

3.4 Subject to paragraph 3.3 above, only members of the Committee have the right to attend and vote at Committee meetings. However, the following will be invited to attend meetings of the Committee on a regular basis:

3.4.1 Director of Operational Finance/Deputy Director of Finance;

3.4.2 Director of Planning, Performance and Productivity; and

3.4.3 Associate Director Always Improving.

3.5 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas of risk or operation that are the responsibility of a particular executive director or manager.

3.6 Governors may be invited to attend meetings of the Committee.

4. Attendance and Quorum

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

4.2 The quorum for a meeting will be three members, including two non-executive directors (one of whom must be either the Committee Chair or the chair of the Audit and Risk Committee) and either the Chief Financial Officer or Chief Operating Officer. A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4.3 When an executive director or manager is unable to attend a meeting they should appoint a deputy to attend on their behalf.

5. Frequency of Meetings

5.1 The Committee will meet at least ten times each year (usually once each calendar month) 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 Financial 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.

7.1 ***Financial planning and performance***

7.1.1 The Committee will review and monitor the following, ensuring these support the achievement of the Trust's objectives, and consider the adequacy and effectiveness of any corrective action proposed:

7.1.1.1 the Trust's long-term financial model;

7.1.1.2 the Trust's long-term and annual financial plans encompassing income, expenditure and capital;

7.1.1.3 the capital plan including any changes in the Trust's performance that may impact on the delivery of the long-term capital plan;

7.1.1.4 financial performance and forecasts and projections including achievement of the control total and other targets;

7.1.1.5 performance against revenue budgets at both Trust and divisional level;

7.1.1.6 capacity, activity and productivity including any significant variation and the impact on income;

7.1.1.7 cash, liquidity and working capital;

7.1.1.8 the use of any working capital facilities; and

7.1.1.9 performance of the Trust's subsidiaries and any joint ventures against agreed performance indicators.

7.2 ***Always Improving Value for Money***

7.2.1 The Committee will ensure that there is an Always Improving: Value for Money (**AIVFM**) programme in place each financial year that aligns with the Trust's annual plan.

7.2.2 The Committee will seek assurance that a recovery plan is in place and being implemented where any AIVFM schemes are at risk of delivery.

7.3 ***Investment***

7.3.1 The Committee will review business cases of £2.5 million or more in value, ensuring that outcomes and benefits are clearly defined and measurable and support achievement of the Trust's objectives and making recommendations to the Board for approval.

7.3.2 The Committee will review capital business cases over £5 million in value, ensuring that outcomes and benefits are clearly defined and measurable and support achievement of the Trust's objectives and making recommendations to the Board for approval.

7.3.3 The Committee will review all business cases identified by the Trust Executive Committee as of significant strategic importance regardless of value, ensuring that outcomes and benefits are clearly defined and measurable and support achievement of the Trust's objectives and making recommendations to the Board for approval.

7.3.4 The Committee will assess benefits realisation through post-implementation reviews, ensuring any learning is shared.

7.4 ***Informatics annual plan***

7.4.1 The Committee will monitor and oversee the delivery of the Trust's annual plan for IT including funding and ongoing alignment with the Trust's objectives.

7.5 ***Estates, facilities and capital development annual plan***

7.5.1 The Committee will monitor and oversee the delivery of the Trust's estates, facilities and capital development annual plan including funding and ongoing alignment with the Trust's objectives.

7.6 ***Risk***

7.6.1 The Committee will monitor risks identified in the Trust's Board Assurance Framework that have been allocated for oversight by the Committee.

7.6.2 The Committee will establish and maintain an overview of the Trust's financial risks and risks to delivery of the Trust's informatics or estates, facilities and capital development plans and ensure the effectiveness and implementation of controls for financial risks and actions to mitigate risks to the delivery of the Trust's informatics or estates, facilities and capital development plans.

7.6.3 The Committee will refer any potential risks to patient safety or quality identified by the Committee to the Quality Committee.

7.6.4 The Committee will commission and oversee assurance deep dives into specific identified risks at the request of either the Committee Chair or the chair of the Board.

7.7 ***Reporting***

7.7.1 The Committee will review any key financial submissions to national bodies before these are presented to the Board for approval.

7.7.2 The Committee will review the National Cost Collection Index for the purposes of benchmarking the Trust's performance.

8. Accountability and Reporting

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

8.2 The 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 financial statements and the appropriateness of the self-assessment of the effectiveness of the system of internal control and the disclosure of any significant internal control issues in the annual governance statement.

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

9. Review of Terms of Reference and Performance and Effectiveness

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

10. References

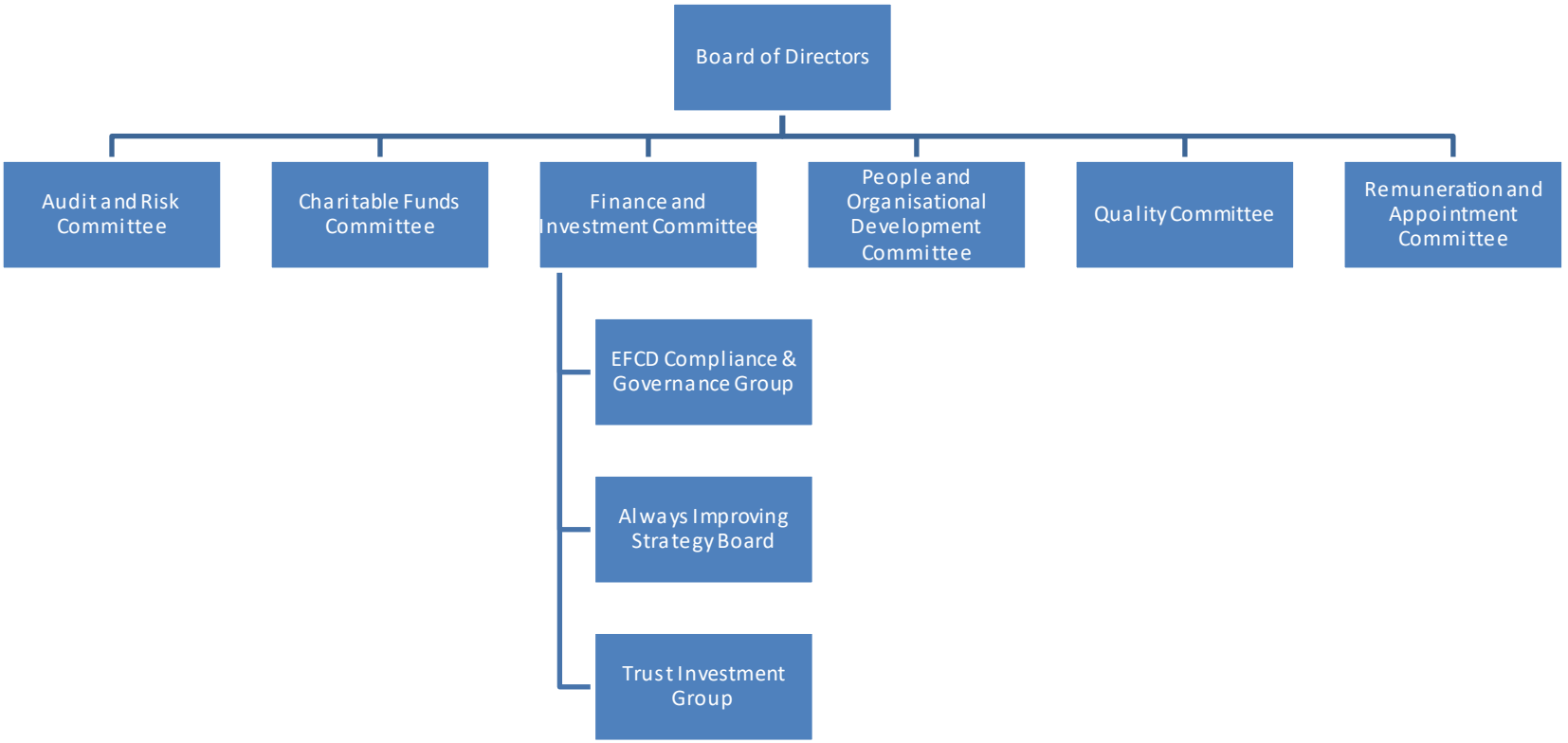
10.1 National Health Service Act 2006

10.2 NHS System Oversight Framework

10.3 NHS Improvement and Care Quality Commission Use of Resources: assessment framework

10.4 Standing Financial Instructions

Appendix A


Board of Directors
Audit and Risk Committee
Charitable Funds Committee
Finance and Investment Committee
People and Organisational Development Committee
Quality Committee
Remuneration and Appointment Committee
EFCD Compliance & Governance Group
Always Improving Strategy Board
Trust Investment Group

Document Monitoring Information	
Approval Committee:	Board of Directors
Date of Approval:	31 March 2022
Responsible Committee:	Finance and Investment Committee
Monitoring (Section 9) for Completion and Presentation to Approval Committee:	November 2022
Target audience:	Board of Directors, Finance and Investment Committee, Staff
Key words:	Finance, Investment, Committee, Board, Terms of Reference
Main areas affected:	Trust-wide
Summary of most recent changes if applicable:	Change to NED Committee membership
Consultation:	Chair and Interim Chair
Number of pages:	8
Type of document:	Committee Terms of Reference
Does this document replace or revise an existing document?	Yes
Should this document be made available on the public website?	Yes
Is this document to be published in any other format?	No

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Quality Committee Terms of Reference**			
Agenda item:	**7.5**			
Sponsor:	**Tim Peachey, Chair of Quality Committee**			
Author:	**Craig Machell, Associate Director of Corporate Affairs and Company Secretary**			
Date:	**31 January 2023**			
Purpose	**Assurance or reassurance**	**Approval** **X**	**Ratification**	**Information**
Issue to be addressed:	The terms of reference for all Board committees should be reviewed regularly, and at least once annually, to ensure that these reflect the purpose and activities of each committee. The terms of reference are approved by the Board of Directors.			
Response to the issue:	No changes are proposed to the current terms of reference. However, it should be noted that the introduction of the new Code of Governance for NHS Provider Trusts in April 2023 may necessitate a further review of the terms of reference.			
Implications: (Clinical, Organisational, Governance, Legal?)	The terms of reference ensure that the purpose and activities of the Quality Committee are clear and support transparency and accountability in the performance of its role 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

Quality Committee Terms of Reference

Version: 4

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Document Status

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1. Role and Purpose

1.1 The Quality Committee (the **Committee**) is responsible for overseeing, monitoring and reviewing the adequacy and effectiveness of all aspects of the clinical governance arrangements of University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**), including the governance, risk management and internal control framework and systems supporting the delivery of safe, high quality, patient-centred care.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of assurance regarding the adequacy and effectiveness of all aspects of clinical governance with a particular focus on quality: patient safety, patient experience and outcomes.

2. Constitution

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

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

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

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

3. Membership

3.1 The members of the Committee will be appointed by the Board and will be:

3.1.1 at least three independent non-executive directors of the Trust, at least one of whom will have a clinical background;

3.1.2 the Chief Nursing Officer;

3.1.3 the Chief Medical Officer; and

3.1.4 the Chief Operating Officer.

3.2 The Board will appoint the chair of the Committee from among its non-executive director members (the **Committee Chair**). In the absence of the Committee Chair and/or an appointed deputy, the remaining members present will elect one of the other non-executive directors to chair the meeting.

3.3 To ensure that non-executive directors hold the majority of votes on the Committee, only two of the executive director members of the Committee shall be invited to vote on any matter. The Committee Chair will have a second and casting vote in the event of a tie.

3.4 Subject to paragraph 3.3 above, only members of the Committee have the right to attend and vote at Committee meetings. However, the following will be invited to attend meetings of the Committee on a regular basis:

3.4.1 Deputy Director of Nursing (Quality);

3.4.2 Medical Lead for Safety (Patient Safety Specialist); and

3.4.3 patient representative(s).

3.5 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas of risk or operation that are the responsibility of a particular executive director or manager.

3.6 Governors may be invited to attend meetings of the Committee.

4. Attendance and Quorum

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

4.2 The quorum for a meeting will be three members, including two non-executive directors and either the Chief Nursing Officer or the Chief Medical Officer. A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4.3 When an executive director or manager is unable to attend a meeting they should appoint a deputy to attend on their behalf.

5. Frequency of Meetings

5.1 The Committee will meet at least eight times each year (at regular intervals throughout the year) and otherwise as required.

6. Conduct and Administration of Meetings

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

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

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

6.4 Draft minutes of Committee meetings and a separate record of the actions to be taken forward will be circulated promptly to all members of the Committee. Once approved by the Committee, minutes will be circulated to all other members of the Board unless it would be inappropriate to do so in the opinion of the Committee Chair.

7. Duties and Responsibilities

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

7.1 ***Patient Safety***

7.1.1 The Committee will review the aggregated analysis of adverse events (including serious incidents requiring investigation (SIRIs) and never events), complaints, claims and inquests to identify common themes and trends and gain assurance that appropriate actions are being taken to mitigate risk and reduce harm.

7.1.2 The Committee will seek assurance on the Trust's safeguarding systems.

7.1.3 The Committee will receive assurance from internal audit on quality and safety reviews.

7.2 ***Patient Experience***

7.2.1 The Committee will consider reports from the Patient Experience team, the Complaints team, the Patient Advice and Liaison Service and other sources of feedback (including local Healthwatch) on all formal and informal patient feedback, both positive and negative, and consider action in respect of matters of concern.

7.2.2 The Committee will consider the results, issues raised and trends in all patient surveys and any patient impacting surveys of the Trust's estate, such as Patient-Led Assessments of the Care Environment (PLACE) that may impact on clinical quality and to seek assurance on the development and implementation of improvement plans.

7.3 ***Patient Outcomes***

7.3.1 The Committee will review the annual clinical audit programme and recommend its approval to the Board, and monitor its delivery.

7.3.2 The Committee will receive reports on Trust-wide clinical outcomes presented to clinical assurance meeting for effectiveness and outcomes (CAMEO) meetings including patient outcomes and compliance with the other aspects of clinical effectiveness activity.

7.3.3 The Committee will receive details of all national clinical audits where the Trust is identified as an outlier or potential outlier. This will include, but is not limited to, mortality outlier alerts.

7.4 ***Quality Improvement***

7.4.1 The Committee will make recommendations to the Board on the determination of quality priorities annually and monitor progress against these priorities.

7.4.2 The Committee will promote safety and excellence in patient care and monitor the implementation and delivery of the Always Improving Strategy and quality improvement activity.

7.5 ***Performance Monitoring***

7.5.1 The Committee will advise the Board on the appropriate quality and safety indicators and benchmarks for inclusion in the Trust's key performance indicators and supporting data quality for these measures.

7.5.2 The Committee will support the ongoing monitoring of ward quality and safety dashboards, to provide assurance from ward to Board.

7.5.3 The Committee will regularly review operational performance where there is ongoing non-compliance with referral and waiting time standards set out in the NHS Constitution or the NHS System Oversight Framework.

7.5.4 The Committee will seek to identify potential evidence and areas of health inequalities between different groups of people.

7.5.5 The Committee will seek assurance that improvement targets are supported by achievable action plans and support the implementation of the Trust's Clinical Strategy.

7.5.6 The Committee will monitor progress in implementing action plans to address shortcomings in the quality of services, where identified.

7.6 ***Risk***

7.6.1 The Committee will ensure that risks to patients are minimised through the application of comprehensive clinical risk management systems.

7.6.2 The Committee will monitor risks identified in the Trust's Board Assurance Framework that have been allocated for oversight by the Committee.

7.6.3 The Committee will triangulate patient safety, quality and clinical risk issues with operational, financial and workforce performance, addressing areas of concern or deteriorating performance as required.

7.6.4 The Committee will commission and oversee assurance deep dives into specific identified risks at the request of either the Committee Chair or the chair of the Board.

7.7 ***Reporting***

7.7.1 The Committee will review the Trust's quality accounts/quality report and any other key non-financial governance submissions to national bodies before these are presented to the Board for approval.

7.7.2 The Committee will receive all reports about the Trust produced by the Care Quality Commission (the **CQC**) and seek assurance on the processes in place to ensure compliance with CQC fundamental standards and the actions being taken to address any recommendations and other issues identified by the CQC.

8. Accountability and Reporting

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

8.2 The Committee will report to the Audit and Risk Committee at least annually on its work in support of the annual governance statement, specifically commenting on the quality accounts/quality report and the appropriateness of the self-assessment of the effectiveness of the system of internal control and the disclosure of any significant internal control issues in the annual governance statement.

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

9. Review of Terms of Reference and Performance and Effectiveness

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

10. References

10.1 National Health Service Act 2006

10.2 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and related guidance from the Care Quality Commission

10.3 Care Quality Commission (Registration) Regulations 2009 and related guidance from the Care Quality Commission

10.4 Health Act 2009

10.5 National Health Service (Quality Accounts) Regulations 2010

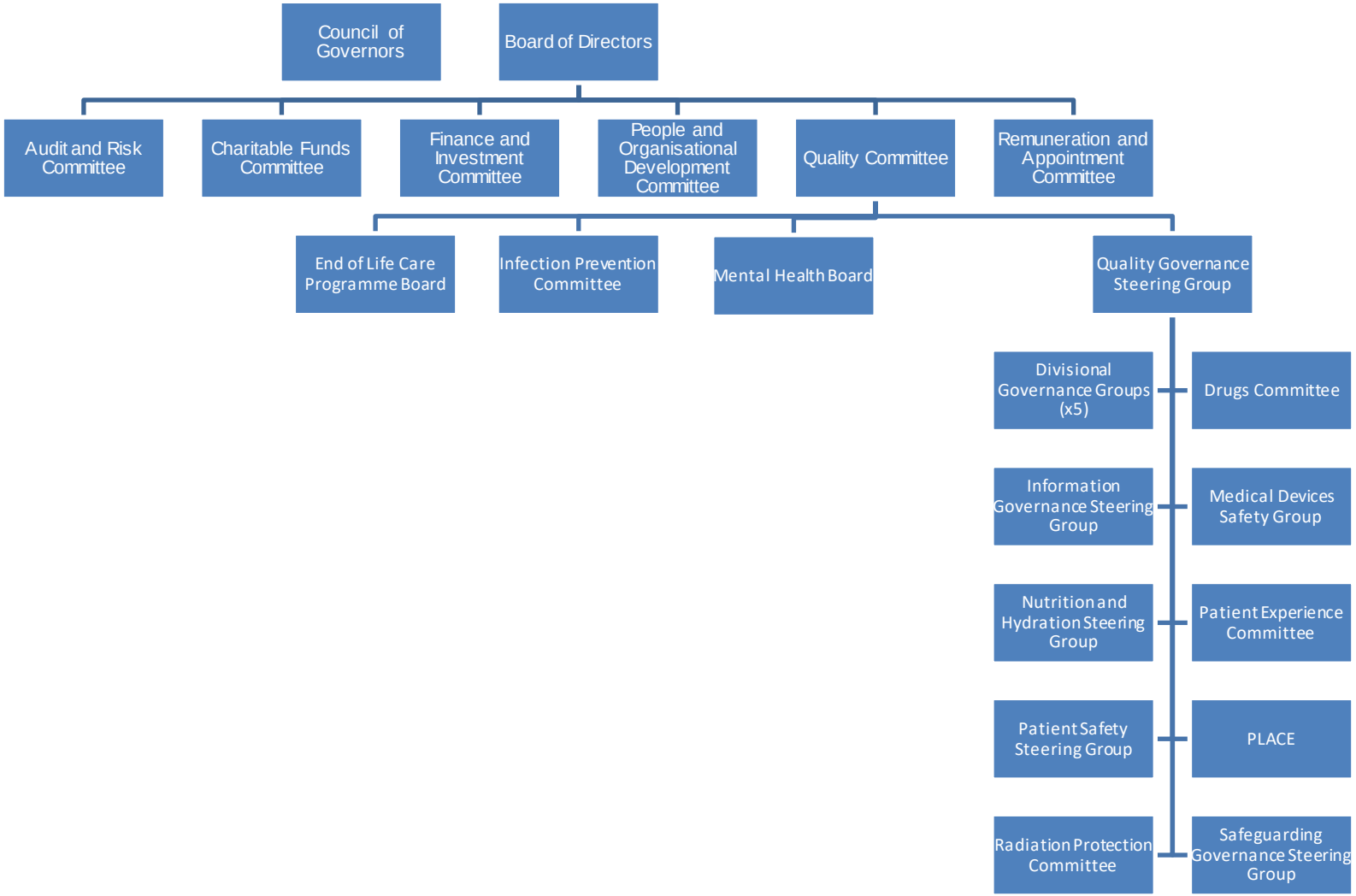
10.6 NHS Foundation Trust Code of Governance

10.7 NHS System Oversight Framework

10.8 NHS Foundation Trust Annual Reporting Manual

10.9 NHS England and NHS Improvement's requirements for quality accounts

Appendix A


Council of Governors
Board of Directors
Audit and Risk Committee
Charitable Funds Committee
Finance and Investment Committee
People and Organisational Development Committee
Quality Committee
Remuneration and Appointment Committee
End of Life Care Programme Board
Infection Prevention Committee
Mental Health Board
Quality Governance Steering Group
Divisional Governance Groups (x5)
Drugs Committee
Information Governance Steering Group
Medical Devices Safety Group
Nutrition and Hydration Steering Group
Patient Experience Committee
Patient Safety Steering Group
PLACE
Radiation Protection Committee
Safeguarding Governance Steering Group

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