University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	29/09/2022
Time	9:00 - 13:00
Location	Microsoft Teams
Chair	Jenni Douglas-Todd

1	9:00	**Chair's Welcome, Apologies and Declarations of Interest** Note apologies for absence, and to hear any declarations of interest relating to any item on the Agenda.
2		**Patient Story** The patient story provides an opportunity for the Board to reflect on the experiences of patients and staff within the Trust and understand what the Trust could do better.
3	9:15	**Minutes of Previous Meeting held on 28 July 2022** Approve the minutes of the previous meeting held on 28 July 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	9:20	**Briefing from the Chair of the Audit and Risk Committee (Oral)** Keith Evans, Chair
5.2	9:25	**Briefing from the Chair of the Finance and Investment Committee (Oral)** Jane Bailey, Chair
5.3	9:30	**Chief Executive Officer's Report** Receive and note the report Sponsor: David French, Chief Executive Officer
5.4	9:40	**Integrated Performance Report for Month 5** Review and discuss the Trust's performance as reported in the Integrated Performance Report. Sponsor: David French, Chief Executive Officer
5.5	10:20	**Finance Report for Month 5** Review and discuss the finance report Sponsor: Ian Howard, Chief Financial Officer

5.6 **People Report for Month 5**

10:30 Review and discuss the people report
Sponsor: Steve Harris, Chief People Officer

5.7 **Safeguarding Annual Report 2021-22 and Strategy 2022-25**

10:40 Receive and discuss
Sponsor: Gail Byrne, Chief Nursing Officer
Attendees: Sarah Herbert, Deputy Chief Nursing Officer/Karen McGarthy, Named Nurse for Safeguarding Children/Corinne Miller, Named Nurse for Safeguarding Adults

5.8 **Break**

10:55

5.9 **Medical Appraisal and Revalidation Annual Report including Board Statement of Compliance**

11:10 Receive and discuss
Sponsor: Paul Grundy, Chief Medical Officer

5.10 **Clinical Outcomes Summary Report**

11:25 Review and discuss
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Diana Ward, Clinical Outcomes Manager

5.11 **Health Inequality - Data Analysis Update**

11:40 Review and discuss
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Jason Teoh, Director of Data and Analytics

6 **STRATEGY and BUSINESS PLANNING**

6.1 **A Smoke-free Site - the UHS Way Forward**

11:55 Review and discuss
Sponsor: Paul Grundy, Chief Medical Officer
Attendees: Helen Ralph, Manager, Transformation Team/Annabel Shawcroft, Clinical Programme Officer, Transformation Team

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

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

12:15 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

7.2 **Feedback from the Council of Governors' (CoG) meeting on 14 September 2022(Oral)**

12:20 Sponsor: Jenni Douglas-Todd, Trust Chair

7.3 **Health and Safety Annual Report 2021-22**

12:25 Receive and discuss
Sponsor: Gail Byrne, Chief Nursing Officer
Attendee: Jane Fisher, Head of Health and Safety Services

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

12:35 Approve the proposed amendments to the Terms of Reference
Sponsor: Steve Harris, Chief People Officer

8 **Any other business**

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

9 **Note the date of the next meeting: 29 November 2022**

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

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

11 **Follow-up discussion with governors**

12:45

University Hospital Southampton
NHS Foundation Trust

Minutes Trust Board – Open Session

Date	28/07/2022
Time	9:00 – 12.20
Location	Microsoft Teams
Chair	Jenni Douglas-Todd (JD-T)
Present	Jane Bailey (JB), NED and Deputy Chair/Senior Independent Director Gail Byrne (GB), Chief Nursing Officer Cyrus Cooper (CC), NED Jenni Douglas-Todd (JD-T), Chair Keith Evans (KE), NED David French (DAF), Chief Executive Officer Paul Grundy (PG), Chief Medical Officer Steve Harris (SH), Chief People Officer Jane Harwood (JH), NED Ian Howard (IH), Chief Financial Officer Tim Peachey (TP), NED Joe Teape (JT), Chief Operating Officer
In attendance	Ellis Banfield, Associate Director of Patient Experience (EB) (items 5.7-5.8) Marie Cann, Interim Senior Midwifery Manager (MC) (item 5.9) Sarah Herbert, Deputy Chief Nursing Officer (SHe) (item 5.11) Helen Potton (HP), Associate Director of Corporate Affairs and Company Secretary (Interim) Femi Macaulay (FM), Associate NED Christine McGrath (CMcG), Director of Strategy and Partnerships Philip Newland-Jones (PN-J), Consultant Pharmacist, Diabetes (item 5.5) 1 member of the public (item 2) 6 governors (observing) 4 members of staff (observing) 0 members of the public (observing)
Apologies	Dave Bennett (DB), Non-Executive Director (NED)

1 Chair's Welcome, Apologies and Declarations of Interest

JD-T welcomed all those attending the meeting which was by Microsoft Teams.

2 Patient Story

PG introduced the patient who advised that she had worked in Health and Social Care for most of her life and also in the voluntary sector supporting those with neurological conditions. She had been coming to UHS for many years with family members and in November was admitted to A&E herself, via ambulance, with multiple infections. Her husband was unable to be with her due to the Covid-19 restrictions and she explained how difficult and isolating that had been.

She talked about the total lack of communication in A&E and then AMU2, where she was left in a side room without access to a buzzer. She urinated on the floor and described how distressing that had been. She was eventually moved to G5 where she found the staff to be kind and compassionate. In

particular she mentioned the Charge Nurse, consultants Sarah Gilson and Mayank Patel and a young man who wanted to do his nurse training. At the end of the week, however, the ward was to be used for Covid patients so she was moved to F2. On arrival a member of staff shouted at the porters that she was not wanted on the ward and would have to go back to where she had come from and return in an hour. The patient refused to return to F2 and was instead taken to F7 where she was welcomed by staff.

On the Sunday there was no heating on the ward and she lost her wedding ring behind a wash basin in a toilet cubicle as her finger had shrunk in the cold. She was extremely distressed but a nurse, using tweezers, retrieved the ring and the patient was keen for that nurse to receive an award.

Board members thanked the patient for sharing her moving story and noted the inconsistencies in her care. GB was aware the patient had shared her experiences with the Clinical Leaders' Group and she acknowledged that many of the issues related to basic nursing care. She offered to meet with the patient and also to write to the staff who had provided excellent care.

- **ACTION: GB**

DAF said that it was a reminder to him that whilst many people came to A&E every day, for each patient it was a moment in a lifetime.

3 Minutes of Previous Meeting held on 26 May 2022

The minutes of the meeting held on 26 May 2022 were approved as an accurate record of that meeting.

4 Matters Arising and Summary of Agreed Actions

Actions 705 and 707 from the previous meeting had been completed and could be closed.

Action 706 - JT advised that it would be some time before the endoscopy suite at Lymington was fully up and running, due to staffing challenges. He had sent an update to Board members (via email) and the action could be closed.

5 QUALITY, PERFORMANCE and FINANCE

5.1 Briefing from the Chair of the Charitable Funds Committee (Oral)

JH provided a briefing on behalf of DB. There had been a meeting of the Charitable Funds Committee on the 25 July 2022.

Earnings to date were £150k down on budget due to the general economic environment and also shortfalls in the fundriaising team due to recruitment and retention problems because of salaries outside of UHS. There had, however, been an improvement in the legacy position. Charity expenditure remained relatively low and more work was being done on that. There was an issue with cash in over 400 different funds and there had been agreement in the meeting to rationalise the funds, unless they were restricted.

The general fund was much healthier and it was hoped that with the rationalisation programme there would be a bigger pot of money to spend on larger projects to support staff, make improvements around the estate and improve working lives.

The Banksy programme was progressing well, particularly in terms of the Well-being Hub and roof garden and should be completed in the current financial year.

Advice from Beechcroft, regarding the management of external fundraisers, was being considered as the Trust was not fully compliant with Charity Commissioner's rules.

SH advised that a full update on the Banksy project would be provided to the Board in August.

- **ACTION: SH**

5.2 Briefing from the Chair of the Finance and Investment Committee (Oral)

JB updated the Board on the meeting of the Finance and Investment Committee held earlier in the week. The following had been discussed:-

- a Spotlight/deep dive on the Cost Improvement Programme. The committee had felt assured that progress was being made.
- where the Trust might end the year financially. Due to the significant internal and external challenges there was a wide potential position which the committee was keen to narrow, going forward.
- three papers 1) Always Improving Quarterly Update 2) Digital Quarterly Report and 3) Always Improving linked to IT Priorities/Strategy. It had been felt that there was now much greater clarity on where digital resources were going and where money was being spent. The committee had identified that there was not yet full integration of the Always Improving/ IT Priorities and Strategy but there was much greater transparency and a clear plan.
- the UHS Pharmacy Limited Quarterly Assurance Report. The committee was happy with progress being made.
- Backlog Maintenance Update. The committee felt that high risk areas were being addresssed and that significant progress had been made.
- a business case on Theatres 10 and 11 (to be discussed at Closed Board 28.7.22).
- a concept paper on how ideas generated in the hospital could be commercialised.
- an update on capital and where money was moving around.
- the Board Assurance Framework and how risks had been ranked (to be discussed at Closed Board 28.7.22).
- whether the committee was getting into too much detail. It was agreed that papers should not deliver too much detail and that the Chair would not allow members to dip into operational areas.

5.3 Briefing from the Chair of the Quality Committee (Oral)

TP summarised the areas considered by the Quality Committee at their meeting on the 18th July. These had included a review of:-

Quality indicators

- there had been an increase in both Catergory 2 and 3 pressure ulcers which had been sustained. Investigation had shown that there was reduced documentation compliance which was thought to be due to significant staff turnover over the last 2 years and reduced training levels during the pandemic.
- the six monthly rolling Never Event total had reached zero.
- the VTE risk assessment was now consistently complaint.

- for two consecutive months there had been a marginal improvement in the length of time a patient spent in ED on an admitted pathway but it was still over 5 hours.

Patient Safety Q4 report

- 2021/22 had seen the highest ever number of coroner inquests and was now double that of 2018/19. It appeared to reflect the policy of the Hampshire Coroner.
- the Trust's incident reporting culture remained strong and the top two themes were medication incidents and slips, trips and falls.
- a significant improvement had been achieved in the closure of NPSA alerts (particularly in Division B) but this had slipped back in recent months and the committee had asked for more detailed explanations.

Ophthalmology update

- the data on harm incidents in Ophthalmology had been reviewed. In 2017 there had been 4 harm incidents, in 2018 11, in 2019 11, in 2020 8, in 2021 4 and in 2022 (to date) 2. The highest severity incidents had been at zero since the beginning of 2021 so significant progress had been made. Whilst there was still a backlog of patients to be treated there was a much more robust system of risk statification and patients were now treated in risk priority.
- although the new department was functioning well it remained difficult to recruit to some staff groups (particularly optometrists) due to high salaries in the high street.

The Complaints Annual Report and the Maternity Safety Q1 Report had been discussed by the committee and would be covered later on the agenda (items 5.7 and 5.9).

A presentation had been given by PG and colleagues on implementing shared decision making. UHS had engaged well with the national team and in addition to complying with the CQUIN, the Trust had also made significant progress in introducing this and was leading nationally. 12 specialties were currently involved and increased use of the My Medical Record platform gave patients more support to make choices.

5.4 Chief Executive Officer's Report

DAF advised that the Trust, like the rest of the country, had been challenged by various external factors. In particular General Practice and Social Care were struggling with capacity which had resulted in pressure on the front and back doors of the hospital and UHS had around 200 patients ready for discharge.

Capacity pressures had not been helped by the Covid situation. As at 27 July 2022 there were 79 patients with Covid at UHS and 44 suspected to have Covid and the Trust was cohorting those patients to prevent transmission.

The heat wave had not helped as little of the hospital was air conditioned and the temperatures on G Level East and West Wings, in particular, had been unbearable. Thousands of ice lollies had been distributed and DAF was keen to acknowledge all that the staff had done during those days.

During that week it had been difficult to maintain the elective programme due to the above pressures and it had been necessary to pause significant sections of

it. The Trust's activity had, however, been at 111% in May and 109% in June, against a national average of 94%. He noted that the July figure would be lower due to the operational pressures mentioned.

He was keen to pay tribute to the whole organisation, which had come together well and had moved out of crisis incident management mode very quickly. In particular he paid tribute to JT and his team. The Communications Team had also done a good job at sending messages out on social media to say that the Emergency Department was under significant pressure and asking people to only attend in a genuine emergency.

He also noted that:-

- all Trusts had received a letter from NHSE regarding the increased pressure on ambulance services and the need to reduce handover delays by adding additional beds elsewhere in hospitals. UHS, however, had some of the best handover times in the region.
- following the above, a letter had been received from the Royal College of Nursing, raising concerns that patient care may be compromised if it was not given in appropraite locations.
- he was keen to invite senior national people to UHS and Matthew Taylor, CEO, NHS Confederation had visited the Trust. DAF had been proud of the executive team and the clinical areas toured (new GICU and the Children's Hospital).
- there had been a national pay award of a flat £1400 (which favoured lower paid staff) and the reaction of the unions had not be favourable and may lead to industrial action and the withdrawal of labour.
- the NHS had been given funding at the start of the year to fund a lower pay award. It would therefore need to fund the extra needed from existing resources and the centre would be cutting back on IT and the roll out of Community Diagnostic Centres.
- the Board had discussed the Modernising our Hospital and Health Services Programme last month. As agreed, a letter had been sent from UHS expressing the Trust's desire to support the programme but also highlighting concern about patient flow implications for the Trust. DAF advised that the letter had been well received.

Decision: The Board noted the report.

5.5 Integrated Performance Report for Month 3

JT highlighted the following:-

- the waiting list had reached 50,000 for the first time ever and was growing each month despite doing more activity than planned, with 107% on electives and 113% across outpatients.
- July had been particularly challenging but UHS was still performing relatively well against comparator teaching hospitals. The NHS target for long waiters (2 years) was zero by the end of July. The Trust had 5 by the end of June and these were all due to patient choice.
- the report included a Spotlight on Referral to Treatment (RTT) waiting lists and there was also a plan to cover one of the main constitutional standards each month, on a rolling basis (e.g. ED, diagnostics, RTT and cancer).
- the RTT Spotlight also included the start of some work on health inequalities within the waiting list. Some of CC's colleagues had helped with a further review which was being written up and EB and his team were

doing work to understand issues within the backlog waiting list. PG was the executive lead.

The following comments were made by Board members:-

- the work on inequalities was excellent and it was good to be moving it forward.
- whether the Trust was certain that it was appropriately looking at clinical need in light of the requirement to reduce waiting lists? PG said that he thought the Trust had the balance right but was concerned that it would become more challenging.
- DAF said that UHS may be disproportionately impacted by the above, given its role as a tertiary referral centre. He advised that the centre had, however, been very clear that 78 and 52 weeks were important targets for UHS. The Trust may, therefore, have to defend what it was doing to the centre if those targets were not achieved.
- JD-T queried what the impact was of health inequalities on the Trust's actions and decisions, particularly in relation to the 20 most deprived areas in Southampton. PG said that the Trust had satisfied itself that it was treating patients on the waiting list with equality. However, some patients would have waited longer to obtain their initial diagnosis and there was evidence that they would ultimately have a worse outcome.
- Coventry had shared work they had done on their waiting lists, which UHS was exploring. The tool re-ordered waiting lists to take into account factors including deprivation, co-morbidities and age and then reprioritised patients on the basis of clinical need.
- JT said he was reasonably confident that no UHS patient had been compromised but the Trust should work on elective care, across the ICS, to ensure there was rebalance across the system.
- UHS had a Health Inequalities Lead starting on the 15 August 2022.
- JT advised that there was a Clinical Prioritisation Group, chaired by PG, that looked at the allocation of theatres, prioritised waiting lists and allocated resources. He was, therefore confident there was strong clinical leadership to ensure the Trust did its best for patients.
- KE suggested having a Trust Board Study Session to look at the projections going forward around 78 and 52 weeks. JT advised that the cancer waiting list had increased by around 1,000 patients so there was also a need to look ahead at the demand on surgery for cancer patients.
    - **ACTION: JT**
- JH queried whether the Coventry data included strategies to help bring other partners in and prevent people coming into hospital in the first place. PG advised that there was an external prevention and inequailtieis board which he attended on behalf of UHS that focussed on those issues.

JT introduced PN-J, Consultant Pharmacist, Diabetes and DAF thanked him for the data in the Spotlight report. He said that it was good to see how well UHS benchmarked against the rest of the country but asked how it could become even better.

PN-J suggested that in a Trust the size of UHS, with the number of diabetic patients it had, it was about upskilling everyone and having staff with an interest in diabetes in every department. He advised that there were link nurses on wards and there was a plan to have a link person in every department. Statutory and Mandatory training was also being discussed.

KE queried whether more recent figures were available and PN-J advised that there were not. He said that the team would like to repeat the Trust's own version of the National Diabetes Inpatient Audit on all its inpatients, on one day, but NHS Digital had stopped the funding since 2019. The Trust was, however, looking to undertake some benchmarking with Portsmouth in the next six months.

Decision: The Board was assured by the report.

5.6 Finance Report for Month 3

IH advised that the Trust had reported a £6.2m deficit for Q1 which was £2.1m adverse to plan. There was a breakeven plan for the year, improving in every quarter, to be a surplus in Q3 and Q4. The underlying performance was consistent at around £3m deficit p.m. He highlighted the following:-

- Cost Improvement Programme (CIP) delivery in Q1 was just below £1.9m, much of which had been driven by operational pressures and availability of key staff to deliver on the CIP. There had, however, been significantly improved identification in Month 3 and a Trust Savings Group had started. Identification was up to £30m, which was 67% of the Trust's target.
- there had been much higher levels of Covid than anticipated in recent months and staff backfill had cost £2.4m more than anticipated in Q1.
- there were underlying pressures from previous years related to block drugs and energy prices were continuing to rise which was a significant pressure on the Trust's underlying position.

There had been strong elective recovery performance in June but July would be more challenging. UHS was one of the best performing Trusts in the SE and nationally and almost £4m of additional income in Q1 had been included from performance activity.

Capital spend year to date was slow but was expected to improve in the coming months with several large programmes commencing, e.g. ward development.

With regard to relative performance, the Trust was struggling with its underlying position. Across the ICS the Trust was reporting a £34m deficit year to date against a £17m plan. It was difficult to see where UHS was against the SE region and the national position. The national CIP target was 5%, with the CIP target for UHS at 4%.

The financial deficit would, in particular, impact on the Trust's cash and ability to invest in future years and whilst the cash balance was currently relatively healthy it was gradually being eroded.

Decision: The Board noted this report.

5.7 Complaints Annual Report 2021-22

EB advised that this report was a statutory requirement under NHS complaint regulations. He advised that complaints were returning to pre-pandemic levels both at the Trust and nationally. There was a significant increase in activity going through PALS and a slightly lower percentage of complaints were being upheld than seen previously.

Complaint themes and categories were those that had to be reported to NHSE and UHS aligned almost exactly to the national picture with the same top four, although values and behaviours and patient care were swapped around.

FMcA asked whether issues similar to those shared in the Patient Story would be included in the complaint numbers. EB advised that the numbers related to matters that had gone direct to the PALS service or to formal complaints that had been made. Issues mentioned to a member of staff (that were not raised through the formal process) would not be captured in the numbers and would, ideally, be dealt with through local resolution. GB advised that issues resolved locally were, however, often reflected in complaint themes.

JD-T noted that the NHS complaints process was complex and suggested that it could be a topic for a Trust Board Study Session, when other ways to track information could also be considered.

- **ACTION: GB/EB**

JH queried whether there was any analysis of complainants in terms of protected characteristics so that services to those groups could be improved. EB said there was not but advised that a Health Inequalities post had been created. The postholder would start in August and one of their key objectives would be to look at capturing that data. A Carers' Lead had also recently started and it was hoped that the experiences of carers could also be captured.

SH queried what was covered by the values and behaviours theme and EB cautioned that different Trusts categorised complaints differently. However, at UHS it included behaviours such as abruptness, rudeness and a member of staff being unprofessional but he noted that these were subjective.

PG advised that clinical teams had seen a significant rise in complaints regarding delays in treatment. Many teams were managing those complaints themselves, which was putting increased pressure on them.

KE queried whether there were areas of the hospital which had a high proportion of upheld or partially upheld complaints and EB offered to provide that data after the meeting.

- **ACTION: GB/EB**

PG advised that if a theme emerged through the complaints process regarding a particular team or individual, he (or a colleague) were sometimes asked to look into it informally. DAF reassured the Board that every complaint letter was signed off by one of the executive directors. GB noted that clinical accreditation was used to pick up on any areas that were struggling and in need of support.

JD-T noted that the number of complaints upheld was significantly lower than the national comparison and she queried whether that had flagged any concerns for UHS. EB said that he would want to select some similar Trusts to benchmark UHS against. Also, once the Ombudsman resumed its activity, the Trust would know whether they had found the Trust's investigations to be thorough and accurate.

Decision: The Board was assured that the report fulfilled the requirements set out in the NHS complaints regulations.

5.8 Learning from Deaths 2022/23 Quarter 1 Report

PG noted that there had been staffing difficulties with ill health in the team and recruitment issues for key roles. EB advised that posts in the Medical Examiner's service were being recruited to and a Mortality Governance Analyst had been appointed.

He noted the summary in the report (page 1) and highlighted that the Hospital Standardised Mortality Ratio (HSMR) had increased. Review of the data had indicated that the denominator for how expected deaths was calculated, did not take into account Covid spikes, where deaths were expected to be slightly raised. He suggested, however, that Board members should be assured that the Trust's numbers remained in the low range.

PG advised that a number of peer comparators had seen the same change in HSMR and he noted that UHS remained 15th best in the country. TP reminded Board members that the metric was a relative risk which was highly sensitive to changes in coding practice and was relatively difficult to interpret.

JH queried the process for sharing learning nationally in terms of themes and trends. EB advised that a national reporting system was expected to be introduced next year which would be a statutory function for Medical Examiners to report on reviewed cases regarding cause of death. It would not, however, refer to quality of care and learning.

Decision: The Board was assured by the report.

5.9 Maternity Safety 2022-23 Quarter 1 Report

GB highlighted the updates on a range of topics which were provided in the report (listed on page 1).

She advised that the final Ockenden report had identified 15 Immediate and Essential Actions and there had been a national request to pause, as there may be recommendations from other reviews. UHS would undertake a gap analysis over the summer, against those recommendations.

DAF, TP and GB had recently met with Jacqueline Dunkley-Bent, Chief Midwife of England and the regional team, who had been positive about the maternity unit at UHS.

MC advised that:-

- the Trust was now compliant with the two actions identified by the Ockenden review team, with the introduction of a mandatory field on Badgernet.
- positive changes continued throughout all safety aspects in maternity.
- work continued to improve safety on all QI projects within maternity and the unit was fully compliant with all the national safety drivers.
- a concern had been raised around the obstetric workforce in the last quarter. A review was taking place and a report would be provided to the Quality Committee in August 2022.
- as part of the provider engagement meeting the CQC had visited and had been positive about their walkabout and the information provided.
- the unit was preparing for a CQC inspection.
- there would be an Ockenden insight visit in September to celebrate and showcase the work of the unit.

TP said that the highest risk services were those where a patient was under shared care. It was then that culture and interdisciplinary respect was crucial and he felt assured that this were thriving in the maternity service at UHS.

He advised that he had read the Serious Incident Reports presented to the Board and had no specific concerns. He felt that the standard of the reports was high.

His two concerns were that training compliance had dropped slightly as staff were unable to attend training due to high levels of staff sickness and pressure on the service. There were, however, statistics on some groups for undertaking maternity emergency training that were below acceptable levels. The team was aware and were dealing with it.

He was also concerned that all the SI reports he had read had been investigated by a multidisciplinary team who all worked somewhere within obstetrics, maternity or neonatology. He had raised this with Emma Northover, Director of Midwifery, who was taking it forward.

During a walkabout on the unit recently he had noticed a lot of basic maintenance that had not been kept up with, particularly on the Labour Ward and he had formally escalated it to David Jones, Director of Estates.

SH was pleased to see the work being done around Freedom to Speak up and was keen to ensure this work continued. MC advised that she undertook a daily walkabout round the maternity service. This was followed up by the operational team who asked questions about clinical safety.

PG advised that four more people had been recruited to the Patient Safety Team, from a variety of disciplines and others were being recruited into the Medical Examiner's team. He suggested that these individuals may be able to work with the maternity team to review cases and MC confirmed that this would be explored.

Decision: The Board was assured by the report.

5.10 Break

5.11 Violence and Aggression against Staff Progress Update

SH stated this this was a fundamentally important issue for the Trust and he introduced SHe who acted as the senior lead on this agenda within the Trust and also chaired the Violence and Aggression Group. SHe highlighted the following key points:-

- the re-launched group had been running for over 18 months and although it had made significant progress, it was important for the Board to understand that there was increasing complexity around violence and aggression both nationally and locally. Southampton was a hotspot, which was reflected in the hospital.
- the exclusion policy had been in place for over a year and had received positive feedback from staff. In that time many warning letters had been issued but only one yellow card which showed the impact it was having. It also made the staff feel supported.
- training and awareness was having a significant impact but there was more to do.

- the Trust's relationship with external stakeholders and the ICS was key, particularly in terms of police engagement. However, Operation Cavell, which Hampshire Constabulary was to have rolled out across the NHS in the county, had been unable to support the demand seen.
- it was more difficult to put processes in place to deal with patients who did not have capacity, e.g. those with brain injuries or withdrawing from drugs.
- the physical element of violence in ED was increasing e.g. nurses pinned to the floor with hands round their throats. The Trust was therefore considering the use of body cameras for senior staff in the department, which may help to make staff feel safer and also lead to convictions.

SH advised that external media would be used to highlight the actions the Trust was having to take. JH queried the storage and management of data from body cameras and SHe advised that policies were in place as these were already worn by the security team.

CC noted the low frequency of violence and aggression between staff members and queried whether it was classified differently. SH said that violence between staff members was extremely rare and when it did happen, there was zero tolerance. Issues with aggression between staff members were picked up through employee relations processes.

KE queried whether the Trust was too lenient in its use of yellow and red cards. SHe advised that ED had only recently started to use the cards as they had a micro system in the department. They were, however, becoming stronger in the use of the cards in relation to repeat behaviour.

SHe advised that further work was planned to analyse data, improve engagement with the police and community and link with the national violence and aggression workforce.

Decision: The Board was assured by the report.

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6 STRATEGY and BUSINESS PLANNING

6.1 Corporate Objectives 2022/23 Quarter 1 Review

DAF advised that the paper provided an update regarding achievement of the Q1 objectives. He noted that there was a high proportion of green but more amber than normal, which was likely to be a reflection of the pressure the organisation was under. He introduced CMcG who highlighted the following:-

- 74% of the objectives for Q1 had been achieved.
- 20% (10) were in the amber zone. A number had been achieved since the report was produced or were due to be achieved in July. Some were around the operational plan and some related to business cases that were still to come.
- 6% (3) had not been achieved. 2 related to financial challenges and 1 related to a business case that dated back to 2019 around the procurement of medicines and had been picked up through due diligence.

The following comments were made:-

- good progress was being made in Q1.
- only 50% of the integrated networks and collaboration were green, which was a concern.

- not all objectives signalled poor progress on the Trust's part and further time and dialogue was needed in relation to working with partner organisations.
- whether red flags could be itemised in an executive summary (similar to KPIs).
- FMcA queried whether the objectives were taken direct from the Strategic Plan and DAF confirmed that they were.
- TP suggested that the pharmay distribution business case (which dated back to 2019) would not be difficult for UHS to execute and he queried how long the Trust would wait as its pharmacy resources were extremely stretched.
- KE asked that the next review was more forward looking rather than backward looking.

CMcG noted that Board members were already aware of the red flag around finance. With regard to integrated network working the ICB was only formally established on the 1st July 2022 and time was needed to develop partnership working.

IH advised that the PHU pharmacy distribution hub related to an STP Wave 3 capital bid in 2017 which the Trust had supported. An update paper had been discussed at the Trust Investment Group in June 2022 and more detail would be brought back in October.

DAF reminded the Board that when it had set the objectives, significant assumptions had been made but events had proved to be very different. The NHS was being overwhelmed by operational pressures and UHS was handling those better than many but it was having an impact on those assumptions.

Decision: The Board was assured by the report.

6.2 Board Assurance Framework (BAF) Update

HP introduced the updated Board Assurance Framework (BAF) and noted that finance and capacity had came out strongly in it. Other strategic risks included staffing and estates which had also been discussed earlier during the Board meeting.

JD-T noted the improvement in the BAF since 2020 and she thanked staff for their work on it. She queried how effective the key controls were and suggested that they were developed. GB, HP and Jake Pursaill agreed to take that forward.

- **ACTION: GB/HP/JP**

Decision: The Board was assured by the report.

7 CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

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

JD-T advised that the CoG had extended TP's appointment for another term. The Constitution had been amended and approved by the governors and Board members would be able to see the changes made. It was also agreed to start the process around the selection of the Lead Governor.

HP advised that the CoG had agreed that JD-T would have a period of time to reflect on the appointment of a Deputy Chair as JB was to stand down at the end of July. JD-T would report back to the CoG on that in October.

- **ACTION: JD-T**

Decision: The Board noted the feedback.

7.2 Register of Seals and Chair's Actions Report

JD-T advised that there had been no seals since the last Board meeting but there had been one action (item 2.1).

DAF noted that the Single Tender Action related to the car park at Adanac which was now open. Southampton City Council were keen to be involved in the official opening and the date would be shared with Board members. The handover had been done well and feedback from users had been positive.

Decision: The Board ratified the Chair's action.

7.3 Trust Constitution

HP advised that the amendments to the Trust Constitution had been approved by the CoG at their meeting on the 20 July 2022.

The amendments reflected the composition of the CoG with a change to the public constituencies to ensure it remained representative. Other changes were a reflection of the CCGs ceasing to exist from the 1 July 2022 with a governor post being transfered to the HIOW Integrated Care Board. A number of minor 'tidying up' changes had also been made.

Decision: The Board approved the amendments to the Trust Constitution.

7.4 Trust Executive Committee (TEC) Terms of Reference

DAF advised that there had been an amendment to the Trust Executive Committee Terms of Reference to incorporate the work being done by IH around financial improvement.

Decision: The Board approved the amendment to the TEC Terms of Reference.

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

DAF advised that the Trust had received a recommendation from UHS Pharmacy Limited (the Trust's outpatient pharmacy wholly owned subsidiary) for the re-appointment of two directors.

Decision: The Board approved the recommendation and authorised DAF to sign the Shareholder Resolution.

8 Any other business

There was no other business.

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

10 Resolution regarding the Press, Public and Others

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

The meeting was adjourned.

University Hospital Southampton
NHS Foundation Trust

List of action items

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 26/05/2022 5.6 Freedom to Speak Up Report				
704.	Comparative information	Byrne, Gail	29/11/2022	Pending
	Explanation action item It was requested that future FTSU reports included comparative information from previous years in order to identify trends and also identified cases from previous reporting periods that had not yet been closed.			
Trust Board – Open Session 28/07/2022 2 Patient Story				
759.	Follow-up	Byrne, Gail	29/09/2022	Completed
	Explanation action item Board members thanked the patient for sharing her moving story and noted the inconsistencies in her care. GB was aware the patient had shared her experiences with the Clinical Leaders' Group and she acknowledged that many of the issues related to basic nursing care. She offered to meet with the patient and also to write to the staff who had provided excellent care. Update: A meeting has been arranged for 25 October 2022.			
Trust Board – Open Session 28/07/2022 5.1 Briefing from the Chair of the Charitable Funds Committee (Oral)				
760.	Banksy project	Harris, Steve	25/08/2022	Completed
	Explanation action item SH advised that a full update on the Banksy project would be provided to the Board in August.			

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 28/07/2022 5.5 Integrated Performance Report for Month 3				
761.	TBSS topic	Teape, Joe	31/12/2022	Completed
	Explanation action item KE suggested having a Trust Board Study Session to look at the projections going forward around 78 and 52 weeks. JT advised that the cancer waiting list had increased by around 1,000 patients so there was also a need to look ahead at the demand on surgery for cancer patients. Update: The October TBSS will have a focus on cancer. Waiting lists will form part of a further TBSS to be held later in the year.			
Trust Board – Open Session 28/07/2022 5.7 Complaints Annual Report 2021-22				
762.	TBSS topic	Byrne, Gail Banfield, Ellis	31/12/2022	Completed
	Explanation action item JD-T noted that the NHS complaints process was complex and suggested that it could be a topic for a Trust Board Study Session, when other ways to track information could also be considered. Update: This has been added to the TBSS Forward Plan.			
763.	Upheld complaints	Byrne, Gail Banfield, Ellis	29/09/2022	Pending
	Explanation action item KE queried whether there were areas of the hospital which had a high proportion of upheld or partially upheld complaints and EB offered to provide that data after the meeting. Update: The data is being compiled.			

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 28/07/2022 6.2 Board Assurance Framework (BAF) Update				
764.	Key controls	• Byrne, Gail • Potton, Helen • Pursaill, Jake	29/11/2022	Pending
	Explanation action item JD-T queried how effective the key controls were and suggested that they were developed. GB, HP and Jake Pursaill agreed to take that forward. Update: Discussions have taken place and work will take place to update.			
Trust Board – Open Session 28/07/2022 7.1 Feedback from the Council of Governors' (CoG) meeting on 20 July 2022 (Oral)				
765.	Deputy chair	• Douglas-Todd, Jenni	19/10/2022	Pending
	Explanation action item HP advised that the CoG had agreed that JD-T would have a period of time to reflect on the appointment of a Deputy Chair as JB was to stand down at the end of July. JD-T would report back to the CoG on that in October.			

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Chief Executive Officer's Report**			
Agenda item:	**5.3**			
Sponsor:	**David French, Chief Executive Officer**			
Date:	**29 September 2022**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** X
Issue to be addressed:	My report this month covers updates on the following items: • Her Late Majesty Queen Elizabeth II • Operational update – Unscheduled Care Village Model • Junior Doctor Bank rates • National HR Recognition • UHS Vaccination Programmes • Genomics consolidation • Alcidion IT Partnership • NHS England Oversight Framework Segmentation Review			
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.			

Her Late Majesty Queen Elizabeth II

Reflecting on the last few weeks following the sad loss of Her Late Majesty Queen Elizabeth II reminds me of the profound place held by public service in the heart of our nation. The long-held values she embodied of dedication, constancy and duty to the people she served are principles shared throughout healthcare and seen here at UHS every day.

I wanted to take this opportunity to note my sincere thanks and gratitude to our teams across the organisation for the management of the Bank Holiday for Her Majesty's state funeral. It was a moment in history unlike anything we've seen before and through teamwork and detailed planning, we managed to strike the difficult balance between continuing scheduled care for many of our patients whilst also supporting and respecting the choices of our staff. Everyone had a part to play in this, whether that be in the planning beforehand, working on the day, or helping to reschedule care. Despite many patients choosing to cancel, we were able to deliver more than two-thirds of our scheduled activity (out-patients and elective) and it was a good example of the organisation working together and putting patients first.

Operational update – Unscheduled Care Village Model

From the 12th-18th September, the Unscheduled Care Village (UCV) model was trialled which involved:

- Relocating the Trauma Assessment Unit and Acute Surgical Unit adjacent to the Emergency Department into part of the Acute Medical Unit,
- Expanding the number of pathways to medical Same Day Emergency Care,
- Enhanced medical presence in the Emergency Department's Pitstop,
- Enhanced Trauma and Orthopaedic consultant cover, and
- Faster access to imaging.

The aims of the trial were to ensure that patients saw the right admitting specialty as early in their pathway as possible. It was hoped that this would help to reduce overcrowding in the Emergency Department, improve performance against the 4-hour emergency access target and ideally reduce the number of admissions.

Early evidence and feedback suggest that the week was received very positively by the teams involved. Despite attendances in line with previous weeks, the performance against the 4-hour standard was circa 20% higher and overcrowding in the department was dramatically reduced. There were also many stories of patients seeing the right doctor sooner and being sent home earlier. Staff feedback has been positive, with people saying how much they enjoyed the new ways of working which had led to improved morale and better teamworking. A formal evaluation and potential next steps will now take place. We are also reviewing what can continue in the short term, whilst a longer-term proposal is developed.

Junior Doctor Bank rates

A negotiated settlement has been reached with the British Medical Association (BMA) for locum bank rates at UHS. In July the Trust entered into negotiations with Junior Doctor representatives and the BMA on the existing rates. Trust attempts to implement a revised rate card during May had been met with significant resistance from juniors across the Trust. The Chief People Officer conducted negotiations with the BMA throughout the summer. The tone of conversations moved from hostile to collaborative and productive, resulting in a mutually agreed solution.

The resultant framework was accepted by 75% of juniors across the Trust and was implemented on 12 September 2022. This provides a greater degree of consistency, fairness and control over Junior pay. It recognises work undertaken in unsocial hours and provides a framework for meeting market force pressures created through external factors. Increased reporting and monitoring has been set in place to assess usage and fill. The framework provides a commitment to uplift rates annually in line with the junior doctor pay award.

National HR Recognition

The UHS Core Human Resources team has been awarded a national Chartered Institute of Personnel and Development (CIPD) award for its work during the pandemic, winning Public Sector HR team of the year. This is a prestigious award and a great recognition of the hard work, dedication and innovation demonstrated by the team through a very difficult period. The leadership of senior HR managers, in particular Adam Pitt and Brenda Carter has been both outstanding and crucial.

UHS Vaccination Programmes

UHS commenced its COVID booster vaccination programme on 12 September, using the now well-established infrastructure at our hospital hub. The hub has been operating throughout September, offering our people and partner organisations a convenient way to get their Autumn COVID booster and seasonal flu vaccine. The COVID booster vaccine is the Moderna Spikevax Bivalent vaccine, a new bivalent vaccine targeting the original strain of COVID and the newer Omicron variant. During the first week, 1500 staff received a COVID booster alongside over 900 flu vaccines.

Promotional media, videos and information are being provided to staff to drive up take-up during this period. A particular focus of this is on risk and efficacy.

UHS also remains the system provider of the complex vaccine allergy service, providing specialist advice and vaccination to those who cannot receive the standard vaccine.

Genomics consolidation

As part of a national restructure of genomic services, UHS and Salisbury NHS Foundation Trust boards approved proposals to consolidate their two genomics laboratories under the management of UHS. Consolidation will be achieved in a three staged approach:

- **Stage 1**: Implement the management transfer, including a Transfer of Undertakings (Protection of Employment) (TUPE) process for Salisbury based staff whose employment will transfer to UHS whilst continuing to work in Salisbury.
- **Stage 2**: Adoption of an interim 'one team, two sites' delivery model.
- **Stage 3**: Physical co-location of the services, once a suitable location is identified.

Following the planned 6 month implementation, stage 1 will complete on the 1st October 2022. Requiring management and organisational changes within the UHS Pathology Care Group, stage 1 delivers a significant expansion of the UHS genomics service from approximately 25 whole time equivalent (WTE) staff to approximately 100 WTE, including the TUPE transfer of approximately 85 WTE staff based in Salisbury. As agreed, UHS will take sole financial responsibility for the service from the 1st October.

Stage 2 of the consolidation will now be progressed and options for stage 3 will be scoped. An implementation decision for Stage 3 will be sought at a later date, subject to a business case for approval by the Board.

Alcidion IT Partnership

We are progressing a modular strategy for the Electronic Patient Record (EPR) that has been successful over a number of years and was included in the Global Digital Exemplar programme with NHSE from 2016-2019. The strategy was revised in 2021, taking account of changes through the COVID-19 pandemic, but the overall approach was considered to remain the best option. Since this time however, a number of pressures and changes have caused the team to consider a partner approach to delivering the objectives.

The [previous] Secretary of State had re-affirmed the target for HIMSS Level 5 digital maturity and added a target date of March 2025 for this. Also, funding would be directed more from the centre (NHSE) through ICSs where a new theme of convergence has emerged as criteria for agreeing funding and strategy. It is clear that unless we can demonstrate ability to deliver at higher pace, spread and interoperability with systems across an ICS, and have a recognised delivery partner, then it will be increasingly difficult to attract funding from the national programme.

It has become very difficult to recruit specialist staff and, with increased demand, it is felt that we need a more adaptable and scalable model. After consideration and a study of the market, a partner for delivery has been selected as the preferred option over wholesale replacement with, for example, a large single system.

The preferred vendor, Alcidion, is included on the recognised NHSE list of EPR suppliers and has an adaptable, modular approach meaning that UHS can adopt systems over time in a logical order, for example when UHS systems come to end of life or technology has moved on. The testing ground for this approach is the ED system, a challenge for several years, and the project will fit in with the Trust's ambition to improve the way its systems improve hospital flow. Due diligence has been carried out both on this system and Alcidion more broadly and the clinical teams are supportive of the direction. However, the parallel approach will mean that UHS is not overly exposed to risk,

In addition, the commercial team has been working with Alcidion and there is an additional benefit in that our successful HICSS (Endoscopy) and My Medical Record programmes will be supported and offered to Alcidion clients.

The recommendation has therefore been approved by the Trust's Executive Committee to support this partnership, whilst mitigating the risk involved by assessing delivery before taking large further steps. The initial investment is £1.2m over twelve months, subject to successful milestone delivery.

NHS England Oversight Framework Segmentation Review

NHS England (NHSE) are required to formally review the segmentation ratings of Integrated Care Boards and local NHS Providers every quarter as part of the System Oversight Framework (SOF) process. Segmentation ratings align to the level and manner of support that an organisation requires. High performing organisations will be placed into segment 1 through to those organisations where there are serious concerns in segment 4.

The Trust received notification from the Hampshire and Isle of Wight Integrated Care Board (HIOW ICB) on 5 August that, following NHSE's quarterly review, HIOW would remain in segment

3 and UHS would remain in segment 2. For the Trust this means that it will continue to receive a range of flexible support with no mandated support required. However, for the system there will be a greater level of oversight and support to ensure that as a system we continue to work in partnership to improve health outcomes for our population.

HIOW ICB noted that there had been good progress in the development of the ICB with a shared view of improvement priorities for the system and providers. Areas for focus in Quarter 2 included material delivery of the financial plan month-on-month and mature place-based/provider collaborative leadership arrangements.

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Integrated Performance Report 2022/23 Month 5**			
Agenda item:	**5.4**			
Sponsor:	**David French, Chief Executive Officer**			
Author	**Jason Teoh, Director of Data and Analytics**			
Date:	**29 September 2022**			
Purpose	**Assurance or reassurance Y**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	The report aims to provide assurance: • Regarding the successful implementation of our strategy • That the care we provide is safe, caring, effective, responsive, and well led			
Response to the issue:	The Integrated Performance Report reflects the current operating environment and is aligned with our strategy.			
Implications: (Clinical, Organisational, Governance, Legal?)	This report covers a broad range of trust services and activities. It is intended to assist the Board in assuring that the Trust meets regulatory requirements and corporate objectives.			
Risks: (Top 3) of carrying out the change / or not:	This report is provided for the purpose of assurance.			
Summary: Conclusion and/or recommendation	This report is provided for the purpose of assurance.			

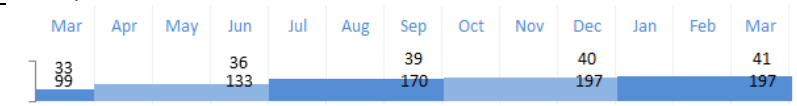
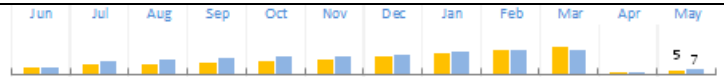
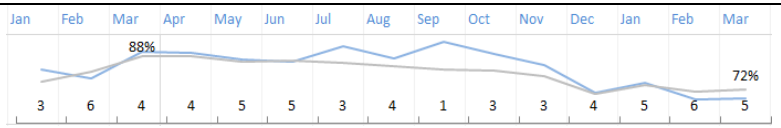
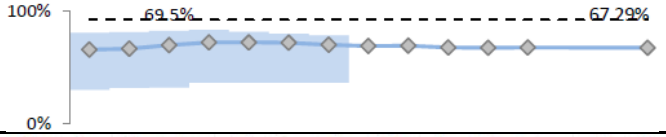
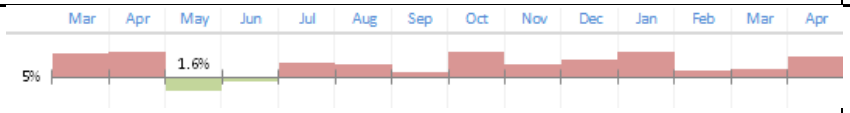
University Hospital Southampton NHS
NHS Foundation Trust

Integrated KPI Board Report

Covering up to
August 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 there have been no material changes in the format of the report.

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

- Correction: For measure PN4 (Achieve compared to R+D Income Baseline), the YTD income increase % figures (red line) were being incorrectly calculated and have now been corrected. The monthly figures remain the same.
- Correction: For measures WR11, WR12, and WR13, the quarter in which each survey result was reported was incorrectly titled. This has now been adjusted.

Summary

This month the 'Spotlight' section contains a report on Cancer performance and an update on appraisals at the Trust.

The Cancer performance spotlight highlights:

- Significant growth in cancer referrals, which are approximately 25% higher than January 2019, has impacted UHS performance.
- UHS has increased capacity to deal with the higher volume of referrals; however, our performance is still below the national cancer targets. This is a national issue – and is demonstrated in the benchmarking stats which shows UHS broadly in line with comparator, large, teaching hospitals.
- As a tertiary treatment centre, UHS also receives the more complex cases from other providers. This further impacts our headline performance.
- We are working closely across relevant Care Groups where referral volumes are impacting cancer performance, alongside the Wessex Cancer Alliance, to continually review our pathways and ensure that we refine our processes to improve the patient experience.

The appraisal spotlight highlights:

- That completed appraisals at UHS have been between 70-80%, and shows how this level was maintained during the COVID-19 periods, even though appraisals were technically paused.
- The level of appraisals is below our own target of 92%. We recognise that appraisals, when done well, can contribute significantly to staff engagement. We have taken feedback from our staff on areas of the appraisals process which need to be improved, and the spotlight highlights improvements which are being made.

Areas of note in the appendix include:

1. Two Week Wait performance has seen a 10% improvement between June to July 2022, particularly due to a recovery in Breast, although overall performance remains just below the target of 93% at 90.6%. UHS remains in the upper quartile of comparator hospitals for Two Week Wait performance.
2. However, other cancer standards remain under pressure due to high referral volumes, with pressures continuing within the skin, head & neck, and urology tumour sites.
3. August 2022 saw a significant reduction in the number of COVID-19 inpatients, and a corresponding reduction in the number of healthcare acquired (2) and probable hospital associated (4) COVID-19 infections.
4. There were a higher number of SIRIs (17) reported in August. Of these six were due to COVID-19 cases in previous months, and three were linked to the Neonatal unit being at Opel 4 status. There were no other significant themes within these reported incidents.

5. The 18 week open pathway (Referral to Treatment – RTT) waiting list has continued to grow in line with the increased referral rate. At the end of August, the waiting list was at over 52,000 patients. There were only six 104+ week waits at the end of August, and all due to patient choice.
6. Patients without a Criteria to Reside in hospital remain extremely high, with an average of 193 patients not meeting the Criteria to Reside standard through August.

Ambulance response time performance

The following is the latest Category 1 to 4 information published by South Coast Ambulance Service (SCAS) published within its July 2022 board papers, relating to the Southampton, Hampshire, Isle of Wight, and Portsmouth area. This information shows that in June there was a worsening of response time, compared to performance earlier in the year.

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

Performance measure	June 22 Actual	YTD Actual	Target
Category 1 Mean	00:09:48	00:09:15	00:07:00
Category 1 90th percentile	00:17:26	00:16:37	00:15:00
Category 2 Mean	00:43:28	00:34:55	00:18:00
Category 2 90th percentile	01:29:15	01:11:54	00:40:00
Category 3 90th percentile	07:03:13	05:11:54	02:00:00
Category 4 90th percentile	08:17:24	06:11:50	03:00:00

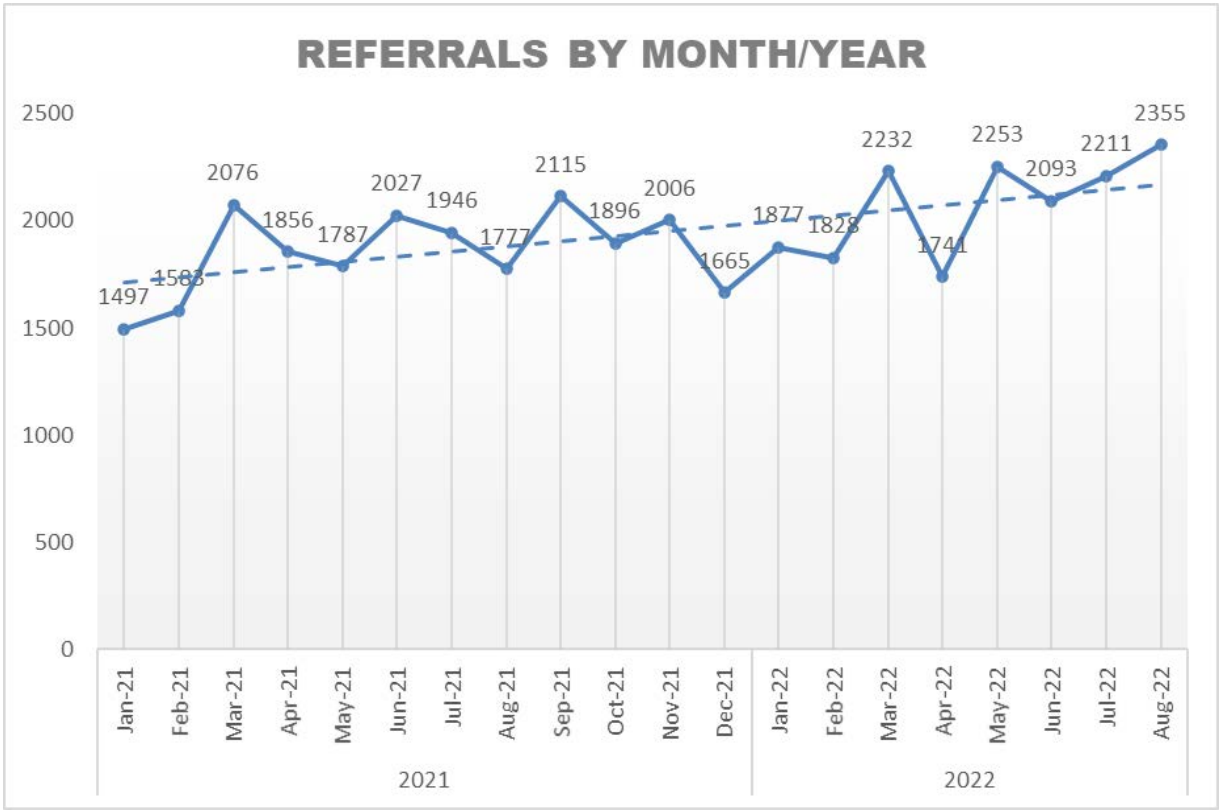
UHS continues to ensure that it does not significantly contribute to ambulance handover delays. Using weekly data which is provided to UHS by SCAS, in the week commencing 12 September 2022, our average handover time was approximately 16.5 minutes across 692 emergency handovers, and just 16.3 minutes across 55 urgent handovers. This is broadly in line with performance the previous month.

Spotlight: Cancer performance

UHS is a specialist teaching hospital, while also being a District General Hospital for the local population, meaning our cancer services are under pressures not seen in other Wessex region hospitals, but replicated with other national, acute, teaching hospitals. Despite the challenges on cancer services, we often benchmark well relative to our teaching hospital peers, and the Hampshire & Isle of Wight ICB overall are top quartile performers for Cancer performance.

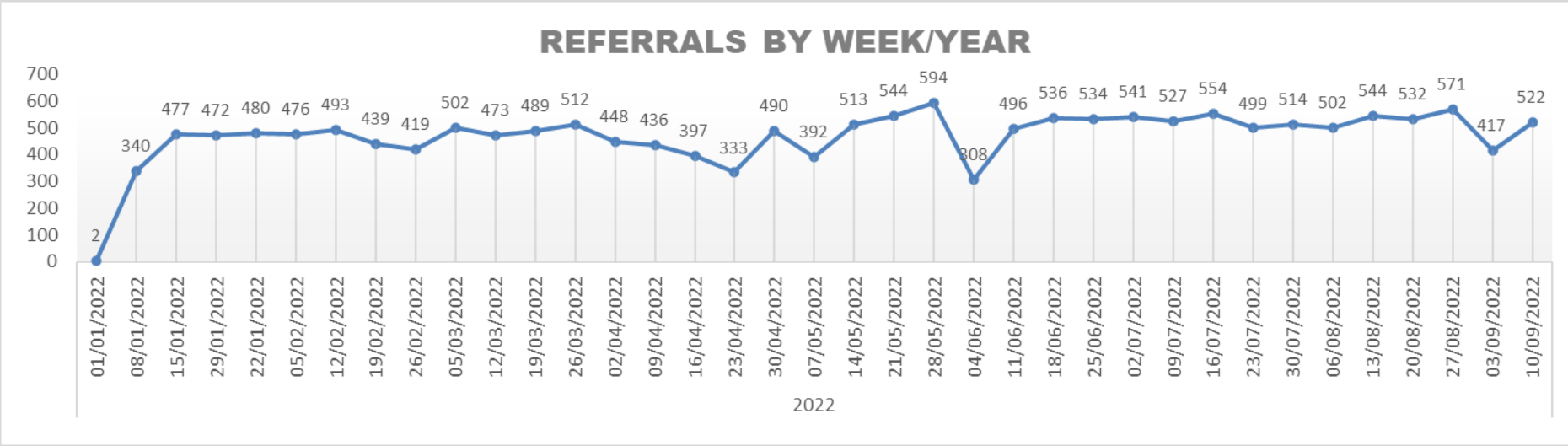
Cancer 2 week wait (2WW) referrals:

Cancer referrals volumes continue to see significant month on month variation. Referrals can be affected by national factors, such as cancer awareness campaigns, or personal events that create national press interest. Managing capacity within a two week window, where there is such wide weekly variation, is very challenging.



- Cancer referrals reduced through the Covid period as patients were unable to be seen in primary care.
- This quickly recovered post-lockdown, and we have seen growth of c25-30% in referrals compared to January 2019 levels (1,786 referrals per month). This has been driven by patients returning to GPs, as well as patient awareness through national campaigns and events.
- Referrals reduced between December 2021 - February 22 (which was in line with historic seasonality). However, since March 22 referrals have continued to climb and August 2022 saw the highest number of monthly referrals ever seen (2,355).

The variation in referral volumes can also be seen week on week – which makes capacity management to meet a 14 day target challenging.



In order to maintain capacity for increased referrals, teams have been actively managing clinics capacity between 31 day treatment and two week wait assessment, as well as using Waiting List Initiatives (WLI) to manage the 'spikes' in demand. However, because referrals are, broadly, dealt with in the order they're received, spikes in demand cause bottlenecks in the pathway which can be challenging to mitigate.

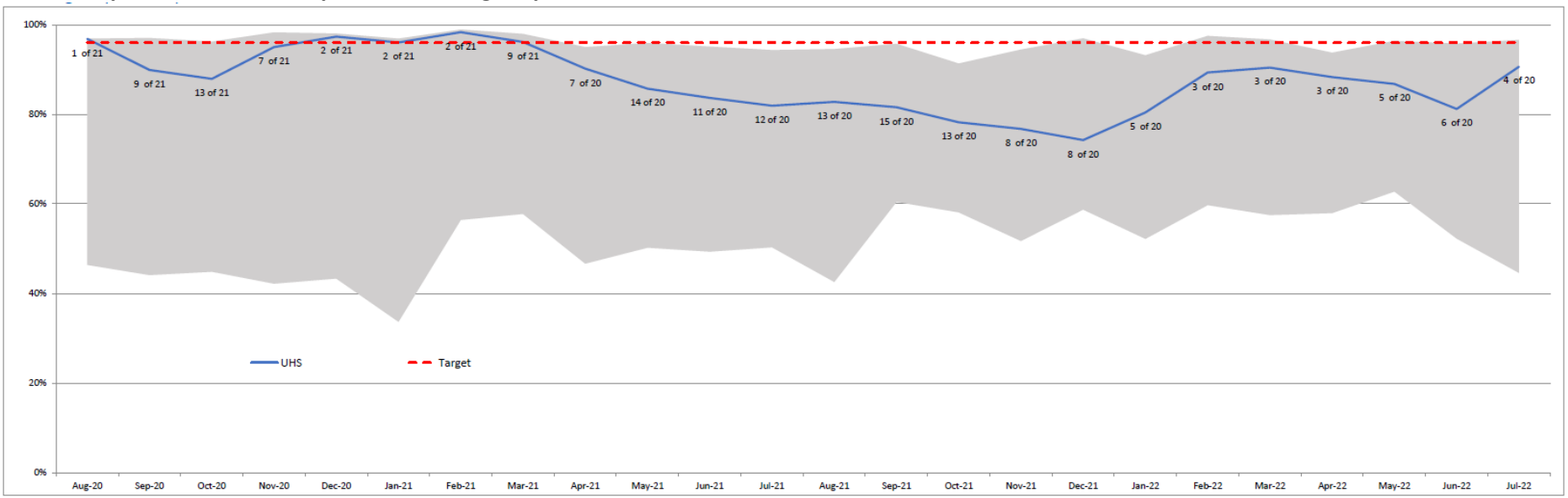
2 week wait (2WW) performance (seen by UHS within 14 days of referral)**:**
The 2WW performance is closely related to the volume of referrals received, and higher referrals have impacted on our 2WW performance, and Q2 performance will be impacted by the record referrals we continue to see. We intend to continue to monitor this performance metric, with an ambition for all patients to be seen by day seven.

In recent months, 2WW performance has been particularly challenged within colorectal, skin, and head and neck; and this continues to be an issue. Gynaecology performance has significantly improved from the previous report (provisional result of 92.6% for August 2022)

Head and Neck capacity continues to be challenged as a locum doctor has left the service. Referrals in 2021/22 have been approximately 25% higher than 2019 (217 versus 173 referrals per month), with August 22 particularly high at 283 referrals. The service is seeking additional resource through waiting list

initiatives, locum capacity, and head and neck specialty doctors. However, we do have a new Associate Speciality doctor starting in September 2022, primarily with a focus on the diagnostic element of the pathway.

UHS 2WW performance vs comparator teaching hospitals

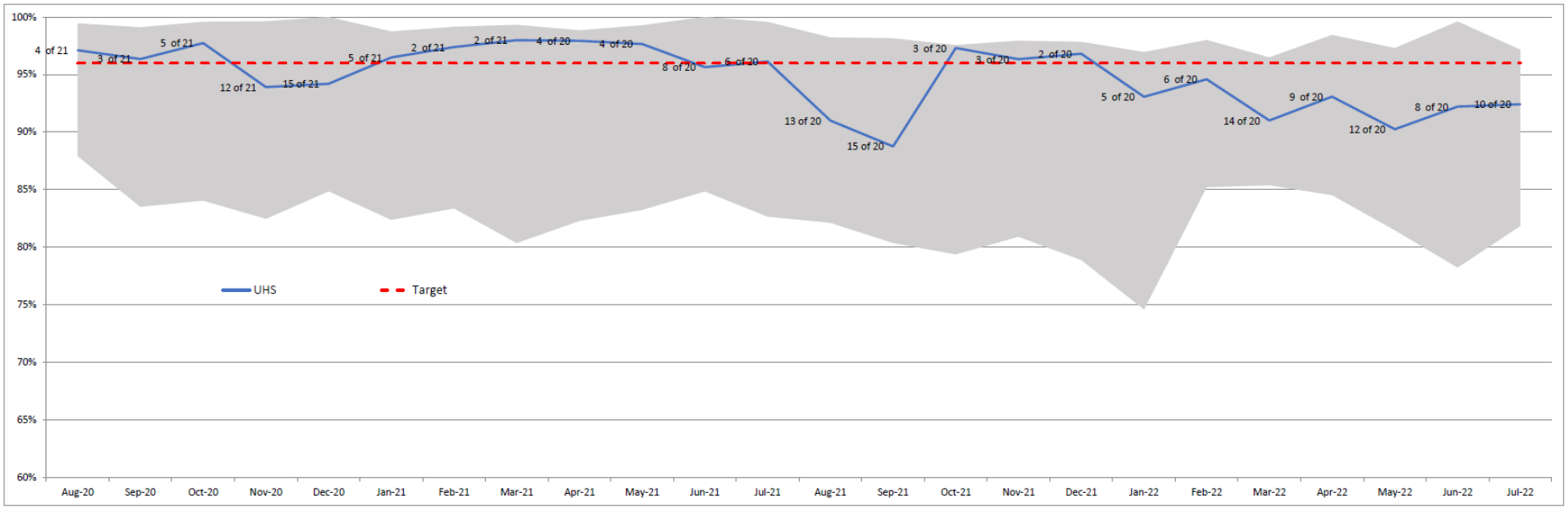


When benchmarking against teaching hospital peers, our performance has improved, driven by the improvement in breast performance. Overall, our performance is in line with other comparator hospitals given the national increase in referral volumes.

28 Day Faster Diagnosis (diagnosed, or cancer ruled out, within 28 days of referral)
This measure has been introduced in Q3 21/22 as a replacement for the 2WW measure and is intended to ensure that patients have a timely diagnosis, or "all clear" within 28 days of being referred to the hospital. UHS performance against this measure has been good, and we continue to achieve the national target of 75%, with performance in Q2 22/23 currently standing at 78%.

31 Day performance (start treatment within 31 days of a diagnosis)**:**
UHS performance has deteriorated against this target in terms of percentage performance (92.4% reported for July, predicted 86.3% for August) but we have treated more patients in August (432) compared to May 2022.

UHS 31D performance vs comparator teaching hospitals



31 Day Performance challenges and actions

In order to maximise our ability to treat patients we have the following actions in place:

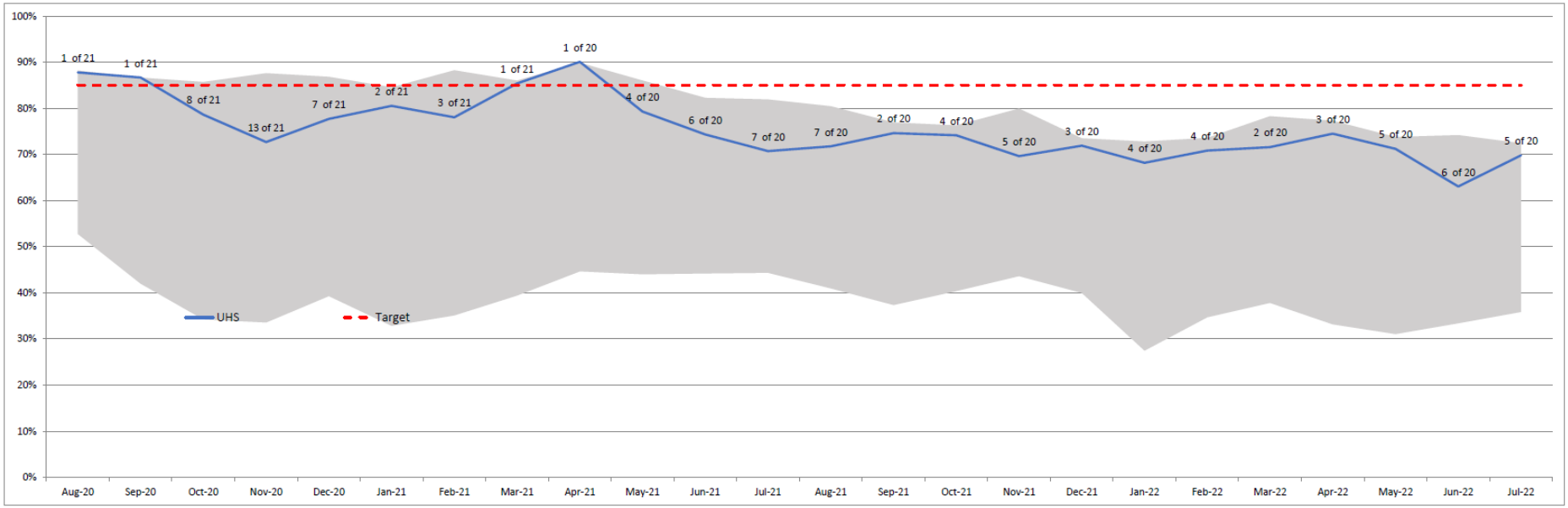
1. Ensuring that our LINAC (linear accelerator) machines are fully resourced, and by looking to reduce DNAs (Did Not Attends).
2. Theatre productivity programme to deliver improved utilisation of our theatres
3. Ongoing recruitment and business case development across specialties where demand outstrips capacity

62 Day performance (treatment within 62 days of referral):

62 day performance has been impacted by our referral and treatment times. However, we continue to benchmark in the upper quartile on 62 day performance compared to other teaching hospitals. This demonstrates that our challenges in cancer performance are aligned with other similar trusts across the country.

In addition, as a tertiary centre, our performance has been impacted by more complex cancer patients who are transferred from other hospitals. When looking at 62 day performance for UHS alone, our current predicted August performance is 71.1% (85% target) compared to tertiary performance at 37%.

UHS 62D performance vs comparator teaching hospitals



In addition to the actions covered above, other areas of improvement that we continue to work on include:

- Skin; we are seeking to introduce the use of tele dermatology to assist in responding to the increasing 2ww referrals this will facilitate early transfer to routine pathway or discharge and allow a straight to surgery model to be introduced – we are out to advert for the posts required to implement this change
- Gynaecology; pathway review being undertaken with plans to implement investigations prior to clinical review in order to facilitate early discharge from the service where appropriate.
- Appointment of some fixed term posts funded by the Wessex Cancer Alliance to support gynaecology and urology pathways.

Overall cancer waiting list

Our overall cancer waiting list (or PTL – Patient Treatment List) is at a record level due to the higher referrals that we have received. The number of "breaches" (patients who have waited over 62 days for their cancer treatment) has also been growing. We are working with the Care Groups, and with the Wessex Cancer Alliance, to implement actions which will improve the cancer pathways and treatment times for patients, and will be developing a recovery glide for our 62 day waiting list. For awareness, some of the actions being implemented within Care Groups are shown below.

UHS Cancer Waiting List and 62 day breaches

Tumour site	Actions
Dermatology	• New pathway going live in December with all referrals to include a photo. • Increasing surgical capacity through insourcing, alongside business case for permanent dermatologist.
Colorectal	• Request for additional endoscopy activity through Community Diagnostic Centres • Working with primary care on Faecal Immunochemical Test (FIT) to reduce referrals
Lung	• Work to reduce delays due to PET CT and Genomic testing (both outside UHS's direct control). • Agree additional funding for lung screening tertiary referrals from other hospitals.
Head and Neck	• Additional associate specialist starting mid-September
Urology	• Additional nurse led clinics being funded.
Sarcoma	• Insourcing capability to focus on benign cases, freeing up consultant capacity for more complex cases.

Spotlight: Appraisals

1. Context

Evidence shows that people perform at their best in the workplace when they have a connection to a common purpose, have mastery in what they do, and have autonomy to act within their scope[1]. In addition, there is substantial evidence to show the clear link between levels of staff engagement (NHS Staff Survey) and patient outcomes.[2]

There are multiple factors that contribute to staff engagement and levels of motivation; regular time with a consistent manager or team leader, regular feedback, and opportunities to talk about development, careers and support needs are vital components. In the NHS the appraisal, supervision and 121 process is the main methodology for this. A meaningful appraisal on an annual basis (NHS minimum) brings everything together and provides the opportunity reflect on what has been achieved in the previous year, what has been learnt, agree new priorities, and agree support for the next year is also important. This process is optimised by regular interactions for feedback, progress updates, and reviews throughout the year via 121s or "supervision".

The Care Quality Commission (CQC) Regulation 18(2) (updated July 2022) states staff should "receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform."

UHS has a workforce KPI of 92% appraisal completion, measured on a 12 month annual rolling basis. There is an 8% threshold for a variety of absence reasons. Medical appraisals are managed under the requirements of the General Medical Council, a medical appraisal is required on an annual basis and reported separately to Agenda for Change (AfC) staff. The reporting mechanism is ESR, only appraisals recorded on ESR will be reported within UHS compliance figures.

The first appraisal date at UHS is 12 months after the start date and annually thereafter. This presents a challenge in terms of appraisal dates being spread across the year and ensuring personal objectives are aligned to annual business/divisional objectives at the start of each financial year.

2. Current situation

When considering impact and compliance we need to consider both quantitative data (the numbers of appraisals completed) vs qualitative data (the meaningfulness of the appraisal experience and the impact.)

[1] Pink, D. (2009). 'Drive,' New York: Riverhead Books.
[2] Employee engagement and NHS performance, Michael A West, Jeremy F Dawson (2012)

Figure 1 shows appraisal compliance between Sept 2020 and August 2022; the rolling 12 month compliance (black line) and the in-month completion (blue bar) vs the target of 92% (red dotted line).

The in-month appraisal completion fluctuates from Sept 2020 to date, we have met the target on two occasions in May and June 2022 (directly after the release of the new appraisal approach). However, it must be noted that during 2020/21 financial year all appraisals were stood down in the NHS nationally due to the Covid Pandemic, despite this we sustained around the 70-80% mark which is an achievement considering the circumstances.

Divisional data (Figure 2) for the same period indicates that Division D appears to have success in completing appraisals, and there is some fluctuation across other divisions and THQ.

Division A has been steadily improving since May 22 with the new appraisal system after a sharp decline in the 12 months prior.

In the annual NHS Staff Survey there are five questions specifically related to experience of appraisals, in 2021 the results for UHS trust wide were as follows:

- 81.9% of 6,733 people said they had received an appraisal in the previous 12 months.
- 22.3% said it helped improve how they do their job.
- 34% said it helped them to agree clear objectives for their work.
- 35% said it left them feeling valued by the organisation.

Figure 1 Appraisal completion Sept 2020 – Aug 2022

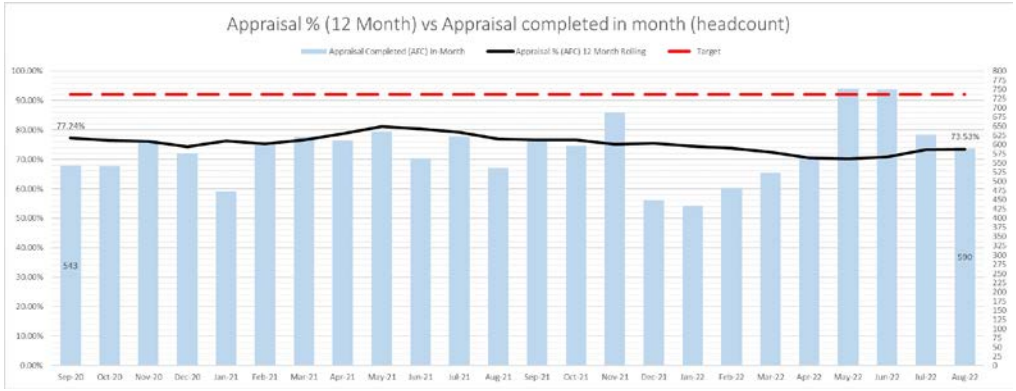
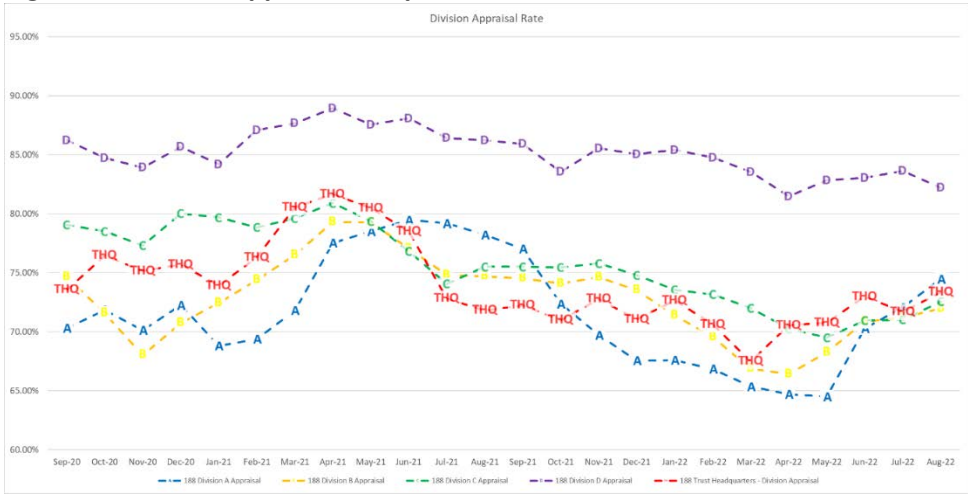


Figure 2 Divisional appraisal completion



The evidence in the staff survey data demonstrated that whilst we may be completing appraisals for the large majority of UHS staff, the quality and meaningfulness of the appraisal experience is not as we would expect.

Figure 3: Staff survey feedback

Locality 1		Comparator (Organisation Overall)	Div A	Div B	Div C	Div D	THQ
Q	Description	n = 6985	n = 1139	n = 1650	n = 1569	n = 1239	n = 1244
q19b	Appraisal helped me improve how I do my job	22.4%	23.0%	24.1%	17.0%	27.2%	22.1%
q19c	Appraisal helped me agree clear objectives for my work	34.3%	31.4%	34.2%	32.1%	36.7%	36.5%
q19d	Appraisal left me feeling organisation values my work	35.0%	31.1%	35.2%	31.5%	37.9%	39.0%

Divisional data correlates closely with the trust wide comparator in terms of low levels of experience in terms of meaningfulness of appraisal vs appraisal completion.

3. The response

Under the "Thrive" element of the UHS People Strategy 22-26 a commitment was made to refresh and relaunch the appraisal process. The aim is to optimise the appraisal experience, make it more meaningful and focussed on the individual. To strip out parts which don't belong in the appraisal conversation and keep it as simple as possible. It is anticipated the changes will increase trust and confidence in the process, and in turn increase meaningful participation.

As part of the People Strategy, the staff survey questions related to quality and meaningfulness of the appraisal experience will be key indicators of improvement. Due to timing between the launch of the new appraisal approach and the 2022 survey, we may not see an improvement in responses until the 2023 survey.

In January 2022 a working group was convened which consisted of representatives from across the organisation including Staffside, HR, staff network leads, operational managers, and clinical professional leaders to review the existing process, engage with staff, and co-design a new draft. In May 2022, UHS launched a new AfC appraisal approach using new paperwork. The new process seeks to put the appraisee at the heart of the process, and for them to lead the conversation, taking a more conversational approach.

The new appraisal document consists of 4 parts:

- Looking back on the last year
- Looking Forward
- Your Development and Wellbeing
- Career Planning.

Working with an industry partner we have developed training, resources, and guidance to help both appraisee and appraiser get the best out of the appraisal. The new training consists of 10 self-directed learning modules hosted on our Virtual Learning Environment (VLE).

All staff have started to use the new paperwork with immediate effect, however a pilot group of 402 staff has been identified to evaluate the new appraisal approach. The following groups are taking part in the pilot:

- All staff in roles 8B and above
- Porters
- All AfC staff on wards G8 and G9

The pilot group are also trialling the concept of an "appraisal period" whereby all appraisals are completed within a given timeframe.

Appraisal periods are used to ensure that appraisals, in particular objectives and investments in people as a result of appraisals, are aligned to the beginning of the financial year, and refresh of business plans. Other benefits are that it allows the appraisal completion to be monitoring and managed more concisely, and it provides clarity on expectation of timelines. The fluctuation of monthly completions on a rolling 12 month basis is eliminated due to the timeline approach where a sliding scale of monthly increases is expected across a smaller timeframe until the end of the appraisal period.

Appraisal periods can be challenging when there are large numbers of appraisals due in a condensed period. It is important in this circumstance that appraisals are delegated through the hierarchy appropriately using "appraisal trees" and pre planning in terms of time and responsibility is effective. A process which places the emphasis on the individual to lead the appraisal also supports the volume issue, lessening the potential burden on the manager/appraiser.

4. Next steps

- The pilot period will conclude at the end of September 2022, an evaluation and in depth analysis will take place with the 402 people in the pilot group. The outcome will be reported through the People Board, and People and OD Committee with any recommendations and actions required.
- Learning resources, training and development opportunities will continue to be developed and uploaded onto the appraisal hub (VLE) including coaching opportunities and support for appraisers to adopt the new approach.
- The trust wide Appraisal Group (representatives across the Trust) will continue to meet and develop phase 2 of the appraisal refresh programme.
- The VLE upgrade and rebrand is planned under the Talent Management workstream. This provides an opportunity to offer a digital appraisal option for those who wish to use it. This work commences in October 2022 and will be completed for launch on 1 April 2023.
- ESR as the mechanism for recording the appraisal remains a barrier. ESR data identified on average a 29 day lag between the appraisal conversation taking place and the recording on ESR. Anecdotal feedback from divisions suggests that appraisals take place but are not always recorded. Due to the

link between appraisal sign off and AfC pay awards, the appraisal MUST be recorded in ESR. However, the aim is to make recording simpler, quicker and easier to access, which in turn will enable us to reduce the risk of inaccurate records and untimely reporting. As part of the VLE upgrade scoping will identify if recording on the VLE could be simpler and quicker, and providing easier access (web access), with the ability to download monthly data sets into ESR records to fulfil the pay process. This method is used by other NHS organisations, and this will be explored as part of this project.

- Refresh eligibility criteria and reporting to ensure accuracy of expectation, only "counting" those who are eligible for an appraisal, removing those who are not eligible. For example, new starters are currently included in the criteria whereby new starters are not eligible for an appraisal within their first year of employment. This will improve our real time ability to meet the target.
- Continue to monitor the appraisal % completion KPI and the Staff Survey indicators related to quality of experience, report via People Report, Divisional Governance and People Governance Structures.

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

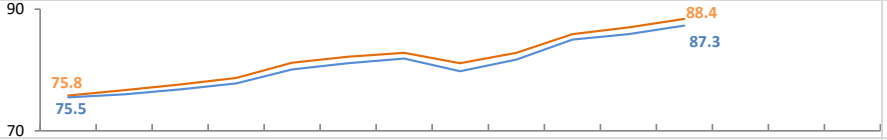
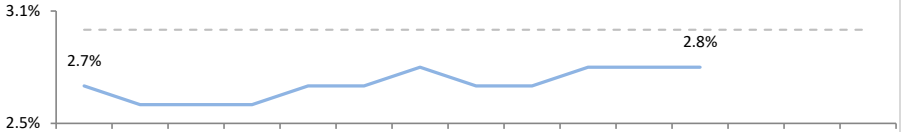
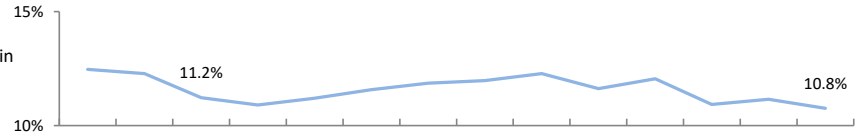
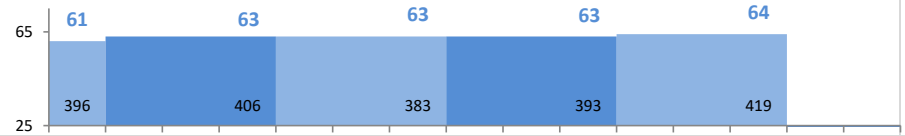
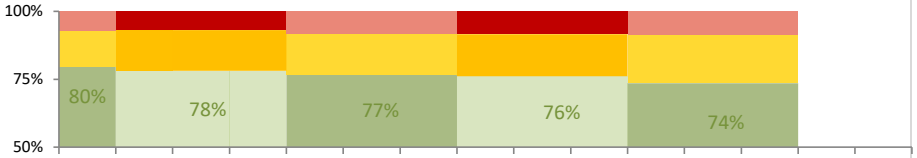
- All patients should receive high-quality care without any unnecessary delay
- Patients can expect to be treated at the right time and according to their clinical priority. Patients with urgent conditions, such as cancer, will be able to be seen and receive treatment more quickly

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.

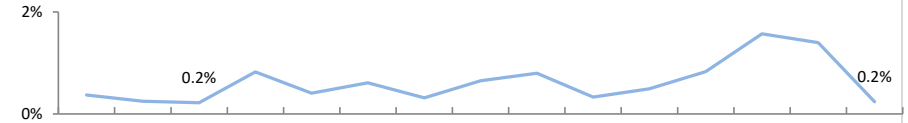
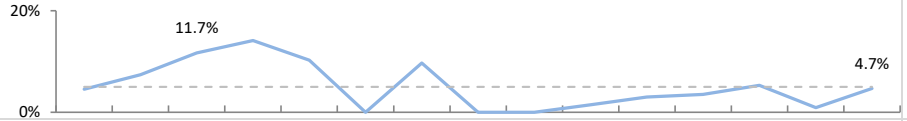
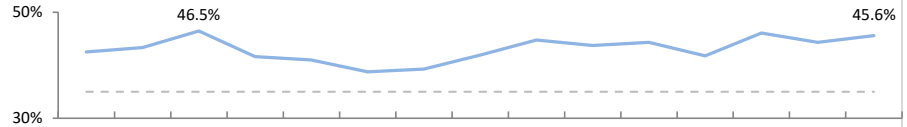
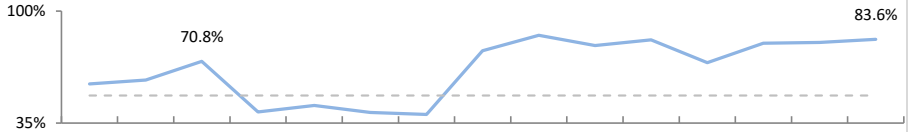
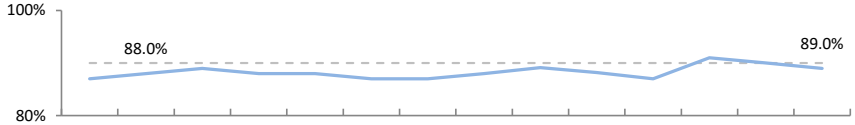
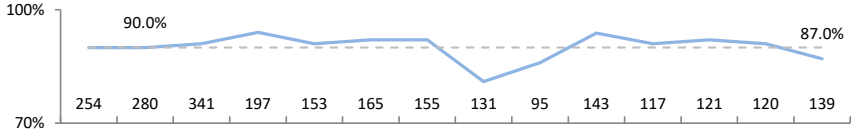
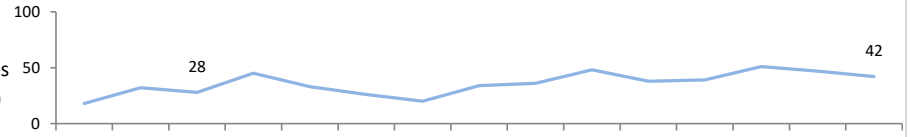
* https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england
** https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england

		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	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)	9	9	71.8%	10	10	10	9	8	6	5	5	3	4	4	65.3%	≥92%	66.3%
		8	8	7	9	9	8	8	8	8	7	7	7	6	6			
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)	15	16	16	17	17	14	16	12	13	13	13	15	14	8	90.6%	≥93%	86.9%
		5	81.9%	13	11	13	14	14	14	9	10	7	5	4	4	5		
UT34-N	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	13	70.7%	15	16	13	12	15	13	13	11	12	7	11	14	10	≥85%	74.4%
		6	7	7	2	4	5	3	4	4	2	3	5	6	5	69.8%		
UT25-N	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 16) South East average (& rank of 16)	4	5	76.7%	4	6	4	5	8	10	6	4	8	4	7	67.3%	≥95%	65.6%
		4	4	4	2	4	3	3	4	4	4	4	4	3	4	3		
UT33-N	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching Hospital average (& rank of 20) South East Average (& rank of 18)	12	9	10	10	10	9	7	6	7	7	7	7	6	7	24.8%	≤1%	23.5%
		17	16	20.8%	16	17	16	15	14	12	13	14	14	13	12	13		

Outcomes		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Monthly target	YTD	YTD target
UT1-N	HSMR - **UHS** HSMR - **SGH**																≤100	85.7	
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 May 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																-	11.3%	
		Q1 21-22		Q2 21-22			Q3 21-22			Q4 21-22			Q1 22-23				Quarterly target		
UT4-L	**Cumulative Specialties** with Outcome Measures Developed (Quarterly)																+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		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Monthly target	YTD	YTD target
UT6-N	Cumulative Clostridium difficile Most recent 12 Months vs. Previous 12 Months	3233	3939	4344	5049	5256	5564	5771	6374	7 9	1611	2118	2524	3332			≤5	32	≤25
UT7	**Healthcare-acquired COVID infection**: COVID-positive sample taken >14days after admission (validated)	0	3	0	7	6	11	21	20	14	42	36	23	47	45	2	-	153	-
UT8	**Probable hospital-associated COVID infection**: COVID-positive sample taken >7 days and <=14 days after admission (validated)	0	0	4	3	9	11	14	17	10	32	35	12	32	38	4	-	121	-
UT9	Pressure ulcers category 2 per 1000 bed days	0.51														0.10	<0.3	0.29	<0.3
UT10	Pressure ulcers category 3 and above per 1000 bed days	0.51														0.29	<0.3	0.40	<0.3
UT11-N	Medication Errors (severe/moderate)	2														2	≤3	11	≤15

		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Monthly target	YTD	YTD target
UT12	Watch & Reserve antibiotics, usage per 1,000 adms Most recent months vs. 2018*95.5%	2,511		2,502										2,949			2,511	8,329	8,200
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)			4												17	-	67	-
UT14	Serious Incidents Requiring Investigation - Maternity			0												0	-	5	-
UT15	Number of high harm falls per 1000 bed days			0.16												0.13	-	0.16	-
UT16	% patients with a nutrition plan in place (total checks conducted included at chart base)	782	606	691	755	787	444	397						53	742	572	≥90%	94.3%	≥90%
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			50												23	-	178	-

Patient Experience		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Monthly target	YTD	YTD target
UT18-N	FFT Negative Score - Inpatients																≤5%	1.0%	≤5%
UT19-N	FFT Negative Score - Maternity (postnatal ward)																≤5%	3.6%	≤5%
UT20	Total UHS women booked onto a continuity of carer pathway																≥35%	44.5%	≥35%
UT21	Total BAME women booked onto a continuity of carer pathway																≥51%	79.2%	≥51%
UT22	% Patients reporting being involved in decisions about care and treatment																≥90%	90.0%	≥90%
UT23	% Patients with a disability/ additional needs reporting those needs/adjustments were met (total number questioned included at chart base)																≥90%	89.3%	≥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)																-	217	-

Access Standards		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	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)	76.7%														67.3%	≥95%	64.7%	≥95%
UT26	Average (Mean) time in Dept - non-admitted patients	03:15														03:28	≤04:00	03:09	≤04:00
UT27	Average (Mean) time in Dept - admitted patients	04:29														05:15	≤04:00	05:07	≤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)	71.8%														65.3%	≥92%	66.3%	≥92%
UT29	Total number of patients on a waiting list (18 week referral to treatment pathway)	43,501														52,188	-	52,188	-
UT30	Patients on an open 18 week pathway (waiting 52 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	2,245														2,469	2,011	2,469	2,011

		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	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)	111	12	9	8	8	8	8	8	8	6	8	5	6	6	6		6	0
		17	18	17	17	17	17	17	17	17	17	17	13	13	13				
UT32	Patients waiting for diagnostics	9,152														10,419	-	10,419	-
UT33-N	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	20.8%	12	9	10	10	10	9	7	6	7	7	7	7	6	7	≤1%	23.5%	≤1%
		17	16	16	17	16	15	14	12	13	14	14	13	12	13	24.8%			
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)	70.7%	13	15	16	13	12	15	13	13	11	12	7	11	14	10	≥85%	68.9%	≥85%
		6	7	7	2	4	5	3	4	4	2	3	5	6	5	69.8%			
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)	96.1%	17	13	16	18	9	9	11	12	14	16	14	16	15	15	≥96%	91.1%	≥96%
		8	6	13	15	3	3	2	5	6	14	9	12	8	10	92.4%			
UT36-N	31 day cancer wait performance - Subsequent Treatments of Cancer (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	95.3%	15	17	13	18	14	16	15	11	14	15	13	9	12	13	≥96.0%	89.9%	≥96.0%
		13	14	10	17	13	15	16	8	11	8	15	10	10	13	89.7%			

R&D Performance		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Monthly target	YTD	YTD target
PN1-L	Comparative CRN Recruitment Performance - non-weighted	10	9	10	9	9	9	8	9	8	9	1	1	3	4	5	Top 10	-	-
PN2-L	Comparative CRN Recruitment Performance - weighted	5	3	4	3	3	3	3	4	4	3	6	8	11	7	7	Top 5	-	-
PN3-L	Comparative CRN Recruitment - contract commercial	12	11	4	4	3	7	7	8	9	10	2	1	3	2	3	Top 10	-	-
PN4-L	Achievement compared to R+D Income Baseline Monthly income increase % YTD income increase %	152.0%	45.0%	143.0%	73.0%	334.0%	-5.0%	0.0%	29.0%	-234.0%	143.0%	359.0%	63.0%	74.0%	65.0%	177.0%	93.7%	93.0%	≥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		Monthly target	YTD	YTD target
WR1-L	Substantive Staff - Turnover **-R12M turnover %** **-Leavers in month (FTE)**	R12M <= 12.0%	15.0%	-
WR2-L	Staff Vacancies **-Nursing vacancies** (registered nurses only in clinical wards) **-All Staff vacancies**	-	-	-
WR3-L	Workforce Numbers (WTE) **-Planned monthly growth in Staff in post** **-Actual monthly growth in Staff in post** *-Including - Doctors in training.* *-Excluding - Chilworth laboratory, Additional hours (medical staff), Bank and agency* *- Substantive SIP only* ** monthly growth is based on a baseline of March 22*	478.1 WTE by March 2023	-	-
WR4-L	Staff - Sickness absence **-R12M sickness %** **-Sickness in month %**	R12M <= 3.4%	4.9%	-

Excel		Monthly target	YTD	YTD target
WR5-L	Non-medical appraisals completed **-R12M appraisal %** **-Appraisals in month**	R12M >= 92.0%	72.5%	-
WR6-L	Medical staff appraisals completed - Rolling 12-months	-	-	-

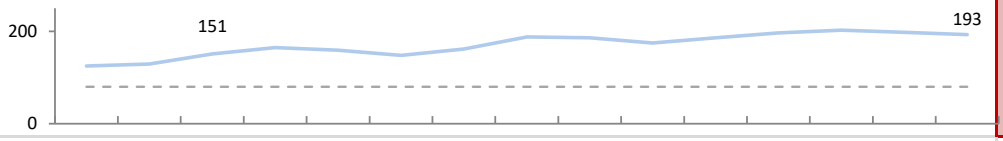
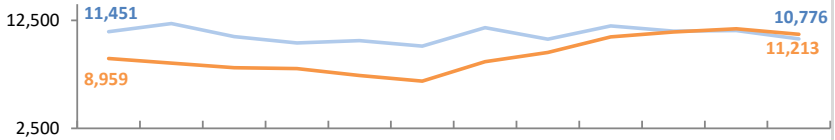
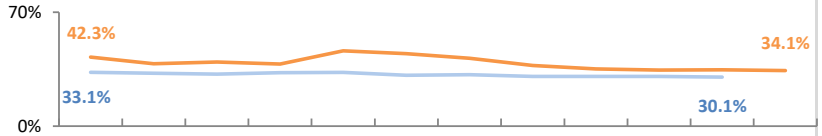
		Q2 21-22	Q3 21-22	Q4 21-22	Q1 22-23	Q2 22-23	Quarterly target		
WR7-L	Staff recommend UHS as a place to work score: National Quarterly Pulse Survey (NQPS) **National NHS Staff Survey**	7.3	7.1	7.24	7.05	6.96	-	-	-
WR7-L - Metric has changed from The Friends and Family Test (%, Q4 2020) to the Pulse Survey (out of 10).									
WR8-L	Staff survey engagement score National Quarterly Pulse Survey (NQPS) **National NHS Staff Survey**	7.21	7.2	7.17	7.08	7.03	-	-	-
WR8-L - Maximum score = 10, Average of "Acute and Acute&Community", group is 7.									

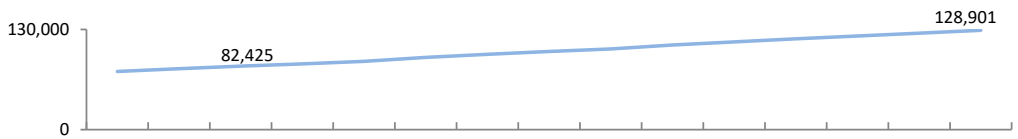
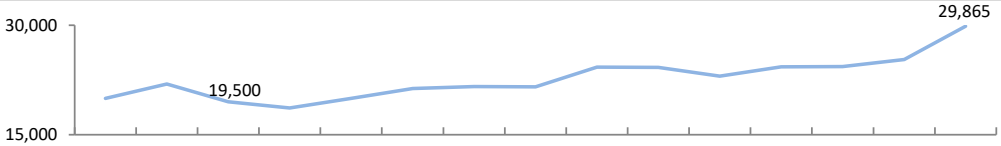
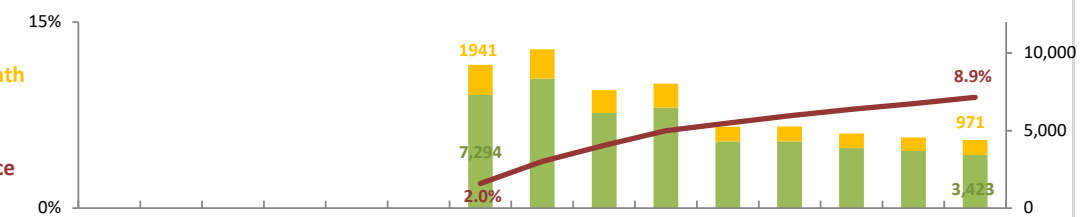
Belong		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Monthly target	YTD	YTD target
WR9-L	% of Band 7+ staff who are Black and Minority Ethnic			10.4%												10.7%	19% by 2026	10.6%	-
WR10	% of Band 7+ Staff who have declared a disability or long term health condition			13.7%												13.4%	-	-	-

		Q2 21-22	Q3 21-22	Q4 21-22	Q1 22-23	Q2 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 7.18	7.36 7.14	7.44 7.12	7.30 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	7.03 7.25	6.90 7.30	7.02 7.18	6.90 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	6.90 7.25	7.00 7.20	6.87 7.19	6.81 7.08	6.62 7.05	-	-	-

WR11, WR12,WR13: Average recommendation score of 10 = Highly recommend to 0 = Strongly not recommended, results from National Quarterly Pulse Survey.

		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Monthly target	YTD	YTD target
FN6	Percentage of staff living locally (inside the Southampton City boundaries)			52.8%												53.5%	-	-	-
FN7	Percentage of staff residing in deprived areas (lowest 30% - national Index of Multiple Deprivation)															24.6%	-	-	-

Local Integration		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Monthly target	YTD	YTD target
NT1	Number of inpatients that were medically optimised for discharge (monthly average)																≤80	195	-
NT2	Emergency Department activity - type 1 This year vs. last year																-	56,578	-
NT3	Percentage of virtual appointments as a proportion of all outpatient consultations This year vs. last year																≥25%	30.4%	≥25%

Digital		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Monthly target	YTD	YTD target
FN1	My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month)																-	128,901	
FN2	My Medical Record - UHS patient logins (number of logins made within each month)																-	126,780	
FN3	Patients choosing digital correspondence - Total choosing paperless in the month - Total offered but not yet choosing paperless in the month - % of total My Medical Record service users who have chosen paperless (cumulative)																-		
FN4	Reduction in transcription through implementation of voice recognition software	In development															-		

Report notes - Nursing and midwifery staffing hours - August 2022

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

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

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

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

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

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

Throughout COVID-19, a growing number of our clinical areas started to move and change specialty and size to respond to the changing situation (e.g. G5-G9, Critical Care and C5). With the evolving COVID-19 position, these wards had in the main returned to their normal size and purpose. Over the last few months COVID-19 numbers again increased so wards and departments have 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. August has seen a decrease in the number of beds required to support COVID-19 and therefore ward configurations are expected to gradually start to return to normal.

Wards Full Name		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered midwives/ nurses	CHPPD Care Staff	CHPPD Overall	Comments
CC Neuro Intensive Care Unit	Day	5201	4782	704	620	91.9%	88.0%	28.8	3.6	32.4	Safe staffing levels maintained; Staff moved to support other wards.
CC Neuro Intensive Care Unit	Night	5182	4814	707	575	92.9%	81.3%				Safe staffing levels maintained; Staff moved to support other wards.
CC - Surgical HDU	Day	2175	1876	705	528	86.2%	74.8%	17.3	4.8	22.1	Safe staffing levels maintained; Staff moved to support other wards.
CC - Surgical HDU	Night	2140	1775	687	480	83.0%	69.9%				Safe staffing levels maintained; Staff moved to support other wards.
CC General Intensive Care	Day	10994	10630	1879	1378	96.7%	73.3%	28.1	3.7	31.8	Safe staffing levels maintained; Staff moved to support other wards.
CC General Intensive Care	Night	10663	10103	1768	1378	94.7%	78.0%				Safe staffing levels maintained; Staff moved to support other wards.
CC Cardiac Intensive Care	Day	6006	4571	1445	831	76.1%	57.5%	30.4	4.8	35.2	Safe staffing levels maintained; Staff moved to support other wards.
CC Cardiac Intensive Care	Night	6023	4649	848	621	77.2%	73.2%				Safe staffing levels maintained; Staff moved to support other wards.
SUR E5 Lower GI	Day	1463	1272	877	965	86.9%	110.0%	3.8	3.3	7.2	Safe staffing levels maintained by sharing staff resource; Increased night staffing to support raised acuity; Support workers used to maintain staffing numbers.
SUR E5 Lower GI	Night	713	663	346	735	93.0%	212.7%				Safe staffing levels maintained by sharing staff resource; Increased night staffing to support raised acuity; Support workers used to maintain staffing numbers.
SUR E5 Upper GI	Day	1510	1257	1031	1134	83.2%	110.0%	4.3	3.9	8.2	Safe staffing levels maintained by sharing staff resource; Increased night staffing to support raised acuity; Support workers used to maintain staffing numbers.
SUR E5 Upper GI	Night	725	753	345	678	103.9%	196.8%				Safe staffing levels maintained by sharing staff resource; Increased night staffing to support raised acuity; Support workers used to maintain staffing numbers.
SUR E8 Ward	Day	2602	2026	1439	1492	77.9%	103.7%	4.3	3.3	7.7	Staff moved to support other wards; Support workers used to maintain staffing numbers.
SUR E8 Ward	Night	1721	1246	1218	1037	72.4%	85.1%				Staff moved to support other wards; Support workers used to maintain staffing numbers.
SUR F11 IF	Day	1918	1596	770	873	83.2%	113.3%	4.5	3.1	7.6	Safe staffing levels maintained.
SUR F11 IF	Night	713	713	699	713	100.0%	102.0%				Safe staffing levels maintained.
SUR Acute Surgical Unit	Day	1486	913	739	795	61.5%	107.6%	7.0	5.4	12.4	Staff moved to support other wards.
SUR Acute Surgical Unit	Night	715	722	699	479	101.0%	68.5%				Staff moved to support other wards.
SUR Acute Surgical Admissions	Day	2196	1995	854	1096	90.8%	128.3%	3.9	2.8	6.7	Safe staffing levels maintained; Increased night staffing to support raised acuity.
SUR Acute Surgical Admissions	Night	1069	1032	1052	1113	96.5%	105.8%				Safe staffing levels maintained; Increased night staffing to support raised acuity.
SUR F5 Ward	Day	1900	1528	1018	1199	80.5%	117.7%	3.6	2.5	6.1	Support workers used to maintain staffing numbers.
SUR F5 Ward	Night	1168	1139	676	680	97.5%	100.7%				Safe staffing levels maintained.
OPH Eye Short Stay Unit	Day	1080	1164	893	851	107.8%	95.3%	20.9	16.5	37.5	Safe staffing levels maintained.
OPH Eye Short Stay Unit	Night	341	341	324	341	100.0%	105.2%				Safe staffing levels maintained. Minimal overnight patients
THR F10 Surgical Day Unit	Day	1463	1370	2700	2299	93.6%	85.2%	4.0	6.1	10.1	Safe staffing levels maintained by sharing staff resource; Staff moved to support other wards.
THR F10 Surgical Day Unit	Night	300	496	280	553	165.2%	197.7%				Increased night staffing to support raised acuity; Continues to be utilised as an inpatient ward, regularly 18 pts overnight.
CAN Acute Onc Services	Day	950	925	661	700	97.4%	105.9%	7.5	7.0	14.5	Safe staffing levels maintained; Increase in acuity/dependency of patients in the month.
CAN Acute Onc Services	Night	358	610	357	737	170.6%	206.7%				Increased night staffing to support raised acuity; Increased night staffing to support raised acuity.
CAN C4 Solent Ward Clinical Oncology	Day	1745	1561	1029	1292	89.5%	125.6%	4.3	4.3	8.6	Safe staffing levels maintained by sharing staff resource; Increase in acuity/dependency of patients in the month.

Wards Full Name		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered midwives/ nurses	CHPPD Care Staff	CHPPD Overall	Comments
CAN C4 Solent Ward Clinical Oncology	Night	1069	845	712	1143	79.0%	160.6%				Safe staffing levels maintained by sharing staff resource; Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
CAN C6 Leukaemia/BMT Unit	Day	2852	2598	49	700	91.1%	1443.4%	7.1	1.7	8.8	Safe staffing levels maintained; Increase in acuity/dependency of patients in the month additional support workers used to support.
CAN C6 Leukaemia/BMT Unit	Night	2053	1881	0	349	91.6%	Shift N/A				Safe staffing levels maintained.
CAN C6 TYA Unit	Day	1257	915	475	78	72.8%	16.4%	9.2	0.5	9.6	Safe staffing levels maintained by sharing staff resource.
CAN C6 TYA Unit	Night	674	642	0	0	95.3%	Shift N/A				Safe staffing levels maintained.
CAN C2 Haematology	Day	2326	2491	1184	996	107.1%	84.1%	5.4	2.7	8.1	Increase in acuity/dependency of patients in the month; Safe staffing levels maintained by sharing staff resource.
CAN C2 Haematology	Night	1783	1810	1066	1143	101.5%	107.3%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAN D3 Ward	Day	1792	1801	801	1187	100.5%	148.2%	4.5	3.5	8.0	Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAN D3 Ward	Night	1063	1094	708	1097	102.9%	154.9%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
ECM Acute Medical Unit	Day	4066	4329	3867	4057	106.4%	104.9%	6.3	5.6	11.9	Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource; Figures still contain additional point-of-care activity and Clinical Coordination - this will be correct from 21/11/22.
ECM Acute Medical Unit	Night	4031	4335	3537	3728	107.5%	105.4%				Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource; Figures still contain additional point-of-care activity and Clinical Coordination - this will be correct from 21/11/22.
MED D5 Ward	Day	1215	1467	1747	1474	120.8%	84.4%	3.0	3.2	6.2	Staff moved to support other wards; Safe minimum staffing levels maintained.
MED D5 Ward	Night	1070	1001	925	1136	93.6%	122.7%				Patient requiring 24 hour 1:1 nursing in the month; Support workers used to maintain staffing numbers.
MED D6 Ward	Day	986	1425	1658	1234	144.5%	74.5%	3.4	3.1	6.5	Skill mix swaps undertaken to support safe staffing across the Unit; Band 4 staff working to support registered nurse numbers.
MED D6 Ward	Night	1025	1006	900	972	98.1%	108.0%				Support workers used to maintain staffing numbers; Safe staffing levels maintained by sharing staff resource.
MED D7 Ward	Day	737	663	1306	1169	89.9%	89.5%	3.1	3.8	6.9	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
MED D7 Ward	Night	713	699	689	539	98.0%	78.2%				Safe staffing levels maintained.
MED D8 Ward	Day	1070	1133	1420	1300	105.9%	91.6%	2.9	3.0	5.9	Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month.
MED D8 Ward	Night	1071	969	931	853	90.4%	91.6%				Safe staffing levels maintained.
MED D9 Ward	Day	1300	1319	1691	1555	101.5%	92.0%	2.5	3.0	5.5	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
MED D9 Ward	Night	1070	828	929	955	77.4%	102.7%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month.
MED E7 Ward	Day	1144	1094	1353	1587	95.7%	117.3%	2.6	3.7	6.3	Safe staffing levels maintained.
MED E7 Ward	Night	713	955	757	1285	133.9%	169.9%				Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month.
MED F7 Ward	Day	742	839	1315	1110	113.0%	84.4%	2.6	3.0	5.5	Band 4 staff working to support registered nurse numbers; Increase in acuity/dependency of patients in the month.
MED F7 Ward	Night	714	725	687	683	101.6%	99.3%				Safe staffing levels maintained.
MED Respiratory HDU	Day	2353	1475	488	299	62.7%	61.2%	14.7	2.7	17.4	Staffing appropriate for number of patients; Level 2 (high care) admitting capacity reviewed on number of available staff.
MED Respiratory HDU	Night	2143	1511	330	241	70.5%	73.1%				Staffing appropriate for number of patients; Skill mix swaps undertaken to support safe staffing across the Unit; Level 2 (high care) admitting capacity reviewed on number of available staff.
MED C5 Isolation Ward	Day	1163	973	1236	392	83.7%	31.7%	6.4	3.0	9.3	Staffing appropriate for number of patients; Skill mix swaps undertaken to support safe staffing across the Unit.
MED C5 Isolation Ward	Night	1070	817	329	437	76.3%	133.0%				Staffing appropriate for number of patients; Skill mix swaps undertaken to support safe staffing across the Unit.
MED D10 Isolation Unit	Day	1195	848	1349	1265	70.9%	93.8%	3.0	4.1	7.1	Safe staffing levels maintained.
MED D10 Isolation Unit	Night	713	727	684	851	101.9%	124.3%				Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month.
MED G5 Ward	Day	1432	1194	1442	1492	83.4%	103.5%	2.7	2.9	5.6	Additional staff used for enhanced care - RNs; Band 4 staff working to support registered nurse numbers; Increase in acuity/dependency of patients in the month.
MED G5 Ward	Night	1070	990	683	926	92.6%	135.5%				Additional staff used for enhanced care - RNs; Safe staffing levels maintained by sharing staff resource.
MED G6 Ward	Day	1452	1260	1456	1252	86.8%	86.0%	2.7	2.8	5.5	Band 4 staff working to support registered nurse numbers; Staff moved to support other wards.
MED G6 Ward	Night	1070	874	682	898	81.7%	131.7%				Safe staffing levels maintained by sharing staff resource.
MED G7 Ward	Day	723	666	969	777	92.1%	80.1%	4.3	4.0	8.3	Staff moved to support other wards; Safe staffing levels maintained.
MED G7 Ward	Night	713	656	325	426	91.9%	131.1%				Skill mix swaps undertaken to support safe staffing across the Unit; Staff moved to support other wards.
MED G8 Ward	Day	1463	1170	1468	1470	80.0%	100.2%	2.5	3.1	5.6	Band 4 staff working to support registered nurse numbers.
MED G8 Ward	Night	1070	771	680	932	72.0%	137.0%				Safe staffing levels maintained by sharing staff resource.
MED G9 Ward	Day	1446	1176	1415	1378	81.3%	97.4%	2.7	2.8	5.5	Band 4 staff working to support registered nurse numbers.

Wards Full Name		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered midwives/ nurses	CHPPD Care Staff	CHPPD Overall	Comments
MED G9 Ward	Night	1070	955	656	840	89.2%	128.0%				Safe staffing levels maintained by sharing staff resource.
MED Bassett Ward	Day	1351	846	2462	2003	62.6%	81.4%	2.1	4.2	6.3	Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month.
MED Bassett Ward	Night	1070	840	1035	1287	78.5%	124.4%				Patient requiring 24 hour 1:1 nursing in the month.
CHI High Dependency Unit	Day	1617	1074	0	205	66.4%	Shift N/A	14.4	1.5	15.9	Non-ward based staff supporting areas; Beds flexed to match staffing; Safe staffing levels maintained.
CHI High Dependency Unit	Night	1070	1043	0	23	97.5%	Shift N/A				Safe staffing levels maintained.
CHI Paed Medical Unit	Day	1993	1841	678	1233	92.4%	181.8%	9.2	5.5	14.7	Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers.
CHI Paed Medical Unit	Night	1705	1813	623	958	106.3%	153.7%				Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers.
CHI Paediatric Intensive Care	Day	6253	5435	1227	327	86.9%	26.7%	27.9	2.1	30.0	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
CHI Paediatric Intensive Care	Night	5702	5117	871	468	89.7%	53.7%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
CHI Piam Brown Unit	Day	3881	2693	1042	431	69.4%	41.4%	12.6	2.3	14.9	Beds flexed to match staffing; Non-ward based staff supporting areas; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing maintained.
CHI Piam Brown Unit	Night	1426	1049	674	253	73.5%	37.5%				Beds flexed to match staffing; Safe staffing levels maintained; Safe staffing levels maintained by sharing staff resource.
CHI Ward E1 Paed Cardiac	Day	2179	1423	654	575	65.3%	88.0%	6.3	2.4	8.7	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing.
CHI Ward E1 Paed Cardiac	Night	1405	1357	317	502	96.5%	158.5%				Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers.
CHI Bursledon House	Day	843	333	576	257	39.5%	44.6%	5.9	4.9	10.8	Beds flexed to match staffing; Safe staffing levels maintained.
CHI Bursledon House	Night	209	110	168	110	52.6%	65.5%				Beds flexed to match staffing; Safe staffing levels maintained.
CHI Ward G2 Neuro	Day	815	662	891	183	81.2%	20.5%	7.3	1.1	8.4	Non-ward based staff supporting areas; Safe staffing levels maintained.
CHI Ward G2 Neuro	Night	705	692	702	24	98.2%	3.4%				Safe staffing levels maintained.
CHI Ward G3	Day	2409	1869	1742	910	77.6%	52.2%	6.6	3.1	9.8	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
CHI Ward G3	Night	1705	1258	980	574	73.8%	58.5%				Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Safe staffing levels maintained.
CHI Ward G4 Surgery	Day	2523	1965	1201	858	77.9%	71.4%	6.8	2.9	9.7	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
CHI Ward G4 Surgery	Night	1651	1356	606	529	82.1%	87.4%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
W&N Bramshaw Womens Unit	Day	1133	993	661	744	87.6%	112.4%	4.8	3.5	8.3	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
W&N Bramshaw Womens Unit	Night	771	725	622	506	94.0%	81.4%				Safe staffing levels maintained; Beds flexed to match staffing.
W&N Neonatal Unit	Day	6402	5064	2116	1194	79.1%	56.4%	10.8	2.4	13.2	Safe staffing levels maintained..
W&N Neonatal Unit	Night	5096	4189	1651	891	82.2%	54.0%				Safe staffing levels maintained..
W&N PAH Maternity Service combined	Day	10608	8776	3549	3148	82.7%	88.7%	10.3	3.3	13.7	Safe staffing levels maintained..
W&N PAH Maternity Service combined	Night	6731	5297	1609	1397	78.7%	86.8%				Safe staffing levels maintained..
CAR CHDU	Day	5066	4244	1787	1295	83.8%	72.5%	15.3	4.5	19.8	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
CAR CHDU	Night	3906	3800	983	1080	97.3%	109.8%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAR Coronary Care Unit	Day	2664	2751	949	1012	103.3%	106.7%	10.2	3.7	14.0	Safe staffing levels maintained by sharing staff resource; Additional staff used for enhanced care - Support workers.
CAR Coronary Care Unit	Night	2389	2345	805	847	98.2%	105.2%				Safe staffing levels maintained; Safe staffing levels maintained.
CAR Ward D4 Vascular	Day	1963	1581	1174	1280	80.5%	109.1%	4.1	3.4	7.5	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
CAR Ward D4 Vascular	Night	1045	1097	968	941	105.0%	97.2%				Safe staffing levels maintained; Safe staffing levels maintained.
CAR Ward E2 YACU	Day	1620	1340	861	981	82.7%	113.9%	4.1	3.6	7.7	Staff moved to support other wards; Additional staff used for enhanced care - Support workers.
CAR Ward E2 YACU	Night	715	694	626	781	97.1%	124.8%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAR Ward E3 Green	Day	1544	1515	1394	1156	98.1%	82.9%	3.4	3.0	6.4	Safe staffing levels maintained; Skill mix swaps undertaken to support safe staffing across the Unit.
CAR Ward E3 Green	Night	715	825	966	917	115.4%	94.9%				Safe staffing levels maintained; Safe staffing levels maintained; ; Twilight RN supplementing.
CAR Ward E3 Blue	Day	1624	1429	903	973	88.0%	107.8%	4.1	3.5	7.6	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.

Wards Full Name		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered midwives/ nurses	CHPPD Care Staff	CHPPD Overall	Comments
CAR Ward E3 Blue	Night	715	721	591	870	100.8%	147.3%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
CAR Ward E4 Thoracics	Day	1539	1379	1389	1250	89.6%	90.0%	4.2	3.2	7.5	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
CAR Ward E4 Thoracics	Night	1353	1026	425	600	75.9%	141.1%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
CAR Ward D2 Cardiology	Day	1386	1008	691	1046	72.8%	151.3%	3.8	4.2	8.0	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
CAR Ward D2 Cardiology	Night	704	645	628	770	91.6%	122.6%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
NEU Acute Stroke Unit	Day	1491	1457	2616	2520	97.8%	96.3%	2.8	5.0	7.8	Safe staffing levels maintained.
NEU Acute Stroke Unit	Night	1023	925	1646	1787	90.4%	108.6%				Band 4 staff working to support registered nurse numbers.
NEU Regional Transfer Unit	Day	1200	958	364	352	79.8%	96.8%	10.9	5.8	16.7	Band 4 staff working to support registered nurse numbers.
NEU Regional Transfer Unit	Night	682	616	621	495	90.3%	79.7%				Skill mix swaps undertaken to support safe staffing across the Unit.
NEU ward E Neuro	Day	1875	1620	1111	1933	86.4%	173.9%	3.8	4.7	8.5	Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month.
NEU ward E Neuro	Night	1377	1312	962	1650	95.3%	171.7%				Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month.
NEU HASU	Day	1543	1313	390	493	85.1%	126.3%	7.3	3.3	10.6	Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month.
NEU HASU	Night	1365	1003	278	539	73.4%	193.9%				Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month.
NEU Ward D Neuro	Day	1876	1817	1856	1729	96.8%	93.1%	3.9	4.1	8.0	Safe staffing levels maintained.
NEU Ward D Neuro	Night	1365	1343	1618	1561	98.4%	96.4%				Safe staffing levels maintained.
SPI Ward F4 Spinal	Day	1548	1500	1119	1563	96.9%	139.7%	3.8	4.0	7.9	Patient requiring 24 hour 1:1 nursing in the month.
SPI Ward F4 Spinal	Night	1012	1001	956	1074	98.9%	112.4%				Patient requiring 24 hour 1:1 nursing in the month.
T&O Ward Brooke	Day	1065	1046	1068	924	98.2%	86.6%	3.3	3.6	6.9	Safe staffing levels maintained; Staff moved to support other wards.
T&O Ward Brooke	Night	713	713	946	989	100.0%	104.5%				Additional staff used for enhanced care - Support workers; Safe staffing levels maintained.
T&O Trauma Admissions Unit	Day	927	808	745	638	87.1%	85.6%	9.0	8.3	17.3	Additional staff used for enhanced care - Support workers; Safe staffing levels maintained; Staff moved to support other wards.
T&O Trauma Admissions Unit	Night	684	577	615	628	84.3%	102.0%				Safe staffing levels maintained; Staff moved to support other wards.
T&O Ward F1 Major Trauma Unit	Day	2357	2302	1886	2130	97.7%	112.9%	4.3	4.4	8.6	Patient requiring 24 hour 1:1 nursing in the month; Additional staff used for enhanced care - RNs; Staff moved to support other wards.
T&O Ward F1 Major Trauma Unit	Night	1783	1717	1715	1990	96.3%	116.0%				Patient requiring 24 hour 1:1 nursing in the month; Additional staff used for enhanced care - RNs; Staff moved to support other wards.
T&O Ward F2 Trauma	Day	1651	1188	1899	2335	71.9%	122.9%	2.7	5.2	7.9	Patient requiring 24 hour 1:1 nursing in the month; Additional staff used for enhanced care - Support workers; Staff moved to support other wards.
T&O Ward F2 Trauma	Night	1024	828	1295	1641	80.8%	126.7%				Patient requiring 24 hour 1:1 nursing in the month; Additional staff used for enhanced care - Support workers; Skill mix swaps undertaken to support safe staffing across the Unit.
T&O Ward F3 Trauma	Day	1608	1628	1900	2114	101.3%	111.2%	3.6	5.3	8.9	Patient requiring 24 hour 1:1 nursing in the month; Additional staff used for enhanced care - Support workers; Staff moved to support other wards.
T&O Ward F3 Trauma	Night	1024	936	1635	1730	91.4%	105.8%				Patient requiring 24 hour 1:1 nursing in the month; Additional staff used for enhanced care - Support workers; Staff moved to support other wards.
T&O Ward F4 Elective	Day	1381	1292	776	757	93.5%	97.5%	3.6	3.0	6.7	Patient requiring 24 hour 1:1 nursing in the month; Additional staff used for enhanced care - Support workers; Safe staffing levels maintained by sharing staff resource.
T&O Ward F4 Elective	Night	682	672	953	882	98.5%	92.5%				Patient requiring 24 hour 1:1 nursing in the month; Additional staff used for enhanced care - Support workers; Safe staffing levels maintained by sharing staff resource.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Finance Report 2022-23 Month 5**			
Agenda item:	**5.5**			
Sponsor:	**Ian Howard – Chief Financial Officer**			
Author:	**Philip Bunting – Director of Operational Finance**			
Date:	**29 September 2022**			
Purpose	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** X
Issue to be addressed:	The finance report provides a monthly summary of the key financial information for the Trust.			
Response to the issue:	**M5 Financial Position** UHS reported a deficit of £2.9m in August 2022, which is now an £11.7m deficit YTD. This is £6.3m adverse to plan across the first five months of 2022/23 for which a £5.3m deficit was planned. **Underlying Position** The in-month position was distorted by several significant adjustments for which one has impacted prior months reported underlying positions. Firstly, a VAT review has been completed with support from external advisors and identified a benefit of £2.5m relating to 2021/22. This has been accounted for in full in August. The learning from this review is currently being implemented by the finance team to make sure any ongoing adjustments are made to VAT treatment in real time. The recurrent benefit has yet to be quantified, however. Secondly a spike in homecare drugs costs (within our block contract) was reported that relates predominantly to backdated charges from the previous three months totalling £0.4m per month across May to July (£1.2m in total backdated). This backdated cost has been reported in August with a further upward adjustment to the in-month position of £0.4m also now reported. This issue is being investigated by the finance team and pharmacy with processes being put into place to try and avoid this happening in future. Thirdly £0.6m of other one-off costs were incurred that have been removed from the reported underlying position. The true underlying position for M5 is therefore a £3.6m deficit. The previous three months have also been restated as £3.3m deficit per month (up from the £2.9m previously reported). The reason for the £0.3m increase from July to August is the emergence of further energy cost increases that are discussed below in more detail.			

The underlying position can therefore be restated as £16.5m deficit YTD. This is £11.2m adverse to the plan for months 1 to 5 (£5.3m planned deficit).

Key drivers

The key drivers for the underlying deficit to plan are as follows:

- Covid costs continuing in excess of plan by £3.7m YTD – although improving in August staff sickness absence backfill costs remain above planned levels in addition Covid related critical care and ED costs.
- Operational Pressures / Emergency Demand – ED continues to experience volumes in excess of planned levels driving up expenditure especially on premium rate staffing. The emergency department is £2m over budget YTD.
- Energy costs / inflationary pressures – energy costs are £0.5m ahead of plan YTD with costs further increasing from 21/22 exit run rate levels. Costs are forecast to increase further in the winter period as discussed below.
- Cost Improvement Plans – due to the considerable operational pressures the development of plans has been delayed. Delivery has however significantly improved in M5 with £12.1m now reported against a plan of £12.9m. The shortfall of £0.8m has however generated an equivalent adverse variance to plan. £9m of achievement YTD should be noted as non-recurrent.
- Elective Recovery Funding – although income has been accrued relating to ERF, minimal financial margin is estimated to have been generated given funding is only remunerated at 75% of tariff. A marginal upside of £1m had been anticipated YTD that has not been achieved.

Further to this £7m of non-recurrent one-off upsides were factored into the plan (£0.6m per month; £3m YTD) that has been omitted from the reported underlying position and was an anticipated gap.

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

- CCG Block Drugs overperformance – £0.6m per month. This continues to be monitored; however, there are no immediate funding solutions for this. Much of the pressure relates to homecare growth for long term conditions that has supported reduced inpatient or outpatient attendances freeing up capacity for priority 1 work.
- Energy costs - £0.8m per month. Although excess inflationary funding has been added to contract envelopes, this doesn't cover exceptional items like energy that had a bigger proportional impact on UHS due to our reliance on gas and end of fixed-rate deals. As stated above this pressure has increased further in 2022/23 with additional detail provided below.

Elective Recovery Framework

UHS achieved 101% in August when measured against the ERF metric. This is slightly down from July where 104% was achieved. August however typically sees a reduction in activity due to increased annual leave therefore

this is not thought to be a signal of reduced recurrent achievement.

The 101% included:

- 98% in elective
- 106% in outpatients (including procedures but excluding follow-ups)
- Capped 85% in follow-ups, with actual activity at 123%

Delivery below 104% means no additional income has been generated and a reduction to the YTD assessment of income has been applied recognising YTD achievement at 106% down from 107% the previous month.

Overall, the YTD activity level being at the planned level of 106% is an extremely positive indication of potential achievement across 2022/23 despite continuing operational pressures and increased ED demand. Year to date Income of £3.8m relating to ERF has been included in the financial position with a downward adjustment of £0.2m on previous months calculations.

It should be observed that increased activity above 19/20 baselines has in part been delivered at additional cost, especially with regards to clinical supplies and variable pay costs associated with the additional activity. At 75% payment the marginal financial gains are minimal, however the benefit to waiting lists and reduced risk of harm for patients waiting is of significant benefit mitigating future costs of treatment.

It should be noted that some uncertainty remains over national calculations of performance. Data has now been received for April and May; however, this is still being reviewed and is only representative of ICS performance and does not include NHS England activity. It is therefore too early to assess its reliability. Discussions continue at ICS level about the mechanism for transacting over/under performance as the most likely scenario is the ICS will receive no additional income across H1. There is also a possibility of ERF moving to block for M7-12, with no payment linked to activity levels. This is not confirmed but is being proposed within HIOW ICS.

Weekly scorecard data for the Southeast continues to illustrate UHS as one of the top (and in many weeks, the top) performers within the region.

Underlying Financial Trajectory

A financial trajectory has been developed illustrating a potential range of scenarios. Due to the level of current uncertainty, particularly with regards to Covid and cost inflation, the range is currently +/- £6m from an intermediate expectation of £44m. This has shifted by £12m from M4 estimations as energy cost forecasts have been applied that are likely to spike over the winter even with the application of a national price cap. The overarching objective for the organisation is to progress towards a month-on-month recurrent breakeven position.

Any underlying shortfall to breakeven in year would lead to a reduced cash balance, a reduced ability to invest in capital and revenue improvements, and increased local, regional and national scrutiny.

Response to the financial challenge

Due to the scale of financial risk, a recovery plan has been developed to drive an improvement trajectory. Progress has been made in the last three months, with the Trust Savings Group (TSG) co-ordinating the programme of financial improvement.

Achievements to date include:

- Initially identified 12 workstreams for exploration which will be reporting progress monthly to TSG
- For all workstreams risks, mitigations and support needs have been identified
- Supporting further CIP identification in month that now exceeds 80% of the £45m target (up from circa 50% in M2).
- Increased engagement with operational and clinical leads ensuring the always improving culture is embedded.

Updates will continue in future months Finance Reports.

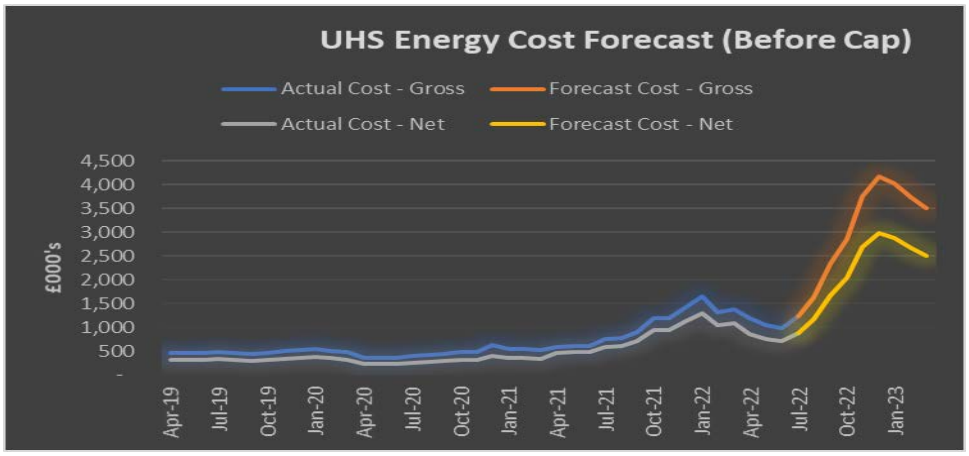
Capital

- The trust has an internal CDEL plan of £49m for 2022/23. Capital expenditure of £8.3m has been reported YTD against this which is £0.6m ahead of plan. YTD spend equates to 17% of total planned spend.
- Many of the major projects have yet to commence and are in the planning phases hence an acceleration in spend is expected in future months. This is particularly notable for the wards development. Spend, and any emerging risks and opportunities, will be monitored closely in year via Trust Investment Group.
- Significant progress continues to be made with external CDEL opportunities:
    - A business case for wards (£10m) has been submitted to NHSE and was successfully approved at the national panel in August.
    - £6.3m of funding for Aseptics pharmacy expansion at Adanac park supported subject to business case approval.
    - Ongoing discussions with HIOW around digital investment of c£3.5m over the next 3 years following national funding announcements.
    - Continued progress with Neonatal modelling regarding confirmed CDEL of £5.1m, noting that this does not include cash funding. There is added complexity within the case due to the potential loss of bed capacity, with mitigation options currently being explored.
    - Confirmed capital funding for the Targeted Lung Programme of £1.4m.
    - Southampton and Southwest Hampshire have had approved the bid for Community Diagnostic Centre expansion at RSH which would lead to £11m capital for UHS over three years with £3.25m being spent this year to commence the project.

Energy Costs

A spotlight on energy costs and potential mitigations has been appended to this paper to offer further insight around the current situation. It should be noted however that current price and volume forecasts project costs increasing to a high of £4m per month in December 2022 which is £3m net of recharged costs to third party occupiers. If this forecast prevailed the gross energy spend for UHS would exceed £30m in 2022/23 up from £6m in 2019/20. This is a fivefold increase in energy costs in three years.

This has been factored into worst case scenario forecast modelling with a more moderated view included within the intermediate case based on the newly announced national price cap. This has yet to be quantified however and in addition wholesale price forecasts are subject to significant volatility, so this remains a highly uncertain area of spend.



Productivity and Growth

Several national sources of benchmarking information have recently been published helping give context to the current scenario for UHS in comparison to historic activity and productivity compared to others.

Firstly, for non-ERF activity the below table provides a helpful insight into the level of prevailing activity growth since 19/20. This shows the significant scale of growth seen particularly in A&E and Non Elective that are driving the operational challenges for the trust. Under a payment by results scenario this growth would be funded however under a block contract UHS must seek to manage costs and work with system partners to alleviate demand in order to stay in financial balance.

Trustwide average monthly value weighted non-ERF activity

	2019/2020	2020/2021	2021/2022	2022/2023	% increase from 19/20
AandE	£1,884,403	£1,505,297	£2,094,310	£2,401,576	27%
Critical Care	£5,717,238	£5,729,086	£6,269,974	£6,424,182	12%
Direct Access	£524,325	£377,956	£469,557	£653,227	25%
Maternity Pathways	£1,030,715	£1,078,084	£962,046	£863,011	-16%
Non Elective Excess Bed Days	£628,695	£303,981	£496,164	£714,208	14%
Non Elective Spells	£18,095,574	£17,145,803	£19,618,962	£20,125,396	11%
Other Tariff Exclusions	£2,906,725	£2,458,268	£2,959,906	£3,057,029	5%
Outpatient Unbundled	£526,471	£483,714	£649,029	£710,351	35%
Tariff Excluded Devices	£1,824,602	£1,731,006	£2,813,967	£3,121,114	71%
Tariff Excluded Drugs	£8,383,040	£10,317,194	£12,621,663	£12,264,271	46%

Additionally, productivity information has been shared for Q1 reviewing real terms cost growth compared to elective cost weighted activity growth. The initial information provided suggested UHS was worse than the national average with costs going up 28% from 19/20 and activity increasing 2% generating a combined reduction in productivity of 20% compared to a national average of 18%. Once however adjusted for non-activity related cost increases i.e. high cost drugs, R&D etc., this can be restated for UHS as 11% productivity reduction when comparing to 19/20. Although clearly still a deterioration this would be significantly better than the national and regional averages of 15% and 14% respectively once adjusting for the same variables.

Pay Award

The consultant and agenda for change pay award will be processed in the month of September averaging 4.5% per employee. This will have an estimated impact of £27m on the annual pay bill for UHS.

Although NHS funding has been made available other commercial and non-NHS income streams will need to be pursued to make sure costs are fully recovered i.e. R&D, private patient tariffs, commercial SLAs etc. This is being progressed with the relevant teams internally.

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)

2022/23 Finance Report - Month 5

Report to:	**Board of Directors and Finance & Investment Committee** **August 2022**
Title:	**Finance Report for Period ending 31/08/2022**
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 5, UHS reported a deficit position of £2.9m adverse which was £2.4m adverse to the planned £0.5m deficit. The YTD position is £11.7m deficit which is £6.3m adverse to the planned deficit target of £5.3m.

2. The underlying position is however £16.5m deficit YTD with one off benefits helping improve the in year reported position. Estimates of the underlying forecast project a deficit range between £38m and £50m with £44m the intermediate scenario. This is heavily influenced by largely uncontrollable costs relating to covid, inflation and energy.

3. M5 YTD CIP achievement is £12.1m, an increase from the £7.5m achieved at M4. Of the £12.1m delivered YTD £5.1m has been achieved by Divisions and Directorates and £7m through Central Schemes. The £12.1m delivery YTD compares to planned YTD delivery of £12.9m. Identification has improved to £37m identified (82% of the total 22/23 requirement).

4. The main income and activity themes seen in M5 were:
    1. UHS has delivered 101% of Elective Recovery activity in M5, below target and plan.
    2. ERF income of £3.8m YTD has been estimated within the position, at 75% marginal rate, off-setting the variable costs of additional activity.
    3. Covid related sickness absence was c70 WTE per day across August reducing from July.

5. The underlying deficit of £3.3m per month is predominantly driven by:
    1. Drugs & Devices (£0.6m per month) – part of our plan which has been offset with CIP
    2. Energy costs – (£0.8m per month) – Inflationary pressure not met with funding
    3. Covid Costs – (£0.8m per month) – continued sickness absence costs and covid spend which has not reduced as per planning assumptions
    4. CIP shortfall – (£0.2m per month) - Although progress has been made savings have not been achieved to the level to bridge the gap to breakeven to date.
    5. Elective Recovery and ERF – a 75% marginal payment covers costs only and fails to cover independent sector or insourcing premium costs. For this reason it has not generated additional margins. £1m was predicted within the YTD plan that has not been met.

Finance: I&E Summary

A deficit position of £2.9m was reported in August adverse to the planned position of £0.5m deficit. The YTD position of £11.7m deficit is also £6.3m adverse to the planned £5.3m deficit target.

No ERF income was booked in month 5 as a result of activity being below the 104% threshold. Covid-related absences were on a downward trend after peaking at c300 WTE in late July however significant annual leave within the month has meant bank and agency costs remain at or above plan.

Of note in month was a spike in drugs costs relating to backdated homecare costs. These increased by £1.4m from the previous month. Work is progressing with pharmacy to try and make sure homecare costs are reported in a more timely manner so as to avoid future spikes in spend.

The trust continues to report a breakeven annual position for 2022/23. The forecast will be reviewed more formally at M6.

		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	69.0	0.7	348.8	347.7	1.0	837.0	834.6	2.5
	Pass-through Drugs & Devices	11.2	14.4	(3.1)	56.1	60.5	(4.4)	134.6	145.2	(10.6)
Other income	Other Income excl. PSF	10.6	14.0	(3.4)	52.8	71.2	(18.4)	126.6	150.8	(24.2)
	Top Up Income	0.8	0.5	0.2	4.2	3.2	1.0	8.3	7.6	0.8
Total income		**92.3**	**97.9**	**(5.6)**	**461.8**	**482.6**	**(20.8)**	**1,106.6**	**1,138.2**	**(31.6)**
Costs	Pay-Substantive	48.9	49.9	1.0	243.8	247.8	4.0	591.6	594.6	3.1
	Pay-Bank	3.1	3.5	0.4	16.3	19.4	3.0	33.2	41.4	8.3
	Pay-Agency	1.2	1.2	0.0	5.9	6.3	0.4	12.0	13.1	1.1
	Drugs	5.1	6.2	1.2	25.8	23.9	(1.9)	59.7	59.8	0.0
	Pass-through Drugs & Devices	11.2	14.4	3.1	56.1	60.5	4.4	134.6	145.2	10.6
	Clinical supplies	6.6	6.6	0.1	35.0	34.5	(0.5)	74.6	80.3	5.7
	Other non pay	15.9	17.9	2.1	79.6	97.9	18.2	189.6	192.5	2.9
Total expenditure		**91.9**	**99.7**	7.9	**462.4**	**490.2**	**27.7**	**1,095.3**	**1,127.0**	**31.6**
EBITDA		**0.5**	**(1.9)**	**2.3**	**(0.7)**	**(7.6)**	**6.9**	**11.2**	**11.2**	0.0
EBITDA %		0.5%	-1.9%	2.4%	-0.1%	-1.6%	1.4%	1.0%	1.0%	0.0%
	Non operating expenditure/income	(0.9)	(0.9)	0.1	(4.6)	(4.4)	0.3	(11.1)	(11.1)	0.0
Surplus / (Deficit)		**(0.5)**	**(2.7)**	**2.2**	**(5.3)**	**(12.0)**	**6.6**	**0.1**	**0.1**	**0.0**
Less	Donated income	(0.1)	(0.3)	0.2	(0.6)	(0.6)	0.0	(1.4)	(1.4)	0.0
	Profit on disposals	-	-	0.0	-	-	0.0	-	-	0.0
Add Back	Donated depreciation	0.1	0.2	0.0	0.6	0.9	0.3	1.3	1.3	0.0
Net Surplus / (Deficit)		**(0.5)**	**(2.9)**	**2.4**	**(5.3)**	**(11.7)**	**6.3**	**0.0**	**0.0**	**0.0**

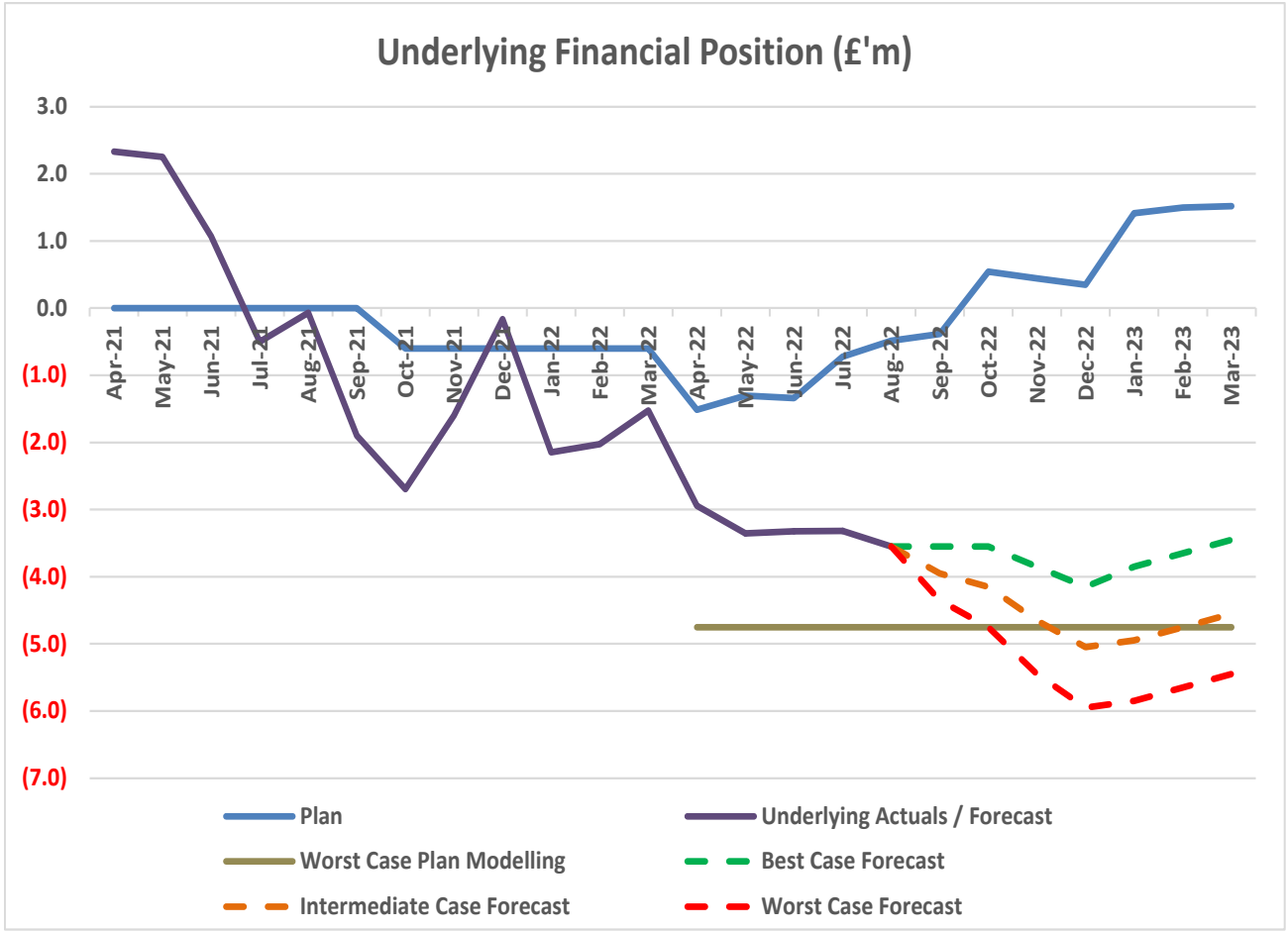
Monthly Underlying Position

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 £3.6m deficit in M5 marginally higher than the reported deficit. This is due to rephasing a one off VAT benefit and backdated drugs costs.

The run rate from month 1 to month 5 is now on average £3.3m deficit per month which is adverse to the planned £1.1m per month, due mainly to energy cost pressures, continuing covid pressures and the delayed delivery of cost improvement plans.

A range of deficit scenarios have been modelled indicating a spread between £38m and £50m. The intermediate scenario stands at £44m deficit. The variables within this projection are detailed overleaf.



Financial Risks

The table illustrates the key variables driving the underlying deficit position. Some of these are more complex to measure than others with monitoring tools for all being developed.

It is acknowledged that this generates a wide ranging forecast between £38m deficit and £50m deficit with an intermediate forecast assessment of £44m deficit. This has shifted quite significantly from the previous month (intermediate case up by £12m) as energy costs have been assessed in more detail with a significant pressure of between £10m and £14m flagged for 22/23 depending on the assessed impact of the commercial energy cap. This has only recently been announced and is being evaluated.

This wide range is partly due to the scale of volatility related to covid together with inflationary and energy pressures.

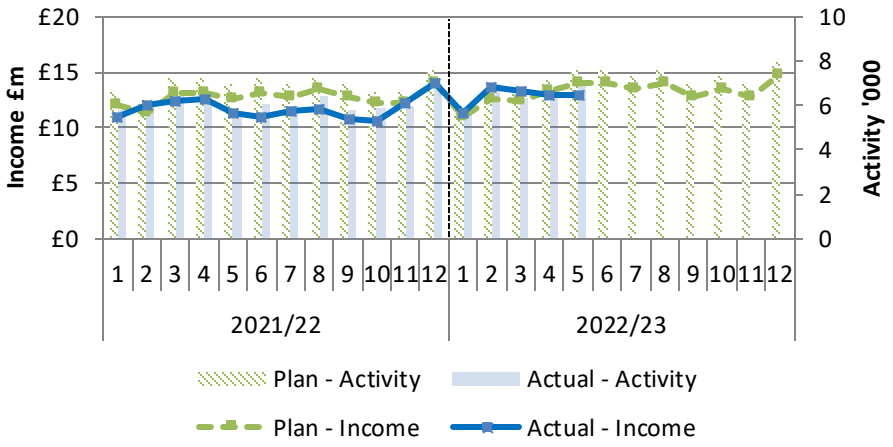
A further risk not within the table relates to the elective recovery fund which may be formally paused for half 2.

				Forecast Assessment		
Risk Variable	**Scenario**	**Controllable / Uncontrollable**	**Original Worst Case Assessment (£m)**	**Best Case (£m)**	**Intermediate Case (£m)**	**Worst Case (£m)**
Cost Improvement Plans not fully delivered	Non delivery of baseline CIP target and central schemes	Controllable	(28.9)	(6.0)	(7.0)	(8.0)
Covid 19 remains at above 'background' levels slowing the release of covid related costs	Covid costs are beyond planned levels.	Uncontrollable	(17.0)	(13.0)	(14.0)	(15.0)
Inflationary pressures impact the price of goods and services	Non pay inflation above funded levels	Uncontrollable	(11.3)	(7.0)	(8.0)	(9.0)
Energy Cost prices continue to rise	Price increase beyond planned pressure	Uncontrollable		(10.0)	(12.0)	(14.0)
Stock outs cause price and/or supply chain risks to materialise	Price increases / lost acivity	Uncontrollable	0.0	(0.5)	(1.0)	(1.5)
Block drugs and devices costs continue to overspend	Overspend on planned value as demand increases or new drugs NICE approved	Uncontrollable	0.0	(1.5)	(2.0)	(2.5)
Total			**(57.2)**	**(38.0)**	**(44.0)**	**(50.0)**

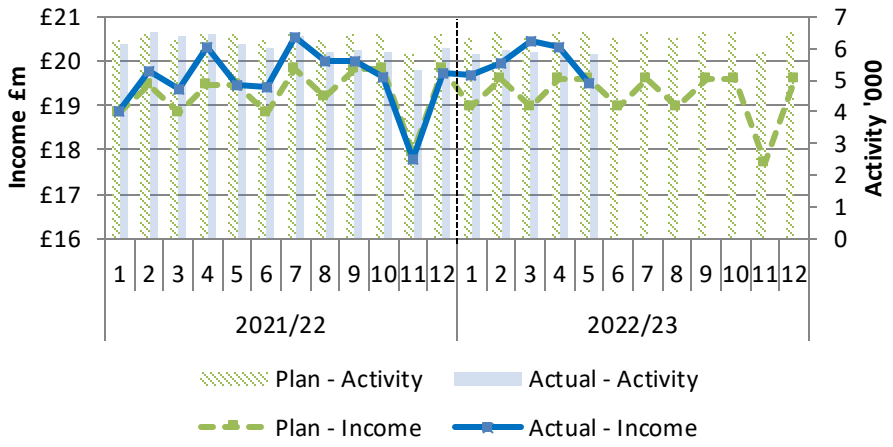
University Hospital Southampton NHS
NHS Foundation Trust

Clinical Income

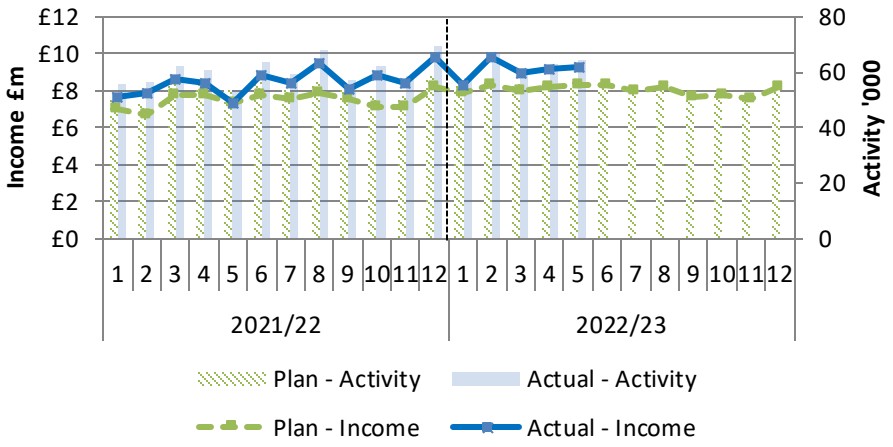
Elective spells



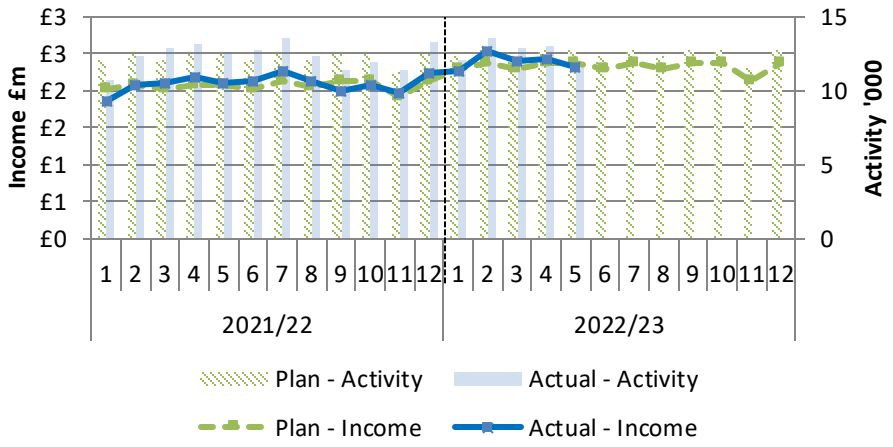
Non elective spells



Outpatients Total



A&E



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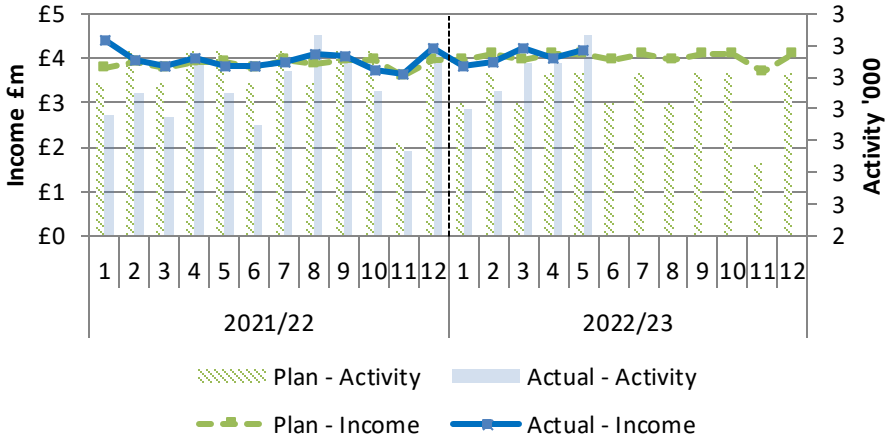
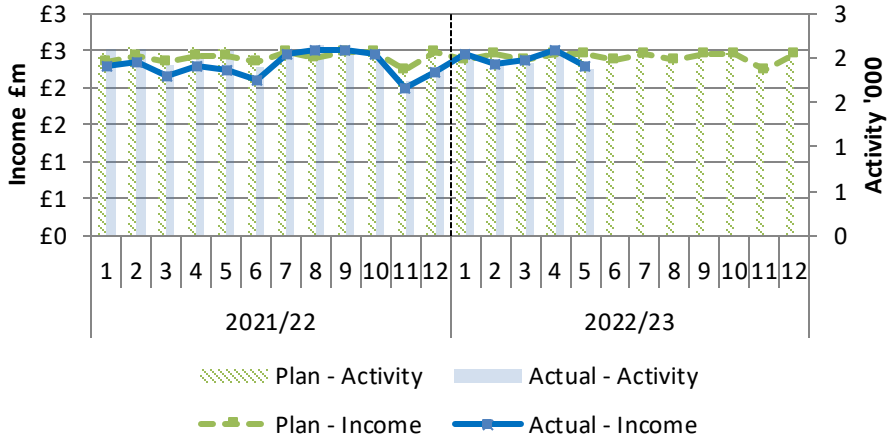
Clinical Income

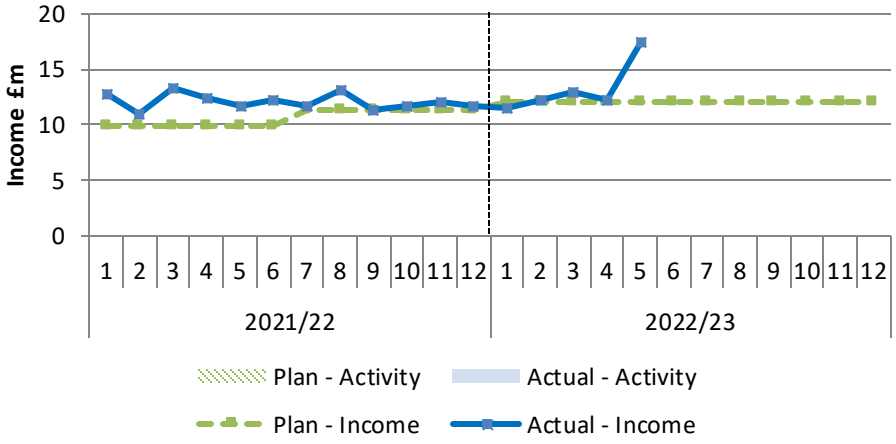
Adult critical care



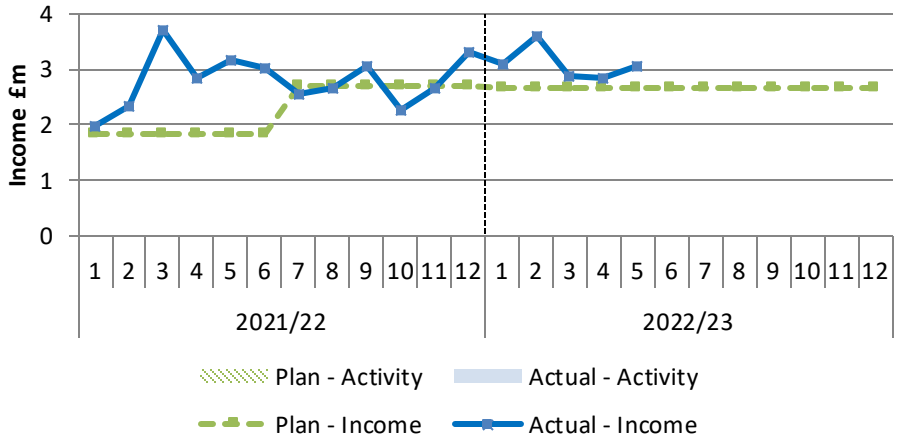
Neonatal & paediatric critical care



Tariff excluded drugs



Tariff excluded devices



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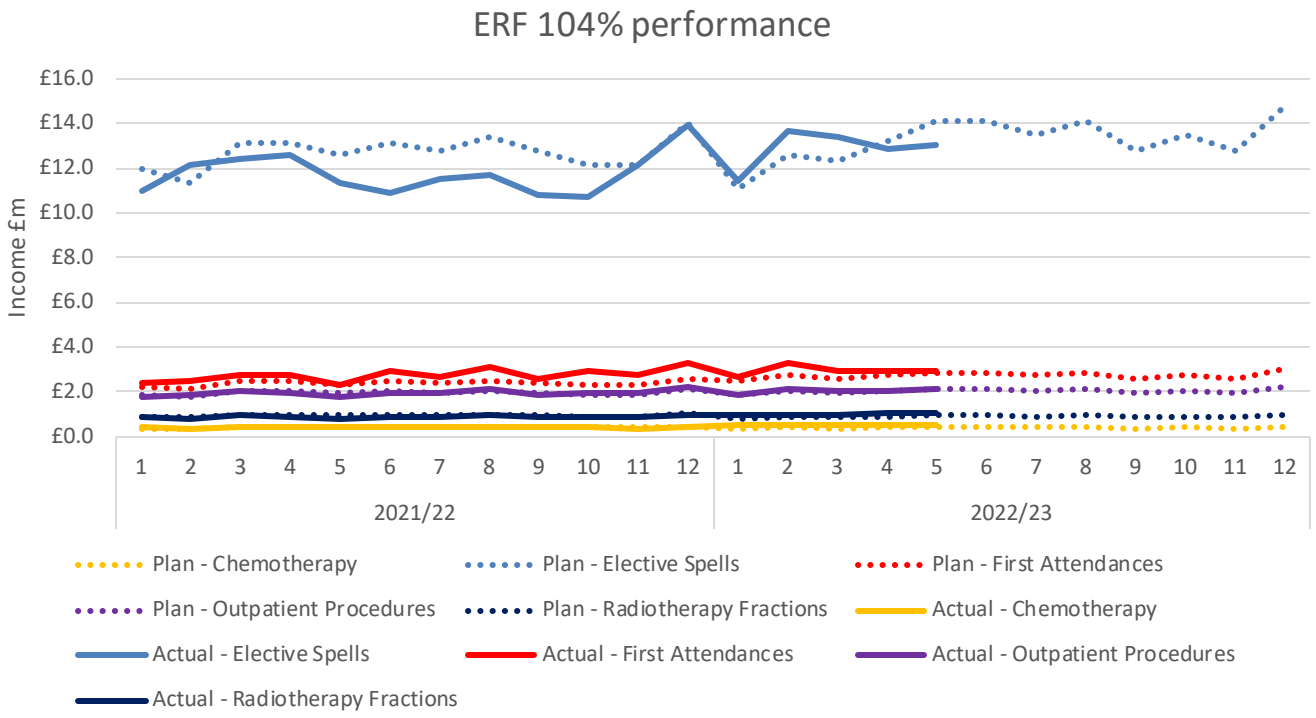
Elective Recovery Fund 22/23

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

In 22/23 the Trust has a 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 M5 performance of 101%. YTD the internal target of 106% is currently being achieved.

An ERF payment of £3.8m year to date has been provisionally included within the Trusts income position, off-setting additional variable costs of delivery. There does however remain some uncertainty over the national calculation with figures recently released for April and May currently under review. Further to this the exact mechanism for transacting this is also under discussion with ICS partners.



Elective Recovery Framework Performance	M1	M2	M3	M4	M5	YTD
Elective performance	99%	107%	110%	101%	98%	103%
Outpatient first and procedures performance	109%	117%	112%	108%	106%	111%
Chemotherapy performance	146%	127%	142%	128%	135%	135%
Radiotherapy performance	119%	112%	114%	116%	115%	115%
Overall ERF performance	**103%**	**111%**	**112%**	**104%**	**101%**	**106%**
Anticipated ERF payment (incl. A&G)	**£815**	**£1,650**	**£1,482**	**£271**	**-£392**	**£3,826**
Outpatient follow up performance	130%	137%	130%	127%	123%	129%

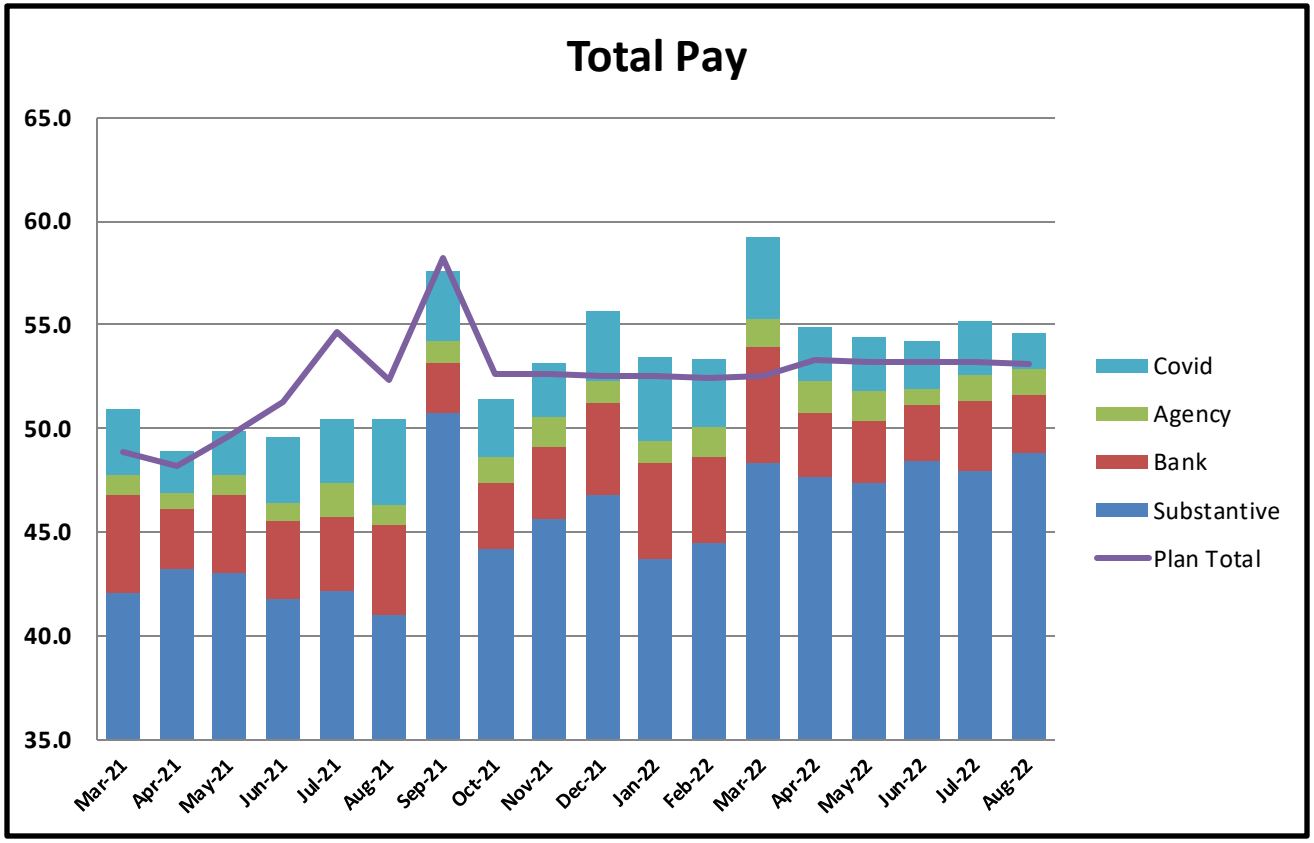
University Hospital Southampton NHS
NHS Foundation Trust

Substantive Pay Costs

Total pay expenditure in August was £54.6m, down from July by £0.6m. The decrease compromises both increases in substantive staff (£0.8m up) but decreases on bank staff (£0.5m) and on covid staff (£0.9m). Covid staff costs are estimated at £1.9m which is £0.9m less than July. Of this £0.7m was bank and agency staff and £1.2m related to substantive/fixed term staff.

A focus on workforce costs is one of the areas of investigation for the Trust Savings Group (TSG) especially with regards to premium rate spend.

The pay award for consultants and agenda for change staff will be processed within September and will cause a step change in the pay costs for the organisation of c4.5%. This is however, in most part, centrally funded.

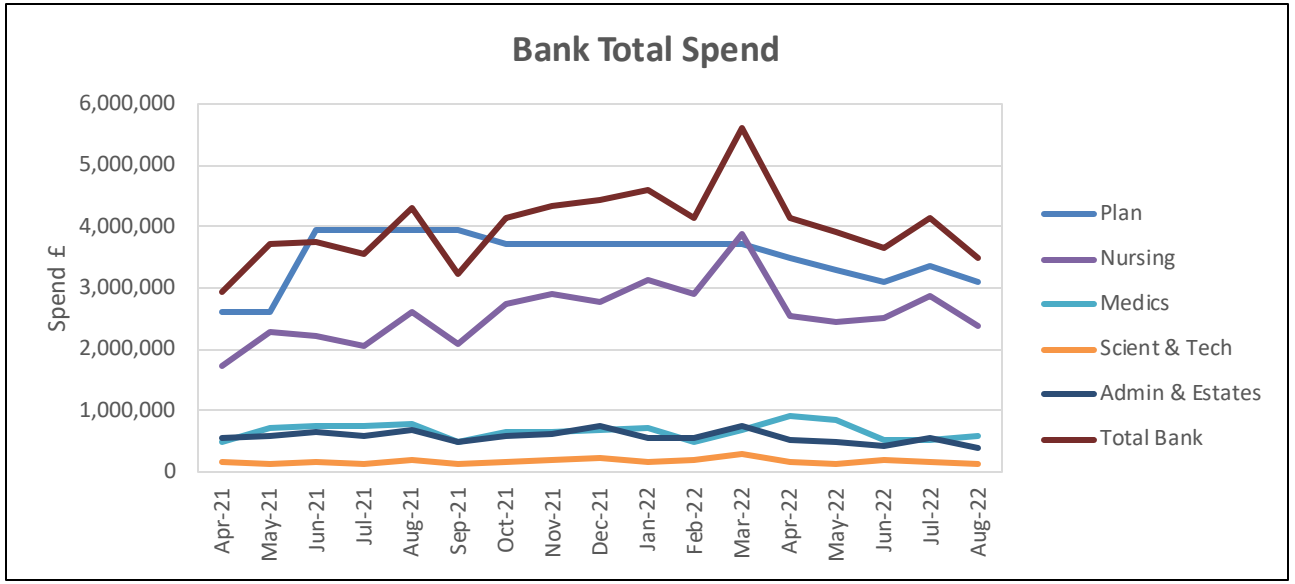


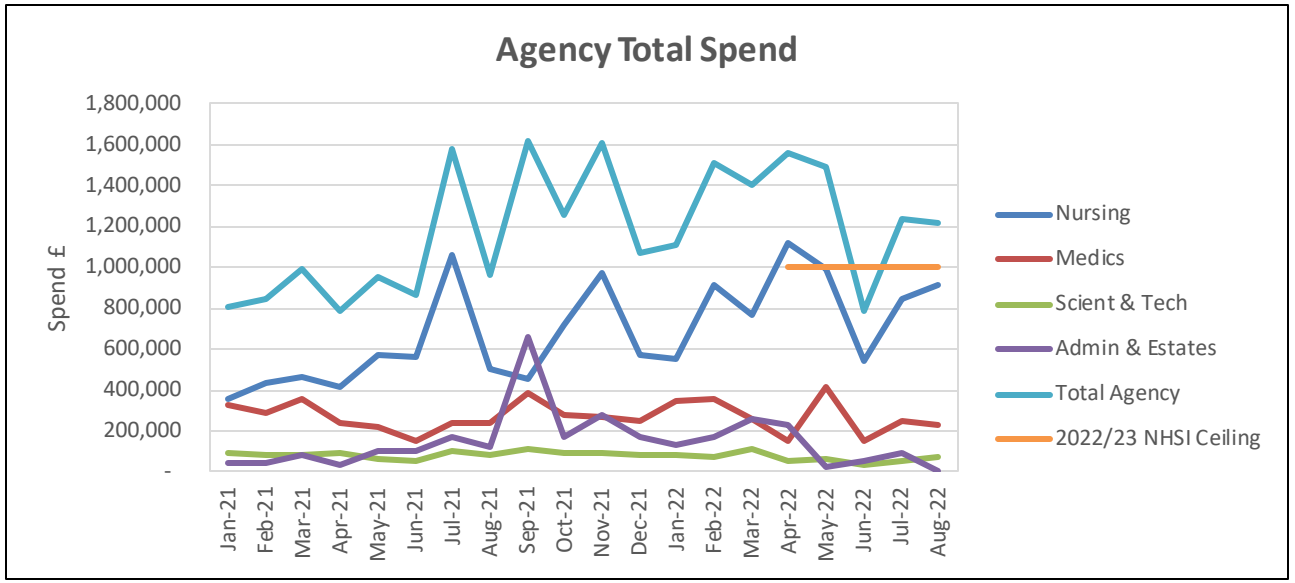
Temporary Staff Costs

Expenditure on Bank staff has decreased month on month by £0.65m. The majority of this decrease was in nursing staff (£0.5m) with the remaining decrease seen in admin and estates staff groups (£0.2m). Expenditure remains above plan on Bank staff this year.

Agency spend was flat from July to August with the £80k decrease in admin and estates staff spend offset by a corresponding increase in nursing staff spend. Spend is above the 22/23 NHSI ceiling.

Although volatile, month to month spend has averaged c£1.4m per month since July 2021. The average spend for the last three months is £1.1m suggesting spend may be starting to decrease marginally.





Covid Costs 22/23

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

YTD costs are £12.4m which is £3.7m ahead of plan. This is due particularly to staff sickness absence and associated backfill costs being incurred which are £0.6m over plan. Critical Care and ED contribute a further £3.6m of costs in excess of plan.

All areas of spend are under review especially those associated with national guidance changes. Alternatively for some areas where an ongoing need has been identified discussions with commissioners have 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.

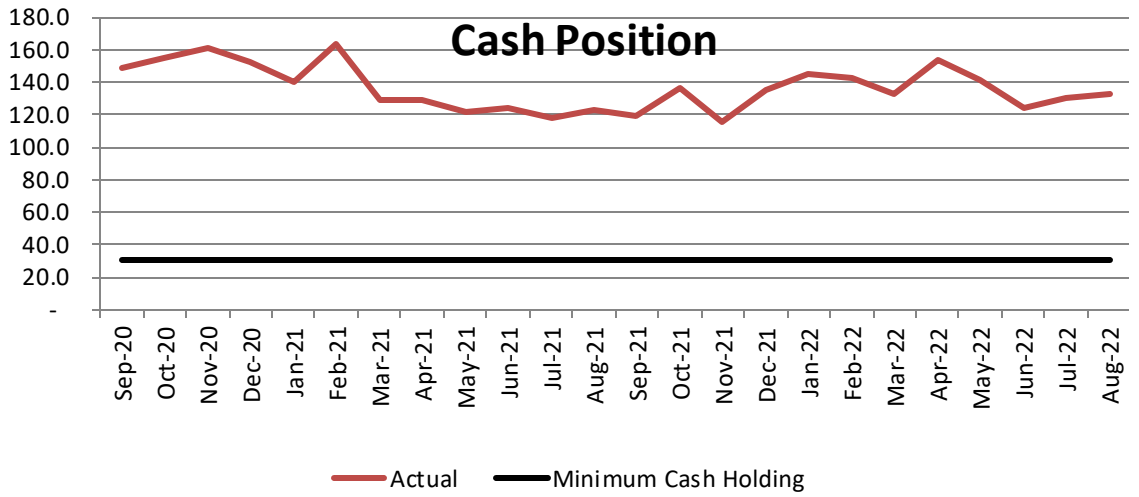
Description	2022/23 Annual Plan (£'000)	2022/23 YTD Plan (£'000)	2022/23 YTD Actual (£'000)	2022/23 YTD Variance (£'000)
Covid Related Staff Sickness / Absence	9,123	3,801	4,417	(616)
Critical Care Additional Capacity	4,914	2,048	3,805	(1,758)
ED Additional Staff / Segregated Pathways	1,800	750	2,587	(1,837)
Car Parking Income - Patients / Visitors	1,320	550	550	0
Additional Cleaning / Decontamination	812	338	386	(48)
C5 uplift to L2 facility for 12 beds for Covid	480	200	200	0
Staff / High Risk Patient Covid Testing	500	208	210	(2)
PPE / Perso Hoods and Consumables	320	133	12	121
Staff Psychology Support	200	83	33	50
Car Parking Income - Staff	183	76	76	0
Clinical Engineering	138	58	0	58
Covid Medical Model (Div B)	115	48	48	0
PAH Theatres social distancing	108	45	0	45
Infection Control Team	107	45	14	31
Other (sub £100k plans)	694	289	30	259
TOTAL	**20,813**	**8,672**	**12,368**	**(3,696)**

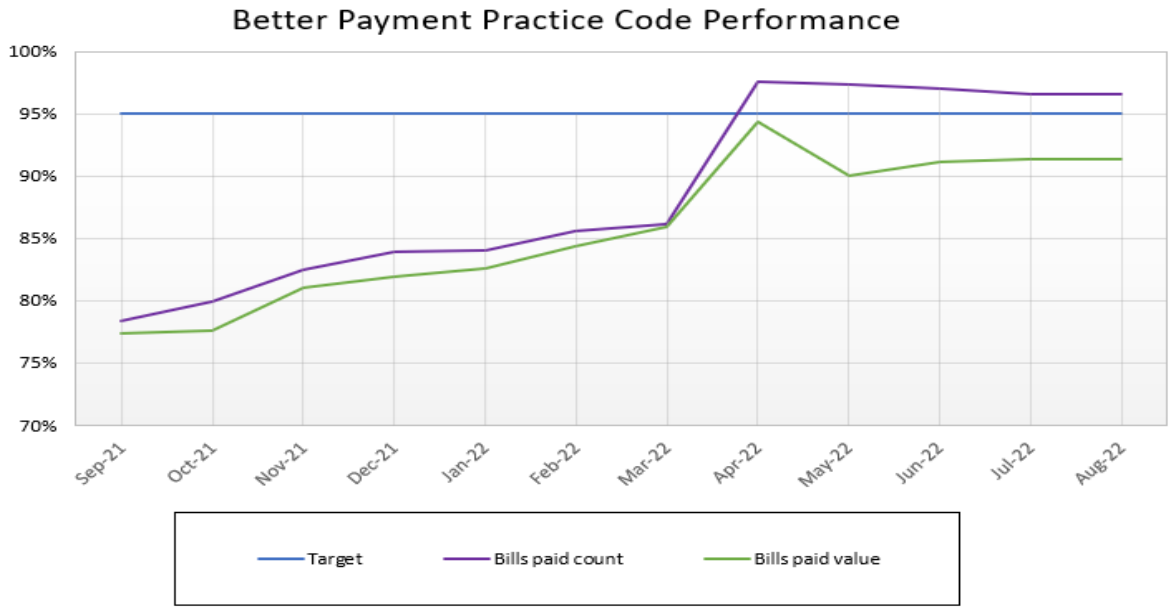
Cash

The cash balance increased by £2.5m in August to £132.8m and is analysed in the movements on the Statement of Financial Position.

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

BPPC in month for August continues to meet the BPPC target YTD for count (96.61%), and has been stable this month for value (91.35%) YTD. Some disruption was expected in M5 due to leave and the processing of UEL at an increasing volume. However, this was mitigated by a change in process to send out receipting prompts earlier, mitigating delays. Implementation of new scanning software has also been successful.





Capital Expenditure

Expenditure on capital schemes was £11.9m in the year to M5 compared to a budget of £8.1m. Total expenditure in August was £3.0m. The main areas of expenditure were on the wards above oncology (£0.9m), the refurbishment of Neuro Theatres 2 and 3 (£0.7m) and other estates schemes such as the installation of NICU pendants. Expenditure on Strategic Maintenance and IT projects was low this month (£0.2m on each)

The Trust has currently spent only 17% of it's £49m Capital expenditure to date, but the rate of expenditure is likely to increase rapidly as large estates projects such as the wards above oncology, theatres refurbs and fit out of C level of the vertical extension start or increase their expenditure. This should ensure that the Trust fully expends all awarded capital by the end of the financial year.

(Fav Variance) / Adv Variance

		Month			Year to Date			Full Year Forecast		
Scheme	Org	Plan £000's	Actual £000's	Var £000's	Plan £000's	Actual £000's	Var £000's	Plan £000's	Actual £000's	Var £000's
Internally Funded Schemes										
Strategic Maintenance (excl. Neuro Ventilation)	UHS	659	189	470	1,929	1,193	736	7,185	6,972	213
Refurbish of Neuro Theatres 2 & 3 (incl. Ventilation)	UEL	0	694	(694)	0	706	(706)	1,800	2,100	(300)
General Refurbishment Fund	UHS	0	0	0	12	0	12	1,097	1,097	0
Refurbishment of Theatres 10 & 11/F level Fit Out	UEL	0	77	(77)	218	352	(134)	5,000	5,000	0
Oncology Centre Ward Expansion Levels D&E	UEL	0	894	(894)	886	2,313	(1,427)	8,000	8,000	0
Fit out of C Level VE (MRI) Capacity	UEL	0	0	0	0	0	0	6,592	6,592	0
Donated Estates Schemes	UHS	435	342	93	788	561	227	5,362	6,501	(1,139)
Other Estates Schemes	UHS	424	496	(72)	773	622	151	2,681	2,894	(213)
Information Technology (incl. Pathology Digitisation)	UHS	445	155	290	2,022	1,458	564	5,448	5,448	0
IMRI	UHS	0	0	0	104	115	(11)	1,300	1,300	0
Medical Equipment panel (MEP)	UHS	125	0	125	250	7	243	2,500	2,500	0
Other Equipment		131	87	44	532	285	247	1,550	1,400	150
Other	UHS	17	194	(177)	639	983	(344)	691	1,151	(460)
Slippage	UHS	0	0	0	0	0	0	(3,380)	(3,560)	180
Donated Income	UHS	(498)	(345)	(153)	(962)	(593)	(369)	(6,760)	(7,749)	989
Total Trust Funded Capital excl Finance Leases		**1,738**	**2,783**	**(1,045)**	**7,191**	**8,003**	**(812)**	**39,066**	**39,646**	**(580)**
Leases										
Medical Equipment Panel (MEP) - Leases	UHS	14	165	(151)	205	165	40	700	700	0
Equipment leases	UHS	35	0	35	70	142	(72)	500	500	0
IISS	UHS	285	0	285	285	0	285	3,115	2,685	430
Fit out of C Level VE (MRI) Capacity	UHS	0	0	0	0	0	0	5,619	5,619	0
Total Trust Funded Capital Expenditure		**2,072**	**2,948**	**(876)**	**7,751**	**8,310**	**(559)**	**49,000**	**49,150**	**(150)**
Disposals	UHS	0	0	0	0	0	0	0	0	0
Top Up to external Schemes		0	0	0	0	0	0	0	(150)	150
Total Including Technical Adjustments		**2,072**	**2,948**	**(876)**	**7,751**	**8,310**	**(559)**	**49,000**	**49,000**	**0**
Externally Funded Schemes										
Maternity Care System (Wave 3 STP)	UHS	0	0	0	89	0	89	89	239	(150)
Digital Outpatients (Wave 3 STP)	UHS	49	15	34	245	88	157	592	592	0
Oncology Centre Ward Expansion Levels D&E	UEL	0	0	0	0	0	0	0	10,000	(10,000)
Neonatal Expansion*	UHS	0	67	(67)	0	68	(68)	0	5,130	(5,130)
Targeted Lung Health Checks CT Scanner	UHS	0	0	0	0	0	0	0	1,363	(1,363)
Pathology Digitisation / LIMS	UHS	0	0	0	0	0	0	0	250	(250)
Transfer from schemes within CDEL	UHS	0	0	0	0	0	0	0	150	(150)
Outside CDEL Limit										
Adanac Park Car Park	UHS	0	0	0	0	3,459	(3,459)	0	3,459	(3,459)
Total CDEL Expenditure		**2,121**	**3,030**	**(909)**	**8,085**	**11,926**	**(3,841)**	**49,681**	**70,183**	**(20,502)**

Notes

Further Funding Anticipated:

Community Diagnostic Centre Phase 2*	3,200
Asceptic Pharmacy Building	1,000
Electronic Patient Record Match Funding	1,068

*Other expenditure will have to be brought forward (e.g. on wards above oncology) to fully utilise the nenotal and community diagnostic hub funding if/when received.

Statement of Financial Position

(Fav Variance) / Adv Variance

The August statement of financial position illustrates net assets of £459.3m.

Receivables decreased by £4.5m due to settlement of £4.2m Prime Infrastructure invoice in relation to the delivery fee for the car park.

Payables increased by £2.1m due to the deferral of HEE income received.

Cash increased marginally to £132.8m but remains significantly lower than at the end of 21/22 driven significantly by the underlying deficit.

Statement of Financial Position	2021/22	2022/23		
	YE Actuals	M4 Act	M5 Act	MoM Movement
	£m	£m	£m	£m
Fixed Assets	471.9	462.8	463.8	1.1
Inventories	17.0	17.1	16.6	(0.5)
Receivables	53.1	59.3	54.8	(4.5)
Cash	148.1	130.3	132.8	2.5
Payables	(204.2)	(196.6)	(198.7)	(2.1)
Current Loan	(1.7)	(1.7)	(1.7)	0.0
Current PFI and Leases	(9.1)	(8.0)	(8.3)	(0.3)
Net Assets	**475.0**	**463.2**	**459.3**	**(3.9)**
Non Current Liabilities	(23.0)	(21.2)	(21.0)	0.2
Non Current Loan	(6.8)	(6.3)	(6.3)	0.0
Non Current PFI and Leases	(33.6)	(33.4)	(32.4)	1.0
Total Assets Employed	**411.6**	**402.3**	**399.6**	**(2.7)**
Public Dividend Capital	261.9	261.9	261.9	0.0
Retained Earnings	115.6	106.3	103.6	(2.7)
Revaluation Reserve	34.1	34.1	34.1	0.0
Other Reserves				
Total Taxpayers' Equity	**411.6**	**402.3**	**399.6**	**(2.7)**

University Hospital Southampton NHS
NHS Foundation Trust

Efficiency and Cost Improvement Programme 22/23 – M5

UHS Total - £37m identified, 82% of the total 22/23 requirement which = £45.4m

Divisions and Directorates - £14.5m of CIP schemes identified, an increase from £13.6m at M4. This represents 73% of it's 22/23 target which = £20m

Central Schemes - £22.5m of CIP schemes identified, an increase from £21.3m at M4. This represents 88% of the 22/23 target which = £25.4m

Of the identified UHS total, £6.4m is Pay, £24m is Non-Pay, and £6.6m is Income

Divisional identification varies from 51% to 96%. A detailed breakdown by Care Group can also be found on slide 18.

Month 5 CIP Identification	Non Recurrent ('000s)	Recurrent ('000s)	Total ('000s)	Target ('000s)	% Identified
Division A	£2,173	£1,899	£4,072	£4,260	96%
Division B	£973	£1,911	£2,884	£5,535	52%
Division C	£1,515	£492	£2,007	£3,938	51%
Division D	£858	£2,152	£3,010	£3,573	84%
THQ	£804	£1,130	£1,934	£2,695	72%
Unallocated Procurement Schemes	£0	£633	£633		
Central Schemes	£10,422	£12,042	£22,464	£25,400	88%
Grand Total	**£16,745**	**£20,259**	**£37,004**	**£45,400**	**82%**

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

University Hospital Southampton NHS
NHS Foundation Trust

Efficiency and Cost Improvement Programme 22/23 – M5

M5 Trust YTD achievement is £12.1m, an increase from the £7.5m achieved at M4.

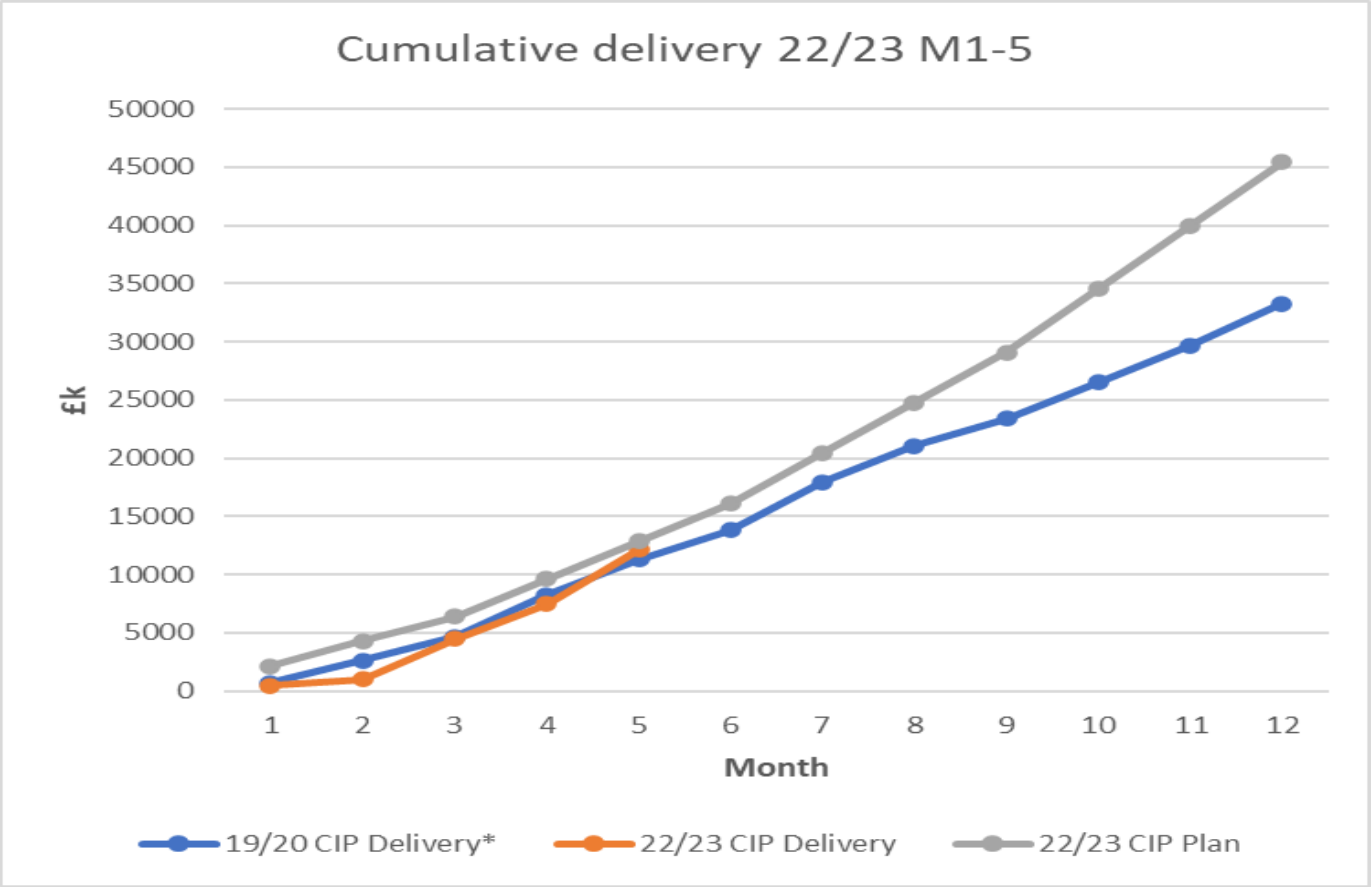
Of the £12.1m delivered YTD:

- £5.1m has been transacted by Divisions and Directorates

- £7m has been transacted through Central Schemes

Of the Trust YTD achievement, £9m is non-recurrent. This includes £5.4m of non-recurrent Central Schemes. £2.1m is a non-recurrent CIP relating to prior year adjustment.

Our £12.1m delivery YTD compares to planned YTD delivery of £12.9m. The plan was phased with a reduced delivery target in earlier months.



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

University Hospital Southampton NHS
NHS Foundation Trust

Efficiency and Cost Improvement Programme 22/23 – M5

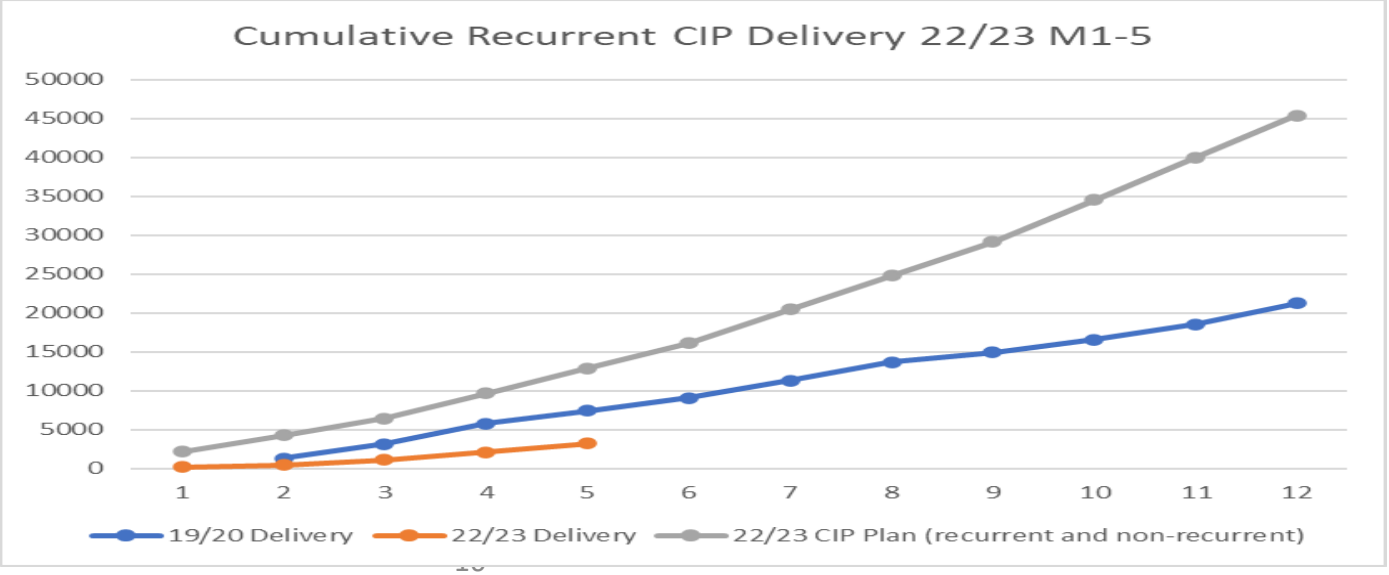
Recurrent cost improvements are important, and significantly advantageous compared to non-recurrent benefits, due to their impact on the future service costs /funds available for investment.

Our aim is to deliver at least 1/12th of the annual CIP target for Divisions/ THQ recurrently within month 12. Month 5 recurrent delivery, and month 12 recurrent CIP currently identified, are compared to the month 12 target in the table.

Further efforts will be made to identify recurrent savings schemes, and to convert non-recurrent schemes to recurrent if this is appropriate.

Cost Improvement Plan Recurrent Delivery Only – At Month 5

Division	Delivered Recurrent CIP in M5 ('000s)	Identified Recurrent CIP in M12 ('000s) (at M4)	Identified Recurrent CIP in M12 ('000s) (at M5)	Target to deliver recurrently within M12 ('000s)
Division A	£68	£146	£188	£355
Division B	£57	£115	£115	£461
Division C	£48	£57	£57	£328
Division D	£172	£100	£267	£298
THQ	£39	£75	£124	£225



Efficiency and Cost Improvement Programme 22/23 – M5

University Hospital Southampton NHS
NHS Foundation Trust

Cost Improvement Plan – Delivery Risk Assessment

- £8.4m (18%) of the 22/23 target value remains unidentified after Month 5, identification and delivery of this value should be considered a medium to high risk.
- All schemes greater than £100k in value represent £24.1m (72%) of the total financial value identified:

Risk Assessment	Number of schemes >£100k	Value (£k	Percentage of value	Percentage of schemes
Green	24	13,315	53%	55%
Amber	12	8,008	36%	32%
Red	6	2,796	11%	14%
Total	44	24,119	100%	100%

- The risk assessment suggests that £17.8m (71%) of the currently identified value is likely to be delivered within the financial year.

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**People Report 2022-23 Month 5**			
Agenda item:	**5.6**			
Sponsor:	**Steve Harris, Chief People Officer**			
Author:	**Workforce Team**			
Date:	**29 September 2022**			
Purpose	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	The People report is a monthly review of key people issues across UHS. People capacity remains a critical issue at the Trust and across the wider health and social care sector. The report is aligned to our UHS **People Strategy key areas of THRIVE, EXCEL AND BELONG.** The report is provided monthly to Trust Executive Committee, to UHS People Board, reviewed periodically by the People and OD committee, and shared with our Trade unions at the Staff Partnership forum. The report appraises progress against key WF KPIs and helps shape action and decision-making in the trust. **Urgent issues to address** This month, in addition to the key details of the report, the Chief People Officer is advising the board of a number of actions that have been agreed to address key workforce challenges across the Trust. These actions complement the existing objectives agreed for the year. The key issues that have been considered and agreed at Trust executive committee include: 1. Action to address retention issues with Advanced Care Practitioners (ACPs) 2. Health Care Assistant (HCA) vacancy (19%) and turnover (19%). Higher leavers in the first 12 months 3. Administrative and clerical turnover currently at 18% 4. People Capacity in the recruitment team responding to a 25% increase in demand 5. The Cost of living for our people at UHS			

Response to the issue:

Key resourcing challenges

The following action has been agreed at TEC in September. It should be noted this was taken within the context of a balanced discussion regarding investments within the current financial context.

Area	Action
ACPs	• Short term **Recruitment and retention premia** to address gap in pay between UHS and other local organisations • A **workforce review** to be undertaken of the 161 ACP roles to look at the scope of role and subsequent job banding, with care taken regarding internal relativity
HCAs	• Continuing to implement **a package of existing measures to reduce** HCA turnover, including expanding new band 3 progression roles. • To continue rolling out training wards, improved induction, and continue the positive work of the HCA support Hub. Continue to increase focus on the realistic nature of role during recruitment to avoid early exit.
Admin and Clerical	• **Dedicated project resources to focus on A&C retention**, career progression, job design, and job satisfaction. Post to complement existing divisional work but increase pace and scale.
Recruitment Resources	• **Increase resources in Recruitment to meet additional 25% demand**. Improve speed and quality through additional recruitment administrators. Dedicated investments in attraction activities (digital advertisement campaigns).

Cost of Living

Trust Executive Committee has approved a range of measures to support staff on cost of living. Recognising UHS cannot control national pay bargaining, or factors such as energy cost inflation, the measures are proportionately targeted on areas that can be reasonably controlled

The measures include:

- Significant reductions in the cost of food at UHS
- Support on Travel to work (Travel discounts, cycle to work)
- The ability to earn more through selling annual leave or through easy access to the Bank
- A freeze in prices at the UHS run Nurseries at 1 April 2022 rates
- Increased promotion of offers, discounts, and financial advice and support
- Crisis support for those most vulnerable

UHS Charity has focused on opportunities for crisis support for those in most need and hardship. A discrete central confidential referral system is to be created to enable access to a hardship fund, food parcels (via another local charity), and free eating at our restaurant.

Anticipated Impact

In an extremely difficult labour market, it is difficult to say with complete certainty that these measures will yield results. However, the anticipated impact is as follows:

- Stopping the current retention issues with ACPs and increasing satisfaction
- Closing the HCA vacancy down through continued recruitment and avoiding early leavers
- Improving the engagement, experience and retention of A&C roles through dedicated focus. The benefits from this are likely to take longer to embed
- Further improving, the speed, reach and quality of recruitment at UHS in the current labour market
- Reducing the well-being and financial concerns of our people, and specifically avoiding turnover of those in most need.

Other areas to note

The People report also notes the following highlight:

- Staff in post continues to increase at UHS in line with our Workforce Plan. The Trust has increased its substantive workforce size by 261 WTE (+44 ahead of plan). However, temporary staffing spending is still higher underpinned by continuing high demand
- Absence, including COVID, still remains an issue at 4.9% overall. Whilst this benchmarks well against others it is still above our target of 3.4%. The higher levels of sickness are contributing to temp staffing spending.
- Continuing roll out of new appraisal process with continued positive feedback from Divisions. Improving quality and depth of conversation as part of the overall career management framework.
- Overseas recruitment for nursing remains on track against our target of 302 in 22/23. UHS has been selected as the lead provider for overseas recruitment for Radiographers in the ICS. An update of final numbers on Nurse recruitment of newly qualified will be provided to the Board in October.
- The People report is being modified to track major investments and subsequent recruitment plan delivery to ensure estate capacity expansion has appropriate workforce on completion.

Implications: (Clinical, Organisational, Governance, Legal?)

Financial Implications are as follows which were approved at TEC

Non-Recurrent Cost	Cost
Cost of living support	£300k
Recruitment and retention premia for ACP	£500k
Project resources A&C	£60k
Annual leave buy out	£450k
Total	£1.31m

Recurrent Cost

Non-Recurrent Cost	Cost
Re-Banding of ACPs	£800k
Resourcing costs in recruitment	£200k
Total	£1m

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	Board is asked to note the report and the actions that have been taken.

UHS People Report

WORLD CLASS PEOPLE

September 2022

THRIVE EXCEL BELONG

Update for Trust Executive Committee

1. To **provide the Trust staffing position** and to provide assurance through the Trust Executive Committee (TEC) of our workforce risks, and associated mitigating actions
2. To **inform and improve decision support** about recruitment and safe staffing alongside our financial and activity plans
3. To **support and facilitate the work** of the Divisional Management Teams (DMTs)
4. To provide an **update against the People Strategy themes of Thrive; Excel; Belong**

TEC is requested to **note the information** in this report.

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 absences (p.5)** have been undulating since January 2022 and steadily decreasing; early July saw peaks of over 300 daily absences, which has reduced to 70 in August

(2) **Vacancies (p.9):** Vacancies in August have reduced, although this is sometimes due to budgetary changes. Consultant vacancies, although slight, have increased and SIP has decreased for the first time in 12 months

(3) **HCA supply (p.10):** Recruitment continues to be strong with 30 new HCAs joining each month on average, and 44 in August 2022, but with a high turnover, particularly within the first year tenure in role, the overall supply remains a persistent issue

(4) **Sickness (p.16):** Rates are at 4.9% (rolling 12 month), considerably higher than our trust target of <3.4%. Covid accounts for 17% of sickness; and anxiety, stress and depression account for 23%.

Workforce Summary

HCA Supply
Over half of HCA leavers leave within 12 months; a third within six months. HCA SIP is increasing

Turnover
There were 120 leavers in August 2022 – fewer than the previous month

Sickness
Sickness has decreased at 4.9% (r12M) owing primarily to reduced Covid impact; MH still high

Covid-19
Covid-related absences have further decreased steadily throughout Aug 2022 (71 avg absence)

THRIVE
In August we had a SIP growth of +312.5 WTE
(Compared with Dec-21 baseline)

EXCEL
Appraisal completions in August have decreased slightly to 590

BELONG
Proportion of our BAME staff at B7+ has further increased in August

Levels of attainment
Senior medic rostering engagement events taking place in September
Medic eJP is LoA 1; close to 2

Patient Safety
Significant decrease in red flag incidents which cited staffing in August (25) compared with July (60)

Other contextual updates
Workforce & Education Strategy 2022-2026 in development
AHP Day on 14 October

NHS England and Improvement Operational Planning Update
Operational workforce return for 2022/23 submitted June 2022
Planning for 2023/24 is expected to start December 2022

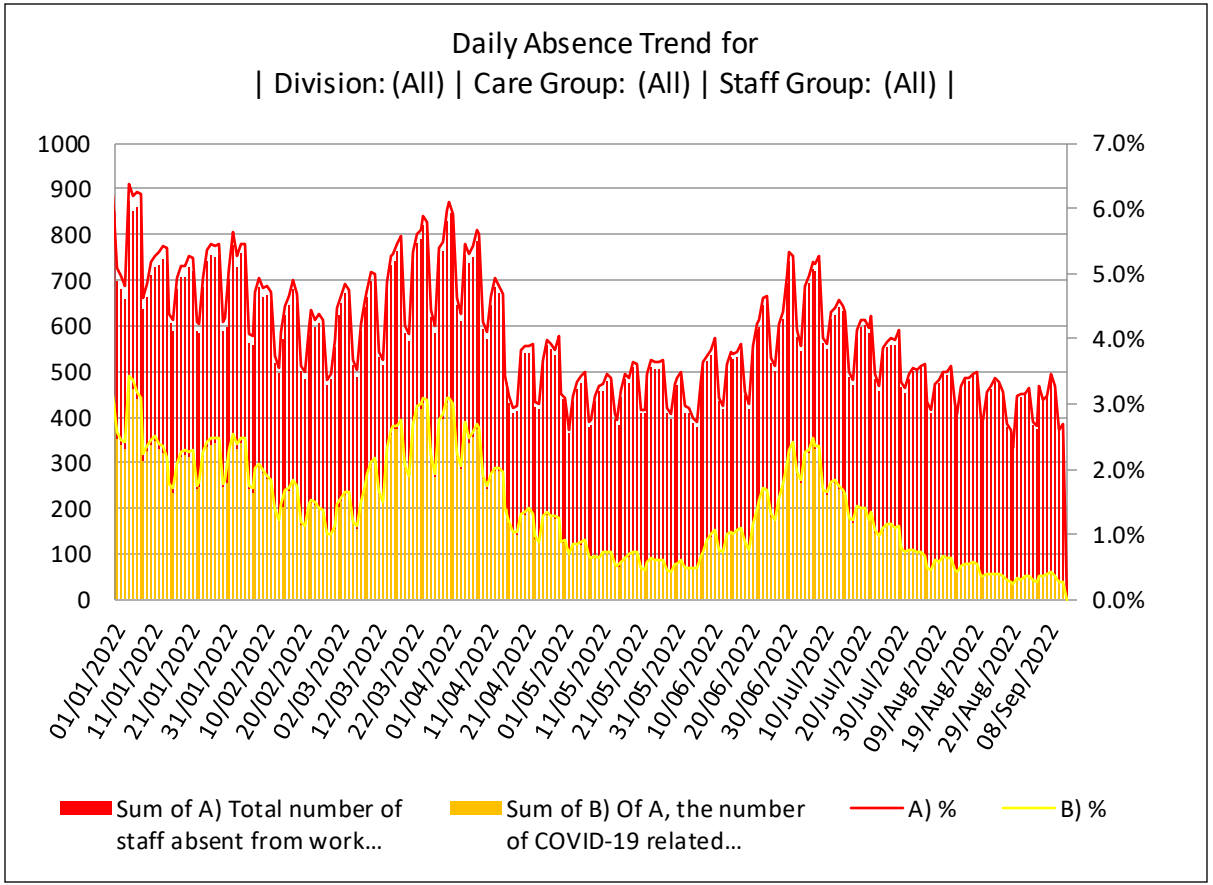
People Report - Covid

COVID UPDATE

Covid-related absences
The average staffing absence in the month of Aug for Covid reasons was **71** (0.5%) headcount; this is lower than July where the average was **219** (1.1%).

Absence due to Covid account for over a third of all absence.

Covid vaccine boosters
UHS will be providing Covid vaccine boosters for its workforce from September 2022.



Source: HealthRoster - Unavailability

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.

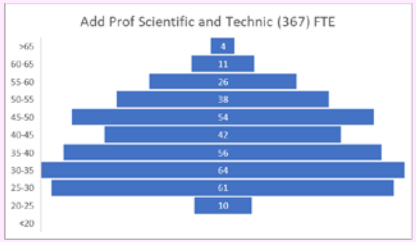
Relevant information:

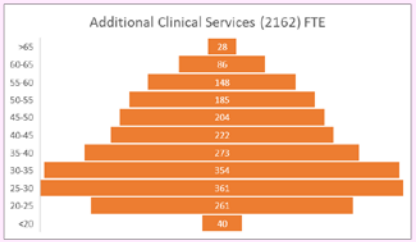
Staff in post | HCA supply | Vacancy rates (all staff; RNs) | Temporary resourcing | Turnover | Sickness absence | NHSEI Levels of Attainment

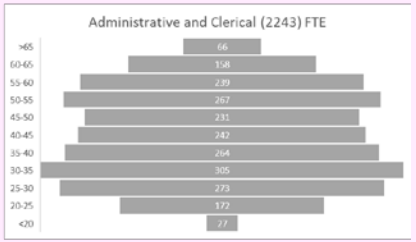
People Report

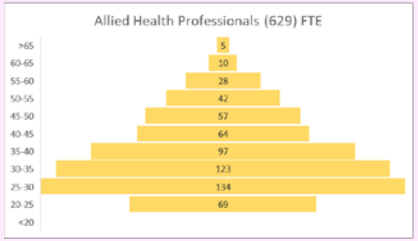
THRIVE | EXCEL | BELONG | PATIENT SAFETY

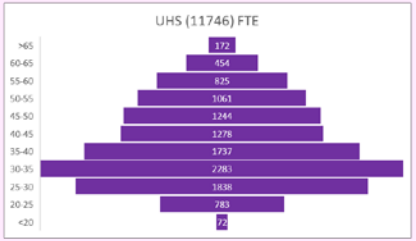
STAFF IN POST (n = 11,746 WTE) – 31 Aug 2022

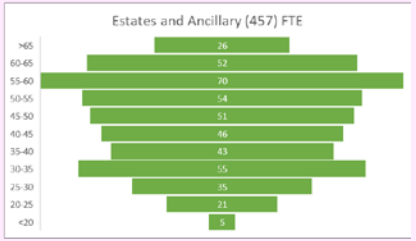


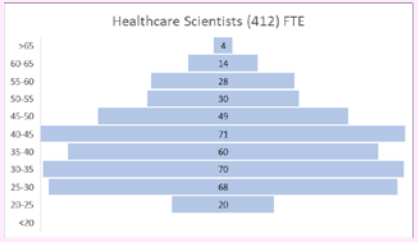


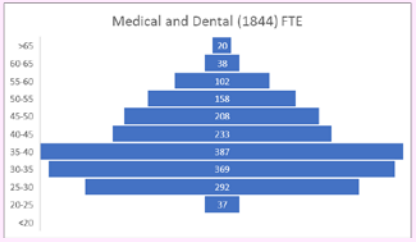


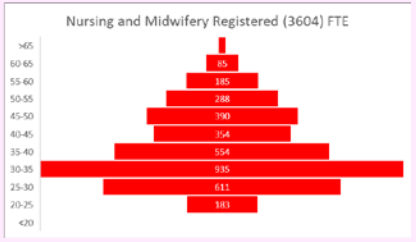












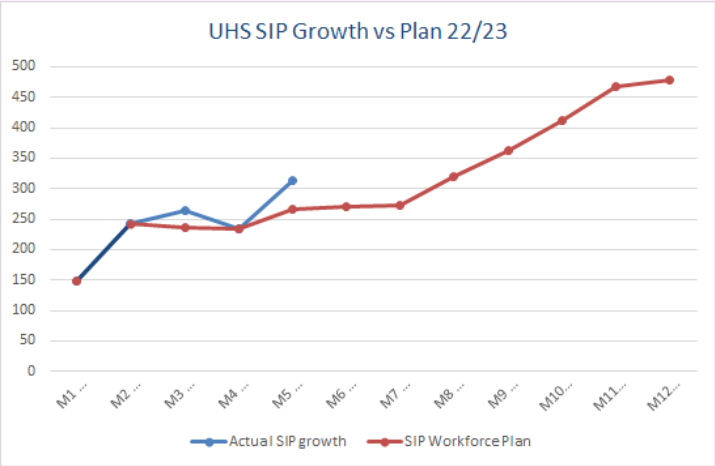
Source: ESR substantive staff as of 31 Aug 2022

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

STAFF IN POST GROWTH – 2022/23

	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 SIP growth	148.0	241.8	263.7	233.9	312.5							
SIP Workforce Plan	148.0	241.8	236.7	234.4	266.1	271.0	273.0	319.0	363.0	412.1	468.1	478.1
Deviation from plan	+0.0	+0.00	+27.0	-0.5	+46.4							



Inclusions:

Month-end contracted staff in post (ESR)

Exclusions:

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

Source: ESR substantive staff as of 31 August 2022

NB: Growth is compared with baseline of Dec-21 for alignment with workforce and finance plan

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TRUST-WIDE VACANCIES (August 2022)

Staffing group	Vacancy* (WTE / %)
Registered nursing (all)	350 / 9.5% ↓
Registered nursing (ward-based only)	303 / 13.5% ↓
Unregistered nursing (bands 2-3 HCAs)	293 / 19.8% ↑
Consultants	52.6 / 7.0% ↓
Junior doctors	-32 / -3.2%
Allied Healthcare Professionals	99 / 16.4% ↓
Healthcare Scientists	44 / 9.8% ↓
UHS Total	**1024 / 8.8%**

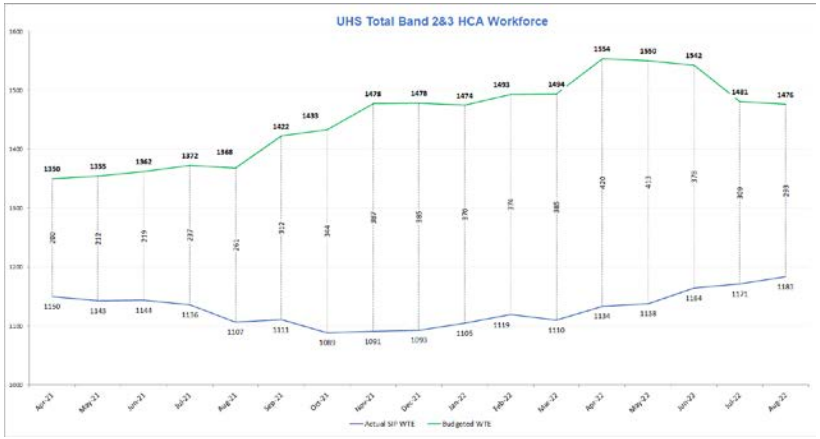
*Calculated by: (Budget – Staff in Post) / Budget in Month

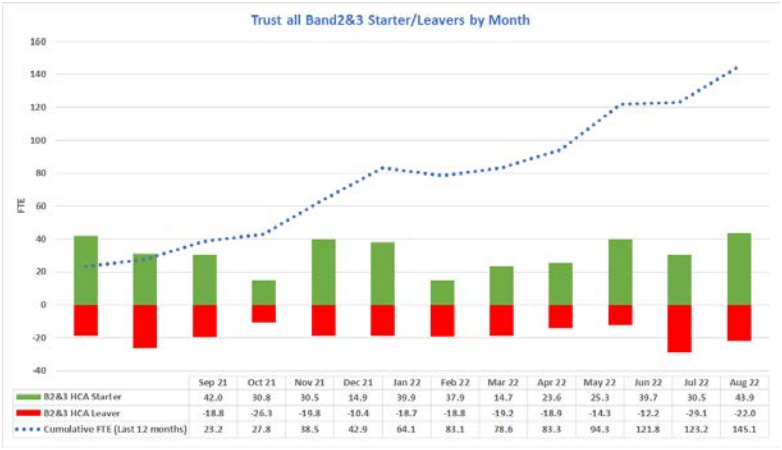
People Report

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 initiatives already in place, including extended two-week inductions, a HCA hub, Welcome Wards, and a HCA Project Lead. Initiatives are showing moderate signs of improved retention.
- Vacancies have decreased significantly from the peak in April 2021 (420 WTE; 27%) to August 2022 (293 WTE; 19.8%)
- The budget, linked to safe staffing and additional capacity and service delivery, has increased in 12 months from 1368 WTE to 1476 WTE. The recent reduction of the budget is due to correcting previous data errors.
- The last 12 months have seen a net increase of +145 WTE HCAs
- There is an additional 129.2 WTE reduction due to HCAs with contract changes (reducing contract hours, moving to non-HCA posts or taking nursing degree or Training Nursing Associate courses). These staff were retained in the UHS workforce
- During the last 12 months, 48% of HCAs left with less than one year service at UHS and 27% had less than six months' service



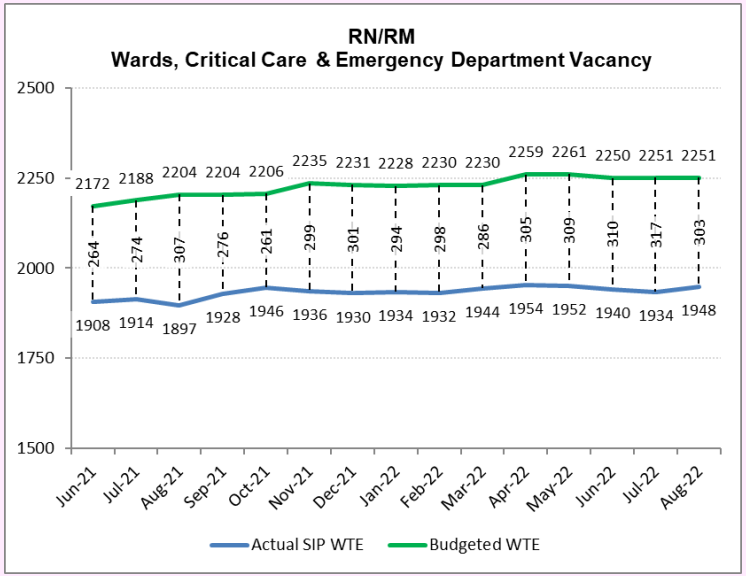


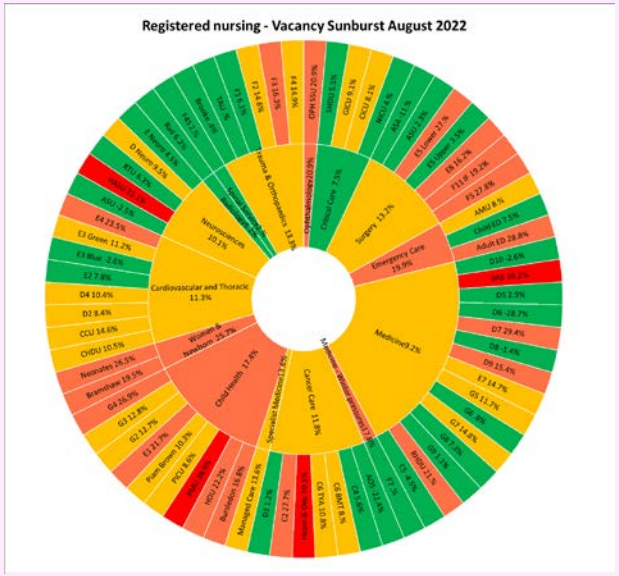
	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22
B2&3 HCA Starter	42.0	30.8	30.5	14.9	39.9	37.9	14.7	23.6	25.3	39.7	30.5	43.9
B2&3 HCA Leaver	-18.8	-26.3	-19.8	-10.4	-18.7	-18.8	-19.2	-18.9	-14.3	-12.2	-29.1	-22.0
Cumulative FTE (Last 12 months)	23.2	27.8	38.5	42.9	64.1	83.1	78.6	83.3	94.3	121.8	123.2	145.1

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

REGISTERED NURSING (WARDS) VACANCIES (Aug-22)

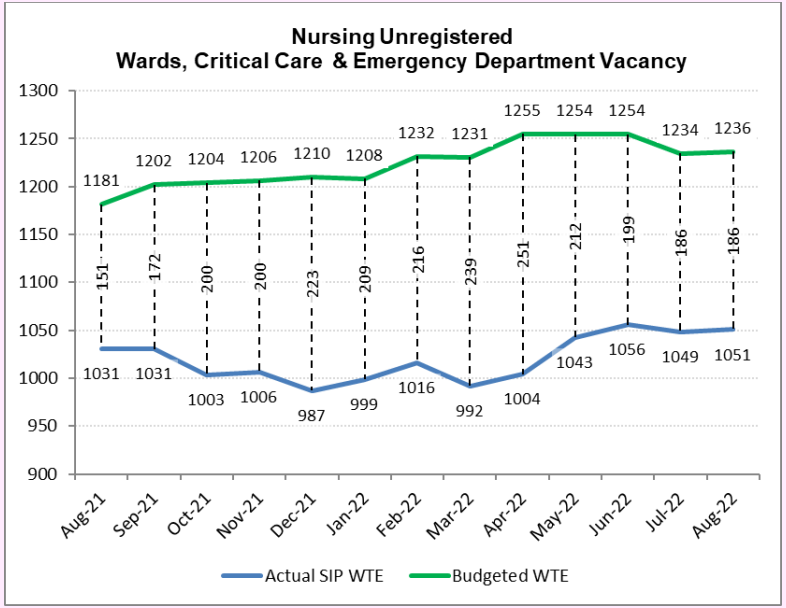


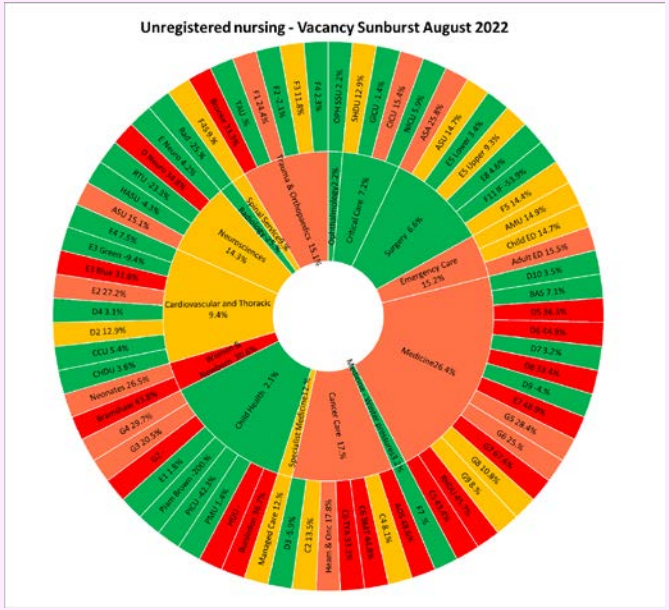


People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

UNREGISTERED NURSING VACANCIES (Aug-22)

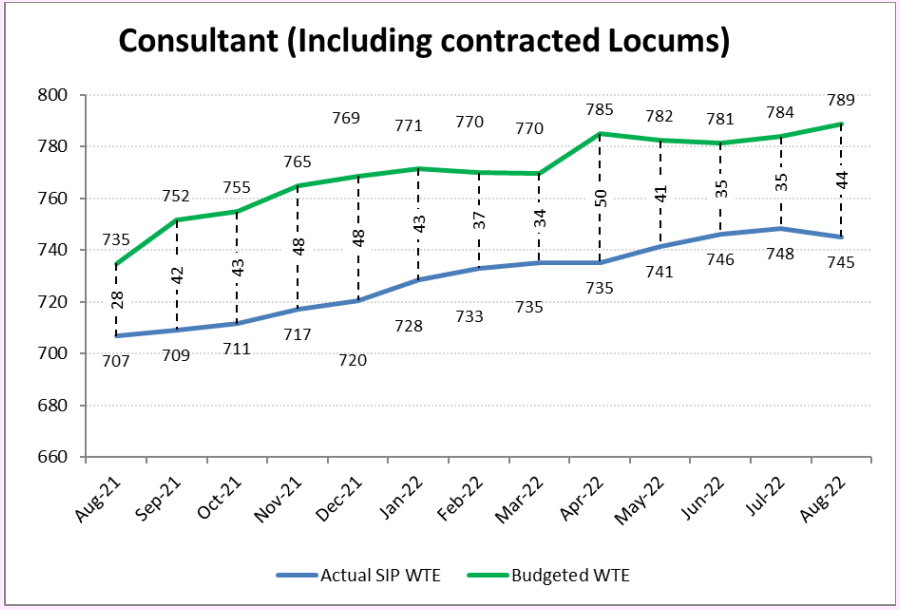




People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

CONSULTANT VACANCIES (Aug-22)



People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TEMPORARY RESOURCING

Status

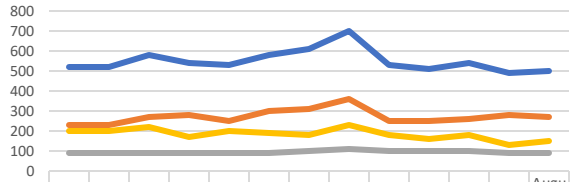
- Qualified nursing demand/fill (FTE): Demand increased from 492 FTE in July to 503 in August, of which, bank filled 269, agency filled 88 and 147 remained unfilled
- Bank fill for qualified nursing decreased from 55% in July to 52% in August.
- Demand is lower than August 2021

- HCA demand/fill (FTE): Demand decreased from 400 in July to 449 in August, of which, bank filled 265, agency filled 56 and 128 remained unfilled
- Bank fill decreased from 62% in July to 58% in August.
- Demand for HCAs 40 FTE higher than in August 2021

Actions

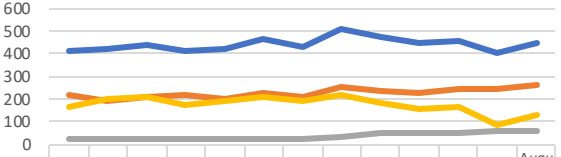
- Rate reduction plan agreed for Critical care and ED.
- Golden Key changes implemented to centralised through the staffing hub. Golden key added to all tier 2 agencies.
- NHSP working to migrate agency HCAs

Qualified Nursing Demand/Fill FTE
(August 21 - August 22)



	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	August
Demand	521	515	582	540	531	582	606	701	530	508	534	492	503
Bank Filled	228	227	267	282	244	299	306	357	249	251	258	274	269
Agency Filled	89	87	93	88	87	90	96	112	97	102	98	93	88
Unfilled	203	200	223	170	201	193	175	232	183	156	179	125	147

Unqualified Nursing (HCA) Demand/Fill FTE
(August 21 - August 22)



	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	August
Demand	409	423	442	415	420	464	433	506	471	444	458	400	449
Bank Filled	218	195	212	218	202	228	212	256	237	230	241	249	265
Agency Filled	21	28	23	22	23	27	25	35	52	54	53	61	56
Unfilled	169	200	208	175	196	209	196	214	183	160	164	89	128

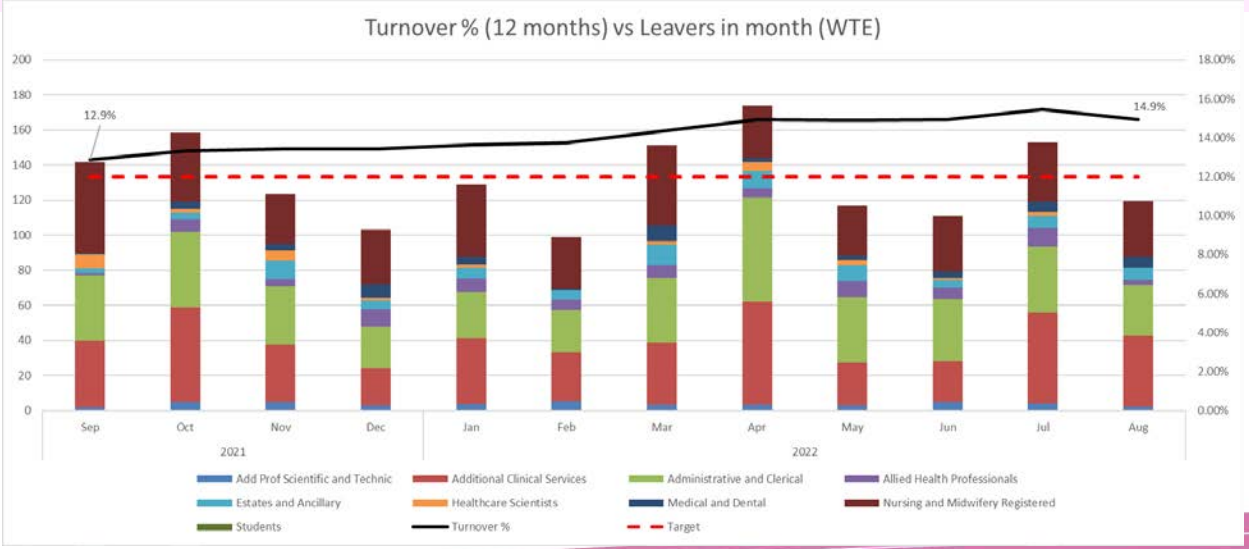
People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TURNOVER

Turnover has been increasing since June 2021, although has been stabilising over the last few months, and dropped in August Turnover has decreased by 0.5% this month as August 2022 had 50 fewer leavers than August 2021. Turnover is currently 14.93% which remains higher than the trust-wide target of <12%.

March 2022 saw an increase in leavers due to retirements; April 2022 was due to the termination of the workforce employed in the Chilworth laboratory; July 2022 was due to increased numbers of voluntary resignations, particularly amongst Additional Clinical Services (HCAs).

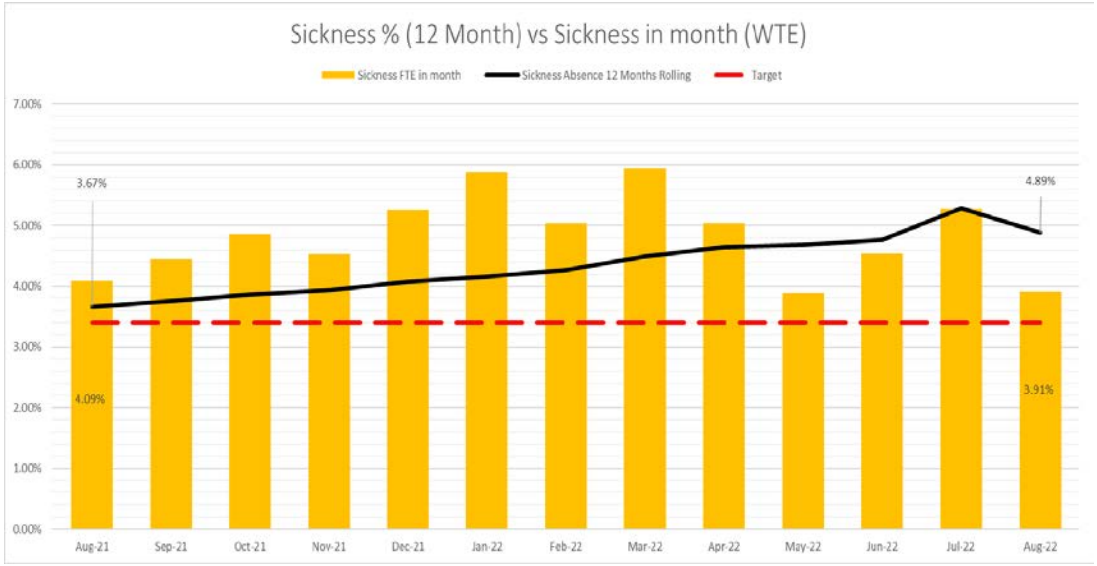


People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

SICKNESS

The rolling sickness rate has been increasing throughout the year but is now starting to reduce. Overall sickness remains higher than 21/22 figures with the current rate at 4.89%. The reasons for this include COVID-related sickness, mental health, gastrointestinal and MSK. Employee relations will work with/assist managers to support staff suffering from work related stress to improve wellbeing and decrease absence levels



Top five reasons for sickness in 2022/23 in August 2022

Absence reason	12M %	1M %
Infectious diseases (Covid)	29.6%	16.6%
Anxiety/stress/ depression	22.2%	22.7%
Other MSK	8.0%	8.4%
Gastro-intestinal	7.1%	10.4%
Other influenza	6.6%	4.6%

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

	Level Attained					
	Ward Based Nurse	Non-Ward Based Nurse	Consultant	Non-Consultant	Allied Health Professional	Pharmacist
Rostering	4	4	0	1	2	2
Job Planning	0	0	1	1	0	0

LOA

Levels of Attainment relate to the extent to which UHS have embedded electronic rostering and job planning across the trust within various staff groups. The highest attainment rating is 4 (organisation-wide with board-level accountability and alignment with budgets and objectives). A LOA of 0 does not mean that there is no electronic rostering or job planning in place; Level 0 means 'fewer than 90% of employees accounted for on eJP or rostering software'

Job planning

- 83% of consultants or SAS doctors have updated their job plan in the last year
- Over half (57%) of job plans are in 'discussion' stage
- There is a relatively low sign-off level for job plans (now 18%) for medics, a reduction from July

Rostering

- Locum doctors are now using the MedicOnline platform to book shifts
- Throughout September there are engagement events with senior medics regarding rostering implementation

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

We currently have **323** staff taking on different level of apprenticeship programmes against 50 framework standards. These include staff working in clinical apprenticeships in nursing, ODP, Occupational Therapy and Diagnostic Radiology. Other non- medical professions e.g. Dietetics, Speech and Language, Midwifery and Radiotherapy are looking to start apprentices as programmes come on stream.

Overall, the 2022/23 focus will be on reviewing systems, process and education to support the need to increase capacity and provide high quality experiences for students which meets their required programme outcomes.

UHS has drawn down **59%** of its apprenticeship levy as of March 2022.

Our current levy pot stands at £4.9M, with an average £200K per month is being added to the levy, and our average spend per month is £160K. We continue to support other organisations with levy transfer of approx. £2K per month, and this is set to increase. Our first cohort of BPP nurse degree apprentices are due to qualify and the majority have applied for post as newly qualified nurses to start in October.

Division	Headcount
Division A	53
Division B	84
Division C	67
Division D	67
THQ	50
CLRN	2
Grand Total	**323**

STUDENTS

UHS has been able to return to a pre-COVID position with increased placement capacity for non-medical students. UHS is also supporting students from an increased number of Higher Education Institutions (HEIs). An example of this is in nursing where the overall student capacity has increased by 60 over the last year. It is noted that apprentices are additional to allocated HEI capacity and so this has led to a significant increase in placement requirements

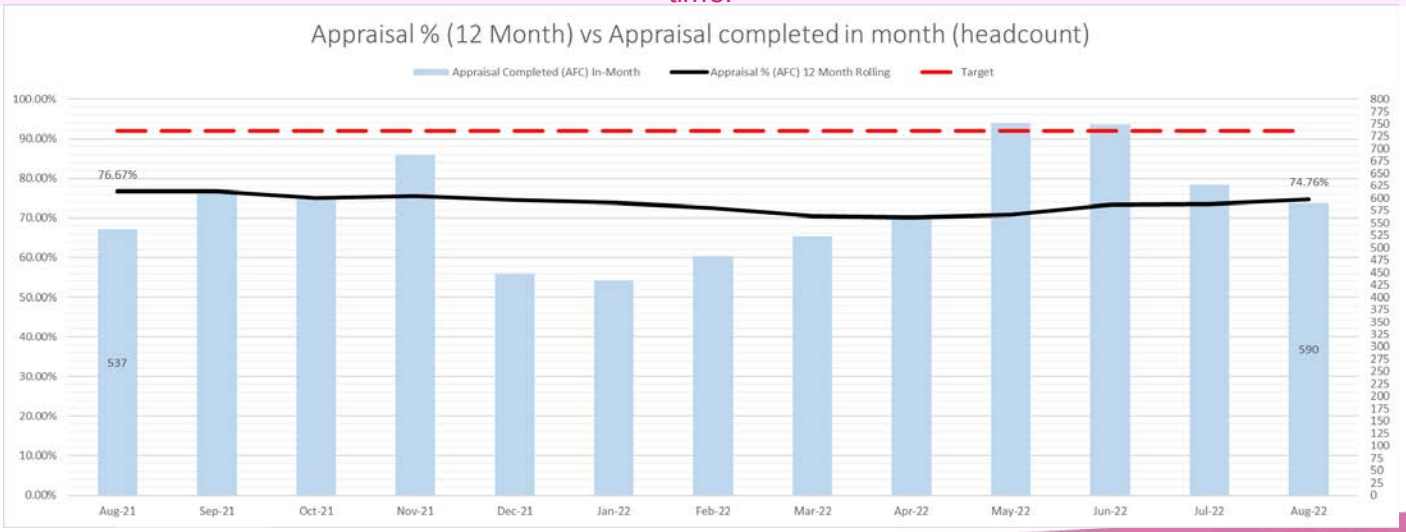
People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

APPRAISALS

2022/23 heralds the launch of a new appraisal process for the trust to enhance the opportunity for staff to have a meaningful yearly appraisal to reflect on what's been achieved during the last year, assess performance, and agree new priorities. The new approach has been developed by a working group consisting of people across the organisation. The first phase includes refreshed appraisal paperwork, supporting guidance for appraisers and appraisees, training and resources.

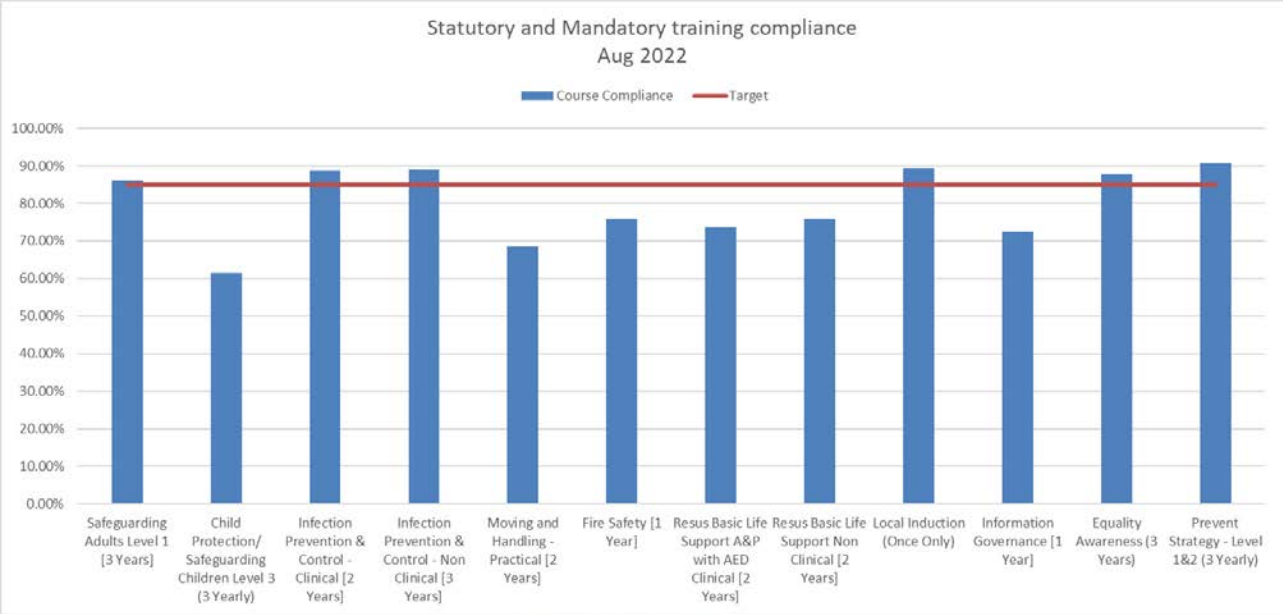
Appraisal completions have been generally increasing since April, resulting in an increase to the 12 month rolling average. Managers are encouraged to enter appraisals onto ESR in a timely way; there is still an average 21 day lag time.



People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

STATUTORY AND MANDATORY TRAINING



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.

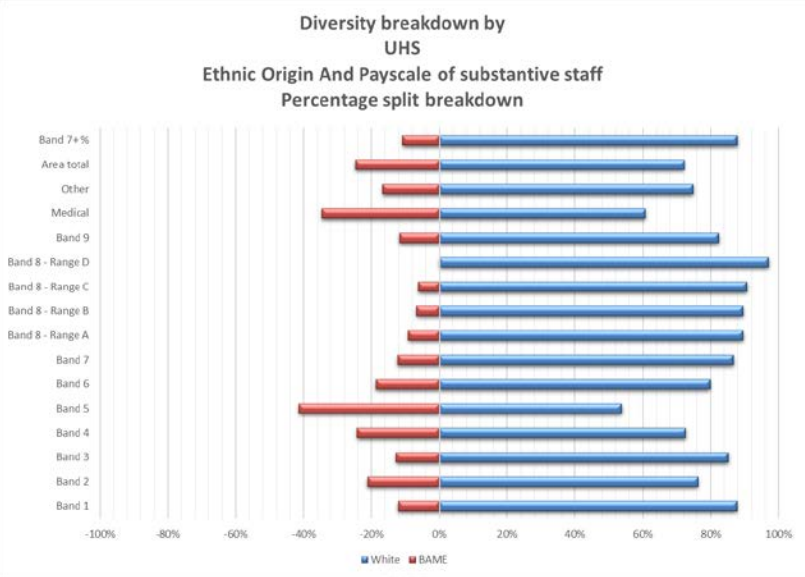
Relevant information:

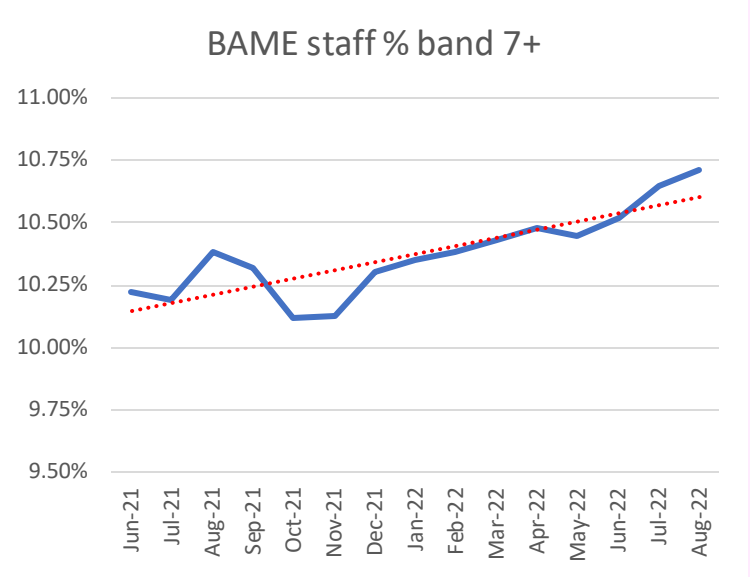
Percentage of staff employed at AfC B7+ from non-white backgrounds | Percentage of staff employed at AfC B7+ with a disability or long-term condition

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

STAFF IN POST - ETHNICITY

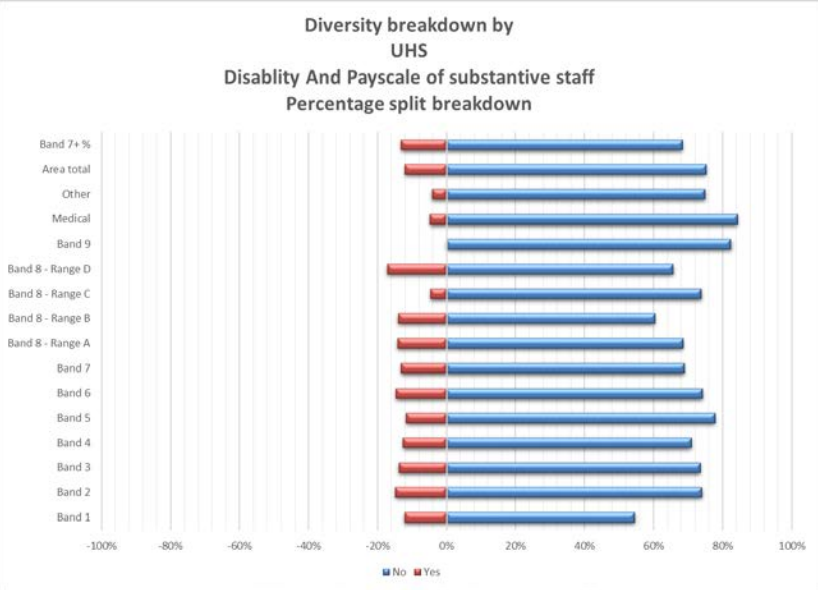


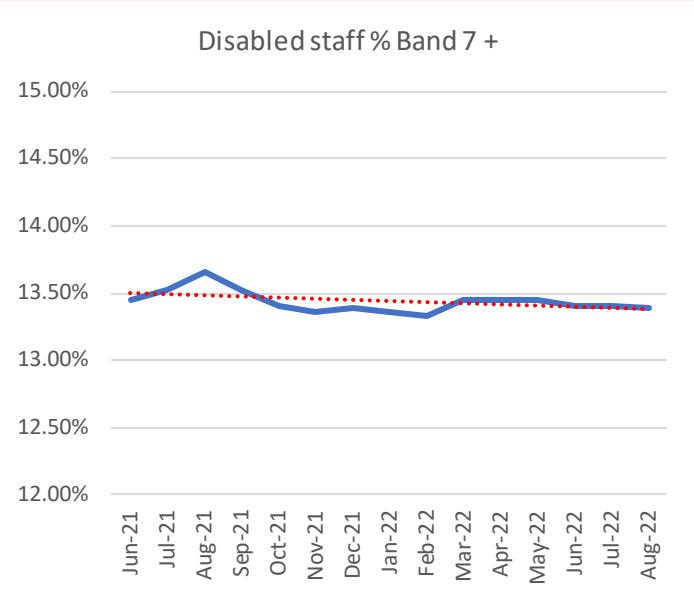


People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

STAFF IN POST – DISABILITY STATUS



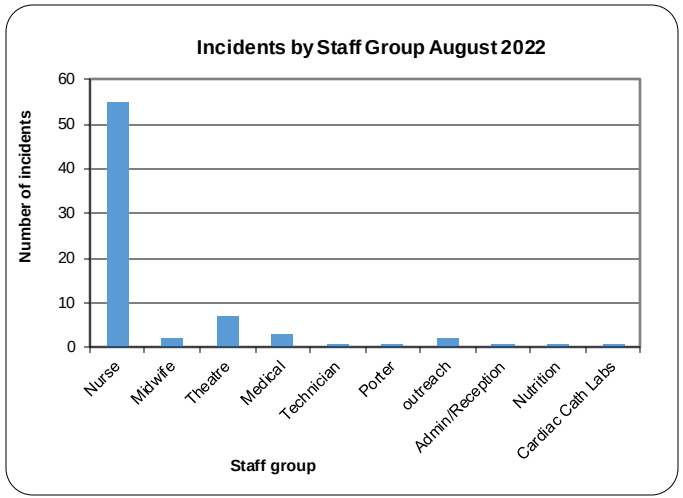


People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

OVERVIEW OF PATIENT SAFETY INCIDENTS AND RED FLAGS

- In total 75 incident reports were received in August 2022 which cited staffing, this is a significant decrease on the previous month with this decrease noted across all Divisions.
- These incidents were rated from near miss to severe/major (4) impact, with 3 rated as moderate impact. This is a significant decrease in the number of incidents with a higher impact rating.
- Red flags reported via the AER system fell significantly this month with the reduction noted across all of the divisions.



Month Incident occurred	Division A	Division B	Division C	Division D	THQ	Trust total
August 2022	28	15	24	7	1	75
Total	28↓ (45)	15↓ (30)	24 ↓ (49)	7 ↓ (21)	1 ↓ (6)	75↓ (151)

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

DIVISIONAL BREAKDOWN:

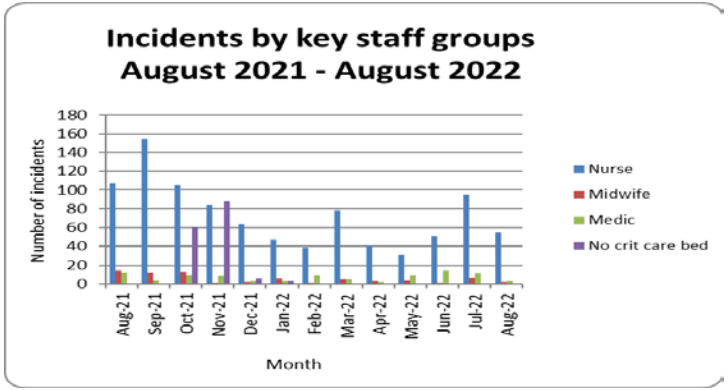
Div A: Twenty-eight incidents reported in August, down from 45 in the previous month. There were 5 red flags reported in the month, a fall on the 5 in the previous month. The incidents ranged from low to moderate impact (1). A reduction in the severity level reported. The incidents related to 6 different staff groups. There were 15 incidents related to nursing, down from 19 in the previous month. Incidents were reported from Critical Care, Surgery and Theatres linked to increased skill-mix challenges. There were 7 incidents reported from theatres where there was an impact on the timeliness or throughput of activity. This is a reduction on previous months. Two incidents were raised related to the current shortfall in outreach support which is under ongoing review by the Division

Div B: Fifteen incidents reported in August 2022, down from the 30 in the previous month. There were 3 red flags reported in the month, down significantly on the 25 reported in the previous month. The incidents ranged from near miss to moderate (2) and severe/major (4) impact. This is a reduction on the previous month but remains at a higher-than-normal level for the Division. A review of the risk rating on some of these incidents is recommended as they do not appear to meet the threshold for severe/major impact. The incidents related to nursing only with the 15 incidents being a reduction on the 28 reported in the previous month. The incidents were reported from a wide range of different areas with no clusters noted. They related to the rising acuity and complexity of the patients matched with the skill, availability, and movement of appropriately trained staff.

Div C: The incidents ranged from near miss to low impact. There were 17 red flag incidents reported, a significant fall on the 38 in the previous month. The incidents related to 3 staff groups with 19 related to nursing (6 from neonates and 6 from PICU), a fall on the 32 in the previous month. There were 2 incidents related to midwifery staffing. The majority of the incidents were reported from PICU/Paediatric high dependency (7) and Neonates (6). These numbers are down significantly on the spike noted in the previous month. The incidents from neonates continue to reflect the capacity and staffing challenges experienced in the month. No incidents were reported this month related to the provision of transport for transfers which had accounted for 7 incidents in the previous month).

Div D: Seven incidents reported in August, down from 21 in the previous month. The incidents were rated as near miss to low impact. The incidents covered 2 staff groups with 6 related to nursing, a fall on the 14 in the previous month. There were 0 red flag incidents, and the Division are asked to review. There were no medical/ACP shortfalls reported in CVT and Neurosciences after a sustained 3 months of these incidents being flagged.

THQ: One incident reported in August, down from 6 in the previous month. The incident was related to pharmacy portering. The incident was rated as low/minor. .



	Red flag category	Number of reports	Div A	Div B	Div C	Div D
August 2022	Delay in medication	5	1	0	4	0
	Delay in pain relief	4	2	1	1	0
	Delay in observations	8	1	1	6	0
	Less than 2 registered	8	1	1	6	0
	Total	**25**	**5**	**3**	**17**	**0**

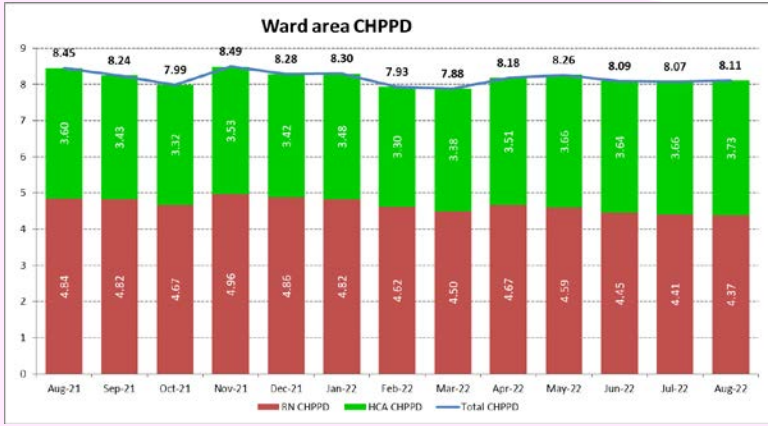
	Red flag category	Number of reports	Div A	Div B	Div C	Div D
July 2022	Delay in medication	18	2	7	9	0
	Delay in pain relief	25	3	8	13	1
	Delay in observations	17	2	5	8	2
	Less than 2 registered	17	2	5	8	2
	Total	**60**	**9**	**25**	**38**	**5**

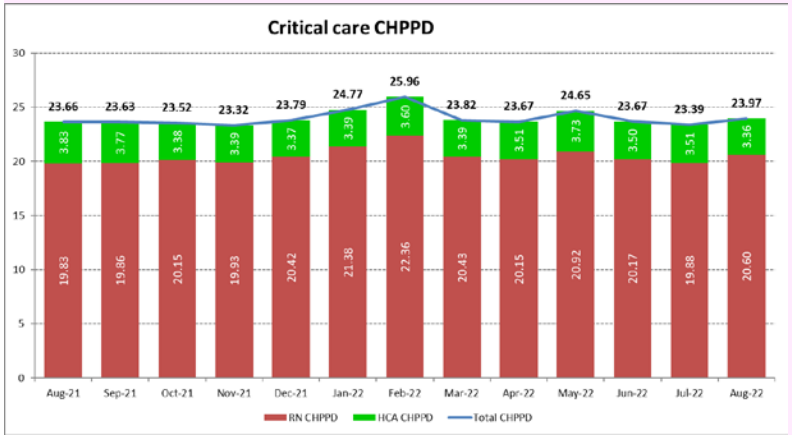
People Report

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

CARE HOURS PER PATIENT DAY

The Ward areas CHPPD rate in the Trust has increased from last month to RN 4.37 (previously 4.41), HCA 3.73 (previously 3.66) overall 8.11 (previously 8.07). 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 increased overall from last month. RN 20.60 (previously 19.88), HCA 3.36 (previously 3.51) overall 23.97 (previously 23.39). 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.

Summary of workforce metrics

Topic (bold font: in the UHS Way strategy)	Status - RAG colours	Next routine update	Further information:
Appraisal levels	Decreasing	September 2022	Published monthly: Internal
Apprenticeships	Improving; however £4m unspent in levy	September 2022	In development
CHPPD- Quality	Improved from July	September 2022	Published monthly: National
CQC Inspection: aspire to outstanding for 'Well Led' category	To be confirmed	To be confirmed	To be confirmed
EDI and Protected characteristics: Age, BAME, Disability, Gender	Proportion of BAME staff at B7+ increasing	September 2022	From EDI and Board KPI report
Levels of attainment for e-Rostering and e-JobPlanning	On course; job plan sign off decreasing	September 2022	In development
Overall staffing position (SIP)	On course; above plan	September 2022	ESR
Pulse survey	UHS reporting better outcomes than peers	TBC	HR
Staffing incidents- Quality	Fewer incidents in August	September 2022	Staffing Incident Report
Staff Survey 2021	Positive engagement and outcomes at high level	Autumn 2022	HR
Staff Unavailability including sickness, headroom	Covid prevalence decreasing	September 2022	ESR
Temporary Resourcing	Improving	September 2022	Temporary resourcing team; ESR
Turnover and retention	Improved in August; still high for HCAs	September 2022	ESR
Vacancies- RNs, unregistered, medical	Stable for RNs; HCA a heightened concern	September 2022	ESR

University Hospital Southampton NHS Foundation Trust

Report to Trust Board of Directors				
Title:	**Safeguarding Annual Report 2021-22**			
Agenda item:	**5.7 i)**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Authors:	**Karen McGarthy, Named Nurse for Safeguarding Children** **Corinne Miller, Named Nurse for Safeguarding Adults**			
Date:	**29 September 2022**			
Purpose	**Assurance or reassurance** **x**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	The safeguarding annual report summarises the key achievements and activity for 2021/2022 and highlights key areas of work for 2022/2023 for adult, child and maternity safeguarding within UHSFT. This includes the Paediatric Liaison Nursing Service, and the LD and Autism Liaison Service. This year has seen an increase in activity and complexity across all services which are evident within the report and highlights the on-going impact of Covid-19 on Safeguarding. The teams have continued to adapt their collaborative working approaches both within UHSFT and across the multi-agency partnership in order to meet this demand. The report has been written to provide high level assurance as to the safeguarding arrangements within UHSFT.			
Response to the issue:	Members of the Board are asked if the report gives the required assurance around UHSFT adult (including learning disability), child and maternity safeguarding services. Summary of key points within the report include: • Progress updates and what we have achieved since the last annual report. • Activity data and analysis • Patient stories for adult, child, Maternity, LD (adult and child) • Key areas of work for 2022/23			
Implications: (Clinical, Organisational, Governance, Legal?)	The safeguarding report outlines the strategic and operational work of the safeguarding team which encompasses clinical, organisational and governance implications			
Risks: (Top 3) of carrying out the change / or not:	Not applicable			

Summary: Conclusion and/or recommendation	The safeguarding annual report has highlighted the safeguarding team's activity for 2021/22. From a strategic and operational perspective this is pivotal to ensure we continue to improve outcomes for children and adults. The key areas of work for 2022/23, are outlined at the end of the report, and align with the safeguarding strategy standards which are also being presented to Trust Board.

Safeguarding Annual Report 2021/2022

Karen Mcgarthy, Named Nurse Safeguarding Children

Corinne Miller, Named Nurse Safeguarding Adults

Julie Davies, Named Midwife Safeguarding

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Introduction

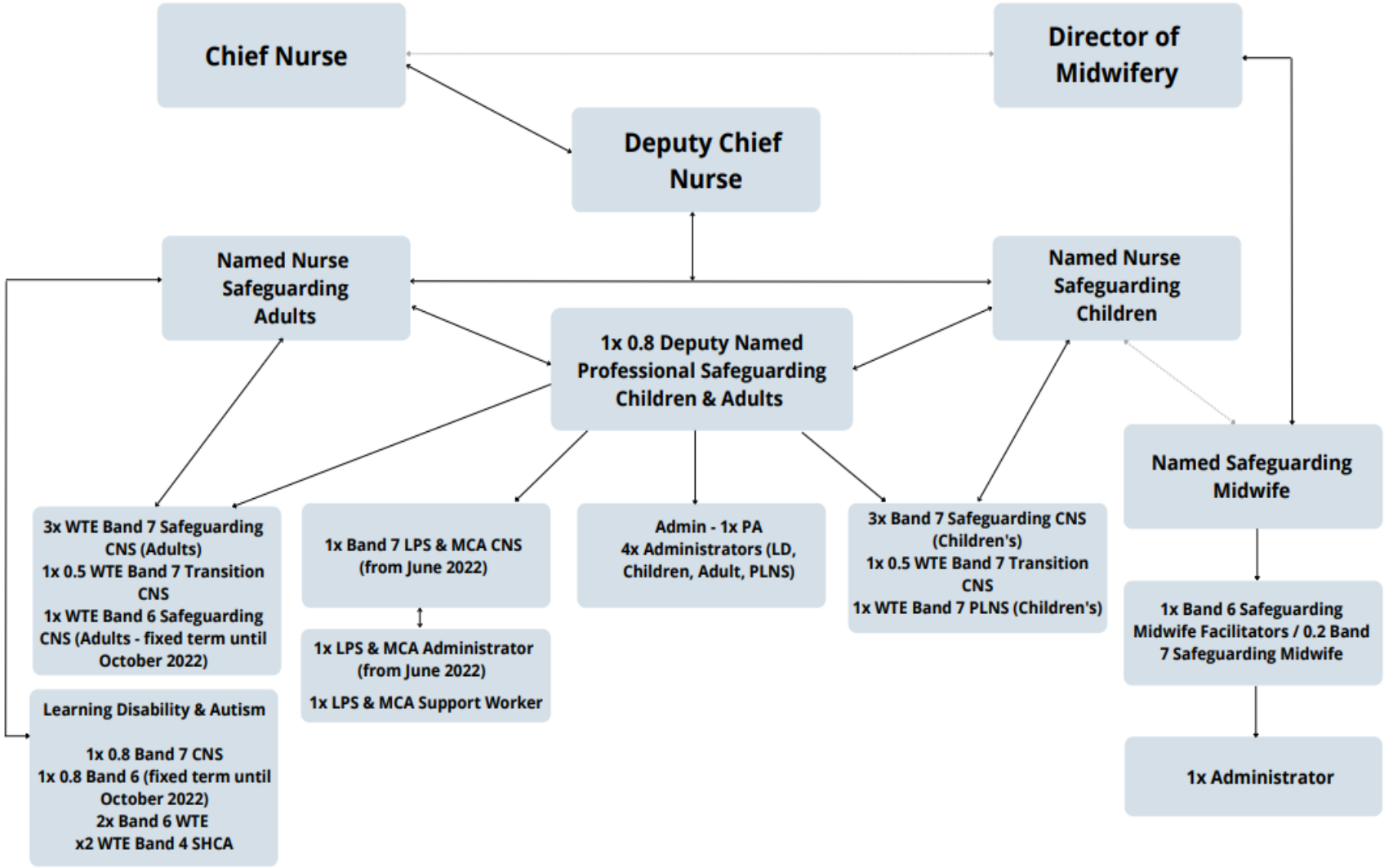
This year's Safeguarding Annual Report summarises the key achievements and activity for 2021/2022 and highlights key areas of work for 2021/2022 for Adults, Children and Maternity safeguarding within UHSFT. This includes the Paediatric Liaison Nursing Service, and the Learning Disability and Autism Liaison Service. This report has been written to provide high level assurance to the Executive Team in relation to the safeguarding arrangements within UHSFT.

With the ongoing impact of COVID-19, the safeguarding team have continued to be innovative and adaptable to enable a continued robust, responsive and supportive service to both UHSFT colleagues and multi-agency partners in order to promote the welfare and safeguard our vulnerable children and adult population. This has meant over the last year some of the safeguarding work has remained remote but with a definite steer to have much more visible on-site presence.

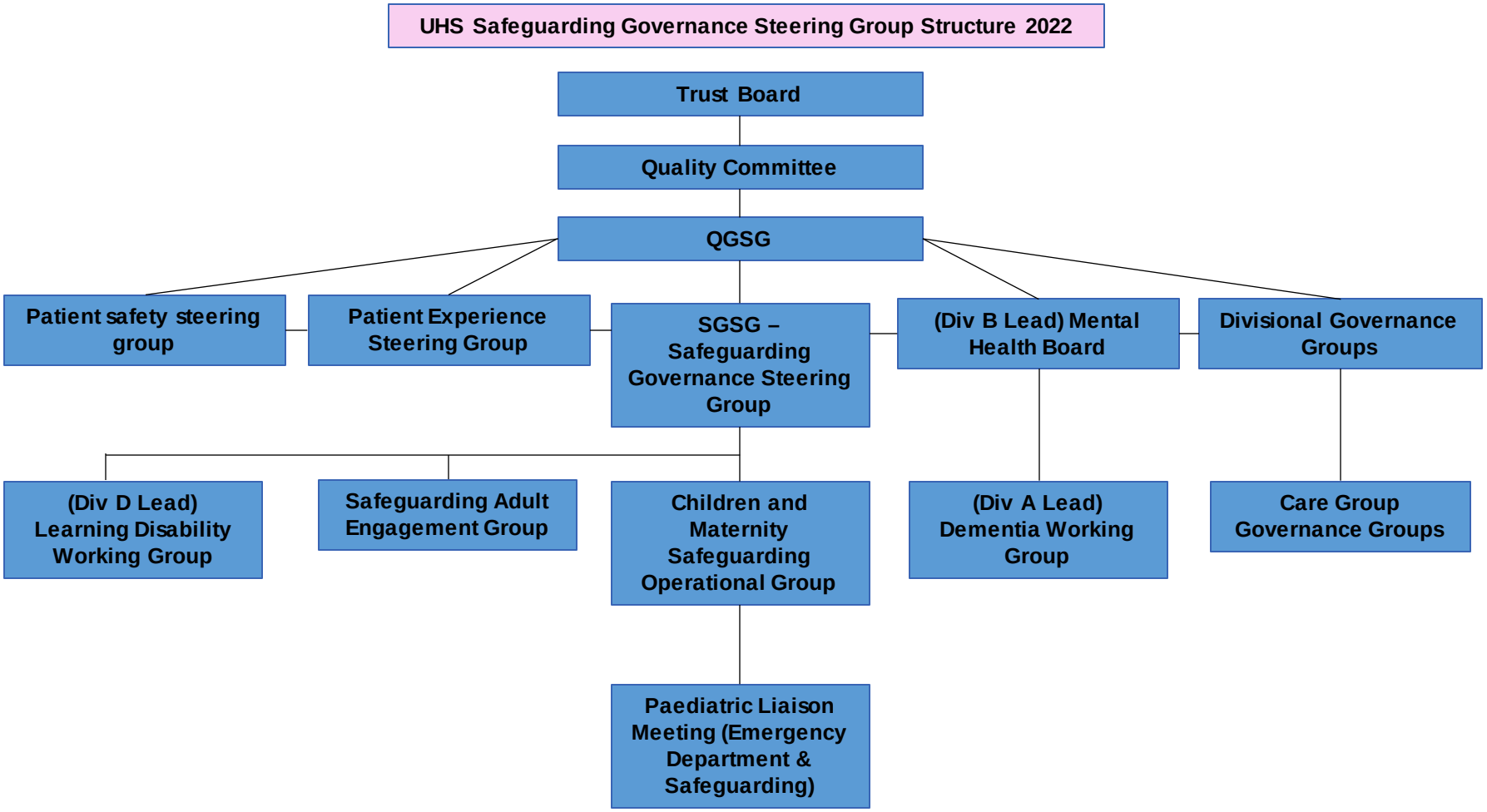
There are a number of longitudinal studies currently ongoing looking at the impact of COVID-19 including the impact of restrictions when the UK was in lockdown. especially in relation to the impact on children and adults, in particular, hidden harm. This correlates with the significant increase in referrals in 2021/2022 to the UHSFT Safeguarding Team, with a high level of complexity within many of these referrals.

As highlighted in last years annual report, the teams have continued to adapt their collaborative working approach both within UHSFT and across the multi-agency partnership in order to meet this demand. However due to the continued increased activity, further staff sickness, staff resignations and new appointments of a Deputy and Named Nurse, this has had an impact on work demands. Although the report will highlight progress with some work streams, capacity and demand has meant that operational case management has needed to be the priority, with some workstreams needing to be put on hold. This increase in demand upon the system has also been acknowledged across the wider Hampshire and Isle of Wight footprint. This will be reflected in this year's report.

Safeguarding Staffing Structure 2022



Governance structure



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Progress updates – Safeguarding

Last year (20/21) we said we would;	We have achieved (21/22);
Review and refinement of the joint safeguarding supervision policy	As a continuation from last years report- the Safeguarding Supervision Policy requires a review across adult, children and maternity safegaurding The plan is to review this in 2022/23. The safeguarding teams continue to offer responsive supervision for staff who require additional advise and support . Some Supervision groups are established within Maternity and Neonatal Services. MDT/Supervision sessions are being reviewed as part of the service delivery with in the children hospital. Regular supervision sessions have been established for VAST and alcohol care teams due to recognition of the increased complexity of their work.
Planning and implementation of the Mental Capacity Amendment Act (2019) and the Liberty Protection Safeguards	Delivery of a further two legal Mental Capacity Act master classes commissioned by UHS. New Level 3 training on VLE which provides a detailed overview of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards in practice. Agreement obtained for the development of new Apex modules to report on and manage Liberty Protection Safeguards applications. Successful recruitment to MCA/LPS lead practitioner and administrator posts. At the point of writing this report, UHS consultation response in respect of the draft MCA code of practice has been submitted. MCA workstreams are being refined and include planning for audits on DoLS and MCA assessments in relation to discharge planning.
Sign off and implementation of the safeguarding strategy	This has been reviewed and includes maternity safeguarding. The Strategy focuses on key priorities, aligning this with the Trusts Values. Date of review 2025
Development of joint training strategy – family approach	As a continuation from last years report- this is a safeguarding priority to implement the joint training strategy, as outlined in the Safeguarding strategy. Due to work demands this has been delayed, however remains a priority and with the development of the level 3 safeguarding adult training, this will support the process.
Network to improve training and ensure an integrated approach with partners agencies to tackle domestic abuse and honour based abuse	As a continuation from last years report, this remains a key priority.

Progress updates – Adults Safeguarding

- Level 3 training mapped to the latest inter-collegiate document and skills for health framework has been written and is awaiting recording and upload to VLE. This training will be role-profiled to all front-line staff and will provide a comprehensive overview of Safeguarding Adults, Consent, the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards in Practice. At the time of writing, Health Education England Level 3 training has been added to VLE and is accessible Trust-wide.

- Work continues with publication to finalise an MCA booklet for patients and their families.

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- UHSFT continue to engage with key partners across the Hampshire and Isle of Wight footprint in relation to the incoming Liberty Protection Safeguards Framework. The Liberty Protection Safeguards will provide protection for people aged 16 and above who are or who need to be deprived of their liberty in order to enable their care or treatment and lack the mental capacity to consent to their arrangements.

- Work has continued with the Technology Team to develop a Deprivation of Liberty Safeguards online application form to help simplify the DOLS process for frontline staff. This work is being carried out in consultation with our Local Authority DOLS teams

- A patient information leaflet in relation to the Safeguarding Adults Agenda has been completed and is awaiting publication. It is envisaged that this resource will prove a helpful guide for patients, explaining the Safeguarding process when a referral has been made

Progress updates – Children's Safeguarding

- Audits –Safeguarding Proforma audit, Child Exploitation audit and Bruising Protocol ICON.
  - The Child Exploitation Audit demonstrated a good level of assurance with UHSFT safeguarding processes, recommendations and actions are currently being shared at divisional and safeguarding meetings. See Maternity section for more detail.
  - Bruising Protocol Audit. The audit demonstrated the importance of on going training for staff on the Bruising Protocol and the ED standard to contact Children Social Services for all children presenting with a bruise. The audit identified on going training for ED staff on the ISF criteria and use of ICON
  - The Safeguarding Proforma audit, and ICON audit within Child Health has been put on hold, although work has resumed , it is scheduled to be completed in the autumn of 2022 The recommendations and actions will be shared at divisional and safeguarding meetings
- As with adult safeguarding to continue to engage with key partners across the Hampshire and Isle of Wight footprint in relation to the newly anticipated Liberty Protection Safeguards Framework. To continue work to improve and embed the application of the Mental Capacity Act (2005) in practice to ensure successful implementation of the Liberty Protection Safeguards (LPS) which applies to 16-17 year olds.
- Work continues with the technology team to improve and refine Apex children's referrals , this includes a children's dashboard and the building of the information sharing form (ED liaison form) onto APEX. Due to capacity and demand this has been on hold, however at the time of writing this report, this work stream has resumed.
- The Level 3 safeguarding training continues to be a delivered across the Trust with 40 sessions offered in 2021/202, see training section

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Progress updates – Maternity and Neonatal Safeguarding

- It has been challenging delivering safeguarding during a global pandemic. However, despite the challenges, maternity and neonatal staff have adapted and continued to identify, refer, manage, and support families during their pregnancy journey. All of which has helped to keep unborn and newborn baby's safe. Underpinning this is the work of the maternity safeguarding team who have supported the staff through training, supervision, giving oversight and support to increasingly complex and demanding safeguarding cases and ensured that there are safe processes and systems in place.
- Following the Launch of the HIPS wide Unborn and Newborn protocol in March 2021,the UHSFT maternity safeguarding team have participated in two HIPS wide audits of the unborn Protocol, currently awaiting feedback and action plans from these audits. The Named Midwife for safeguarding is also a participant in the Unborn Protocol Strategic Group set up to ensure there is continuous quality assurance and promotion of the protocol.
- The Safe Sleep and ICON audit completed in December 2021 demonstrated a good level of compliance in giving safe sleep and ICON advice to all families. A further audit of Safe sleep and ICON is planned for December 2022 to reassure continued compliance following the introduction of Badgernet in June 2021. Any family identified as having increased risk factors in the postnatal period are given a safe sleep and ICON pack on hospital discharge or following a home birth. Babies discharged from the neonatal unit or transitional care have a Safe Sleep risk assessment before discharge/transfer.
- In 2021 a safeguarding training package was launched for Maternity and Neonatal Newly Qualified Midwives and Nurses (NQMN). From November 2022 Maternity Safegaurding will be hosting a bespoke full day training session for NQMN which will compliment the safeguarding competency workbook which all NQMN staff are asked to complete. This will support NQMN to meet their level 3 safeguarding training requirements
- Badgernet maternity information system was introduced in June 2021, Maternity safeguarding have continued to work with 'Clevermed' (Badgernet provider) to improve data collection and discuss any challenges encountered in safeguarding practice, working with maternity staff to ensure that safeguarding systems within Badgernet are understood and that safeguarding documentation is complete by providing updates and how to guides
- Work continues to integrate harmful practices policies and training with the wider trust and partner agencies.

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Progress Updates - Learning Disability (LD) / Autism

- Development of easy read information for patients; due to staff shortages within the team, this work-stream is currently paused.
- Two skilled Band 6 Learning Disability nurses have been successfully recruited and have started in post. Recruitment has been undertaken as a joint initiative with colleagues in Southern Health Foundation Trust with the aim for the nurses to work across both Trusts as part of a new and innovative rotational post to work across the system.
- Monthly meetings between Southern Health and UHSFT have been established to provide oversight of the joint rotational posts and to enable contemporaneous sharing of resources between hospital and community LD teams.
- Work continues to test and implement an Apex module for use by the Learning Disability and Autism Liaison team in order to promote ease of internal referrals into the service.
- Work has commenced on production of a Standard Operating procedure for the Learning Disability and Autism team in order to provide clarity around service delivery.
- Leading on South Acute Nurses Network – first meeting held March 2021 with good representation across Hampshire, Portsmouth, IOW and Channel Islands.
- Work to develop patient pathway is continuing to be led by Pathway Matron and Divisional Clinical Director (Division B).

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Key achievements - Safeguarding Adults

- High levels of capacity and demand on the Safeguarding Adults team have continued over the past year and due to this the team have focussed on prioritising patients in terms of their immediate safety and protection planning.
- The new Deprivation of Liberty assurance process has been successfully implemented and continues to ensure a more timely and robust process for sharing DOLS data with Local Authority colleagues.
- Establishment of the Liberty Protection Safeguards Governance Steering Group (LPSGSG) to oversee the successful implementation of the anticipated Liberty Protection Safeguards.
- Successful establishment of the new MCA/LPS/DoLS team whose work focusses on embedding MCA as everyday business across UHS.
- A continuous focus on ED – to ensure that Safeguarding concerns are recognised and referred in line with due process with ongoing support for the VAST team.
- Daily on site presence of the Adult Safeguarding Team during core working hours. This has enabled the team to provide a timely response when immediate and complex safeguarding concerns are identified.
- Publication of Safeguarding Adults Matter newsletter has increased to four times a year and is widely disseminated across the Trust.
- Updating of MCA/DoLS Staffnet pages including additional information about advocacy and process for making advocacy referrals.
- Adult Safeguarding Staffnet pages have been updated to include 4LSAB guidance in relation to fire safety, Safe and Well visits and newly updated hoarding guidance.

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NHS Foundation Trust

Key achievements - Safeguarding Adults

- Weekly meetings with the patient safety team have been established in order to ensure contemporaneous case discussion where there is an interface between safeguarding and patient safety concerns.
- Fortnightly meetings with Discharge Hub have been established to facilitate complex case discussion.
- Six weekly safeguarding supervision for the Alcohol Care Team led by the Named Nurse.
- Weekly reflective supervision for VAST team, Alcohol Care Team and Mental Health team has been successfully established.
- The Safeguarding Adult Engagement Group has been successfully embedded and runs every 8 weeks with strong attendance from across the Trust.
- Participation in National Safeguarding Awareness Week in November 2021 reiterating the importance of Safeguarding being everyone's business.
- Continued support with embedding of the 4LSAB Multi-Agency Risk Management Framework (MARM) into practice with particular emphasis in ED where clinicians are now leading MARM meetings.
- Continued engagement with the Local Safeguarding Adults Boards and participation in Statutory Reviews and Practitioner Workshops.
- Involvement in the development of the 4LSAB Multi-Agency Fire Safety Framework which was published in May 2021. Ongoing work to embed this framework at UHSFT continues, with a particular focus on ED.

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NHS Foundation Trust

Key achievements-Safeguarding Children

- At the time of writing this report , the Child Protection and Safeguarding Children Policy and Procedures has been reviewed, updated and ratified and is available to staff on staff net.
- Paediatric Liaison Nursing Service (PLNS) Guidelines 2022– the guidelines support staff to understand the requirements for when to complete an ISF and how this is then triaged by the Safeguarding Children Team. The guidelines were sent to community partners once approved at SGSG.
- Children's Safeguarding staffnet page- this has had a full review and includes all relevant links to UHS procedures and HIPS procedures. It outlines what to do if you have a concern and who to contact in and out of hours..
- Child Exploitation/Child Sexual Exploitation Audit, completed , see Maternity section.

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- Bruising Protocol Audit finalised . See progress updates.
- Extensive Level 3 Safeguarding Children programme offer to staff, with planned sessions and offer of some bespoke sessions to teams, totalling 40 face to face/virtual in 2021/22. This enabled staff to access training, to meet their statutory and mandatory requirements.
- Despite staffing changes, the Safeguarding Children Team have resumed face to face ward rounds and have established a blended face to face/virtual approach.
- The Safeguarding children team have commenced Bi Monthly Drop sessions in ED and monthly drop in session in Eye casualty. This is an opportunity for safegaurding case discussion with the safeguarding nurses
- Safeguarding Newsletter – the Children's Safeguarding Team have commenced a 2 monthly safeguarding newsletter which is available on Staffnet and is distributed by email. The newsletter focuses on local and national legislation, learning from Child Safeguarding Practice Reviews.

Key achievements-Safeguarding Children

- NG205 looked after-children-and-young-people 2021, replacing 2010 version. The guideline covers how organisations, practitioners and carers should work together to deliver high-quality care, stable placements and nurturing relationships for looked-after children and young people. Gap analysis completed with Children's Hospital management oversight and approval.

- Department for Education -Keeping Children Safe Department for Education Gap analysis completed and special addition newsletter to raise awareness to staff of children not in education during the Pandemic

- Section 11 - KEEPING CHILDREN SAFE. Under Section 11 of the Children's Act 2004, every other year UHSFT are required to complete the Hampshire, Isle of Wight, Portsmouth & Southampton (HIPS) Safeguarding Children Partnerships Section 11 self-assessment tool, this was submitted on 4th January 2021 . HIPS requested an update on action plans and clarifications provided in response to the feedback on UHSFT S11 Assessment completed in 2019/20. Following submission in Oct 2021, feedback was received in early Jan 2022 and included

  The HIPS Board partners noted the thoroughness of the response which was helpful. They acknowledged the significant ongoing impact of COVID-19 on UHFST as an acute trust and the evident continued commitment to safeguarding and improvement. They noted the mitigation in place regarding enabling staff to access level 3 Safeguarding Children Training and the significant work undertaken in relation to policy, process and responding to learning from case reviews.

- Embedding Local safeguarding Children Partnership (LSCP) guidance, protocols, recommendation from multiagency audits and Child Safeguarding Practice Reviews (formerly known as Safeguarding Children Reviews) at UHSFT. This included an agenda item on the Children and Maternity Safeguarding Governance Group, included in the quarterly SGSG reports and Divisional Governance reports, shared at Child Health Sisters Meetings and Safeguarding Champions Meetings and embedded in Level 3 Safeguarding Children Training.

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NHS Foundation Trust

Key achievements-Safeguarding Children

- Continued representation at the Local Safeguarding Children Partnership Board and subgroups
- JTAI
  - In 2021/22 Southampton Safeguarding Children Partnership (SSCP), Southampton Practice and Improvement Group (SPIG), the priority themes have been Domestic Abuse Multi-agency response to children living with domestic abuse. and children who are at risk of, or who are experiencing sexual exploitation (CSE) & criminal exploitation (CE) The priority themes align with the National Joint Targeted Area Inspection (JTAI) themes. Analysis has been completed and submitted by UHSFT on these themes to SPIG which has enabled a multiagency review of all submissions to; identify any themes, recommendations and actions across the partnership. The final reports have been submitted to the SSCP Board.
- Other JTAI submissions:-
  - SSCP Solihull JTAI inspection , this was requested in respect of the multi-agency response of initial need and risk.
  - JTAI Dry Run- HSCP -theme at the 'Front Door'
  - JTAI Pilot HSCP -with inspectors -The Front Door'.
  - JTAI Dry Run –SSCP children who are at risk of, or who are experiencing sexual exploitation (CSE) & criminal exploitation (as part of the SSCP priority theme)

Key achievements for Maternity and Neonatal Safeguarding

- The Safeguarding in Maternity Services has been reviewed and updated in December 2022 this compliments and is aimed to be used alongside the HIPS Unborn and Newborn Protocol.
- The Maternity Missed Appointment Guideline has been reviewed and updated in May 2022.
- Child Sexual Exploitation/Criminal Exploitation (CSE/CCE) joint audit between PLNS, Maternity and Children's Safeguarding team. This was a questionnaire sent to all staff in targeted areas Emergency Department, Maternity and CAMHS who have direct contact with children. The results demonstrated that all staff working directly with children had some understanding of CSE/CCE. However, the questionnaire highlighted that knowledge is variable and that some 'leveling up' of this knowledge amongst staff was required to ensure that staff feel confident in understanding the risks associated with CSE/CCE, use of screening tools and referral pathways. There is an on-going audit plan these include a review of CSE/CCE training and guidelines, review of screening tools and strategies to encourage staff working with children to make every contact count in terms of asking if a child feels safe, if they need help and if there is anyone making them feel sad or scared.
- The Named Midwife completed an audit of local authority safeguarding cases over the Q3 period following a period of challenging safeguarding cases and delayed discharges. The findings were used to engage the local authority in discussions as to how we could improve joint working and delays in discharges. This had led to some joint actions, regular meetings and improved communications.
- Maternity Safeguarding Team continue to deliver and facilitate one to one and/or group supervision via Microsoft Teams or face to face to NEST Midwifery Teams, universal and core Midwifery and Neonatal staff when indicated or on requested. NNU offer group safeguarding supervision alongside the NNU psychologist. Midwifery staff in the Maternity Safeguarding Team receive regular safeguarding supervision from Designated Nurses or Deputy Named Nurse in the Children's Team. In addition to this Nest Midwives receive regular supervision from a psychologist to promote resilience and emotional well-being within the teams due to the challenging caseloads they hold.
- A quarterly newsletter for safeguarding in maternity was launched in 21/22 which includes safeguarding themes and learning from national and local reviews.

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Key achievements for Maternity and Neonatal Safeguarding continued

- Review of Maternity Level 3 Safeguarding Training offer which includes a 15 minute update on the yearly Prompt session and in addition 4 hours face to face training (including perinatal mental health and domestic abuse/harmful practices). Each year we aim to have a focus topic this year it has been on Young Parents following published local reviews.
- Participating in joint agency Southampton Mash audits and Southampton Neglect strategy.
- JTAI Dry Run- HSCP -theme at the 'Front Door': Midwives from UHSFT attended a discussion with the Inspectors and contributed to audits and information gathering.
- From December 2021 any parents whose baby is taken into care and are separated are offered a memory box which includes foot prints, a book, a poem and blankets. UHSFT will become part of a national pilot scheme for Hope boxes for parents and baby' separated at birth due to legal proceedings and taken into care.
- The Maternity safeguarding team work closely with the Perinatal Mental Health (PNMH) Midwife and the NNU family liaison team meeting who meet regularly to have oversight and offer support and advice for women that have babies on the NNU and have mental health difficulties. This is expanding our MDT working and enhancing the care women and families are receiving regarding their mental wellbeing. This is an important part of the think family agenda and preventative work.
- PNMH Champions training continues, with a further 4 training dates this year that receives interest from midwives, MSW's and NNU staff to enhance their skills and knowledge in PNMH.
- A psychologist is in post, from the Maternal mental health service providing support to women with significant birth trauma or tokophobia. She is based in PAH 1 day a week and is accessible to staff for further support and advice.

Key achievements- Learning Disability (LD) / Autism

- Ongoing support of patients, families/carers and clinicians for planned, emergency admissions and outpatient appointments across the trust
- Facebook groups; Autism Patient Forum & Learning Disability Forum
- Workplace groups; Support Group for Autistic Employees & Learning Disability & Autism Champions
- Ongoing management of LD & ASC flags/passport/AI needs/mortality data spreadsheet.
- Specialist support of internal LeDeR reviews on a monthly basis. Due to ongoing sickness absence within the team this work has currently been paused.
- Supporting LeDeR Reviewers (telephone support, remote access to medical notes & Structured Judgement Reviews / Patient Safety Scoping)
- 1 x B4 continues on Nurse training (commenced September 2020).
- Reduced service / staffing on risk register March 2021
- Successful recruitment to team administrator post with current backfill until appointee starts in post October 2021 following maternity leave.
- Launch of Newsletter. Due to ongoing sickness absence within the team this work has currently been paused.
- Creation of accessible information; Covid testing (drive thru / home testing),EEG (Neurophysiology),Scans (Radiology), Visiting restrictions. Due to ongoing sickness absence within the team this work has currently been paused.
- Work has commenced on embedding a Standard Operating Procedure for the team.

Key achievements- Learning Disability (LD) / Autism continued

- The paediatric service has been successfully established and has received positive feedback.
- IT updates including admission alerts for children flagged with LD/ASC
- Reimplementation of the hospital passport for child health.
- Future projects include; learning disability and autism champion training, Makaton training for staff working in the LD / Autism team /child health, LD and autism friendly environment and development of best practice pathways for interventions such as blood tests and admissions.
- Ongoing participation in IMEG/scoping/LeDeR processes/ complaints processes. Due to ongoing sickness absence within the team this work has currently been paused.
- Learning Disability & Autism Working group (via Teams)
- Learning Disability Friendly Ward task and finish group; UHS (This was due to recommence January 2021 but due to staffing challenges within the team has been paused.)
- Participation in Sunflower lanyard working group.
- Liaison with Carers Lead UHS.

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Safeguarding Story – Children

Sally (pseudonym name) was a 11-year-old girl who was retrieved by the Paediatric Intensive Care team at University Hospital Southampton NHS Foundation Trust from a local hospital.

The child had initially been brought to her local emergency department (ED) by ambulance. She was in an incredible poorly, described as being floppy and pale. She was found to be very anaemic, very underweight, appearing unkempt with dirty fingernails and extreme headlice. Sally needed emergency blood transfusions, electrolyte replacements and intravenous fluids . Sally was also clinically hypothermic with a temperature of around 35.2c.

Whilst the medical teams were considering an organic cause the first and most likely cause was extreme neglect. The team at PICU (Paediatric Intensive Care Unit) contacted Out of Hours children's services and the police. A number of medical investigations were undertaken to confirm any medical diagnosis There was no organic reason and assessed that her presentation was due to long term neglect.

The mother was arrested and the child was placed under Police Protection Order. A children's services social worker visited PICU and initial strategy meeting held. All information was shared, and plans made, which included arranging a child protection medical for the sibling. Histories were taken from the mother, and these were found to be inconsistent and not in keeping with the medial findings or from what the child was saying. The UHS Safeguarding children team liaised with the referring hospitals safeguarding team. A child protection Medical for the sibling showed that they were in a similar state of neglect minus the critical level of illness.

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Safeguarding Story – Children continued

A further reconvened strategy was held, coordinated by the safeguarding children team and an Emergency Protection Order (EPO) was granted by the courts. The joint section 47 enquiry with police continued. The lead paediatric consultant supported the EPO process with support from the safeguarding children team by providing the preliminarily report for courts. It was during this meeting that the UHS safeguarding children team advised they would be completing a Child Safeguarding Practice Review (CSPR) request.. Sally was transferred to continue her recovery at her local hospital.

This patient story, demonstrates the UHSFT values – Patients first, Working together and Always improving:

Patient First:

Through Sally's admission to UHS it was clear she was put first. Her needs, her lived experience and her voice was at the forefront of decision making. The UHS professionals recognised the abuse this child had suffered and took appropriate steps and actions to prevent further harm.

Working Together:

The UHS professionals worked collaboratively with multiple teams both internally and externally to protect Sally. This included Police and Children's social care, all working together with the shared goal of safeguarding Sally and her sibling.

Always improving

UHS were able to quickly recognise that this child was suffering from neglect. As an organisation we remain vigilant to the signs and symptoms of abuse, and how to spot it. Recently Southampton Children's services launched a new Neglect toolkit and later in 2022 a Task and Finish group will be set up , led by the safegaurding Children Team to support this toolkit being utilised across the hospital to support staff to be able to spot when a child is or could suffer from neglect.

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Safeguarding Story - Adult

Sara was a 24 year old woman who arrived at ED by ambulance following an assault by her husband. She had arrived in the UK on a spousal visa from Bangladesh following an arranged marriage 2 years ago.

Sara disclosed to ED staff that she had experienced multiple assaults since her marriage, which were increasing in frequency. Sara felt that her life was at risk and wanted to leave her marriage but was fearful of possible repercussions from both her husband's family and her own family. Sara spoke little English, did not work and rarely left her home. She had no friends in the UK and was socially isolated. Her own family all remained in Bangladesh. Prior to arriving at UHS, Sara had been planning to leave her marriage and had hidden her personal documents within the home and had started hiding money from her husband.

On arrival in ED Sara was referred to the Vulnerable Adult Support Team (VAST), who made an immediate referral to the adult safeguarding team and requested an interpreter in order that they could communicate with Sara effectively and understand her views and wishes.

The police had been informed of the assault by the ambulance service and VAST, and her husband was arrested. Due to Sara's concerns that she remained at risk from her family, she was admitted to UHS as a place of safety, a protection plan was put into place and Sara's information was anonymised. Sara's husband had been released on police bail and there was the potential that he could attend UHS to try to gain access to Sara.

The Adult Safeguarding team made a referral to the IDVA as Sara was clear that she wished to leave her marriage and supported police prosecution of her husband, and a search for a space in a refuge was commenced. Contact with the Home Office to establish Sara's right to remain in the UK was also made as this would affect her eligibility for a refuge space.

Safeguarding Story – Adults continued

The Home Office granted Sara the right to remain in the UK and a refuge space was successfully sourced for Sara out of area. At this point she left UHS to begin the next stage of her life.

This patient story demonstrates the UHSFT values – Patients First, Working Together and Always Improving:

Patients First:

At all times during her admission to UHS, Sara's views and wishes were kept central to the safeguarding process and she was kept updated as to what was happening next on a daily basis. Interpreter services were sourced and utilised to maintain effective communication with Sara. Sara was at UHS during Ramadan and the Adult Safeguarding team offered a referral to UHS Spiritual Care team. Sara was also provided with home cooked food to break her fast by staff members who shared her religious beliefs.

Working Together:

UHS staff worked collaboratively with outside agencies (Police, Home Office, Domestic Abuse Services) to keep Sara safe until a safe discharge destination had been sourced.

Always improving

UHS staff identified the risk of further abuse from Sara's husband and family and reacted immediately and in accordance with her wishes to secure her safety. Patient stories are shared and discussed at every Safeguarding Adult Engagement Group meeting to further embed learning across UHS.

Patient Stories – Learning Disability (LD) / Autism

- Sharon had a moderate learning disability and lived with her elderly mother. The family had always declined additional input from services.
- Sharon was brought to UHS after falling in the bathroom during the night. She had been on the floor for some time before her mother found her.
- Sharon had limited speech and the ward referred her to the LD team for support with communication.
- The LD nurse noted that Sharon's body language indicated that she might be in pain. Ward staff said that Sharon always said no when asked if she needed any pain relief and would spit tablets out. The LD nurse suggested that analgesia was given via a different route to manage Sharon's pain.
- During her hospital stay, the LD nurse noticed that Sharon was becoming more restless. She was due to be discharged home with antibiotics but the LD nurse advised against this due to Sharon being non-compliant with taking oral medication, and no further investigations had been undertaken since the change in her behaviour.
- Sharon's discharge was delayed and following investigations, she was found to have a bowel obstruction. She was subsequently referred to the palliative care team for onward pain management.
- The LD nurse supported Sharon's mother when she was informed of her daughter's prognosis and remained involved in Sharon's care until her death.

Patient Stories – Learning Disability (LD) / Autism (Adult)

- This patient story demonstrates the UHSFT values – Patients First, Working Together and Always Improving:
- Patients First:
- The LD nurse advocated for Sharon by supporting clinical staff in providing analgesia in a form that Sharon would tolerate and advising ward staff how to recognise and respond appropriately to her non-verbal cues. The LD nurse took a whole family approach by also acting as a resource and support for Sharon's mother.
- Working Together:
- The LD nurse worked alongside ward staff and medical teams to support their communication with Sharon throughout her admission.
- Always improving
- The LD nurse shared her specialist knowledge with ward staff to support them with communicating with Sharon effectively and understanding her non-verbal cues. Ward staff will be able to utilise this knowledge in future when working with patients with a learning disability who need additional support with communication.

Patient Stories – Learning Disability (LD) / Autism (Child)

- Jason had a severe learning disability and autism and was transferred from his local hospital to UHS with severe abdominal pain and malnutrition. Jason was extremely distressed and struggling to cope in the hospital environment. A referral was made to the LD/Autism team.
- Jason was diagnosed with Crohn's disease and required invasive treatment.
- The LD/ASD paediatric nurse supported Jason and his mother by building a rapport and undertaking some desensitisation work. The LD/ASD nurse created social stories, contacted his special school and worked with the gastro team to make reasonable adjustments to help him during this distressing time.
- A key focus of the work undertaken was around transitions between the car and hospital as Jason found this very hard to manage, often taking 2 hours to complete.
- After 6 weeks, Jason would get out of the car and greet the LD/ASD nurse with a hug. They would then walk to the ward together, he would be seen immediately for his treatment and the LD/ASD nurse would walk back with him to the car.
- Jason is now accessing treatment at his local hospital which he was unable to manage previously due to his anxieties. This has been achieved through making reasonable adjustments and consistency of approach.

Patient Stories – Learning Disability (LD) / Autism (Child)

- This patient story demonstrates the UHSFT values – Patients First, Working Together and Always Improving:
- Patients First:
- The LD/Autism nurse worked with the child and mother to introduce reasonable adjustments, thus supporting access to required care and treatment. Practice was child centred throughout.
- Working Together:
- The nurse worked with colleagues within UHS, education provider and the child's local hospital to ensure joined up working and continuity of care.
- Always improving
- This case highlights best practice in keeping focus on the child and how reasonable adjustments were introduced and sustained throughout treatment. This patient story has been used to embed learning around supporting children with LD in clinical areas.

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Patient Stories- Maternity

Helen (pseudonym) was admitted to the antenatal ward due to difficulties in controlling her newly diagnosed diabetes. This was her first pregnancy, and she was 32 weeks gestation at the point of admission. Helen had a pre-pregnancy BMI of 65 and this had increased to 74 during the pregnancy. It quickly became clear on the ward that Helen required a significant amount of support from staff with her self-care, and that her physical health had begun to suffer at home as a result.

Helen had, earlier in the pregnancy, been offered referrals to Adult Safeguarding, MASH and Early Help to explore what support could be offered to her both during the pregnancy and whilst she adjusts to being a new parent, but she declined all offers. These were suggested again during the admission, but again, Helen declined, insisting that they were unnecessary. She advised that her partner assisted her at home with self care, and that she did not anticipate having any difficulties in meeting the needs of a newborn baby. Advice was sought from Adult Services who felt that she did not meet the threshold for intervention, and at this time there was no clear evidence of risk to the (still unborn) baby so no referral to children's services could be made without consent.

After a number of days and staff building a rapport with Helen on the ward, Helen recognised that she was finding even quite basic mobilising, toileting and personal hygiene tasks extremely difficult without support, and consented to a referral to Early Help. An assessment was commenced, and Helen agreed that the Family Support Worker could explore her wider family support at home. Following this initial assessment the case was stepped up to a section 17 assessment and was assigned to a social worker in recognition of the complexity of the case. The Early Help worker also remained involved and a Family Group Conference took place via Teams so that Helen could attend from the ward.

Helen had a planned Caesarean Section at 36 weeks gestation and within a few days returned to the ward. A robust and tightly planned timetable was agreed between family members to ensure that Helen was well supported at all times to be able to care for her baby at home. A discharge planning meeting was held to ensure that support continued on discharge home

Patient Stories- Maternity-continued

Reflecting Good Practice:

- This case demonstrates the Trust Values in action:
- Working Together: Every professional worked towards the common goal of ensuring the optimum outcome for mother and baby. Communication with both internal and external professionals was thorough and comprehensive, with meetings held in a timely way and with the right people.
- Patients First: Helen and her baby were held consistently at the centre of their care planning. She was treated with compassion and respect, with an emphasis on maintaining her dignity. Helen's choices were heard to ensure that the care decisions made were person-focussed and in the interests of both Helen and the baby at all times.
- Always Improving: this case was challenging for staff directly providing care, not least due to the unusually high levels of personal care required to ensure Helen's wellbeing. However, support and advice was sought from appropriate departments to ensure that her care was of the highest standard. This included sourcing appropriate specialist equipment and liaising with other professionals with whom we had not previously dealt. As a result, if similar support is required in future, the process will be smoother and more familiar for ward staff.

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Activity – Safeguarding Adults

Safeguarding Referrals = **2142 – 21/22** (31% increase from 20/21 -1635)

DoLS = **646 – 21/22** (10% increase from 20/21 - 589)

Total number of SAMA cases: 38 (35% increase from 20/21 - 23)

Training delivered; adult sessions = 0 / joint adult & child sessions = 3

Statutory Activity

- **6 statutory scoping's for SAR's 4 of these however were IMRs which required more detailed analysis of the events including a review of policies and learning.** (9 – 20/21)
- **Supported with 1 court of protection case this year (1 – 20/21)**
- **2 referrals made to SSAB for consideration of SAR's**

AER's screened: 836 (77% increase from 20/21 - 471)

Complaints screened: 34 (70% increase from 20/21 - 20)

Section 42 enquiries: 259 (162% from 20/21 - 99)

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Analysis of Safeguarding Adults data

- The **31%** increase in referrals into the Safeguarding Adults team reflects the operational workload and the ongoing impact of the Covid-19 pandemic. The referral numbers, however, do not recognise the complexity of many of the referrals which are multi-faceted and the time taken to manage these complex cases in conjunction with our Local Authority colleagues.

- There has been a **162%** increase in cases meeting threshold for S42 enquiry. This increase reflects the complexity of many of the cases managed by the Adult Safeguarding Team over the last year as well as the increased level of referrals overall into the team. The ED have reported a significant increase in flow over the past 12 months which will also account for some of the increase in referrals.

- There has been a **10%** increase in applications relating to DoLS referrals. There remains a delay, however, in authorisation by the Supervisory Body which is recognised and reflected on the Trust's Risk Register. This is a nationwide issue since the Cheshire West ruling in 2014 whereby the "acid test" provided additional clarity as to what constitutes a deprivation of liberty.

- There has been a **35%** increase in SAMA referrals (concerns in relation to members of staff who are in a position of trust) in the past year. An increase in referrals continues to be noted by other provider organisations across the system. This increase in referrals has had a significant impact on the workload where collaboration with HR is required to review risks and decide on required actions.

Analysis of Safeguarding Adults data continued

- The number of complaints screened and responded to by the Safeguarding Adults Team has increased by **70%.** This is a significant increase although not as high as the preceding year. It remains unclear as to why this increase has continued although it is reasonable to consider this may be due to the ongoing impact of the Covid – 19 pandemic.

- AER's screened by the Safeguarding Adults Team allow for a Safeguarding lens to be cast over incidents reported within the Trust. This year 836 reports were screened, representing an increase of **77%** from last year. A major contribution to the reduced number screened last year was a system fault which prevented the Safeguarding Adults Team from viewing reports for some months.

- The team continue to work with IT colleagues on how best to record on APEX in terms of new updates and improvements. This year we have increased use of the contact log function to record advice calls and emails where a safeguarding referral is not required but the team provide support for staff wishing to discuss concerns. The newly established MCA/LPS team also utilise this feature to manage cases which are not open to the wider safeguarding team.

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Activity – Safeguarding Children

21/22 Safeguarding referrals to UHSFT Safeguarding Children Team =1318 (1524 in 2020/21) . Of these referrals the main reason for referral was a child with a mental health issue -475, Parent an inpatient -213, Actual harm -191 (165 in 2020/21), Suspected harm - 138 (140 in 2020/21)

Telephone/email advice = 482 (453 in 2020/21), this indicates a slight increase from last year.

Serious Incident reporting = 65 (60 in 2020/21) completed for unexpected child deaths, non-accidental injury, complex cases and distributed to key leads within the organisation.

AER's screened: 119 (119 in 19/20)

Statutory Activity

- 27 requests for statutory scoping's for Serious Case Reviews. These requests are predominately from Southampton, Hampshire and Portsmouth Safeguarding Children Partnerships
- Of the 27 requests submitted, the Safeguarding children Team have contributed to 9 of these, due to the child/sibling/parents receiving care at UHSFT. This is slightly less from 13 in 2020/21. All of the 27 requests have to be reviewed, completed and submitted whether the child/siblings/parents have had contact with UHSFT or not.

Published Child Safeguarding Practice Reviews

10 Reviews were published in 2021/22 from Hampshire and Southampton Safeguarding Children Partnerships . Any reports where UHSFT are not directly involved are reviewed for any transferable learning. Children and Maternity Safeguarding are required to update the Partnerships on a quarterly basis on all the ongoing and completed reviews; progress needs to be evidenced as to how learning improvements are being progressed within the organisation.

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Activity – Safeguarding Children

Total number of LADO cases = 21 (this includes UHSFT and staff not employed by UHSFT). This is slightly lower than 2020/21 - 29

Paediatric Liaison Nurse Specialist (PLNS) Team,

triaged 6004 Information sharing forms (ISF) in 2021/22. This is a significant increase from 2020/21 of 3759 and 3766 in 2019/20.
Of the 6004 ISF's completed, 2,434 were for the 0-4 age group, compared to 1,192 in 2020/21

Other Specific ISF data related to children
Deliberate self harm 2021/22 -**898 (** 2020/21 -676)
Drugs and Alcohol 2021/22 -**177** (2020/21-119)
Assaults 2021/22- **222** (2020/21- 113)

PLNS reviewed 32,064 Emergency Department attendance letters to ensure all children who are aged 0-17 years have had an ISF completed where appropriate (16,449 in 2020/21**)**

NNU reports The Princess Anne Neonatal Unit (NNU) is one of the largest units in the country caring for up to 23 intensive and high dependency beds and 14 special care cots; The PLNS Team have been responsible for disseminating 1480 NNU Reports (new admissions and updates) in 2021/22 an increase from 1423 in 2020/21

Safeguarding Children Training Level 3

40 sessions delivered (20 sessions delivered in 20/21 and 32 sessions delivered in 19/20)

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Summary and Analysis of Safeguarding Children data

- **Safeguarding referrals to UHSFT Safeguarding Children Team-** the figures are strongly indicative of the impact of the national lockdowns, with routine surgery being paused/delayed The figures indicate the complexity of the cases referred to the team. The highest reason for referral to the UHSFT Safeguarding Children Team was children with a mental health issue and parents admitted to UHSFT, this is consistent with 2020/21 The referrals require strong collaboration with the UHSFT Children's Hospital , including CAMHS, Adult and Maternity Safeguarding Teams, multiagency partnership working with social services and police with many cases leading to meetings in order to put a plan in place to safeguard the child.
  - There are clear pathways which support staff to assess whether a referral to the Safeguarding Children Team is required. The UHSFT safeguarding children Training offer as per the Intercollegiate Document 2019, and daily ward rounds whether face to face or virtual facilitated by the Safeguarding Children Team support staff to recognise risk and what actions are needed.
  - As per pathway, all children admitted to UHSFT with a mental health concern should be referred to the team.
  - All children who are 16/17 years and admitted to an adult area, are reviewed daily by the Safeguarding Children Team to ensure no further actions are needed to safeguard the child.
  - It is predicted that as routine admissions increase and with the increased numbers attending ED that the numbers are likely to be higher in 2022/23

- **Serious Incident form** This is a slightly higher figure than in 2020/21 and evidences the level of complexity of referrals to the Safeguarding Children Team. The last 2 years have shown a significant increase from the 2019/2020 figures, indicating the impact of Covid-19.. All of these cases would require a multiagency meeting coordinated by the Safeguarding Children Team

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Summary and Analysis of Safeguarding Children data continued

- **ISF's** There is a significant increase (59.7%) in the number of ISFs completed in 2021/22. This increase includes where a child presents with a mental health concern and children (0-4 years). It could be surmised that this younger age group have had limited access to GP and Health Visitor face to face appointments.
  - An ISF is required when it is identified there are possible safeguarding concerns- this can range from a safety issue where a child swallows a tablet to a child presenting with suspected/actual harm.
  - It is a requirement that all children presenting to ED with a mental health concern should have an ISF completed.
  - An ISF is also required where an adult presents with a safeguarding concern (mental health/substance misuse/domestic abuse) where it is identified they are a parent/carer.
  - The PLNS guidelines 2021 outline the requirements of completing an ISF and how this information is then risk assessed and shared with partner agencies
  - All 16/17 year olds who attend ED are reviewed by the Paediatric Liaison Nurses to ensure no further actions are needed to safeguard the child

- **ED Letters** The Number of ED letters generated for all children attending the department has significantly increased. Despite the high volume of ED attendances, the number of ISF's completed provides a good level of assurance that children or adults (who are parents/carers) seen in ED actions were taken to safeguard and promote their welfare.

- **Level 3 safeguarding children training** The number of level 3 safeguarding children training sessions available for staff to attend, significantly increased from 20 sessions in 2020/21 to 40 sessions in 2021/22.

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Activity Maternity 2021-22

- Notification of vulnerabilities-Liaison forms (social) = 813
- Mash referrals submitted = 291
- Unborn/New-born's Subject to Child Protection Plan = 81
- Unborn/New-born's subject to Child in Need Plan = 70
- Baby's removed with a police protection order = 4 (20-21 = 1 which is a 75 % increase)
- Number of FGM-cases highlighted to service 10 (increase of 13% in FGM cases since 2019-20)
- FGM Information Share (FGM-IS) = 10
- CP-IS tab checked 46 (new stats not collected 20-21)
- Teenage Pregnancy numbers at conception:

  Under 16 years = 31 / Aged 17-18 years = 79
- UHSFT Serious incidents template completed involving maternity safeguarding = 6 (10 in 20-21)

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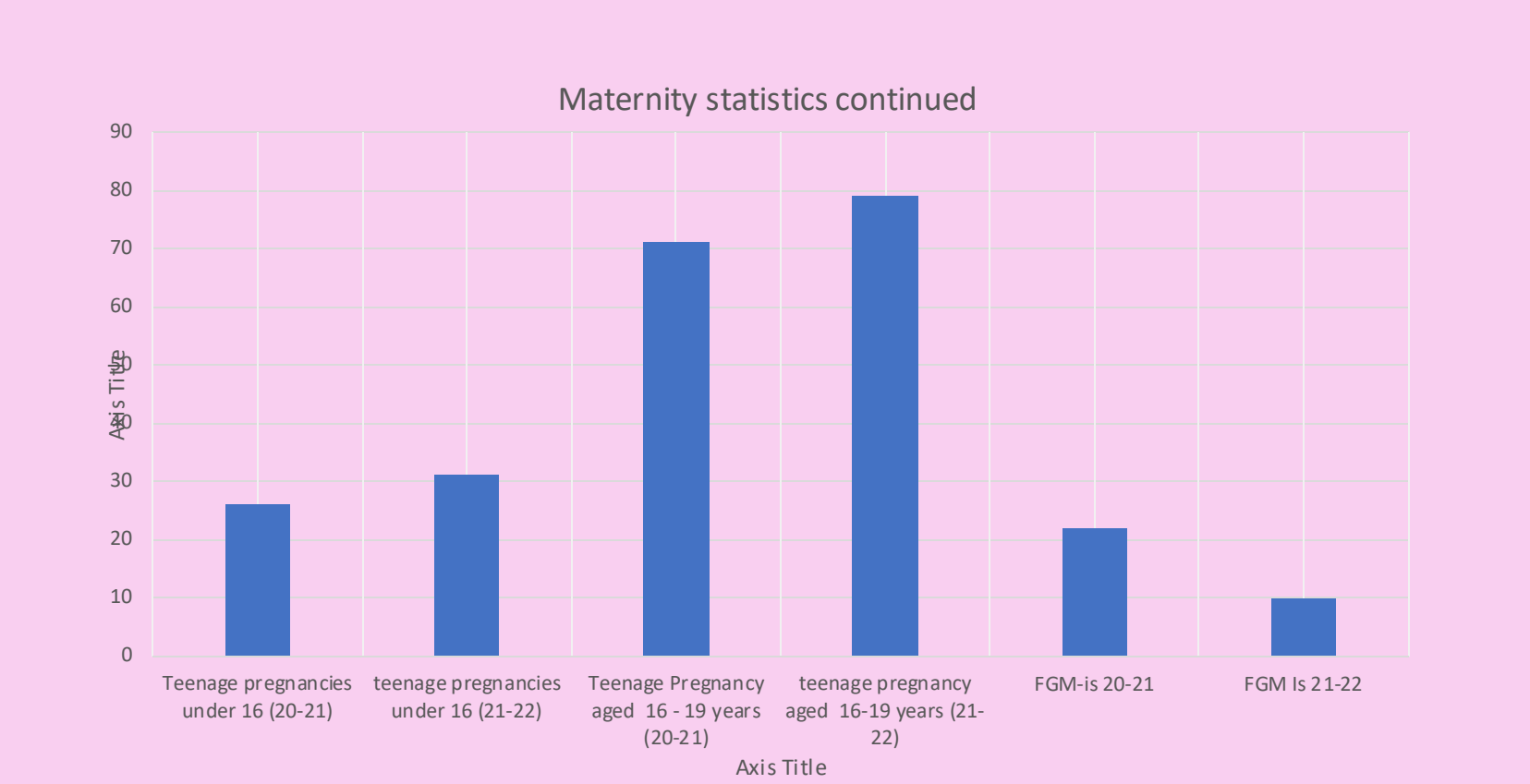
Activity Maternity 2021-22 continued



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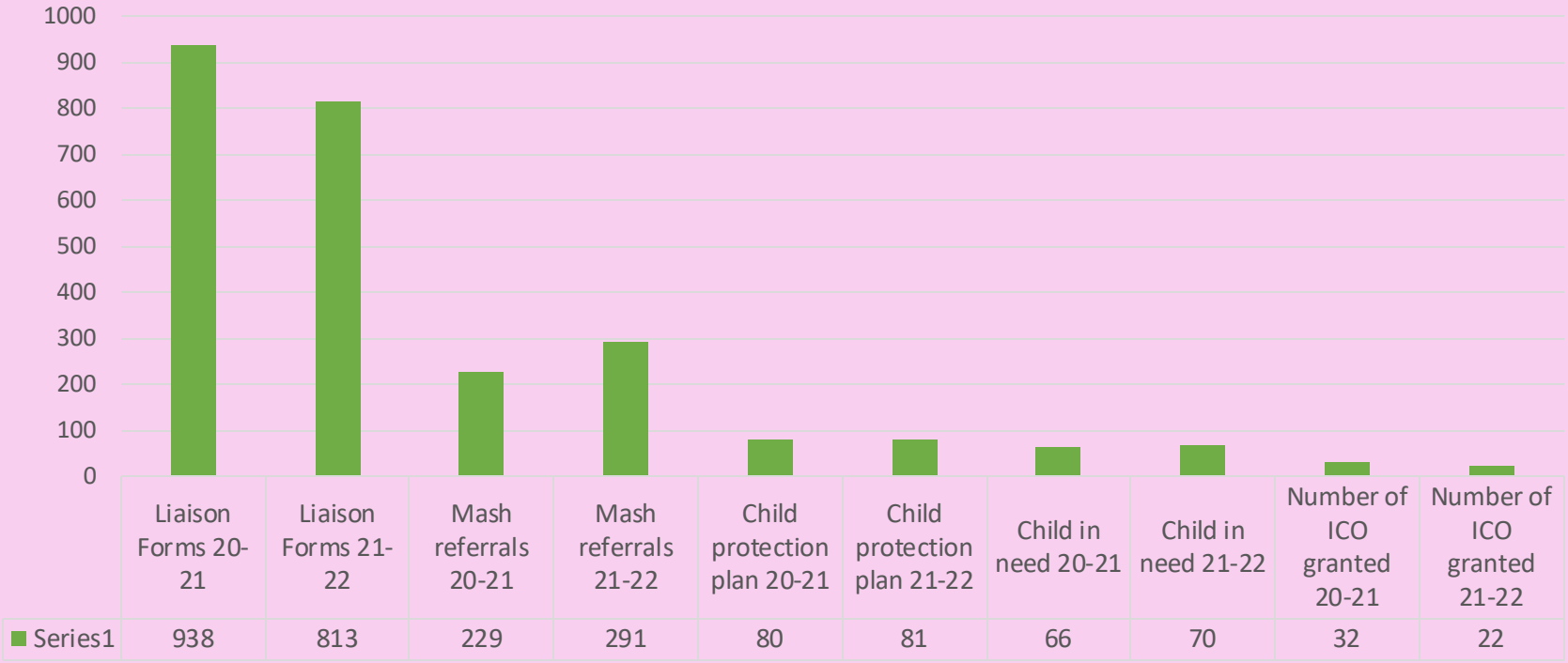
Maternity statistics comparison 20-21 and 21-22



	Liaison Forms 20-21	Liaison Forms 21-22	Mash referrals 20-21	Mash referrals 21-22	Child protection plan 20-21	Child protection plan 21-22	Child in need 20-21	Child in need 21-22	Number of ICO granted 20-21	Number of ICO granted 21-22
Series1	938	813	229	291	80	81	66	70	32	22

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Analysis of Maternity data

- In 2021 Maternity launched the Badgernet Information system. This has led to some challenges with collecting maternity safeguarding data and we are working closely with Clevermed (Badgernet provider) to improve this. We currently operate a spreadsheet to reassure and compare statistics. The statistics for the annual have been complied using the data from Badgernet and the spreadsheet. It is reassuring that the statistics remain largely similar to the previous years reporting (20-21).

- There has been a slight increase in Mash referrals which is similar to the national picture.

- The level of pregnancies in aged 19 years and under has increased again this year, however we have noted a decrease in quarter 4 reporting which may reflect that schools have re-opened and sexual health services have resumed.

- In the next year of reporting we aim to undertake more in depth analysis of data for example local authority time scale data and undertake a domestic abuse audit.

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Activity – Learning Disability and Autism Team

Adults -1315 (1096 2020/21)

Learning Disability -826 (676 2020/21)

Autism -299 (184 2020/21)

Learning Disability and Autism -51 (38 2020/21)

Inappropriate -139 (174 2020/21)

Children -692

Learning Disability – 138 (Q3 and 4 only)

Autism – 134 (Q3 and 4 only)

Learning Disability and Autism – 87 (Q3 and 4 only)

Inappropriate – 1 (Q3 and 4 only)

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Analysis of Learning Disability and Autism Data

- **Adults data:**
- There has been a **20%** increase in LD/Autism team referrals overall from the previous year.
- Referrals for patients with LD diagnosis have risen by **22%.**
- Referrals in relation to autism have significantly risen with an increase of **62.5%.**
- Referrals for patients with dual LD/AHD diagnosis have also increased by **34%.**
- Inappropriate referrals have reduced by **20%.**
- The figures above show a significant increase in team activity with a decrease in inappropriate referrals. This suggests that awareness of the team and the service they offer has continued to increase, with the number of inappropriate referrals reducing. There is again a significant increase in referrals for autistic patients.
- The team continue to experience staffing challenges which have impacted on service delivery.
- The team have regular contact with community LD teams in order to promote seamless transition of care between hospital and home.

- **Children's data:**
- Data collection has changed from Q3 onwards, meaning that a breakdown of data between LD and autism diagnosis is not available for Q1 and Q2.
- As the paediatric service is newly established, it is not possible to provide data for the previous year but due to the new recording process this data will be available next year.
- There are less inappropriate referrals into the paediatric service as patients referred into the team have usually received a LD/autism diagnosis and are more frequently known to community teams.

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Training Compliance

Mandatory training report by Divisions as of 05.05.22

	Div. A % (Targeted audience)	Div B % (Targeted audience)	Div C % (Targeted audience)	Div D % (Targeted audience)	Trust HQ % (Targeted audience)	Trust % (Targeted audience)	Trust Target
Safeguarding Adults level 1 (3yr)	**88.2%** 2310	**88.5%** 2497	**92.0%** 2528	**91.0%** 2124	**84.8%** 801	**89.5%** 10252	>85%
Safeguarding Adults level 2 (3yr)	**82.0%** 2126	**83.8%** 2420	**88.2%** 2349	**86.1%** 2078	**74.4%** 531	**84.5%** 9497	>85%
Mental Capacity Act level 1	**88.2%** 68	**84.2%** 245	**88.1%** 336	**82.3%** 622	**71.6%** 155	**83.1%** 1426	>85%
Mental Capacity Act level 2	**55.5%** 2160	**58.5%** 2383	**64.3%** 2254	**54.2%** 1359	**45.9%** 344	**58.1%** 8493	>85%
Prevent levels 1&2	**86.9%** 305	**88.6%** 946	**91.7%** 943	**84.3%** 362	**89.4%** 1508	**89.1%** 4061	>85%
Child Protection level 1	**73.7%** 198	**80.9%** 742	**88.9%** 395	**76.1%** 263	**87.5%** 1249	**84.0%** 2845	>85%
Child Protection level 2	**73.8%** 2059	**78.2%** 1972	**82.3%** 1036	**77.0%** 2052	**63.8%** 471	**76.3%** 7586	>85%
Child Protection level 3	**52.9%** 138	**44.0%** 511	**67.7%** 1467	**58.3%** 60	**66.3%** 83	**61.1%** 2255	>85%

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Analysis of Training compliance

The impact of the pandemic on all statutory and mandatory training compliance is recognised across the Trust with capacity and demand being a significant issue for staff to access training

Children's training

The compliance for level one Safeguarding Children Training remains fairly static at 84% compared to 85.9% in 2020/21,

for level Two Safeguarding Children Training has shown a small decrease from 82.7% compared to 82.7% in 2020/21

For level Three Safeguarding Children Training is at 61.1% compared to 73.9% in 2020/21.

Level 3 requires a minimum of 12 hours of training to completed within 3 years as per the Intercollegiate Document 2019. The current figures reflect the capacity/demand within the hospital for staff to complete the training requirements; in addition, a new reporting system to accurately record the required 12 hours went live in Jan 2021.

Actions to support improved compliance-

- Standing agenda item at the Safeguarding Steering Group to ensure all actions to improve compliance are being reviewed
- Dates for training advertised for the year to support managers to roster staff to be released for training
- 40 training sessions delivered , the majority planned sessions but some bespoke sessions delivered , for example, Taplin's Nursery staff withapproximately 40 staff in attendance.
- Regular meetings with the education leads to review compliance for each division and highlight areas of low compliance
- Upgrade of training page to support staff to understand and complete training requirements
- Review of passporting for new staff joining the Trust
- Review of NQN's training requirements with support from the Universities.
- Regular comms from the safeguarding team reminding staff of the requirements
- Adult's Training
- Compliance levels for Safeguarding Adults Levels One and Two training remain stable at 91.4% and 83.2% respectively. In 2020/21 figures were 89.5% and 84.5%. This indicates a slight increase in Level One figures and a slight decrease for Level 2. At the time of writing, Health Education England Level 3 e-learning package has been added to VLE. It remains a priority action for UHS Level 3 training to be recorded and uploaded.
- MCA Levels One and Two compliance is currently 83.1% and 58.1% respectively. This shows an increase from last year's figures of 78.5% and 57.3%.
- Compliance with Prevent Level 1 & 2 training has improved from 57.3% and 88.4% in 2020/21 to 58.1% and 89.1%.

Key areas of work for 2022/23

Joint

- Review and refinement of the joint safeguarding supervision policy
- Planning and implementation of the Mental Capacity Amendment Act (2019) and the Liberty Protection Safeguards
- As an action from the safeguarding strategy , to develop a safeguarding training strategy
- To further develop domestic abuse processes in collaboration with Maternity, ED, all adult areas, Children's Hospital and well being lead which encompasses support for both our patients and staff

Adult specific

- Continue work to improve and embed the application of the Mental Capacity Act (2005) in practice to ensure successful implementation of the Liberty Protection Safeguards (includes further development of legal master classes and simulated training)
- Development and launch of a MCA leaflet for patients and visitors.
- Audits: DoLS, MCA in relation to discharge planning.
- Completion and launch of level 3 safeguarding adult training

Children's

- Audits – safeguarding proforma audit, ICON and Safe sleep.
- As with adults, continue work to improve and embed the application of the Mental Capacity Act (2005) in practice to ensure successful implementation of the Liberty Protection Safeguards which applies to 16-17 year olds
- Continue to improve the use of technology – APEX, children's dashboard and ISF

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Key areas of work 2022/23 continued

LD / Autism

Further roll out of the LD friendly ward initiative

On-going input in to the development and pilot of national mandatory LD and autism training packages

Maternity

- Audit of Safe Sleep, ICON, CP-IS and FGM
- Review of Maternity Safeguarding Policy
- Review Substance Misuse Policy

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Glossary

The glossary refers the key words or terms that are used within this annual report.

LSAB Local Safeguarding Adults Boards covering Southampton and Hampshire

LSCP Local Safeguarding Children Partnerships (formerly Boards) covering Southampton and Hampshire.

CCG Clinical Commissioning Groups covering Southampton and Hampshire

Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need.

ASC Autistic Spectrum Condition

Child Safeguarding Practice Review (previously known as Serious Case Review (SCR) is undertaken by a safeguarding children board when a serious case of child abuse takes place. The criteria for review are outlined in Working Together 2015. The aim is for agencies and individuals to learn lessons to improve the way in which they work

Child Protection Information Share (CP-IS) a programme to assist information sharing between the local authority and heath. CP-IS identifies and safeguards unborn babies and children who are subject to a child protection plan when attending unscheduled healthcare settings in England

DoLS (Deprivation of Liberty Safeguards) are measures to protect people who lack the mental capacity to make certain decisions for themselves. They came into effect in April 2009 using the principles of the Mental Capacity Act 2005, and apply to people in care homes or hospitals where they may be deprived of their liberty.

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Glossary continued

Domestic Homicide Reviews DHR are commissioned by local Safer Communities Partnerships in response to deaths caused through cases of domestic violence. They are subject to the guidance issued by the Home Office in 2006 under the Domestic Violence Crime and Victims Act 2004. The basis for the domestic homicide review (DHR) process is to ensure agencies are responding appropriately to victims of domestic abuse offering and/or putting in place suitable support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

Hate Crime Defined as any crime that is perceived by the victim, or any other person, to be racist, homophobic, transphobic or due to a person's religion, belief, gender identity or disability. It should be noted that this definition is based on the perception of the victim or anyone else and is not reliant on evidence.

ICB (Integrated Care Board) A statutory organisation which was legally established on 1 July 2022, bringing the NHS together locally to improve population health and establish shared strategic priorities within the NHS. ICB's replace Clinical Commissioning Groups.

ICS (Integrated Care System) On 1 July 2022, integrated care systems (ICSs) became the new intermediate tier of the health system in England. ICSs have been given four broad aims by national policymakers, including to: improve outcomes in population health and health care. tackle inequalities in outcomes, experience and access to services.

ISF (Information Sharing Form) A UHSFT hospital system whereby clinicians in ED assess risk (red flags) and identify children/adults where an ISF should be completed. The Paediatric liaison Nursing service assess all completed ISFS to ensure all actions are taken to safeguard the child, this includes sharing the information with external health agencies (GP, Health Visitor, School Nurse) and social services for allocated cases.

JTAI (Joint Target Area Inspection) Examine how well agencies work together in a local area to help and protect children. Inspectors consist of CQC, Ofsted, HM Inspectorate of Probation and HM Inspectorate of Constabulary

LADO (**Local Area Designated Officer)** Involved in the management and oversight of individual cases of allegations of abuse made against those who work with children as set out in the allegations against people who work with children procedure. Their role is to give advice and guidance to employers and voluntary organisations; liaise with the Police and other agencies, and monitor the progress of cases to ensure that they are dealt with as quickly as possible consistent with a thorough and fair process.

Glossary continued

LeDeR -The Learning Disability Mortality Review Programme Established to drive improvement in the quality of health and social care service delivery for people with learning disabilities (LD) by looking at why people with learning disabilities typically die much earlier than average

Looked After Child (LAC) is a child who is accommodated by the local authority, a child who is the subject to an Interim Care Order, full Care Order or Emergency Protection Order; or a child who is remanded by a court into local authority accommodation or Youth Detention Accommodation. In addition where a child is placed for adoption or the local authority is authorised to place a child for adoption - either through the making of a Placement Order or the giving of Parental Consent to Adoptive Placement - the child is a Looked After child.

Looked After Children may be placed with parents, foster carers (including relatives and friends), in Children's Homes, in Secure Accommodation or with prospective adopters.

LPS The new **Liberty Protection Safeguards** was due to come into force in October 2020 (currently delayed due to Covid 19 pandemic) via the Mental Capacity (Amendment) Act 2019. The LPS will replace the Deprivation of Liberty Safeguards (DoLS) as the system to lawfully deprive somebody of their liberty

MARM (Multiagency Risk Assessment Framework) supports management of cases relating to adults where there is a high level of risk but the circumstances may sit outside the statutory adult safeguarding framework but for which a multi-agency approach would be beneficial.

Glossary continued

Mental Capacity Act (2005) provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they may lack capacity in the future. It sets out who can make decisions, in which situations, and how they should go about this.

Mental capacity refers to whether someone has the mental capacity to make a decision or not.

NEST A team of midwives with reduced caseload number specifically to support woman with additional social or significant mental health problems. The team provide bespoke care of the families designed around their individual needs

PREVENT is the government's counter-terrorism strategy, whose aim is to:

- respond to the ideological challenge of terrorism and the threat from those who promote it
- prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support
- Work with sectors and institutions where there are risks of radicalisation that needs to be addressed.

SAMA: The Care Act (2014) requires that any employers who are also providers of care and support, not only have a duty to the at risk adult, but also a responsibility to take action in relation to the employee when allegations of abuse are made against them.
To ensure a consistent, fair, proportionate and transparent approach, the Local Safeguarding Adults Board has developed an allegations management framework, strongly advocating that Trust's have a Safeguarding Allegation Management Advisor (SAMA).

Glossary continued

Serious Adult Review (SAR) is undertaken by a safeguarding adults when a serious case of adult abuse takes place. The aim is for agencies and individuals to learn lessons to improve the way in which they work.

SIRI (serious incident requiring investigation) is a term used for serious incidents in the NHS requiring investigation. It is defined as an incident that occurred in relation to NHS-funded services resulting in serious harm or unexpected or avoidable death of one or more patients, staff, visitors or members of the public.

SUDI (Sudden Unexpected Death in Infants) is deemed to have occurred where there is no known pre-existing condition which would make the death predictable.

NHS
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Report to Trust Board of Directors				
Title:	**Safeguarding Strategy 2022-25**			
Agenda item:	**5.7 ii)**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Authors:	**Karen McGarthy, Named Nurse for Safeguarding Children** **Corinne Miller, Named Nurse for Safeguarding Adults**			
Date:	**29 September 2022**			
Purpose	**Assurance or reassurance** **x**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	The safeguarding strategy sets out UHSFT's purpose and vision to ensure that service users continue to get a robust, consistent and person-centered response in relation to safeguarding, when accessing our services. The Strategy has been reviewed and has been further developed as a 3-year plan. The strategy has been reviewed in collaboration with adult, children and Maternity Safeguarding.			
Response to the issue:	Members of the Board are asked if the strategy gives the required assurance around the UHSFT strategies purpose and vision to safeguard children and adults.			
Implications: (Clinical, Organisational, Governance, Legal?)	The safeguarding strategy outlines the strategic and operational plan which encompasses clinical, organisational and governance implications			
Risks: (Top 3) of carrying out the change / or not:	Not applicable			
Summary: Conclusion and/or recommendation	The safeguarding strategy has highlighted its purpose of • working in partnership to uphold the rights of children and adults • ensuring that the voice of the adult and / or child is at the centre of all we do (making safeguarding personal) • promoting a family approach to safeguarding • supporting an open and transparent culture whereby safeguarding is everybody's business This is outlined within the 3 standards, aligned to the trust's values within the safeguarding strategy. The strategy outlines the plan of action for improving the qualitative and quantitative safeguarding outcomes for children and adults under our care and will be monitored though the safeguarding governance steering group.			

Safeguarding Strategy 2022-2025

1

Introduction

The term 'safeguarding' covers everything that assists children, young people and adults at risk to live a life that is free from abuse and neglect, and which enables them to retain independence, wellbeing, dignity and choice.

It encompasses prevention of harm, exploitation and abuse through provision of high-quality care, effective responses to allegations of harm and abuse, responses that are in line with local multi-agency procedures and lastly, using learning to improve services to patients.

Every NHS-funded organisation and each individual healthcare professional working within them has a responsibility to ensure that the principles and duties of safeguarding children and adults are holistically, consistently and conscientiously applied; the well-being of those children and adults being at the heart of what they do.

UHSFT recognises that safeguarding is a shared responsibility and remains committed to working in collaboration with multi-disciplinary and multi-agency partners to safeguard the adults and children who use our services and their families.

Furthermore, UHSFT endeavours to provide a range of quality assurance activities. These would include operational and strategic functions to support key areas of safeguarding work, embrace change, respond to emerging themes and strive to ensure all safeguarding processes are robust and effective.

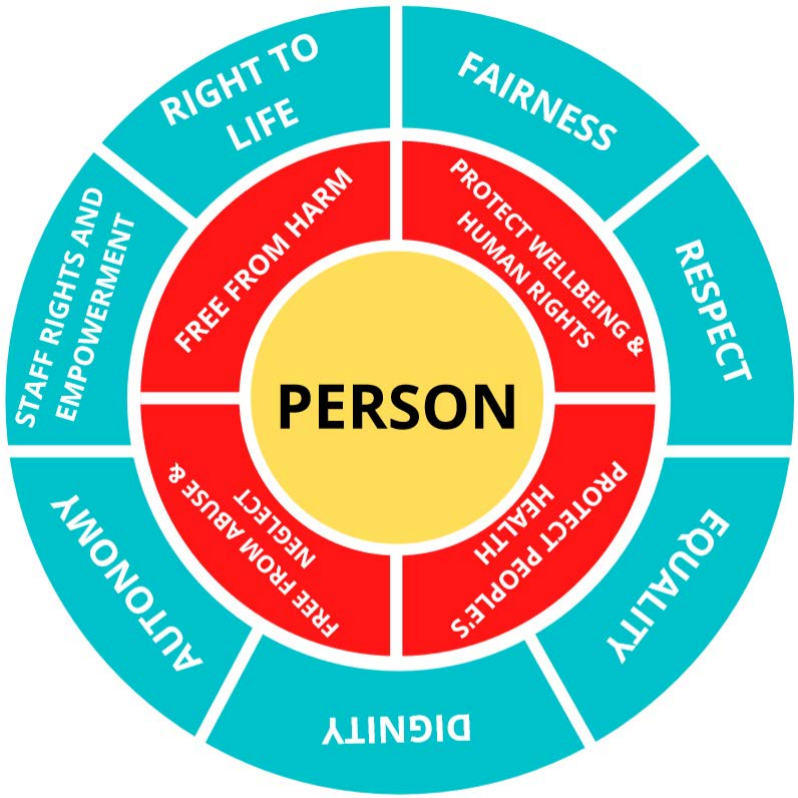
This safeguarding strategy therefore sets out UHSFT's purpose and vision to ensure that adults, children and families continue to experience a robust, consistent and person-centered response in relation to safeguarding.

Following further review, this strategy has been extended for a further three years in order to embed these principles. It will be reviewed in February 2025.

Purpose

- To work in partnership to uphold the rights of children, adults and families
- To ensure that the voice of the adult and / or child is at the centre of all we do (making safeguarding personal)
- To promote a family approach to safeguarding
- To support an open and transparent culture whereby safeguarding is everybody's business

This strategy is underpinned by the H



Human Rights and Safeguarding

Everyone has a responsibility to be aware of the rights of others and to show respect for them. The Human Rights Act (1998) sets out fundamental rights and freedoms that everyone in the UK is entitled to. The following articles have been highlighted as they specifically pertain to the care of people accessing UHSFT services and the role of safeguarding;

- Right to life (Article 2);
- Right to be free from torture and treatment of a degrading nature (Article 3);
- Right to be free from slavery and labour that is forced and not of free will (Article 4);
- Right to liberty and security (Article 5);
- Right to have your private and family life respected (Article 8);
- Right to free thought, conscience and religion and the right to freely express your personal beliefs (Article 9);

Legislative Framework for Children (including LAC) and Adults

- UN Convention on the rights of the child 1989 – adopted by the UK in 1990
- Children Act 1989 & 2004
- The Crime and Disorder Act 1998
- Female Genital Mutilation Act 2003
- The Mental Capacity Act 2005
- Convention on the Rights of Persons with Disabilities 2006
- Mental Health Act 2007
- NICE guidance: Promoting the quality of life of looked-after children and young people – PH No 28 (2010 updated 2015)
- Children and Families Act 2014
- The Care Act 2014
- Modern Slavery Act 2015
- Serious Crime Act 2015
- Domestic Abuse Act (2021)

- Promoting the health and well-being of Looked After Children Statutory Guidance 2015
- Looked After Children: Knowledge, skills and competences of health care staff 2015
- Care & Support Statutory Guidance- Section 14 Safeguarding
- Children and Social Work Act 2017
- 'Working together to safeguard children' Statutory Guidance (HM Government 2018)
- Adult Safeguarding: Roles and Competencies for Health Care Staff 2018
- Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework
- Safeguarding Children and Young People:
  Roles and Competencies for Healthcare Staff: Intercollegiate Document (RCN, 2019)

Standard 1 – patients first; voice of the child / making safeguarding personal

What is it and why is it important?

Voice of the child;
Child safeguarding practice reviews and local reviews frequently highlight the importance of seeing; observing and hearing the child and ensuring the practitioner clearly records this. This includes considering the unborn child and the circumstances they will be born into. Providing an environment in which the child feels confident, safe and powerful is fundamental for the child to have the opportunity to express their views and feelings. UHSFT has a commitment to delivering a child focused approach to safeguarding ensuring the child is at the centre of all safeguarding enquiries, supporting and promoting their welfare and protecting them from harm.

Making Safeguarding Personal; (MSP) enables safeguarding to be done with, and not to, people – 'no decision about me, without me'.

UHSFT has a commitment to ensuring a person-focused approach to safeguarding. MSP is person led and outcome focused, ensuring that the individual is engaged in the safeguarding process and so enhancing their involvement, choice and control as well as improving their quality of life, wellbeing and safety.

The adult concerned must always be at the centre of adult safeguarding enquiries, and their wishes and views sought at the earliest opportunity and throughout the process.

How will we achieve it?

Current safeguarding referral processes support staff to complete an Apex referral as well as the safeguarding proforma. Maternity staff will complete a Badgernet notification of social vulnerabilities. Emergency department information sharing forms should be completed for identified safeguarding concerns. Ensuring the unborn child and child's voice is captured, recorded and where appropriate acted upon is required to promote their wellbeing and prevent harm. The safeguarding teams deliver this message through training, supervision, policy, ward rounds and when supporting and advising staff with safeguarding referrals.

MSP is integrated into the current referral processes. The team will undertake further work to understand how well this is being applied in practice. In addition, safeguarding nurse specialists will continue to be visible and provide leadership in ensuring an outcome focused approach.

Furthermore, through embedding the Mental Capacity Act (2005) and shared decision making in practice, it ensures all we do aligns with putting people at the centre of decision making, promoting empowerment and choice.

How will we measure it?

By the end of 2025 UHSFT- to audit the safeguarding proforma and Emergency Department records to ensure the child voice is captured and actions taken to promote the child's welfare.

By the end of 2025, UHSFT will have undertaken an audit against current practice using the national MSP toolkit developed and updated by The Local Government Association in 2020. The toolkit aims to provide practical support to people working in practice.
https://www.local.gov.uk/msp-toolkit

Standard 2 – Working together; Partnerships

What is it and why is it important?

It is widely understood that responsibility to try and prevent, recognise and respond to harm or abuse applies to a wide range of services and individuals. Responsibilities specifically for NHS staff are enshrined in international and national legislation (NHS Accountability and Assurance Framework 2019). It is vital that we work in partnership to ensure that adults, children and families are holistically, consistently and conscientiously supported when safeguarding concerns are identified. Whilst UHSFT collaborates with a range of external multi-agency partners and patients, the focus of this standard is about working in partnerships with; the emergency department, maternity services, adult services and child health to ensure a consistent and family approach for our patients.

How will we achieve it?

Strategically, the Safeguarding Governance Steering Group brings together senior leads from across these departments to support delivery of the safeguarding agenda. We will continue to use this forum to engage with stakeholders and shape future practice. The Safeguarding team engage and collaborate with the wider safeguarding system including the Hampshire and Southampton boards/partnerships and subgroups.

Operationally, we work and manage safeguarding cases with external multi-agency partners. The Multi-Agency Risk Management Framework (MARM) is well embedded and will continue to be used to support patients 'at risk' in a collaborative way.

We will commit to setting up a working group which brings together safeguarding leads from each of the above areas to align policies and processes.

How will we measure it?

By the end of 2025 there will be a formal working group set up for leads across each of the above departments with a work plan outlining how all trust wide guidance documents, i.e. for domestic abuse, female genital mutilation, will be reviewed and aligned.

Standard 3 – Always improving; Training and Education

What is it and why is it important?

To ensure patients receive pro-active and high quality safeguarding it is important that the healthcare workforce is suitably skilled and supported. The intercollegiate documents for adults and children set out the roles and competencies for staff at every level working within healthcare services. Because the children's intercollegiate document is more established in practice, the aim of this standard is to align training and education across the adult and child agendas which will ensure; a family approach to safeguarding, mandatory and regulatory compliance with the documents and opportunities to learn when things go wrong and also from good practice.

How will we achieve it?

We will ensure a full review of trust wide safeguarding training in partnership with key stakeholders from divisional education teams and departments across the trust. Where appropriate, links will be made with partner providers across the STP footprint and in particular with the local integrated care systems, as set out in the NHS Long Term Plan, which will include pass porting of training.

How will we measure it?

By the end of 2025 there will be a joint adult and child safeguarding education strategy that will include a full delivery plan.

Delivery of the Strategy

Accountability

Standard NHS Safeguarding contract

Hampshire and Southampton Safeguarding Children's Partnership

Hampshire and Southampton Adults Boards

Quarterly and Annual Reports submitted to commissioners and internal, governance groups i.e. Child and Maternity Safeguarding Operational Group, Safeguarding Governance Steering Group, Quality Governance Steering Group, Trust executive Committee, and board

Key Groups and Committees Responsible for Delivering This Strategy

The Trust's Safeguarding Governance Steering Group (SGSG) is responsible on behalf of the Trust Executive Committee and Trust Board, for monitoring the delivery of this strategy.

The Safeguarding Team led by the Children's, Adult and Midwifery named safeguarding professionals are responsible for the delivery of this strategy.

Additional Trust groups include, but are not exclusive to;
Clinical Accreditation Scheme and Clinical Quality
Patient Safety Steering Group
Divisions and Care Groups
Child and Maternity Operational Group
Statutory and Mandatory Operational Group

Each monitors local delivery via their boards and governance groups, and report progress via Quality Governance Surveillance Group

Staff Roles and Responsibilities

It is all staff's responsibility to promote and safeguard the welfare of children and adults in their care.

All staff have a statutory obligation to escalate any safeguarding concerns to a senior member of staff or the safeguarding team.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Medical Appraisal and Revalidation Annual Report including Board Statement of Compliance**			
Agenda item:	**5.9**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Author:	**Liz Brown, Medical HR Operations Manager**			
Date:	**29 September 2022**			
Purpose	**Assurance or reassurance**	**Approval** x	**Ratification**	**Information** x
Issue to be addressed:	The Annual Organisation Audit submission has been stood down since 2020, but the annual board report and the Statement of Compliance has been simplified so that organisations are still able to report appraisal rates.			
Response to the issue:	Medical appraisals were stood down for much of 20/21 to allow clinicians to support the Trust response to the pandemic, missed appraisals were therefore considered an approved deferment. This approach continued into the first half of 2021/22. When able, individuals were encouraged to participate in the appraisals process. Normal appraisal requirements returned in the latter part of 2021/22.			
Implications: (Clinical, Organisational, Governance, Legal?)	The responsible officer (RO) has a statutory duty to ensure compliance with NHS England and GMC requirements for appraisal and revalidation. The Chief Medical Officer is the RO for the Trust.			
Risks: (Top 3) of carrying out the change / or not:	Compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended) and related guidance.			
Summary: Conclusion and/or recommendation	The Board is asked to note the summary information included in this report and acknowledge the interim changes to the national reporting requirements. The Board is asked to approve the "Statement of Compliance" at Appendix A, confirming that the organisation, as a designated body, is in compliance with the medical profession regulations.			

Section 1 – General:

The board of University Hospitals Southampton NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: None Comments: Yes Action for next year: None

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: Roll out and embed the new appraisal system, mandating usage of the online system will ensure greater governance and visibility Comments: A medical appraisal and revalidation IT solution (SARD) was procured and implemented in January 2022. Action for next year: Use of the electronic appraisal system to be mandated from 1st April 2022 and full functionality to be utilised.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Procure, roll out and utilise all functionality of a new appraisal system. Comments: All connections are reviewed and managed by the medical HR team. Action for next year: Continue to embed and utilise all functionality of the appraisal system.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: None Comments: Policy is due for renewal, updates to be made in line with national guidance changes as applicable and the reflect the electronic appraisal system. Action for next year: Publish updated policy.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: Doctors will collect patient feedback through the appraisal software system, once procured the UHS team will work with developers to ensure electronic collection is accessible, this includes development of a QR code. Comments: A external peer review of the appraisal process has not taken place since January 2019, the primary recommendation from the review was a requirement for UHS to review the methodology for the collection of patient feedback. SARD facilitates all patient feedback via a variety of collection options. Action for next year: Encourage expansion of electronic patient feedback collection and move away from paper-based surveys. Work to commence with the UHS digital team to explore an automated collection system.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Support requests for access to this group via the central team. Comments: Enlisted support of local appraisers to facilitate access to appraisal and CPD, this is difficult to manage for individuals that undertake limited work in multiple areas. Trust appraisal leads aware and able to support as required. Action for next year: None

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: Appraisal leads to publish process and the appraisal software platform will support the management of deferments or postponements within the AOA framework. Comments: Approved deferments can now be managed within the electronic appraisal system. The Medical HR team manage this in partnership with the RO, Deputy RO and individual doctors. The national pause to appraisals and COVID deferments has delayed production of a published process. Action for next year: Deferment's process to be formalised in the updated policy document.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Appraisal leads to publish process and the appraisal software platform will support the management of deferments or postponements within the AOA framework. Comments: Doctors with overdue appraisals are contacted and reminded of their responsibility to complete their appraisal. A list of doctors with an overdue appraisal of 3 months or more without an acceptable reason will be submitted to the RO and the monthly Decision Making Group meeting. The circumstances of each case will be reviewed with action determined. The Trust reserves the right to undertake appropriate action where a doctor fails to take sufficient steps to participate in the appraisal process. Automated reminders via the appraisal system highlight approaching and overdue appraisals and remind doctors of their obligation. Action for next year: Deferment's process to be formalised in the updated policy document.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: None Comments: The Trust's Medical Appraisal and Revalidation policy is compliant with national policy and has been approved via the central policy ratification group. Action for next year: Policy is reaching regular review point, updates to be included as required.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: None Comments: There are currently 171 trained consultant appraisers, responsible for 933 appraisals per annum for consultants and senior doctors. Fellows are appraised by their education supervisor and the appraisal process also covers a formal end of placement review. Action for next year: None

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year: None Comments: The appraisal leads deliver a range of in-house training, regular appraisal leads meetings are held for information sharing and development. All appraisers should attend update training every 2 years or undertake CPD related to appraisal. All appraisees are surveyed following their appraisal, collated feedback reports will be available via SARD once sufficient data has been collected. In previous appraisal cycles a selection of appraisal output forms were reviewed and scored via a validated form. Trust appraisal leads reviewed the appraisals of the care group appraisal leads. Results showed good quality appraisal outputs. Another review will be carried out once the electronic appraisal system has been in place for 1 year. Action for next year: Appraisal output quality assurance exercise planned for Q4, SARD has an appraisal summary and PDP audit tool within the platform. This functionality will support the review and it is possible to create 3 reports: overall summary, a section report and the individual appraiser report. Summary to be presented to the decision making group.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: None Comments: All doctors are asked to rate the quality of appraisal and the suitability of the appraiser. A proportion of all appraisal documentation is reviewed by the care group lead appraiser. Action for next year: Share collated appraisee feedback reports with all appraisers, Trust appraisal leads to address any developmental feedback with individuals. ASPAT review planned for Q4.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2022	**1260**
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	**929**
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	**301**
Total number of agreed exceptions	**116**

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: None

Comments: During the period 1 April 2021 – 31 March 2022 the RO made 265 positive recommendations and 97 deferral recommendations. Deferrals are a combination of auto deferred by the GMC (COVID arrangements), absence and additional time required. Numbers of deferrals are expected to normalise now we have moved into the normal appraisal cycle following interim COVID arrangements.

Action for next year: Reduce the number of deferrals submitted but utilising the automated functionality of SARD. Appraisal reminders are sent to appraisees at regular intervals, accurate compliance rates are reported to the DMG monthly and concerns escalated to Divisional Clinical Directors to enable earlier intervention. In the year of revalidation the HR appraisals lead proactively reminds individuals of all requirements for a positive submission.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: None

Comments: Where a deferral was recommended, the doctor was notified with confirmation of the actions required.

Action for next year: None

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: None Comments: Complaints and serious incidents are discussed and reflected upon as part of the process. Local and Divisional governance reports are reviewed at the Quality Governance Steering group, the group reports to the Trust Executive Committee and the Board. Action for next year: None

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: None Comments: Management teams monitor performance of teams and review complaints and incidents at monthly governance meeting. An annual report of any doctor with more than three complaints is presented to the Chief Medical Officer. Activity data is available from divisional analysts at the request of doctors in advance of appraisal. Action for next year: None

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: None Comments: Concerns regarding a doctor's performance or conduct are managed through the Handling of Concerns Relating to the Conduct and Performance of Doctors and Dentists Policy. Concerns are addressed accordingly with support from HR. The Trust has a lead for Patient Safety, and a Deputy Chief Medical Officer, who both assist the Chief Medical Officer with any escalations or serious concerns, through a formal process. Action for next year: None

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.

Action from last year: None Comments: All cases at UHS are stored on secure online software (ER Tracker). Case level information is extracted from ER Tracker into a report to be discussed at the monthly ER Performance Board – this group is chaired by the Head of Employee Relations and has a staff-side representative, the ER team, and more recently the FTSU Guardian in attendance. All medical cases are discussed at this group, which looks at whether the case is being managed in a fair, timely, and proportionate way and in line with EDI principles. Following the meeting, a monthly ER report is compiled and distributed to key stakeholders (including the designated NED). An ER Performance Report is submitted to the People and OD Committee (a Trust Board sub-group) on a biannual basis to appraise the board on ER activity and key themes. The designated NED for medical cases is sent a copy of the terms of reference (TOR) document for any new medical cases and meets with the Head of Employee Relations on a quarterly basis to discuss all medical cases and provide oversight. Practitioners are able to contact the NED if they have any concerns with how a case is being managed. The CMO, Case Manager, and Head of Employee Relations meet on a monthly basis to discuss all cases, and also meet regularly with NHS Resolution and the GMC. Action for next year: None

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year: None Comments: A process is in place for transferring information and concerns between the RO and other ROs where UHS connected Doctors undertake regular work. Action for next year: None

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: None

Comments: The UHS policy for Handling of Concerns Relating to the Conduct and Performance of Doctors and Dentists is in line with Maintaining High Professional Standards guidance. All policies are ratified by the relevant Trust 'expert' group following consultation with all applicable groups. This also applies to all clinical governance and safeguarding policies and processes.

Action for next year: None

Section 5 – Employment Checks

7. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: None

Comments: The medical HR team is responsible for undertaking pre-employment checks, in line with NHS Employers mandatory standards. The temporary resourcing team are responsible for ensuring that appropriate pre-employment documents are provided for any temporary workers, supplied via a locum agency.

Action for next year: None

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

New Actions:

- Use of the electronic appraisal system is mandated from 1st April 2022 and full functionality to be utilised
- Encourage expansion of electronic patient feedback
- Review and republish medical appraisal incorporating the formal deferment of appraisal process
- ASPAT functionality is available within SARD, QA review planned for Q4
- Reduce the number of revalidation deferrals

Overall conclusion:

The response to the pandemic continued to impact on appraisals in 2021/22, however great improvements have been made this year. The procurement and implementation of the new electronic appraisal system. The SARD systems gives accurate real time compliance information, allows greater scrutiny, and removes the challenges associated with a manual system. The functionality to enable patient feedback, colleague feedback and accurate reporting supports the quality improvement activity previously highlighted.

Section 7 – Statement of Compliance:

The Board of University Hospital Southampton NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Chief executive or chairman

Official name of designated body: University Hospital Southampton NHS Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Clinical Outcomes Summary Report - National and International Outcomes 2022**			
Agenda item:	**5.10**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Author:	**Diana Ward, Clinical Outcomes Manager**			
Date:	**29 September 2022**			
Purpose	**Assurance or reassurance** X	**Approval**	**Ratification**	**Information** X
Issue to be addressed:	• Increase the number of specialties reporting outcomes and the total number of outcomes reported • **64/86 services** are reporting outcomes which now totals some **484 outcomes** all relevant to patients • More patient- centred outcomes are encouraged to build a full set of outcomes and progress the outcomes programme • Quality of Life outcomes using ED-5D questionnaires are being added to My Medical Record			
Response to the issue:	• Support and promote the Trust's clinical strategy of Outstanding patient outcomes by: • Developing a Communications strategy to increase engagement with clinical outcomes across the trust and publish outcomes locally and nationally • Widen the reach of CAMEO (clinical assurance meeting for effectiveness and outcomes) by encouraging clinical teams to bring more of their Consultants, Specialist nurses, Matrons to CAMEO to report their outcomes and talk about the improvement story of their department • Ambitions for CAMEO/clinical outcomes programme are that all specialties will report their outcomes and improve on them year – on- year. Outcomes can be published as evidence of World Class care online/via publications			
Implications: (Clinical, Organisational, Governance, Legal?)	Clinical and organisational implications are raised within this report.			
Risks: (Top 3) of carrying out the change / or not:	• Failure of assurance to trust board in areas lacking in outcomes • Failure to maximise on positive publicity from areas of excellence, recruiting the best staff, etc • Failure to identify areas for focussed improvement resulting in sub-optimal outcomes			

Summary: Conclusion and/or recommendation	Divisions should encourage all clinical areas to identify more specific patient outcomes which affect a large proportion of their patients. Many National audits produce infographics which are easy to understand and meaningful to patients. Wide representation at CAMEO is encouraged including Consultants, clinical leads, Matrons, Specialist Nurses, and Care Group managers. *Please see the Clinical Outcomes Programme document for a full departmental update. Further information is available on request from diana.ward@uhs.nhs.uk List of services that are yet to report outcomes to CAMEO: • Palliative medicine • Hepatology • Clinical Immunology and allergy • Infectious diseases • Chemical pathology • Clinical physiology • Paediatric ophthalmology • Paediatric surgery and urology • Paediatric orthopaedics • Paediatric endocrinology • Paediatric clinical immunology and infectious diseases • Paediatric Dermatology • Paediatric Nephrology • Paediatric Rheumatology • Paediatric sleep service • Paediatric spinal

Key to RAG (**R**ed, **A**mber, **G**reen) ratings

Outcome performance RAG:

Red	Below the expected target range	OR	Lower quartile
Amber	Within the expected target range		Middle quartiles
Green	Meeting or exceeding the target		Upper quartile

2. Clinical outcomes Summary

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
Emergency Surgery	Planned admission to critical care following surgery when the risk of death is ≥ 5%	Dr Patrick Tapley	National Emergency laparotomy outcomes (NELA)	177	82.3%	88.46%	Updated Q1 2022/23 from CAMEO report on NELA data period January 2021-December 2021 inclusive
	Consultant surgeon and Consultant Anaesthetist in theatre when risk of death is ≥ 5%			177	90.1%	87.2%	Updated Q1 2022/23 from CAMEO report on NELA data period January 2021-December 2021 inclusive
	Mortality			177	8.7% risk adjusted	12.42% Non risk adjusted ↓	Updated Q1 2022/23 from CAMEO report on NELA data period January 2021-December 2021 inclusive Cases reviewed quarterly at M&M meeting with invitation of operative surgeon to discuss cases and identify areas of improvement (rating from green to amber)
	Median post-operative Length of Stay (LOS)			177	15.1 days mean	16.5 days mean 10.3 median	Updated Q1 2022/23 from CAMEO report on NELA data period January 2021-December 2021 inclusive
	Arrival in theatre within a timescale appropriate for urgency			177	85%	75.5%	Updated Q1 2022/23 from CAMEO report on NELA data period January 2021-December 2021 inclusive Action plan in place
	Post-operative assessment by elderly care			177	27%	44%	Updated Q1 2022/23 from CAMEO report on NELA data period January 2021-December 2021 inclusive Slowly improving, increased number of sessions allocated to DMOP team
	Pre-operative; CT scan reported by consultant radiologist			177	85%	67.6%	Updated Q1 2022/23 from CAMEO report on NELA data period January 2021-December 2021 inclusive Action plan in place
	Risk documented before surgery			177	84%	83.7%	Updated Q1 2022/23 from CAMEO report on NELA data period January 2021-December 2021 inclusive Repeated highlighting to surgical team of need to do this. Action plan in place
	Consultant surgeon in theatre when risk of death is ≥ 5%			177	96%	94.9%	Updated Q1 2022/23 from CAMEO report on NELA data period January 2021-December 2021 inclusive
	Consultant Anaesthetist in theatre when risk of death is ≥ 5%			177	93%	92.3%	Updated Q1 2022/23 from CAMEO report on NELA data period January 2021-December 2021 inclusive
	Planned admission to critical care following surgery when the risk of death is ≥ 10%			177	87.6%	88.5%	Updated Q1 2022/23 from CAMEO report on NELA data period January 2021-December 2021 inclusive
	Unplanned admission to critical care			177	3.2%	1.7%	Updated Q1 2022/23 from CAMEO report on NELA data period January 2021-December 2021 inclusive
	Unplanned return to theatre			177	4.8%	7.3% ↓	Updated Q1 2022/23 from CAMEO report on NELA data period January 2021-December 2021 inclusive (rating from green to amber)

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
Thyroid Disease Parathyroid Disease Adrenal Disease	Hypocalcaemia treatment @ 6/12	James Kirkby-bott	British ssociatio n of Endocrin e and Thyroid Surgeons	64	3.7%	0%	Updated July 2021 with April 20-Aril 21 data Numbers of all are too small to be reliable. A single complication could put yououtside of the funnel plot.
	Persistent hypercalcaemia			64	4.5%	4.2%	
	Mortality			64	0.1%	0%	
Upper GI	Average length of stay/days	Fergus Noble	National	159	11	9	Updated Q4 2021/22 from CAMEO report National Oesophago-gastric Cancer Audit (NOGCA) 2021 Outcome data for oesophageal or stomach cancer between 1 April 2017 and 31 March 2020. Targets represent AUGIS nationally set targets for resection margins and the national median for mortality rather than the 99.8% control limit set nationally. Benchmarking comparing to the 37 national UK resectional centres: Length of stay 4th out of 37 Mortality data reperesents 15th out of the 37 Adequate Lymphadenectomy 11th out of 37 Positive longitudinal resection margin oesophagectomy 4th of 37 Positive longitudinal resection margin Gastrectomy 1st out of37 Circumferential resection margin Joint 10th out of 37
	Positive Longitudinal Resection Margin oesophagectomy				5%/4%	0.9%	
	Positive Longitudinal Resection Margin gastrectomy				5%/9%	0%	
	Positive Circumferential Resection Margin				30%/22%	15%	
	% Adequate Lymphadenectomy				87.9%	95%	
	Oesophagectomy 30 day mortality				1.6 %	0.7%	
	Oesophagectomy 90 day mortality				3.2%	2.7%	
	Gastrectomy 30 day mortality				1.6 %	0.7%	
	Gastrectomy 90 day mortality				3.2 %	2.7%	
Urology	Nephrectomy: Complication rate	Richard Lockyer	National	119	2.45%	1.27%	Updated May 2021 with 2017/19 data from BAUS website
	Nephrectomy : Transfusion rate			115	4.85%	5.29% ↓	
	Nephrectomy : Mortality rate			0/119	0.39%	0%	
	Nephrectomy : Length of stay			114	Open 6 Lap 3 Robot 2	Open 6 Lap 3 Robot 0	28 open 86 laparoscopic 0 robotic
	Prostatectomy: experiencing at least one genitourinary complication requiring a procedural/surgical intervention within 2 years of radical prostatectomy	Tim Dudder-idge	NPCA	122	6%	6.27%	Updated Q4 2021/22 from NPCA Report 2021 data April 19 to March 2020
	Prostatectomy: readmitted as an			216	14%	10.59%	

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
	emergency within 90 days of radical prostatectomy						
	Prostatectomy: patients receiving a procedure of the large bowel and a diagnosis indicating radiation toxicity (gastrointestinal complication) within 2 years of radical radiotherapy			80	10%	10.11%	
	Cystectomy: Transfusion rate	Julian Smith	National	112	16.93%	11.3%	Updated May 2021 with 2017/18 data from BAUS website
	Cystectomy: 30 day Mortality rate			0/115	1.25%	0%	
	Cystectomy: 90 day Mortality rate			115	2.08%	0.87%	
	Cystectomy: Length of stay (open)			114	10	6	
	Urethroplasty: Intra-operative complication rate	Rowland Rees	National	42	%	0 ↑	Updated June 2021 from CAMEO report data period 11/08/2020-14/06/2021. The low complication rate and very low readmission rate are outcomes to be proud of. This data reflects a regional tertiary service providing definitive surgery for men with recurrent urethral stricture disease. It is now amongst the top 5 centres in the UK in terms of volume, and serves Hampshire, Dorset and Wiltshire, currently on a single-surgeon basis. The outcomes are good and compare favourably with other UK centres.
	Urethroplasty: Post-operative complication rate (<30 days) (Clavien-Dindo grade 2 & 3a)			42	%	4.7% (2) ↑	
	Urethroplasty: Mortality			42	%	0	
	Urethroplasty: Readmissions			42	%	2.4% (1)	
	Percutaneous nephrolithotomy, (PCNL): Transfusion rate	Bhaskar Somani	National	20	1.76%	0%	Updated June 2022 from CAMEO report None of the patients needed transfusion 2-3 days in line with the national average
	PCNL: Post-operative Length of Stay (open)			20	2-3 days	2-3 days ↑	
Oral & Max. Fax. Surgery	Free flap success rate	Mr Roger Webb	National		92%	98%	Updated Q4 18/19 - Our free flap success rate is up to 98% and for the past 3 years is 100% for head and neck reconstruction. This has happened in spite of an ever increasing demand and makes the case for centralisation with QAH much stronger.
ENT (including Paediatric ENT)	Getting it Right First Time % 2WW referrals seen in 2WW	Huw Jones	National	2077	95.7%	87.96%	Updated Q1 2022/23 from CAMEO report data period April 2021-May 2022 Action plan in place
	Mean LoS Emergency patients		Internal	2077	N/A	4 days	Updated Q1 2022/23 from CAMEO report data period April 2021-May 2022 No national target
	Mean LoS Inpatients		Internal	2077	N/A	2 day	Updated Q1 2022/23 from CAMEO report data period April 2021-May 2022 No national target
Surgery / HPB / NET	30 day mortality	Zaed Hamady, Thomas	National	1063	2.5%	0.63%	Added Q4 2019/20 Data from 2016-2018

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
		Armstrong					
General Surgery	Pelvic exenterations Median operation duration (in hours)	Alex Mirnezami			6.5-27 hours	14.2 Hours	Newly added Q1 2021/22 422 cases to date the second largest UK series. 11 cases >20 hours one of only 3 units internationally to have reported this type of surgery
	30 day mortality					0.2%	Newly added Q1 2021/22 1st /422 lowest reported internationally
	5 year survivial					57%	Newly added Q1 2021/22 Without surgery <4% with exceptionally poor QOL. 27% of referrals previously on a palliative pathway now converted to curative
Colorectal Surgery	90-day mortality (adjusted)	Mr Dudding	National	743	3.2%	0.7%	Updated April 2022 ACPGBI Clinical Outcomes Publication 2020. Patients diagnosed with bowel cancer between April 2014 and March 2019.
	90-day mortality (adjusted)		National	173	2.7%*	2.2%	Updated Q4 2021/22 from NBOCA annual report 2021 published Feruary 2022 data from 2019/20
	30-day unplanned readmission				10.7%*	5.5%	* National findings
	2-year mortality (adjusted)				17.7%	15.4%	
	Risk adjusted length of stay >5 days				58%*	60%	
	18-month stoma rate (reversal)					N/A	*Stoma rate not reported in this report
	APER rate				28%	27%	
Theatres	Compliance with stop points for safety in theatres	Awaiting Lead name	National / internal	189	100%	77%	Audited this year, revised process, to reaudit. The "stop points for safety" has been introduced, to ensure patient safety in theatre. All specialities now use this checklist. Data collected showed an overall compliance across all specialities of 77% but requires improvement. It is important to re audit to see if improvements and compliance have been embedded.
	Recovery discharge times.		Local			TBC	To review the time between ready for discharge to actual discharge to ward. Development changed from Red to Amber as now have the data which will be reported shortly.
Anaesthetics	Never events	Lucy White / Anna Walton	Local	every theatre case	0	2 ↓	Updated June 2022 from CAMEO report 2 never events recorded during Jan-Dec 2021. One wrong side block, 1 wrong site surgery. Recommendations made, an action plan produced and specific learning to be delivered. Incidents and actions shared with all divisions and relevant care groups
	Epidural response time for women		Local	236	>80%		Updated June 2022 from CAMEO report

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
	requesting epidural analgesia in labour (local PAH audit)				within 30 minutes of request	91.5% within 30 mins	Need to ensure anaesthetists available to support obstetric anaesthetists when increased demand. To repeat annually but need to add more information from follow-up of patients post obstetric anaesthetic to database especially rate of headache
	Trustwide Inpatient Pain Management Positive experience of pain management from patient feedback		Local PREM	4991	>90%	97%	Updated June 2022 from CAMEO report Excellent patient feedback from Friends and Family. Specific Pain team feedback positive though negative when team not available for input with the patients
	Adequate staff and systems must be in place to provide timely pain management to all inpatients. Time from referral to review April-December 2021			881	Timely >80%	67% review same day ↓	Updated June 2022 from CAMEO report Need to increase service capability as more complex patients requiring input. Business case to increase staffing capacity to cover the service. Patients are not able to be reviewed due to capacity of the team. These patients could potentially be optimised for discharge if seen earlier
	All major trauma cases with GCS < 9 to be intubated at scene or within 30 minutes of arrival (adult)		TARN data	28	100%	89% ↓	Updated June 2022 from CAMEO report The 3 cases were examined and deemed inappropriate to intubate.
	Consultant Anaesthetist to hold Major Trauma Bleep every week daytime session		CLW data	Weekday cover 8am – 6pm	100%	76%	Updated June 2022 from CAMEO report Need an increase in number of Major trauma trained anaesthetists with ability to hold the Major trauma bleep
	Every trainee anaesthetic list has a named consultant anaesthetist supervising and immediately accessible on 1646 bleep		CLW data	Weekday cover 8am – 6pm	100%	100%	Updated June 2022 from CAMEO report Continued coverage to ensure it is clear to everyone in theatres who is supervising and how to contact
	Rib fracture pathway should be followed and documented for all rib fracture patients			111	>80%	64%	Newly added June 2022 from CAMEO report data for 2021. A rib fracture pathway can reduce ICU utilisation and decrease pulmonary complications. Feedback shows improved identification and management of this high risk group, including appropriate analgesic regimens, referral for anaesthetic blocks and catheters, and surgical fixation. The pathway requires re-promotion of rib fracture pathway and streamlining of documentation.
	Anaesthetic allergy service Referral to review times			71	No data	2 to 115 weeks wait	Newly added June 2022 from CAMEO report Data for 2021. UHS is a leading centre for anaesthetic allergy testing. Business case required for addition of

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
							pharmacist to the team to assist in preparation of the medications. This could ensure an extra patient per list is seen, 40 extra patients per year and a dramatic reduction in wait times
	UHS day case brain biopsy surgery Number day cases			66	No data	94%	Newly added June 2022 from CAMEO repor Data for 2021. UHS leading hospital in this service. Only one other hospital in the UK undertakes this work. Cost saving, bed saving, great patient satisfaction
	Paediatric Rolling Audit Post operative nausea and vomiting (PONV)			99	<10%	4%	Newly added June 2022 from CAMEO report Data collected for a month at a time. This rolling audit has resumed with increasing numbers.
	Incidence of PONV in post-operative period -Anti-emetics to be prescribed			99	>80%	78%	Newly added June 2022 from CAMEO report Increase in prescribed anti-emetics
	Cannula flushing - All cannulae flushed			87	100%	97%	Newly added June 2022 from CAMEO report All cannulae to be flushed and documented
	Temperature between 36-370C in recovery			81	100%	84%	Newly added June 2022 from CAMEO report Temperature to be monitored peri-operatively
	Rate of regional nerve blocks in theatre for neck of femur fracture (NOF) patients undergoing fixation		NHFD / Local audit	626	National rate GA58.6% Spinal 45.8%	RA in GA 86% RA in spinal 72.4%	Updated June 2022 from CAMEO report Data for 2021. Anaesthetists encouraged to place blocks when possible and repeat after 6 hours if necessary. Anaesthetists state at sign in and out if block placed and document as clearly as possible if block sited
Critical Care	Unit acquired infections in the blood	Dr Susan Townser Lisa Showell, Sanjay Gupta	National	1614	3%	8.6% ↓	Updated Aug 2022 from CMP report data April 21 to March 2022 - Out of Hours discharges which remain high. This reflects the current, ongoing trust (and national) issues with capacity. It remains a risk to our patients which is being worsened by a lack of Outreach staff over some nights. The GICU staff can do little to influence this other than identify potential discharges as soon as possible
	Out-of-hours discharges to the ward (not delayed)			1614	1.9%	6.4%	
	Bed days of care post 8 hour delay			1614	2.5%	0.8%	
	ACC02aii Bed days of care post 24 hour delay			1614	1.4%	0.3%	
	Risk adjusted acute hospital mortality			1614	19.1%	19.5%	
	Unplanned readmissions within 48 hours			1614	1.2%	1.8%	
	ACC15 Standardised mortality ratio (using ICNARC risk adjustment model) for critical care patients		SSQD	1614	1%	5.5%	Updated Aug 2022 from CMP report data April 21 to March 2022
Cardiac ICU	ACC02ai Percentage of total available critical care bed days utilised for patients more than 24 hours after the decision to discharge (Validated)	Andy Curry	SSQD	0/1472	1.6%	0%	Updated Q2 21/22 from CAMEO report October 2021 Latest data taken QSIS Q4 21/22

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
	ACC15 Standardised mortality ratio (using ICNARC risk adjustment model) for critical care patients			1045	1.0%	2.1%	Updated Aug 2022 from CMP report data April 21 to March 2022
Neuro ICU	ACC02ai Percentage of total available critical care bed days utilised for patients more than 24 hours after the decision to discharge (Validated)	Ben Thomas	SSQD	13/1196	1.6%	1.1%	Updated Q2 21/22 from CAMEO report October 2021 Latest data taken from QSIS Q4 21/22
	ACC15 Standardised mortality ratio (using ICNARC risk adjustment model) for critical care patients			621	1%	4.4% ↑	Updated Aug 2022 from CMP report data April 21 to March 2022
Ophthalmology	Endophthalmitis rates post intravitreal injection	Gabriella De Salvo	National	4740	<0.07%	0.00%	Updated June 2022 with Q4 2021/22 data
	Endophthalmitis following cataract surgery			929	0.14%	0.0%	Updated June 2022 with Q4 2021/22 data
	Posterior Capsular Rupture			929	2%	1.08%	Updated June 2022 with Q4 2021/22 data
	Timely consultation for R3 (urgent) screening positive	Christina Rennie		24/28	≥80% < 6 weeks	85.7%	Updated January 2022 from CAMEO report data for Q2 2021/22 data
	Timely consultation for R2/M1 (routine) screening positive			24/52	≥70% < 13 weeks	46.2% ↓	Updated January 2022 from CAMEO report data for Q1 2021/22 data
Medical and Clinical Oncology	IV antibiotics given within 1hr in suspected cases of neutropenic sepsis	SSr Jess Stansby	Local	233	>80%	78.5%	Updated Q4 2021/22 from CAMEO report data from July 20 to Dec 21 Audit of initial antibiotic delivery in patients with suspected neutropenic sepsis presenting as emergencies to UHS Cancer Care. >80% is a self-imposed target [no national target]
	IV antibiotics given within 1hr in suspected cases of neutropenic sepsis with confirmed neutropenia			65	>80%	76.9%	Updated Q4 2021/22 from CAMEO report data from July 20 to Dec 21 Patients with confirmed neutropenia represent the most vulnerable patient group
	Bowel Tumour - 2020	Ioannis Karydis	NCRAS at Publish Health England	183	3.6%	2.2%	Updated Q4 2021/22 from CAMEO report data varies from 2017 to 2019. All outcomes have changed from last year. * SACT - systemic anti-cancer therapy **Data (national & UHS) derived from same dataset & time-period and risk adjusted for age/sex/fitness (comorbidities & performance status) of populations *** data amalgamated for 2 consecutive years
	Breast Tumour - 2020			174	2.7%	0.9%	
	CUP Tumour – 2017&18***			15	14.1%	19.9%	
	Gastric Tumour – 2017&18***			34	7.9%	4.3%	
	Lung Tumour – 2019&20***			301	10.5%	8.7%	
	Ovarian Tumour – 2018&19***			67	8.3%	6.3%	
	Pancreatic Tumour – 2017&18***			61	14.1%	10.7%	
	Prostatic Tumour – 2018&19***			117	5.4%	3.4%	

Speciality	Outcome		Clinical Lead	Driver	Outcome performance			Actions / Comments
					Sample size	Target / Range	UHS RAG	
	Bowel Tumour – 20/21			Internal SACT dataset ***	145	3.6%	3.4%	
	Breast Tumour – 20/21				253	2.7%	2%	
	Gastric cancer – 20/21				13	7.9%	7.7%	
	Lung Tumour – 20/21				194	10.5%	7.7%	
	Ovarian Tumour – 20/21				90	8.3%	5.5%	
	Pancreatic Tumour – 20/21				41	14.1%	2.4%	
	Prostate Tumour – 20/21				52	5.4%	0%	
	All malignancies – 20/21				2012	4.44%	3.7%	
	All malignancies – curative - 20/21				784	1.52%	1.5%	
	All malignancies – palliative - 20/21				1169	7.11%	5.2%	
Cancer Care	Proportion of patients assessed by specialist nurse		Mr Andrew Bates	National Lung Cancer Audit (NLCA)	340	73.4%	67.4%	Updated March 2021 newly added Data from the NLCA report 2020 data period 2018 UHS were understaffed in 2018 in comparison to 2021. To give context there was only 1 WTE CNS in post at the worst point. Today we have 4.33 WTE CNS also in the process of recruiting a 0.53 WTE band 4 CSW to bring us in line with other NHS trusts
	Proportion of patients with stage 111B/IV and PS 0-1 who have systemic anti-cancer treatment					66.7%	50.8%	Updated March 2021 newly added Data from the NLCA report data period 2018
	Proportion of patients with pathological confirmation of cancer					Standard 75%	69.7%	Updated March 2021 newly added Data from the NLCA report data period 2018. England score was 69.4% so scored better than that but did not meet the standard
	Proportion of patients who have anti-cancer treatment					Standard 60%	60.6%	Updated March 2021 newly added Data from the NLCA report data period 2018. The England score was 58.5%.
	Proportion of patients with stage 1/11 and PO 0-2 with curative intent					80.8%	74.4%	Updated March 2021 newly added Data from the NLCA report data period 2018
	Proportion of patients with NSCLC who undergo surgery					18.4%	23%	Updated March 2021 newly added Data from the NLCA report data period 2018
	Proportion of patients with SCLC who undergo chemo					68.9%	77.1%	Updated March 2021 newly added Data from the NLCA report data period 2018
	Proportion of patients alive at 1 year after diagnosis					38.7%	44.8%	Updated March 2021 newly added Data from the NLCA report data period 2018
Clinical Haematology Bone Marrow Transplant Unit	Overall survival (OS) for all allogeneic transplants - target is maintaining allogeneic transplantation results	Sibling	Kim Orchard	National	70	46%	51%	Updated Q4 2021/22 from CAMEO report data from Jan – Dec 2021
		Unrelated donor			233	50%	57%	

Speciality	Outcome		Clinical Lead	Driver	Outcome performance			Actions / Comments
					Sample size	Target / Range	UHS RAG	
	equal to or better than the BSBMT UK benchmarking results 5 year follow up							
	Overall survival (OS) for all autologous transplants - target is maintaining autologous transplantation results equal to or better than the BSBMT UK benchmarking results				436	68%	69%	The most recent analysis of the WBMTP (UHS) autologous transplant outcomes are statistically significantly above the BSBMT benchmark results
	Overall survival (OS) at 1yr for all autologous transplants				436	92%	94%	
	Overall survival (OS) at 1yr for all allogeneic transplants				304	71%	80%	
	Non-relapse Mortality (NRM)-should be equal or less than the BSBMT benchmark 1yr time-point	Autologous			436	3%	1%	Updated Q4 2021/22 from CAMEO report Non-relapse Mortality (NRM) is substantially below the benchmark
		Allogeneic Sibling			70	13%	10%	
		VUD			233	20%	10%	
	EBMT Allogeneic transplantation	% patients dying within 100 days of transplant		European	500+	4%	0.9%	Updated Q4 2021/22 from CAMEO report Data from 2018/19 Our centre in Southampton has performed extremely well and actually has the best transplant outcomes for allogeneic transplantation and 3rd best for autologous transplants in Europe – this is out of 395 transplant centres across UK and Europe These important results show the risk-adjusted analysis for our centre for allogeneic transplants and autologous transplants. Taking into account variables such as age, disease and comorbidity etc
	EBMT Autologous transplant	% patients dying within 100 days of transplant			500+	4%	0.9%	
Emergency Medicine	Survival to hospital discharge		Ben Chadwick Katie Baker	NCAA	113 patients	20%	46%	Updated Q1 22/23 from NCAA data Apr – Dec 2021
	ROSC (Return of Spontaneous Circulation)			NCAA	115 patients	50-51%.	69.6%	Updated Q1 22/23 from NCAA data Apr – Dec 2021
HIOWAA	Mortality within 24 hours of admission		John Gamblin				TBC	Added May 2021 from CAMEO report
	Adverse incidents in critical interventions						TBC	Added May 2021 from CAMEO report
	Compliance in KPI's for pre hospital						100%	Added May 2021 from CAMEO report

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
	emergency anaesthesia						Especially difficult to achieve during Covid 19 with impact of PPE on clinical performance
	Overall intubations					95%	
Liaison Psychiatry	Core 24 standard in achieving a 1 hour response time to referrals from the ED	Alexa Redman /	National	2200	100%	75%	Updated January 2022 from CAMEO report Data from January to December 2021
	ED referrals seen within 4 hours		National	2200		95%	Updated January 2022 from CAMEO report Data from January to December 2021
	Routine ward referrals being seen within 3 days		Local	2132	100%	95%	Updated January 2022 from CAMEO report Data from January to December 2021
	Discharge plan in place for ED referrals – 4 hours			2200		56%	Newly added January 2022 from CAMEO report data from January to December 2021
Medicine for Older People (falls)	NAIF - Completion of multifactorial risk assessment before inpatient hip fracture	Jonathan Sparkes	National		N/A	N/A	Update from September 2020 CAMEO report – Benchmark results not available
	CQUIN			83%	80%	52%	Update from September 2020 CAMEO report – CQUIN must reach 80% overall. An action plan is in place. CQUIN suspended for 2021/22.
	1) Mobility assessment						
	1) Providing walking aid			66%			
	2) Postural blood pressure			67%			
	3) Medication review			36%			
Geriatric Medicine	Mortality	Ibrahim Bodagh	Internal	sample: 347	(73.3–90.8) Expected 424	8.17%	Updated from CAMEO report September 2021 – Data from Mar – Feb 2021 Both observed mortality and HSMR are low
	HAI infection				N/A	38	Updated from CAMEO report September 2021 – Data from September 2020 to September 2021. Most infections were C.diff (not all contracted in hospital), more rational use of antibiotics
	Complaints					11	Updated from CAMEO report September 2021 – Data from September 2020 to September 2021
	Length of stay					7.2 days	Updated from CAMEO report September 2021 – Data from September 2020 to September 2021. Despite pressure form Covid-19 pandemic, LOS remained low
	Readmissions within 30 days					9.9%	Updated from cameo report September 2021 - Data from September 2020 to September 2021. Need to monitor and staff to consider the risk of readmission when discharging patients
	Readmission within 7 days					6.3%	Updated from CAMEO report September 2021 – Data

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
							from September 2020 to September 2021
General Internal Medicine	HSMR	Elizabeth Estabrook	Internal	June 2019 – May 2020	TBC	52.4%	Update from September 2020 CAMEO report - GIM is performing very well. The GIM consultants who have all contributed over the last year, have a combined current 1 year rolling HMSR (June 2019-May 2020) of 52.4%. This has fallen from 88.5% last year. A 36 month rolling HSMR for the GIM team currently sits at 73.4%. This is far below national average.
	Crude hospital mortality			20/1195	Around 10%	1.7%	Update from September 2020 CAMEO report - Aug 2019 - Jan 2020 and May – Aug 2020 GIM = Total 20 deaths • 20 deaths/1195 patients = 1.7%. • This compares favourably with 2.5% observed last year.
	Length of Stay			May – Aug 2020	TBC	5 days	Update from September 2020 CAMEO report - Safari WR GIM 1 and 2 Team model Aug 2019 - Jan 2020 • GIM downstream LOS = av 6.5 days • AMU + GIM downstream LOS = av 9.6 days Ward based GIM team on F7 then E7 May –Aug 2020 (12 wks) • May – Aug 2020 GIM downstream LOS av 5.3 days This again compares favourably with last year where total LOS including AMU = 10.9 days and Downstream GIM=7.0 days. Ward based working has improved LOS. Patients moving down stream faster have also reduced LOS by decreasing time on AMU.
	Complaint rate			1/1195	TBC	<0.084%	Update from September 2020 CAMEO report - x1 complaint/1195 patients managed (<0.084%). This compares with 2/1480 patients last year. GIM have continued to receive a number of cards/positive F and F compliments
	Readmission rate			Aug 2019 – Jan 2020 170/910 pts May – Aug 2020	TBC	Aug 19 – Jan 2020 18.6% May – Aug 2020 2.8%	Update from September 2020 CAMEO report - 910 patients managed (Aug 2019-Jan 2020) • 66 <7 day readmissions = 7.2% • 104 <30 day readmissions = 11.4% • Total 170 readmissions = 18.6% 285 patients managed (May- August 2020 • 4 <7 day readmissions • 4 <30 day readmissions

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
				8/285 pts			• Total 8 readmissions = 2.8% This compares with 7% 7 day readmission and 9.4% 30 day readmission rate last year. There has been a marked improvement in readmission rate after changing to ward based working. This is likely to relate to enhanced MDT working/daily MDT board rounds.
	30 day readmission rate (SAMBA)		National		21%	9.4%	Updated March 2021 newly added
	High harm fall rate			4	TBC	4	Update from September 2020 CAMEO report - x4 high harm falls from August 2019 to Aug 2020 Impact • X1 NOF – severe/major • X1 NOF – catastrophic/death – coroner – death by natural causes with fall contributing • X1 fall with bruising – moderate • X1 #ankle – severe/major Compared to only 2 the year before.
	Hospital acquired infections			0	TBC	NIL	Update from September 2020 CAMEO report - MRSA, MSSA, C diff, Ecoli, GRE • August 2019 – end Jan 2020 (6months) - nil • May- Aug 2020 (3 months) nil • July 2018-July 2019 nil Same results as last year.
Specialised Endocrinology Services including Diabetology Medicine	END08c Mean length of stay (LOS) in days following Pituitary surgery for Cushing's.	Mr Philip Newland-Jones	SSQD / QSIS dashboard			NDA	**Update September 2020** from CAMEO report **No Data Available** for these metrics
	END18 Proportion of paediatric patients leaving the paediatric service seen by the adult endocrinology team prior to transfer to adult services					NDA	
	END24 Mean length of stay (LOS) in days following non-cancer Adrenal surgery (excluding ITU days)					NDA	
	Diabetes reported errors					**21 reported**	**Updated September 2022** from CAMEO report Unfortunately there is no national data as the Inpateint service audit stopped in 2019. From November 21 to April 22 there has been 21
	Prescription errors					NDA	
	Insulin errors					NDA	

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
	BGL management errors					NDA	diabetes reported errors
	Severe hypoglycaemia					NDA	
	Pts reported mealtimes suitable					NDA	
	Pts reported meal choice suitable					NDA	
	Pts reported satisfaction in DM care					NDA	
	Pts received foot assessment within 24hrs of admission					NDA	
	Pts received foot assessment during admission					NDA	
	Inpatients on IV insulin infusion					NDA	
	Use of IV insulin deemed inappropriate					NDA	
	Patients seen by DM team					NDA	
	HARMS		National diabetes pump audit	297		**10 cases**	**Updated September 2022** from CAMEO report There are currently 297 Adult patients under the care of the Insulin pump service with approx. 30 new ones each year. From Aug 21 to Aug 22 there has been 10 cases submitted
	Blood pressure <140/80					NDA	
	Cholesterol<5					NDA	
Gastro-enterology	Crohn's disease patients - remission achieved	Fraser Cummings	National	48	68%	52%	Inflammatory Bowel Disease (IBD) programme - Biological therapies adult UHS 52% (11/21), national results 68% (502/741)
	Crohn's disease patients with adverse event recorded at 3 month follow-up			30	8%	10%	UHS 10% (3/30), national results n=1343 8% (108)
Rheumatology	RA QS33 Standard 2: Assessed within 3 weeks of referral	Rakhi Seth Dinny Wallis	National		Target is 80%	**54%**	**Updated September 2022** from CAMEO report Data 21/22 Increase clinic capacity and admin support
	RA QS33 Standard 3: Started DMARD within 6 weeks of referral				Target is 80%	**57%**	**Updated September 2022** from CAMEO report Data 21/22 This will improve when the above does
Respiratory Medicine	Inpatient Mortality (HES)	Zoe Pond	National	302	3.9%*	5.3%*	Updated from CAMEO report September 2019 *IP mortality and within 30 to 90 days of admission is from 2017 COPD report published May 2019. Caveats on limited numbers within local and national dataset at this time. HSMR data currently 99.0 **Dr Foster data for 30/7 readmissions shows us to have a readmission rate of 22.4% compared to 25.1% nationally and 24% locally *** Historical data published 2017 from 2014 with up to
	Mortality within 30 days of admission (all causes)			302	6.1%*	5.6%*	
	Mortality within 90 days of admission (all causes)			302	11.3%*	10.9%*	
	COPD readmission rates (within 30 days of discharge)				25.1%	22.4%**	
	All causes readmission rates (within 30 days of discharge)			302	24.8%*	22.6%*	

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
	COPD readmission rates (within 90 days of discharge)			1226	22.6%***	29.6%****	date data not available ****Local audit data April 2018 to March 2019
	All causes readmission rates (within 90 days of discharge)			98%	43.1% ***	59.2% ***	
	Length of stay			302	4 days*	4 days*	
	Best Practice Tariff (all 3 achieved in >60% patients)			394	>60%	83% (Q1-Q3 2019/20)	Updated June 2021 from COPD report published & BPT report Q1-Q3 2019/20
	Specialist Respiratory Review		National		Target 60%	82.0% (Q1 2020)	
	Discharge Care Bundle			127/380		33%	Updated June 2022 from COPD report moved from green to amber rating data from October 2021 – March 2022
	Specialist review within 24 hours of admission			267/400		67%	Updated June 2022 from COPD report data from October 2021 – March 2022
	Patients offered nicotine products to help abstain		National	33	National average 32.4%	30.3% ↓	Updated from March 2022 – BTS National Smoking Cessation Audit 2021 data.
	Smoking status recorded in the notes		National	200	National average 78.6%	71% ↓	Updated from March 2022 – BTS National Smoking Cessation Audit 2021 data.
	Patient death while an inpatient:	Ben Marshall	National	180	10%*	10%	Updated September 2019 from BTS Adult Community Acquired Pneumonia (CAP) 2018/9 audit: *national mortality.
	Mortality		Internal	869	20-50% **	20-50%*	Current audit on patients over 80 will continue to monitor. *Better 30-day outcomes at UHS **Target: *20-50% rising with each year from 80yrs*
Dermatology	Post-op complication rate	Caroline Murray	National	2241		1.33%	Updated from CAMEO report September 2021 – data January – June 2021 mean 374 procedures / mo complication rate mean 1.33/month
	Adequately treated Squamous Cell Carcinoma (SCC)		Local	100	Not set	98%	Updated from CAMEO report September 2021 – Continue to monitor
	Adequately treated Basal Cell Carcinoma (BCC)		National	395	95%	95.44%	Updated from CAMEO report September 2021 – Continue to monitor
	Clinical Standards for the Managed Clinical Network					NO DATA	Updated from CAMEO report September 2021 – Updated from CAMEO report September 2021

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
	Surgical wound infection		Local	2241		1.03%	Updated from CAMEO report September 2021 – data from Jamuary – June 2021 mean 374 procedures / mo infection rate mean 3.83/month or 10.3%
Cystic Fibrosis (adults)	1. Age adjusted FEV % predicted at annual review	Mark Allenby	National	99/292	66.5% mean	69%	Updated from CAMEO report September 2021 – reporting period 1/1/20 to 31/12/20 #5 - Lower use of DNAse has been reviewed by the team. Outcomes continue to improve with improving lung function. Many patients have also commenced on new CFTR modulator therapies this last year, possibly contributing to the increase in BMI seen (#3). #4 - Dramatic reduction in patients labelled chronically infected with Pseudomonas may not be a real reflection. Patients have been reviewed less frequently so have provided fewer sputum samples. In addition, newer treatments reduce sputum production making it harder to obtain sputum samples
	2. Age adjusted best FEV % predicted			240/292	69.4% mean	71%	
	3. Age adjusted BMI among patients aged 16 years and over			277/292	23.5 mean	23.8%	
	4. Proportion of patients with chronic pseudomonas aeruginosa			67/292	32.5% mean	23.8%	
	5. Proportion of patients receiving DNase treatment			182/292	73.6% mean	64.8%	
	6. Proportion of patients on hypertonic saline treatment				35% mean	38.3	
	CFS04-A Percentage of patients admitted to single room/cubicle		SSQD Q3 21/22	30/30	100%	100%	Updated Q3 2021/22 data from QSIS – We retain complete compliance with the Cystic Fibrosis (Adult) SSQD indicators.
	CFS05-A Percentage of patients admitted to a ward staffed by CF specialist staff			30/30	98.2%	100%	
	CFS09-A Percentage of routine CF appointments at multidisciplinary clinic where patient was seen by Physiotherapist			210/210	84.4%	100%	
	CFS10-A Percentage of routine CF appointments at multidisciplinary clinic where patient was seen by Dietitian			210/210	81.6%	100%	
	CSF11a-A Percentage of patients seen … by a clinical psychologist within 12 months prior to latest annual review			25/25	38.2%	100%	
	CFS13-A Percentage of urgent CF admissions that were admitted <24 Hours			*/*	90.5%	83.3% ↓	To few to show numbers
Medical Genetics	FTT feedback	Daniela Iancu	Local PROM	420/5430		97%	Newly added from CAMEO report September 2021 – data from September – August 2021 420 responses from

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
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(Wessex Clinical Genetics Service)							5430 clinic/ward appointments approx. 7.8%. 203 positive
	GEN06 Rate of written complaints about the genetics department	Andrew Powers	SSQD / QSD dashboard	0/1923	0.1%	0%	Updated July 2022 from QSIS data Q4 2021/22
	GEN08 Of all patients seen in clinical genetics who had prenatal diagnosis during the period, the number who received their prenatal genetic test result within 5 working days of the clinic receiving the laboratory report			17/17	100%	100%	Updated July 2022 from QSIS data Q4 2021/22
	GEN09 Proportion of appointments that are not attended			151/2427	7.1%	6.2% ↓	Updated July 2022 from QSIS data Q4 2021/22 Back to amber rating
	GEN12a Number of serious Untoward Incidents involving patient care			0		0	Updated July 2022 from QSIS data Q4 2021/22
Nephrology	All patients with AKI stage 3 are reviewed by specialist	Becky Bonfield Kirsten Armstrong	NICE CG148	50	90%	100%	Updated Q1 2022/23 – 50 cases per month are reviewed.
	All patients with AKI receive a urinalysis test		NICE CG148	50	90%	34%	Updated Q1 2022/23 – 50 cases per month are reviewed. This is subject to a piece of service improvement work with the EPR and GDE teams to ensure closed loop of urinalysis requesting and test results.
	Information about in hospital AKIs should be sent to their primary care provider to ensure continuity of care with regards to medications and appropriate follow up to prevent and detect chronic kidney disease		CQUIN 2015/16 AKI	50	90%	92%	Updated Q1 2022/23
Pathology (Cellular)	Turnaround times for specimen reporting in Cellular Pathology	Karwan Moutasim	Internal	56673	75%	81.7%	Updated from November 2021 CAMEO report National targets (RCPath) are 80% of cases authorised within 7 calendar days of the procedure, and 90% of cases authorised within 10 calendar days of the procedure. Local UHS targets were agreed and have been ratified by our UKAS inspectors. The target is that 75% of cases should be reported in 10 days of the procedure. The department continues to meet the 75% internal TAT target. Pre-pandemic, the department had addressed many challenges, including recruiting staff into vacancies,

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
							creating clear pathways and audit and warning systems for specimens. Three new consultant posts have been appointed to during the pandemic. UKAS accreditation was retained at the last inspection (April 2021) with another visit scheduled for spring 2022. Although the workload reduced at the start of the pandemic, we are now at levels similarly to pre-pandemic in terms of histology requests and comparisons are made to 2019 (where specimen numbers are similar). Going forward, a combination of metrics including number of slides will be utilised in addition to number of requests and specimens. Scientist-led dissection service is now fully operational. New LIMS, Southern Counties Network related activity and digitalisation projects all underway.
	Turnaround times for Bowel Cancer Screening Programme specimens in Cellular Pathology		Internal	636	90%	92%	Updated from November 2021 CAMEO report National targets (BCSP) are 90% of cases authorised with final report available within 7 calendar days of the procedure. (significant increase in numbers in comparison to 12-month period in 2019 (417) and 2020 (408))
	Turnaround times for Breast Cancer Screening Programme specimens in Cellular Pathology				90%	97.7%	Updated from November 2021 CAMEO report National targets (BSP) are 90% of cases authorised with final report available within 10 calendar days of the procedure. Comparable numbers to 2019 (1188)
	Blood unit traceability		Internal	34,082	100%	98.9%	Updated from November 2021 CAMEO report MHRA target is 100% traceability, and this is non-negotiable; however, the figure will never be 100%. The figure is the units fated automatically using BloodTrack to fate the unit. When traceability is missing, an AER is raised and the clinical area are asked to review notes to identify manual evidence that the unit in question was transfused.
	Turnaround times for A&E samples Biochemistry – renal profile Biochemistry – low risk chest pain pathway troponin		Internal	1 hr 90 mins	90%	95% 94.2%	Updated from November 2021 CAMEO report TAT is defined as the time taken between receipt of sample and results being validated. The date and time the result was validated is when the result becomes

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
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	Haematology – clotting screen Haematology – D Dimer Haematology – Full blood count			1hr 1hr 2hr (all 90%)		93.8% 94.5% 98.4%	available to ward enquirers. The target for % achieved quoted turnaround times is 90%. Please note that the previous target was incorrectly reported as 95%. Previous issues with barcode quality have been rectified. ESR no longer routinely have a one-hour TAT target after discussion between ED and haematology consultants. ESR no longer reported here.
	No. of moderate or above incidents by the department – to measure safety of the service and patient (customer) feedback		Internal	N/A	0	18	Updated from November 2021 CAMEO report 18 incidents (moderate impact or above were recorded between October 2020 and October 2021. The previous year's figure captures a 6 month period. The incidents were all trended to look for recurrent causes, and errors were more common at interface between pathology and external areas (reception) or between pathology departments. There was one major / severe incident relating to the frequent breakdown of the Alinity (virology platform) during December 2020-Jan 2021 and some work had to be referred off-site. This also had an impact on Covid testing during the 2nd peak. A complaint was made to the supplier (Abbott) and a 2nd instrument was offered but no space and inadequate electrical supply issues encountered.
Maternity	Stillbirth deaths	Raji Para - suraman, Alison Millman	National	18/4709	0.4%	0.4%	Updated Q1 2022/23 from CAMEO report Data from 1at April 2021 – 31st March 2022 UHS 3.7 per 1000 births
	National Maternity and Perinatal Audit (NMPA) outcome - third- and fourth-degree tear rate.			132/3461	3.1%	3.5%	Updated Q1 2022/23 Data from NMPA 2018/19 2022 report. As expected
	National Maternity and Perinatal Audit (NMPA) Proportion of singleton, term, live-born infants with a 5-minute Apgar score of less than 7			111/4880	1.1%	2.3%	Updated Q1 2022/23 Data from NMPA 2018/19 2022 report. Higher than expected
	NHS Digital Clinical Quality Improvement Metrics (CQIM) proportion of women who had an obstetric haemorrhage of 1500 ml or more	Hannah Leonard / Raji Para-suraman / Alison Millman	National		28 (per 1000)	31 (per 1000 births) ↑	Updated Q1 2022/23 from CAMEO report Data January 2022 Rating changed from red to green

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
Fetal medicine	FMe02 Proportion of pregnancy losses within 14 days of CVS procedure, after the exclusion of pregnancies terminated	Sally Boxall		2/56	1-2%	3.6%	Updated Q1 2022/23 from CAMEO report Published data suggests 1-2% miscarriage rate post CVS. UHS figures suggest that 2 out of 56 women miscarried following CVS
	FMe02a Proportion of cases with a missing outcome (CVS)			6/103	1.9%	5.8%	Updated Q1 2022/23 from CAMEO report Outcome data is requested from referring hospitals as per Q4 21/22 QSIS data
	FMe03 Proportion of pregnancy losses within 14 days of amniocentesis procedure, after the exclusion of pregnancies terminated			1/119	0.5-1%	0.8%	Updated Q1 2022/23 from CAMEO report Published data suggests 0.5-1% miscarriage rate post amnio. UHS figures suggest that 1 out of 119 women miscarried following amnio
	FM03a Proportion of cases with a missing outcome (amniocentesis)			7/168	1.1%	4.2%	Updated Q1 2022/23 from CAMEO report Outcome data is requested from referring hospitals as per Q4 21/22 QSIS data
	FMe04 Number of intrauterine transfusions performed			17		17	Updated Q1 2022/23 from CAMEO report This number significantly varies year on year
	FMe04a Number of practitioners who carriemedicald out a intrauterine transfusion			3		3	Updated Q1 2022/23 from CAMEO report
	FMe05 Number of complex interventional procedures – fetoscopies, cord occlusions or placental laser ablations performed			0		0	Updated Q1 2022/23 from CAMEO report
	FMe05a Number of practitioners who carried out a fetoscopy, cord occlusion or placental laser ablation			0		0	Updated Q1 2022/23 from CAMEO report
	FMe06 Proportion of newly suspected / diagnosed major fetal anomalies or other life-threatening fetal conditions referred to the fetal medicine centre that are seen within 3 days		National	185/222	77.4%	83.3% ↑	Updated Q1 2022/23 from CAMEO report data from Q4 2021/22 QSIS (changed from Amber to Green)
Neonates	Unexpected term admissions to NNU at birth and later of term babies (37+0 and over)	Victoria Puddy	ATAIN dashboard	3923 live births q1-q3 20/21	< = 5% Local target National target <6%	4%	Updated Q1 2022/23 from CAMEO report National ATAIN scheme requires all Trusts to be below 6% by March 2019. NHS South target is to be below 5% by March 2019. UHS NICU is a regional surgical and cardiac centre accepting women for delivery of expected babies with congenital conditions

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
							Data for2021/22 = 4.0% data excludes cardiac and surgical abnormalities. Figure % of all live births. 5.2% including all cardiac and surgical abnormalities, still below national target. Slight increase in Q1 may reflect practice changes during initial COVID period. Within agreed target, benchmarked against national and network ODN quarterly reports for ATAIN figures
	MBBRACE UK 2019		National	All in-born infants. 5396 year	Comparison-on with equivalent case mix units	2019	Updated Q1 2022/23 from CAMEO report See the Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK) Report Jan-Dec 2019 (published October 2021). The annual MBRRACE-UK report quoted is the most recently published and is the only source of data that offers outcome comparisons of rates by level of service provision across comparator groups. UHS stillbirth, neonatal and extended perinatal mortality rates comparator group Level 3 NICU with neonatal surgical provision. This stabilised & adjusted mortality rate can be updated only on an annual basis as their reports are published. Neonatal mortality (UHS born neonates) has been greater than 5% higher than the comparator group average for Trust & Health Boards with Level 3 NICU and Surgery. There is no comparator group average for surgical and cardiac centres. UHS Surgical & Cardiac centre Higher percentage of total deaths due to congenital anomaly compared to UK average (60% UHS Trust vs 35% UK wide) reflective of fetal medicine / cardiac / complex case referral pathways for delivery in UHS and neonatal care 1.66 (1.10-2.53) NHS Southampton CCG (2915 births in 2019) Amber The death numbers were greater in 2019, 25% inborn babies (MBRRACE data set) deaths had congenital cardiac anomalies, 60% MBBRACE reportable neonatal deaths associated congenital anomaly
	Neonatal deaths					3.08 per 1000 births 95%CI 2.06 to 4.54) ↓	
	Extended perinatal deaths				6.12 per 1000 live and still births comparator group	6.88 per 1000 births (95%CI 5.67 to 9.03) ↓	
	MBBRACE UK 2019 Deaths				Comparis	2019	Updated Q1 2022/23 from CAMEO report

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
	including congenital anomaly				on-on with equivalent case mix units		Neonatal mortality (UHS born neonates) 2019 is up to 5% higher or 5% lower than the national comparator group for neonatal mortality when congenital anomalies are excluded.
	Neonatal Death					1.31 per 1000 live (95% C1 0.85 to 1.98) ↓	Comparator group includes NICU with surgical centre no comparator group for surgical cardiac centres Similar rates to comparable surgical / cardiac centres
	Extended Perinatal Death					4.53 per 1000 live (95% C1 3.91 to 5.79 ↓	UHS has higher than average 24 – 27 week gestation birth comparative to national average for Trusts
Badgernet (source for NNAP results)	Antenatal steroids	Victoria Puddy / Mark Johnson	National		90.8%	90.8%	Updated Q1 2022/23 from CAMEO report NNAP results updated with 2020 data published 13th March 2022. Unit level comparator NICU, Network and national rate Highlighted in National NNAP 2021 report for high achievement in admission temperature measure NM : New measure BPD data combined 2018-2020 (3 year) Significant BPD or death less than 32 weeks Continued ongoing improvements in BPD measure with QI work on preterm stabilisation, non-invasive respiratory strategies (LISA less invasive surfactant administration, non-invasive ventilation, PEEP delivery room, volume ventilation, high flow, early extubation, low dose prophylactic steroids Some changes in this reporting year 2020 may reflect changes / staffing and restrictions during the Covid 19 pandemic ie reduction in parent presence on one or more ward round at any point, breast feeding rates at discharge, separation late preterm infant 34 -36 weeks once admitted to NNU. Mitigated by V create, video communication access, Neonatal Family Support and psychology support
	Mothers received magnesium sulphate who delivered < 30 weeks gestation				84.6%	91.1%	
	Admission Temperature within 36.5 - 37.5 0C for < 32 weeks gestation				70.6%	90.2%	
	Deferred Cord Clamping < 32 weeks for 1 min				29.1%	25.6%	
	Consultation with parents within 24 hours of admission				95.5%	99.8%	
	Screening for Retinopathy of prematurity on time <32 weeks				95.1%	91.4%	
	BPD Bronchopulmonary dysplasia or death				38.3%	40% ↓	
	Early feeding breastmilk				82.2%	85.9% ↓	
	Mothers milk at discharge from neonatal care < 33 weeks				60.1%	59.5%	
	Recorded clinical follow up at 2 years of age for babies < 30 weeks				68.4%	76.9% ↑	
	Parents on Consultant ward rounds at any point 494/607 admissions				84.2%	81.4% ↓	

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
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	Necrotising Enterocolotis < 32 weeks				6.4%	6.3%	Continued low rates of necrotising enterocolitis, early colostrum, donor breast milk availability (DBM Milk Bank), weekly nutrition rounds, feeding protocols for high-risk infants to reduce risk of NEC. Higher year on levels may reflect reporting changes Continued improvements in a number of quality indicators ie. Magnesium Sulphate (Precept program/ QI work), 2 year follow up data (recording and data accuracy issue for infants returned to local services). Improvement due to allocated named developmental FU lead reviewed processes for case identification following local review/audit 2020 Increase in infection rates reflects accurate data entry for 2020. High rates of infection for < 32 week gestation, comparator groups NICU not combined surgical /cardiac units. Acknowledge high infection rates, QI measures of line care bundle, central line insertion practice (line trolley, pack, electronic trigger for PICC lines > 28 days. Hand hygiene ANTT training
	Minimising separation term infants >37 weeks excluding surgery				2.8 days	2.8 days ↑	
	Minimising separation late preterm 34 – 36 weeks				6.3 days	7.6 days ↓	
	Sepsis pathogenic organism blood culture positive < 32 weeks				5.8%	12.4% ↓	
	Sepsis pathogenic organism blood culture positive > 32 weeks				0.2%	0.2%	
	CLABSI Central line associated infection <32 weeks gestation **QSID**				7.3	7.8 per 1000 line days	Updated Q1 2022/23 from CAMEO report Increase in data accuracy for 2020, incomplete data input for 2019. Does not reflect increased rate Within comparison for national NICU comparator group average
	Number of central line associated bloodstream infections >=32 weeks				32.8	2.7 per 1000 line days	Updated Q1 2022/23 from CAMEO report
	Nurse staffing % shifts with staffing numbers				78.6%	52.2%	Newly added Q1 2022/23 from CAMEO report Average additional number of staff per shift 1.0 per shift (compared to 0.9 for unit level NICU comparison) Action plan in place
	Nurse staffing QIS staffing				47.2%	24%	
Gynaecology (inc. Gynae-Oncology)	Discharge on day 1 following laparoscopic hysterectomy	Dimitrios Miligkos	Hospital records and coding	165	N/A	80%	Updated Q1 22/23 from CAMEO report 96% discharged by day 2 (last two years 96% and 95%). There were no day cases in this cohort.
	Readmission rate following laparoscopic hysterectomy			165	N/A	5.5%	Updated Q1 22/23 from CAMEO report There were 5 returns to theatre in this cohort (3x vaginal bleeding but no abdominal haematoma, 1x vaginal

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
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							dehiscence, 1x pelvic abscess) 5.5% (9 patients) readmission rate. Readmissions included pelvic collection, abdominal pain, vaginal vault haematomas/infection and pyelonephritis/UTI. 12.7% reviewed in the Gynae Assessment Unit and managed as outpatients. We have low threshold for seeing patients in the Gynae Assessment Unit. There is the facility for USS and doctor review which gives reassurance to patients and helps us avoid unnecessary readmissions. Low threshold for assessment is an integral part of enhanced recovery and should not be regarded as failure of our practice.
	Rate of PUL in women presenting to the EPAU		Departmental audit	862	8-31%	14.9%	Updated Q1 22/23 from CAMEO report This data is over a period of 6 months
	Surgical management of ectopic pregnancy			54	N/A	50% ↓	Updated Q1 22/23 from CAMEO report Data over a period of 6 months. Our figures highlight a balanced approach to the management of ectopic pregnancy tailored to the individual patient. •Management of ectopic pregnancy: Medical 15% Surgical 50% Expectant 35%
	Rate of LLETZ performed under LA		QA colposcopy data	427/497	80%	85.9%	Updated Q1 22/23 from CAMEO report Our figures are above the BSCCP standard. This year we have trained new colposcopists and this has helped massively to increase our capacity and meet targets of seeing referrals within the suggested timeframe. Despite some recently accredited colposcopists, we have a very good rate of LA LLETZ. We are making sure that our new colposcopists are supported and refer some patients for treatment under LA to more experienced colposcopists if necessary.
	Proportion of women seen within 6 weeks of referral			2456	99%	99.6%	Updated Q1 22/23 from CAMEO report Excellent outcomes for colposcopy across all national targets.

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
	Proportion of women with moderate or severe dyskaryosis offered appointment within 2 weeks of referral				93%	98.1% 97.84%	Updated Q1 22/23 from CAMEO report 98.1% for moderate dyskaryosis 97.84% for severe dyskaryosis
	Proportion of women with ?invasive or ?glandular smear offered appointment within 2 weeks of referral				93%	100%	Updated Q1 22/23 from CAMEO report
	Complications of outpatient hysteroscopy		Departmental database	153	N/A	0%	Updated Q1 22/23 from CAMEO report
	Complications of outpatient treatment urogynaecology			126	N/A	0%	Newly added Q1 22/23 from CAMEO report
	Laparoscopic sacrocolpopexy •Discharge on day 1			20	N/A	50%	Newly added Q1 22/23 from CAMEO report Since the introduction of the laparoscopic approach, 44% of all sacrocolpopexies have been performed laparoscopically. Our results demonstrate low conversion and complication rate but also excellent clinical outcomes which are comparable to open surgery with all the benefits of laparoscopic surgery for patients and the service. •50% of patients discharged on day 1, 40% on day 2, 10% on day 3 (one converted to open) •1 conversion to laparotomy (case No5) and 1 case with a bladder injury managed conservatively (case No3) •No mesh erosion and no vaginal vault prolapse recurrence
	•Conversion to laparotomy					5%	
	•Complications					5%	
	•Recurrences					0%	
Breast Surgery	30 day unexpected return to theatre rate	Dr Natalia Robson / MChristina Summerhayes (Clinical Lead)	Departmental data	5/744	5%	0.7%	Updated Q1 22/23 from CAMEO report - Reporting period 1st January 2021 – 31st December 2021 Surgical outcomes remained excellent despite sharp increase in work burden, lack of theatre capacity, and inadequate support staff
	Complication rate			39/744	10%	5.2%	Updated Q1 22/23 from CAMEO report
	Haematoma requiring surgical evacuation rate			5/744	5%	0.7%	Updated Q1 22/23 from CAMEO report
	Implant loss rate			0/35 <30-day loss 3/35 >30-day loss	9%	0% 8.6%	Updated Q1 22/23 from CAMEO report
	Two week wait referral performance			5209 symptomatic	93%	48.6% ↓	Updated Q1 22/23 from CAMEO report In 2020 4446 referrals / screening Referrals increased in 2021 by over 33.5%

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
				730 screening			Gone from green to red rating Action plan inplace
	28 Referral to diagnosis (FDS) performance				85%	95%	Updated Q1 22/23 from CAMEO report Action plan in place
	62 day referral to treatment performance				85%	52.5% ↓	Updated Q1 22/23 from CAMEO report Has gone from green to red rating. Action plan inplace
	Emergency presentation performance				<15%	0.16%	Updated Q1 22/23 from CAMEO report
	Cancers diagnosed at Stage 1 & 2				75%	57.9% ↓	Updated Q1 22/23 from CAMEO report In 2020 reported no. cancers 248 In 2021 >600 cancers diagnosed Has gone from green to red rating. Action plan in place
Bursledon House (Child and Adolescent Psychiatry)	Children's Global Assessment of Functioning (C-GAS). Improvement in CGAS score during admission	Dr Amanda Freeman	Local	6/9	N/A	100%	Updated October 2021 from CAMEO report One functional band of improvement (mean change of 10 points, range 5-12) in 100% of all 6 patients scored.
	Children's Goal attainment scaling (GAS)			91/101	N/A	39% achieved expected outcome	Updated October 2021 from CAMEO report 37% better than expected, 17% much better than expected
Paediatric Respiratory Medicine - Cystic Fibrosis	Age adjusted FEV % predicted at annual review, among patients aged 6 and over	Gary Connett	National	185	87.9% mean	89.9% mean	Updated November 2021 from November CAMEO report 2nd out of 10 largest UK CF networks for FEV1; top quartile of all 33 networks
	Age adjusted best FEV % predicted (GLI) among patient aged 6 and over				94.6% mean	94% mean	Updated Q1 21/22
	Age adjusted BMI percentile among patients aged 2-15 years			185	54% mean	56.1% mean	Updated November 2021 from November CAMEO report 2nd out of 10 largest UK CF networks for FEV1; top quartile of all 33 networks
	Proportion of patients with chronic pseudomonas aeruginosa			5	5.9%	2.5%	Updated November 2021 from November CAMEO report 2nd out of 10 largest UK CF networks for FEV1; top quartile of all 33 networks
	Proportion of patients receiving DNase treatment				63.5%	68%	Updated Q1 21/22
	Proportion of patients on hypertonic saline treatment				33.8%	21.8%	Updated Q1 21/22
Paediatric Respiratory Medicine - Asthma	Steroids Administered within 1 hour	Woolf Walker	National	182	36%	15% ↓	Updated November 2021 from November CAMEO report Asthma QIP in situ for all 3 of these outcomes.
	Inhaler technique checked during admission				62%	31%	

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
	Personalised Asthma Plan Provided				45%	30%	
Paediatric Intensive Care	Standardised adjusted mortality rate	Gareth Jones	National		1	0.5%	Updated January 2022 from Paediatric Intensive Care Audit Network (PICANet) Annual report 2021 (data 2018-2020 data).
	Unplanned extubations				4.5%	3% ↑	
	Emergency readmission to PICU within 48hrs			37/2349	1.6	1.6	
	Relative rate of emergency readmissions within 48 hrs of discharge				1.6%	0.9%	
Paediatric Gastro-enterology	Crohn's disease patients – remission achieved	Nadeem Afzal	National		55%	G	Inflammatory Bowel Disease (IBD) programme - Biological therapies paeds UHS n=0, national results 55% (54/99) UHS n=0, national results 6% (17/286)
	Crohn's disease patients with adverse event recorded at 3 month				6%	G	
Paediatric Cardiology - Congenital Heart Disease	Regional and national PPD rates for infants who underwent a procedure in the first year of life for any cardiac malformation – 2020/21	Dr Trevor Richens, Mr Antonio Ravaglioli, Dr Tara Bharucha Nicola Viola	National	22/34	52.4%	64.76%	Updated June 2022 from NCAP CHD report 2022
	Fetal cardiac diagnosis (year 2020-2021): Data submitted to NICOR, related to national standards – seen within 3 calender days			149/174		83%	Newly added October 2021 from CAMEO report
	Fetal cardiac diagnosis (year 2020-2021): Data submitted to NICOR, related to national standards - Contacted by FCNS on same day			58/87		66.66%	Newly added October 2021 from CAMEO report FCNS – Foetal cardiac nurse specialist
	30 day mortality for paediatric cardiac surgery and paediaitric cardiac interventions (3 year)			17/729	Expected survival 97.7%	Actual survival rate: 97.7%	Updated October 2021 from CAMEO report Data from 2018/2021. Actual versus expected 30 day mortality for paediatric cardiac surgery and paediatric cardiac interventions
	Survival data compared to national outcomes for the years 2018-2021			742/760	Actual survival rate: 1.004%	Actual survival rate: 0.998%	Updated June 2022 from NCAP CHD report As expected mortality per 2.22%
	Antenatal diagnosis of hypoplastic left				92.3%	100%	Updated October 2021 from CAMEO report

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
	heart syndrome (Wessex)						
	Post surgical use of extracorporeal life support				2.48%	1.33%	Updated June 2022 from NCAP CHD report data from 2018/21 Below national average rate of complications good outcome / outcome of pride
	Post surgical use of renal replacement therapy (dialysis)				4.10%	2.22%	Updated June 2022 from NCAP CHD report data from 2018/21 Below national average rate of complications good outcome / outcome of pride
	Data quality indicator (DQI) 2020/21					98.75%	Updated June 2022 from NCAP CHD report This is an excellent achievement again this year. This demonstrates a continued strong commitment to good quality verified clinical data. There appears to be a very robust culture of clinical audit embedded within the Trust. The Validation Team would like again, to commend the efforts of the CNS and Data Analyst (DBMs) in maintaining this at time when there have been considerable challenges both technically and with staffing these roles' Data Quality Audit for CHD Procedures.
	Post surgical unplanned placement of a pacemaker				1.50%	1.78%	Updated June 2022 from NCAP CHD report data 2018/21 Outcome of concern requiring improvement action plan in place
	Post surgical prolonged pleural drainage (over 7-10 days)				1.86%	0.89% ↑	Updated June 2022 from NCAP CHD report data from 2018/21 Improved from amber to green rating
Paediatric Diabetic Medicine	Structure of services	Nicola Trevelyan	National			Improved	Updated October 2021 from CAMEO report Data from April 2020 - March 2021 Good in roads with service structure with rebanding of nursing team and business case for expansion for psychology support which was accepted and recruited to although psychologist on maternity leave and with 1 wte senior nurse off on long term sick
	Care Processes Delivered			298 (91%)	>90%	Between 19.7% & 90% (71%)	Updated October 2021 from CAMEO report Data from April 2020 - March 2021 Outcome requiring improvement with action plan. Good progress being made with QI projects to improve delivery of care processes prior to next NPDA submission
	HbA1c mean			298		65	Updated October 2021 from CAMEO report Data from April 2020 - March 2021
Paediatric Oncology	Mortality	Juliet Gray / Laura Bengree		2998		5.3%	Newly added Q4 21/22 from CAMEO report Data for all of oncology from April 2020 to April 2021
	SSQD Rate of chemotherapy related incidents.		National SSQD / QST	21/131		21 incidents	Updated Q4 21/22 from CAMEO report A significant improvement with chemoptherapy errors down from 59. Action plan in place and reviewed 3 monthly
	SSQD Proportion of patient surveys returned.			262	35%	37%	Newly added Q4 21/22 from CAMEO report Action plan NHS U16 cancer patient experience survey in

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
							place
	SSQD Proportion of patient surveys with positive responses			262	92%	83%	Newly added Q4 21/22 from CAMEO report Action plan NHS U16 cancer patient experience survey in place
	SSQD Proportion of eligible children offered access to nationally available clinical trials			131	66%	100%	Newly added Q4 21/22 from CAMEO report Over the last year all CYP eligible for a trial were offered this as a treatment option at the point of diagnosis or relapse. Of the 100% of patients offered a trial, 1% declined and another 1% was ineligible due to trial criteria.
	SSQD Proportion of patients completing treatment, who receive an end of treatment summary and follow-up care plan within 3 months			22/23		22	Updated Q4 21/22 from CAMEO report All EOT summaries should be completed within 6 months of completing treatment, 22 patients have EOT summaries completed. These summaries vary in the information that is recorded, as per guidance we need to ensure that these summaries capture patient treatment toxicities, a long-term follow-up plan, potential late effects, and summary of treatment. To formalise the consistency of this information we are creating an EOT summary proforma. Action plan in place.
	No of patients who have had tumour banked		NHS E PCT service specification Paed Oncology	131		46 (tissue bank) 27 (cell bank)	Newly added Q4 21/22 from CAMEO report
	No of patients who have been admitted to PICU within 30 days of SACT			131		17 (emergency) 17 (elective)	Newly added Q4 21/22 from CAMEO report In 2021 emergency admission to PICU for CYP resulted in a length of stay between 2 & 33 days.
	Number of PTC referrals refused					0	Newly added Q4 21/22 from CAMEO report Over the last year we have not refused a referral to the PTC.
	Whole Genome Sequencing for all patients diagnosed with malignant disease.		NICE guidelines	131	100%	61	Newly added Q4 21/22 from CAMEO report WGS discussion will be recorded using a flowchart for new patients – this will be signed and documented within the CYP records. Paediatric Oncology pathways have been written for patients with Solid Tumour, these will be adapted for CYP with Haematological Malignancy & CNS Tumours. ROD training to CNS by Genomic team is in process.
Paediaitrc	BMT02a-P Precentage of patients	Mandy Day	SSQD	6/6	91.7%	100%	Updated November 2021 from November CAMEO report

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
Clinical Haematology	with successful engraftment						data 2020-2021
	BMT06-P Percentage of transplant patients registered in research trials			6/6	8.6%	100%	Updated November 2021 from November CAMEO report data 2020-2021
	BMT09a-P Percentage of patients alive at 1 year post transplant			5/6	90.9%	83.3%	Updated November 2021 from November CAMEO report data 2020-2021
	BMT13-P Percentage of patients dying within 100 days of transplant			0/6	6.6%	None	Updated November 2021 from November CAMEO report data 2020-2021
	HAEM02 Proportion of children (aged between 2 and 16 years old) within at risk group (S/S and S/bets 0 Thal) receiving trans cranial doppler monitoring within Trust			0/6	74.3%	None	Updated November 2021 from November CAMEO report data 2020-2021
Paediatric Allergy day ward	Food challenges average time from clinic to challenge (in days)	Dr Stephanie Cross	Internal	271	N/A	6.3 months	Newly added November 2021 from report to CAMEO 188 (range 11-736) January to end of September 2021 2020 9.2 months
	Drug challenges average time from clinic to challenge (in days)		Internal	32	N/A	9.7 months	Newly added November 2021 from report to CAMEO 291 days (range 20-861) to end of September 2021 2020 9.8 months
Therapies	Post Intensive care Rehab Team (PIRT) – short pilot study	Denise Gibson, Anette Purkis	Internal	14	N/A		Changed outcomes December 2021 from CAMEO report Small project but demonstrates how enhanced therapy in ward areas following critical care stay can reduce ward length of stay, improve patient flow and improve patient's clinical outcomes
	Tracheostomy Practitioner Role Safety aspects of care		National	36	100%	100%	Changed outcomes December 2021 from CAMEO report Part of the ward round for TP role is ensuring all safety equipment and bed head signage is in place to reduce risks for tracheostomy patients
	Tracheostomy Practitioner role Education		National	80	80%	92%	Changed outcomes December 2021 from CAMEO report To continue rolling Tracheostomy study day and ensure mandatory for certain staff
	Therapy outpatient: patient experience	Denise Gibson, Lisa Osborne-Jenkins	Local	1209	N/A	97%	Changed outcomes December 2021 from CAMEO report A total of 97% rated the service as 'very good' or 'good', an action plan inplace
	Therapy outpatient electronic records		Local	68	N/A	7/16 met	Changed outcomes December 2021 from CAMEO report 7/16 standards >90% compliance met 4/16 standard close at 80-90% compliance Working group to amend template to include additional information on goal setting, body chart info and discharge

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
							information. Also introduction of PROM on MMR will address standards not met, an action plan is inplace
	Therapy outpatients exercise resource		Local	3245	N/A	58% digital	Changed outcomes December 2021 from CAMEO report Valued by patients – 58% who want digital resources, an action plan is inplace
Speech Therapy	Auditing compliance of ward discharge for patients with dysphagia against the oropharyngeal dysphagia policy: 100% of patients who require thickened fluids have the correct recommendation on their Home Medicine Record (HMR) Division A, B & D ward patients	Sanet de Wet Emma Hodge	Local	66	N/A	16%	Changed outcomes December 2021 from CAMEO report SLT have considered other parts of the discharge process in order to ensure patients are aware of their correct SLT recommendations as the HMR is currently designed in a way that does not allow SLT input.
	Auditing compliance of ward discharge for patients with dysphagia against the oropharyngeal dysphagia policy: 100% of patients who require thickened fluids have Nutilits Clear thickening powder on their To Take Out Records (TTOs) Division A, B & D ward patients		Local	66	N/A	5%	Changed outcomes December 2021 from CAMEO report Learning points: Not all patients are prescribed thickener by medical team or pharmacy when recommended by SLT due to a lack of formal process for SLT handing over. Development of a robust process for prescribing thickener to patients for whom it is recommended.
Dietetics (adult and children)	To explore nutritional and growth impact of the pandemic on children with IBD, focusing on the 1st national lockdown from March to early summer 2020. For children under the IBD service: •19% were mildly malnourished 27% managed a TECS-nutrition review	Claire Wood	Local	116	N/A	19% pt with BMI SDS <1	Changed outcomes December 2021 from CAMEO report Patients with low BMIZ prior to lockdown became more malnourished. During the ongoing pandemic it is important to identify those children with nutrition risk, focusing support on this group of children The role of the dietitian is to assess nutritional status and to facilitate a MDT plan for the patient that improve growth outcomes.
	To explore the patient and MDT experience of implementing a digital dietary intervention programme for children with kidney failure and adults with IBD. Patients and families identified the following themes: •Experiences of using the programme		Local	20	N/A	Patient use of the online app continues to rise 69% uptake in 1 specialist	Changed outcomes December 2021 from CAMEO report Digital dietary assessment facilitates patient's self-care and improve engagement in their care. Digital dietary assessment releases clinical time to enable shared decision making and the 'ask 3 questions' (patient empowerment programme) when seeing patients in clinic. Digital transformation is needed in dietetics using standard, accurate national tools to transform patient

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
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	•Recommendations to improve use •Issues with food diaries generally •Patient education and support •Behaviour change potential					chronic clinic, with 98 days of intake recorded (ranging from 1 to 14 per patient assessment)	care, the patient experience and delivery safety, better quality care. Funding needs to be invested in workforce systems to enable this at organisational and national levels.
	To explore dietetic input on patient outcomes for adults with stage 3 non-small cell lung cancer undergoing radical treatment (radiotherapy +/- chemotherapy).		Local	37	N/A	57% patients experienced < 3% weight loss. Overall improvement in weight loss -2.2%	Changed outcomes from December 2021 CAMEO report Dietetic intervention as a core part of the MDT, reduces weight loss, improved QoL, ensure prompt dietetic assessment, advise and support. Long term funding is needed in this and other under resources areas where nutritional outcomes are poor.
Pharmacy	Medicines helpline patient satisfaction	James Allen	Local	5 per month *	>5	5.9	Updated December 2021 from CAMEO report (*sample) Satisfaction is graded 0-6 with 6 being high satisfaction. Average satisfaction April – Sept 2021 = 5.9
	Discharge medicines turnaround times		Local	100%	≥90%	66%	Updated December 2021 from CAMEO report Sample = 100% dispensary TTOs (all targets) Deterioration since previous result Ongoing programme of work with transformation team
	Medicines reconciliation on admission		National	100%	≥80%	72%	Updated December 2021 from CAMEO report Sample = 100% inpatient admissions Average rate Nov 20 - Oct 21 = 72%
	Dispensing error rate		Local	100%	≤0.018%	0.016%	Updated December 2021 from CAMEO report Sample = 100% items dispensed from dispensary areas (SGH, RSH) Average error rate Nov 20 – Oct 2021= 0.016% Some variance month to month but maintained at expected levels.
	Referral to Community Pharmacy		Local	100%	Approx 200per	180	Newly added December 2021 from CAMEO report Reported as average number of referrals per month. No reported referrals in Jan and Feb reduced overall

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
					month		proportion. Performance for last 6/12 above threshold of 200 referrals per month (average 234).
Audiology	Vestibular patient outcomes	Lauren Summers / Bernard Watson	Local				Updated December 2021 from CAMEO report Not enough data to include in this report
	Tinnitus Function Index (TFI)		Local				Updated December 2021 from CAMEO report Not enough data to include in this report
	Paediatric Patient Satisfaction Questionnaire		Local	69	N/A	98%	Updated December 2021 from CAMEO report
	Vestibular Patient Satisfaction Questionnaire		Local				Updated December 2021 from CAMEO report Not enough data to include in this report
Medical Physics	Proportion of patients with malignant disease treated with Stereotactic Radiosurgery (SRS) or Stereotactic Radiotherapy (SRT) within 2 weeks of the decision to treat.	Claire Birch	SSQD	28	92.9 %	95.7 %	Updated December 2021 from CAMEO report Data reported for period Apr '21 – Jun '21
	Number of Tier 1 and 2 patients treated with SRS/SRT				100	198	Updated December 2021 from CAMEO report
	The percentage of treatment plans requiring off-protocol concessions for patients receiving radiotherapy		Local	2049	5.3%	4.8%	Updated December 2021 from CAMEO report
Cardiology	Use of radial access	Simon Corbett	Local BCIS database	699	92.8%	83%	Updated June 2022 from NCAP report 2022 Data from April 20 – March 21
	Daycase discharge after elective PCI			128	71.4%	74.2%	Newly added Q2 21/22 from CAMEO report October 2021 reporting period Jan 2018-Dec 2020
	Unadjusted in-hospital mortality after PPCI for STEMI			247	N/A	4.9%	Newly added Q2 21/22 from CAMEO report October 2021 reporting period Jan 2018-Dec 2020 The best measure of performance for mortality is to compare risk-adjusted mortality to predicted mortality (and this has not yet been provided by NICOR)
	Percentage of patients with STEMI receiving primary PCI within 90 minutes of hospital arrival ("door-to-balloon time")	Dr Michael Mahmoudi	HICCS / MINAP data	219	75%	89.35% ↑	Updated Q2 21/22 from CAMEO report October 2021 reporting period April 2020 – March 2021
	Percentage of patients with NSTEMI receiving PCI within 96 hours		HICCS / MINAP data	417	75%	93.4%	Updated Q2 21/22 from CAMEO report October 2021 reporting period April 2020 – March 2021

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
	In-hospital heart failure mortality	Andrew Flett	In-house data	461	9.3%	8.9%	Updated Q2 21/22 from CAMEO report October 2021 We are monitoring our own mortality rate and can see that for the subsequent year 2019-2020 the death rate was 9.5% (5.5% if looked after on a cardiology ward). 2020-2021 was 8.9% (5.5 % if in cardiology)
Cardiac Surgery	Major cardiac arrests – mortality	Mr Dimitrios Pousios	National	773	TBC	No data	Updated June 2022 from NCAP report 2022 Data from April 20 – March 21 no mortality data found in report but risk adjusted survival was as expected
	Elective/Urgent Cases – mortality			773	TBC	No data	
	CS03 Rate of deep wound infection		SSQD	773	0%	0%	Updated June 2022 from NCAP report 2022 Data from April 20 – March 21
	CS04 Readmission rate within 30 days of discharge			773	0.2%	No data	Updated June 2022 from NCAP report 2022 Data from April 20 – March 21
	CS05 Length of stay			773	7.8 days	10.3 days	Updated June 2022 from NCAP report 2022 Data from April 20 – March 21
	CS06 Percentage of urgent cases operated on within 7 days of angiogram (target 75%)			773	34%	39%	Updated June 2022 from NCAP report 2022 Data from April 20 – March 21
Vascular	Elective Infra-Renal AAA Repair – risk adjusted survival data 2018-2020	Sabine Sonnenberg	National	76 cases, 42EVAR, 34 open	98.6%	98.8%	Updated December 2021 from National Vascular Report (NVR) 2021
	Carotid Endarterectomy – risk adjusted stroke free survival data 2018-2020			63	97.8%	99.1%	
	Elective Infra-Renal AAA Repair Median (IQR) length of stay for open repairs (days) data 2020			34	7 days	6 days	
	Elective Infra-Renal AAA Repair Median (IQR) length of stay for EVAR (days) data 2020			42	2 days	1 day	
	Repair of complex AAAs Median (IQR) length of stay (days)			52	5 days	1 day	Updated September 2021 from NVR 2020 Annual report
	Emergency repair of ruptured AAA Median(IQR) length of stay (days)			40 cases 5 EVAR	9 days	10 days ↓	
	Emergency repair of ruptured AAA Adjusted in hosp mortality			40 cases	34.5%	24.3%	
	Carotid endarterectomy median			63	2 days	1 day	Updated December 2021 from NVR 2021

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
	(IQR) length of stay (days)						
	Lower limb bypass Emergency Median (IQR) length of stay (days)			386	7 days	4 days	
	Lower limb bypass Median Risk adjusted survival 2018-2020			423	97.2%	98.1%	Updated December 2021 from NVR 2021
	Major lower limb amputation Median (IQR) length of stay (days)			283	22 days	13 days	
	Major lower limb amputation Median (IQR) Risk adjusted survival 2018-2020			423	97%	98%	Updated December 2021 from NVR 2021
	Carotids have surgery within the 14day NICE recommended time period			92	67%	57% ↓	Updated September 2021 from NVR 2020 Annual report
Thoracic	In hospital survival rate (30 days)	Martin Chamberlain	National	301	98.1%	99%	Updated from CAMEO report September 2020 - Updated from National Lung Cancer Consultant Outcomes Publication 2019 (2017 patient cohort).
	Length of stay (median) (Days)				6 days	4 days	
	1 year adjusted survival		Internal		84.7%	91%	
	Resection rates (UHS patients only)				18.4% UK	18.0%	
	Pneumonectomy Rate				3.5% UK	3.3%	Newly added Q2 21/22 from CAMEO report October 2021
Neurosurgery	Neuro-oncology Overall complication rate	Andrew Durnford	National			5.8%	Updated April 2022 from CAMEO presentation
	Neuro-oncology Infection rate for craniotomies/VP Shunts					2.1%	Updated April 2022 from CAMEO presentation
	Neuro-oncology Intracerebral haemorrhage rate					<1%	Updated April 2022 from CAMEO presentation
	Neuro-oncology patient experience access to CNS				80%	82%	Updated April 2022 from CAMEO presentation the brain tumour charity patient experience survey
	Neuro-oncology patient experience Understanding about prognosis				76%	87%	Updated April 2022 from CAMEO presentation the brain tumour charity patient experience survey
	Neuro-oncology patient experience What to expect in recovery after treatment				80%	90%	Updated April 2022 from CAMEO presentation the brain tumour charity patient experience survey
	Unit mortality				2.4	2.2	Neurosurgical National Audit Programme (NNAP) unit adjusted mortality rate 2.2 v national rate of 2.4

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
	Cranial LOS average elective				7.5 days	3.8 days	Updated Q4 21/22 from CAMEO report
	Cranial LOS non elective				18.9 days	10.9 days	Updated Q4 21/22 from CAMEO report
	British Shunt Registry Infection rates				6%	0%	Newly added Q1 2021/22 from CAMEO report Data from 01/04/-30/09/2019 (Also paediaitrc neurosurgery shunt outcome under paediaitrcs from the adult report.
	Wound infection rates				2.7%	0%	Newly added Q1 2021/22 from CAMEO report Data from 01/04/-30/09/2019
	New procedures with 90 day revision				8.7%	3.6%	Newly added Q1 2021/22 from CAMEO report Data from 01/04/-30/09/2019
	New procedure with 30 day infection				0.6%	0%	Newly added Q1 2021/22 from CAMEO report Data from 01/04/-30/09/2019
Paediatric Neurosurgery	Paediatrics shunt related procedures non elective LOS	Andrew Durnford	National		14.6 days	9.7 days	Newly added Q1 21/22 from CAMEO report
Neurology	PML rate from disease modifying drugs in MS	Jo Lovett Georgina Burke Jane Miller	Local	0 (1556)	0%	0%	Updated March 2022 No new cases in the last 12 months
	% patients with symptomatic improvements after treatment for headache disorders in the specialist clinics			N/A	N/A	N/A	Reviewed March 2022 Patient Reported Outcomes for headache treatment clinic. The headache clinic stopped completely for a while and since restarting has been afflicted with data capture and My MR reporting issues. No data has been collected for some time
	Neuro Epilepsy: No. patients using My Medical Record			147		147	Newly added March 2022 Updated 28/07/2022
	Neuro Motor Neurone Disease: No. patients using My Medical Record			38		38	Newly added March 2022 Updated 28/07/2022
	Neuro Parkinsons Disease: No. patients using My Medical Record			64		64	Newly added March 2022 Updated 28/07/2022
	Neuro Huntingtons Disease: No. patients using My Medical Record			74		74	Newly added March 2022 Updated 28/07/2022
	Neuro Multiple Sclerosis: No. patients using My Medical Record			1330		1330	Newly added March 2022 Updated 28/07/2022
	Headache readmission rate			12 (410)	9.3% (National	2.9%	Newly added March 2022 Percentage of non-elective patients with a spell level HRG code starting AA31

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
					av. From GIRFT report)		discharged in 2022 who then were readmitted (non-elective) and discharged in 2022 with the same HRG code.Updated 27/07/2022 with Jan-Jun 22 data
Neuro Rehabilitation	Number of patients being reviewed by therapist 4-6 weeks post injection	Emily Thomas	National	67	85%	69.2%	Updated Q4 2021/22 from CAMEO report Not all patients reviewed in our service, so no control over this. Some pts DNAd appts we don't have the data for offered vs attended. Managed to reduce average length of time between injections from 30.1 weeks to 15.78 weeks
	Number of patients achieving stated goal of botulinum therapy using GAS-lite methodology		Outcome measure	65%	65%	70%	Updated Q4 2021/22 from CAMEO report Audit data 1st half year 70% achieved, 17% partially achieved, 10% did not achieve
Stroke	90% stay on the stroke unit (BPT)	Sue Evans for CAMEO - Lynne Davies for data	SSNAP	263	90%	88.78% ↓	Updated Q4 with Q3 data 2021/22 from CAMEO report Latest SSNAP Report is Sep – Dec 2021
	CT within an hour of admission for acute strokes (BPT)			263	50%	50.2%	Updated Q4 with Q3 data 2021/22 from CAMEO report Latest Report is Sep – Dec 2021
	Patients thrombolysed within 1 hour of clock start (BPT)			23	55%	59.5%	Updated Q4 with Q3 data 2021/22 from CAMEO report Consultant team to do TPA audit to ensure accurate data. Action plan in place
	Patients receive a joint health and social care plan on discharge (Contract)			263	90%	87.4% ↓	Updated Q4 with Q3 data 2021/22 from CAMEO report
	Average LOS			263	N/A	16 days mean	Updated Q4 with Q3 data 2021/22 from CAMEO report On-going Stroke case management, close working relationship with DC teams. Weekly MDT consultant lead. Regular board rounds. Weekly Band 7 patient review Action plan in place
	SSNAP rating A				A	B ↓	Updated Q4 with Q3 data 2021/22 from CAMEO report Action plan to be created by MDT, meeting end of April
	Median time seen by a stroke consultant (hours/mins)			263	06.00	02.23 mins	Updated Q4 with Q3 data 2021/22 from CAMEO report
	Median time seen by a stroke nurse (mins)			263	60mins	0.22mins	Updated Q4 with Q3 data 2021/22 from CAMEO report
	Discharged with a name contact			263	95%	98%	Updated Q4 with Q3 data 2021/22 from CAMEO report
	Median minutes of OT			263	32mins	38mins	Updated Q4 with Q3 data 2021/22 from CAMEO report Staffing issues noted due to COVID Action plan in place
	OT assessment within 72 hours			263	90%	93%	Updated Q4 with Q3 data 2021/22 from CAMEO report

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
	Median minutes of PT			263	32mins	30mIns ↓	Updated Q4 with Q3 data 2021/22 from CAMEO report
	PT assessment within 72 hours			263	90%	93%	Updated Q4 with Q3 data 2021/22 from CAMEO report
	Rehabilitation goals within 5 days			263	75%	83%	Updated Q4 with Q3 data 2021/22 from CAMEO report
Trauma & Orthopaedics	Primary Knee replacement PROMs	Chris Jack Jane Miller	Contract	29 (137)	16.886 (England Average)	No data due to small numbers (NHSD do not report on <30 records)	Updated May 2022 from CAMEO report Final 20/21 figures released Feb 2022. Target should be "Not significantly worse than 16.886 (England Average)". Sample size: 29 was the number of complete PROMs records that NHS digital were able to process. 137 was the number of eligible hospital procedures. The IT department were working on a PROMs module within My Medical Record to help improve our participation and response rate however this has been on hold for some years due to higher priority work
	Primary Hip replacement PROMs			50 (180)	22.981 (England Average)	22.485%	Updated May 2022 from CAMEO report Final 20/21 figures released Feb 2022. Target should be "Not significantly worse than 22.981 (England Average)". UHS is not outlying. Sample size: 50 was the number of complete PROMs records that NHS digital were able to process. 180 was the number of eligible hospital procedures
	Fragility Fractures best practice tariff (includes femoral fractures and fractured neck of femur)	Simon Tilley Jane Miller	National Hip Fracture Database / HES data	203	53.8%	16%	Updated May 2022 from CAMEO report National average taken from NHFD assessment benchmark summary 2021 updated 15/04/22. BPT Q4 21/22 taken from BPT report run 19/04/22
	Return to original residence ('Home to home') within 30 days			693	70.9%	68.7%	Updated May 2022 from CAMEO report The figures on the left are from the National Hip Fracture Database KPI overview and are annualised values averaged over 12 months to the end of February 2022
	120 day follow up			*	41.7% (ntl average)	61.6% ↑	Updated May 2022 from CAMEO report The figures on the left are from the National Hip Fracture Database dashboard report for Southampton General for 2021 (most recent dashboard updated 15/04/22). No. of cases not supplied on NHFD dashboard report

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
	Fractured Neck of Femur mortality			686	Es expected	Better than expected	Updated May 2022 from CAMEO report No recent (2021 onwards) mortality data is available on NHFD, so we have continued to use Dr Foster information. In-hospital mortality is 'better than expected'. Data from Dr Foster and covers period 01/21 to 12/21 benchmarked against September 21
	Linkability	Doug Dunlop Jane Miller	National Joint Registry	379*	95%	99%	Updated Q4 2021/22 Linkability is the proportion of records which include a valid patient's NHS number compared with the number of procedures recorded on the NJR. This measure remains green for a sixth year. Data is for the 2020 calendar year and was published in the 18th annual NJR report.
	Consent Rate				95%	89% ↑	Updated Q4 2021/22 During the worst of the pandemic, we were not able to go onto wards to collect NJR consents as would normally happen. Retrospective letters were sent requesting consent but the response rate was lower than normal. Data is for the 2020 calendar year and was published in the 18th annual NJR report. 33% of NHS hospitals achieved a consent rate of greater than 95%
	Knee Revision Rate (revised within 5 years of primary procedure)				Not outlying	Not outlying	Updated Q4 2021/22 Although not outlying as a service, some individual surgeons are near or at the threshold for outlying. An in-depth review was conducted in Feb 21 which indicates an implant problem. This has been escalated to the NJR for investigation nationally, with actions being taken locally in the meantime. Data is for the 2020 calendar year and was published in the 18th annual NJR report.
	Hip Revision Rate (revised within 5 years of primary procedure)				Not Outlying	Outlying	Updated Q4 2021/22 A review of revisions was undertaken which revealed an issue with the CPT stem, which is now being investigated by the NJR. Since dropping the use of the CPT stem at UHS - which was identified as the reason for UHS outlying - the survival figures for the individual surgeons are already improving. The expectation is that grouped hospital data will improve over time as well. Data is for the 2020 calendar year and was published in

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
							the 18th annual NJR report. *379 includes both hip and knee replacements, separate figures are not noted in the 18th annual NJR report.
	Compliance (Primary Hip and Knee replacements)			641	85%	98%	Updated Q4 2021/22 Data is for the 2020 calendar year and was published in the 18th annual NJR report. National average is around 88% (from Best Practice Tariff October report)
	Ankles Primary ankle replacement NJR compliance	Graeme Taylor	National Joint Registry	4	95%	100%	Newly added June 2022 from CAMEO report Figures taken from Management feedback report 20/21 (not available publicly) >100% compliance is due to some procedures appearing to be NJR eligible from the description, but then not being coded with the exact combination of procedure codes defined by the NJR as being 'NJR eligible'. Coding has been reviewed and is correct. NB: Data quality audit work for early procedures didn't commence until after the 20/21 report was published so this figure is likely to be inaccurate at time of writing.
	Revision ankle NJR compliance			1	95%	100%	Newly added June 2022 from CAMEO report Figures taken from Management feedback report 20/21 (not available publicly) NB: Data quality audit work for early procedures didn't commence until after the 20/21 report was published so this figure is likely to be inaccurate at time of writing
	Ankle revision rate at 5 years			16	6.59%	12.5%	Newly added June 2022 from CAMEO report Figures taken from Management feedback report 20/21 (not available publicly). Unadjusted revision rates recorded for the Trust and the whole NJR for primary joint replacements, for cases linked to an NHS number. Please note that the calculation of the revision rate excludes Debridement and Implant Retention (DAIR) procedures where there was no modular exchange. DAIR procedures that included a modular exchange are included in the calculation. NB: Data quality audit work for early procedures didn't commence until after the 20/21 report was published so this figure is likely to be inaccurate at time of writing.

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
	Shoulder - Primary shoulder replacement NJR compliance	Mr George Cox	National Joint Registry	11	95%	110%	Newly added May 2022 from CAMEO report Figures taken from Management feedback report 20/21 (not available publicly) >100% compliance is due to some procedures appearing to be NJR eligible from the description, but then not being coded with the exact combination of procedure codes defined by the NJR as being 'NJR eligible'. Coding has been reviewed and is correct. NB: Data quality audit work for early procedures didn't commence until after the 20/21 report was published so this figure is likely to be inaccurate at time of writing.
	Revision shoulder replacement NJR compliance			1	955	100%	Newly added May 2022 from CAMEO report Figures taken from Management feedback report 20/21 (not available publicly) NB: Data quality audit work for early procedures didn't commence until after the 20/21 report was published so this figure is likely to be inaccurate at time of writing
	Shoulder revision rate at 5 years			38	4.45%	2.63%	Newly added May 2022 from CAMEO report Figures taken from Management feedback report 20/21 (not available publicly). Unadjusted revision rates recorded for the Trust and the whole NJR for primary joint replacements, for cases linked to an NHS number. Please note that the calculation of the revision rate excludes Debridement and Implant Retention (DAIR) procedures where there was no modular exchange. DAIR procedures that included a modular exchange are included in the calculation. NB: Data quality audit work for early procedures didn't commence until after the 20/21 report was published so this figure is likely to be inaccurate at time of writing.
	Shoulder PROMS National % pre-op questionnaires collected			927 (3833)	24.2%	24.2%	Newly added May 2022 from CAMEO report No UHS PROMS figures have been published by the NJR and we do not have access to this data. A local collection is being investigated but would require investment in admin support and ideally an integrated My Medical Record module. NB: Data quality audit work for early procedures didn't

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
							commence until after the 20/21 report was published so this figure is likely to be inaccurate at time of writing.
	Elbow - Primary elbow replacement NJR compliance			12	95%	133.33%	Newly added May 2022 from CAMEO report Figures taken from Management feedback report 20/21 (not available publicly). >100% compliance is due to some procedures appearing to be NJR eligible from the description, but then not being coded with the exact combination of procedure codes defined by the NJR as being 'NJR eligible'. Coding has been reviewed and is correct.
	Revision elbow NJR compliance			2	95%	200%	Newly added May 2022 from CAMEO report Figures taken from Management feedback report 20/21 (not available publicly) >100% compliance is due to some procedures appearing to be NJR eligible from the description, but then not being coded with the exact combination of procedure codes defined by the NJR as being 'NJR eligible'. Coding is checked for each of these procedures to ensure genuine mistakes do not slip through. NB: Data quality audit work for early procedures didn't commence until after the 20/21 report was published so this figure is likely to be inaccurate at time of writing.
	Elbow revision rate at 5 years			21	5.64%	9.52%	Newly added May 2022 from CAMEO report Figures taken from Management feedback report 20/21 (not available publicly). Unadjusted revision rates recorded for the Trust and the whole NJR for primary joint replacements, for cases linked to an NHS number. Please note that the calculation of the revision rate excludes Debridement and Implant Retention (DAIR) procedures where there was no modular exchange. DAIR procedures that included a modular exchange are included in the calculation. NB: Data quality audit work for early procedures didn't commence until after the 20/21 report was published so this figure is likely to be inaccurate at time of writing.
	Major Trauma PROMS ISS 8 +	Emma Bowyer /	TARN data	49/292	>90% / 28.2%	16.8%	Updated from CAMEO report May 2021 22/25 with action plan in place

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
	24/7 Plastic surgery cover	Jane Smart			7 Days	7 Days ↑	Updated Q4 2021/22 Updated from CAMEO report September 2020 - Recent paper to the execs has been approved in principle. VFM is just being finalised. 7 day cover for plastic surgery supported and implement from Nov 2020 but not 24/7. This will support UHS MTC in achieving the orthoplastic quality indicators.
	BPT Consultant on arrival			55/209	42.1%	26.3%	Updated from CAMEO report May 2021 21/25 with action plan in place
	Quality of TARN Data (Data accreditation)			379/313	97%	100%	Updated May 2022 from CAMEO report Data from Q3 2021/22
Trauma & Orthopaedics Paediatric MTC	C 08 - Consultant led trauma team including a paediatrician or paediatric ED specialist on arrival for patients with ISS >15 (**paediatric**)	Emma Bowyer / Jane Smart	TARN Data	6	44%	**50%**	**Newly added August 2022** from TARN paediatric dashboard sent after CAMEO meeting
Trauma & Orthopaedics	KPI 3 Identification (spinal fractures)	Charlotte Toogood	FLSDB		13%	11.3%	Newly added June 2022 from CAMEO report data from March 21 to February 22 ADOPT QI study will facilitate increase in spinal fracture identification. Action plan inplace
	KPI 4 Time to FLS assessment within 90 days			100%	70.2%	98.5%	Updated June 2022 from CAMEO report data from March 21 to February 22
	KPI 5 Time to DXA within 90 days			100%	31%	50.2% ↑	Updated June 2022 from CAMEO report data from March 21 to February 22 Continue to work closely with the osteoporosis centre and fully utilise eQuest DXA bundle
	KPI 7 Bone therapy recommended				55.8%	75.7%	Newly added June 2022 from CAMEO report data from March 21 to February 22 Current audit to review % of inpatients discharged on bone therapy as recommended by their fragility assessment and closer working with FLS community teams to support commencement of Rx. Action plan inplace
	KPI 10 treatment started by first follow up				22.5%	15.5%	
	KPI 11 Adherence to prescribed anti-osteoporosis				14.8%	0%	Newly added June 2022 from CAMEO report data from March 21 to February 22 National reduction in adherence from last year. Emphasis during FLS assessment on importance of adherence to medication and support through treatment. Action plan in place
Trauma & Orthopaedics	Hip replacement surgical site infection	Joyce Banga	National	112	0.5%	0.9% (1)	**Newly added September 2022** Data from the national surveillance of surgical site infections report 2020/21. Only 1 surgical site infection in hip replacement which was unavoidable due to the health risks of the patient.
	Knee replacement surgical site infection			38	0.4%	0% (0)	

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
Spinal Surgery Services	Emergency readmissions to service within 30 days of discharge	Ali Nader-Sepahi Jane Miller	Local	220	<5%	0.91%	Updated July 2022: Patients discharged between 01/04/2022 and 30/106/2022 with an HRG classed as spinal surgery by NHSE who were then readmitted as an emergency in 30 days of discharge and coded with a spinal surgery HRG. HRGs were used as the most representative of the spinal service as a whole, but may include some cranial patients..
	Length of stay Cervical patients		Local	20	2 days	1.114	Updated July 2022: Average length of stay for elective patients discharged between 01/04/2022 and 30/06/2022 with a primary procedure in below list. Primary anterior decompression of cervical spinal cord and fusion of joint of cervical spine Primary foraminotomy of cervical spine Other specified primary decompression operations on cervical spine Primary anterior excision of cervical intervertebral disc and interbody fusion of joint of cervical spine Prosthetic replacement of cervical intervertebral disc
	Length of stay Lumbar patients		Local	12	3 days	1 day	Updated July 2022 - Average length of stay for elective patients discharged between 01/04/2022 and 30/06/2022 with a primary procedure in below list. Primary posterior laminectomy decompression of lumbar spine Primary posterior decompression of lumbar spine NEC Other specified primary decompression operations on lumbar spine
	British Spinal Registry compliance		National	139 (213)	50%	65.3%	Updated July 2022 - Percentage of spinal surgery procedures (defined using the HRG spinal surgery list provided by NHSE) for patients discharged between 01/04/2022 and 30/06/2022 which have corresponding records on the British Spinal Registry and where the patient has consented to have their demographics recorded on the BSR. Target used has come from the national Best Practice Tariff.
Interventional	Risk adjusted survival	Rob Allison	National	77	98.6%	98.9%	Updated November 2021 from CAMEO report

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
Radiology	Length of stay (LOS) EVAR		NVR	33	2 days	1 day	Data from National Vascular Registry (NVR) 2020
	Death within 30 days		Gastrostomy	68	11-17%*	2.5%	Newly added November 2021 from CAMEO report data from April 2020-March 2021 Mortality 2.5% (1 death) - unrelated to RIG insertion. Median time referral to insertion discontinued data collection due to difficulties in calculation because of large number of factors. *CIRSE 2016 standards of practice review literature
	Blood transfusion requirement	Tim Bryant	National PCNL		2.1%	0% ↑	Updated November 2021 from CAMEO report Update from Prof Somani re 2020 / 21 results. National BAUS database no longer active. Urology are locally collecting data and have found no cases of urosepsis Calavien III, transfusion or organ injury. Urology will continue to provide CAMEO outcomes for this and this will be removed from Radiology CAMEO.
	LOS				2	No data	
	Stone complexity grade III/IV					pathology	
	Recurrence free survival @ 5 years	David Breen	Local Cryoablation	168		No new data	Updated November 2021 from CAMEO report Cryo-ablation Renal RCC – local database no new data for this year. However excellent performance with no concerns in previous years. *literature
	Metastases free survival @ 5 yrs					No new data	
	Overall survival @ 5 years					No new data	
	Primary success				94%*	No new data	
	Major complications				3-7% *	No new data	
Diagnostic Radiology	CT attend to report time - In-patient <24 hours	Faraz Sheikh / Drew Maclean	Local			97%	Updated November 2021 from CAMEO report Data from November 2020 – November 2021 The MR report times for inpatient and outpatient are comparable to that 2018-2019. This could reflect increased activity seen post COVID. Significant number of inpatient MRI done is Neuroradiology and there has been recently shortage of consultants within this subspecialty due to retirements and splitting of the group into DNR/INR. There remains a national shortage of radiologists and this is compounded due to increased diagnostic imaging being undertaken. For instance, MRI has increased by 4%, 3.7% increase in CT volume overall and ED CT scans have increased by 16.8% cf to prepandemic times Oct 2018-2019. We are
	CT attend to report time - Outpatient <1/52					80%	
	MR to attend to report time in-patient < 24 hours					78%	
	MR attend to report time Outpatient <1/52					55%	
	CT attend to report time – ED <4 hrs					70%	

Speciality	Outcome	Clinical Lead	Driver	Outcome performance			Actions / Comments
				Sample size	Target / Range	UHS RAG	
	CT attend to report time – ED <24 hrs					96%	utilising outsourcing to help with the staffing issues and increased demand.
Mechanical Thrombectomy	NIHSS (improved)	Jason Macdonald	National	53	70.32%	79.25%	Newly added November 2021 from CAMEO report Thrombectomy data is from SSNAP registry – Mar 2020 Thrombectomy outcomes excellent compared to national.
	Thrombectomy and / or thrombolysis complications			1	5.5%	1.9%	
	Rankin score at discharge			53	4	3	

Clinical Outcomes Programme

The Clinical outcomes team is unique to UHS. It comprises 4 components. The clinical outcomes team is led by Mr James Kirkby-Bott who stepped up from deputy to become the Director of Clinical Outcomes in 2019. Clinical Effectiveness became "Clinical Outcomes" and transformed its portfolio from old world to new establishing a unique clinical outcomes peer review programme into the clinical effectiveness portfolio with a thriving, comprehensive and engaged clinical audit programme, fully Consultant-evaluated NICE guidance programme, a NCEPOD programme which results in 4 studies per year on average and New Procedures Advisory Group safely appraising new surgical techniques and devices before they are introduced to UHS. Supported by manager Diana Ward (appointed in July 2019) and team members Diane Penfold, Richard Dacombe and Katherine Bessant the renewed clinical outcomes department continued its journey to encourage all specialities and care groups to report their clinical outcomes and story via CAMEO.

The aim of the programme is to create a reproducible system linking the output of UHS to its clinical governance system. It offers senior management the opportunity of oversight and understanding of what the Trust delivers and how well it delivers it. There is a mechanism of escalation of outcome orientated problems and successes outside of the divisional framework and this has been helpful in the past where change has proved difficult but important to achieve. Tracheostomy care was a good example of this programme working well.

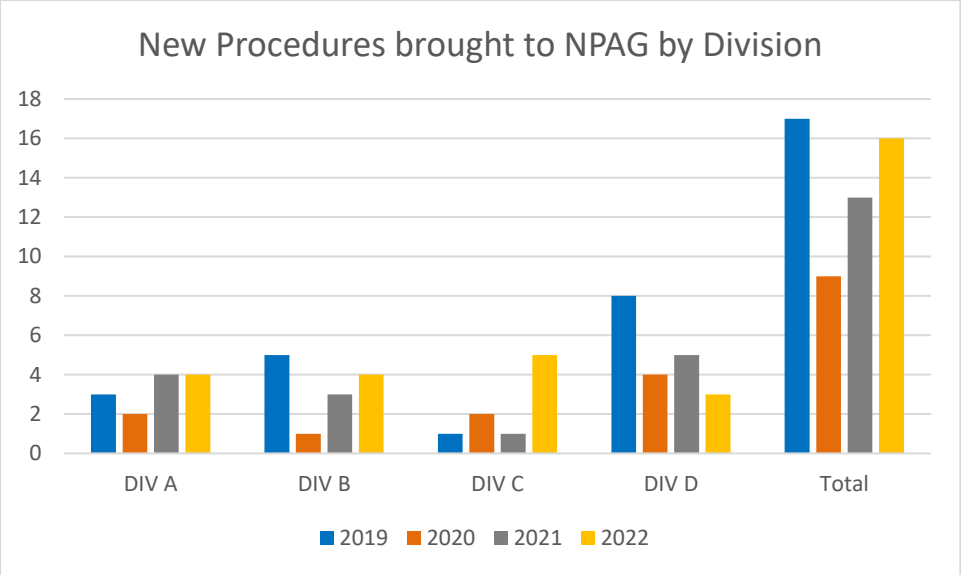
There are 4 components to the clinical outcomes programme that are interlinked:

1. New Procedure Advisory Group (NPAG)
2. Clinical Effectiveness Programme
3. Audit and service evaluation
4. CAMEO

- NPAG

This is a formal route for the introduction of new technology onto Trust practice giving support to clinicians introducing this and reassurance to the Trust that what it is investing in delivers the required outcomes. The director of outcomes appoints a Chair for NPAG who convenes meetings supported by a group of peers that evaluate the evidence and reasons for wanting to introduce new technology. It is not for research projects that have their own governance structure.

UHS is one of very few Trusts to have a clinical outcomes programme and new procedures advisory group (NPAG) in the UK. Recently clinical researchers from Bristol sought consultation on the new procedures surgical innovation programme at UHS: reviewed processes/ documentation and findings to feed into their study and produce data fields for their "Introduce" study on surgical innovation implementation in the UK. UHS is a pilot site for this study and is uploading data monthly. January-July 2022 16 new surgical procedures/devices have been approved by the New Procedures Advisory Group (NPAG) with a further 7 applications scheduled to present. The panel-style group is fully facilitated by the clinical outcomes team.



- Clinical effectiveness programme

The effectiveness portfolio is set by external groups such as NHS England. It comprises NICE guidance and NCEPOD. NHS England publishes the quality accounts list which comprises of national audits, enquiries and quality improvement programmes which trusts are to review and participate in. NHS are expected to adhere to and report yearly on those that have been participated in and are judged on this for some payments at CQC visits. Experience has taught the clinical outcomes director that these objectives are often not patient centred nor have meaning to patients. They tend to comprise surrogate markers of outcomes that are set by 'experts'. It is the bed rock of the outcomes programme that anyone employed as a consultant at UHS is an expert in their field. These experts are encouraged to explain, when they find any outcome measures forced on them, why they do not think they are suitable so this can be denoted as consciously non-compliant in the NICE/NCEPOD register. The clinical outcomes team collate UHS compliance with these audits and guidance and keep the register updated. The Trust can then use this to demonstrate compliance to commissioners with our contractual obligations on performance against targets.

The UHS full, comprehensive NICE guidance programme and escalation procedure including clinician-led GAP analysis was highly praised by Commissioners in 2021. It was streamlined in 2020 alongside the NICE policy to allow demonstration of compliance and trust wide cascade of guidance without being labour intensive. The department has encouraged specialties to participate in numerous NICE guidance consultations, most recently concerning encouraging induction before 40 weeks of pregnancy for ethnic minority groups and the concerns for those women and service provision. New NICE guidance has increased year on year: January-August 2021- 111 new pieces of guidance/updated guidance, 130 for the same period in 2022.

Clinical effectiveness audits are a part of the commissioning process and service we offer within our contracts with commissioners. We must be able to demonstrate compliance with these measures. There are approximately 190 Quality Standards and 1250 current pieces of guidance applicable to UHS. These are all monitored and followed up when non-compliant. We report non-compliance and conscious non-compliance to the Head of Compliance, who in turn reports to the commissioners of UHS services.

Gap analysis tools created by the clinical outcomes team are used in clinical audit/evaluation and as evidence in business cases. They are frequently used to resolve queries from commissioners via our compliance team. Figure 1 shows an illustrative flow chart from publication to initial assessment and subsequent review for NICE guidance and Quality Standards.

Compliance with the consultant led part of the programme is through a timeline of emails and email escalations. 2 emails go to the consultant nominated as the guideline lead. On failure to review after the second email the Divisional director is notified and if still no response the CMO is notified. Escalation rarely proceeds beyond the 2nd and 3rd points.

- Audit programme

The audit programme is divided into clinical audits and service evaluations. Audit is our performance measured against a published benchmark. Service evaluation is a study of an outcome or processes at UHS to show how we are performing so that this can inform quality improvement and change.

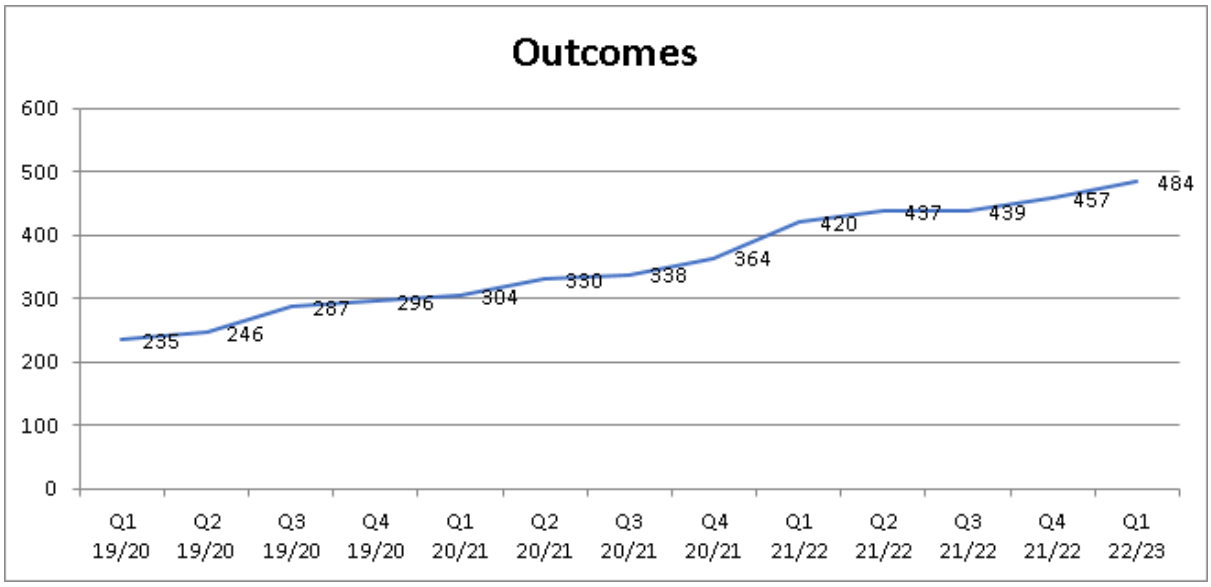
Clinical audit activity at UHS is thriving. Training and support is readily available from the department. The team have now developed an online training resource which can be downloaded and used by any member of staff with access to the UHS intranet. Ad hoc training sessions are occasionally requested that the team fulfil. This use to be achieved by organising face to face training sessions but since COVID we use Microsoft Teams and remote access to deliver training and solve user-end problems with using this system. Over the past three years the department has collaborated with the developers of Electronic Audit System "ULYSSES" to provide a user-friendly system that now accommodates service evaluations, clinical audit and registration of quality improvement projects which search features and live updates to provide a "library" of previous audits to help people plan their own projects and facilitate rapid shared learning. Colleagues are rewarded for their clinical audit work with certificates. Since early 2020 2,000 certificates have been awarded. Clinicians use these as evidence in their applications/ appraisals and appreciate the recognition for their efforts to improving patient care.

The department has a long tradition of hosting successful clinical audit conferences. In Autumn 2019 CO ran its annual conference which attracted 150 delegates and over 70 posters. This programme of engagement was postponed due to COVID.

	Audit (not inclusive of Quality Accounts)	Service Evaluation
Current Live Projects (Aug-22)	588	222
Complete & Closed Since System Inception	1692	143

- CAMEO (Clinical assurance meeting for effectiveness and outcomes)

CAMEO has evolved from relative infancy to a well-established and respected programme. James Kirkby-Bott chairs the meeting supported by a multi-disciplinary panel of consultants and senior support services staff providing peer review to specialties/ care groups from all areas of UHS. In July 2019 44 out of 87 specialties were reporting into CAMEO, by April 2021 (despite COVID and a temporary suspension of the programme) it was 57/87 and in July 2022 it's 64 (64/87). 74% of specialties are reporting 484 active clinical outcomes with that number continuing to climb.



Graph of progression in outcomes measured since 2019.

The programme for services to present their outcomes is sent out 6-18 months in advance depending upon when in the year they are presenting. Meetings are monthly. Each meeting includes several services from one of the divisions with 10 meetings a year. There is no meeting in August due to the frequency of leave then and there is a spare meeting in March for a roundup of any cancelled meetings. Meeting emails and diary are sent to Divisions and their governance leads. The clinical effectiveness lead of each service and CCGL are also notified, and reminders sent. These are then expected to notify their consultants.

The programme has an established route of escalation to the Quality Committee which has enabled specialties with specific needs to access the support they need for example, business case support to recruit two tracheostomy nurses for GICU after years of delays.

The process of encouraging colleagues to bring outcomes to this meeting has been slow requiring clear explanation and encouragement. Presenting one's outcomes has been feared in medicine. The background to this 'fear' has been a poor track record in the health service of appointing blame. Given that it has been NHS doctrine since the mid 1990's that every patient has a named consultant responsible for their care this fear is felt by many. As NHS teams have developed since the 1990's there has been a loss of control over decision making; being held accountable for the outcomes of

many; in a team that you are not necessarily the lead of or have any control of the membership of. Being responsible for every patient under your name can be quite harrowing. In the acute specialties this may mean being responsible for medical conditions you have little training in and for patients you may never meet.

The remedy to this apprehension has been to force nothing. Use positive pressure by vocalising good practice and outcomes. Positive reinforcement is slow but encourages ownership of outcomes and installs pride in good outcomes. In an increasingly demoralised workforce this approach has worked. By paying attention to processes in analysing less good outcomes it is easier to get to the source of problems with no blame attached and to help support getting the right help. It is proactive rather than reactionary. Over several years we have managed to increase participation so a point that it will become cultural and embedded if dealt with sympathetically.

The number of national audits that teams take part in allows easy benchmarking and consistency in outcomes measures over time. Using the CAMEO data, In April 2021 James Kirkby-Bott and Diana Ward presented a paper of Excellent UHS clinical outcomes to the Trust Board including National and International benchmarked data. The paper was well received and one of the first papers of its kind in the UK comparing trust level data nationally and internationally (where available). The team have noticed an exponential increase in contact from colleagues asking for advice across the portfolio thanks to the raised departmental profile across UHS/ Nationally. Other trusts regularly make contact to ask for advice/observe our established programmes.

CAMEO does not and probably could not cover every outcome, but the aim is it that it reports on the majority of a service's activity. Where possible given as patient centred or outcomes with clear meaning to patients. For example: patients using the colorectal service might not just want to know the chance of surviving their operation, as the numbers that don't are very small. They would like to know if they have a colostomy or stoma as part of their care how likely it is to be reversed and how long they'd wait. Patients having a hip replaced might like to know how long their new hip will last and the likelihood of needing it revised. Mum's coming to deliver a baby may want to know the odds of going home with a healthy baby. The list goes on, but you have to record outcomes in order to answer questions. Services can report core outcomes annually and snapshots of other activity as one-off examples to highlight the breadth of what they do. The clinical support services have highlighted imaginative and useful ways of using both over the past few years in physiotherapies, audiology, and dietetics.

Sometimes the measures recorded are not obviously patient orientated. Explaining these measures and why they are used can help provide better information that is clearer to understand. The way we do this is to encourage the use of infographics. Many clinical databases do this as part of what they offer (figure 2). The important part is the explanation and communication of what these mean to you as a patient. When such data is collected it can be used as part of shared decision making (SDM). In fact, SDM cannot be meaningful without this data.

Infographics are designed to be published. Figure 3 is an example of an infographic produced from outcomes submitted to CAMEO. They could become part of a services web presence explaining what the service does and expectations before patients even arrive for their first appointment. Given communication failure is behind 90% of complaints would this not be an effective tool for a hospital? Clinical outcomes has an internal dependency on the Comms team which caused significant delay to

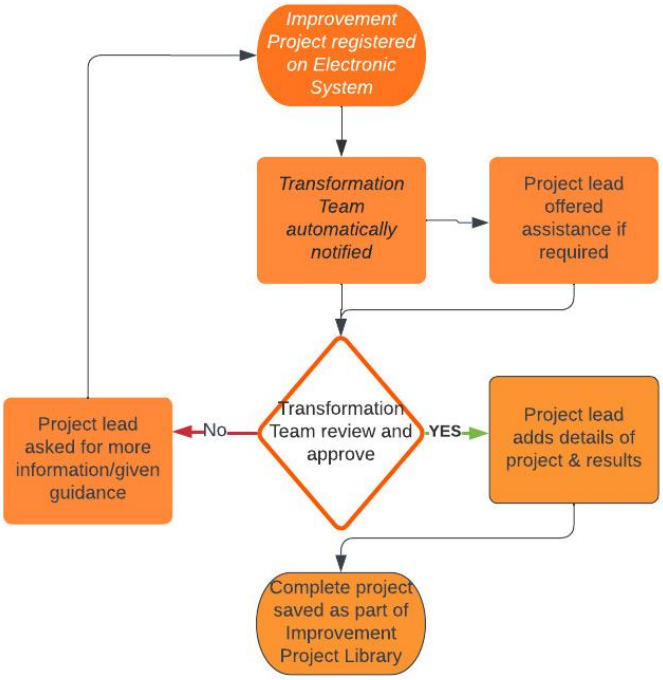
the increasing public engagement objective. It took significant effort including numerous meetings on Teams, emails with significant delays to try to set up a process for adding infographics to the public website. CO agreed to provide service descriptions and infographic explanations suitable for the world-facing website that are received within CAMEO reports. It was recently decided that Comms will design the infographic to ensure a consistent house-style and despite several emails chasing this up the output has stalled. UHS has a unique peer-review clinical outcomes programme with significant clinician/specialty/care group engagement, and it appears rather regressive to avoid informing patients and the wider health community about it and clinical outcomes successes.

Our dependency on digital teams has held up work on patient reported experience measures. Since 2020 the department planned to collect and utilise patient reported experience and outcome data via EQ-5D quality questionnaires to support specialties to improve their clinical outcomes. It was identified that My Medical Record (MmR) was an ideal platform for this patient contact. The EuroQoL questionnaire is generic but applicable to most active interventions and treatments be they surgical or pharmacological or psychological. The digital team can only do so much at once though. Their team had staffing issues and have been unable to facilitate this except for paediatric hernia and ankyloglossia (tongue tie). Although these had been loaded onto the system the CO manager used her network to find out that these questionnaires were not visible to patients and data was not being collected. This was corrected once the right MmR team member was identified. This data is now available for the clinician collecting it to use these outcomes as part of the shared decision making process he has on explaining treatment options and expected outcomes.

There are still several specialties/care groups not reporting their outcomes to CAMEO. It has been identified that some of these departments don't yet collect their clinical outcomes. They are being supported by the department but have not yet presented or submitted outcomes. Figure 4 lists services we are waiting to hear from.

- Quality improvement

There is a large and natural overlap between the clinical outcomes a service produces and quality improvement. It is very natural for clinicians to want to offer the very best and we do that using information gathered from feedback. Audit and service evaluations are formalised feedback. Feedback can be objective outcome measures or experience measures. We have systems for recording all of these or are trying to develop them as described above. Quality improvement is about using models of change to get the most from feedback to improve services. Quality improvement is not part of the clinical outcomes programme. But we run the systems they use for collating information to use in appropriate models for change.



Next steps:

1. Make it easy and straightforward to get mMR working with the EuroQoL questionnaire for services to use and adjust to suit their needs
2. Get Communications team to go ahead with the infographics generated from each CAMEO
3. Give each service a webpage they can populate with useful information and outcomes for service users
4. Link engagement in the clinical outcomes programme with business case development.

Figure 1 – NICE Guidance and Quality Standards flow chart

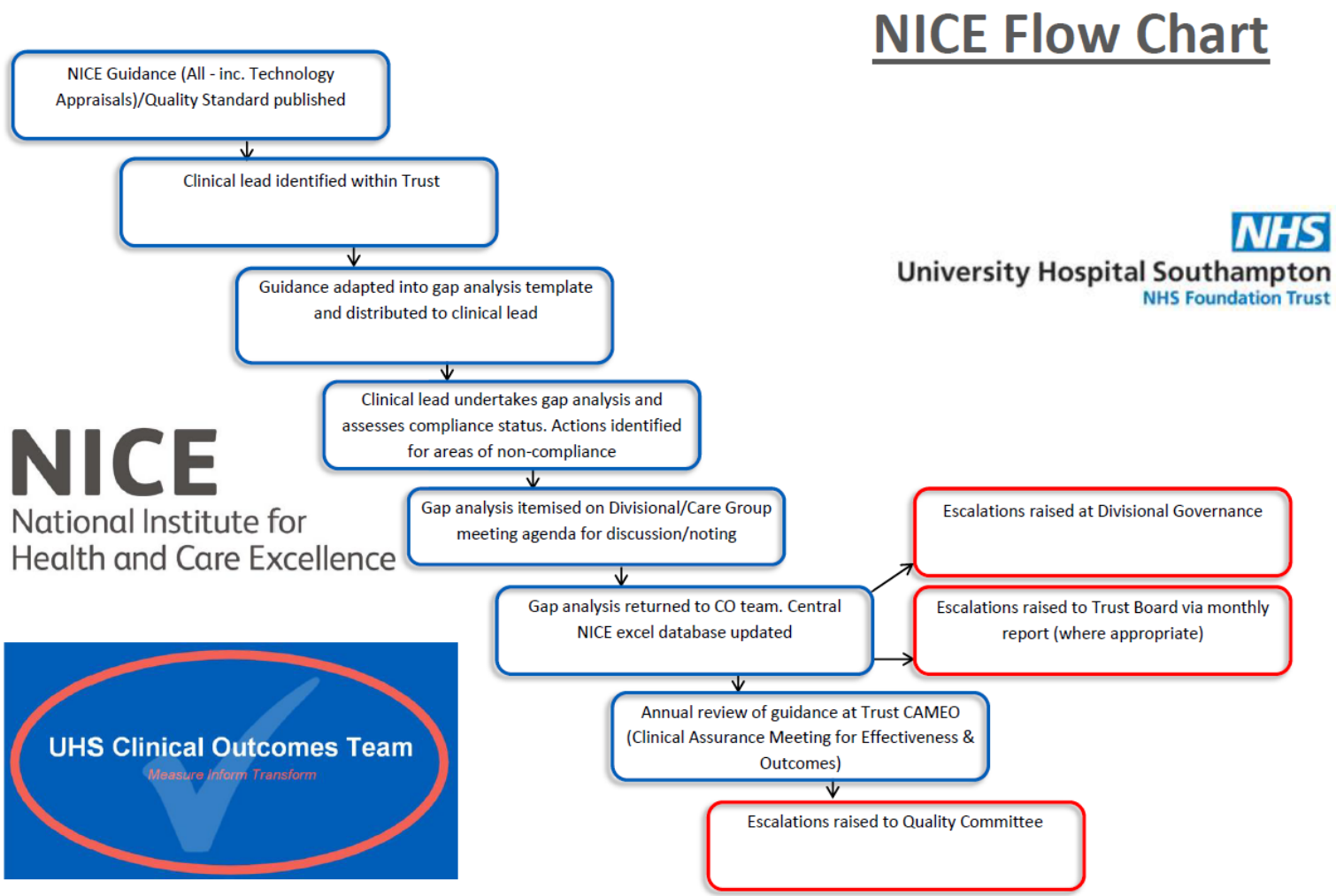


Figure 2 – Infographic from the National Neonatal Audit Programme presented to CAMEO

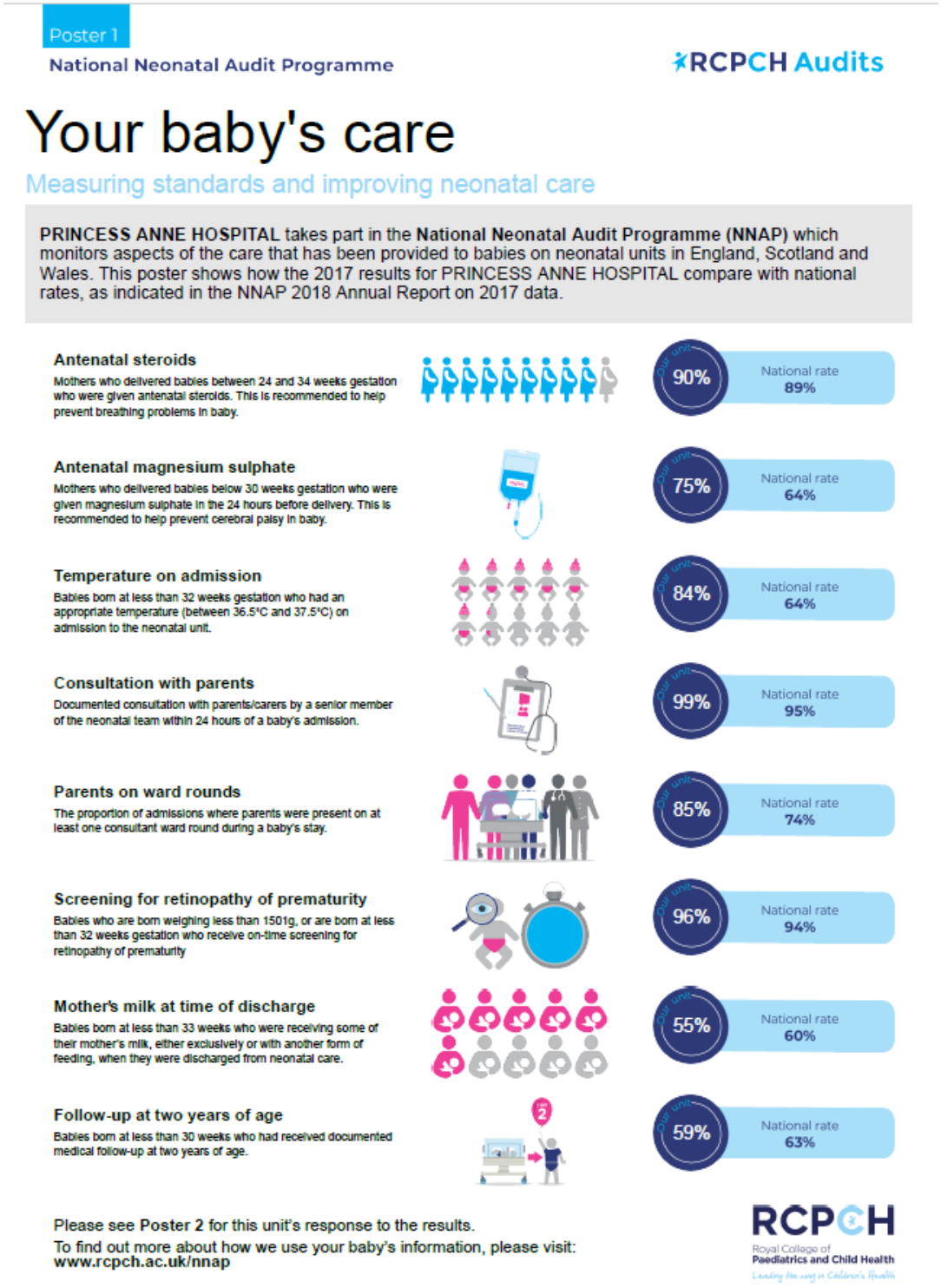


Figure 3 – Infographic developed from the Haematology service CA

Figure 4. List of services that are yet to report outcomes to CAMEO.

- Palliative medicine
- Hepatology
- Clinical immunology & allergy
- Infectious diseases
- Chemical pathology
- Clinical physiology
- Paediatric ophthalmology
- Paediatric surgery and urology
- Paediatric orthopaedics
- Paediatric endocrinology
- Paediatric clinical immunology and infectious diseases
- Paediatric dermatology
- Paediatric nephrology
- Paediatric rheumatology
- Paediatric sleep service
- Paediatric spinal

UHS Clinical Outcomes Team

Measure Inform Transform

University Hospital Southampton NHS
NHS Foundation Trust

Excellent National and International outcomes

Preface 2022

Welcome to the second National and International outcomes of excellence report that the Clinical Outcomes department has produced. The first was presented in April 2021 to the Board.

The team would like to thank Mr James Kirkby-Bott, Consultant General Surgeon, for his enthusiasm, vision, and dedication to the department since becoming Director three years ago. He has recently resigned from UHS but was influential in the reporting and robust peer review of all the outcomes reported in this work.

Currently 64 of 86 services (487 outcomes) are reporting outcomes through CAMEO. CAMEO (clinical assurance meeting for effectiveness and outcomes) is a novel process that is not knowingly repeated elsewhere in the NHS. It meets once a month at UHS. It is a transparent, peer review process where each service is invited to report outcomes annually that form part of a report presented monthly to the Quality committee so that the Executive board and Trust members can have assurance and certainty about the quality of care provided by UHS, the transparency of our clinical governance process and get feedback on what their interventions as board members achieves.

We have listed all 86 services, so it is clear who reports outcomes back to the Trust and what they are reporting. Not every service has national or international benchmarks to aim for making comparison difficult at times. If they did have benchmarks to compare against then there would be more UHS services recognised as International and National class reported here. In the absence of benchmarks, services should aim to achieve high quality patient centred outcomes.

CAMEO is a powerful source of communication. It is a peer platform which not only reports outcomes but also allows explanations of where National effectiveness standards are not patient orientated: why and what else could be reported more meaningfully. It allows the Trust members and board to see their results, support services where needed and champion success. It has the potential to allow UHS to become the first port of call for all potential service users and commissioners of services. Giving information and setting expectations of what services can offer up front.

As CAMEO develops, we hope more services will see the value of reporting through this process and that outcomes will have a patient centred externally facing dashboard that is service driven.

Diana

Diana Ward (manager), Richard Dacombe, Diane Penfold and Katherine Bessant – The clinical outcomes team.

International Excellence

Research & Development

QC report: March-2022

- The team led the **world's first** COVID booster trial. They informed government policy on the booster programmes with recommendations of timelines and dosing. The study continues looking at fourth doses and reduced doses of the booster for 18–30-year-olds

Bone Marrow Transplant Unit

QC report: April-2022

Metric		**UHS**	**BSMT Benchmark**
Overall survival (OS) for all allogeneic transplants - target is maintaining autologous transplantation results equal to or better than the BSBMT UK benchmarking results	Unrelated donor	57%	50%
Overall survival (OS) at 1yr for all autologous transplants		94%	92%
Non-relapse Mortality (NRM)-should be equal or less than the BSBMT benchmark 1yr time-point	Autologous	1%	3%
	Allogeneic Sibling	10%	13%
	VUD	10%	20%

- Our centre in Southampton has performed extremely well and has the best transplant outcomes for allogeneic transplantation and **3rd best for autologous transplants in Europe** – this is out of 395 transplant centres across UK and Europe

National Excellence

Spinal Surgery QC report: May-2021		
Metric	**UHS**	**National**
Emergency admissions to service within 30 days	0.34%	<5%
British Spinal Registry compliance	81.7%	50%

Stroke QC report: May-2021		
Metric	**UHS**	**National**
The percentage of patients who are thrombolysed and reach the stroke unit within 4 hours	83%	70%
• Excellent time to CT brain scan and seen by a stroke specialist nurse and physician after arrival in the emergency department		
• UHS has been "A rated" for two years and is in the top 30% of centres for Stroke services		

Maternity QC report: July-2021		
Metric	**UHS**	**National**
Stillborn deaths - 14 stillbirths/5,193 babies born at PAH	2.70 per 1000 births	4.10 per 1000 births
• UHS have been national pioneers of the model providing case-loading care teams. The model focusses efforts on women who have serious mental illness, socially challenging situations, non-English speaking, addiction, homelessness, social services involvement, suffer domestic violence, asylum seekers, recently or suspected of being trafficked. PAH allocates these women to the "Needing Extra Support Teams" (NEST). 12% of UHS population needs NEST care		

Neonates QC report: July-2021		
Metric	**UHS**	**National**
Temperature on admission < 32 weeks	94%	70%
Above national average for several of the NNAP quality indicators including antenatal maternal magnesium sulphate	89%	85%
Mothers milk at discharge for preterm infants < 33 weeks	70%	58%
Low rates of necrotising enterocolitis (NEC)	3%	6%

Breast Services
QC report: July-2021

Metric	UHS	National
62-day referral to treatment performance	97.5%	93%
Emergency presentation performance	97.7%	85%

T&O Fractured neck of femur
QC report: July-2021

Metric	UHS	National
Excellent National Hip Fracture database case completion capturing data on bone health of non-hip fragility fracture patients, medical history, lifestyle factors, falls risk assessments and fracture risk, thus reducing their future risk of osteoporotic and hip fractures	88.9%	79.3%

Hip & Knee Data
QC report: July-2021

- NJR Quality Data Provider has been awarded to UHS for the fourth consecutive year due to: Full compliance with annual data quality audits
- 95% or above compliance (based on the revised compliance in the DQ audit results), payment of subscription, timely responses to patient safety alerts

Maxillofacial
QC report: August-2021

- 147 cases (in the past 3 years) were completed as a tertiary referral centre for all combined craniofacial resections which account for 15 to 20%. UHS is one of the leading centres for this type of work in the country
- 3-year free flap survival currently running at 100%, UK averages 92% and most of the top units about 96%. UHS 5-year free flap is now up to 99.8%

Nephrology
QC report: October-2021

Metric	UHS	National
Altruistic kidney donations: WKC is the 2nd highest in the country for altruistic kidney donations	>90%	65%

- Pre-emptive transplant rate: WKC has the 2nd highest pre-emptive listing rate in the country. The pre-emptive rate in our LD programme for last year was 37.5% of the total transplanted

Dermatology
QC report: October-2021

- MEIN (Medical Education Innovation) award, Soton Uni – Dr Caroline Murray and team for adapting to provide the first live, remote Dermatology attachment (nationally)

Medical Genetics
QC report: October-2021

- 2020/2021 marked the introduction whole genome sequencing service nationally for medicine and the bringing those tests into mainstream specialties

Respiratory
QC report: October-2021

Metric	UHS	National
June 2021 report shows a fall in inpatient mortality to 2.2%, with a national average of 3.9%	2.2%	3.9%

Cardiology ACS (Acute Coronary Syndrome)
QC report: November-2021

Metric	UHS	National
Patients with STEMI receiving primary PCI within 90 minutes of arriving at hospital ("door to balloon time")	89.5%	75%

Thoracic Surgery
QC report: November-2021

- Shortest UK post- operative length of stay for lung resection 4 days
- 7th largest centre nationally in terms of operations (300) performed per year with 5 surgeons

Vascular Surgery
QC report: November-2021

Metric	UHS	National
Major lower limb amputation Median (IQR) length of stay (days)	13	22
Repair of complex AAAs Median (IQR) length of stay (days)	1	5

Critical Care
QC report: November-2021

Metric	UHS	National
The sickest patients (those requiring invasive ventilation) had a mortality of 39% which compares favourably to the national 56.2%	39%	56.2%

- Nationally UHS were in the top 3 hospitals for Covid outcomes. We were interviewed as one of the top hospitals after wave 1 to see what other hospitals could potentially learn from our approach. We did equally well in Wave 2, despite the increased numbers of patients thanks to a whole hospital effort to support the Team. Consultants from anaesthetics, NICU and PICU joined the Consultant group, nurses from all around the Trust were redeployed in a Team nursing structure and Consultants and other staff from all specialities contributed by joining the Proning and patient Liaison teams, thus freeing up GICU staff to help with direct patient care

Emergency Medicine
QC report: January-2022

Metric	UHS	National
National survival to discharge from in- hospital cardiac arrest	34.3%	20%
ROSC (Return of Spontaneous Circulation)	56.9%	50-51%

Paediatric Intensive Care
QC report: January-2022

Metric	UHS	National
Age adjusted median FEV % predicted, amongst patients aged 6 or over	89.9%	87.9%
Proportion of patients with chronic pseudomonas aeruginosa	2.5%	5.9%
• 2nd out of 10 largest UK Cystic Fibrosis networks for FEV1: Top quartile of all 33 networks		

Paediatric Cardiology
QC report: January-2022

- Lowest incidence of emergency procedures (surgery or transcatheter) following catheter procedures (<0.3%)
- Second lowest incidence of catheter-related device embolisation for the UK and NI (0.63%)
- Data Quality Indicator (DQI) is 98.25%. “This is an excellent achievement”: Data Quality Audit for congenital heart disease procedures 2019-2020)

Radiology
QC report: January-2022

Metric	UHS	National
Gastronomy death within 30 days. CIRSE 2016 Standards of Practice review of literature	2.5%	11-17%
Thrombectomy/Thrombolysis complications	1.9%	5.5%

Pathology
QC report: January-2022

Metric	UHS	National
Specimen reporting	81.7%	75%
Bowel cancer specimens within 7 calendar days	92%	90%
Breast cancer specimens within 10 calendar days	97.7%	90%

Dietetics
QC report: January-2022

- UHS is the first children’s hospital in the UK to explore the patient experience and undertake a collaborative improvement project to improve standardization of dietary assessment across clinical and research centres

Medical Physics QC report: January-2022		
Metric	**UHS**	**National**
Increased the number of SRS treatments we are delivering to 198 in a year. This means we delivered 39 more treatments this year compared to last year, and 60 more than in 2019	198 Patients	100 Patients

Pharmacy QC report: January-2022
• UHS remains a national leader regarding the rates of patients where their medicines information is communicated to their regular community pharmacy upon discharge. This service now forms part of the standard contractual requirements for acute trusts and is expected to be the subject of a national CQUIN. UHS refers approximately 2% of discharges per month to community pharmacy with a focus on cases where there are high-risk medicines or complexity around the medicine's regimen on discharge. Through continuous monitoring it is estimated that throughout 20-21 the scheme has avoided 106 re-admissions

Research & Development QC report: March-2022
• Since April 2021, 173 new studies have been opened, 8,572 participants have been recruited and UHS is ranked 9th in the country for recruitment to research studies
• 22 different vaccines have been trialled and UHS has been key in ensuring some of the vaccines have enough data to be able to be approved in the UK. This includes AstraZeneca and Janssen
• Personal respirator hoods, designed at Southampton, have been recommended as an effective and cost-effective way to protect against COVID
• The trust led the point of care testing trials and technology is now in use across acute trusts nationwide

Ophthalmology QC report: March-2022		
Metric - UK National Incidence (BOSU 2004) for endophthalmitis yearly rate:	**UHS**	**National**
Following cataract surgery - 1089 cases	0%	0%
Following intravitreal injections - 4011 cases	0%	0.02-0.06%
Posterior capsular rupture	0.42%	2%

Report to the Trust Board of Directors				
Title:	**Health Inequality – Data Analysis Update**			
Agenda item:	**5.11**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Author:	**Jason Teoh, Director of Data and Analytics** **Ellis Banfield, Associate Director of Patient Experience** **Leo Westbury, Senior Research Fellow – University of Southampton MRC Lifecourse Epidemiology Centre**			
Date:	**29 September 2022**			
Purpose	**Assurance or reassurance** **Y**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	A key strategic priority of the NHS is to reduce healthcare inequalities within the population. UHS needs to ensure that we review, and address, any significant inequality within our service.			
Response to the issue:	This paper outlines some of the analysis conducted to date, and how there is no clear evidence of inequality within the service that UHS offers. UHS will continue to develop and deepen its understanding of health inequalities under the leadership of the new Head of Health Inequalities who started in mid-August 2022.			
Implications: (Clinical, Organisational, Governance, Legal?)	• Where inequalities are identified, we will need to revise our operational processes accordingly • Additional funding required to further develop, and deepen, our analysis, understanding, and action to address inequalities.			
Risks: (Top 3) of carrying out the change / or not:	• Patient harm if health inequalities go undetected. • Reputational risk if UHS does not address inequalities.			
Summary: Conclusion and/or recommendation	The Board is asked to note the work undertaken so far.			

Overview

An NHS definition of health inequalities explains this as "*unfair and avoidable differences in health across the population, and between different groups within society … Within this wider context, healthcare inequalities are about the access people have to health services and their experience and outcomes*."

We have seen COVID-19 highlighted the disparity in health equality across England, with disadvantaged groups impacted by COVID-19 to a greater extent than other patients. As such, it is important for UHS to continue to examine whether there is any inadvertent bias or inequality within the services it offers, and to look to address these where possible.

A data led approach

UHS continues to build and develop its understanding of how to track and monitor health inequalities. To an extent, our thinking is still relatively immature and developing; however, we are confident we can build on the foundational thinking and analysis that has already been conducted.

Initially, we have reviewed whether people on our waiting list are treated equally. We have analysed patient characteristics (such as age, address, ethnicity, gender, etc), and assessed whether there is equality between these characteristics when cross referenced across some of our data sets. For example: do patients broadly wait similar times on our Referral To Treatment (RTT) Waiting List, and is performance similar when looking at Outpatient metrics?

We have worked with the University of Southampton MRC Lifecourse Epidemiology Centre (led by Professor Cyrus Cooper), to increase the sophistication of our analysis, and a report into this analysis is in Appendix 1.

The initial results

Both the UHS led and MRC led analysis has indicated that there is no obvious sign of inequality within the waiting list (i.e. an extremely weak correlation is shown between indicating factors and risk of breaching waiting time targets). We have reported this back to Trust Exec Committee (TEC) in October 2021, and within the Integrated Performance Report to Trust Board in July 2022.

This applies even to parts of the waiting list which have gained national attention; for example, longer waits within Gynaecology have not shown to have statistical significance of inequality over and above other areas of the waiting list.

Data limitations

We are pleased that there is no clear sign of inequality within the factors that we have looked at so far. However, our analysis has focussed mainly on waits, and hindered by missing protected characteristics data – such as ethnicity, which is only present for 75% of our patients, and in some cases does not have the necessary granularity required.

Other protected characteristics which we would also have liked to explore are not easily captured within our patient information: for example, whether the patient is part of the traveller community.

This means one of the first steps in deepening the quality of analysis will be to broaden the availability of patient identifiable data. This could be done through closer engagement with Primary Care (who

until now have been unwilling to share and merge data sets), but is also likely to require increasing the public awareness of health inequalities and to get the public to voluntarily share additional data points with us.

Developing health inequalities analysis at UHS

UHS's new Head of Health Inequalities started in mid-August and is reviewing our Health Inequalities strategy, and the different areas which we want to explore in further detail. Initially, our expectation is that she will focus on: access, experience, outcomes, and mortality.

The Business Intelligence (BI) team will continue to develop its analysis of various potential health inequalities – including the focus areas for the Head of Health Inequalities (i.e. beyond access and waiting times). In addition, the Transformation team already have this capability built into their Outpatient Transformation KPIs, and the BI and Transformation teams will work to develop this type of analytical capability further.

However, this may not go far enough, and we may wish to start to look at treating people to achieve more equitable outcomes. For example, work conducted by University Hospitals Coventry & Warwickshire NHS Trust in conjunction with Deloitte, has started to review whether a patient's protected characteristics might mean they are proactively reprioritised within the waiting list.

This type of work will require deeper and more comprehensive analysis and may require additional tools to be developed. The Trust is exploring funding a senior analyst to work on health inequalities analysis alongside the Head of Health Inequalities. This is expected to cost in the region of £60-70k.

Appendix 1
The following report was written by Dr Leo Westbury, a senior research fellow at the University of Southampton.

Socioeconomic inequalities in UHS waiting times

Summary

This report extends the initial analysis of sociodemographic inequalities in UHS waiting times that was presented to the Trust Board of Directors in October 2021.

In this extended analysis (accounting for other sociodemographic and admission characteristics and restricting to adults only):

- Patients aged ≥75 years had significantly lower risk of breaching the 18-week waiting time target compared to any other age group with higher risks observed for younger ages
- Associations between sex and deprivation in relation to risk of breaching the 18-week target were weak
- Among men, BAME patients had significantly lower risk of breaching the 18-week target compared to 'British / other white' patients, regardless of adjustments used; among women, risks were similar between these two ethnic groups

These findings are broadly in agreement with those in the previous October 2021 report. However, some of the associations outlined in the previous report do not reach statistical significance. Limitations of analyses are that ethnicity was unknown for 25.3% of adults and many BAME patients may have described their ethnicity as British.

Aim

To extend the initial analysis of sociodemographic inequalities in UHS waiting times (presented to the Trust Board of Directors in October 2021) by implementing multivariable models to account for several factors when examining associations. A secondary aim was to review the key findings from the October 2021 report in light of the new analysis.

Methods

Patient characteristics were described using summary statistics. Sociodemographic characteristics of interest included age, sex, ethnicity and index of multiple deprivation (IMD) quintile. Associations between individual sociodemographic characteristics and risk of breaching the 18-week RTT waiting time target were examined using logistic regression. The following sets of adjustments were use: no adjustments; other sociodemographic characteristics; other sociodemographic characteristics, stage of waiting list pathway, patient priority group and specialty category. Sex-adjusted and sex-stratified analyses were performed and analyses were restricted to adults (aged 18 years and older).

Results

Characteristics of the 37750 patients who were included in the analysis sample are presented in Table 1. Median (lower quartile, upper quartile) age was 58 (40, 72) years; 10540 (27.9%) breached the 18-week RTT waiting time target.

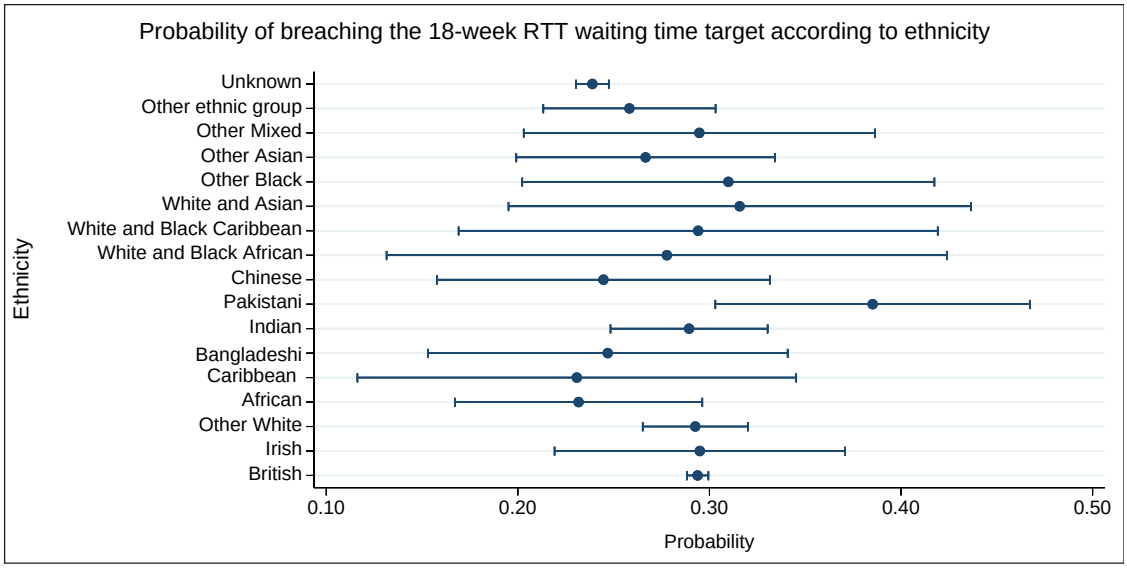
Associations between sociodemographic characteristics and risk of breaching the 18-week target among the pooled sample of men and women are presented in Figure 1. Patients aged ≥75 years had significantly lower risk of breaching the 18-week target compared to any other age group, regardless of adjustments used; higher risks were observed for younger ages. Men had higher risks than women in univariate analyses and when adjusted for other sociodemographic characteristics but not when additionally adjusted for stage of waiting list pathway, patient priority group and specialty category. Compared to 'British / other white' patients, patients of unknown ethnicity had a significantly lower risk, regardless of adjustments used. Compared to patients in the richest IMD quintile, patients in the second poorest quintile had significantly lower risk in univariate analyses and after adjustment for other sociodemographic variables; differences in risk according to IMD quintile were not statistically significant after additionally adjusting for stage of waiting list pathway, patient priority group and specialty category.

Some findings differed when stratified according to sex (Figures 2 and 3). Among men, BAME patients had significantly lower risk compared to 'British / other white' patients, regardless of adjustments used; among women, risks were similar between these two ethnic groups.

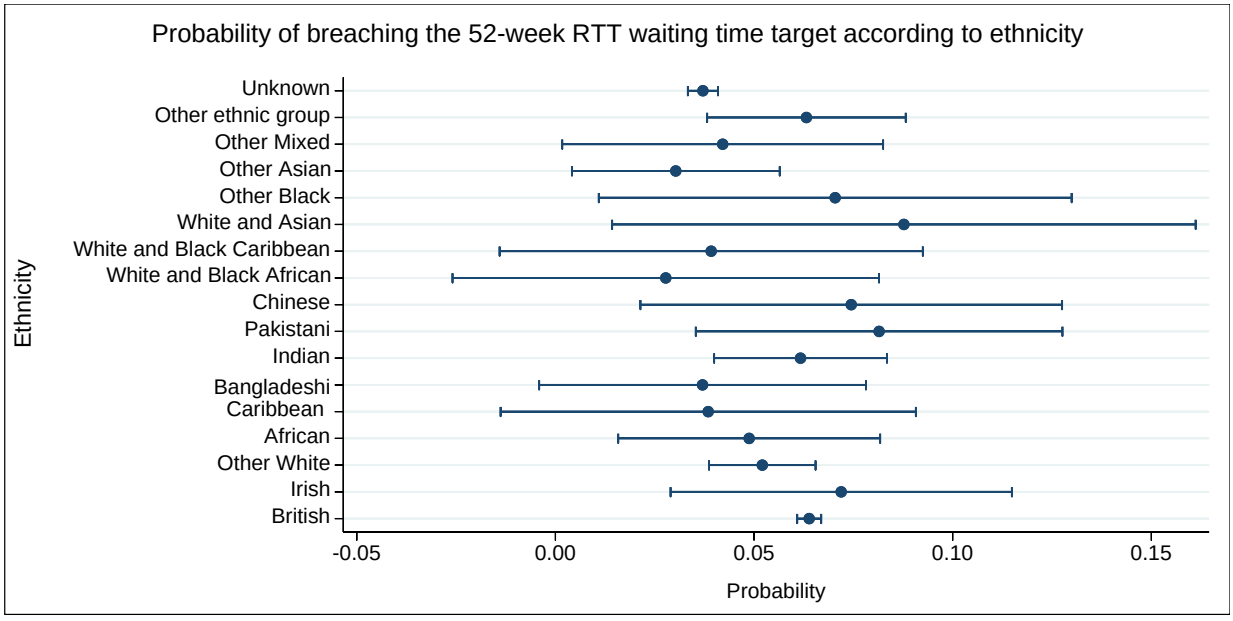
Comments on key findings of the October 2021 report

- *BAME classified patients aren't as likely to breach the waiting list as British classified patients*
  This was the case among men, regardless of adjustments used but this association was not statistically significant among women or in the sex-adjusted analysis which included men and women.

- *When looking at the likelihood of breaching 18 weeks wait by ethnicity, the top 2 most likely to breach are Pakistani and British patients.*
  Pakistani patients were most likely to breach the 18-week target compared to any other ethnicity. However, the wide confidence intervals mean that some of these differences in likelihood between ethnicities were not statistically significant.



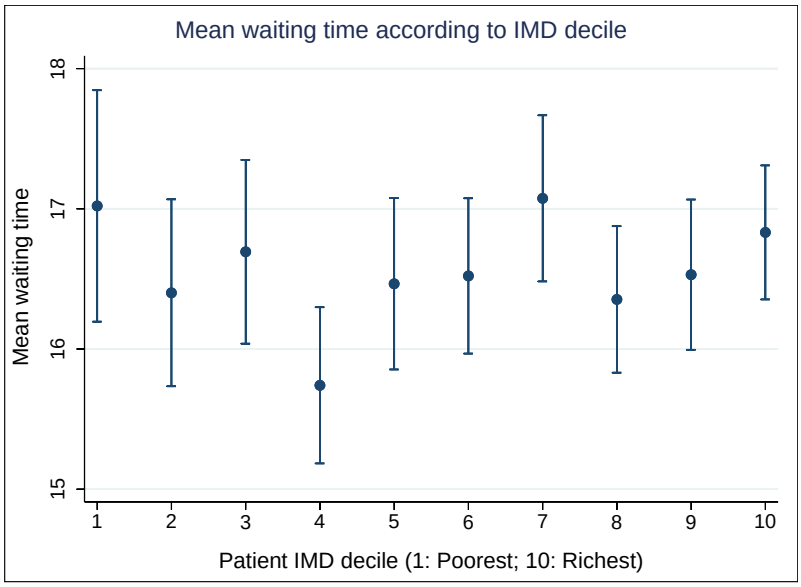
- *When looking at waiting over 52 weeks, British patients are most likely to wait longer compared to other groups. White and Asian classified patients also appear to be more likely to wait longer.*
  The wide confidence intervals mean that many ethnic differences in risk of breaching the 52-week target were not statistically significant.



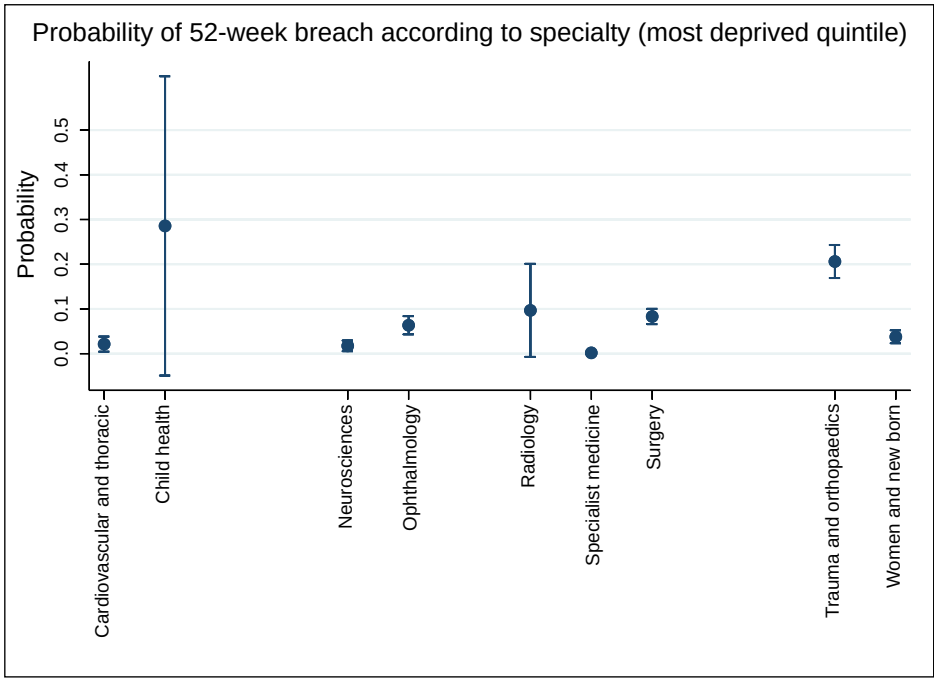
- *Despite there being fewer patients in more deprived areas they have a higher chance of being on the waiting list than those less deprived suggesting that deprivation will impact overall health.*
  It was not possible to examine this using only the dataset that I was provided with.

- *When it comes to average wait times, there isn't a standout deprivation decile that is more at risk of waiting longer.*

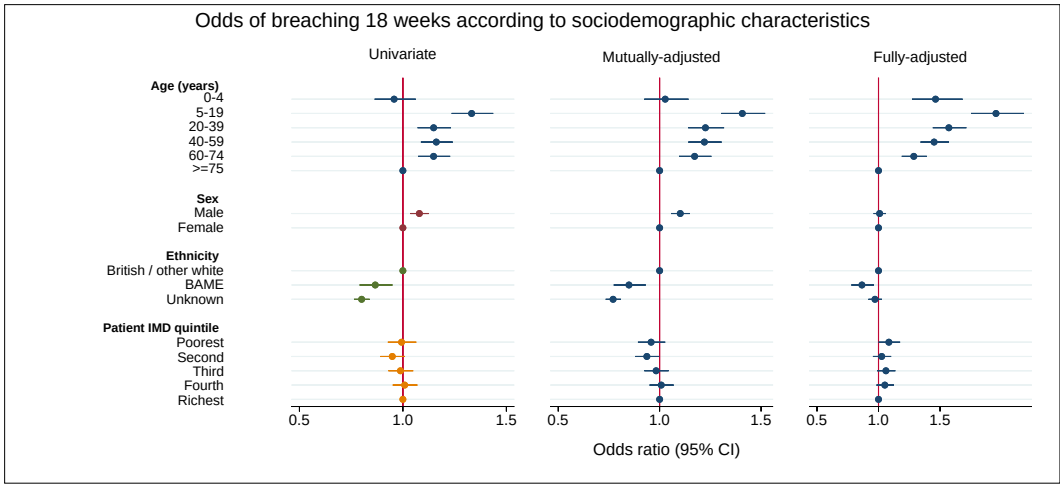
This is supported by the graph below and results shown in Figures 1-3.



- *When analysing by specialty and deprivation, it identifies ophthalmology and cardiac surgery where those most deprived are much more likely to wait over 52 weeks.*
  It is difficult to examine the probability of breaching the 52-week target according to specialty as some specialties have very few observations, resulting in no patients in these specialties breaching the target. These sparse categories are omitted from the figure below.



- *Certain age groups are likely to wait longer than others - namely 5-9 year-olds and 15-18 year-olds.*
  The figure below supports these results; ages 5-19 years were at the highest risk of breaching 18 weeks, regardless of adjustments used.



Univariate: No adjustments
Mutually-adjusted: Adjusted for other sociodemographic characteristics
Fully-adjusted: Adjusted for other sociodemographic characteristics, stage of waiting list pathway, patient priority group and specialty category

- *There is more analysis required of the data in relation to child health. There are some very long waiting children in some specialties as well as outliers in ethnicity and deprivation and these potential connections need to be reviewed and understood alongside more generally understanding why children can expect to wait longer.* There were differences in waiting times according to specialty, ethnicity and deprivation within the 5-9 and 15-18 age group. However, each of these age groups contained less than 2000 patients, resulting in few observations in some of the categories when stratified further according to specialty and ethnicity. Therefore, it may be difficult to robustly examine these differences using the current dataset.

Conclusion

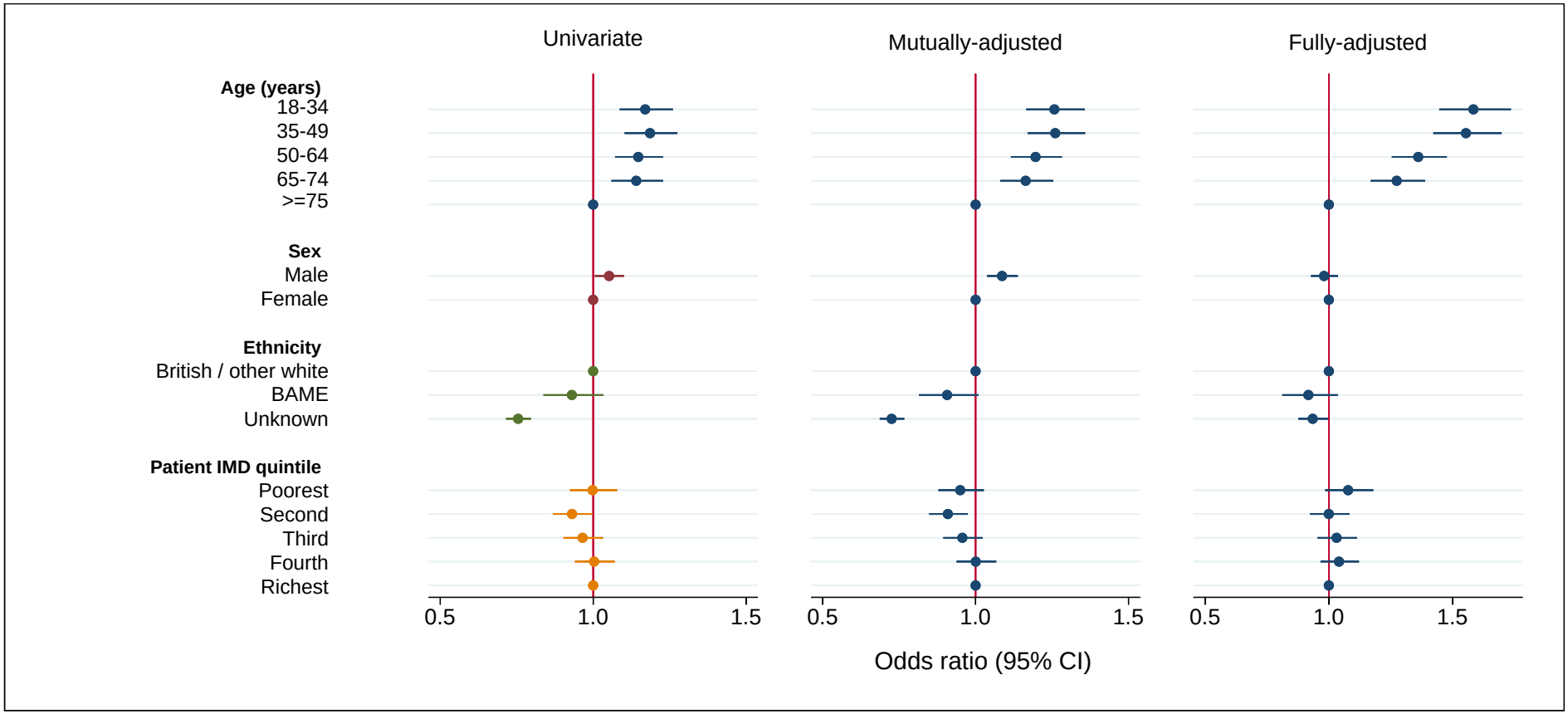
Even after accounting for sociodemographic and admission characteristics, younger adults had significantly greater risk than older adults of breaching the 18-week waiting time target; BAME men had significantly lower risk compared to 'British / other white' men. Associations between sex and deprivation in relation to risk of breaching the 18-week target were weak. Some of the associations outlined in the previous October 2021 report do not reach statistical significance.

Limitations of analyses are that ethnicity was unknown for 25.3% of adults and many BAME patients may have described their ethnicity as British.

Table 1: Characteristics of the 37750 adults in the analysis sample

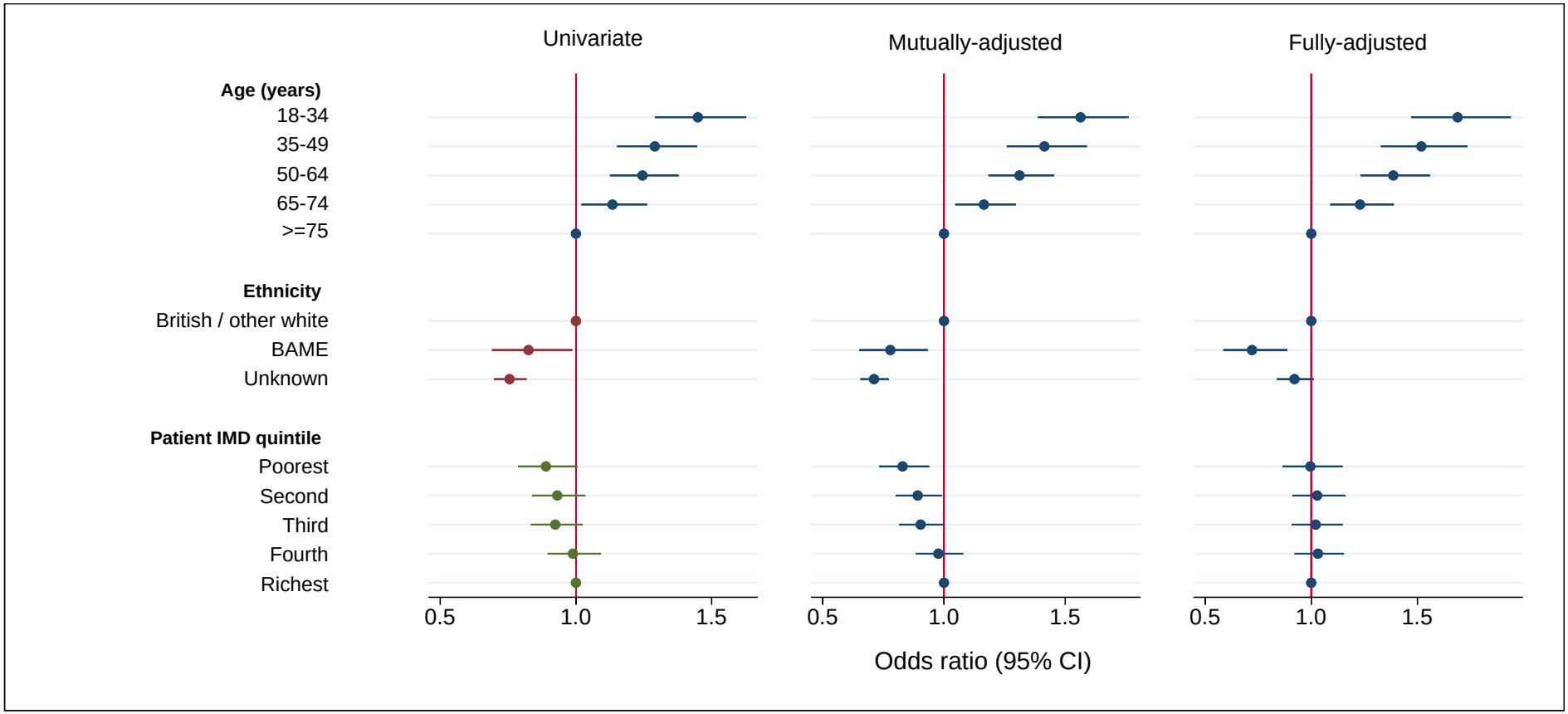
Patient characteristic	Median (lower quartile, upper quartile) or N(%)
Age (years)	58.0 (40.0, 72.0)
Male sex	15691 (41.6%)
Ethnic group	
British	25185 (66.7%)
Other white	1195 (3.2%)
BAME	1835 (4.9%)
Unknown	9535 (25.3%)
Index of multiple deprivation quintile	
Poorest	4693 (12.6%)
Second	7006 (18.8%)
Third	7495 (20.1%)
Fourth	8222 (22.0%)
Richest	9919 (26.6%)
Stage of waiting list pathway	
Waiting for outpatient grading - to be assigned	320 (0.8%)
Waiting for outpatient contact - no previous attendance	20346 (53.9%)
Waiting for outpatient contact - previously attended	7189 (19.0%)
Waiting for admission	8979 (23.8%)
No active wait	916 (2.4%)
Patient priority	
Routine	25901 (72.5%)
Urgent	6925 (19.4%)
Cancer patient (2 week wait)	2923 (8.2%)
Specialty category	
Cancer care	1140 (3.0%)
Cardiovascular and thoracic	2449 (6.5%)
Child health	37 (0.1%)
Emergency care	3 (0.0%)
Medicine	110 (0.3%)
Neurosciences	3597 (9.5%)
Ophthalmology	6113 (16.2%)
Pathology	5 (0.0%)
Radiology	221 (0.6%)
Specialist medicine	7789 (20.6%)
Surgery	8060 (21.4%)
Theatres	41 (0.1%)
Therapies and non clinical Sup	78 (0.2%)
Trauma and orthopaedics	3708 (9.8%)
Women and new born	4399 (11.7%)
RTT wait breached 18-week target	10540 (27.9%)
RTT wait breached 52-week target	2133 (5.7%)

Figure 1: Odds of breaching the 18-week RTT waiting time target according to sociodemographic characteristics



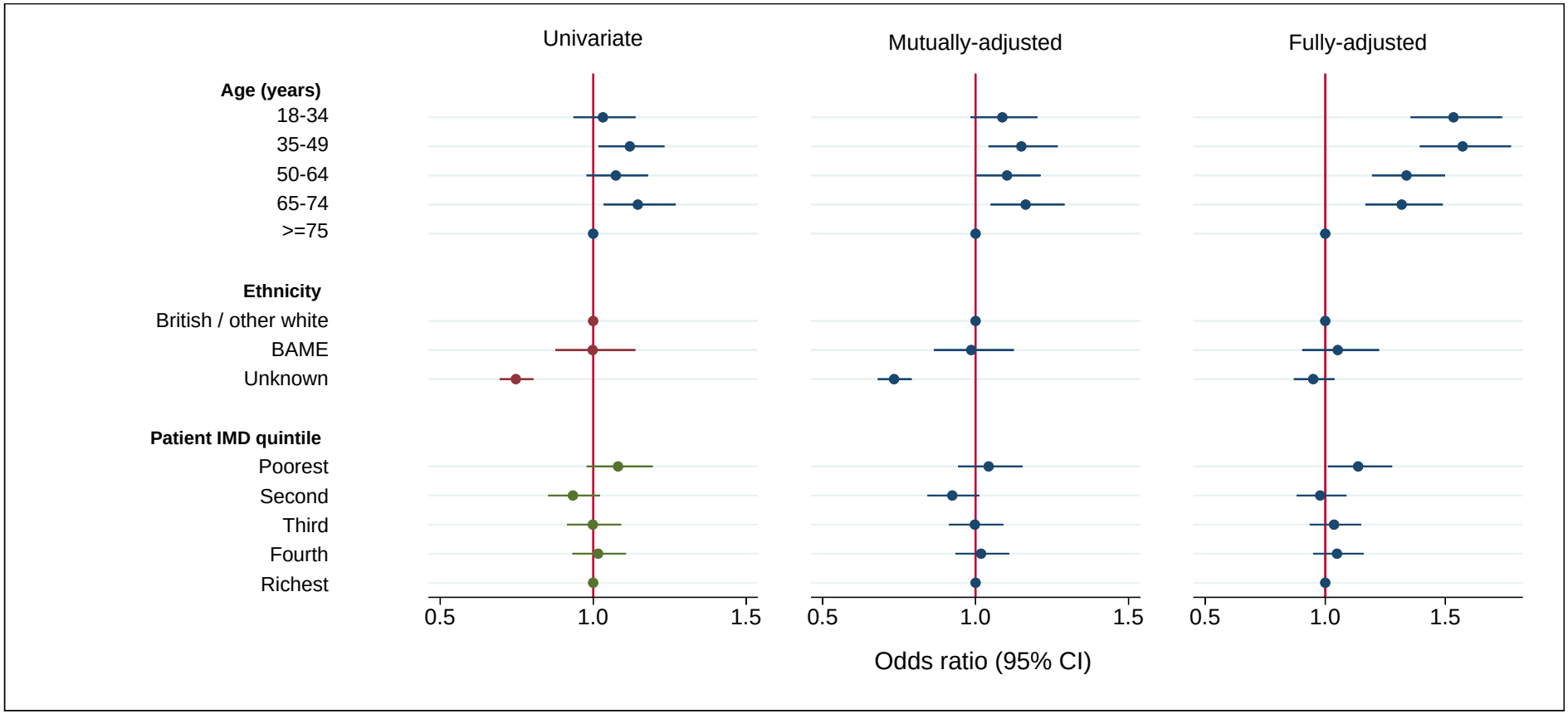
IMD: Index of multiple deprivation
Univariate: No adjustments
Mutually-adjusted: Adjusted for other sociodemographic characteristics
Fully-adjusted: Adjusted for other sociodemographic characteristics, stage of waiting list pathway, patient priority group and specialty category

Figure 2: Odds of breaching the 18-week RTT waiting time target among men according to sociodemographic characteristics



IMD: Index of multiple deprivation
Univariate: No adjustments
Mutually-adjusted: Adjusted for other sociodemographic characteristics
Fully-adjusted: Adjusted for other sociodemographic characteristics, stage of waiting list pathway, patient priority group and specialty category

Figure 3: Odds of breaching the 18-week RTT waiting time target among women according to sociodemographic characteristics



IMD: Index of multiple deprivation
Univariate: No adjustments
Mutually-adjusted: Adjusted for other sociodemographic characteristics
Fully-adjusted: Adjusted for other sociodemographic characteristics, stage of waiting list pathway, patient priority group and specialty category

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**A Smoke-free Site - the UHS Way Forward**			
Agenda item:	**6.1**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Author:	**Kerrie Beyer, Jake Wilkins, Annie Shawcroft, Katie Lovely, Helen Ralph.**			
Date:	**29 September 2022**			
Purpose	**Assurance or reassurance**	**Approval** X	**Ratification**	**Information**
Issue to be addressed:	In January 2018 the Smokefree Action Coalition launched the NHS Smokefree Pledge, updating the NHS Statement of Support for Tobacco Control launched in 2014. The Pledge is designed to be a clear and visible way for NHS organisations to show their commitment to helping smokers to quit and to providing smokefree environments which support them. On No Smoking Day 2022 (9th March 2022), the NHS Smokefree Pledge was relaunched to bring it into line with the Government's ambition for England to be smokefree by 2030 and commitments made to improve smoking cessation support available through the NHS in the NHS Long Term Plan. The Pledge's relaunch took place alongside the relaunch of its sister document, the Local Government Declaration on Tobacco Control. This report provides a summary of progress so far in developing a strategy to: 1. Align the Trust smoking policy to the national expectation all NHS trusts go 'smoke- free'. 2. Commit to pledge UHS to the Government's ambition to make England smokefree by 2030 and tackle health inequalities in smoking prevalence The report includes key areas of success and concern, describes challenges, and suggests options for successful implementation.			

Response to the issue:	• The UHS Tobacco Dependency Steering Group surveyed staff and service users for their opinion on UHS becoming a 'smoke-free' site. • 999 responses were received. • 12% of responses were from responders who confirmed are smokers. This aligns with statistics published by the Office of National Statistics (ONS) which states 13.9% of adults in England smoke (Appendix four) • An initial options appraisal was generated following the survey. • Option One: Completely smoke free • Option Two: Mid-point: Promoting smoking cessation and removing smoking shelters from prominent positions e.g. main entrance • Option Three: No change • This options appraisal will be used to inform a consultation process to fully establish all risks, benefits, and financial implications. The proposed consultation period would be 6 months, led by Paul Grundy with the support of the Transformation Teams Clinical Programme.
Implications: (Clinical, Organisational, Governance, Legal?)	• Our Values: pledging to this initiative and completing a consultation with staff and service users reflects our three core values and allows us to grow strong collaborative working across all areas of UHS. • National NHS Strategy: a pledge and strategy links to the objectives of the national NHS Smoke-free pledge. • CQC Ratings: It aims to support the delivery of an authentically 'Outstanding' NHS organisation under CQC ratings, and specifically to support Outstanding in the Well Led Domain. • Financial Impact: The strategy will require ongoing appropriate investment and resource requirements will be subject to the annual budget setting and business case process. • System Collaboration: The strategy will require collaboration with staff, service users and partners to UHS.
Risks: (Top 3) of carrying out the change / or not:	The risk implications for the Trust: • National reputation: If UHS does not adopt the national 'smoke-free' stance it could be perceived as not supporting our local population to avoid long-term health conditions and failing to support health equality. • Financial Impact: The strategy will require some ongoing appropriate investment and resource requirements will be subject to the annual budget setting and business case process. • Stakeholder Engagement: The Steering group recognise that the trust could go smoke free by putting up signs and removing shelters, however, the challenge would be ensuring compliance. Therefore, not only the logistics but identify ways of maximising compliance will be explored over the 6 months consultation period.

	Returning to the Board with a robust meaningful implementation plan in March 2023.
Summary: Conclusion and/or recommendation	Trust Board is asked to • approve the launch of a full consultation process in line with Public Health England's 'Stoptober initiative October 2022. • support that consultation programme being completed between September 2022 and March 2023. • consider if the "no change" option should be removed altogether for the consultation programme if approved.

1 Commitment in Principle to Pledge to go 'Smoke-Free' and future consultation programme

1.1 As local health leaders we acknowledge that:

- Smoking is the leading cause of premature death, disease, and disability in our communities.
- Smoking places a significant additional burden on health and social care services and undermines the future sustainability of the NHS.
- Healthcare professionals have a key role to play in motivating smokers to try to quit and offering them further support to quit successfully.
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities.

1.2 UHS aspires to commit to:

- Treat tobacco dependency among patients and staff who smoke in line with commitments in the NHS Long Term Plan and Tobacco Control Plan for England.
- Ensure that smokers within the NHS have access to the medication and support they need to quit in line with NICE guidance on smoking in secondary care.
- Create environments that support quitting through implementing smokefree policies as recommended by NICE.
- Deliver consistent messages about harms from smoking and the opportunities and support available to quit in line with NICE guidance.
- Actively work with local authorities and other stakeholders to reduce smoking prevalence and health inequalities.
- Support Government action at national level.
- Publicise this commitment to reducing smoking in our communities and join the Smokefree Action Coalition (SFAC), the alliance of organisations working to reduce the harm caused by tobacco.

2. Options appraisal

2.1 The options appraisal can be found in Appendix one.

2.2 The UHS Tobacco Dependency Steering Group advises option three ('no change') would hold a significant reputational risk.

2.3 In line with the NHS Long term plan there is a smoking cessation service being developed from September 2022 to increase awareness and prescribe nicotine replacement therapy for all patients who smoke prior to and on admission, as well as provide support to quit. This work is expected to be establish within 6 months.

2.4 Other local Trusts, Salisbury, Portsmouth and Hampshire Hospitals have already declared themselves as smoke-free sites. There is an indication from the Hampshire and Isle of Wight ICS expectation that UHS follows. Appendix Three outlines how Portsmouth Hospital University NHS trust has gone 'Smoke-Free', however the Tobacco Dependency Steering Group advises there are significant differences between the Trusts and that UHS may have different risks to consider and mitigate.

3. Consultation Period

3.1 During the proposed 6-month consultation programme the following stakeholders will need to contribute: Pharmacy, Estates, Communications, Security, Fire Safety, Legal, Patient Partner, Local Residents, Finance, Occupational Health, Human Resources and Staff Representatives.

3.2 The consultation programme will include the non-exclusive list of tasks illustrated in the Gantt chart below (Appendix 2). The tasks include consultation/ focus groups with all relevant stakeholders to collaborate and mitigate identified risks, monthly steering group meetings and reporting back to the Trust Board.

4. Next steps

4.1 The UHS Tabaco Steering group recognise there is further work required to fully inform the options as outlines specifically in Appendix one.

4.2 The Board is asked to approve and support a consultation programme being completed between September 2022 and March 2023.

Appendix One: Options Appraisal

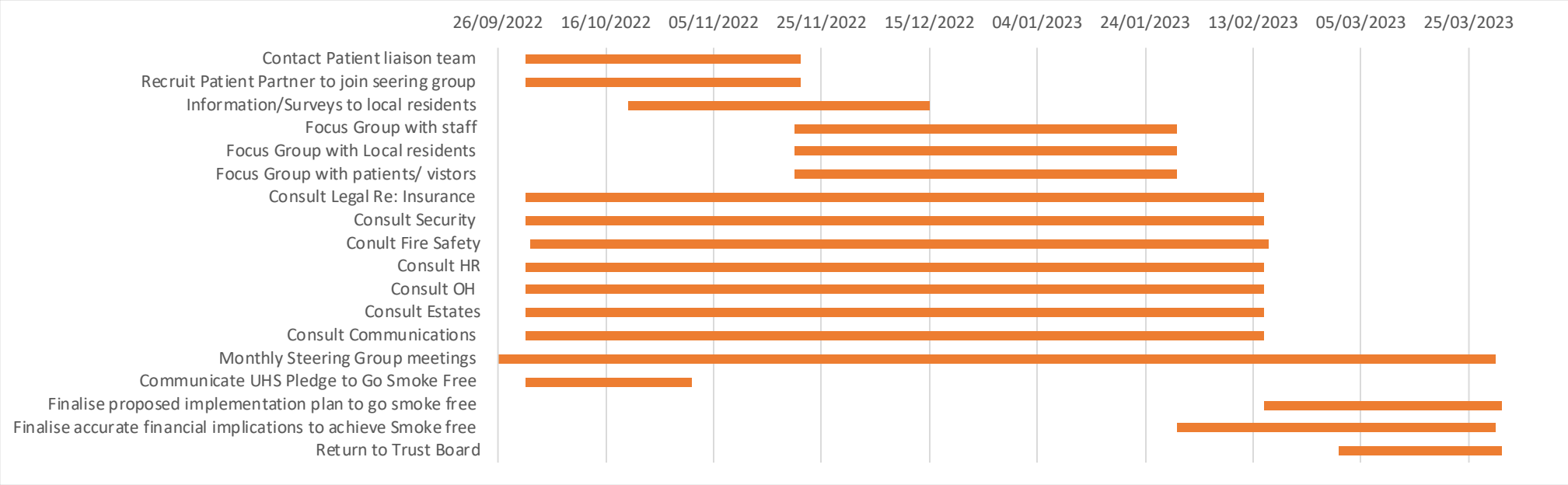
Option	Considerations
1) "Completely Smoke-Free" (by smoke free we mean no smoking anywhere within the Trust and its grounds)	**Benefits** • There is a national drive and expectations set out from the ICS and Public Health that we sign the national NHS smoke free pledge in October 2022. • Improved environment for all. • Shows commitment as a local trust to supporting a healthy lifestyle and environment. • Setting an example as a healthcare provider. • We will look more professional as a Trust. • Underlines commitment to prevent illness. • Cleaner outside space for social interaction. • More welcoming atmosphere. • Reduced secondary smoke. • Potential to link with other health initiatives if some existing shelters are adapted for example to bike sheds e.g., 'we share clean air'. • If we start spreading the smoke free message, even without fully enforcing to start, there is the potential that staff and patients could be more aware of and open to accessing smoking cessation support. This helps us to achieve our overall goal of health promotion. • Reduction in complaints about smoking on site
	Risks • Risk of violence and aggression towards staff if mitigations are not effective. • Risk we could need investment in security staff. • Risk of pushing smoking out into the local residential areas if there are no smoking shelters • Risk of fires if smoking takes place in uncontrolled areas.

	• Increased risk of absconding for those who are currently escorted to shelters but may decide to leave the site to smoke instead. • Risk of increased littering if people do still smoke within the grounds. Also littering outside residential areas could increase, as we would need to remove bins with ash tray part on top, so we aren't promoting smoking. • Risk of union action • Risk of patient or staff safety if going off site for night workers and patients with mobility issues. • Risk of staff taking longer breaks or not enough time to eat food and go for a cigarette. • Smoking staff and patients may feel we are taking away their rights or freedom. • Staff going off site to smoke in uniform.
	Potential Mitigations: • Provide additional training and investment to security • Statutory and Mandatory Training on Smoking Cessation advise and supporting use of NRT • Development of a Smoking Cessation Service within the acute setting • Consideration of acceptance of use of e-cigarettes in trust grounds
	Additional Work Required: • Further consultation with staff, patients, visitors, and local residents through focus groups. • Consult with estates, security, OH, Legal and Fire to determine financial costs. • Invite and maintain engagement from estates, security, OH, legal, Fire and Pharmacy in bi-weekly operational meetings • Continue and maintain good engagement with monthly Steering group meetings • Consult with patient partner and invite to monthly steering group
2) **Midpoint e.g. Smoking Shelters moved to less prominent locations**	**Benefits** • Keeping some shelters encourages a social space for smokers. • Improved impression of site by patients and visitors compared with current locations. • Main entrances and exits more accessible. • Second-hand smoke contained.

	• Slightly less distance for staff and patients to walk to smoke • Less impact on local residents • May be lesser risk of fires.
	Risk • Fails to deliver the correct message on promotion of healthier lifestyles • Reputational impact as we could not fully declare that we are going smoke free and may be the only organisation in the ICS/nationally not doing so. • Smoking shelters at the parimeter could still push some smoking out into the local residential areas and could cause challenges. • Still requires tight management and presence to emphasise staff and visitors using the correct areas – this could bring similar risks of violence and aggression. • More stress for staff having to approach and redirect smokers to shelters. • Causes a grey area if signage isn't clear because we are still allowing smoking in shelters. • Longer to get to an appropriate shelter, people might not bother if it seems like too much effort.
	Additional Work Required: • Further consultation with staff, patients, visitors, and residents through focus groups. • Consult with estates, security, OH, Legal and Fire to determine financial costs. • Invite and maintain engagement from estates, security, OH, legal, Fire and Pharmacy in monthly operational meetings • Continue and maintain good engagement with monthly Steering group meetings • Consult with patient partner and invite to monthly steering group
3) No Change	**Benefits** • Better control over risk of fires • No additional work is required at a time when the healthcare system is under increased operational pressure already. • The smoking population, of both staff and patients, will not experience any change preventing them from smoking as they currently do.

	Risk • Poor impression to visitors and the public • Poor press around not improving the hospital environment and following national guidance. • Reputational impact of not being able to sign up to the NHS smoke free pledge, leaving UHS vulnerable as the only organization locally not doing so. • Not showing enough support to non-smoking staff to make their workplace environment better. • Risk of not supporting staff and patients to quit smoking • Continued complaints from patients and visitors, and staff, who witness smoking on site and therefore are subject to second hand smoke
	Additional Work Required None

Appendix Two: Gantt Chart of Identified Tasks to date



Appendix Three: Outlines how Portsmouth Hospital University NHS trust went 'Smoke Free'

How did PHT go smoke free?

University Hospital Southampton NHS Foundation Trust

- 2 years ago signed up to the NHS pledge to go smoke free
- Promoted smoke free during Stoptober, raising awareness of the changes, and that they would be smoke free from 14th January 2019.
- The team behind this – No project team- committee of individuals, Communication & Engagement Manager, it was the communications team which took ownership of the project, but worked closely with Portsmouth City Council, Volunteers Bureau, and Estates.

- The smoke free pledge was launched by the smoke free action coalition, a clear and visible way for organisations to show their commitment to helping smokers quit and provide smoke free environments which support them. You can sign up here http://smokefreeaction.org.uk/smokefree-nhs/nhs-smokefree-pledge/
- Commit to the actions listed in the pledge, download and get signed by the chair, chief executive, and medical director or clinical lead. Then display somewhere visible so that people can see your commitment.

- 28 day stop smoking challenge led by PHE. Mobile App quit genius can support individuals through the Stoptober challenge. Evidence suggests that those who manage to quit smoking for a period of 28 days are 5 times more likely to remain smoke free for good.

https://www.quitgenius.com/blog/a-guide-to-stoptober-2018

Resource and financials
- Internal communications team budget
- Supplies and information from Portsmouth City Council
- Backed by smoke free policy
- Promotional package with agency - £2500
- Changing smoking signage around the trust - £6000
- No smoking day
- Promotion at yearly open day

How did PHT go smoke free?

University Hospital Southampton NHS Foundation Trust

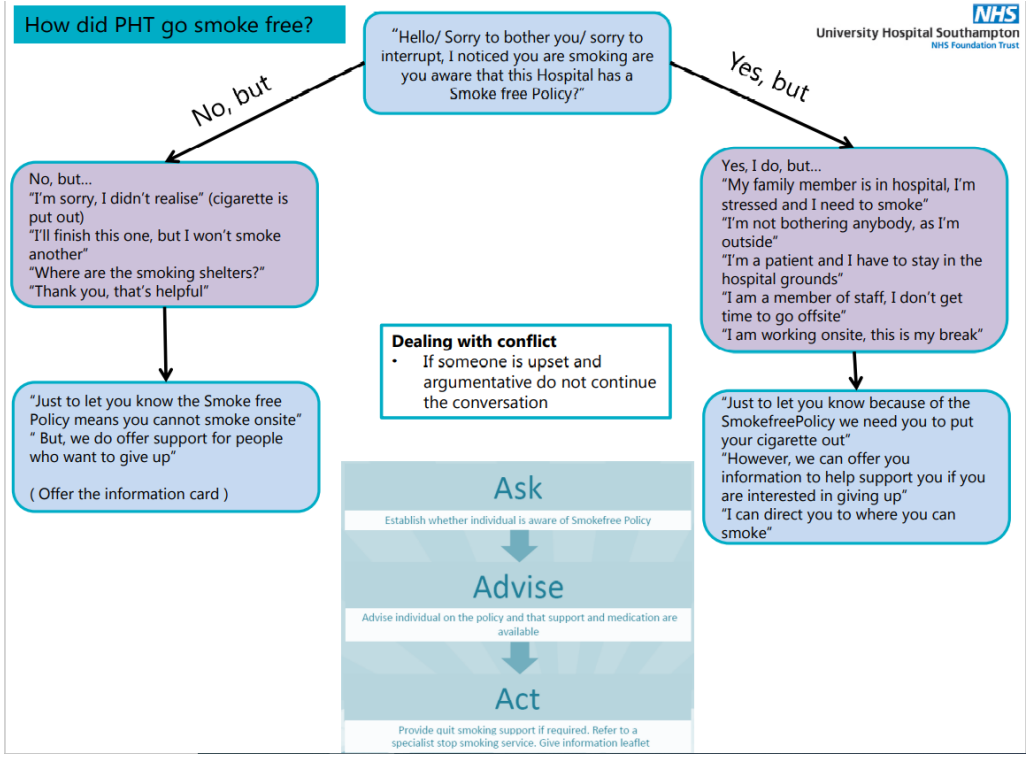
Smoke Free Ambassadors
- 35 smoke-free ambassadors at present. These are volunteers that are happy to approach patients and members of the public smoking on the hospital site. A training course was delivered in conjunction with Portsmouth City Council wellbeing.

Roles of the ambassador
- Represent Portsmouth Hospitals NHS Trust
- Inform patients and visitors of smoke free policy
- Take responsibility for regular social media announcements
- Give out credit card sized handouts
- Provide Brief Advice
- Make appropriate referrals

Skills which make a good ambassador
- Compassion
- Good people skills
- Passion
- Empathy
- Listening skills
- Appropriate body language
- Non-judgemental
- Tactful

Why are they smoking onsite?
Before approaching an individual -
- Take your time…
- Take a slow breath
- Consciously bring your curiosity into play e.g. "I wonder why they are smoking". "I wonder if they are a patient." "I wonder if they have a loved one undergoing treatment". "Are they a staff member".
- Approach them with open body language
- Ask the question
- Listen carefully to the other person
- When you're ready, respond

How did PHT go smoke free?



What interventions are PHT using to be smoke free?

Promotion

- PHT have changed all of their current smoking shelters to bike sheds. It would have cost them a lot of money to have the smoking shelters removed completely so used this as an alternative. They promoted the use of the shelters as bike sheds at their open day by raising awareness for their campaign 'we share clean air' linking up going smoke free with cleaner, healthier ways to travel.
- Vaping is only promoted as a smoking cessation tool instead of cigarettes but it isn't offered as an NRT.

Enforcement

They are trying to convey the message that smoking is an anti-social behaviour. They realise explaining harmful effects to the persons health is not a strong enough reason to encourage someone to leave the grounds to smoke. By making it a behaviour issue then they are almost shaming them which has more of an effect.

Nicotine Replacement Therapy (NRT)

The following is offered to patients whilst receiving inpatient treatment:

- Patches
- Mouth-spray
- Inhalator
- NICE guidelines combination of two products.

Patients will need to be written up a prescription by the pharmacy team if they wish to continue using NRT products once they are discharged from hospital.

Staff

Staff are not allowed to taking patient's outside to have a cigarette. If they aren't well enough to get themselves outside and off the grounds to smoke, then they can either vape on hospital grounds (providing they can get outside themselves) or be offered NRT.

Again they are portraying to the patient that it is an anti-social behaviour and selfish of them to expect to take a nurse away from the ward to take them outside for a cigarette.

Item 1: Pledge card help up by staff/patients/ members of the community to promote going smoke free

Where are PHT at now?

NHS
University Hospital Southampton
NHS Foundation Trust

Phase 2

- 'How to keep the ambassadors engaged'

  Thinking about a monthly raffle (voluntary staff) / to keep the motivation

- Environmental impact on their neighbours

  Initially sending out letters to the neighbours within ¼ mile and keeping lines of communication open to keep strong relations

Dear Resident

Trust Headquarters
F Level, Queen Alexandra Hospital
Southwick Hill Road
Cosham
PORTSMOUTH, PO6 3LY
Tel: 023 9228 6770

Dear resident,

I am writing to let you know that we have taken steps towards Queen Alexandra Hospital becoming a completely smoke free site from Monday 14 January 2019.

Going smoke free means that smoking will not be permitted anywhere on our premises. Whilst smoking rates have declined in Portsmouth over the last few years the levels are still higher than the national average – as too are the deaths rates due to smoking in Portsmouth. In fact, almost 1 in 5 of all deaths in Portsmouth can be directly attributed to smoking.

As one of the one of the largest employers in Portsmouth and one of the busiest acute hospitals in the UK, I believe we have a responsibility to help reduce rates of smoking and, in turn, the serious illnesses related to it. As a result, we are not only making QA a smoke free site, but also doing our part to help support people who wish to quit smoking for good.

Our staff are being trained to help smokers refrain from smoking while in our care. Patients admitted either as an emergency or planned admission will be offered nicotine replacement therapy (NRT) and will be offered a referral for ongoing support. We also have a number of 'Smoke Free Ambassadors' who have been trained to offer smokers details of our new smoke free policy as well as offer them advice on how to quit for good.

We are aware that becoming a smoke free site may have an impact on our local community and we have been working closely with partner organisations such as Portsmouth City Council to ensure that smoking related littering is kept to a minimum in the areas directly surrounding our hospital site. However, should you have any concerns in this area, please go to www.portsmouth.gov.uk/ext/community/community-wardens to report the issue or call 023 9282 2251.

Our hospital has benefitted from the support of our local community over many years and I hope you agree that our decision to become smoke free is in the interests of our patients, our staff and our local community.

Yours sincerely,

Mark Cubbon
Chief Executive

Portsmouth Hospitals Smoke Free Policy: Important points

University Hospital Southampton
NHS Foundation Trust

QUICK REFERENCE GUIDE

1. Patients and visitors are not permitted to smoke cigarettes within Trust buildings or on Trust grounds. E-cigarettes are permitted in the hospital grounds but away from doors and windows.

2. Staff are not permitted to smoke in, or on, any part of the Trust site. Staff may use e-cigarettes but should ensure their uniform is covered up and they are not identifiable as 'on duty' staff.

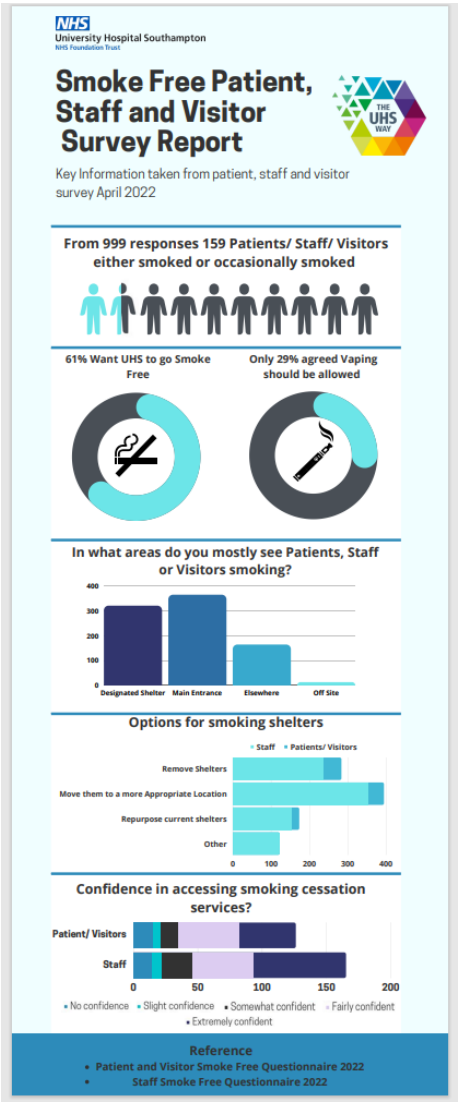
3. Uniformed staff are prohibited from smoking whilst in their uniform and whilst on duty. This includes refraining from smoking in vehicles when travelling on Trust business e.g. between home visits.

4. When attending meetings or other events at venues where smoking is permitted, staff are expected not to smoke because:

- they are representing the Trust
- it is important not to expose others to passive smoke.

5. We aim to promote and develop a culture across all our buildings and sites that smoking is not acceptable, and that everyone respects this. Shifts in culture and behaviours can take time and will not be achieved simply by enforcing policies. The required culture change will be achieved by staying committed to smoke-free as it becomes everyday behaviour. When people do smoke on our grounds, we will see this opportunity rather than a failure or breach of the Policy and respond accordingly.

Appendix Four: Survey Data Infographic



University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Register of Seals and Chair's Actions**			
Agenda item:	**7.1**			
Sponsor:	**Jenni Douglas-Todd, Chair**			
Date:	**29 September 2022**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification** **Y**	**Information**
Issue to be addressed:	This is a regular report to notify the Board of use of the seal and actions taken by the Chair in accordance with the Standing Financial Instructions and Scheme of Delegation for ratification.			
Response to the issue:	The Board has agreed that the Chair may undertake some actions on its behalf. There have been no seals affixed since the last report.			
Implications: (Clinical, Organisational, Governance, Legal?)	Compliance with The NHS Foundation Trust Code of Governance (probity, internal control) and UHS Standing Financial Instructions and Scheme of Delegation.			
Risks: (Top 3) of carrying out the change / or not:				
Summary: Conclusion and/or recommendation	The Board is asked to **ratify** the Chair's actions.			

1 Signing and Sealing

There have been no seals affixed since the last report.

2 Chair's Actions

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

2.1 **Award of contract** for the annual rental charge for the Multi-Storey Car Park at Adanac Park, Southampton, to Canada Life Limited. The contract is for a 40-year lease between Canada life and the UHS Trust, at a total contract cost of £25,696,600 excluding VAT. Approved by the Chair on 5 September 2022.

2.2 **Award of a call-off contract** for the provision of services at Nuffield Health Hospital, Southampton, under the Increasing Capacity Framework agreement, for 36 months at a cost of up to £3,000,000 excluding VAT. Approved by the Chair on 6 September 2022.

2.3 **Award of a call-off contract** for the provision of services at Practice Plus Group, Southampton, under the Increasing Capacity Framework agreement, for 24 months at a cost of up to £1,000,000 excluding VAT. Approved by the Chair on 13 September 2022.

3 Recommendation

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

Report to the Trust Board of Directors				
Title:	**Health and Safety Annual Report 2021-22**			
Agenda item:	**7.3**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Jane Fisher, Head of Health & Safety Services**			
Date:	**29 September 2022**			
Purpose:	**Assurance or reassurance** √	**Approval**	**Ratification**	**Information** √
Implications: (Clinical, Organisational, Governance, Legal?)	1. Staff may suffer injury or illness which could result in litigation (personal injury claims), staff may leave, and recruitment opportunities affected. 2. Regulatory enforcement action by the Health & Safety Executive (HSE) or Care Quality Commission (CQC) 3. Non-compliance with industry and national standards 4. Reputational damage to the Trust.			
Risks: (Top 3) of carrying out the change / or not:	As above.			
Summary: Conclusion and/or recommendation	The Health & Safety Services Department continues to provide advice, guidance and support to staff at all levels of the Trust to ensure that a positive health and safety culture is embedded into the Trust's activities. Members of Trust Board are asked to continue to support the following key safety matters via their senior management and operational teams; • Ensure all health and safety-related hazards are identified, risks are assessed and controlled appropriately, with suitable action plans for improvements in place. • Ensure that workstation assessment checklists are completed and reviewed on an annual basis. • Promote the "No Excuse for Abuse" campaign and encourage staff to report violence and aggression incidents. • Ensure safety sharp devices are used correctly, and safe systems of work are followed. • Ensure all staff working in high-risk pathways and/or involved in aerosol-generating procedures are fit tested to two models of FFP3 mask (including PeRSo respirators, where appropriate). • Monitor and challenge the lack of or incorrect use of personal protective equipment/clothing (PPE); ensure that poor compliance is managed appropriately. • Actively encourage staff to report near miss incidents so that serious accidents can be prevented. • Check the accuracy of adverse event reports and correct any reporting discrepancies as soon as possible. • Record all work-related absences on HealthRoster (tick the "Industrial Injury" box) and report the case directly to the H&S Team within 24 hours of such absences being notified.			

1. Introduction

This report provides a summary of the activities carried out by the Health & Safety Services Department, including health and safety (H&S), moving and handling (M&H) and mask fit testing.

The Health & Safety Services Department continued to advise, guide and support staff at all levels to ensure that a positive health and safety culture is embedded into all of the Trust's activities.

The Corporate Health & Safety Committee (CHSC), chaired by the Chief Nursing Officer (CNO), met quarterly; it monitors the Trust's activities in relation to staff health and safety, moving and handling and FFP3 resilience, receiving quarterly reports from all three services. The committee also received quarterly reports on staff health and safety compliance from Divisional Risk and Governance Groups and key supporting departments (EFCD, Occupational Health, Claims and Insurance Services).

Appendices are provided with summaries of the reported adverse event statistics (for health and safety, moving and handling and violence and aggression), the face fit testing service and the in-house, self-assessed health and safety audits, from 1st April 2021 to 31st March 2022.

2. Summary of Activities

The three services continued to support pandemic-related activities, in particular advising on social distancing and Covid-safe policy compliance and supporting the FFP3 mask fit testing service.

Other Covid pandemic-related support has included;

- Working with the Fire Safety team to advise the Estates Small Works department on conversion of non-clinical areas to office space, to further enable social distancing of staff in these areas.
- Providing support, advice and guidance to the staff at the Hampshire and Isle of Wight Saliva Testing Programme at Chilworth with regular site visits; the contracted Health & Safety Officer role proved to be extremely valuable, and the onsite presence ensured that all contractors (and staff) followed safety rules and practice appropriately.
- Contributing to the outbreak meetings led by the Infection Prevention & Control team, to ensure that lessons are learned and implemented when pockets of Covid infections arise within the hospital.
- Continuing to support working from home for many colleagues, with wellbeing and ergonomic advice and assessments.
- Covid-Secure walkabouts and reviews; working with the IP&C and EFCD Teams to ensure that the Trust implemented and maintained the national and UHS Covid-19 guidance.
- Providing advice, support and contributing to the weekly IP Gold Command meetings.

These activities have been carried out in parallel with much of our "business as usual";

- "Alert, Advise and Assure" reports were provided to the Quality & Governance Steering Group (QGSG) as required.
- Meetings with the Health & Safety and Moving & Handling Leads continued bi-monthly.
- Monitoring reported accidents and incidents and supporting managers with investigations to ensure that lessons were learnt and implemented to prevent reoccurrence.
- Collaboration with Occupational Health to support staff returning to work and for assessment of workplace adjustments.

- Advising local Health and Safety Leads and Moving and Handling Trainers on matters that concern them and their local teams; there are currently 104 active Health and Safety Leads and 111 Moving and Handling Trainers, although some of these role-share, and some cover more than one ward/department or team.
- Ongoing peer reviews for the new and current M&H trainers; this process provides assurance that the local trainers are/remain competent to train others in people handling.
- Supporting the MEP bids and Rolling Replacement Programme for hoisting and manual handling equipment across the Trust; working with suppliers and manufacturers to demonstrate and trial new and specialist equipment.
- Assisting clinical staff with complex patients/care needs to ensure both staff and patients remain safe (advising on risk assessments, delivering bespoke training and identifying appropriate equipment).
- Supporting staff and line managers to complete the annual DSE/workstation self-assessments; ongoing reminders are sent out to ensure staff review their workstation annually.
- Supporting the "No Excuse for Abuse" campaign to raise awareness that violence and aggression towards staff is not acceptable and perpetrators may be prosecuted. The policy was reviewed and updated by the H&S team, with consultation across the Trust, to reflect the way UHS manages violence and aggression and supports its staff to report incidents to the police; it has been renamed as "The Prevention and Management of Abuse, Violence and Aggression Towards Staff".
- Delivering health and safety and moving and handling training to staff at all levels, and the introduction of two new health and safety training courses;
  - "H&S Risk Assessment Awareness for Line Managers" – to help managers who counter-sign risk assessments to understand what makes a good risk assessment and why a manager's agreement is important.
  - "Incident Investigation Techniques" – a course aimed at those who investigate and close out incidents on the Ulysses Safeguard Reporting system, to help their understanding of what and how information should be included.
- Ensuring that the Health and Safety, Moving and Handling and Fit Testing pages of Staffnet are kept up to date and include the latest information to act as a 'One-Stop Shop' for the latest information and guidance.
- Regular liaison and co-operation with non-Trust organisations including Serco and the University of Southampton, particularly in response to incidents that affect them as well as UHS.

3. Summary of the Face Fit Testing Service and FFP3 Resilience

The central mask fit testing service continued to be delivered by an external provider with two external fit testers on site Monday to Friday (8.30am to 4.30pm); this has been funded by the Department of Health & Social Care, in response to the Covid-19 pandemic and as part of the national FFP3 Resilience Strategy.

This service was extremely well received and grew as the number of staff who needed a fit test increased, but also because care groups could no longer support the in-house model of providing fit testing; an average of 250 fit tests are completed in the central hub each month.

n.b: funding for this service will end in March 2023 and all Trusts are expected to fund their own fit testing services in order to meet the requirements of the national FFP3 Resilience Strategy.

PeRSo 3.2 respirators were given national approval for use in healthcare settings beyond the pandemic, and a programme to upgrade all units was successfully completed. All resources and training materials have been reviewed and updated and are available on Staffnet.

An overview and summary of fit testing and FFP3 mask/PeRSo usage is provided in Appendix 3 and a summary of our response to the FFP3 Resilience Strategy is provided in Appendix 4.

4. Management of Health & Safety-related Risks

Line managers are required to sign off health and safety risk assessments and action plans as part of the risk management process, and there is a formal requirement to indicate how the assessments have been communicated to staff.

All departments and care groups report on health and safety-related risks identified in their risk registers to their respective divisional governance groups and are noted by the CHSC.

There were no specific health and safety-related risks escalated to TEC (staff wellbeing and low morale was highlighted in divisional risk registers).

However, there are still some risk issues across the Trust that the department is trying to support;

- Ward/Dept based M&H trainers are still needed in each division; recruiting local M&H trainers has been an ongoing issue for clinical areas in particular, due to pressures in the services, which has meant that staff cannot be released to undertake the training, and this impacts on overall training compliance.
- Significant difficulties booking suitable rooms for teaching practical M&H sessions; the lack of training facilities meant that we could not offer as many courses as was needed. Alternative external venues were explored and a new training room, owned by Direct Healthcare Group (DHG) in Romsey, has been offered free of charge and is being used for train-the-trainer and refresher courses.
- Visits to satellite sites could not be accommodated due to capacity in the small H&S Team and the covid restrictions, however mask fit testing was supported at SGH and at the RSH, and regular onsite support provided to the staff at the Saliva Testing Laboratory in Chilworth in order to manage specific issues to keep the programme on track.

5. Enforcement Agencies

There were no inspections or enforcements issued by the Health & Safety Executive (HSE) this year.

6. Health & Safety-related Policies

Review of the Health & Safety policy was delayed due to the pandemic (a thorough review has recently been undertaken; the revised policy was submitted to the CHSC in July and will be ready for publication in September 2022).

7. Proactive Monitoring: Inspections and Audits

The programme of inspections and tours could not be resumed due to the ongoing pandemic restrictions, but also due to lack of capacity in the small H&S Team, which meant that there was no formal monitoring of the management of health and safety within wards or departments.

This year's annual internal health and safety self-audits were conducted using an online Microsoft Forms survey, with the intention of making it easier for wards/departments to respond. The online format also enabled us to target questions for particular respondents and analyse/evaluate compliance more effectively.

A summary of the health and safety self-audit findings is provided in Appendix 5.

The dangerous goods safety audit programme was completed by the contracted external company who act as the Trust's Dangerous Goods Safety Adviser (DGSA).
The recommendations for action were communicated to the relevant departments to include in their action plans. Common themes were similar to last year;

- security of waste in compounds and stores,
- poor segregation of different types of waste by wards/departments
- correct labelling of packages being sent outside the Trust.

Actions have generally been completed, although they will not be considered closed until formally declared complete at the next DGSA visit to the relevant departments.

Biological safety advice continued to be provided via an honorary contract with the University of Southampton's Biological Safety Adviser. The Covid restrictions limited the usual onsite visits and support, but advice was provided remotely where applicable.

8. Reactive Monitoring: Statistical Summaries of Adverse Event Reports (AERs)

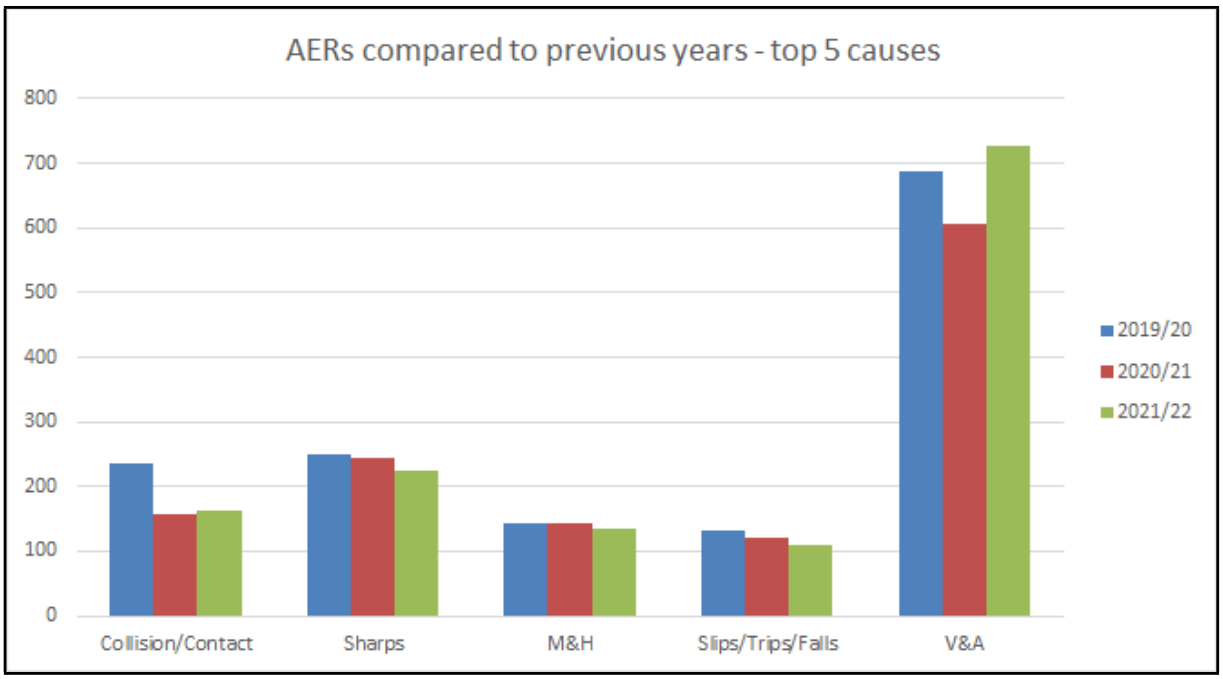
8.1 Adverse Events Involving Staff and Visitors

Compared to the previous year, "All Incidents" numbers (which include violence and aggression) rose by 6.9%. However we need to be cautious about comparisons with pandemic years and compared to the last non-pandemic year "all incidents" were down by 15%.

Violence and Aggression incidents can relate to either patients acting aggressively as a result of their clinical condition, or for no identifiable clinical reason: although these categories are separated for RIDDOR incidents, unfortunately the way that the Ulysses Safeguard reporting system records violence and aggression means that they cannot be easily separated for "all incidents".

A summary of the health and safety-related AERs is also provided as an infographic poster in Appendix 1 (a breakdown of the specific incident causes was presented to the CHSC).

Year	H&S AERs	V&A AERs	Total
2018/19	1993	592	2585
2019/20	1902	687	2589
2020/21	1441	605	2046
2021/22	1455	733	2188



8.2 RIDDOR Reportable Incidents

A total of thirty-five (35) incidents were reported under the Reporting of Injuries, Diseases & Dangerous Occurrences Regulations (RIDDOR), with causes remaining the same as previous years; (moving and handling, and slips, trips and falls are the main causes).

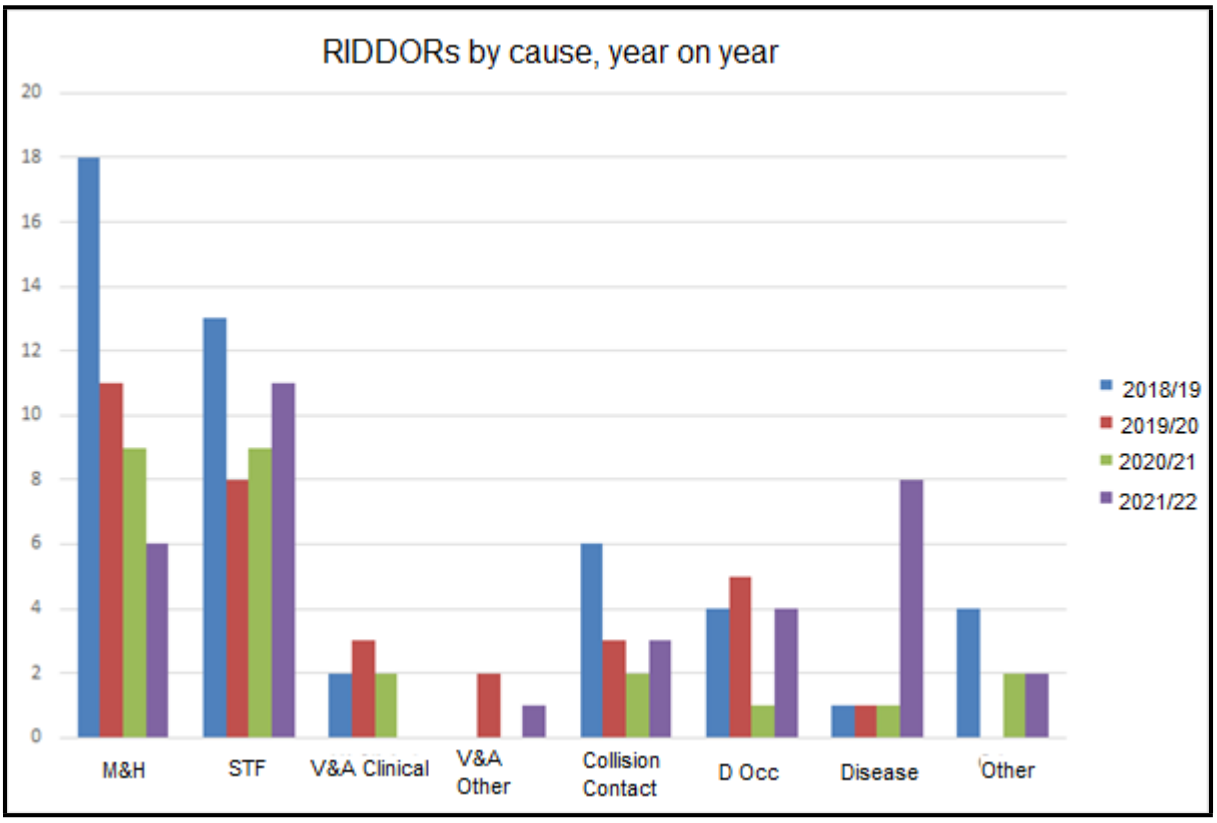
The profile of staff types affected by RIDDOR incidents remains very similar to previous years, and broadly reflects the numbers of staff in each of the staff groups, so the proportions are generally what would be expected.

RIDDOR incidents are reported to the Health and Safety Executive by the Health and Safety Services Team, following investigations conducted locally in wards/departments and followed up by the H&S Adviser, M&H Adviser and/or the Head of H&S Services.

The Trust has a legal obligation under RIDDOR to investigate, review and report cases where staff have contracted corona virus that is work-related. Line managers investigate and follow-up such cases (as with other sickness absences) and refer to the H&S Team to investigate further if necessary.

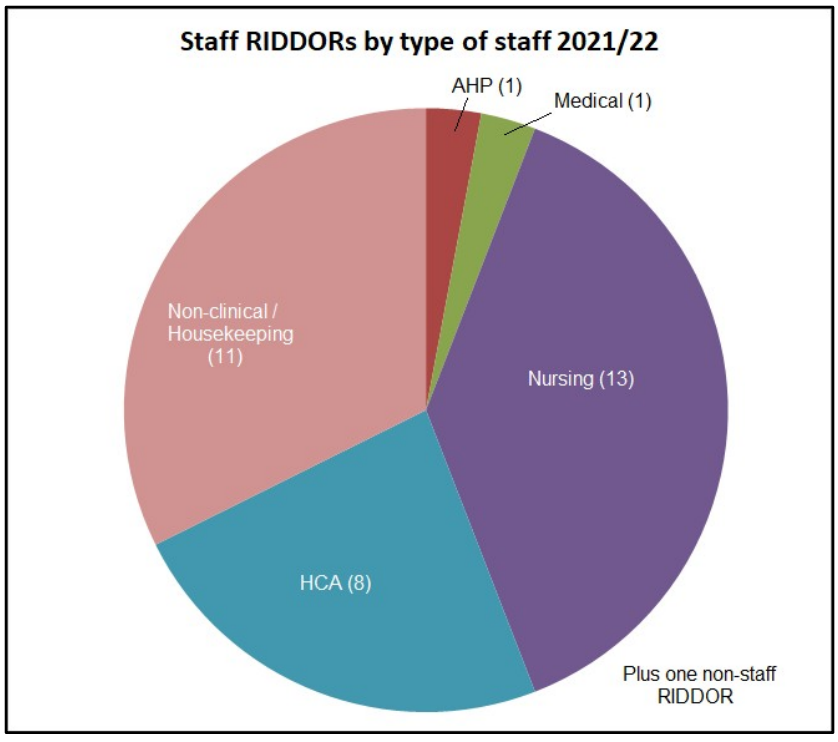
All RIDDOR reportable incidents are reviewed at a monthly RIDDOR review panel to ensure investigations have been carried out appropriately, to identify any outstanding actions and the lessons learnt to help prevent recurrence, and to monitor cases for emerging trends.

The trend of numbers of RIDDOR reportable incidents over the past four years
2018-19 = 48 / 2019-20 = 33 / 2020-21 = 26 / 2020-21 = 35



Note:
"Violence and Aggression – Clinical" refers to incidents where patients are acting aggressively as a result of their clinical condition or their behaviour is affected by prescription medication.

"Violence and Aggression – Other" incidents are those where staff are affected by patients or their visitors or chaperones acting aggressively without any clinical cause. These are separated into different incident types and although the effect on staff is generally the same, the causes have to be managed differently.

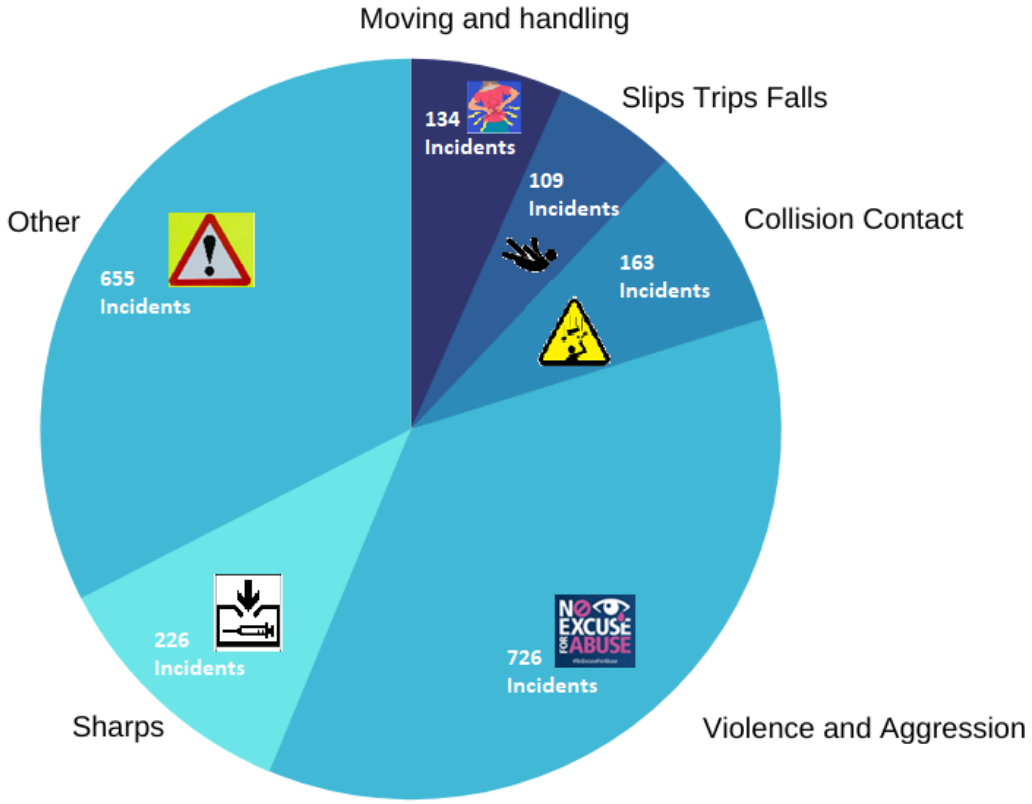


Health and Safety AERs
Trust year 2021/2022

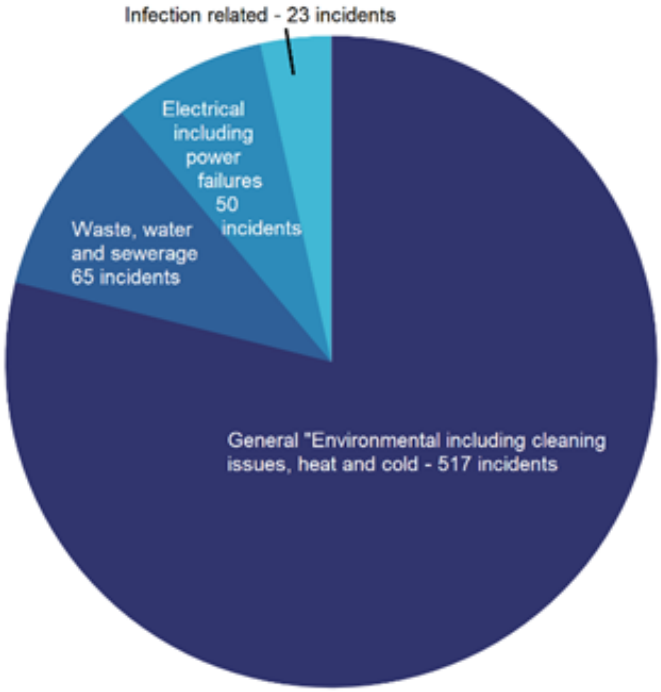
University Hospital Southampton NHS Foundation Trust

SUMMARY INFOGRAPHICS FOR H&S-related INCIDENTS and TRAINING 2021-2022

Adverse Event Reports (AERs)



Incidents classified as "other causes" above - not directly health and safety related



HSE Health and Safety Executive

UHS Incidents reportable to the Health and Safety Executive under the RIDDOR Regulations - Trust year 2021 - 2022

1 x Allied Healthcare Professional

1 x Doctor or Consultant

13 x Nursing

8 x HCA

11 x Housekeeping / non-clinical

1 x patient or member of the public

HSE Health and Safety Executive

UHS Incidents reportable to the Health and Safety Executive under the RIDDOR Regulations - Trust year 2021 - 2022

6 x Moving and Handling / Musculoskeletal

11 x Slips / Trips / Falls

4 x Dangerous Occurrence (sharp)

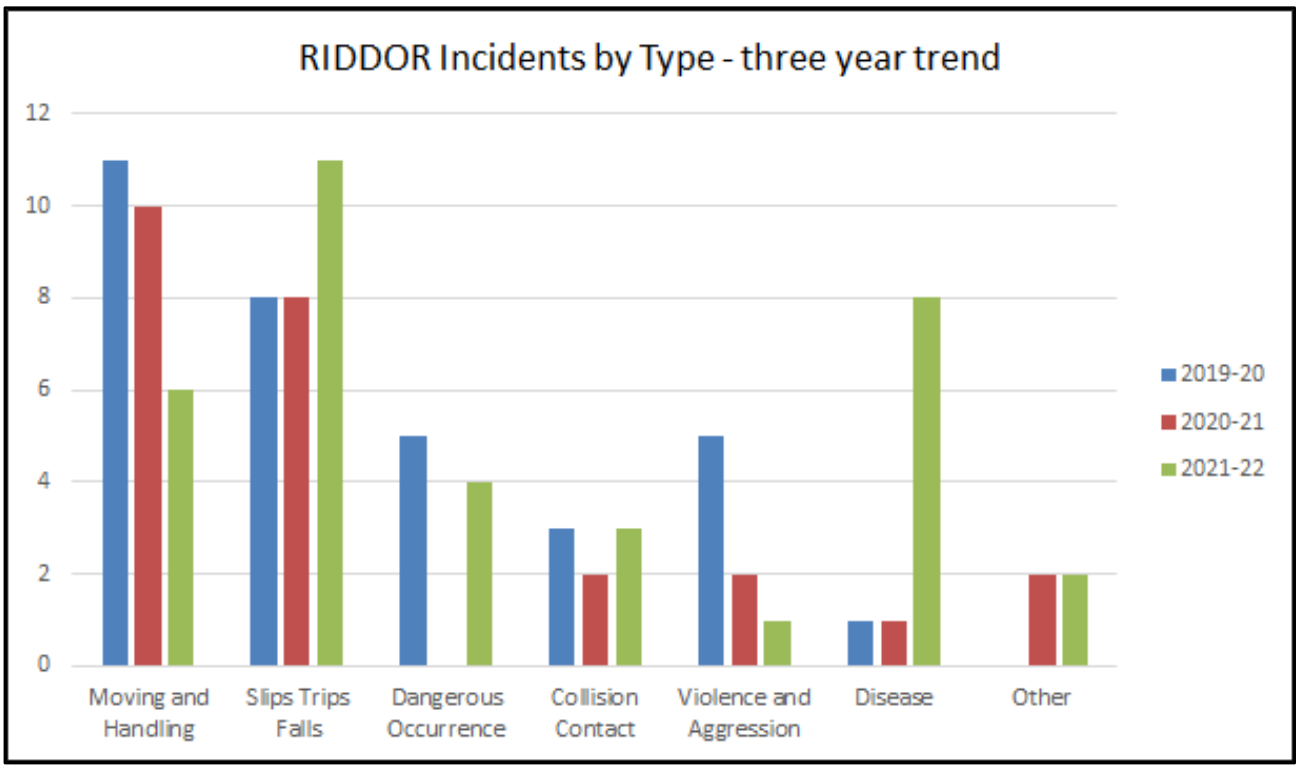
3 x Collision / Contact

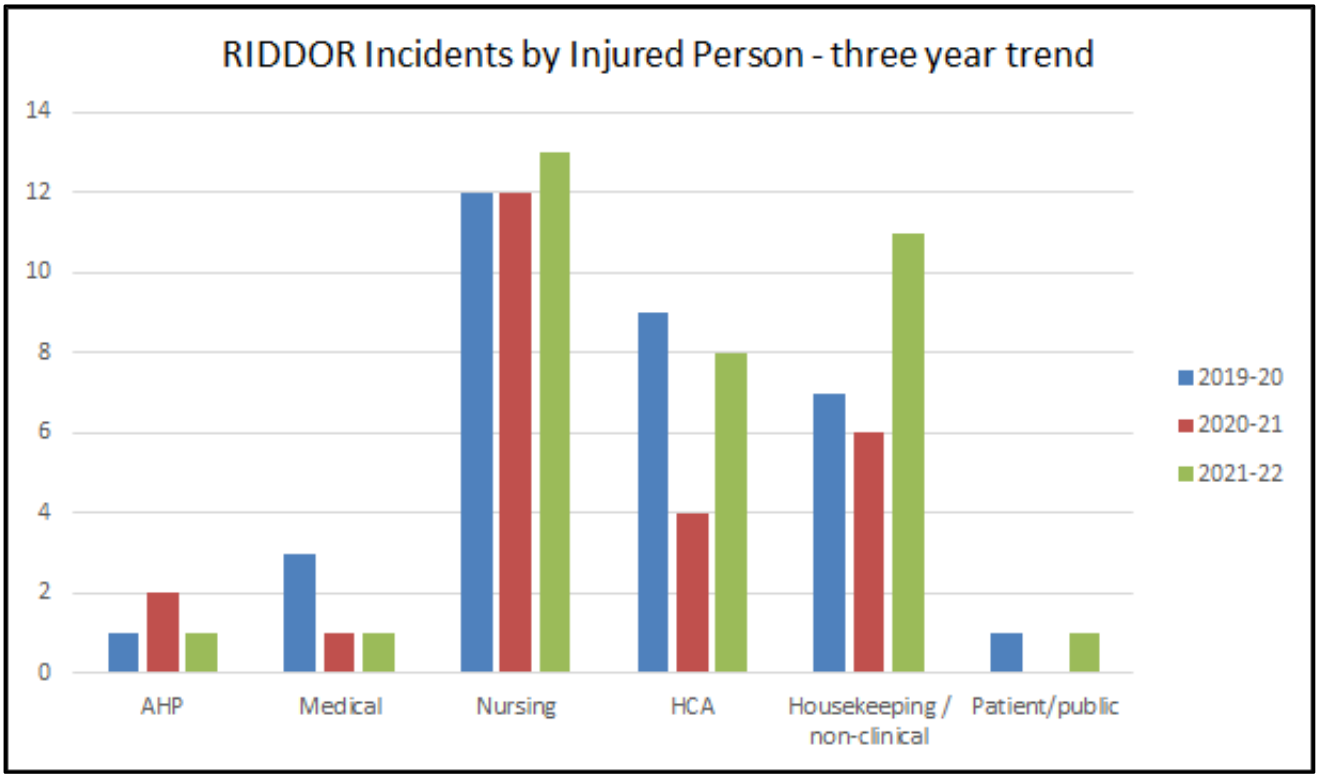
1 x Violence and Aggression

8 x Covid-19 or other reportable disease

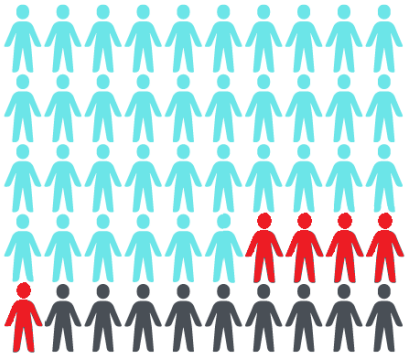
2 x "other incident" (1 x electric shock, 1 x hit by falling patient)

Summary of RIDDOR Reportable Incidents



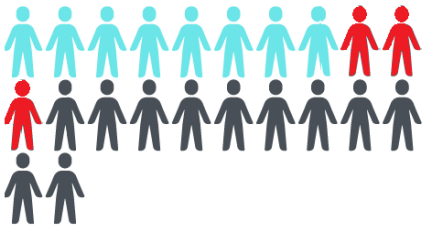


Health and Safety Training Attendance 2021-22



H&S Leads:
Places available: 50
Bookings: 41
Attendances: 36

Risk Assessment:
Places available: 50
Bookings: 38
Attendances: 34



COSHH:
Places available: 22
Bookings: 11
Attendances: 8

Risk Assessment Awareness for Line Managers:
Places available: 18
Bookings: 4
Attendances: 4

Incident Investigation for Line Managers:
Places available: 18
Bookings: 4
Attendances: 4

= attended as booked

= booked but did not attend

= place available but not booked

Moving and Handling Training Attendance 2021-22

Moving and Handling train-the-Trainer for Clinical Leads:

Places available: 60
Bookings: 52
Attendances: 39

"Places available" does not include sessions which had to be cancelled because of trainer absence

Moving and Handling refresher for Clinical Leads:

Places available: 22
Bookings: 11
Attendances: 8

Moving and Handling train-the-Trainer for Non-clinical Leads:

Places available: 22
Bookings: 12
Attendances: 10

= attended as booked

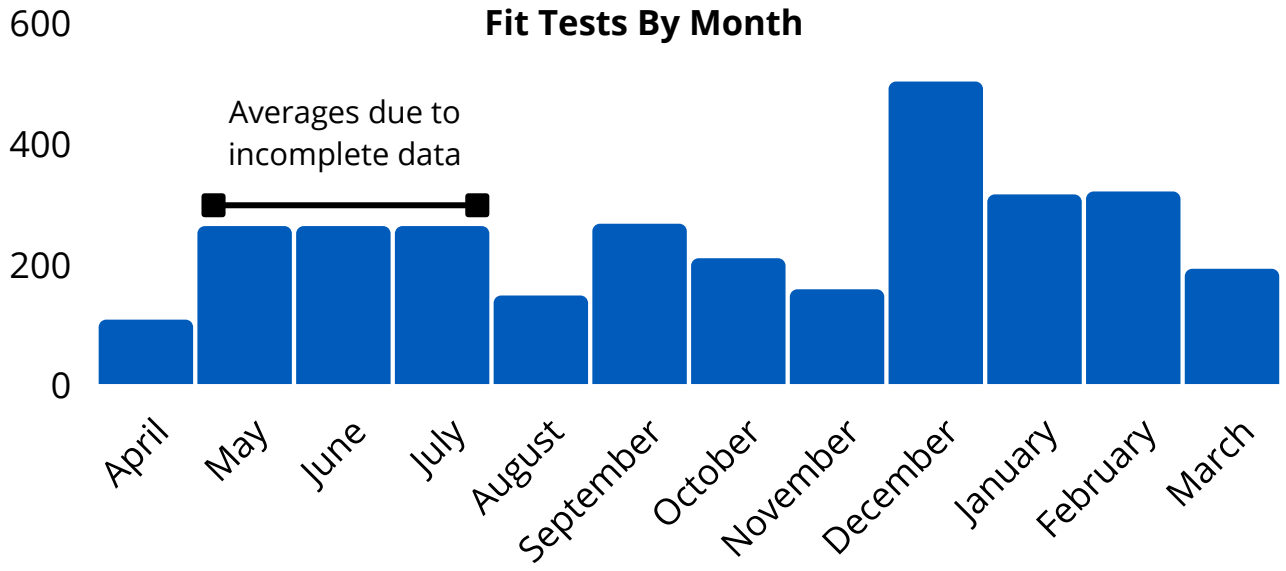
= booked but did not attend

= place available but not booked

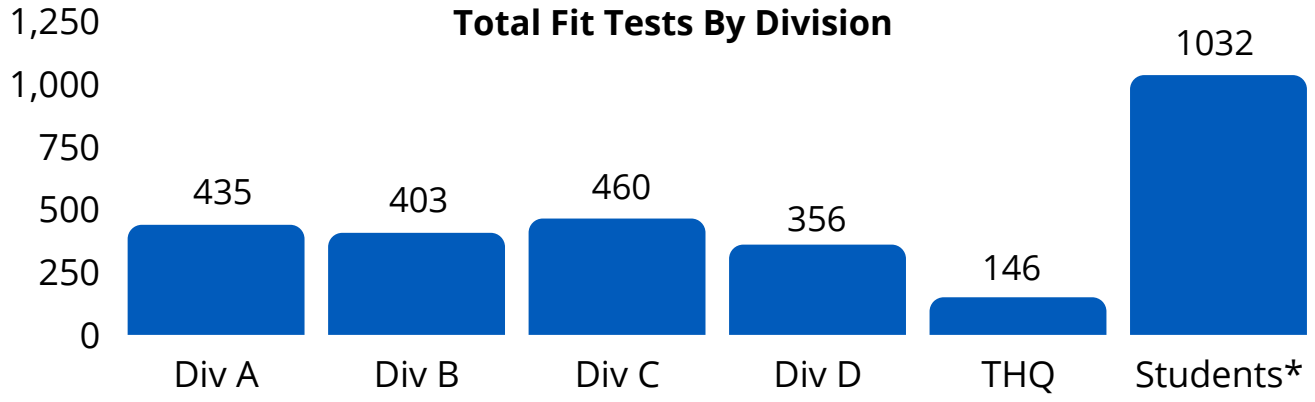
UHS FFP3 And Fit Testing 2021/2022

Fit Testing Overview

In the financial year 2021/2022, a total of 2920 fit tests were undertaken at UHS. 2832 (96.9%) of these fit tests were carried out by the Central Fit Testing Hub which is currently staffed by Ashfield Healthcare. Each month an average of 250 staff are fit tested with a 92% pass rate.



Throughout 2021/2022, ten disposable FFP3 masks were available to staff and two reusable FFP3 options (PeRSo and 3M 7500 reusable face mask). In line with the FFP3 resilience, guidelines fit testers aimed to keep the amount of staff fit tested to each mask below 25%.

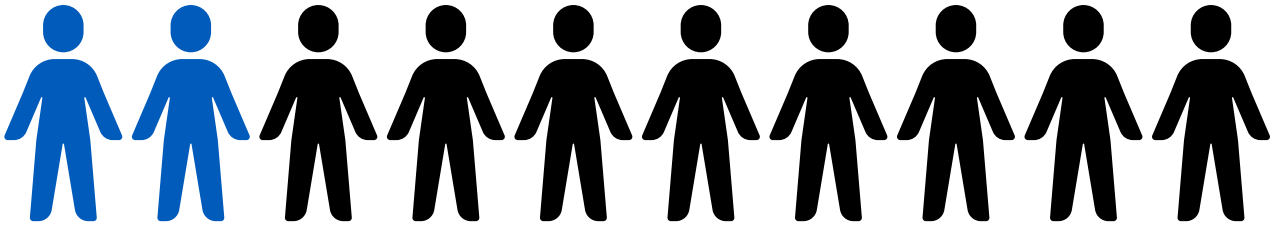


*An average of 86 students fit tested each month.

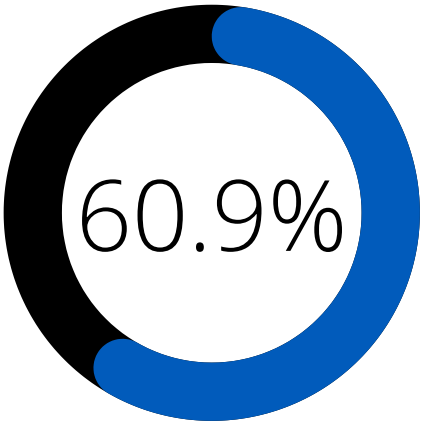
In March 2022, 35% of fit tests carried out resulted in a pass on the GVS F31000 mask. In response to this, we requested staff to book a fit test appointment and be tested to a different mask. Since March 2022 we have limited the amount of staff fit testing to GVS masks and have managed to considerably decrease the reliance UHS has on GVS F31000 masks.

Fit Testing Training

39 Portacount Fit Testers Trained



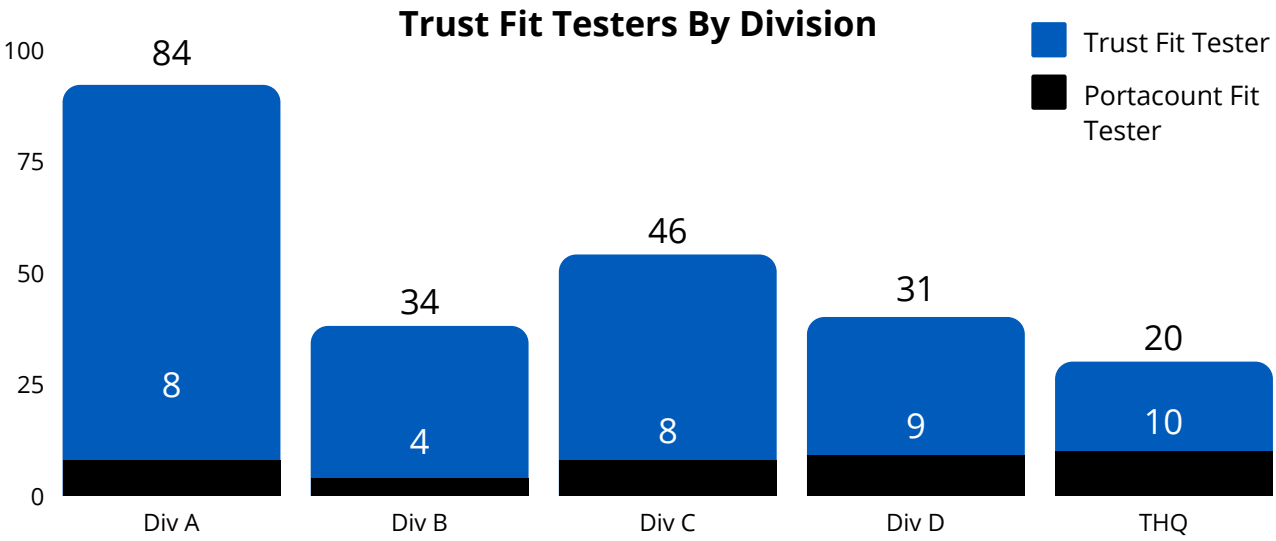
215 Total Fit Testers At UHS



Of Portacount training places filled.

In 2021/2022 we continued to provide fit testing training sessions. Over the year, eight Portacount training sessions were provided by external trainer RPA with a total of 39/64 (60.9%) places filled.

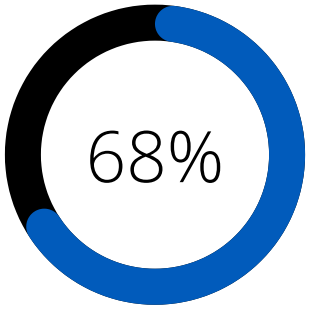
The total number of trained fit testers at UHS is now 215. 39 of these fit testers have been trained to fit test using the Portacount method of fit testing and all 215 fit testers have been trained to use the hood/taste method.



In March 2022, Sam Carter-Chappell joined the Health and Safety team as Lead Fit Test Trainer. This new role will enable the Trust to become independent in its training of fit testers. The role will also allow the Trust to work in line with the FFP3 Resilience Principles which will become part of the EPRR Principles in 2022.

PeRSo Respirators

In December 2021, the Trust began the rollout of the 3.2 PeRSo Respirator upgrade. The 3.2 upgrade replaces the hose and filter to bring the respirators in line with the BFI standard.

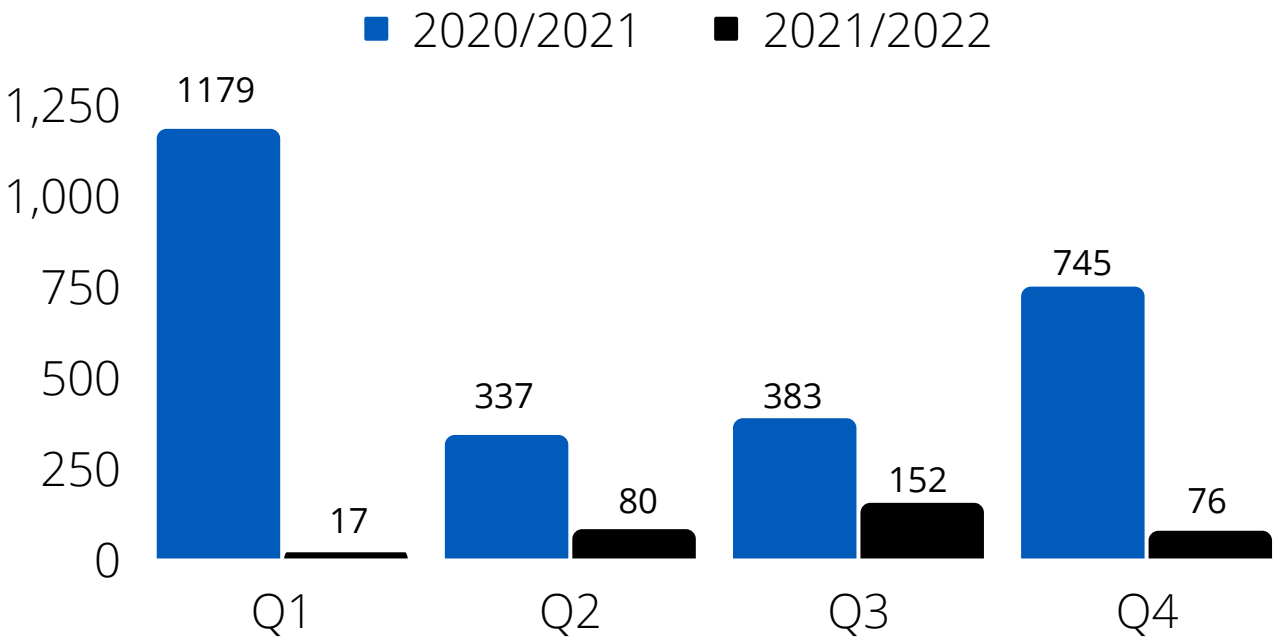


Of PeRSo Respirators were upgraded between December 2021 and March 2022.

- 2289 PeRSo Respirators have been serviced and upgraded (Between December 2021 and March 2022).
- 369 PeRSo Respirators were issued to staff in 2021/2022.
- 3352 PeRSo Respirators have been issued to staff since September 2020.

The PeRSo team are continuing to upgrade all remaining PeRSo Respirators and will be expected to complete the upgrade in Q2.

Number of PeRSo Respirators Issued By Quarter



There has been a tail-off of PeRSo Respirators issued to staff in the past financial year. However all PeRSo Respirators issued to staff will continue to need servicing every six months in order to keep in line with the BFI standards.

University Hospital Southampton FFP3 Resilience Report

DHSC has set five FFP3 resilience principles that Trusts are expected to follow as part of their FFP3 strategy. At UHS we are currently working in line with all five of these principles and have a detailed strategy to become fully compliant within the next 12 months.

1 All FFP3 users should be fit tested to two different masks (ideally three)

UHS Strategy

- We have 10 different FFP3 masks available in the Trust.
- All new fit tests aim to fit test staff to two masks.
- Staff are required to get fit tested every two years

2 FFP3 users should rotate between the FFP3 masks they are fit tested to

UHS Strategy

- We have created posters reminding staff to rotate the masks they use.
- Rotating FFP3 masks will help with supply issues and help protect user's skin integrity.

3 Trusts must ensure that less than 25% of staff are fit tested to each FFP3 mask.

UHS Strategy

- We monitor mask usage quarterly and keep track of rising trends in reliance to one mask type.
- We have lowered the percentage of staff fit tested to GVS and Alpha masks from 30% to below 25%.

4 Front line stocks will be managed at no more than 7-10 days per SKU

UHS Strategy

- We have a detailed 'Trust Position' which tracks how many days of stock we have of each FFP3 mask. Our current stock levels for FFP3 masks are between 18 and 484 days.

5 Trusts must record fit testing results on ESR and review usage every quarter.

UHS Strategy

- We have developed a new digital fit test record sheet which automatically updates fit testing records on HealthRoster and VLE.
- We have confirmed with Ashfield Engage that the current data recording method used in the Trust meets the DHSC standard and that we do not need to use ESR to record data.

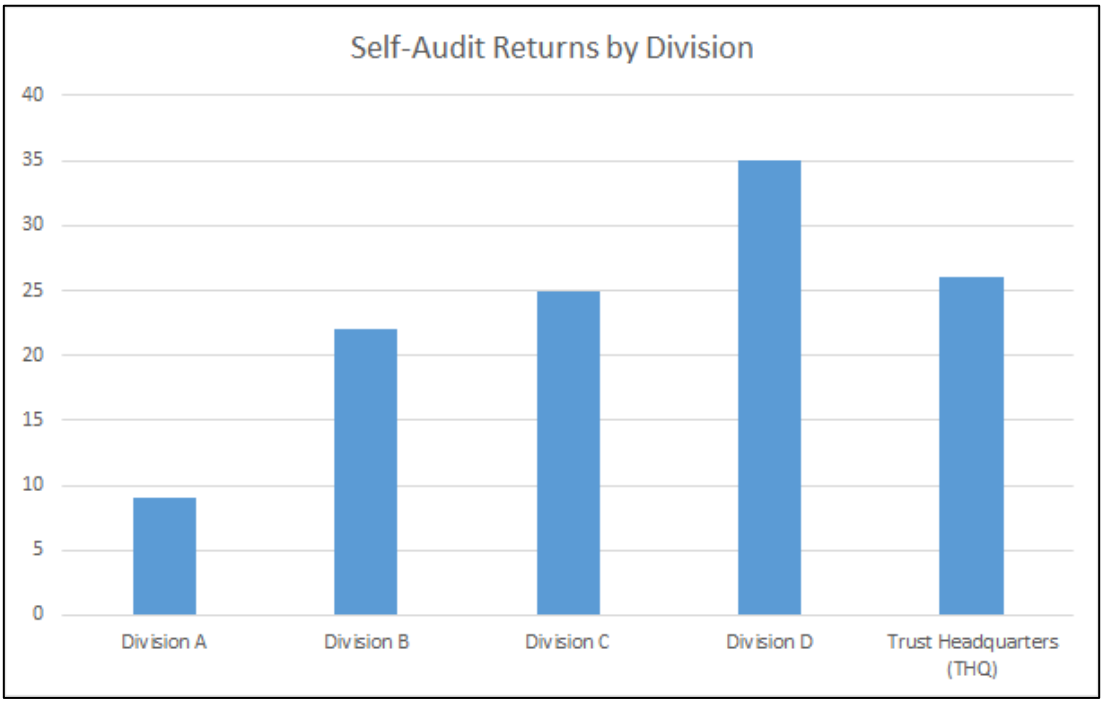
Appendix 5:

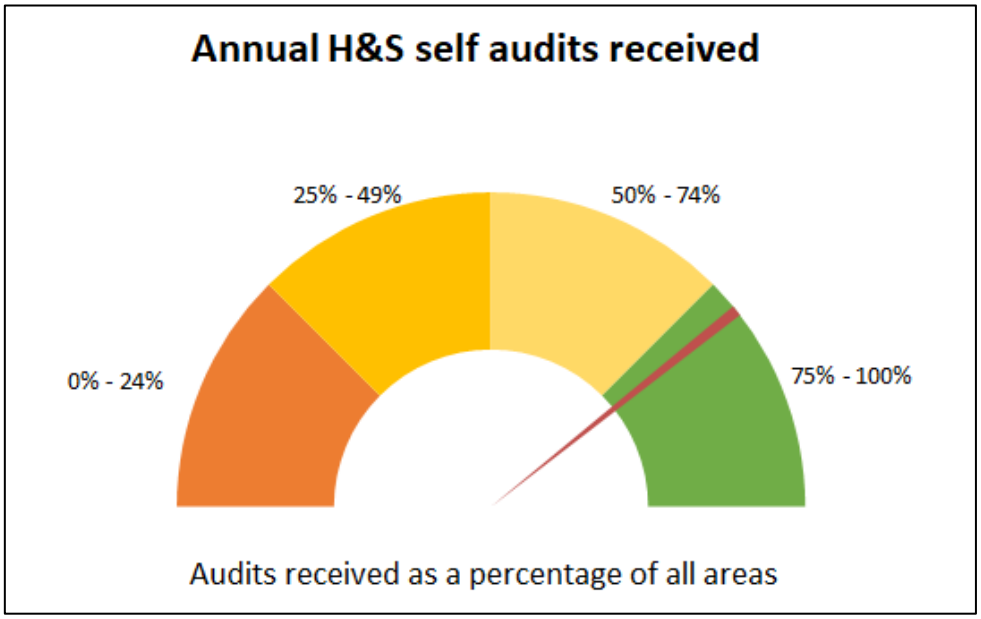
Summary of Annual Internal Health and Safety Self-Audits

(Returns received during Q1 2022/23)

This year's annual health and safety self-audits were conducted using a Microsoft Forms survey, with the intention of making it easier for departments to respond; the Forms format also enabled us to target questions at particular respondents – for example, non-clinical departments did not see questions aimed at clinical areas only.

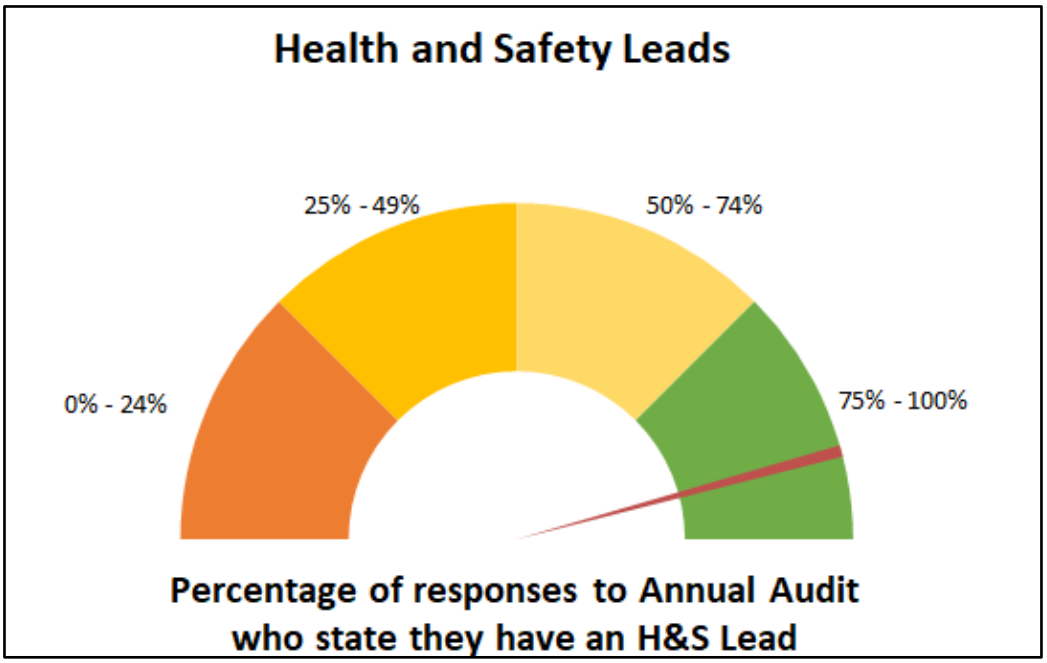
By the closing date of May 31st, 117 responses had been received.

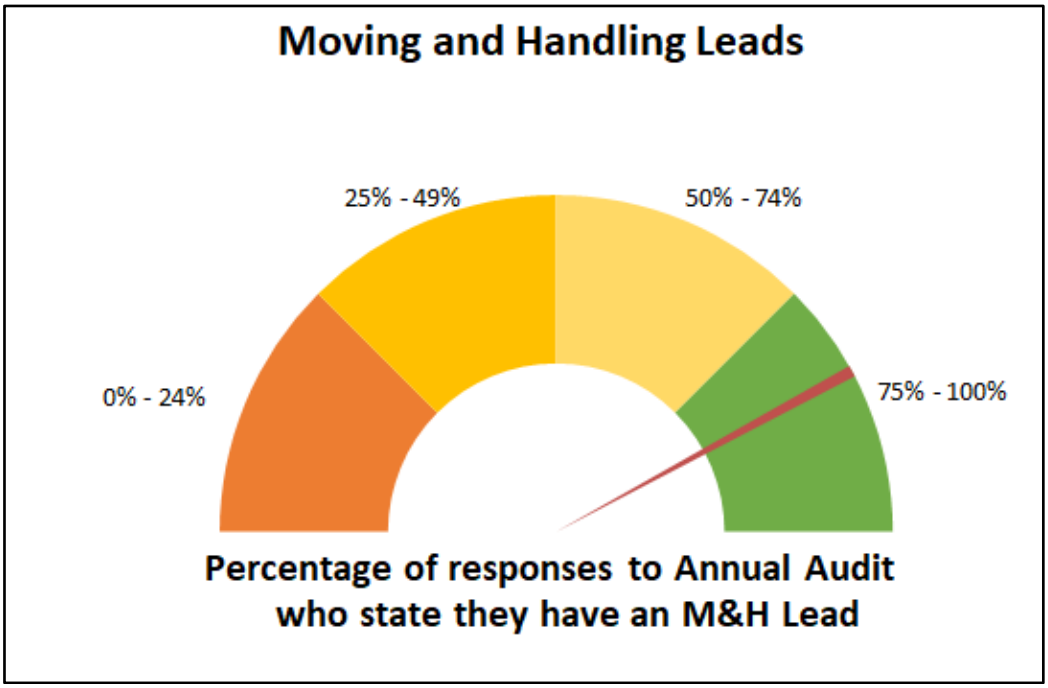




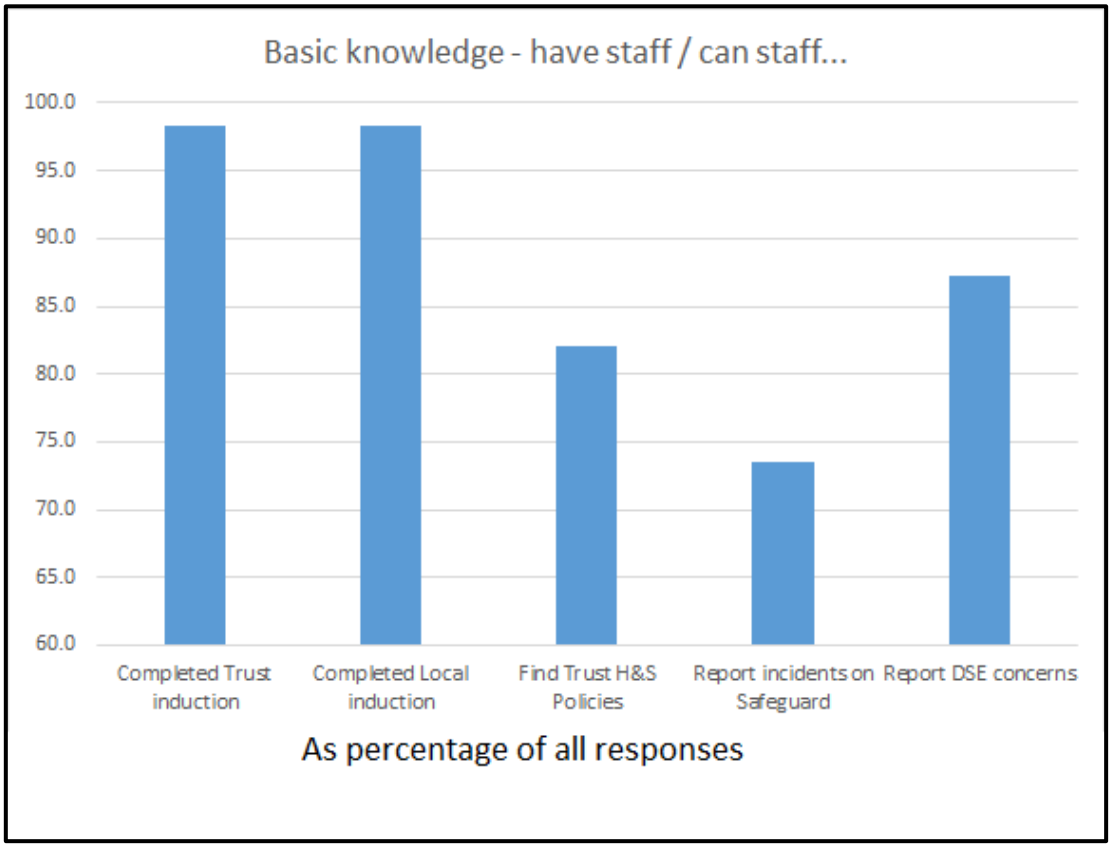
H&S and M&H Leads

Questions answered by all departments included two aimed at identifying how many had Health and Safety Leads and Moving and Handling Leads/Trainers.

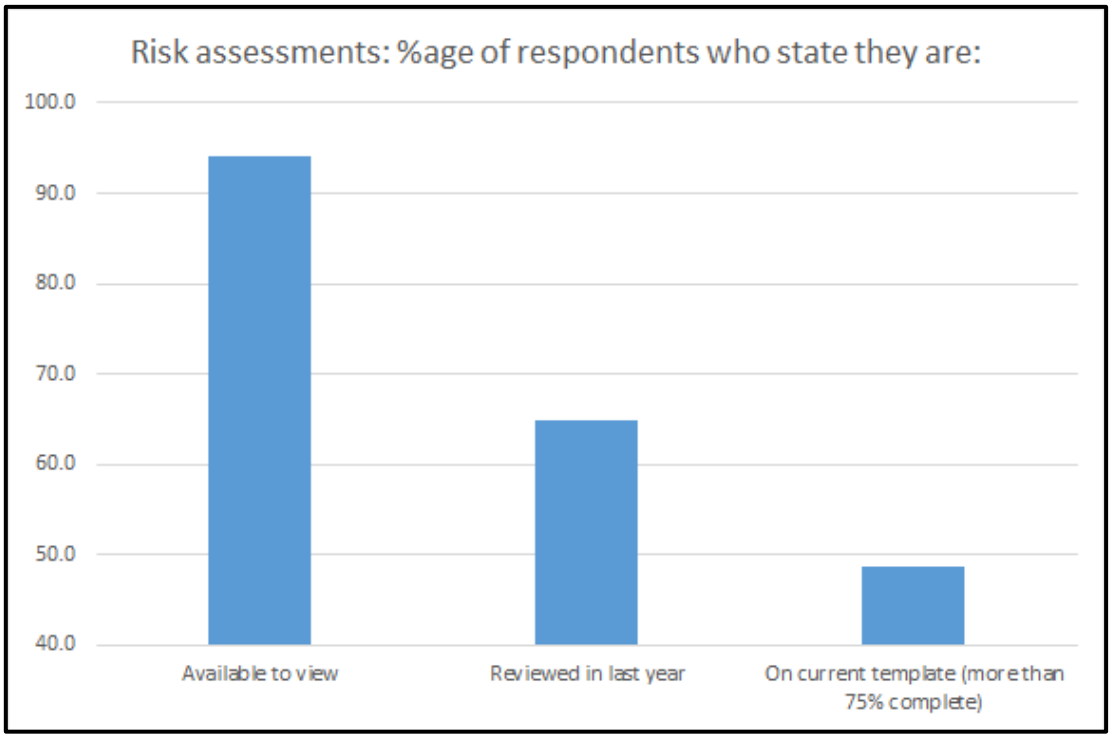




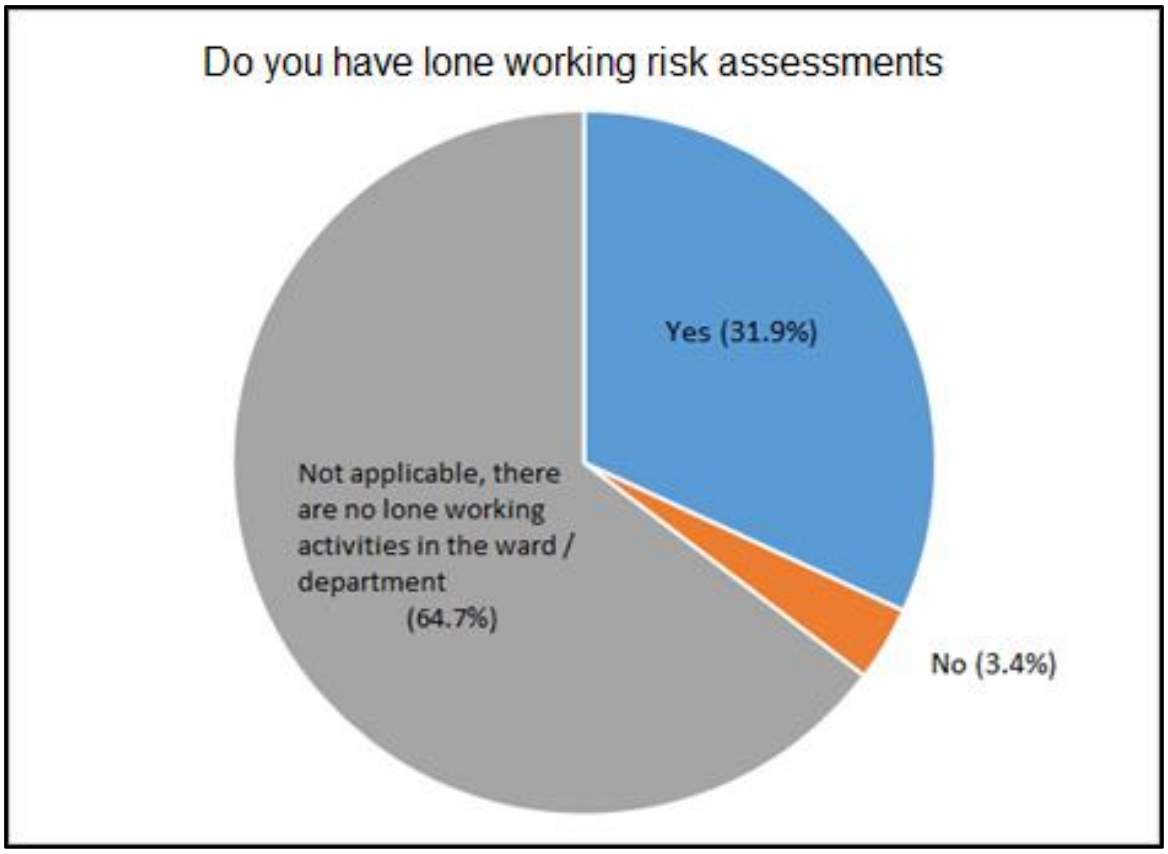
Knowledge of Health & Safety
The audit explored what basic knowledge staff have of health and safety-related subjects.

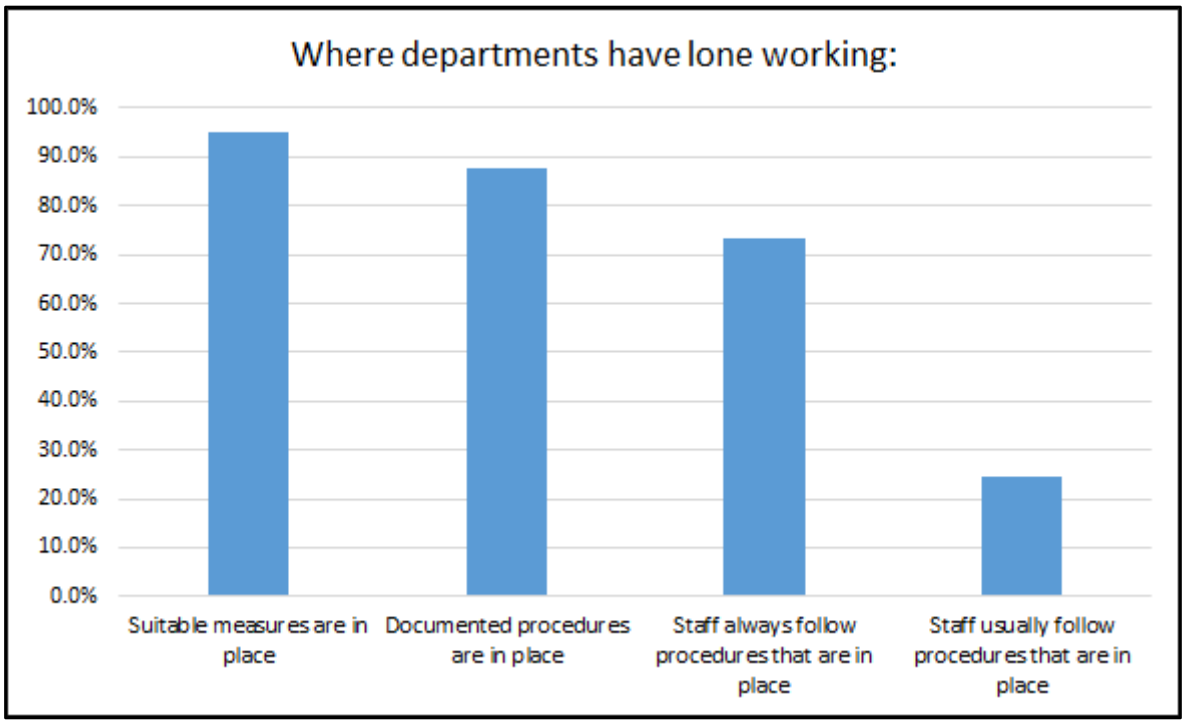


Risk Management
Risk assessment is the first stage in the management of health and safety in the workplace, both the Trust and the Health and Safety Executive (HSE) place great importance on getting risk assessments right; we measured the current state of the risk assessment process.

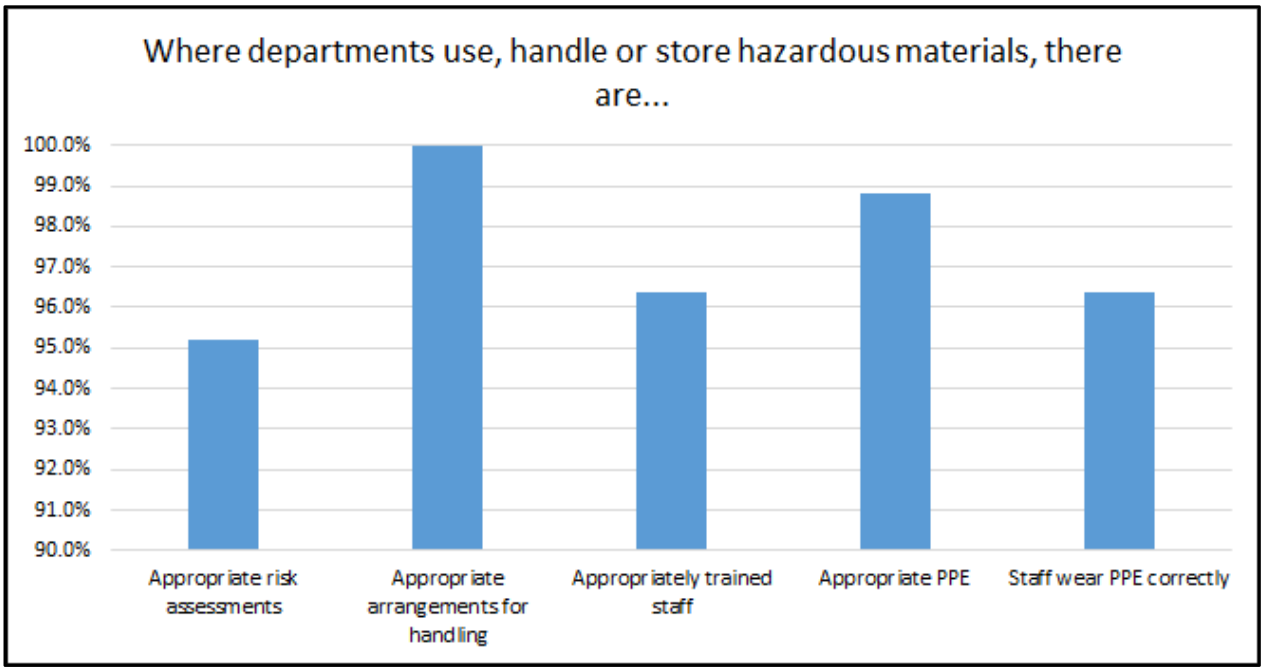


Lone Working
Lone working has previously been highlighted as a concern, so we asked some questions around how departments are managing this, and the responses were positive.

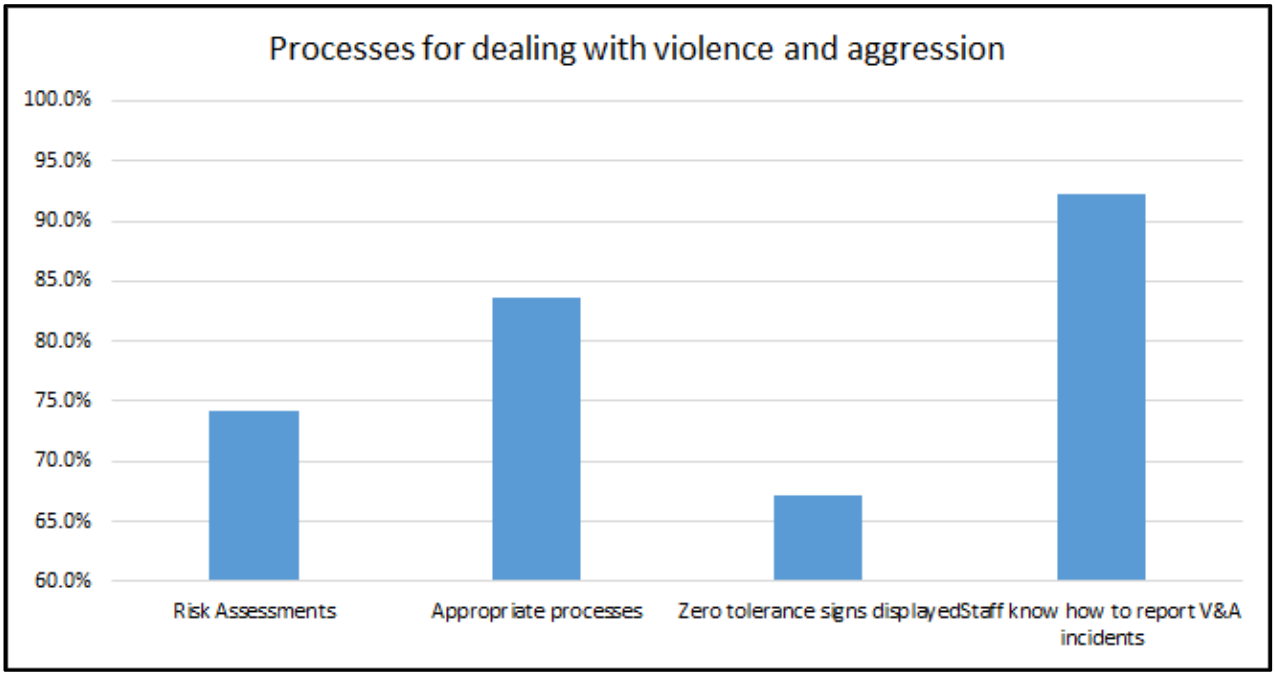




Hazardous materials
Where departments use, store or handle hazardous materials, they were asked about their arrangements for managing this safely.

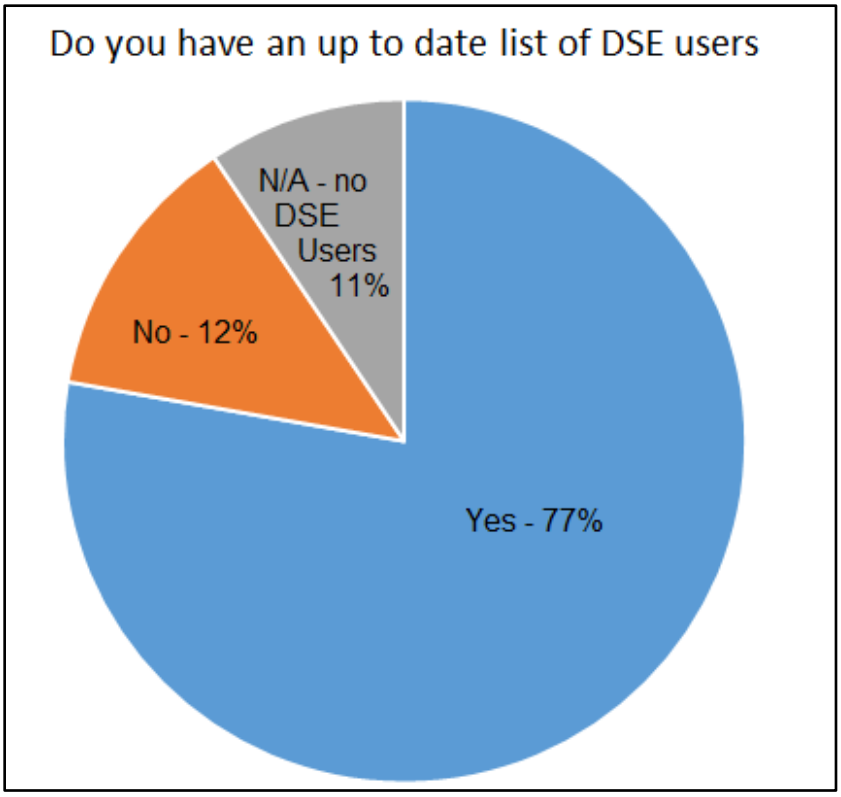


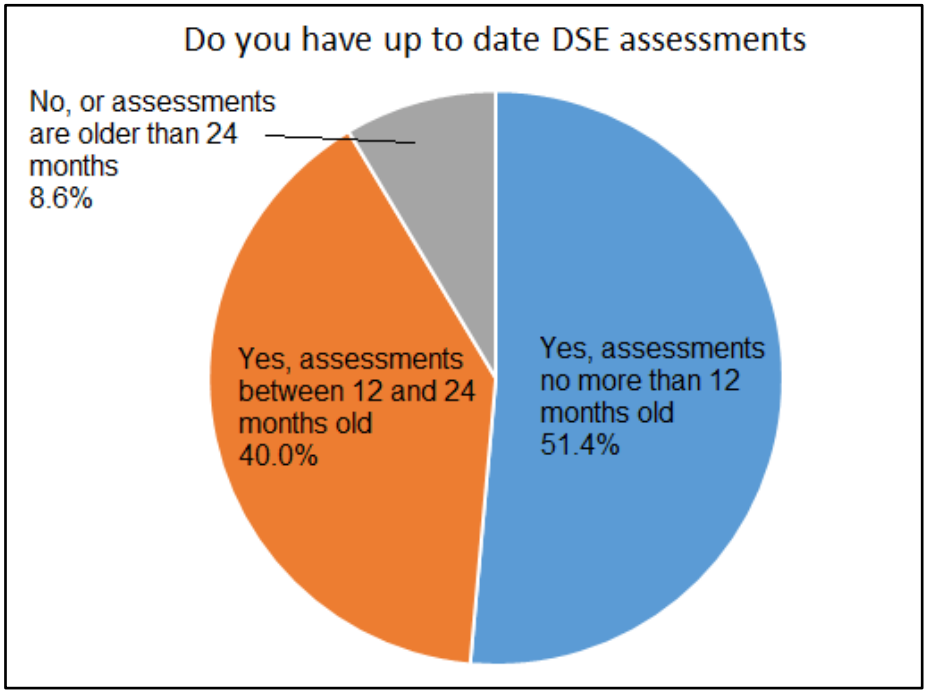
Violence & Aggression
All departments were asked what processes they had in place for managing risks of violence and aggression.



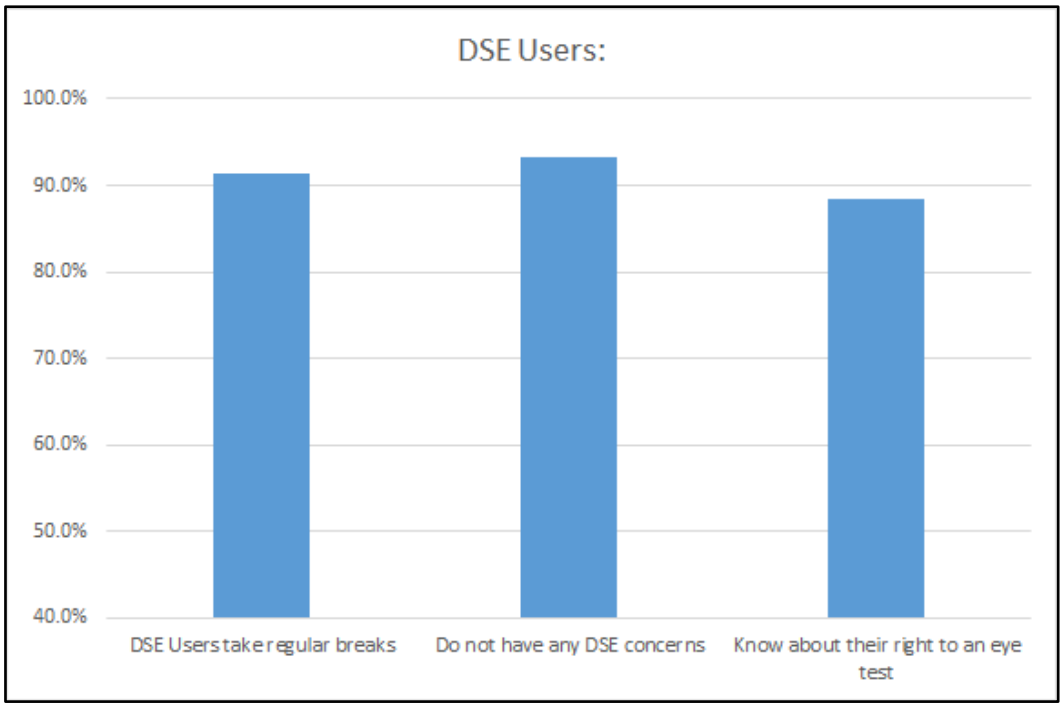
Display Screen Equipment (DSE)
Musculoskeletal pain and disorders can sometimes be caused by the use of display screen equipment, so in light of the increase in numbers of staff working from home/agile working, this was another important aspect to review.

It is a legal requirement for DSE users to carry out a workstation assessment; part of the audit was about how departments/wards manage this.





The audit asked participants to comment on staff's personal management of DSE issues, and any concerns being reported;



University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**People and Organisational Development Committee Terms of Reference**			
Agenda item:	**7.4**			
Sponsor:	**Steve Harris, Chief People Officer**			
Author:	**Helen Potton, Associate Director of Corporate Affairs and Company Secretary (Interim)**			
Date:	**29 September 2022**			
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:	The Terms of Reference have been updated to reflect the move to a part 1 open and part 2 approach to meetings. They have also been updated to reflect the three Pillars of the People Strategy. In addition the opportunity to reflect that deputies do not count towards quoracy has been taken.			
Implications: (Clinical, Organisational, Governance, Legal?)	The terms of reference ensure that the purpose and activities of the People and Organisational Development Committee are clear and support transparency and accountability in the performance of its role.			
Risks: (Top 3) of carrying out the change / or not:	1. Non-compliance with the National Health Service Act 2006 and the Trust's constitution relating to the composition of Board committees. 2. Non-compliance with specific guidance and policies relating to Trust staff and good practice around the governance and assurance of quality within NHS organisations. 3. The Board of Directors and the committee may not function as effectively or receive the required information and assurance without terms of reference in place.			
Summary: Conclusion and/or recommendation	The Board of Directors is asked to approve the revised terms of reference. These have been reviewed by the People and Organisational Development Committee and are recommended for approval.			

People and Organisational Development Committee Terms of Reference

Version: 2

Date Issued:	29 April 2021
Review Date:	April 2022
Document Type:	Committee Terms of Reference

Contents

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled.
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1. Role and Purpose

1.1 The People and Organisational Development Committee (the **Committee**) is responsible for overseeing, monitoring and reviewing the development and implementation of the people and organisational development strategies and operational plans for University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**), including the three areas of culture, capacity and capability and skills and the Trust's response to specific workforce issues arising from the coronavirus pandemic and the recovery of the organisation.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of assurance regarding the Trust's culture, capacity and capability and skills in support of the provision of world-class care for all.

1.3 To undertake its duties the Committee will split the agenda between an open Part 1 meeting and a closed Part 2 meeting. The split will facilitate a broader attendance on a range of topics to enable a more rounded discussion that includes a wide variety of different views. The duties and responsibilities of the Committee are more fully described in paragraph 7 below.

2. Constitution

2.1 The Committee has been established by the Board. The Committee has no executive powers other than those set out in these terms of reference. It is supported in its work by other committees established by the Board and other committees and groups as shown in Appendix A.

2.2 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee.

2.3 In carrying out its role the Committee is authorised to seek reports and assurance from executive directors and managers and will maintain effective relationships with the chairs of other Board committees to understand their processes of assurance and links with the work of the Committee.

2.4 The Committee is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions.

3. Membership

3.1 The members of the Committee will be appointed by the Board and will be:

3.1.1 at least two non-executive directors of the Trust;

3.1.2 the Chief Executive;

3.1.3 the Chief Nursing Officer;

3.1.4 the Chief Medical Officer; and

3.1.5 the Chief People Officer.

3.2 The Board will appoint the chair of the Committee from among its non-executive director members (the **Committee Chair**). In the absence of the Committee Chair and/or an appointed deputy, the remaining members present will elect one of the non-executive director members present to chair the meeting.

3.3 Only members of the Committee have the right to attend and vote at part 1 and part 2 Committee meetings. However, the following will be invited to attend part 1 meetings of the Committee on a regular basis:

3.3.1 the Director of Education, Training and Workforce;

3.3.2 the Deputy Director of Education, Training and Workforce;

3.3.3 the Assistant People Director;

3.3.4 the Head of Occupational Health & Wellbeing;

3.3.5 the Head of Employee Relations;

3.3.6 the Head of Business Partners;

3.3.7 the Chair of the Joint Staff Side Committee;

3.3.8 the Director of Communications or equivalent;

3.3.9 the Freedom to Speak up Guardian; and

3.3.10 the leads from the One Voice (BAME) staff network and Long-Term Illness and Disability (LID) Staff Network Group.

3.4 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas of risk or operation that are the responsibility of a particular executive director or manager.

3.5 Governors may be invited to attend meetings of the Committee.

4. Attendance and Quorum

4.1 Members should aim to attend every meeting and should attend a minimum of two-thirds of meetings held in each financial year. Where a member is unable to attend a meeting they should notify the Committee Chair or secretary in advance.

4.2 The quorum for a meeting will be three members, including two non-executive directors and either the Chief People Officer or the Chief Nursing Officer. A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4.3 When an executive director or manager is unable to attend a meeting they should appoint a deputy to attend on their behalf. A deputy for an executive director will not count towards quoracy.

5. Frequency of Meetings

5.1 The Committee will meet at least six times each year and otherwise as required.

6. Conduct and Administration of Meetings

6.1 Meetings of the Committee will be convened by the secretary of the Committee at the request of the Committee Chair or any of its members.

6.2 The agenda of items to be discussed at the meeting will be agreed by the Committee Chair with support from the Chief People Officer. The agenda and supporting papers will be distributed to each member of the Committee and the regular attendees no later than four working days before the date of the meeting. Distribution of any papers after this deadline will require the agreement of the Committee Chair.

6.3 The secretary of the Committee will minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance and any declarations of interest.

6.4 Draft minutes of Committee meetings and a separate record of the actions to be taken forward will be circulated promptly to all members of the Committee. Once approved by the Committee, minutes will be circulated to all other members of the Board unless it would be inappropriate to do so in the opinion of the Committee Chair.

7. Duties and Responsibilities

The Committee will carry out the duties below for the Trust whilst making reference to the People Strategy and in particular the three pillars of Thrive, Excel and Belong.

7.1 ***Culture***

7.1.1 The Committee will ensure that there are robust policies, systems and procedures for the development and monitoring of an inclusive culture with the Trust.

7.1.2 The Committee will review and monitor the following, ensuring these support the achievement of the Trust's objectives and identifying areas for action at a corporate and local level, ensuring follow up takes place:

7.1.2.1 staff and team engagement;

7.1.2.2 compassionate and inclusive leadership;

7.1.2.3 quality improvement;

7.1.2.4 equality, diversity and inclusivity;

7.1.2.5 bullying and harassment;

7.1.2.6 staff sickness and wellbeing an protecting our staff from risks relating to Covid-19;

7.1.2.7 Freedom to Speak Up and raising concerns;

7.1.2.8 people aspects of the corporate and clinical strategy; and

7.1.2.9 Change Champions.

7.2 ***Capacity***

7.2.1 The Committee will ensure that there are robust policies, systems and procedures to ensure delivery and monitoring of workforce planning and recruitment and retention of staff.

7.2.2 The Committee will review and monitor the following ensuring these support the achievement of the Trust's objectives and identifying areas for action at a corporate and local level, ensuring follow up takes place:

7.2.2.1 strategic workforce planning;

7.2.2.2 recruitment and retention;

7.2.2.3 staffing levels;

7.2.2.4 reports from the Guardian of Safe Working Hours;

7.2.2.5 talent management;

7.2.2.6 reward including pensions;

7.2.2.7 CQUINs;

7.2.2.8 bank and agency staff; and

7.2.2.9 volunteers.

7.3 ***Capability and Skills***

7.3.1 The Committee will ensure that there are robust policies, systems and procedures to ensure delivery and monitoring of staff appraisal and development.

7.3.2 The Committee will review and monitor the following ensuring these support the achievement of the Trust's objectives and identifying areas for action at a corporate and local level, ensuring follow up takes place:

7.3.2.1 appraisals;

7.3.2.2 education and training;

7.3.2.3 mandatory training;

7.3.2.4 gaps to meet the long-term corporate and clinical strategy;

7.3.2.5 the annual staff survey;

7.3.2.6 the 'fit and proper persons' requirements;

7.3.2.7 the Staff Friends and Family Test; and

7.3.2.8 flu vaccinations and other national vaccination programmes.

7.4 ***Risk***

7.4.1 The Committee will monitor risks identified in the Trust's Board Assurance Framework that have been allocated for oversight by the Committee.

7.4.2 The Committee will establish and maintain an overview of the Trust's people risks and ensure the effectiveness and implementation of controls for people risks and actions to mitigate these risks.

7.4.3 The Committee will refer any potential risks to patient safety or quality identified by the Committee to the Quality Committee.

7.4.4 The Committee will commission and oversee assurance deep dives into specific identified risks at the request of either the Committee Chair or the chair of the Board.

7.5 ***Reporting***

7.5.1 The Committee will advise the Trust Board on the appropriate key performance indicators, measures and benchmarks in the three areas of culture, capacity and capability and skills.

7.5.2 The Committee will ensure robust supporting data quality for any key performance indicators, measures and benchmarks within the areas of culture, capacity and capability and skills.

7.5.3 The Committee will review any submissions to national bodies before these are presented to the Board for approval.

8. Accountability and Reporting

8.1 The Chair of the Committee will report to the Board following each meeting, drawing the Board's attention to any matters of significance or where actions or improvements are needed.

8.2 The Committee will report to the Audit and Risk Committee at least annually on its work in support of the annual governance statement, specifically commenting on the staff report and the appropriateness of the self-assessment of the effectiveness of the system of internal control and the disclosure of any significant internal control issues in the annual governance statement.

8.3 Appendix A sets out the sub-committees that report to and support the Committee in fulfilling its duties and responsibilities. The Committee will receive the minutes of those meetings and at least an Annual Report of their work.

9. Review of Terms of Reference and Performance and Effectiveness

9.1 At least once a year the Committee will review its collective performance and its terms of reference. Any proposed changes to the terms of reference will be recommended to the Board for approval.

10. References

10.1 Employment Rights Act 1996

10.2 Equality Act 2010

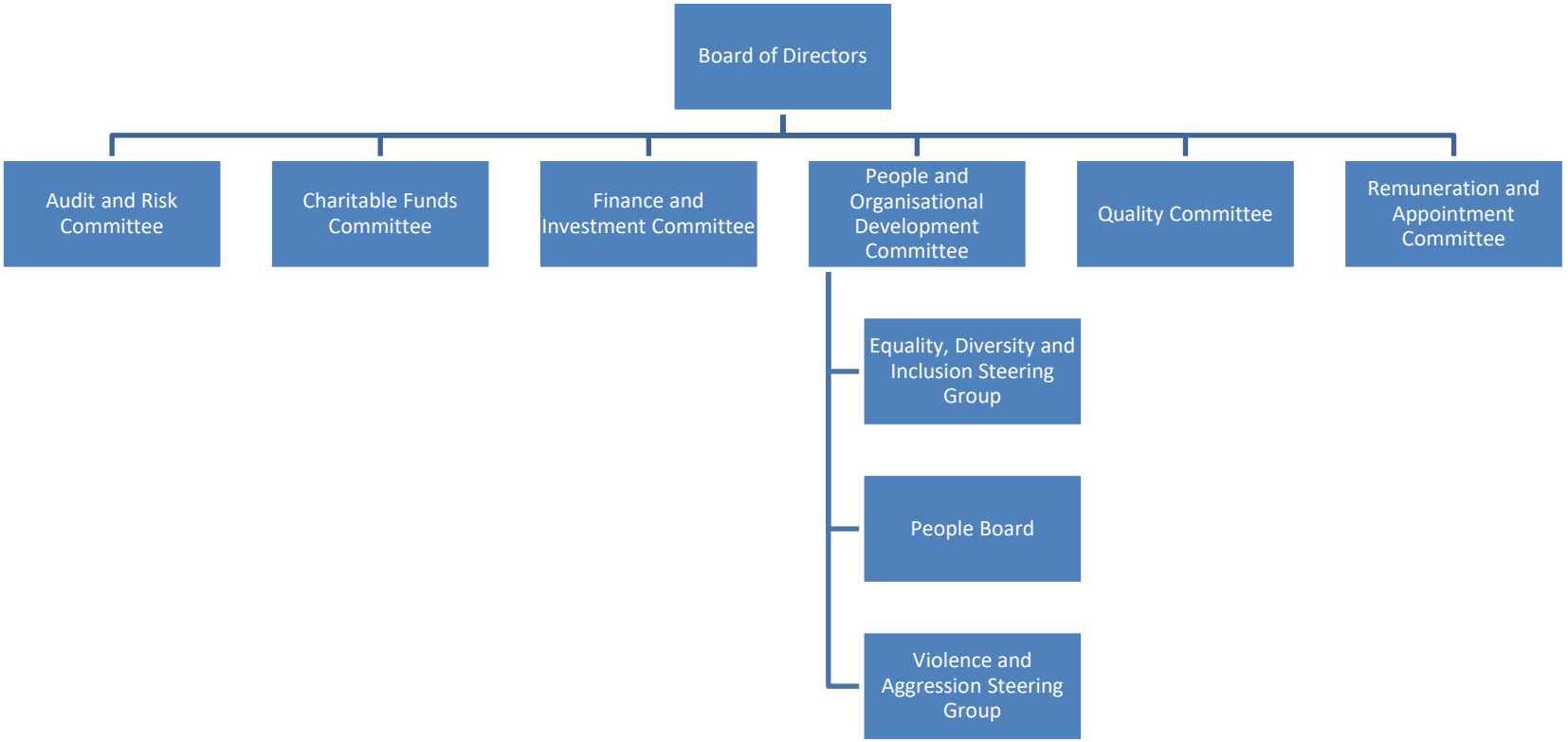
10.3 Public Interest Disclosure Act 1998

10.4 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

10.5 NHS Constitution

10.6 Terms and conditions of service for doctors and dentists in training (England) 2016 - December 2019

Appendix A


Board of Directors
Audit and Risk Committee
Charitable Funds Committee
Finance and Investment Committee
People and Organisational Development Committee
Quality Committee
Remuneration and Appointment Committee
Equality, Diversity and Inclusion Steering Group
People Board
Violence and Aggression Steering Group

People and Organisational Development Committee Terms of Reference	Version: 2

Document Monitoring Information	
Approval Committee:	Board of Directors
Date of Approval:	29 April 2021
Responsible Committee:	People and Organisational Committee
Monitoring (Section 9) for Completion and Presentation to Approval Committee:	April 2022
Target audience:	Board of Directors, People and Organisational Development Committee, Staff
Key words:	People, OD, Committee, Board, Terms of Reference
Main areas affected:	Trust-wide
Summary of most recent changes if applicable:	Reformatting, membership, attendees and committee structure
Consultation:	Chief People Officer
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