University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	06/06/2024
Time	9:00 - 13:00
Location	Conference Room, Heartbeat/Microsoft Teams
Chair	Jenni Douglas-Todd
Apologies	Diana Eccles, Tim Peachey (from 12:00)

1	9:00	**Chair's Welcome, Apologies and Declarations of Interest** Note apologies for absence, and to hear any declarations of interest relating to any item on the Agenda.
2		**Patient Story** The patient or staff story provides an opportunity for the Board to reflect on the experiences of patients and staff within the Trust and understand what the Trust could do better.
3	9:15	**Minutes of Previous Meeting held on 28 March 2024** Approve the minutes of the previous meeting held on 28 March 2024
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)** Dave Bennett, Chair
5.3	9:30	**Briefing from the Chair of the People and Organisational Development Committee (Oral)** Jane Harwood, Chair
5.4	9:35	**Briefing from the Chair of the Quality Committee (Oral)** Tim Peachey, Chair
5.5	9:40	**Chief Executive Officer's Report** Receive and note the report Sponsor: David French, Chief Executive Officer

5.6 **Performance KPI Report for Month 1**

10:00 Review and discuss the report
Sponsor: David French, Chief Executive Officer

5.7 **Finance Report for Month 1**

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

5.8 **Break**

10:45

5.9 **People Report for Month 1**

10:55 Review and discuss the report
Sponsor: Steve Harris, Chief People Officer

5.10 **Infection Prevention and Control 2023-24 Annual Report**

11:10 Receive and discuss
Sponsor: Gail Byrne, Chief Nursing Officer
Attendees: Julian Sutton, Interim Lead Infection Control Director/Sue Dailly, Infection Prevention Matron

5.11 **Learning from Deaths 2023-24 Quarter 4 Report**

11:20 Review and discuss the report
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Jenny Milner, Associate Director of Patient Experience

5.12 **Freedom to Speak Up Report**

11:30 Review and discuss the report
Sponsor: Gail Byrne, Chief Nursing Officer
Attendee: Christine Mbabazi, Equality & Inclusion Adviser/Freedom to Speak Up Guardian

5.13 **Fuller Inquiry Report**

11:45 Receive and note the report
Sponsor: David French, Chief Executive Officer
Attendee: Gavin Hawkins, Divisional Director of Operations, Division B

6 **STRATEGY and BUSINESS PLANNING**

6.1 **CRN Wessex 2023-24 Annual Performance Report**

11:55 Receive and note the annual report
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Clare Rook, Chief Operating Officer, CRN: Wessex

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

12:10 Review and discuss the update
Sponsor: Gail Byrne, Chief Nursing Officer
Attendees: Craig Machell, Associate Director of Corporate Affairs and Company Secretary/Lauren Anderson, Corporate Governance and Risk Manager

7 CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

7.1 Feedback from the Council of Governors' (CoG) Meeting 1 May 2024 (Oral)
12:25
Sponsor: Jenni Douglas-Todd, Trust Chair

7.2 Register of Seals and Chair's Actions Report
12:30
Receive and ratify
In compliance with the Trust Standing Orders, Financial Instructions, and the Scheme of Reservation and Delegation.
Sponsor: Jenni Douglas-Todd, Trust Chair

8 Any other business
12:35
Raise any relevant or urgent matters that are not on the agenda

9 Note the date of the next meeting: 25 July 2024

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

Minutes Trust Board – Open Session

Date	28/03/2024
Time	9:00 – 13:00
Location	Microsoft Teams
Chair	Jenni Douglas-Todd (JD-T)
Present	Dave Bennett, NED (DB) Gail Byrne, Chief Nursing Officer (GB) Jenni Douglas-Todd, Chair (JD-T) Keith Evans, Deputy Chair and NED (KE) David French, Chief Executive Officer (DAF) Paul Grundy, Chief Medical Officer (PG) Steve Harris, Chief People Officer (SH) Jane Harwood, NED/Senior Independent Director (JH) Ian Howard, Chief Financial Officer (IH) Tim Peachey, NED (TP) Joe Teape, Chief Operating Officer (JT)
In attendance	Martin De Sousa, Director of Strategy and Partnerships (MDeS) Craig Machell, Associate Director of Corporate Affairs and Company Secretary (CM) Lauren Anderson, Corporate Governance and Risk Manager (LA) (item 6.1) Ceri Connor, Director of OD and Inclusion (CC) (item 4.12) Diana Hulbert, Guardian of Safe Working Hours and Emergency Department Consultant (DH) (item 4.14) Sophie Limb, HR Project Manager (SL) (item 4.12) 1 member of the public (item 5) 6 governors (observing) 5 members of staff (observing) 1 members of the public (observing)
Apologies	Diana Eccles, NED (DE)

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

The Chair welcomed attendees to the meeting. There were no interests to declare in the business to be transacted at the meeting.

It was noted that apologies had been received from Diana Eccles.

The Chair provided an overview of her activities since February 2024, including visits to hospital departments, meetings with peers and other key stakeholders.

2. Minutes of the Previous Meeting held on 30 January 2024

The draft minutes tabled to the meeting were agreed to be an accurate record of the meeting held on 30 January 2024, subject to amending a reference to 'radiology' on page four to 'radiotherapy'.

3. Matters Arising and Summary of Agreed Actions

It was noted that all actions had been completed or were not yet due.

In terms of action 1102, the service was provided by NHS Blood and Transfusion, and funding had been removed.

4. QUALITY, PERFORMANCE and FINANCE

4.1 Briefing from the Chair of the Audit and Risk Committee

The chair of the Audit and Risk Committee was invited to provide an overview of the meeting held on 18 March 2024. It was noted that:

- The committee had reviewed the losses and special payments report and noted that although the individual size of each occurrence was not material, these instances nonetheless did have a significant impact on individual patients.
- The committee reviewed the Board Assurance Framework (item 6.1).
- The committee reviewed an internal audit report on data quality and noted that there were only some minor matters to address. In addition, there were no outstanding actions from previous reports.
- The committee reviewed the internal audit plan for 2024/25, which would include examination of long waiters, the discharge process and rostering.
- The external audit plan for the 2023/24 financial year was agreed.

4.2 Briefing from the Chair of the Charitable Funds Committee

Steve Harris was invited to provide an overview of the meeting held on 27 March 2024. It was noted that:

- The charity was in a position to transfer to the new charitable company.
- Gail Byrne would be appointed as a director of the new charitable company on a temporary basis to represent the Trust.
- The annual report and accounts for 2023/24 would be the final item of business requiring Board approval.

4.3 Briefing from the Chair of the Finance and Investment Committee

The chair of the Finance and Investment Committee was invited to provide an overview of the meeting held on 25 March 2024. It was noted that:

- The committee reviewed the Finance Report for Month 11 (item 4.10) and the planning for 2024/25, noting that the underlying position presented a challenge for 2024/25.
- The committee reviewed the Trust's productivity assessed against that in 2018/19. The NHS England formula showed a 18% decline in the Trust's performance. However, the basis of the formula was open to debate and the perception in the organisation was different given the demands on the Trust's capacity. The Trust's modified formula showed a lower decline in productivity and work was ongoing with the central team.
- The committee reviewed the maintenance requirements in the Trust's estate, which were significant owing to its age.
- The committee reviewed the proposed capital prioritisation for 2024/25 and 2025/26.

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

The chair of the People and Organisational Development Committee was invited to provide an overview of the meeting held on 20 March 2024. It was noted that:

- The committee reviewed the People Report for Month 11 (item 4.11) and noted that the additional recruitment controls were having an impact.

- The committee reviewed the Staff Survey results (item 4.12), noting that key themes were staff burnout and morale.

4.5 Briefing from the Chair of the Quality Committee

The chair of the Quality Committee was invited to provide an overview of the meeting held on 18 March 2024. It was noted that:

- The committee reviewed the patient safety and experience reports for the third quarter and noted some concerns regarding infection prevention control and pressure ulcers. In addition, there was some concern about overcrowding in the resuscitation area.
- The committee had carried out a thematic review of never events, especially in Dermatology.
- The committee reviewed the Trust's performance in terms of its quality priorities for 2023/24. The Trust had achieved all its objectives, except one, which had been partially achieved. It was intended that there would be eight quality priorities in 2024/25.
- It had been confirmed that the Integrated Care Board would fund the tobacco dependency programme in 2024/25.
- Work was also taking place to provide additional capacity in the Paediatric Intensive Care Unit.

4.6 Chief Executive Officer's Report

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

- The Hampshire and Isle of Wight Integrated Care Board (HIOW ICB) had launched a consultation on how it will re-shape itself for the future. The ICB had been required to reduce its running costs by 20% during 2024/25 and by a further 10% during 2025/26.
- Junior doctors had voted to continue industrial action for a further six months.
- In the Spring Budget, the Chancellor announced additional funding for the NHS, although, once inflation had been taken into account, the NHS budget would remain broadly flat.
- The NHS England Workforce Race Equality Standard data report showed some improvements, but further work was required.
- Steve Brine, the Member of Parliament for Winchester and Chandler's Ford had been hosted by the Trust on a visit the week before. This afforded an opportunity to discuss the Hampshire County Council consultation, social care and non-criteria to reside.
- The latest NHS patient survey showed a reduction in satisfaction, but this was largely due to waiting to get into the system.
- There was significant pressure from NHS England for trusts to achieve the targets set. The Trust has demonstrated strong performance during 2023/24 across the six targets.
- A nurse from the Trust has received a national recognition award based on their work on the 'Diabasics' initiative and the first episode of 'Surgeons at the Edge of Life', filmed at Southampton General Hospital, had been broadcast on BBC2.
- Thanks were expressed to all staff for their performance during the year.

4.7 Performance KPI Report for Month 11

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

- In terms of the Trust's performance compared with comparators, the Trust was top quartile for the majority of indicators and top half for others.

- There were 19 patients who would breach the 78-week wait target at year end, 18 of which were corneal patients where materials were unavailable. It was noted that there was a national shortage of materials.
- There were expected to be about 50 breaches of the 65-week wait target, of which around 30 were corneal patients.
- The Trust had achieved diagnostic performance of 92% achieving the six-week target.
- There had been high volumes of patients in the Emergency Department during February and March 2024. However, the Trust had achieved 70.6% for type 1 performance and expected to achieve the 76% target by the end of March 2024.
- The Trust's Referral To Treatment metric was beginning to improve and there were some examples of very good waiting list management in Trauma and Orthopaedics and in Women and New Born.
- The key point to emphasise was that, although it might not seem so at times, the Trust was out-performing most other comparable organisations. It was considered appropriate that staff communications should be worked on to reinforce this message.

In terms of the Trust's Key Performance Indicators:

- The Quality Committee had seen significant improvements in diagnostic performance.
- The two-week wait cancer target performance had also improved since April 2023.
- Unfortunately, due to significant challenges with flow, overnight ward move performance had dropped significantly during the month, leading to poor patient experience.
- In addition, the rate of pressure ulcers appeared to be increasing.

4.8 Non-Criteria to Reside Spotlight Report

Joe Teape was invited to present the Non-Criteria to Reside Spotlight Report, the content of which was noted. It was further noted that:

- Management of non-criteria to reside patients was one of the Trust's biggest risks in terms of its operational and financial performance and achievement of its targets.
- The Trust has seen 20%+ of beds occupied by patients without criteria to reside, which significantly impacted patient flow in the Emergency Department and has led to ambulance handover delays.
- In addition, stays in hospital of longer duration were known to lead to worse patient outcomes.
- The Trust was unable to have a significant impact on this issue, as the main driver was insufficient funding availability in local authorities.
- In terms of what the Trust could do, work was ongoing to improve the discharge process by having conversations about care needs early on as part of the Trust's flow transformation programme.

4.9 Break

4.10 Finance Report for Month 11

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

- The Trust had received £24.6m of cash support from NHS England and £5m in funding in relation to the impact of industrial action between December 2023 and February 2024.
- A year-end deficit of £1.4m was forecast.
- The Trust's underlying monthly deficit was currently £4m, and the Trust's underlying deficit had been £4-5m a month during 2023/24.
- Cost Improvement Programme delivery was expected to be £62m at year end, an increase of £17m compared to the previous year.

4.11 People Report for Month 11

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

- Total workforce had reduced by 20 whole-time equivalents (WTE) during the month, although the Trust remained 266 WTE above plan.
- Use of bank staff had reduced, although it was expected that more bank staff would be used in March 2024 as substantive staff used leftover annual leave before year end.
- Average turnover was 11%, below the target of 13.6%.

The Board discussed the report and noted that it was necessary to review training expectations in order to make best use of staff time. In addition, it was noted that funding for internationally recruited nurses was likely to reduce and that apprentice and student nurse numbers had reduced.

4.12 UHS Staff Survey Results 2023 Report

Ceri Connor, Sophie Limb and Steve Harris were invited to present the UHS Staff Survey Results 2023 Report, the content of which was noted. It was further noted that:

- The Trust scored above average in all of the People Promise areas and there had been an improvement in the areas regarding managers and appraisals.
- However, the overall NHS average had increased, thus narrowing the gap.
- The participation rate was lower than in the previous year and the overall scores hid pockets of concern.

The Board discussed the results of the Staff Survey. It was noted in particular that the Trust had invested significant sums into wellbeing, but that morale was low. It was considered that this demonstrated the importance of local management to staff morale.

In addition, the Board discussed the impact of the change in approach from granting significant autonomy during the pandemic to increasing levels of control, which had been received negatively by staff. However, it was noted that, whilst in some areas, such as with regard to patients, there was a general culture of accountability, there appeared to be less of a general culture of accountability with respect to finances and budgets. The possibility of 'earned' autonomy was considered as a means of mitigating against those who had acted properly being penalised by the actions of others.

4.13 Maternity and Neonatal Perinatal Quality Surveillance Dashboard Report

The Maternity and Neonatal Perinatal Quality Surveillance Dashboard Report was noted.

It was further noted that the additional information in respect of post-partum haemorrhage data (action 1101) was contained within the report and had been discussed at a maternity safety champions' meeting.

4.14 Guardian of Safe Working Hours Quarterly Report

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

- There had been seven exception reports constituting a breach and resulting in a financial penalty, which were due to exceeding the maximum 13-hour shift duration. All reports were from General Surgery.
- There were also concerns in Gynaecology due to the complicated rotas, inadequate rest provision and facilities.
- The position of a junior doctor was a difficult one due to a lack of patient contact during the pandemic, industrial action and changes in the assignment of foundation posts.

Action:

Paul Grundy and Diana Hulbert agreed to include an item regarding junior doctors on a future Trust Board Study Session agenda.

5. Patient Story

David Livermore was invited to relate his experience of attending an appointment at the Eye Unit in October 2023 and, in particular, the difficulties he encountered as a wheelchair user. It was noted that his treatment had been carried out in a room inappropriate for his needs and that he had been asked personal questions in the waiting room.

Following discussion with the Board of his experiences, David Livermore offered his services to the Trust to advise on disability access as an 'expert patient'.

6. STRATEGY and BUSINESS PLANNING

6.1 Board Assurance Framework (BAF) Update

Lauren Anderson was invited to present the Board Assurance Framework (BAF) update, the content of which was noted. It was further noted that:

- The Trust's Risk Management Policy and Strategy had been updated, with the main changes being in relation to the Trust's risk appetite following the Trust Board Study Session held in December 2023.
- Work was being carried out to improve the Board's visibility of operational risks and to improve links between operational risks and the BAF.

7. CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

7.1 Register of Seals and Chair's Actions Report

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

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

7.2 Remuneration and Appointment Committee Terms of Reference

It was noted that the Remuneration and Appointment Committee had reviewed its terms of reference at its meeting held on 28 March 2024. It was further noted that some minor changes were proposed, largely to update references to documentation and NHS organisations, and, in terms of the executive pay guidance, to better reflect current practice and the available frameworks.

Decision:
Having reviewed the Remuneration and Appointment Committee terms of reference tabled to the meeting, it was agreed to approve these terms of reference.

8. Any other business

There was no other business.

9. Note the date of the next meeting: 6 June 2024

10. Resolution regarding the Press, Public and Others

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

The meeting was adjourned.

List of action items

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 28/03/2024 4.14 Guardian of Safe Working Hours Quarterly Report				
1127.	Junior Doctors	• Grundy, Paul • Hulbert, Diana	27/06/2024	Pending
	Explanation action item Paul Grundy and Diana Hulbert agreed to include an item regarding junior doctors on a future Trust Board Study Session agenda.			

Report to the Trust Board of Directors				
Title:	**Chief Executive Officer's Report**			
Agenda item:	**5.5**			
Sponsor:	**David French, Chief Executive Officer**			
Date:	**6 June 2024**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	My report this month covers updates on the following items: • Infected Blood Inquiry • General Election • Industrial Action • HEFMA Award • Capital Funding • 2024/25 Planning			
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.			

Infected Blood Inquiry

On 20 May 2024, the Infected Blood Inquiry published its report into more than 30,000 people becoming infected with HIV and hepatitis C after being given contaminated blood products in the 1970s and 1980s. The report said that:

- Too little was done to stop importing blood products from abroad, which used blood from high-risk donors such as prisoners and drug addicts;
- In the UK, blood donations were accepted from high-risk groups until 1986;
- Blood products were not heat treated to eliminate HIV until the end of 1985, although the risks were known in 1982; and
- There was too little testing to reduce the risk of hepatitis from the 1970s onwards.

The UK Government has established a compensation scheme for those impacted.

The report can be read at: http://www.infectedbloodinquiry.org.uk/reports

NHS England's formal response to the report is attached as Appendix 1.

During the Inquiry, the Trust was made aware of patient cases which would be cited in the report and was offered an opportunity to comment. We chose not to comment in detail on individual cases, primarily due to the time elapsed since they happened.

NHS England has commissioned an ongoing patient support service for those affected and it is likely that UHS will be one of two providers in the region offering this service. Funding for a five-year period has been confirmed.

General Election

The Prime Minister has announced that a general election will be held on 4 July 2024. There are a number of practical implications for the Trust as a public body to maintain political impartiality and to ensure that public resources are not used for the purposes of political parties or campaign groups during the pre-election period which commenced on 25 May 2024 and will continue until the day after the election.

During this period, the following key principles should apply:

- No activity should be undertaken which could be considered politically controversial or influential.
- NHS trusts have discretion in their approach, but must be able to demonstrate the same approach for every political party, official candidate and designated campaign group.
- The NHS may be under media spotlight, locally and nationally, so it is advisable to have a plan in place for how the organisation will manage the pre-election period and the potential for the organisation to be singled out in the media.

Normal business and regulation needs to continue during the pre-election period. However, where a board meeting needs to take place, the agenda should be confined to those matters requiring a board decision or oversight. Matters of future strategy or future deployment of resources may be construed as favouring one party over another and should be avoided. Use of the confidential part of the agenda to discuss matters which may be politically controversial is not recommended.

Care should be taken not to comment on the policies of political parties or campaign groups.

Organisations should not start long-term initiatives or undertake major publicity campaigns unless time critical (such as a public health emergency).

Public consultations should not be launched during the pre-election period, and it is advisable to extend the period for those already running to take into account the pre-election period.

The timing of the election means that formal Secretary of State approval for the Solent / Southern transaction is unlikely to happen before the election and therefore the formation of the new Trust, previously scheduled for 1 June, is likely to be delayed.

Industrial Action

On 29 May 2024, it was announced that junior doctors would stage a five-day strike, commencing on 27 June 2024 and ending on 2 July 2024. This will be the eleventh walkout by junior doctors since March 2023. As during previous periods of industrial action, the Trust will seek to minimise any impact on patient care by organising consultant cover wherever possible.

HEFMA Award

Paula Melhuish, Deputy Director of Estates and Capital Development, received the Outstanding Service Award from the Health Estates and Facilities Management Association on 13 May 2024. Paula has been a long-serving and esteemed colleague at UHS and has recently announced her retirement.

Capital Funding

Due to its Emergency Department performance at the end of 2023/24, the Trust was awarded an additional £2m in capital departmental expenditure limit (CDEL) as part of a scheme to reward high-performing trusts. There were several categories where the top-10 performing trusts received additional CDEL, including absolute ED 4-hour % performance and most improved ED 4-hour performance. NHS England agreed that the type 3 Urgent Treatment Centre attendances at RSH and Lymington should be included in the overall UHS performance and that, combined with significantly improved 4-hour performance at SGH, this meant that UHS was in the national top-10 for absolute ED 4-hour performance.

terms of using the CDEL allowance, plans are being developed to increase the department's same day emergency care (SDEC) capacity. The additional CDEL is not cash-backed so we are in discussions with NHSE regarding the cash funding.

2024/25 Planning

The CFO and I will update the Board on the status of the 2024/25 planning round which is not yet finalised. At a meeting in London with NHS England executives, the ICS was asked to improve its position further in return for some financial incentives. This challenge was accepted, although the allocation of this further stretch to individual providers has not yet been agreed.

The structure and leadership of the ICS-wide transformation programmes has been reviewed and changed. The structure of the programmes was considered by CEO, Chairs and ICB colleagues and it was agreed there should be six programmes for 2024/25, as set out below. The Board should note that I requested to retain the leadership role on the Planned Care programme, mostly because we have an agreed way forward, have good traction and can now see improvement happening. In addition, I was asked to take on leadership of the Workforce programme which, following discussion with the Chair, I have agreed to do.

Programme	CEO lead
Mental Health	Ron Shields, SHFT
Discharge	Penny Emerit, PHU
Urgent and Emergency Care	David Eltringham, SCAS
Local Care	Alex Whitfield, HHFT
Planned Care	David French, UHS
Workforce	David French, UHS

Each programme has been asked to set out its objectives and deliverables for the year ahead by 18 June 2024. I will share the results of this exercise with the Board in due course.

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - medical directors
  - chief nurses
  - chief operating officers
  - chief people officers
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - regional heads of nursing
  - regional heads of communications

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

20 May 2024

Dear colleagues,

Publication of the Infected Blood Inquiry final report

Earlier today, the Infected Blood Inquiry published its final report at: www.infectedbloodinquiry.org.uk/reports. The Prime Minister has subsequently issued an apology on behalf of successive Governments and the entire British state.

On behalf of the NHS in England, now and over previous decades, Amanda Pritchard issued a public apology, saying:

“Today’s report brings to an end a long fight for answers and understanding that those people who were infected and their families, should never have had to face.

“We owe it to all those affected by this scandal, and to the thorough work of the Inquiry team and those who have contributed, to take the necessary time now to fully understand the report’s conclusions and recommendations.

“However, what is already very clear is that tens of thousands of people put their trust in the care they got from the NHS over many years, and they were badly let down.

“I therefore offer my deepest and heartfelt apologies for the role the NHS played in the suffering and the loss of all those infected and affected.

“In particular, I want to say sorry not just for the actions which led to life-altering and life-limiting illness, but also for the failures to clearly communicate, investigate and mitigate risks to patients from transfusions and treatments; for a collective lack of openness and willingness to listen, that denied patients and families the answers and support they needed; and for the stigma that many experienced in the health service when they most needed support.

“I also want to recognise the pain that some of our staff will have experienced when it became clear that the blood products many of them used in good faith may have harmed people they cared for.

“I know that the apologies I can offer now do not begin to do justice to the scale of personal tragedy set out in this report, but we are committed to demonstrating this in our actions as we respond to its recommendations.”

The report is sobering reading, documenting failings over multiple decades, and making recommendations across a wide range of areas, including recognition, support and compensation; education and training; monitoring of and testing for Hepatitis C; the safety of blood transfusions; preventing future harm, via duty of candour and regulation; as well as giving patients a voice.

We write now to set out the initial steps we are taking in response.

Support for those affected

The Department of Health and Social Care is providing £19 million over five years to provide a bespoke Infected Blood Psychological Support Service which is expected to be rolled out later this summer.

We have listened to the experiences of those involved, including patients, their families and staff, and are working with them to design and develop this service, which will provide dedicated support for those affected, located around the country.

This service will include talking therapies, peer support, and psychosocial support, as well as access to other treatments or support for physical or mental health needs where appropriate.

In the interim, the existing England Infected Blood Support Service remains available here: www.nhsbsa.nhs.uk/england-infected-blood-support-scheme.

Further information about existing testing and support services, including those commissioned by the Government, can be found at: www.nhs.uk/infected-blood-support.

Supporting affected staff

It is important to also recognise that some of our colleagues may be affected by the publication of today's report in some way, whether through personal or professional connection to the issue.

Employers may therefore wish to increase promotion of their local health and wellbeing support for staff. Details of nationally-commissioned routes of support, including the 24/7 text helpline Shout and NHS Practitioner Health, can be found at NHS England - Support available for our NHS People.

Continuing to find and treat people with blood-borne viruses

Although it is likely that the majority of those who were directly affected have now been identified and started appropriate treatment given the time that has elapsed since the last use of infected blood products, there may be people who have not yet been identified, particularly where they are living with asymptomatic Hepatitis C.

We ask that systems continue to work with partners, including community groups and charities, as well as Hepatitis C Operational Delivery Networks, to promote local testing options for anyone at risk, or anyone who is concerned. This should include promotion of the new national service for at-home Hepatitis C self-testing kits, available via hepctest.nhs.uk.

For those who are concerned about the risk of HIV infection, further information can be found here: information on HIV diagnosis and the HIV testing services search tool.

Hepatitis B, another infection that can be linked to infected blood, usually clears up on its own without treatment; however, people concerned about Hepatitis B infection should be directed towards relevant hepatitis B information or their local sexual health clinic or GP practice.

Today's report highlights that in some cases those affected by infected blood products were told of their diagnosis in ways which were insensitive and inappropriate. We would therefore ask you to ensure that patients and their families are supported through the process of receiving test results – of whatever kind - in a compassionate and considerate way.

Ensuring patients can access the right information.

We recognise following the publication of this report, some patients may raise questions directly with their primary and/or secondary care teams, or through other points of contact with the NHS. We will be sharing materials with relevant service providers to ensure frontline clinicians and other colleagues in patient-facing roles are able to provide appropriate information or signposting.

We expect that this will be particularly relevant to:

- Providers of NHS 111 services
- GP practices and community pharmacies
- Trusts providing services where blood products are used
- Mental health providers

Maintaining confidence in current blood and blood products and related treatment

The infected blood and blood products that have been the subject of this Inquiry were withdrawn in 1991. In the intervening decades, comprehensive systems have been put in place to ensure the safety of both donors and recipients of blood and blood-derived products.

Today, blood and blood products are distributed to NHS hospitals by NHS Blood and Transplant (NHSBT), which was established in 2005 to provide a national blood and transplantation service to the NHS. NHSBT's services follow strict guidelines and testing to protect both donors and patients.

NHS Blood and Transplant has published clear information about these processes here: Infected Blood Inquiry - NHS Blood and Transplant (nhsbt.nhs.uk).

Nationally, NHS England will work with NHS Blood and Transplant and others to communicate the safety of current blood products.

Assessing further recommendations and next steps

As set out above, the final Inquiry report includes a number of important recommendations for the NHS. NHS England will be considering these in detail alongside the Department for Health and Social Care and other relevant bodies.

In addition, an Extraordinary Clinical Reference Group is being convened to inform any immediate actions which should be taken.

The next steps from this work will be shared as soon as possible, including through relevant clinical networks.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive
NHS England

Professor Sir Stephen Powis
National Medical Director
NHS England

Dame Ruth May
Chief Nursing Officer
England

Dr Emily Lawson DBE
Chief Operating Officer
NHS England

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Performance KPI Report 2024-25 Month 1**			
Agenda item:	**5.6**			
Sponsor:	**David French, Chief Executive**			
Author	**Sam Dale, Associate Director of Data and Analytics**			
Date:	**6 June 2024**			
Purpose	**Assurance or reassurance Y**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	The report aims to provide assurance: Regarding the successful implementation of our strategy. That the care we provide is safe, caring, effective, responsive, and well led.			
Response to the issue:	The Performance KPI Report reflects the current operating environment and is aligned with our strategy.			
Implications: (Clinical, Organisational, Governance, Legal?)	This report covers a broad range of trust performance metrics. It is intended to assist the Board in assuring that the Trust meets regulatory requirements and corporate objectives.			
Risks: (Top 3) of carrying out the change / or not:	This report is provided for the purpose of assurance.			
Summary: Conclusion and/or recommendation	This report is provided for the purpose of assurance.			

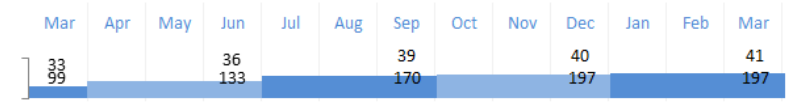
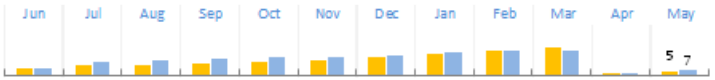
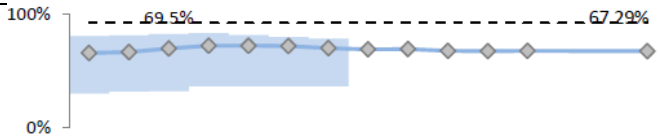
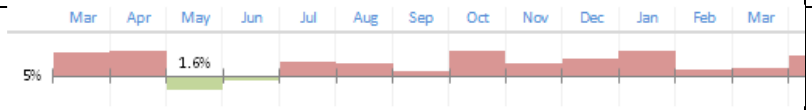
University Hospital Southampton NHS
NHS Foundation Trust

Performance KPI Board Report

Covering up to
April 2024

Sponsor – David French, Chief Executive Officer
Author – Sam Dale, Associate Director of Data and Analytics

Report guide

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

Introduction

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

Due to the timing of the April 2024 Board meeting, the following referral to treatment data points were not included in the March KPI report. They have now been updated for March 2024 and April 2024: -

- 31 - Patients on an open 18 week pathway (within 18 weeks)
- 33 - Patients on an open 18 week pathway (within 52 weeks)
- 34 - Patients on an open 18 week pathway (within 65 weeks)
- 35 - Patients on an open 18 week pathway (within 78 weeks)
- 35a - Patients on an open 18 week pathway (within 104 weeks)
- 32 - Total number of patients on a waiting list (18 week referral to treatment pathway)

Changes of note within the report itself: -

- 53 – The digital metric monitoring page loading time for the CHARTS system has been tightened from under five seconds to under three seconds
- 55 – The metric monitoring the rollout of inpatient noting for nurses has been removed as this is now considered complete. This will be revisited when the noting solution is rolled out for doctors
- 39 - The 2024/25 national cancer target changes will be reflected next month when April 2024 data is made available
- 40 - The 2024/25 national cancer target changes will be reflected next month when April 2024 data is made available
- 37 - The metric now reflects the published 2024/25 national year-end target of 5% of patients waiting over 6 weeks for diagnostics

Summary

This month's spotlight report covers diagnostic performance. It highlights that UHS consistently increased the volume of elective diagnostic tests delivered throughout the 2023/24 financial year and into the start of the 2024/25 financial year. The diagnostic waiting list reduced by 12% in 2023/24 and in April 2024, 89.6% of patients received their diagnostics within six weeks. The national performance target has been set at 95% by March 2025 and the organisation is working with all services to ensure we maintain waiting times for services that are compliant and address any demand and capacity barriers preventing achievement. The paper describes the activity and performance trends for the hospital and explores modality sites in more detail.

Areas of note in the appendix of performance metrics include: -

1. The Emergency Department (ED) four hour performance position reduced to 66.0% (April 2024) from 71.7% (March 2024) for type 1 attendances, however UHS remain in the top quartile when compared to peer teaching hospitals across the country.
2. In April, the overall RTT waiting list increased by 2.4% to 59,485.
3. The trust continues to report zero patients waiting over 104 weeks and reported 15 patients waiting over 78 weeks for April 2024. All 15 patients are within ophthalmology and impacted by the ongoing national shortage of corneal graft tissue which is being overseen by NHS Blood and Transplant service. The longest waiting patients will be booked for surgery as soon tissue has been confirmed.
4. The trust reported 66 patients waiting over 65 weeks which predominantly reflects corneal transplant patients again and low volumes within gynaecology and several surgical specialties. The trust is committed to achieving the national target of zero patients waiting over 65 weeks by September 2024 and the ambition to achieve zero patients waiting over 52 weeks by March 2025.
5. The volume of patients not meeting the Criteria to Reside in hospital decreased in April averaging 216 which is a 10% reduction compared to March 2024, yet this remains a significant impact on patient flow through the organisation.
6. There were zero never events reported for April 2024.
7. The volume of medication errors reduced to two in April 2024 which is now below the monthly target following the increase seen in March 2023.
8. The number of Gram-negative bloodstream infections continues to be marginally above the monthly target of 19. The increased incidence in cases continues to be reported both nationally and locally across the Hampshire and Isle of Wight integrated care system.
9. The digital metric to monitor page loading times on CHARTS system has successfully remained at 99% despite increasing the time target by 40%.

Ambulance response time performance

The latest unvalidated weekly data is provided by the South Coast Ambulance Service (SCAS). In the week commencing 13th May 2024, our average handover time was 16 minutes 56 seconds across 725 emergency handovers and 22 minutes across 52 urgent handovers. There were 44 handovers over 30 minutes, and six handovers taking over 60 minutes within the unvalidated data. The volume of weekly handovers over 60 minutes increased by 73% from March 2024 (averaging 7.5 per week) to April 2024 (averaging 13 per week).

Spotlight: Diagnostic Performance

The following report is based on the validated April 2024 submission.

Introduction
Diagnostics are a critical component of a patient's pathway, facilitating an accurate and complete diagnosis, personalised treatment plans and the appropriate monitoring of a patient's condition. Timely access to diagnostic tests is essential for ensuring that patients receive an early diagnosis whilst improving patient experience and delivering an efficient use of NHS resources.

The 2024/24 NHS priorities and operational planning guidance confirmed that "systems are asked to continue to work towards the elective care recovery plan target of 95% of patients receiving their tests within 6 weeks". The national ambitions acknowledged that the NHS delivered record diagnostic activity in 2023, but also highlighted that additional capacity in community diagnostic centres had been partly offset by an unprecedented increase in unscheduled diagnostic activity in acute trusts.

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

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

Our teams prioritise diagnostic procedures based on clinical urgency (for example patients with cancer) but aligned to this is a continual review of the longest waiting diagnostic patients. This spotlight paper highlights the current diagnostic performance position for UHS against the national targets and other hospitals. It also describes the current volumes of activity being delivered and the impact on the waiting list. We explore any performance concerns across the different modalities, outlining the challenges that services are facing and the steps being taken to achieve the 2024/25 target.

In summary, there was an overall reduction in the diagnostic waiting list across the 2023/24 financial year as UHS successfully increased the delivery of diagnostic activity to manage current levels of demand. The diagnostic waiting list currently stands at 8,849 patients (April 2024) which is a reduction of 12% since April 2023 (10,033 patients) and 24% since the peak levels seen in June 2022 (11,671 patients). The April 2024 performance position is 89.6% for the percentage of patients receiving diagnostic tests within six weeks. The latest comparison data available (March 2024) placed the hospital 5th when ranked against peer teaching hospitals across the country. All organisations are facing challenges due to high demand, workforce shortages and equipment limitations and funding, but the organisation is striving to achieve the 95% target set for 2024/25.

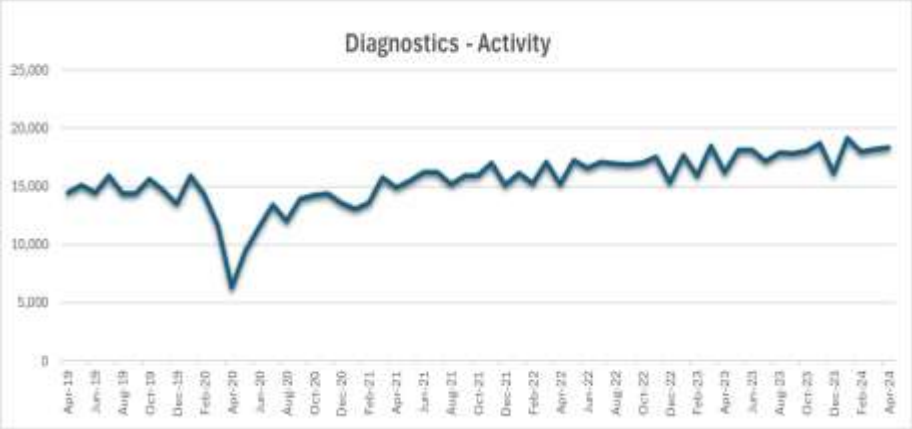
Activity and Waiting List

Elective diagnostic activity being delivered at UHS consistently increased throughout 2023/24 and into 2024/25 helping to manage the waiting list despite high referral volumes and the complications caused by industrial action throughout the previous year.

Graph 1 illustrates that diagnostic activity levels delivered in 2023/24 were 6% higher than 2022/23 and 17% higher than pre-pandemic levels.

Overall there was a 12% reduction in the diagnostic waiting list across the 2023/24 financial year (graph 2) despite some levelling off in winter months and a small recent increase which is being closely monitored. The waiting list stands at 8849 patients for April 2024 which breaks down into 6096 patients waiting for imaging tests, 1815 for physiological measurements and 938 for endoscopic tests.

The care groups developed actions plans at the start of 2023/24 to increase activity levels and better manage service demand. These included more efficient booking processes, capacity reconfigurations, DNA rate reductions and improved referral management. These proved extremely successful in several areas but the continued high referral volumes, inpatient diagnostic demand and staffing vacancies have impacted the position in recent months. Challenged services are revising their current strategies to ensure the successes seen last year can be maintained across 2024/25.



Graph 1: Activity Delivered by Month

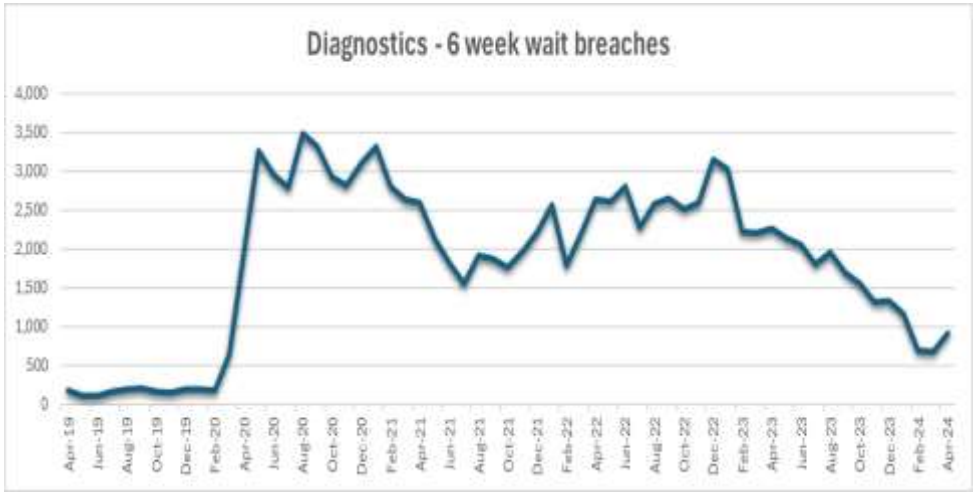
Graph 2: Waiting List Size by Month

Performance Position

The Trust submitted performance position (Graph 4) illustrates an upward trajectory across the 2023/24 financial year reaching 92% in both February and March 2024. Prior to this, the trust had not reported levels above 90% since the pandemic.

Similarly the actual volume of patients breaching the six week wait target recently reduced to below 1000 for the first time since the pandemic. 679 patients breached in February 24 and 679 patients in March 24. There was a small increase in April 24 (918 patients).

Whilst the trust is measured by the overall diagnostic performance position, table 5 highlights the recent performance by individual diagnostic modality group. The areas with a challenging position are explored further in the modality section.



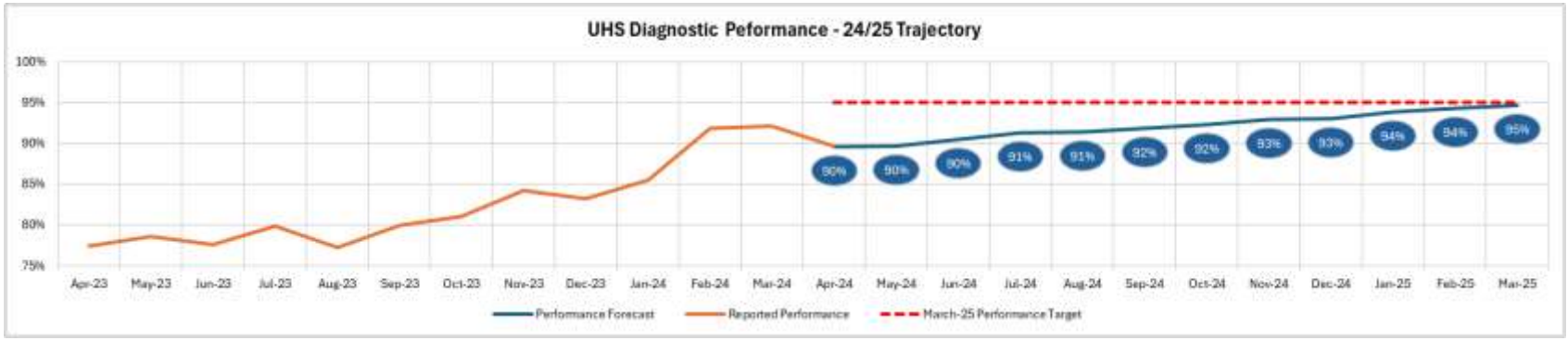
Graph 3: Volume of 6 week breaches by Month

Graph 4: Diagnostic performance (%) by month

Diagnostic Modality	Feb-24	Mar-24	Apr-24
CT	99%	99%	100%
MRI	90%	88%	81%
NOUS	97%	97%	94%
Endoscopy	85%	85%	84%
Cardiology	86%	85%	83%
Sleep Studies	68%	69%	76%
Neurophysiology	84%	95%	95%
Barium Enema	96%	92%	91%
Dexa Scan	100%	100%	99%
Audiology Assessments	100%	99%	100%
Urodynamics	83%	82%	75%
Trust wide Position	**91.8%**	**92.2%**	**89.6%**

Table 5: Monthly six week performance % by modality

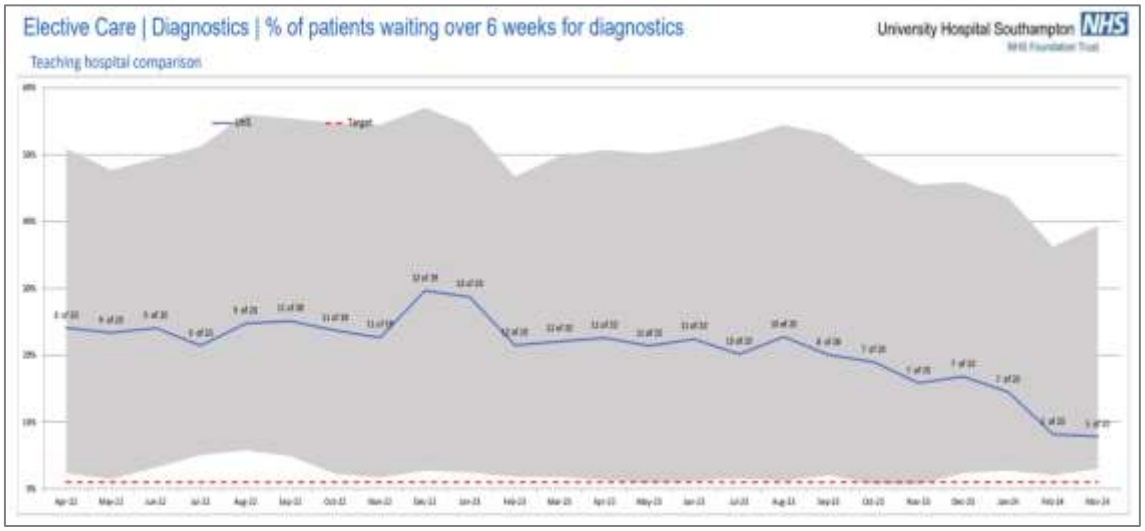
The diagnostic performance position is published every week at test level to support pathway validations, address operational pressures and monitor trajectories through care group performance meetings. This analysis is complemented by live Power BI dashboards within multiple services for full granularity on waiting times at a patient level. Recent performance discussions focussed on understanding the small decline in the April 2024 position and the action plans behind service trajectories which support the Trust's trajectory to achieve the 95% national target by March 2025 (see graph 6).



Graph 6: UHS Diagnostic performance trajectory by month

The trust also monitors performance for key metrics against other hospitals in the South East region and, perhaps more appropriately, against peer teaching hospitals nationally.

Graph 7 highlights that the strong performance improvements seen in UHS are not mirrored across all teaching hospitals, as the trust moved from the third quartile into the first quartile across the 2023/24 financial year. This is further evidenced locally as the Trust is now ranked 4th within the South East against for all hospitals.

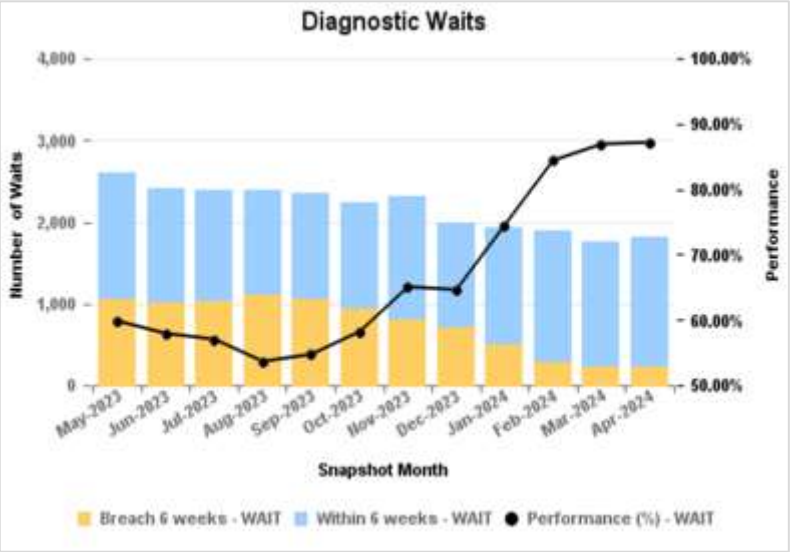


Graph 7: Diagnostic performance ranking vs peer teaching hospitals

Modality Focus
For reference, we also provide a short commentary on some of the challenges between the modalities.

The **Physiological Modality** includes Audiology, Echocardiography, Neurophysiology and Sleep Studies. The significant waiting list improvements seen in the Autumn of 2023 have continued through winter and into the start of the 2023/24 financial year. The April 2024 performance for this cohort is 87.2% with 233 patients breaching the six week waiting time target. The waiting list currently stands at 1,815 patients.

In early 2023/24, the neurophysiology department undertook a service review to address a performance position which consistently averaged at 45%. In April 2024 the service reported performance levels of 95% for the second month in a row. Whilst the service review highlighted efficiency opportunities within pathway management and booking processes, the significant improvements reflect the adoption of insourcing to provide additional weekend capacity. A third registrar also joined the service in April 2024 which will increase activity. This improved performance is expected to continue throughout the year as insourcing continues alongside an increased focus on reducing the DNA rate within the service.



Graph 8: Performance and waits for all physiological metrics

Sleep studies remain the one challenged area within the physiological modalities. This service has seen a significant increase in referrals across all hospitals often attributed to specific lifestyle conditions within the national population. A series of actions previously outlined included DNA rate improvements, implementation of texting reminder services and recruitment of an additional Band 6 physiologist. These measures have driven a performance improvement from 55% in December 2023 to 76% in April 2024. However the service is now carrying two vacancies and funding barriers have prevented further investment into the respiratory equipment needed to manage the inpatient sleep service.

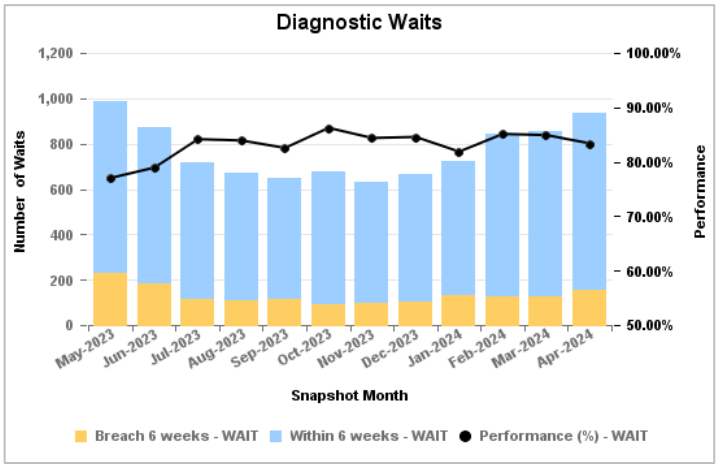
The **Endoscopy Modality** includes colonoscopy, cystoscopy, flexi-sigmoidoscopy and gastroscopy for both adult and paediatric services. The April 2024 performance position is 84% with 156 patients breaching the six week waiting time target. The waiting list currently stands at 938 patients. A current challenge within the Gastroscopy service is general anaesthetic capacity which has lowered performance levels to 90% in April 2024 for a service which has historically been above the national target. Anaesthetist recruitment is in progress which will support additional activity and an improved trajectory towards the 95% target is therefore anticipated for the second half of the year.

A national shortage of the contrast dye Gastrografin is currently impacting colonoscopy services within all hospitals. The agent supports the effective delivery of CT colonoscopies which are clinically appropriate for low suspicion cancer referrals. As cancer cases must continue to be prioritised, patients are receiving full colonoscopies which impacts the capacity available for the routine service. UHS has seen an increase from 75 to 95 referrals per week for this service which is currently performing at 90%. We anticipate this will continue to impact the waiting list until the shortage has been resolved.

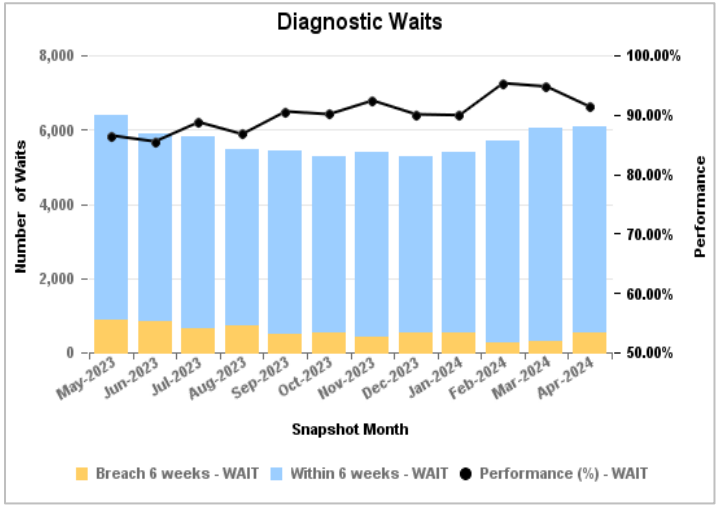
The paediatric endoscopy service has a small impact on the overall trust position, but continues to report well below the national target. The April 2024 performance was 40% with 76 patients breaching six weeks. This team have limitations on activity throughput as the procedure requires general anaesthetic and therefore theatre capacity. The team are exploring insourcing opportunities and a demand and capacity analysis will be completed in June to quantify the level of additional capacity required to meet the 95% target.

The **Imaging Modality** includes MRI, CT, Non-Obstetric Ultrasounds, Dexa Scans and Barium Enemas. The April 2024 performance position is 91% with 529 patients breaching the six week waiting time target. The waiting list currently stands at 6096 patients. Performance has remained consistently high for general MRIs and CTs throughout 2023/24 (98% across quarter four) and is expected to continue in 2024/25 subject to any change in inpatient referral volumes.

The challenged diagnostic continues to be cardiac MRIs which remain at 60%. Whilst performance is expected to improve through 24/25 as referrals from Portsmouth, Salisbury, the Isle of Wight and the Channel Islands are restricted, the service has had three recent resignations or retirements.



Graph 9: Performance and waits for all endoscopy metrics



Graph 10: Performance and waits for all imaging metrics

The full impact of replacing these staff will not be fully realised until they are embedded and fully trained. A business case for seven day working is going through approval stages but the service can only be fully implemented once full recruitment has taken place. In the interim, there are plans to put on Sunday lists where feasible within the existing staff levels.

Ultrasound performance (97% in March 2024) is expected to continue throughout 2024/25 with the only risk being the high level of vacancy within the sonographer team and the shortage of head and neck specialist radiologists. This is being addressed by upskilling the competency levels of the existing sonographers.

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

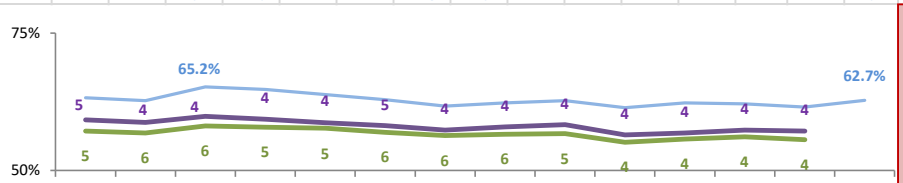
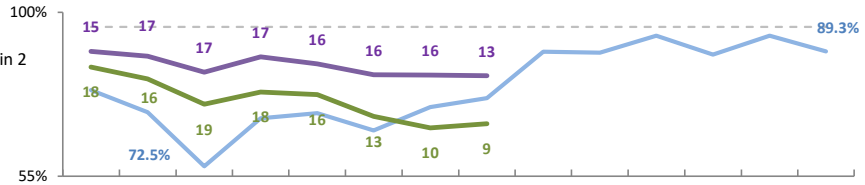
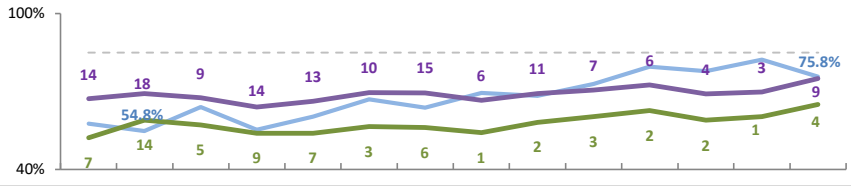
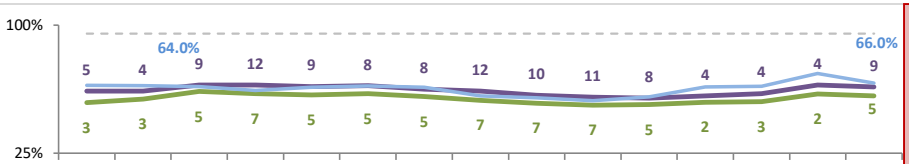
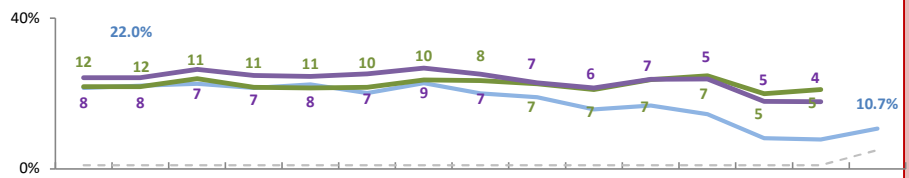
The NHS pledges to provide convenient, easy access to services within the waiting times set out in the Handbook to the NHS Constitution

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

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

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

		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD
31	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)																≥92%	62.7%
38	% Patients following a GP referral for suspected cancer seen by a specialist within 2 weeks (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)																≥96%	80.2%
38 - Beginning December 2023, NHSE published Cancer data no longer includes 2 week wait as a cancer standard for benchmarking. Data shown for October 2023 onwards will reflect internally reported UHS position for each month, but will not include Teaching Hospital/South East Hospital data																		
39	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)																≥85%	63.3%
39- The 2024/25 national cancer target changes will be reflected next month when April 2024 data is made available																		
28	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 16) South East average (& rank of 16)																≥95%	66.0%
37	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching Hospital average (& rank of 20) South East Average (& rank of 18)																≤5%	10.7%
37 - As of April 2024, YTD and **Monthly Target changed from 1% to 5%** to reflect latest guidance																		

Outcomes		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
1	HSMR - **UHS** HSMR - **SGH**	87.85												90.26			≤100	82.2	≤100
		86												88.97					
		75																	
2	HSMR - Crude Mortality Rate	3.1%															<3%	2.8%	<3%
		2.8%												2.7%					
		2.5%																	
3	Percentage non-elective readmissions within 28 days of discharge from hospital	15%															-	12.1%	
		11.9%												12.5%					
		10%																	
		Q1 23-24			Q2 23-24			Q3 23-24			Q4 23-24			Q1 24-25			Quarterly target		
4	**Cumulative Specialties** with Outcome Measures Developed (Quarterly)	80															+1 Specialty per quarter		
		75																	
		72			72			73			75			75					
		70																	
5	Developed Outcomes RAG ratings (Quarterly) Red Amber Green	100%																	
		34			37			41			42			37					
		82			75			67			65			80					
		75%																	
		340			333			337			338			343					
		50%																	

Red : below the national standard or 10% lower than the local target
Amber : below the national standard or 5% lower than the local target
Green : within the national standard or local target

Safety		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
6	Cumulative Clostridium difficile **Most recent 12 Months** vs. **Previous 12 Months**	11	12	18	27	24	35	28	49	35	60	47	66	55	72	65	81	73	91	77	97	84	105	4	12	≤5	12	≤5
7	MRSA bacteraemia	0	0	0	0	0	1	0	0	1	2	1	2	0	1	1	0	1	0
8	Gram negative bacteraemia	14	32	14	19	27	16	21	15	25	18	17	20	19	15	31	≤18	31	≤18
9	Pressure ulcers category 2 per 1000 bed days	0.54														0.39	<0.3	0.39	<0.3
10	Pressure ulcers category 3 and above per 1000 bed days	0.65														0.24	<0.3	0.24	<0.3
11	Medication Errors (severe/moderate)	3														2	≤3	2	3
12	Watch & Reserve antibiotics, usage per 1,000 adms **Most recent months** vs. **2018*95.5%**	2,479	2,789												2,765	2,757	2,765	2,757	2,765

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

Safety		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
13	PSII's (based upon month reported, excluding Maternity)	6														2	-	2	-
13a	Never Events															0		0	
14	PSII's- Maternity	1														0	-	0	-
15	Number of falls investigated per 1000 bed days	0.08														0.12	-	0.12	-
16	% patients with a nutrition plan in place (total checks conducted included at chart base)	94.5%														96.5%	≥90%	97%	≥90%
		780	1600	844	871	788	806	798	772	770	894	879	956	930	949	889			
17	Red Flag staffing incidents	13														11	-	11	-

Maternity		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
18	Birth rate and Bookings Birth Rate - total number of women birthed Bookings - Total number of women booked	383 / 432	387 / 513	416 / 449	402 / 477	418 / 450	417 / 382	400 / 424	400 / 442	467 / 446	409 / 469	428 / 392	406 / 483	401 / 429	428 / 409	411 / 448	-	-	-
19	Staffing: Birth rate plus reporting / opel status - number of days (or shifts) at Opel 4.	0	2	1	1	4	6	1	3	3	1	4	4	0	6	0	-	-	-
20	Mode of delivery % number of normal birthed (women) % number of caesarean sections (women) % other	36.0% / 54.8%	36.7% / 48.8%	40.6% / 46.9%	32.6% / 53.0%	43.3% / 43.3%	43.7% / 38.6%	44.8% / 44.8%	43.0% / 43.5%	43.5% / 44.3%	43.5% / 45.2%	38.6% / 49.3%	39.2% / 47.3%	38.9% / 50.6%	40.9% / 46.7%	43.8% / 46.0%	-	-	-

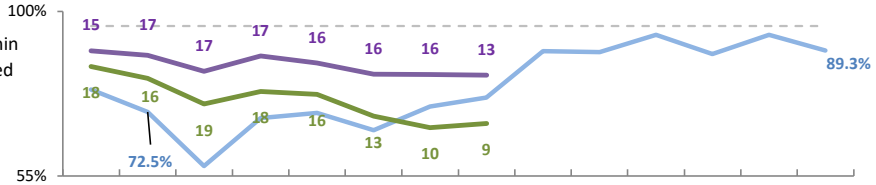
Patient Experience		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
21	FFT Negative Score - Inpatients	3%		0.9%												0.0%	≤5%	0.0%	≤5%
		0%																	
22	FFT Negative Score - Maternity (postnatal ward)	10%		1.0%												0.0%	≤5%	0.0%	≤5%
		0%																	
23	Total UHS women booked onto a continuity of carer pathway	30%		11.8%												12.2%	≥35%	12.2%	≥35%
		0%																	
24	Total BAME women booked onto a continuity of carer pathway	80%		31.2%												21.4%	≥51%	21.4%	≥51%
		5%																	
25	% Patients reporting being involved in decisions about care and treatment	100%		89.0%												89.5%	≥90%	89.5%	≥90%
		80%																	
26	% Patients with a disability/ additional needs reporting those needs/adjustments were met (total number questioned included at chart base)	100%		93.0%												88.2%	≥90%	88.2%	≥90%
		70%	290	209	209	300	301	287	249	214	234	336	208	272	304	268	339		
26 - Performance is a scored metric with a "Yes" response scoring 1, "Yes, to some extent" receiving 0.5 score and other responses scoring 0.																			
27	Overnight ward moves with a reason marked as non-clinical (excludes moves from admitting wards with LOS<12hrs)	200		62												54	-	54	-
		0																	

Access Standards		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
28	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 16)	100% 5 3	4 3	64.8% 5 5	12 7	9 5	8 5	8 5	12 7	10 7	11 7	8 5	4 2	4 3	4 2	66.0% 9 5 25%	≥95%	66.0%	≥95%
29	Average (Mean) time in Dept - non-admitted patients	06:00 03:09 01:00														03:19	≤04:00	03:19	≤04:00
30	Average (Mean) time in Dept - admitted patients	08:00 05:32 01:00														05:59	≤04:00	05:59	≤04:00
31	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	75% 5 5	65.2% 4 6	4 6	4 5	4 5	5 6	4 6	4 6	4 5	4 4	4 4	4 4	4 4	4 4	62.7% 4 50%	≥92%	62.7%	≥92%
32	Total number of patients on a waiting list (18 week referral to treatment pathway)	60,000 56,568 40,000														59,485	-	58,435	-
33	Patients on an open 18 week pathway (waiting 52 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	8,000 5 12	4 11	4 11	4 11	4 9	3 8	3 8	3 8	2 8	2 8	2 9	2 10	3 9	3 10	1,816 0	≤2,011	1,880	≤2011

		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
34	Patients on an open 18 week pathway (waiting 65 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	5	5	4	4	4	4	5	5	3	3	3	3	3	3	66	-	19	-
		12	12	11	11	10	9	9	9	8	8	8	6	7	8	510			
35	Patients on an open 18 week pathway (waiting 78 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	6	4	4	5	8	8	7	6	5	6	5	5	5	15	21	0	-	0
		15	12	10	11	12	11	10	9	9	9	9	8	8					
35a	Patients on an open 18 week pathway (waiting 104 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	1	1	1	8	14	17	15	16	12	13	13	1	1	0	0	0	-	0
		1	1	1	13	13	17	13	14	10	11	9	1	1					
36	Patients waiting for diagnostics	10,438													8,849		-	8,849	-
37	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	12	12	22.6% 11	11	11	10	10	8	7	6	7	5	5	4	10.7%	≤5%	10.7%	≤5%
		8	8	7	7	8	7	9	7	7	7	7	7	5	5				

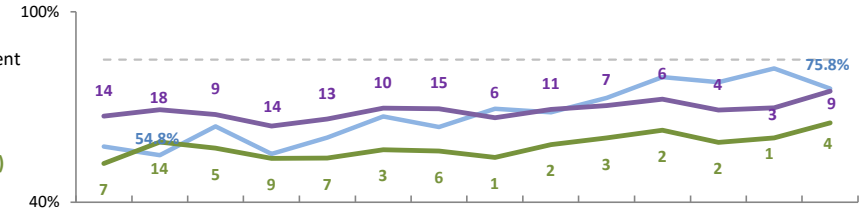
37 - As of **April 2024**, **YTD and Monthly Target** changed from **1% to 5%** to reflect latest guidance

		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
38	% Patients following a GP referral for suspected cancer seen by a specialist within 2 weeks (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	15	17	17	17	16	16	16	13							89.3%	≥96%	80.2%	≥93%
		18	16	72.5%	19	18	16	13	10	9									



38 - Beginning December 2023, NHSE published Cancer data no longer includes 2 week wait as a cancer standard for benchmarking. Data shown for October 2023 onwards will reflect internally reported UHS position for each month, but will not include Teaching Hospital/South East Hospital data

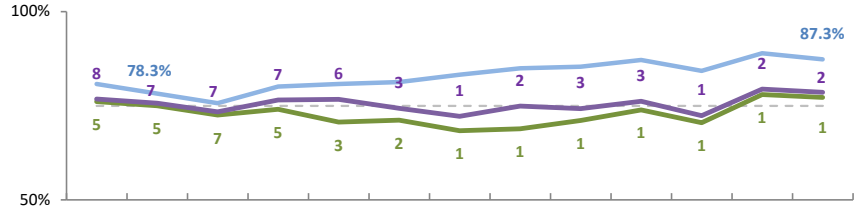
39	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	14	18	9	14	13	10	15	6	11	7	6	4	3	75.8%	9	≥85%	63.3%	≥85%
		7	54.8%	14	5	9	7	3	6	1	2	3	2	2	1	4			



39 - From October 2023 data onwards, the 62 day standard metric published in NHS england data combines Urgent Suspected Cancer and Breast Symptomatic with previously excluded Screening and Upgrade routes.

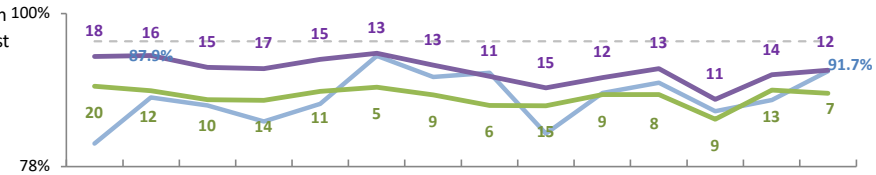
The 2024/25 national cancer target changes will be reflected next month when April 2024 data is made available

40	Cancer 28 day faster diagnosis Percentage of patients treated within standard UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	8	78.3%	7	7	6	3	1	2	3	3	1	2	2	87.3%	2	≥75%	79.3%	≥75%
		5	5	7	5	3	2	1	1	1	1	1	1	1		1			



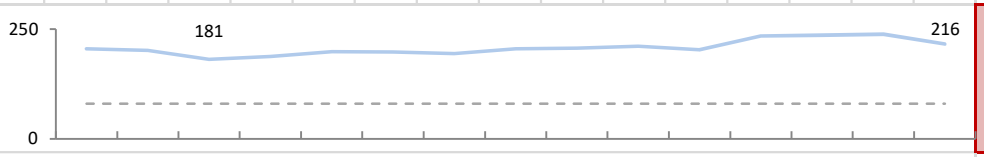
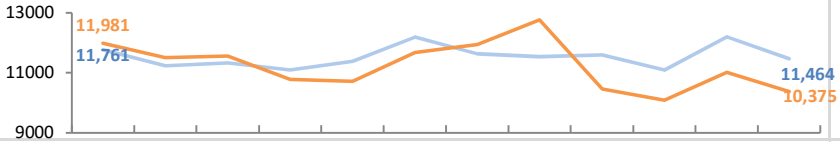
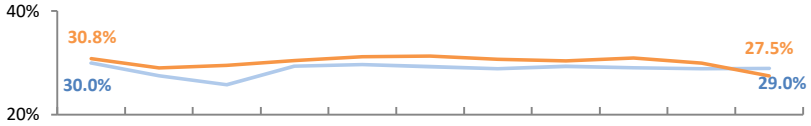
40 - The 2024/25 national cancer target changes will be reflected next month when April 2024 data is made available

41	31 day cancer wait performance - decision to treat to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	18	16	15	17	15	13	13	11	15	12	13	11	14	12	91.7%	≥96%	89.1%	≥96%
		20	87.9%	12	10	14	11	5	9	6	15	9	8	9	13	7			



41 From October 2023 data onwards, the 31 day standard metric published in NHS england data combines First Treatment and Subsequent Treatment routes.

R&D Performance		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
43	Comparative CRN Recruitment Performance - non-weighted	15	13	14	17	19	19	21	17	17	16	15	15	15	15	9	Top 10	-	-
44	Comparative CRN Recruitment Performance - weighted	11	9	9	6	12	14	15	12	11	12	9	11	11	11	6	Top 5	-	-
45	Study set up times - 80% target for issuing Capacity & Capability within 40 Days of Site Selection			25%	47%	59%	64%	46%	60%	67%	46%	88%	55%	50%	64%	50%	-	-	-
46	Achievement compared to R+D Income Baseline Monthly income increase % YTD income increase %	69.5%	35.6%	50.7% 50.7%	65.2%	84.7%	104.1%	45.8%		133.3%	133.3%	84.7%	65.2%	157.6%	75.0%	26.8% 26.8%	≥5%	-	-

Local Integration		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
47	Number of inpatients that were medically optimised for discharge (monthly average)																≤80	216	-
48	Emergency Department activity - type 1 This year vs. last year																-	11,464	-
49	Percentage of virtual appointments as a proportion of all outpatient consultations This year vs. last year																≥25%	29.0%	≥25%

Digital		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Monthly target	YTD	YTD target
50	My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month)																-	198,859	-
51	My Medical Record - UHS patient logins (number of logins made within each month)																-	34,353	-
51 - The YTD Figure shown represents a rolling average of MMR logins per month within the current financial year																			
52	Average age of IT estate Distribution of computers per age in years																-	-	-
53	CHARTS system average load times - % of pages loaded under 3s																		
53 -Data only available from April 2023 onwards.																			
From **April 2024** , metric was changed from % loading time**s under 5s** to % loading times **under 3s**																			
		Q1 23-24			Q2 23-24			Q3 23-24			Q4 23-24			Q1 24-25					
54	Cyber attacks / phishing / incidents blocked Average # Malware attempts blocked per month (10s) Average # Phishing emails blocked per month (100s) Average # Ransomware attempts blocked per month																-	-	-
54	Ransomware attempts have been included within # of Malware attempts as part of changes to Cyber Security reporting data source from Q4 23-24 onward																		

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Finance Report 2024-25 Month 1**			
Agenda item:	**5.7**			
Sponsor:	**Ian Howard – Chief Financial Officer**			
Author:	**Philip Bunting – Director of Operational Finance** **David O'Sullivan – Assistant Director of Finance – Financial Performance**			
Date:	**6 June 2024**			
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:

Context

UHS submitted its latest planning submission on 2nd May, during the M1 close-down period. As outlined in the planning paper, there also remains a likelihood that a further resubmission will be required in the coming weeks.

As a result of the late financial planning submission, budgets for each cost centre, directorate and division were not set for M1. The financial results below are therefore indicative and used to highlight movement in cost/income from M12 and ensure we retain visibility and grip of our overall financial position whilst we finalise granular budgets for each area.

M1 Financial Position

UHS reported a deficit of £3.8m in M1, which is in line with the deficit plan. The overall deficit plan for the year is £17.4m, with monthly financial improvement required during H1 as system transformation programme initiatives are expected to start to deliver.

Underlying Position

UHS entered the year with an underlying deficit of between £4m-£4.5m per month. This has deteriorated as a result of real-terms funding cuts in our overall allocation. M1 ERF performance was 118%, which whilst a significant level, was £1.9m below our planned target (based on no industrial action, approved business cases and impact of transformation programmes). However, our temporary staffing costs reduced by £1.2m from M12.

We are currently reporting an underlying deficit of £6.1m in M1. However, this will be reviewed within M2, with the expectation that ERF and other income may be under-reported.

Deficit Drivers

The drivers of our financial deficit continue to be:

- As a result of real-terms funding cuts from HIOW ICB, and growth in activity above block funding levels, we are currently under-funded on this contract by circa £33m.
- Growth in the number of patients with no criteria to reside (NCTR). The Trust has additional

	surge capacity open and has utilised additional bed capacity intended to support the elective programme to manage this growth, resulting in a significant unfunded cost pressure. • Growth in the number of patients presenting with mental health conditions only who would be better cared for in an alternative care setting. • A shortfall in additional funding for nationally negotiated pay awards in prior years. • We also entered the year with an underlying deficit from previous years, with pressures outlined above plus non-pay inflation pressures, particularly in relation to energy prices. High-cost drugs spend was also significantly above block funded levels. We continue to raise these financial pressures, particularly those linked to unfunded levels of additional activity, with our commissioners and hope to resolve these issues in the future. **Cash** We ended the year with a cash balance of £79m, which reduced by £22m to £57m in April. This is a result of payment of capital creditors and M12 invoices, as well as timing of E&T income and other income linked to delayed financial planning. Moving into 2024/25 additional vigilance will be applied and early warning systems maintained in order to assess the ongoing viability of the capital programme and also ensure the NHS England draw down process is ready if and when required.
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. • Cash risk linked to volatility above. • Inability to maximise CDEL (which cannot be carried forward) and the risk of a reducing internal CDEL allocation for 2024/25.
Summary: Conclusion and/or recommendation	Trust Board is asked to: • Note the finance position.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**People Report 2024-25 Month 1**			
Agenda item:	**5.9**			
Sponsor:	**Steve Harris, Chief People Officer**			
Author:	**Workforce Team**			
Date:	**6 June 2024**			
Purpose	**Assurance or reassurance** X	**Approval**	**Ratification**	**Information**
Issue to be addressed:	The UHS People Strategy (World Class People) sets out our goals to support the delivery of the Trust's Corporate Strategy. The 5-year Strategy, based on the insights from our UHS people, was approved by the Trust Board in March 2022. Its key areas of THRIVE, EXCEL, and BELONG shape the work of people focus across UHS. The monthly people report summarises progress against the delivery of the critical metrics in the strategy. It is provided monthly to Trust Executive Committee and People and OD Committee. The information is based on April (M1)			
Response to the issue:	Key items to note for Month 1 of the People Report • **Overall workforce** (Temp and Perm) fell by 234 WTE in month. This was primarily driven by a significant fall in bank and agency utilisation. • The **substantive workforce** has fallen by 64 WTE and has remained broadly flat since the introduction of additional controls. 20 WTE were part of the transfer out of the UHS Charity to its new independent model. Our plans this year account for expected increases in substantive workforce over the summer due to newly qualified healthcare staff beginning at UHS. • **Temporary staffing** usage fell significantly during April, driven by lower staff unavailability (leave, sickness). Bank reduced by 153 WTE, and agency fell to its lowest level in over a year at 82 WTE. A drop in demand for mental health utilisation supported our agency reductions. • The **annual workforce plan** has been submitted as part of the NHSE operating plan cycle. The plan predicates workforce reductions based on system assumptions for the delivery of significant improvements in non-criteria to reside (NCTR) and mental health patients at UHS.			

	• A number of CIP reductions are also being transacted in THQ, with vacancies being removed/remodelled. • **Recruitment controls continue** at present with the Clinical Prioritisation Panel (CPP) reviewing all vacancies prior to advertisement. This continues to ensure an appropriate balance of risk. • A process of **re-setting the trusts budgeted establishment** has been completed working in partnership with divisions to set an affordable workforce limit (AWL). • Detailed **forecasting** continues for 24/25 to provide decision support to recruitment planning. This will be completed for the remainder of the financial year. • **Absence** was low again at 3.5% per month, meeting our target to remain below 3.9% during the year. • Turnover again was lower during April at 0.7% in month. Our rolling average for Turnover is 11.4% which remains below our target for 24/25. • Meetings have taken place with each Divisional team to review the **staff survey** to discuss areas of focus and support. People Board and TEC have agreed the 24/25 objectives as part of year 3 of the People Strategy. These have also been reviewed at People and OD committee. Objectives include a focus on: • Delivery of our **workforce plan** including overall management of workforce within agreed cost envelope, and continued reductions in temporary staffing costs • To continue to focus **on attendance, wellbeing and turnover** to sustain below target. • Delivery of improved people development through the roll out of an **electronic appraisal** • Continued delivery of our new **leadership development** programmes • Review of capability and capacity to deliver the **long term NHS workforce plan** • Improved **deployment and rostering of people** • Targeted **action to improve staff experience** and increase participation rates in the staff survey • Continued increase in focusing on **celebrating our amazing workforce** and their achievements • Delivery of Year 2 of our **inclusion and belonging strategy** with a particular focus on the experience of staff with disabilities and long-term conditions.
Implications: (Clinical, Organisational, Governance, Legal?)	Implications are for good governance, meeting legal requirements, and providing safe clinical and organisational delivery.

Risks: (Top 3) of carrying out the change / or not:	Our strategic risks are set out in the UHS business assurance framework (BAF) Specifically for world class people: 3a: We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles. 3b: We fail to develop a diverse, compassionate, and inclusive workforce, providing a more positive staff experience for all staff. 3c: We fail to create a sustainable and innovative education and development response to meet the current and future workforce needs identified in the Trust's longer-term workforce plan.
Summary: Conclusion and/or recommendation	Trust Board is required to: • Note the feedback from the Chief People Officer and the People Report

UHS People Report

WORLD CLASS PEOPLE

April 2024

THRIVE EXCEL BELONG

Workforce Management

NARRATIVE | WTE GRAPHS | WTE WATERFALL | MENTAL HEALTH

Total workforce reduced by **234 WTE** against M12 (March) position. This was underpinned by a reduction in the substantive workforce of **64 WTE** and a significant drop in temporary staffing utilisation. Annual leave utilisation was much lower in April resulting in lower demand for bank cover. Some staffing groups, such as Nursing & Midwifery and Healthcare Scientists, saw an increase of 1 WTE and AHPs saw an increase of 5 WTE. Other staffing groups saw a net reduction in substantive WTE. The staffing groups with the largest reductions were Admin and Clerical (-37 WTE), Medical and Dental (-22 WTE), Estates and Ancillary (-6 WTE), Add Prof Scientific and Technic (-5 WTE) and Additional Clinical Services (-2 WTE). April saw fewer leavers (76 WTE) compared with March (143 WTE).

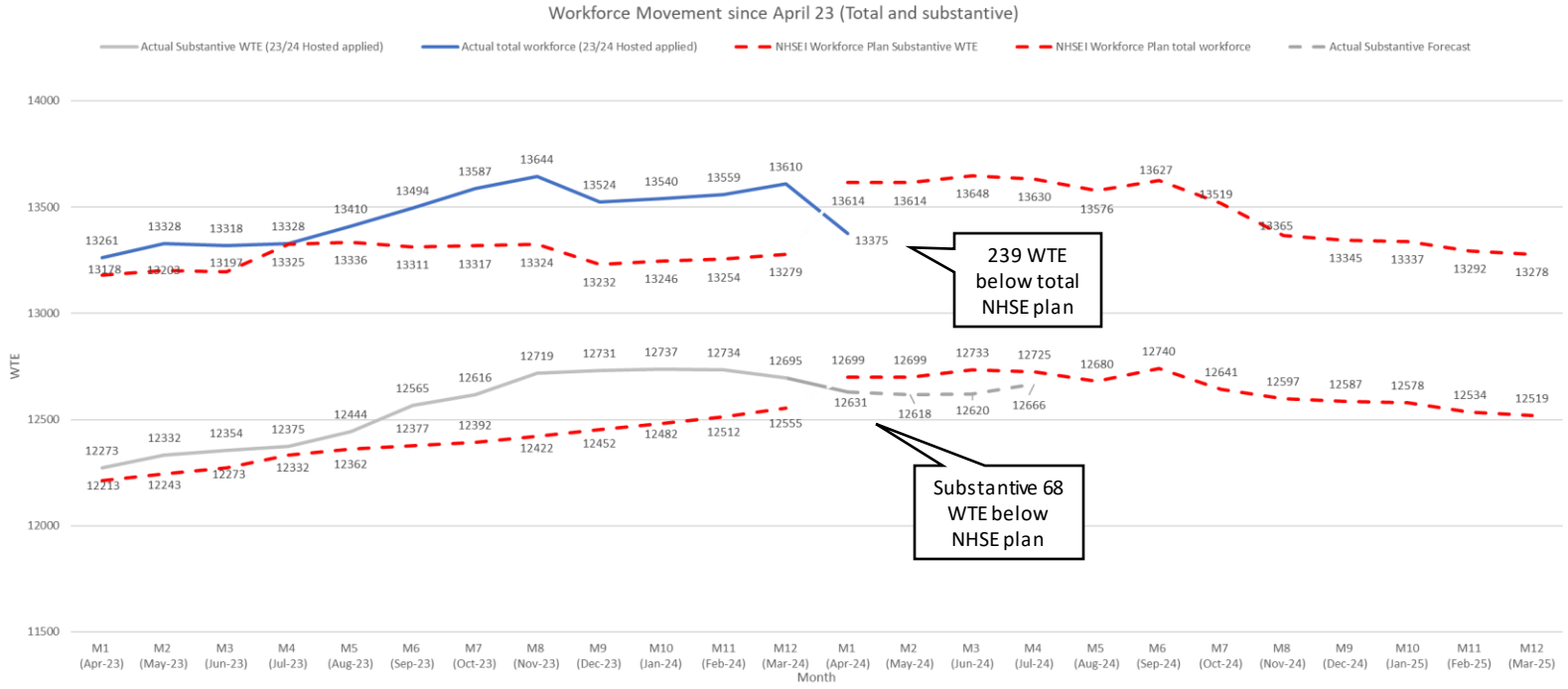
Category	WTE	Comments
Admin and Clerical WTE reduction	(37)	18.9 (WTE) transferred under TUPE (Transfer of Undertakings Protection of Employment) from Charitable Funds; this contributed largely to the reduction in A&C staff between March and April 2024 while others were split across all divisions
Medical and Dental WTE reduction	(22)	Many departments have had training doctors rotate; and a high number of resignations between March and April has increased their vacancies. It is expected that these gaps will be filled from summer (the main rotations intake in August)
Other staff group WTE reduction	(5)	Fewer starters in April compared with March
Decrease in bank usage	(153)	Reduced overall demand and usage of bank staff in all departments in April. AHPs reduced by 33%, Registered Nursing reduced by 25%, and Unregistered Nursing reduced by 16% compared with March
Decrease in agency usage	(17)	Decreased in line with reduced mental health WTE requirements in April
Total	**(234)**	

Bank usage **decreased** from March to April by 19% (816 to 662 WTE)

Agency usage **decreased** from March to April by 17% (99 to 82 WTE)

Workforce Management

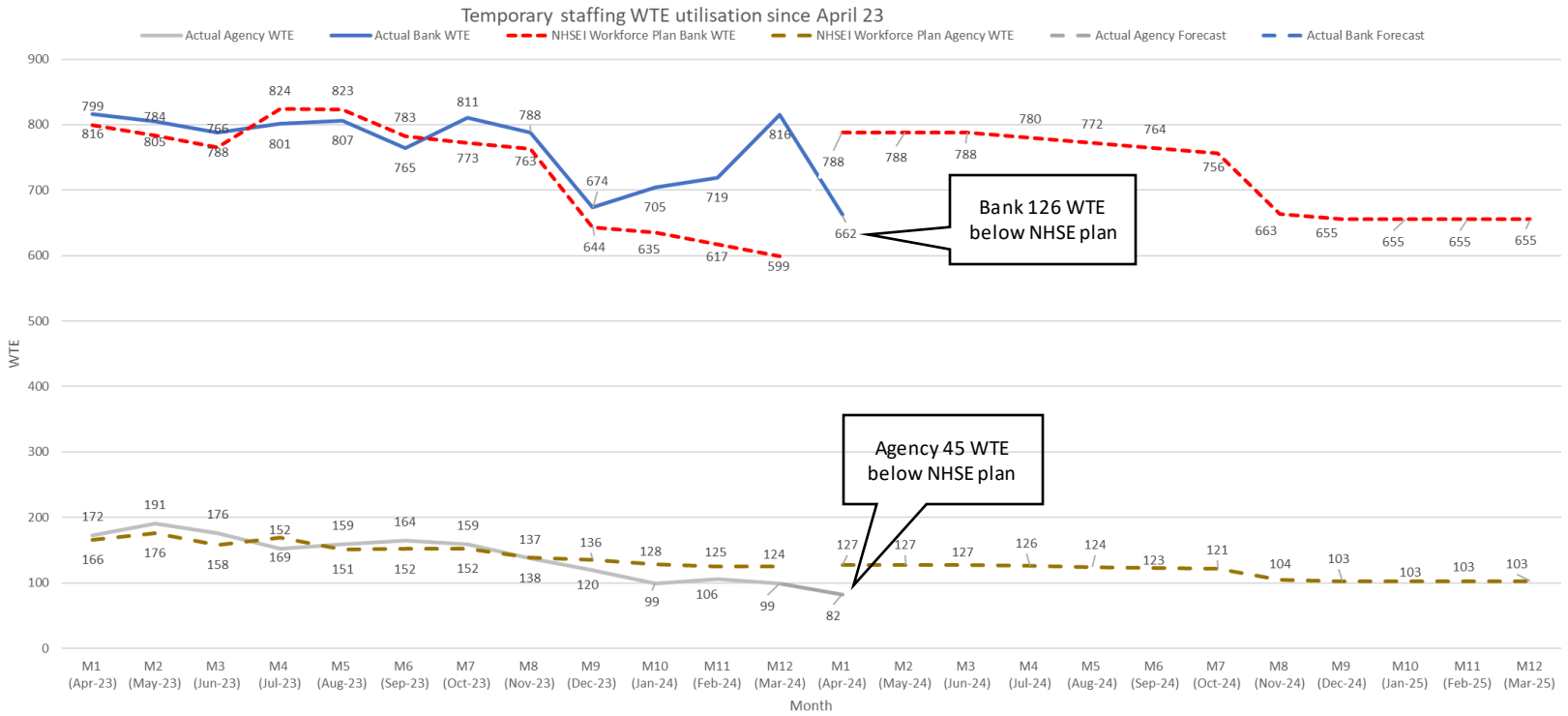
NARRATIVE | WTE GRAPHS | WTE WATERFALL | MENTAL HEALTH



Source: ESR as of April 2024

Workforce Management

NARRATIVE | WTE GRAPHS | WTE WATERFALL | MENTAL HEALTH



Source: NHSP Bank + THQ Medical Bank & Agency (NHSP Agency & 247 Agency) as of April 2024

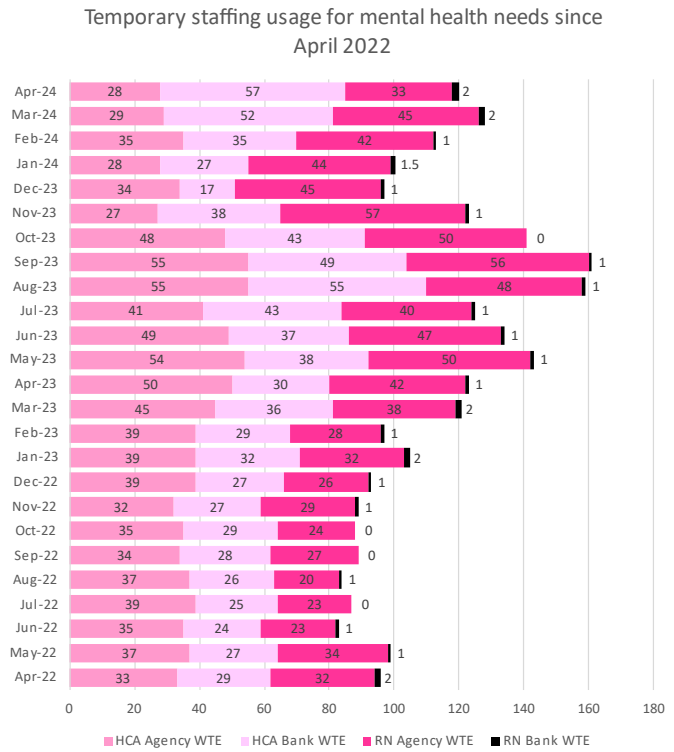
Workforce Management

NARRATIVE | WTE GRAPHS | WTE WATERFALL | MENTAL HEALTH

Mental Health narrative:

- Mental Health (April 2024):
  - Total of 120 WTE of temporary resources required for MH needs (nursing and HCAs).
  - 35 WTE were MH Registered Nursing, (33 were agency).
  - 85 WTE HCAs (28 agency & 57 bank).

- The continued mental health pressures present a safety, quality, and financial challenge to the Trust. UHS continues to escalate to the ICB and press for more comprehensive system solutions to this issue.
- A detailed record of each request is kept and is regularly reviewed by the MH team ensuring each patient is known to the specialist team and is being reviewed.
- Mental health workers are being actively migrated to bank by NHSP.
- Exploring MH training with NHSP for all workers.



People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

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

1. THRIVE

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

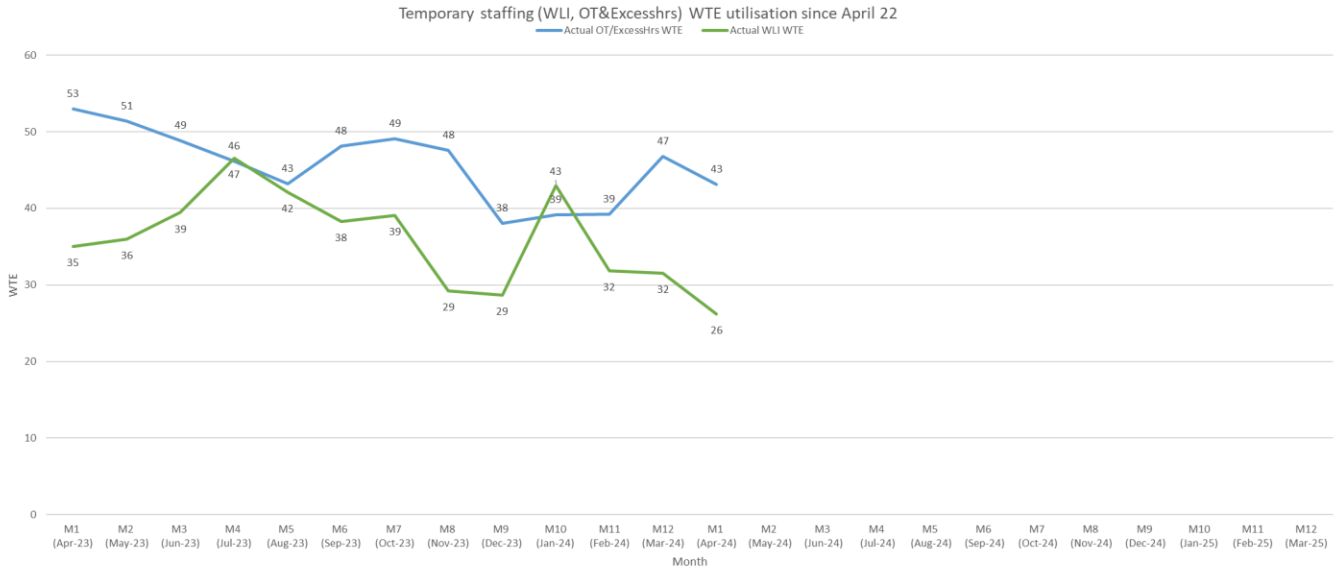
Relevant information:

Workforce Plan 2024/25 | Staff-in-Post | Temporary Resourcing | Turnover | Sickness absence | Job Planning

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

WLI Movement	M11 – M12	M12 – M1	M1 – M2	M2 – M3	M3 - M4	M4 – M5	M5 – M6	M6 – M7	M7 – M8	M8 – M9	M9 – M10	M10 – M11	M11 – M12	M12- M1	2023/24 M12 – 2024/25 M1
															Total
	16	-17	1	3	7	-4	-4	1	-10	-1	14	-11	0	-5	**-5**



Overtime and excess hours WTE decreased by 4 WTE in April 2024 and WLI decreased by 5 WTE

Source: HealthRoster as of April 2024; retrospective WLI figures have been updated from April 2023

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

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

	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M7 (Oct)	M8 (Nov)	M9 (Dec)	M10 (Jan)	M11 (Feb)	M12 (Mar)	YTD Growth	Sparkline Trend
Add Prof Scientific and Technic	379	383	381	380	386	393	402	404	403	402	401	402	25	
Additional Clinical Services	2106	2113	2118	2129	2124	2153	2143	2143	2146	2158	2152	2136	42	
Administrative and Clerical	2256	2271	2284	2287	2282	2295	2298	2321	2328	2317	2304	2288	37	
Allied Health Professionals	682	673	681	690	691	699	703	702	698	698	700	696	24	
Estates and Ancillary	383	381	385	386	380	380	382	382	385	382	380	380	-3	
Healthcare Scientists	486	484	486	491	494	493	490	496	493	497	497	498	11	
Medical and Dental	2087	2074	2065	2061	2109	2120	2134	2145	2137	2161	2183	2184	105	
Nursing and Midwifery Registered	3850	3910	3912	3908	3935	3987	4009	4072	4086	4069	4060	4053	188	
Students (Apprentices)	43	43	43	43	43	43	54	53	53	53	58	58	14	
Grand Total	**12273**	**12332**	**12354**	**12375**	**12444**	**12565**	**12616**	**12719**	**12731**	**12737**	**12734**	**12695**	**442**	

Substantive increase is due to improved vacancy fill and new approved business cases. Students increase was due to new courses starting.
Source: ESR substantive staff as of March 2024; includes consultant APAs and junior doctors' extra rostered hours, excludes Wessex AHSN, UEL and WPL. Numbers relate to WTE, not headcount.

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

Substantive Monthly Staff in Post (WTE) for 2024/25

	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M7 (Oct)	M8 (Nov)	M9 (Dec)	M10 (Jan)	M11 (Feb)	M12 (Mar)	YTD Growth	Sparkline Trend
Add Prof Scientific and Technic	397													
Additional Clinical Services	2135													
Administrative and Clerical	2248													
Allied Health Professionals	703													
Estates and Ancillary	374													
Healthcare Scientists	499													
Medical and Dental	2165													
Nursing and Midwifery Registered	4052													
Students (Apprentices)	58													
Grand Total	**12631**													

Source: ESR substantive staff as of April 2024; includes consultant APAs and junior doctors' extra rostered hours, excludes Wessex AHSN, UEL and WPL (same criteria as 23/24). Numbers relate to WTE, not headcount.

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TRUST-WIDE TURNOVER (April 2024)

Turnover (12-month rolling) has improved for several staffing groups compared with May 2023.

Staffing group	Leavers (WTE) in month	Turnover 12m rolling %
Add Prof Scientific and Technic	3.4	9.6%
Additional Clinical Services	18.5	16.5%
Administrative and Clerical	15.8	12.7%
Allied Health Professionals	5.3	11.0%
Estates and Ancillary	6.4	13.1%
Healthcare Scientists	2.0	8.9%
Medical and Dental	4.8	5.6%
Nursing and Midwifery Registered	20.0	8.4%
UHS total	**76.1**	**11.4%**

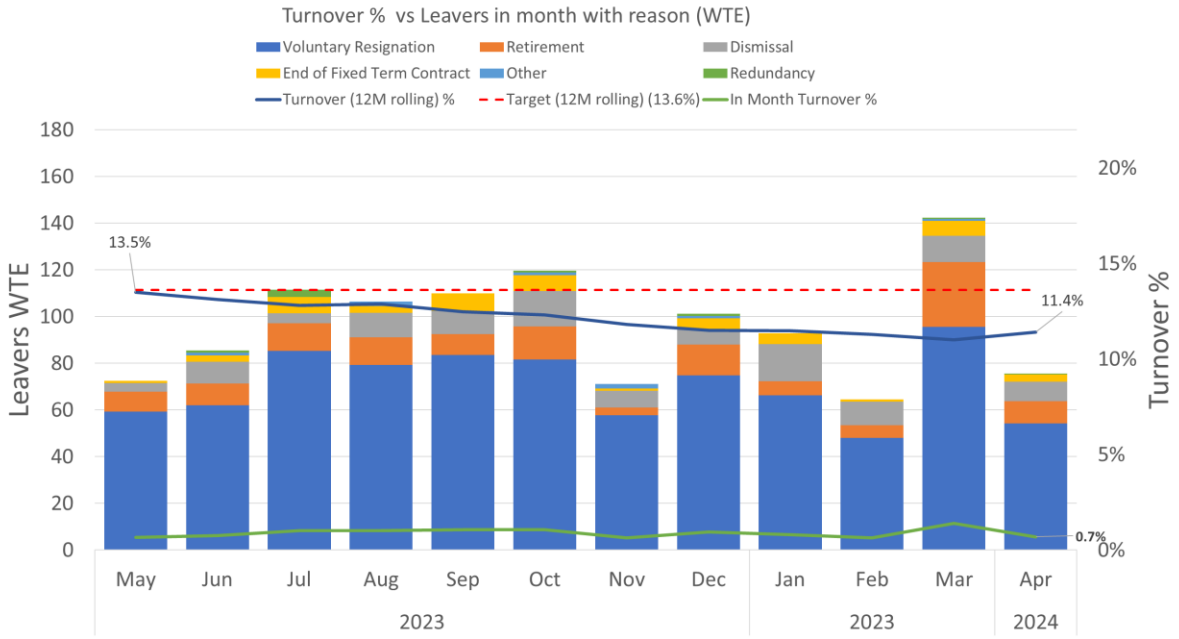
Source: ESR leavers April 2024 (excludes junior doctors)

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TURNOVER BY LEAVING REASON

In April 2024, a total of 76.1 WTE employees left the organisation. This is lower than 142. 9 WTE recorded in March 2024, with Voluntary Resignation accounting for 71% of all leavers at 54.3 WTE, and Retirement accounting for 12% of all leavers at 9.4 WTE. Dismissal accounted for 11% at 8 WTE while End of Fixed Term contract accounted for 4% at 3 WTE.

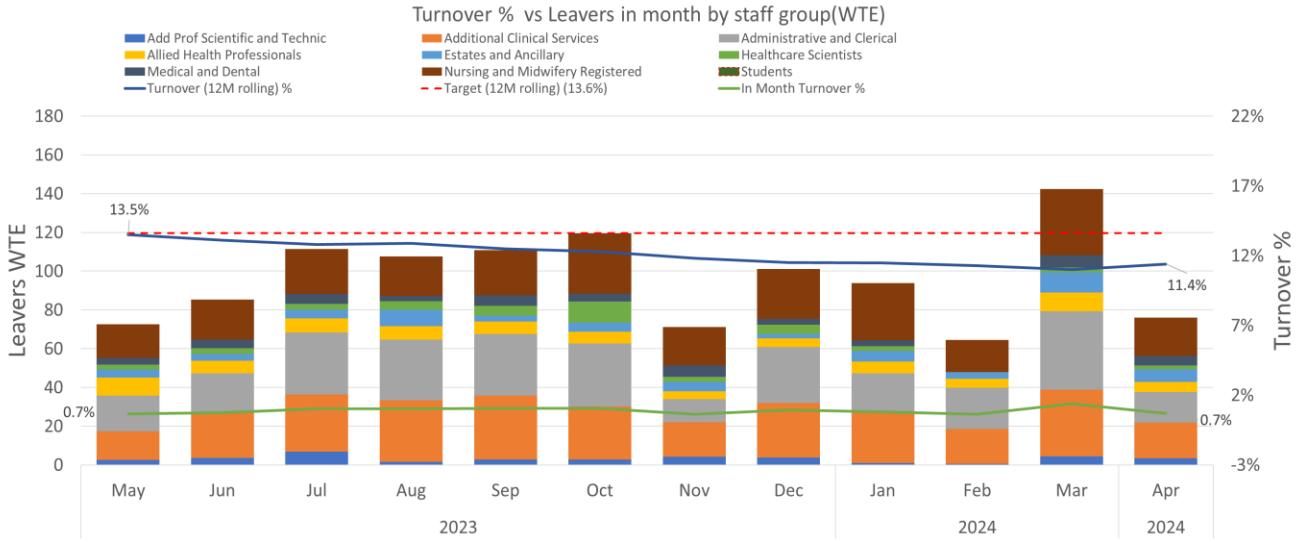


Source: ESR Leavers Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TURNOVER BY STAFF GROUP

Despite the 0.4% increase in Turnover (12-month rolling) for April 2024 compared to March 2024, Turnover is still on a downtrend keeping Turnover below the Trust target of <13.6% at 11.4%; in April 2024 (in month turnover was 0.7%) there were 76.1 WTE leavers, which is 66.8 WTE lower than March 2024 figures.



Top reasons for leaving by staff group	
Add Prof Scientific & Technic	Not feeling valued/recognised
Additional Clinical Services	Not feeling valued/recognised
Admin & Clerical	Not feeling valued/recognised
Allied Health Professionals	Pay
Estates & Ancillary	Lack of job satisfaction; Retirement; Career Change; Lack of development opportunities
Healthcare scientists	Relationship with colleagues
Medical & Dental	Personal circumstances; Not feeling valued/recognised; Lack of job satisfaction
Nursing & Midwifery	Excessive workload or pressure; Dependents/Carers responsibilities

- This data is from respondents to the exit survey for quarter 3 (October, November and December 2023)
- The table above covers those who left UHS only (leavers)

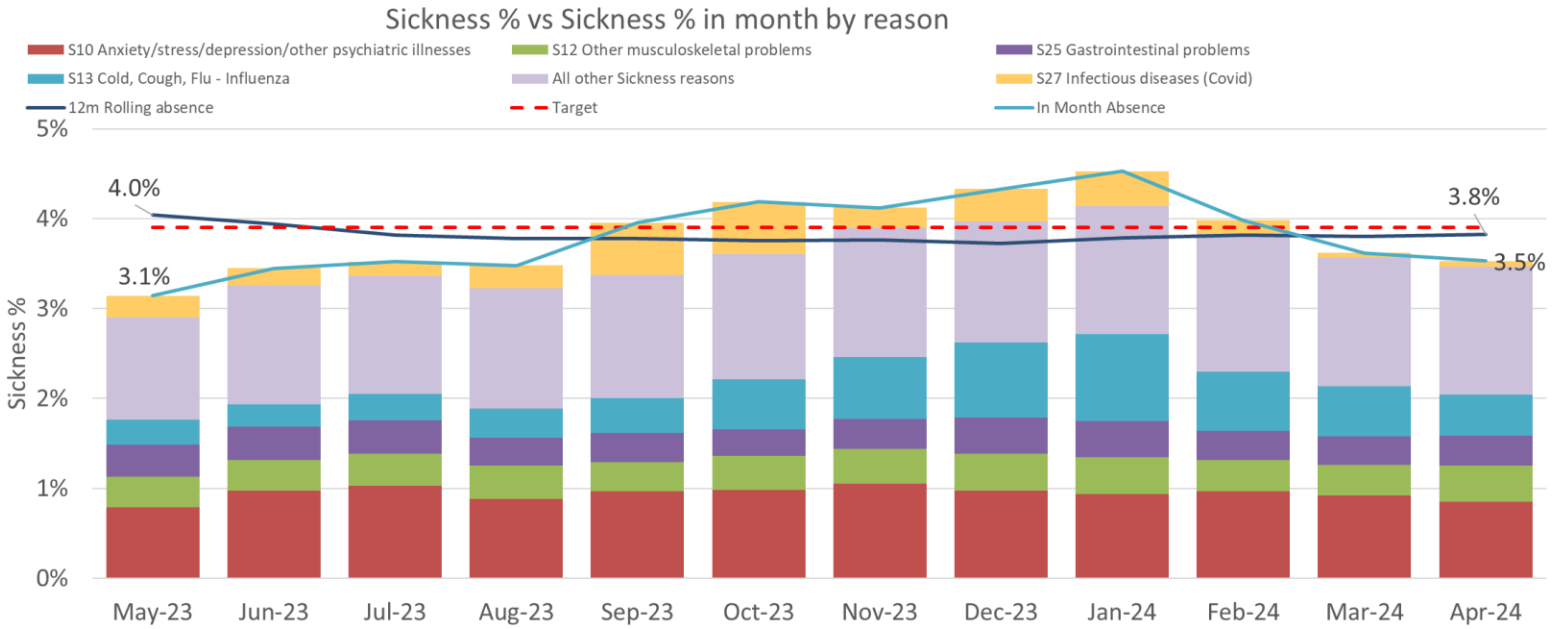
Source: ESR – Leavers Turnover WTE, HRBPs

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

SICKNESS

The current rolling sickness rate as of April 2024 is 3.8%, which is below the sickness target for 24/25 (<3.9%). In-month sickness for April 2024 was 3.5%. The current rolling sickness rate for April 2024 is lower than May 2023 figure (4.0%).



Source: ESR – Sickness data

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

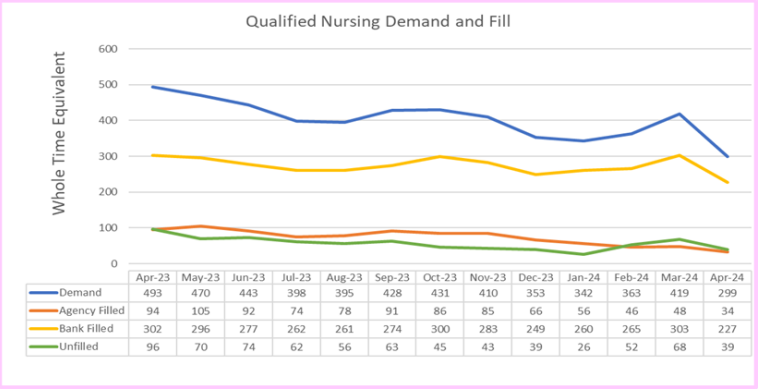
TEMPORARY RESOURCING

Status

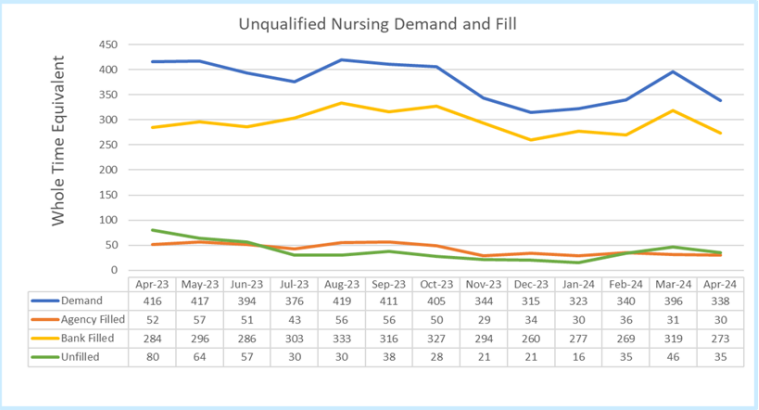
- **Qualified nursing demand/fill (WTE):** Demand decreased from 419 in March to 299 in April, of which, bank filled 227 (down 76 on last month), agency filled 34 (down 14 on prior month) and 39 remained unfilled (down 29 on prior month).
- Bank fill for qualified nursing increased from 72.3% in March to 75.79% in April.
- Demand for April is 194 WTE lower than April 2023.
- **HCA demand/fill (WTE):** Demand decreased from 396 in March 338 in April, of which, bank filled 273, agency filled 30 WTE (30 WTE were MH HCAs) and 35 remained unfilled.
- Bank fill for HCA increased from 80.47% in March to 80.68% in April.
- Demand for HCAs is 78 WTE lower than in April 2023.

Actions

- Agency rate reduction plan – cap compliance from 1st April 2024 for all agency.
- Migration of Mental health agency workers to NHSP on going.
- Further analysis on shift demand vs vacancy rate
- Additional controls in cascade implemented to reduce agency fill further, bumping and Golden keys.



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Demand	493	470	443	398	395	428	431	410	353	342	363	419	299
Agency Filled	94	105	92	74	78	91	86	85	66	56	46	48	34
Bank Filled	302	296	277	262	261	274	300	283	249	260	265	303	227
Unfilled	96	70	74	62	56	63	45	43	39	26	52	68	39

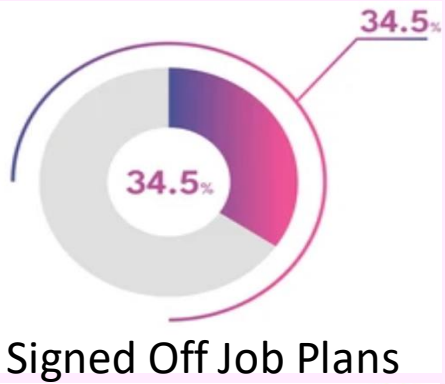


	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Demand	416	417	394	376	419	411	405	344	315	323	340	396	338
Agency Filled	52	57	51	43	56	56	50	29	34	30	36	31	30
Bank Filled	284	296	286	303	333	316	327	294	260	277	269	319	273
Unfilled	80	64	57	30	30	38	28	21	21	16	35	46	35

Source: NHSP April 2024

People Report

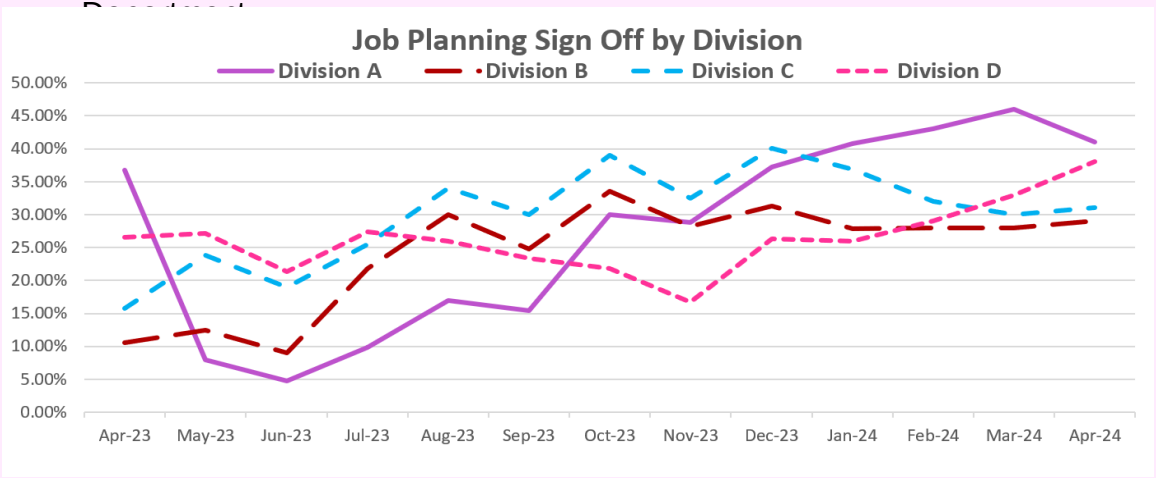
THRIVE | EXCEL | BELONG | PATIENT SAFETY



Signed Off Job Plans

Active Job Plans

- Job planning sign off levels stable at 34.5%
- Active Job Plans stable at 89%
- Division A Job Planning Consistency Report
- Options to change Job Planning Cycle and Renewal sent to LCNC
- 30 Seconds of Job Planning News – Job Plan Sign Off Update, Informing on proposed changes and Minor system update for multi-Sign Off by



People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

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

2. EXCEL

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

Relevant information:

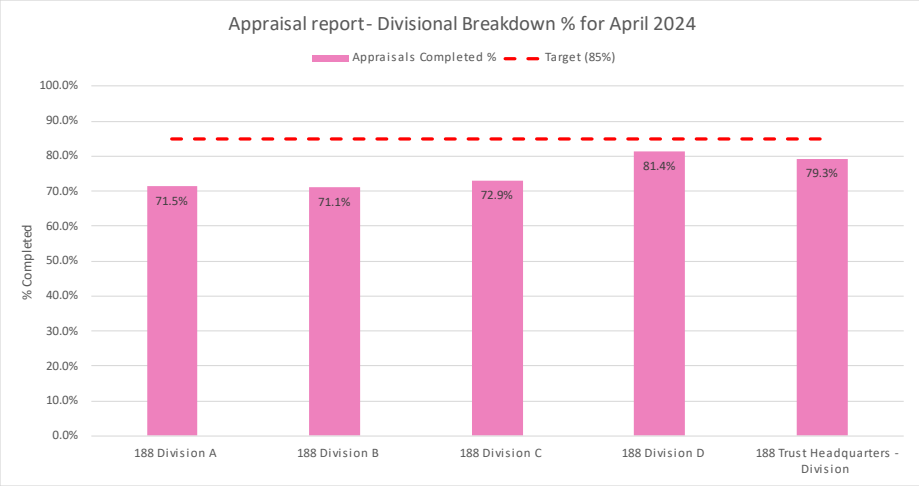
Appraisals | Statutory and Mandatory Training compliance

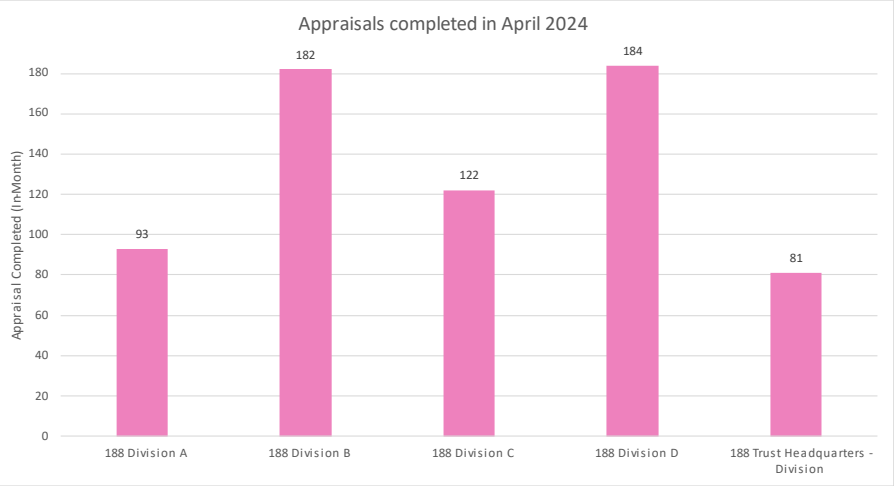
People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

APPRAISALS

A total of **662** appraisals **(74.7%)** were completed in M1 (April 2024).
Phase 2 of the 'Appraisal Improvement Project' has started. This involves the development of the digital appraisal using new 'Talent' functionality on the VLE





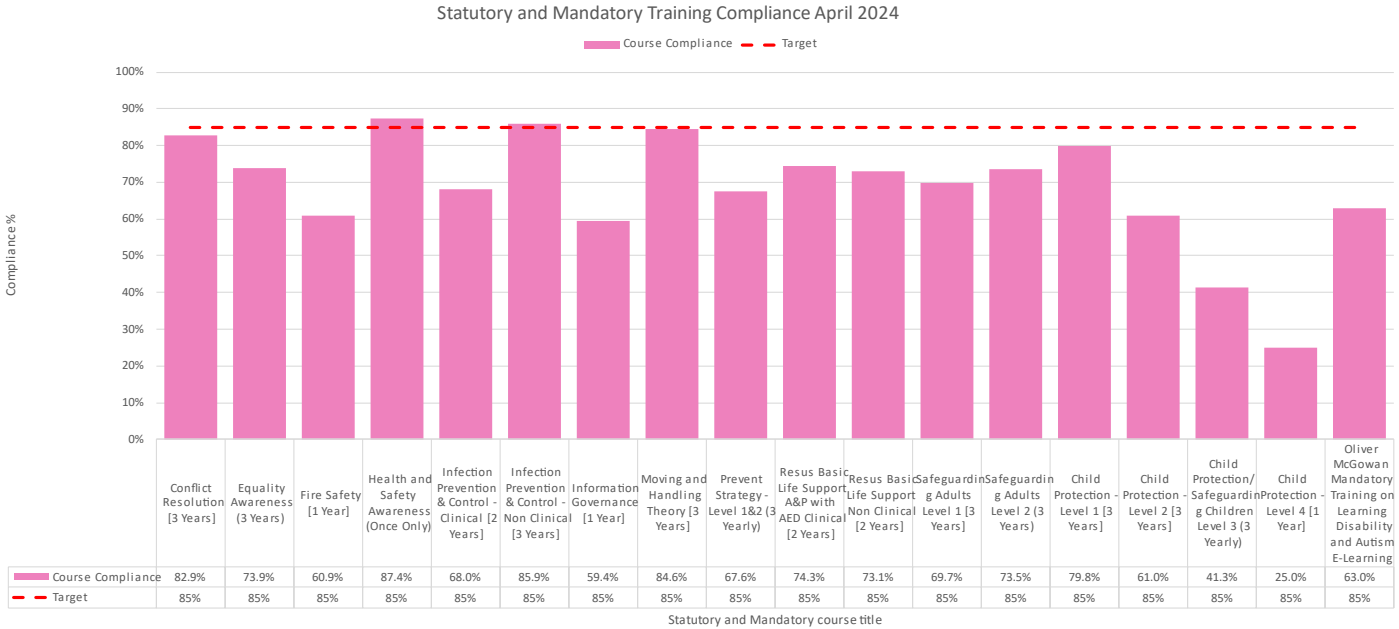
Source: ESR – Appraisal data for Divisions A, B, C, D and THQ only

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

Statutory and Mandatory Training

Free ‘Totara digital accessibility’ add-on in testing.



	Conflict Resolution [3 Years]	Equality Awareness (3 Years)	Fire Safety [1 Year]	Health and Safety Awareness (Once Only)	Infection Prevention & Control - Clinical [2 Years]	Infection Prevention & Control - Non Clinical [3 Years]	Information Governance [1 Year]	Moving and Handling Theory [3 Years]	Prevent Strategy - Level 1&2 (3 Yearly)	Resus Basic Life Support A&P with AED Clinical [2 Years]	Resus Basic Life Support Non Clinical [2 Years]	Safeguarding Adults Level 1 [3 Years]	Safeguarding Adults Level 2 (3 Years)	Child Protection - Level 1 [3 Years]	Child Protection - Level 2 [3 Years]	Child Protection/ Safeguarding Children Level 3 (3 Yearly)	Child Protection - Level 4 [1 Year]	Oliver McGowan Mandatory Training on Learning Disability and Autism E-Learning
Course Compliance	82.9%	73.9%	60.9%	87.4%	68.0%	85.9%	59.4%	84.6%	67.6%	74.3%	73.1%	69.7%	73.5%	79.8%	61.0%	41.3%	25.0%	63.0%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Source: Virtual Learning Environment (VLE)

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

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

3. BELONG

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

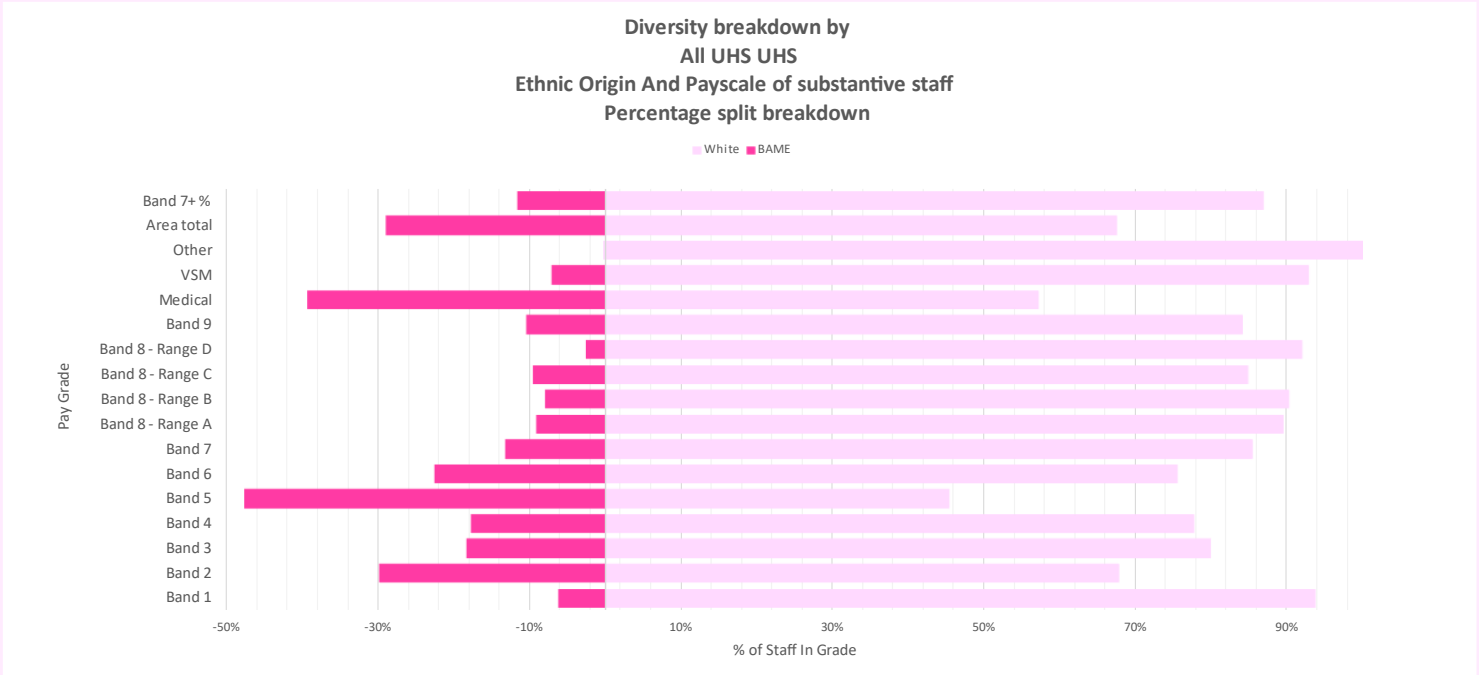
Relevant information:

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

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

STAFF IN POST – ETHNICITY

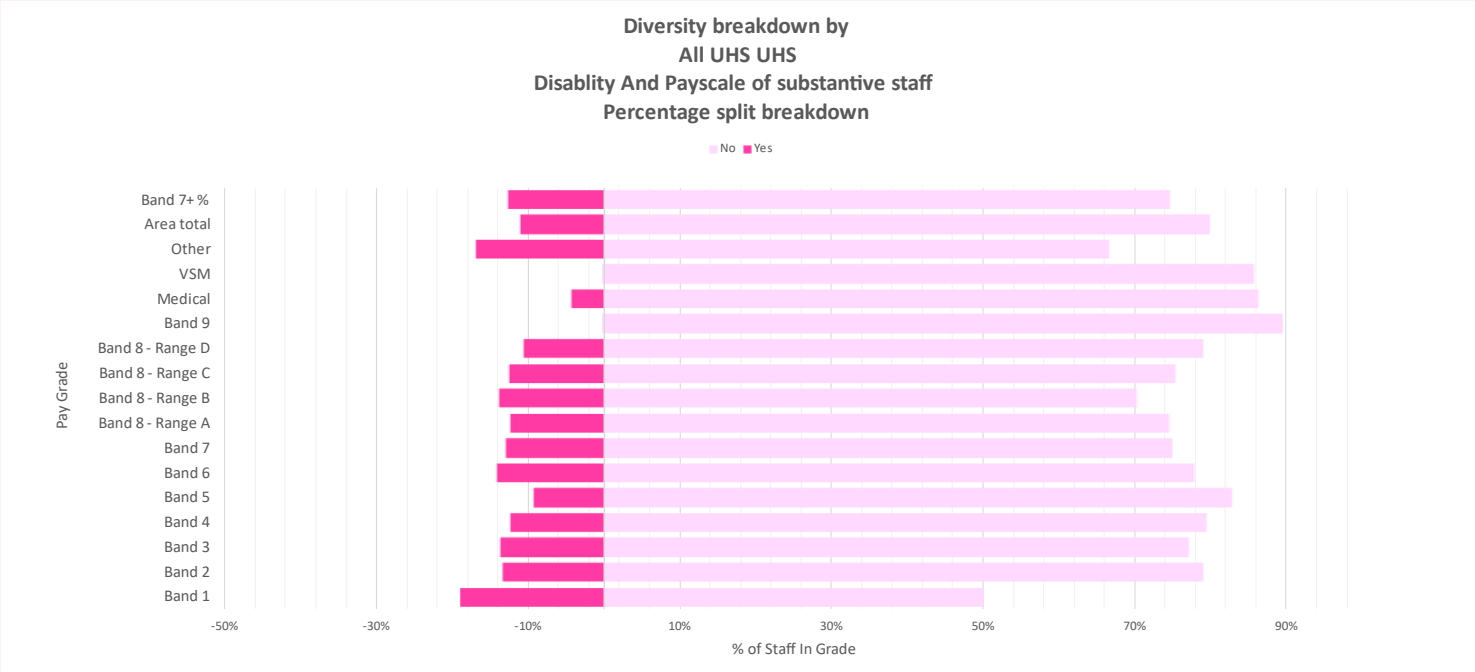


Source: ESR – April 2024

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

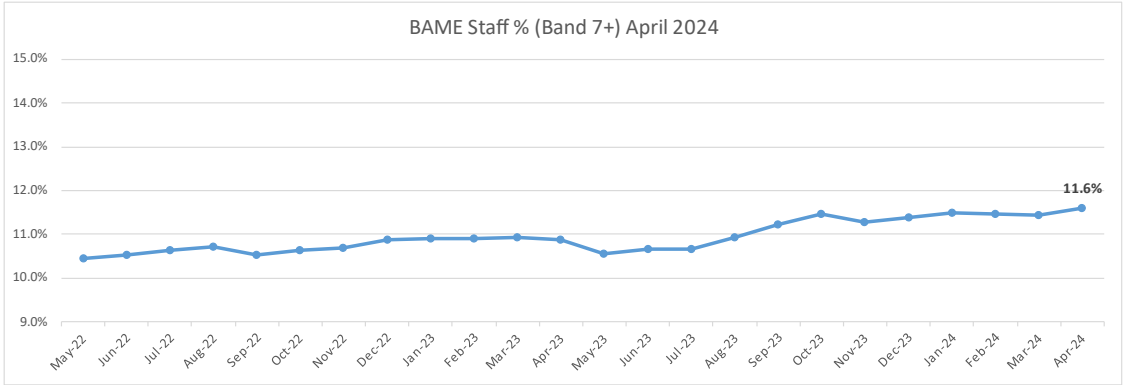
STAFF IN POST – DISABILITY STATUS

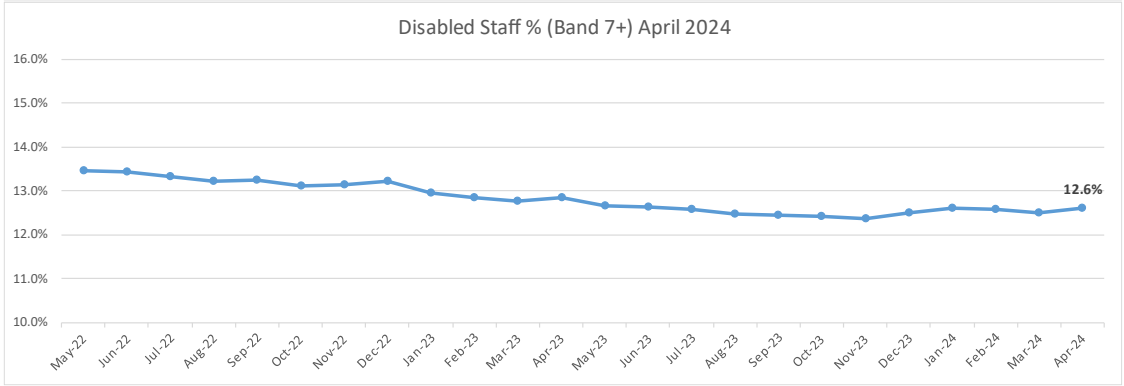


Source: ESR - April 2024

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY





STAFF IN POST – ETHNICITY and DISABILITY

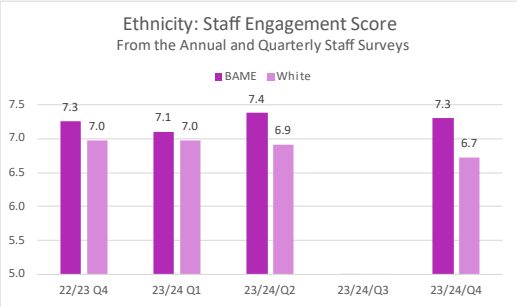
- Work continues under the themes of the Inclusion and Belonging Strategy
- Following the results of the 2023 Workforce Disability Equality Standard (WDES) at UHS which showed that disparity levels between those with disability and those without at UHS have increased, an action plan has been agreed to specifically focus on improving experiences of disabled colleagues

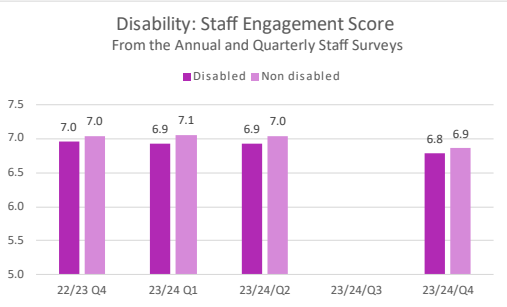
Source: ESR

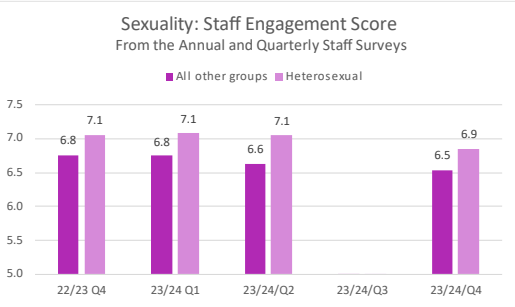
People Report

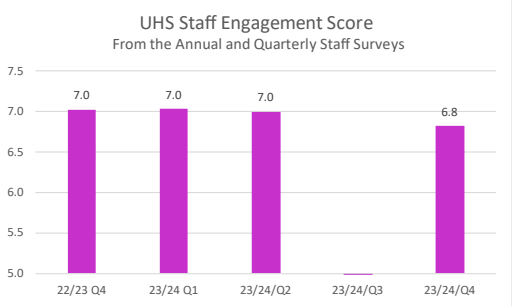
THRIVE | EXCEL | BELONG | PATIENT SAFETY

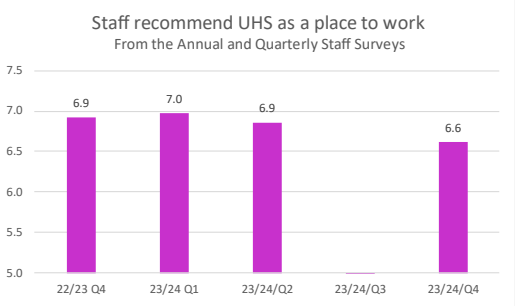
Pulse Survey – Q2 2023/24











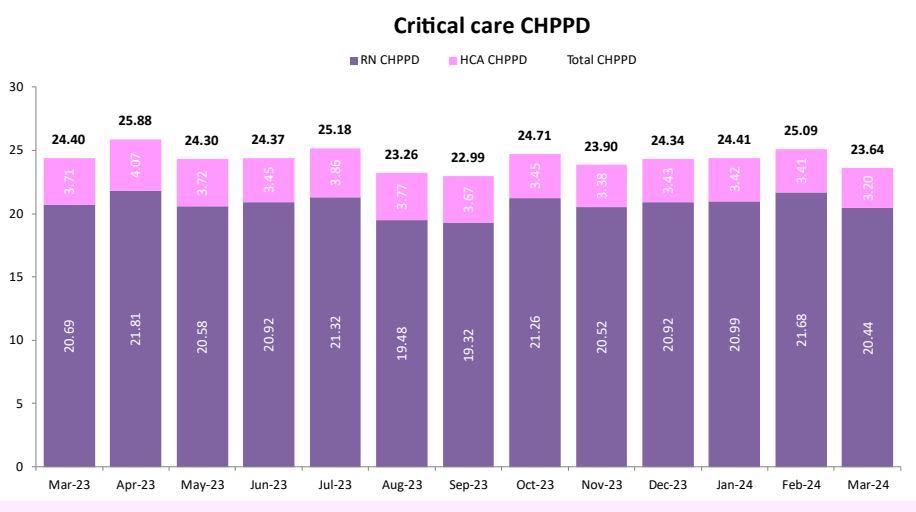
Source: Picker (Qualtrics)

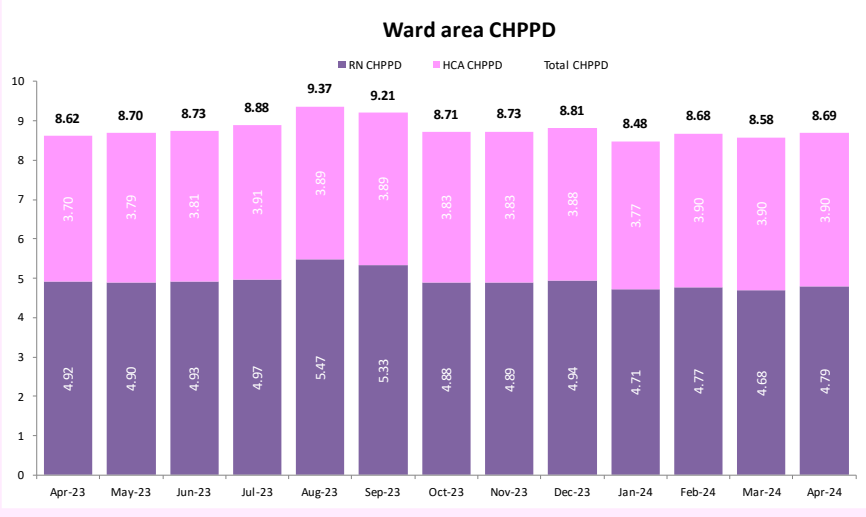
People Report

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

CARE HOURS PER PATIENT DAY
April 2024

The Ward areas total CHPPD rate in the Trust increased by 0.1 from last month to 8.7 from 8.6. RN decreased from 4.7 to 4.8, while HCA remained the same at 3.9.





The CHPPD rate in Critical care increased overall by 1.6 from March 2024. RN 21.7 (previously 20.4), HCA increased from 3.2 to 3.5. Overall, 25.2 (previously 23.6). Staffing on intensive care and high dependency units is always adjusted depending on the number of patients being cared for and the level of support they require.

Source: HealthRoster & eCamis

Appendices

Workforce Management

Area	Action taken forward
New substantive recruitment Controls	• A senior clinical oversight prioritises all recruitment and identifies critical posts that require start dates sooner. This is supported by risk-based assessments on impact. • Additional controls on fixed-term contract extensions, hours changes, and internal recruitment requests are in place. • Planned nursing recruitment for 24/25 has been approved at TEC including overseas resourcing for 24/25. • HCA recruitment is continuing each month to cover expected turnover • Fully centralised admin and clerical recruitment process initiated for patient-facing Band 2/3 Divisional posts. The prioritisation of placement is to be led by divisions. • Externally funded / hosted posts proceeding straight to recruitment
Forecasting	• Detailed staff group and care group forecasting analysis was undertaken in 2023/24 and will continue into 2024/25 • This is based on known starters and predicted leavers /turnover • This will be used to support continued decisions relating to recruitment controls
Temporary Staffing Controls	• The CNO is leading a specific nursing group focused on bank demand supported by Finance and Workforce. • Dual approval for nursing NHSP shifts was enacted on 3 January 2024 • Nursing rosters on wards have been reviewed to ensure maximum deployment of staff • The Deputy CNO continues to review the use of mental health nursing agency, including reviewing opportunities for safe reduction. • Role by role review of all A&C bank and agency by executive directors with assignments agreed to end where feasible. Executive sign-off for all new A&C bank and agency placements.
Reporting	• Continued weekly reporting on WF (substantive, bank, agency) internally and to the ICB, including quantification of mental health pressure. Weekly reporting updated to include variation to forecast in addition to plan • Divisional WF trajectories completed for all divisions and THQ; to be provided in divisional data packs for monthly review meetings

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Infection Prevention and Control Annual 2023-2024 Report**			
Agenda item:	**5.10**			
Sponsor:	**Gail Byrne, Chief Nursing Officer/Director of Infection Prevention & Control**			
Author:	**Julie Brooks, Consultant Nurse Infection Prevention & Control and Deputy Director of Infection Prevention & Control** **Dr Julian Sutton, Lead Hospital Infection Control Doctor**			
Date:	**6 June 2024**			
Purpose:	**Assurance or reassurance** √	**Approval**	**Ratification**	**Information** √
Issue to be addressed:	To review progress and performance in reducing the risk of healthcare associated infection (HCAI) in UHS and provide a 2023/24 report.			
Response to the issue:	This report provides an overview of performance and progress in relation to reducing the risk of healthcare associated infection including: • Performance against key infection indicators. • Assurance of infection prevention standards, practice and processes. • Identification of learning and actions to further reduce risks of HCAI to patients, staff, the organisation and the public.			
Implications: (Clinical, Organisational, Governance, Legal?)	Legal duty to protect service users and staff from avoidable harm in a healthcare setting: 'Code of Practice on the prevention and control of Infection'/ Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the legal duty to ensure the health and safety of all employees whilst at work and of any persons affected by the Trust's activities, as per the Health and Safety at Work etc. Act 1974.			
Risks: (Top 3) of carrying out the change / or not:	• Risk of harm to staff and patients due to healthcare associated infection. • Risk of reputational and financial penalty from enforcement action. • Increased length of stay of inpatients who acquire healthcare associated infection leading to reduced organisational productivity.			
Summary: Conclusion and/or recommendation	Performance in 2023/24 in relation to HCAIs and other infections has been challenging, with national target thresholds in a number HCAI indicators and antimicrobial usage exceeded. Improvements are required in a range of indicators along with an enhanced focus to ensure that fundamental standards of IP&C practice and prudent antimicrobial prescribing are consistently applied. Members of Trust Board are asked to: 1. Review the report and the identified actions detailed in each section and ensure these are addressed via the Divisional Governance processes, with relevant teams and staff groups. 2. Ensure that plans are in place within Divisions/Care Groups to improve IP&C practice standards and antimicrobial prescribing and ensure leadership and consistent application of expected standards by all staff to reduce risk of transmission of infection. 3. Note the ongoing concerns in relation to the clinical environment including limited side room capacity, poor ventilation and ageing ward infrastructure and the risk that this poses to the ability to effectively prevent and control infection.			

1.Introduction

Category		Annual Limit	Action /Comment
National Objectives:	MRSA bacteraemia (Threshold = 0)	R	7 MRSA BSI attributable to UHS
	Clostridioides difficile infection (Threshold = 60)	R	105 cases in 2023/24
	E coli Bacteraemia (Threshold = 120)	R	147 cases in 2023/24
	Klebsiella Bacteraemia (Threshold = 56)	R	58 cases in 2023/24
	Pseudomonas Bacteraemia (Threshold = 33)	G	24 cases in 2023/24
Other	MSSA		59 post 48hr cases in 2023/24
	VRE		12 post 48hr cases in 2023/24
Antimicrobial Stewardship	Prudent antibiotic prescribing	R	NHS standard contract requires a reduction in the use of broad-spectrum antibiotic usage of 10% for 2023/24 (against a 2017 baseline)
Provide assurance of basic infection prevention practice:	Assurance of Infection Prevention Practice Standards	R	89/144 areas did not meet requirements needed to achieve full IP&C accreditation at year end 2023/24.

2. Analysis

2.1 Healthcare Associated Infection

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

MRSA Bacteraemia (MRSA BSI)

7 cases of Healthcare Associated (HOHA/COHA) MRSA BSI attributed to UHS in 2023/24 against a nationally set threshold of 0. This compares to 4 cases in 2022/23. 3 cases occurred in Q4 as summarised below (summary of previous cases presented in Q3 report). All cases underwent a detailed concise review led by the Infection Prevention Team and an after action review (AAR) with the relevant clinical teams to identify learning and areas for improvement

Summary of Q4 cases:

January 2024 (CV&T) Hospital Onset / Healthcare Associated	75-year-old male transferred from Salisbury for cardiac surgery. Unwell on admission to UHS and cultures identified an MRSA BSI. Treated with antibiotics for the MRSA BSI from admission, pre, perioperatively and post operatively (for 48rs) under the advice of a Consultant Microbiologist. Patient's condition deteriorated 5 days after cessation of antibiotics and a further blood culture taken again cultured MRSA. Thought likely to be re-lapse of infection/continuing infection following cessation of antibiotics likely due to ongoing endovascular MRSA infection and/or infective endocarditis.
January 2024 (Neuro) HOHA Hospital Onset / Healthcare Associated	79-year-old female admitted with a head injury following a fall and diagnosed with intracranial mass and haemorrhage requiring neurosurgery and admission to NICU. The patient was not previously known to be colonised with MRSA and tested negative for MRSA on admission to UHS, and in subsequent MRSA screens taken after admission, up until the positive MRSA blood culture which was taken 33 days after admission. The source of the MRSA BSI was not clear Review of the case identified that appropriate measures to reduce the risk of MRSA infection in a patient not known to be MRSA positive were taken (e.g. risk reduction washes and MRSA screening); theatre practice review confirmed that expected measures were in place to prevent surgical site infection and no concerns were noted with the patients wound. Incidental learning from the case review identified that improvements were required in relation to documentation of IV cannulas.
March 2024 (Cancer Care) Community Onset / Healthcare Associated	94-year-old male who attends UHS twice monthly for supportive red blood cell transfusions (2 visits in March prior to positive blood culture). The patient was not previously known to be colonised with MRSA and was admitted to UHS unwell with fever, agitation, confusion, generally unsettled, and an area of swelling and redness noted on left lower leg. Blood culture and nose/groin swab tested positive for MRSA on admission. MRSA screens taken on the last inpatient admission (Jan 2024) had been negative and the patient has therefore subsequently acquired MRSA either during his inpatient admission in Jan/Feb 2024, during day case visits to UHS for treatment or in the community (has carers at home). The source of the MRSA BSI was not clear – patient was treated for a chest infection and had blisters on leg but no positive cultures to indicate these as a clear source. Review of the case identified that additional MRSA screens taken during the previous inpatient admission were not tested as they were taken with the incorrect swabs. It was also identified that the patients care during day case attendance for blood transfusions was documented on a separate system accessed by Cancer Care staff which lacked key information. An action was identified to address this.

Typing of all cases of MRSA BSI to date have confirmed that they are un-related.

Whilst a range of MRSA prevention and reduction strategies remain in place within UHS guidance and policies (e.g. MRSA screening on admission, risk reduction washes following admission to hospital, ongoing focus and awareness on IP&C practice standards) key learning from review of the 7 MRSA

BSI cases identified gaps in the application of measures to prevent MRSA acquisition and subsequent infection and assurances in practices relating to invasive device care:

- Patients not receiving risk reduction washes following admission to hospital.
- Patients who were found to be MRSA positive (or known to be MRSA positive on admission) not receiving MRSA decolonisation therapy / delay in prescribing and commencing MRSA decolonisation therapy following confirmation of the positive MRSA result.
- Gaps in assurance in relation to insertion, management and observation of intravenous cannula (incomplete documentation).

Additional learning was also identified relating to concerns with the cleanliness/aging of equipment in theatres and concerns with practice/theatre etiquette.

Local improvement actions were identified and agreed for the areas involved along with wider trust-wide actions and sharing of learning from the case reviews.

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

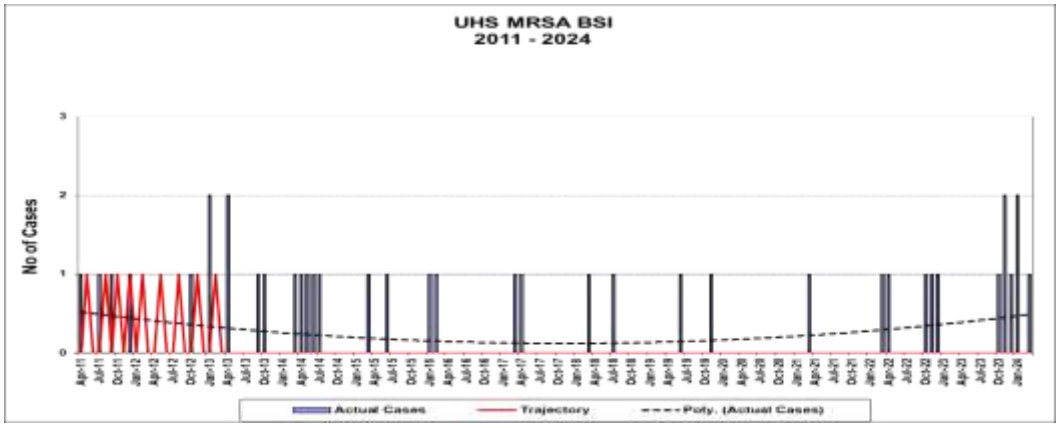
**Hospital-onset, healthcare associated (HOHA) - Specimen date is ≥3 days after the current admission date (where day of admission is day 1)*

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

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

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

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



UHS has an attributable MRSA BSI rate of 1.74 cases/100,000 bed days and ranks 6 of 8 self-selected peer hospitals. Top quartile, median and lower quartile marker rates are 0.4, 1.1 and 1.8 cases/100,000 bed days.

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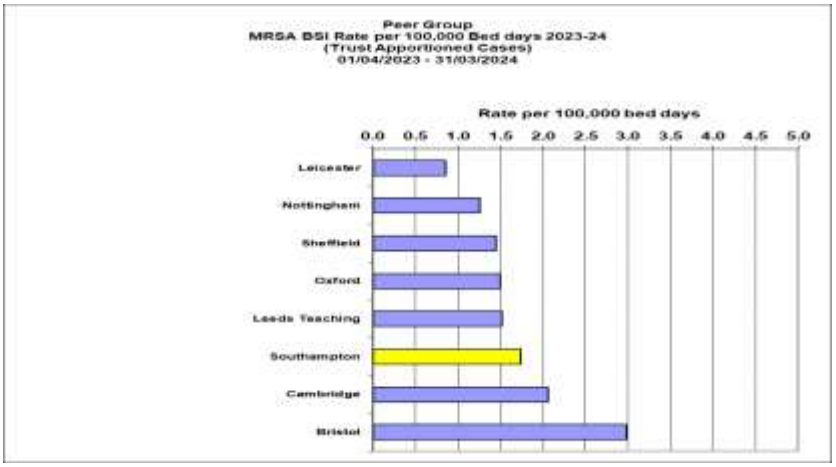
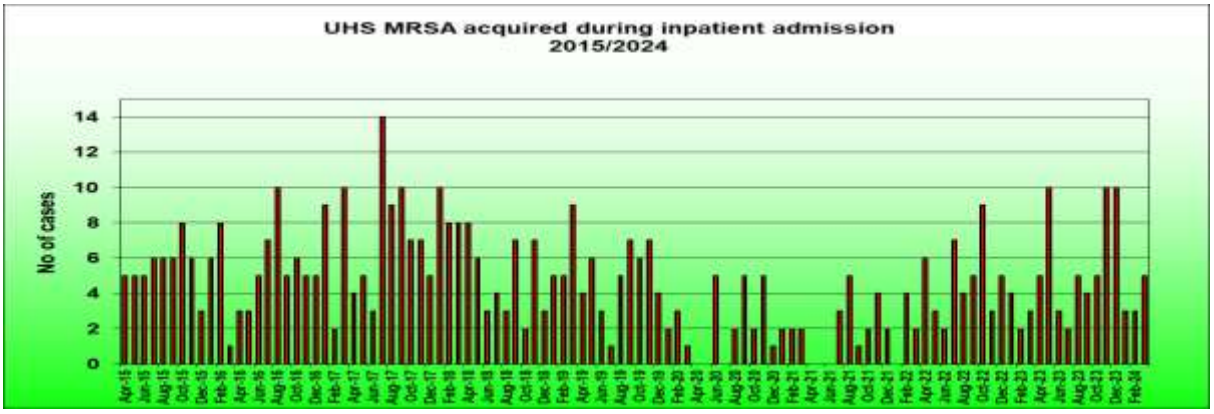


Acquisition of MRSA colonisation in UHS

68 patients acquired MRSA (colonisation or infection) in UHS in 2023/24 compared to 54 patients in 2022/23.



In response to the increase in cases of MRSA acquisition and MRSA BSI's seen in Q3, MRSA infection prevention & control (IP&C) practice reviews (by the Infection Prevention Team) were introduced for patients who are newly colonised with MRSA to ensure that all expected measures were undertaken as per UHS policy. Top themes from the reviews undertaken in Q4 included:

- Lack of documented evidence that patients received risk reduction washes following admission to hospital.
- Topical MRSA decolonisation therapy not prescribed following confirmation of the positive MRSA result.
- UHS isolation risk assessment not completed.
- Patients were not supplied with a trust information factsheet on MRSA.

Actions and interventions taken to support improvements in practice were undertaken in Q3 and Q4, including education, awareness and communication activities regarding the required measures to prevent MRSA colonisation and infection. Further enhanced focus will be taken in 2024/25 specifically relating to:

- Continued MRSA IP&C practice reviews by the Infection Prevention Team (IPT).
- Focused MRSA ward rounds/reviews in Q1 and provision of targeted education/training to support improvements in practice.
- Focus on improving documentation of intravenous cannula insertion and ongoing care.
- Focus on IP&C practice standards in theatres.

Clostridioides difficile (C.difficile)

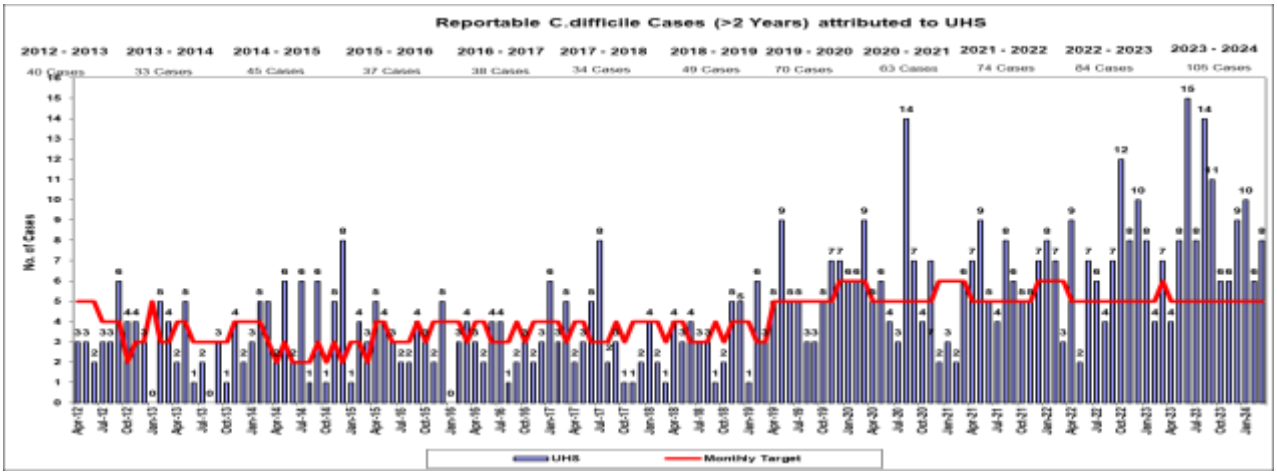
Trusts are required under the NHS Standard Contract 2023/24 to minimise rates of C. difficile so that they are no higher than the threshold levels set by NHS England and Improvement. Trust-level thresholds comprise total healthcare-associated cases i.e. Hospital-onset healthcare associated (HOHA) and Community-onset healthcare associated (COHA). UHS were set a national performance threshold of 60 cases for 2023/24.

End of year outcome

105 cases in 2023/24 against a nationally set threshold of 60. This compares to 84 cases in 2022/23.

- 26 Community Onset – Healthcare associated (COHA)
- 79 Hospital Onset – Healthcare associated (HOHA)

2023/24	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
HOHA	3	7	11	5	11	9	5	4	9	7	4	4	**26**
COHA	1	1	4	3	3	2	1	2	0	3	2	4	**79**



The increased incidence in C. difficile cases continues to be reported both nationally and locally across the Hampshire and Isle of Wight integrated care system (HIOW ICS) likely reflecting increased frailty and complexity post pandemic.

Concise reviews were undertaken for cases in Q1 and Q2 which identified that the majority of patients had one or more risk factors for developing C. difficile diarrhoea including prior or current exposure to antibiotics or other high-risk medications, comorbidities, advanced age, impaired immune status. All patients had received antibiotics prior to developing CDI and in the majority of cases prescribing was appropriate and in line with UHS prescribing guidelines.

IP&C practice reviews (253) were undertaken throughout the year on wards where patients with a newly confirmed positive result are isolated (toxin positive and toxin negative cases irrespective of whether hospital/ community onset or healthcare/community associated) for assurance that all expected standards are in place to reduce the risk of onward transmission.

During 2023/24, 3 C.difficile outbreaks (cases identified as the same ribotype) and 27 periods of increased incidence (PII) were declared (two or more new cases of C. difficile on a ward in a 28-day period). Actions were implemented in response which included enhanced cleaning of the whole ward with Sochlor/Actichlor Plus; increased activity on the ward by the IPT (including a formal weekly review of the ward/observations of practice); review of isolation procedures; request for review of antibiotic usage; enhanced communications with staff; C. difficile isolates sent to the national reference laboratory for strain typing (ribotyping).

Key themes/learning from IP&C C.difficile practice reviews, PII reviews & outbreak investigations during 2023/24 identified:

- Isolation risk assessments not completed.
- Incorrect cleaning products were used for the cleaning of equipment being used on patients in isolation with confirmed or suspected infectious diarrhoea/C.difficile.
- Commodes were found to be visibly soiled with body fluids including faeces (an improvement in practice was noted in Q4 in relation to cleanliness of commodes).
- Commodes checked and clean but missing an "I am clean" label.
- Patients with suspected infectious diarrhoea were not isolated within 2 hours of onset of loose stools.
- Missed opportunities to undertake hand hygiene.
- Overuse of gloves.
- Waste not being segregated correctly in isolation rooms as per waste management policy.

Actions and interventions to support improvements in practice and improved outcomes for patients taken in 2023/24 have included:

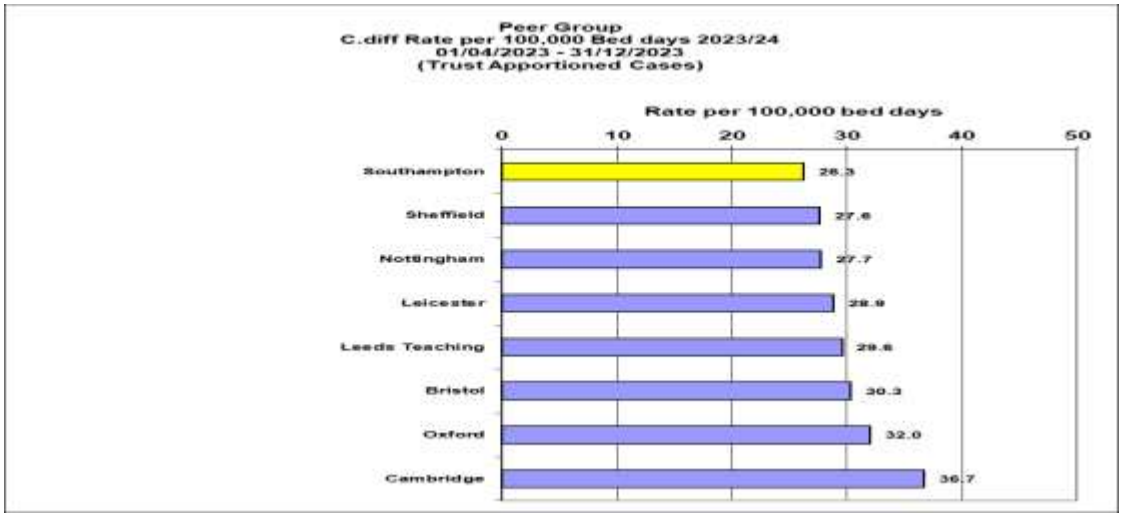
1. Ongoing focus on antimicrobial stewardship (AMS) and application of the principles of prudent antimicrobial prescribing – antimicrobial stewardship ward rounds (microbiologists & pharmacists), introduction of combined IP&C and AMS wards rounds (by IPT and pharmacy-micro team), education/awareness during World Antimicrobial Awareness week.
2. Ensuring appropriate treatment of CDI cases and reducing risk of relapse.
3. Completion of the national point prevalence survey (PPS) for healthcare associated infection and antimicrobial use to provide further data on antimicrobial prescribing practices across the Trust.
4. Actions and ongoing focus on improving infection prevention and control practice and cleaning standards, including cleanliness of commodes.
5. Training/awareness for clinical staff on clinical equipment cleaning, including commodes, and on the assessment and management of patients with unexplained/unexpected diarrhoea.
6. Launch of the 'give up the gloves' campaign to support reduction of unnecessary use of gloves.
7. IPT ward rounds which include a focus on isolation care and IP&C practices.

Further enhanced focus will be taken in 2024/25 specifically relating to:

1. Improving IP&C practice standards including equipment cleanliness (particularly cleanliness of commodes), hand hygiene practices, appropriate glove use and isolation care, with assurance from Divisions/Care Groups that processes and plans are in place to drive and sustain improvements in practice.
2. Antimicrobial stewardship and application of the principles of prudent antimicrobial prescribing including accelerated review and update of UHS prescribing guidelines and identification of targeted improvement measures following analysis of antimicrobial usage data from the national PPS survey.

Improvement actions continue to be taken at a system level within HIOW ICB including focus on antimicrobial prescribing practices, use of PPI's, education and awareness within health and social care settings.

UHS ranks first out of 8 self-selected peer acute trusts, with a rate of 26.3 cases/ 100,000 bed days. Comparative data needs careful interpretation because of differences in test selection, methodology and reporting criteria between trusts.



Post 48 hr Bacteraemia (excluding MRSA)

Trusts were required under the NHS Standard Contract 2023/24 to minimise rates of Gram-negative bloodstream infections so that they are no higher than the threshold levels set by NHS England and Improvement. Trust-level thresholds comprise total healthcare-associated cases i.e., Hospital-onset healthcare associated (HOHA) and Community-onset healthcare associated (COHA).

Post-48h BSI	2023-24	2022-23	2021-22	2020-21	2019-20
E coli	147 (120)	154 (127)	138 (151)	67	67
Klebsiella	58 (56)	51 (73)	64 (64)	40	57
Pseudomonas	24 (33)	35 (36)	30 (34)	13	24
MSSA	59	45	43	36	30
VRE	12	4	9	7	12

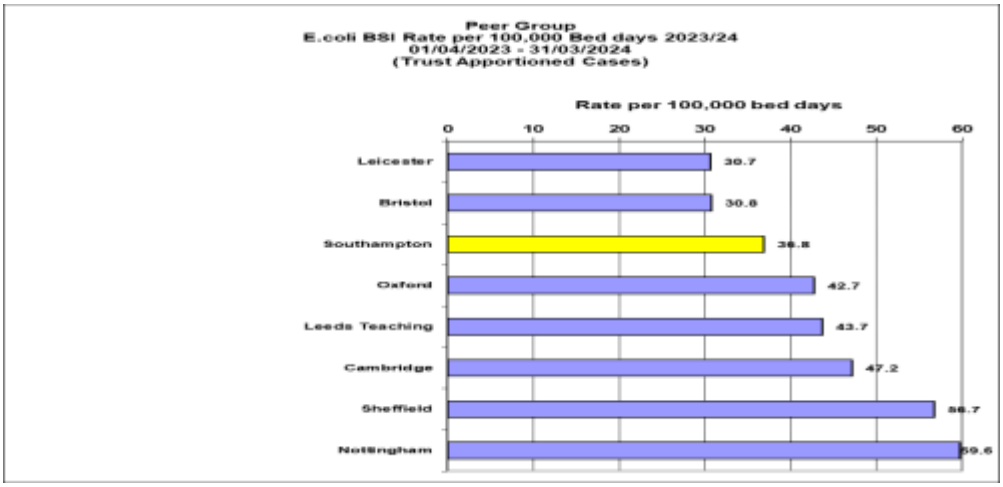
(National thresholds in brackets)

E coli Bacteraemia: UHS were set a threshold of 120 Cases for the Year 2023/24

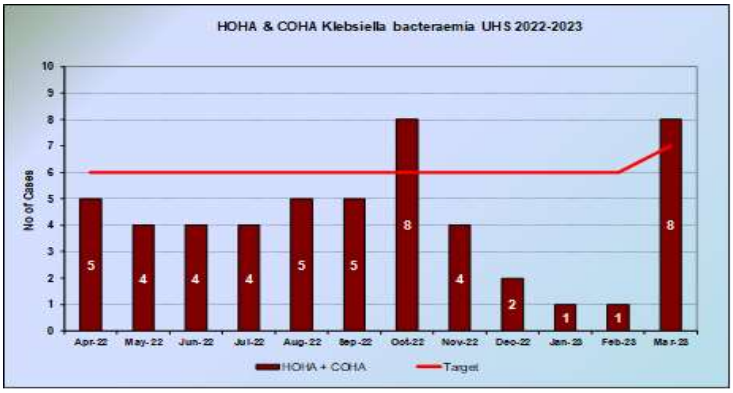
End of year outcome

147 cases in 2023/24 against a threshold of 120

- 57 Community Onset – Healthcare Associated (COHA)
- 90 Hospital Onset – Healthcare Associated (HOHA)



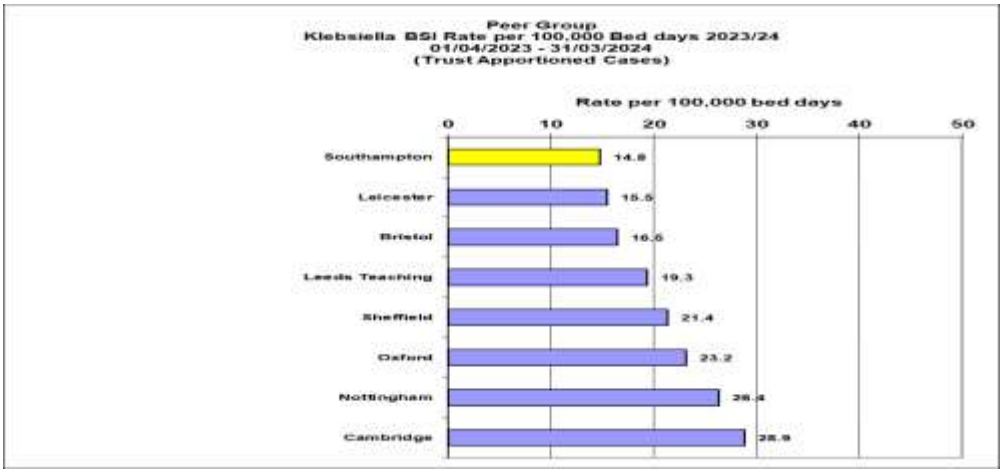
Klebsiella Bacteraemia: UHS were set a threshold of 56 Cases for the Year 2023/24



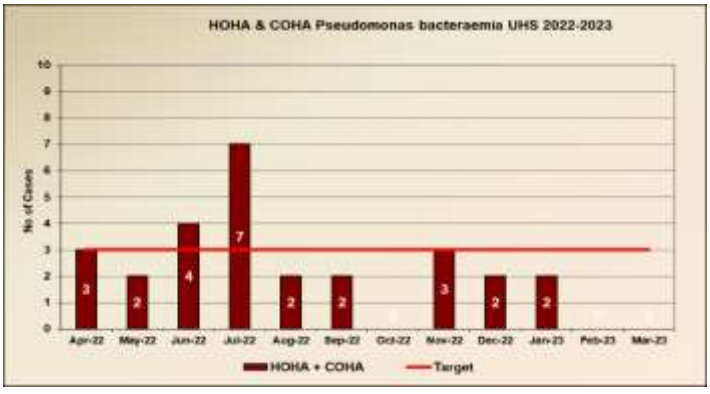
End of year outcome

58 cases in 2023/24 against a threshold of 56

- 17 Community Onset – Healthcare Associated (COHA)
- 41 Hospital Onset – Healthcare Associated (HOHA)



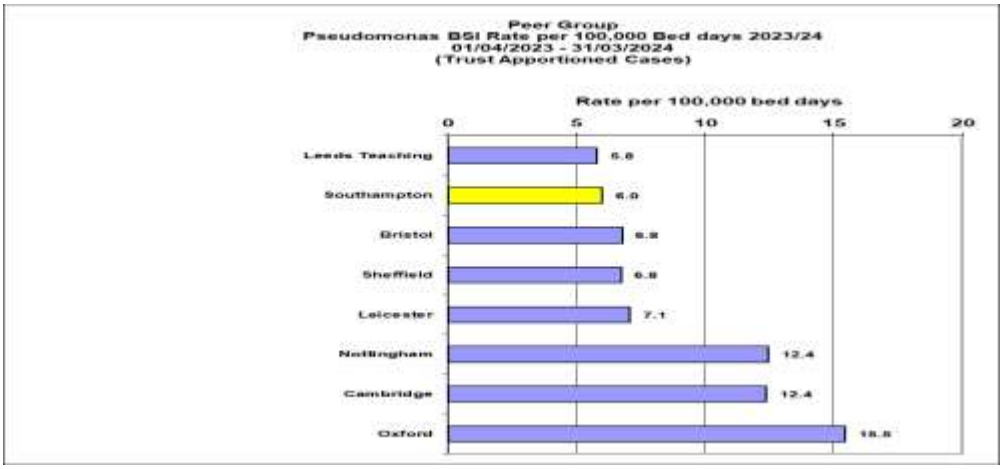
Pseudomonas Bacteraemia: UHS were set a threshold of 33 Cases for the Year 2023/24.



End of year outcome

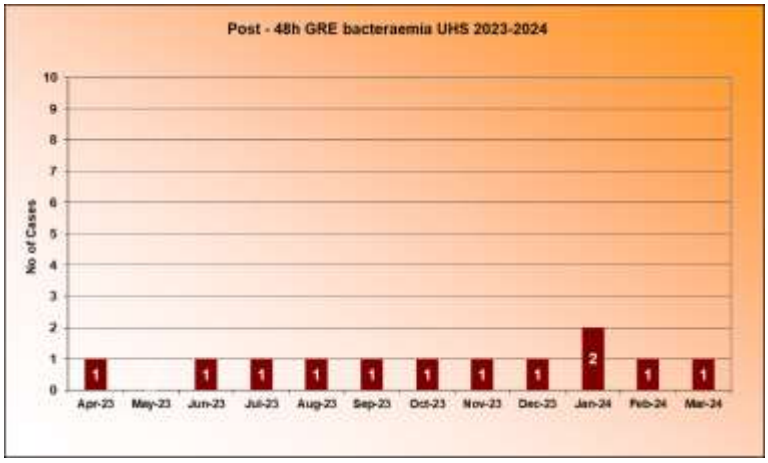
24 cases in 2023/24 against a threshold of 33

- 8 Community Onset – Healthcare Associated (COHA)
- 16 Hospital Onset – Healthcare Associated (HOHA)



MSSA Bacteraemia 59 cases in 2023/24. No nationally set threshold level but ongoing focus to minimise MSSA bloodstream infections.

VRE Bacteraemia 12 cases in 2023/24. No nationally set threshold level but ongoing focus to minimise VRE bloodstream infections.



Summary of case reviews for 2023 2024

A total of 300 cases of healthcare associated BSI (gram negative, MSSA & VRE) were reviewed in 2023/24. The likely source of infection was determined as:

Lower Urinary tract (catheter associated)	13.33% (n=40)
Lower Urinary Tract	13.00% (n=39)
Intravascular device (including Pacemaker/ ICD or CVC)	12.33% (n=37)
Unknown/Unclear	11.00% (n=33)
Hepatobiliary	9.00% (n=27)
Skin or Soft Tissue (including ulcers, cellulitis, diabetic foot infections without OM)	7.66% (n=23)
Lower Respiratory Tract (pneumonia, VAP, bronchiectasis, exac COPD etc)	7.33% (n=22)
Not Recorded	7.00% (n=21)
Gastrointestinal or Intra-abdominal collection (excluding hepatobiliary)	6.67% (n=20)
Likely Gut Translocation	4.33% (n=13)
Bone and Joint (no prosthetic material)	1.00% (n=3)
Bone and Joint (with prosthetic material)	1.00% (n=3)
Colonised from Mother	1.00% (n=3)
Neutropenic Sepsis	1.00% (n=3)
Upper Urinary Tract (pyelonephritis/ abscess)	1.00% (n=3)
Cardiovascular or Vascular (with prosthetic material e.g. EVAR, stent, valve, prosthetic fistula)	0.67% (n=2)
Cardiovascular or Vascular (without prosthetic material e.g. EVAR, stent, valve, prosthetic fistula)	0.67% (n=2)
Central Nervous System	0.67% (n=2)
Upper Respiratory Tract and ENT	0.67% (n=2)
No Clinical signs of infection	0.67% (n=2)

In Q1 and Q2, for cases that were deemed as likely to be associated with indwelling urinary catheters, intravascular devices, ventilator associated pneumonia or surgical site infection, a concise case review and IP&C practice review was undertaken by the IPT. Findings and learning from case reviews undertaken in Q2 remained similar to those identified in Q1. In Q3 and Q4 only cases of E-Coli BSI that were deemed as likely to be associated with indwelling urinary catheters, intravascular devices, ventilator associated pneumonia or surgical site infection and MSSA BSI that were deemed as likely to be related to intravascular devices, were subject to a concise case review and IP&C practice review by the IPT.

88 concise case reviews/IP&C practice reviews were undertaken overall in 2023/24 with key themes/learning identified as:

- Gaps in documentation and assurance related to daily review and care of IV devices including reason for retention of cannula and CADI form completion.
- Gaps in documentation and assurance related to insertion, daily review and care of urinary catheters including ongoing reason for catheter, daily review and TWOC.
- Gaps in documentation/assurance relating to prevention of surgical site infection (pre and post operative care).
- Hand hygiene practices not meeting expected standards and overuse of gloves.

Focus on reducing healthcare associated BSI has been ongoing in throughout 2023/24 with delivery of actions within the UHS BSI improvement plan including:

1. Focus on reducing risk of catheter associated UTI (CAUTI) through management of urinary catheters, avoiding unnecessary catheterisation and appropriate early removal of catheters.
    - Ongoing project work in T&O to reduce the duration of catheterisation & development of a flowchart for the early removal of catheters with pilot of a nurse led TWOC protocol.

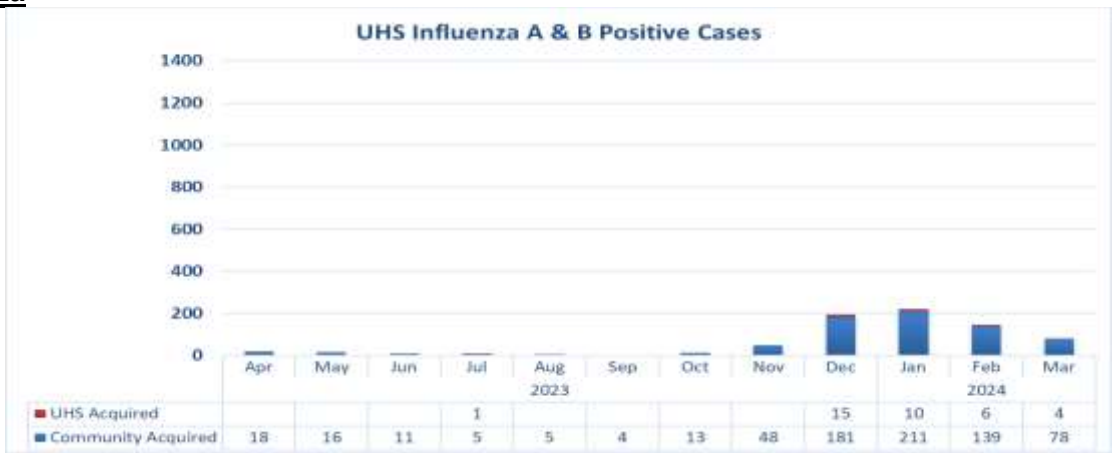
- Development of a urinary catheter dashboard on inpatient noting to provide oversight and mechanism for review of patients with urinary catheters at ward level.

2. Improving IV device care and management
   - Finalisation and approval of an updated operating procedure for the preparation and administration of Injectable Medicines, which includes removal of the requirement to use non-sterile gloves as part of ANTT (aseptic non-touch technique) therefore placing greater emphasis on hand hygiene.
   - Development of updated ANTT guidelines for IV (peripheral & central) drug administration.
   - Education and awareness activities relating to skin preparation prior to IV device insertion and for ongoing care (delivered to wards by company representatives), principles of aseptic non-touch technique and the insertion and management of invasive devices.
3. Improving hand hygiene practices and reducing gloves use
   - Ongoing observation, education and awareness activities related to hand hygiene.
   - Launch of the 'Give up the gloves' campaign.
4. Launch of the UHS Fundamental Care Commitments e.g. nutrition & hydration, mouth care, promoting mobility, maintaining skin integrity, bladder and bowel care, personal hygiene, communication, pain management, led by the Deputy Chief Nurse.
5. Review of documentation of invasive device care and management, including review of the forms on the electronic Inpatient Noting system.

2.2 Respiratory Viruses

Prevalence of influenza , RSV and COVID-19 was lower in 2023/24 compared to 2022/23.

Influenza



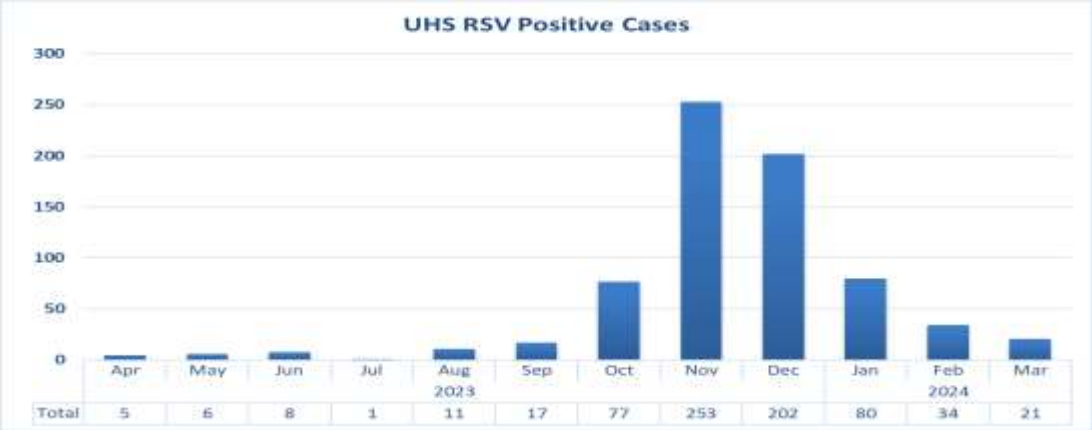
Influenza activity in 2023/24 was significantly lower (60%) than in 2022/23 with 765 cases compared to 1908 in 2022/23. The majority of positive cases were identified in patients attending the emergency department or in admission areas by rapid in-lab testing. Reporting of results within 2 hours facilitated early decision making re: patient management (e.g. decision to admit/discharge) and appropriate patient placement to minimise the risk of transmission to other patients.

Of the patients who twsted positive in the emergency department 176 (31%) were admitted to hospital.

Source	Number of Cases	Number Admitted
ED	560	176
Admission Areas	116	
Inpatients	73	
Outpatients / Clinics	16	
Total	765	

The majority of cases seen within UHS were community acquired/community onset, with 36 cases categorised as healthcare associated (samples taken from inpatients after 5 days of admission to UHS).

RSV



RSV activity in 2023/24 was lower than the previous year with 715 cases in 2023/24 compared to 979 in 2022/23. The majority of cases occurred in Q3 as per expected seasonal trend. Of the 715 cases 439 were in children (0-17Yrs) and 276 adults (>=18 Yrs.)

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Most of the cases were seen in the emergency department (521). Of the patients who tested positive in the emergency department 117 (22.5%) were admitted to hospital.

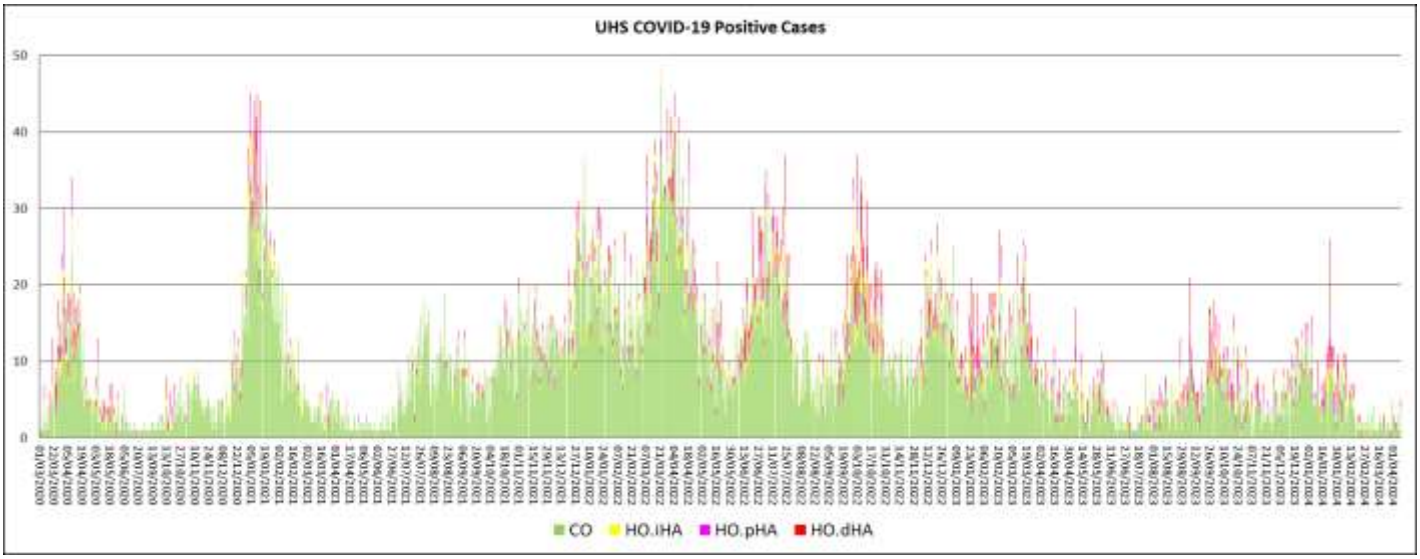
Within the Children's hospital RSV cohort bays were expanded as needed. Most positive cases were rapidly identified in patients being admitted to the Trust with minimal in-hospital transmission and no identified outbreaks.

Source	Number of Cases	Number Admitted
ED	521	117
Admission Areas (AMU)	47	
Inpatients	112	
Outpatients / Clinics	35	
Total	715	

49 cases (45 adults and 4 paediatric) of RSV were categorised as healthcare associated (samples taken from inpatients after 5 days of admission to UHS).

COVID-19

Prevalence of COVID-19 fluctuated during 2023/24 but was significantly lower than in 2022/23. This may in part be reflective of changes in testing policy introduced within UHS in March 2023 (cessation of the requirement to routinely test asymptomatic patients on or prior to admission to align with national guidance) alongside an overall drop in community prevalence. Increasing case numbers seen within UHS in October and December 2023 were associated with an increasing prevalence in the community, in-hospital transmission and outbreaks occurring.



Cases identified in UHS: 1st April 2023 to 31st March 2024

	Community Onset (CO)	Indeterminate (HO.iHA)	Probable (HO.pHA)	Definite (HO.dHA)
Q1 (April – June)	365	32	26	45
Q2 (July-Sept)	342	35	48	63
Q3 (Oct-Dec)	503	39	53	59
Q4 (Jan – Mar)	307	38	39	59
Total	**1,517**	**144**	**166**	**226**

Definitions of apportionment of COVID-19 in respect of patients diagnosed within hospitals
Definite (HO.dHA): *hospital-onset definite healthcare-associated first positive specimen date 15 or more days after admission to Trust (RCA required)*
Probable (HO.pHA)*: hospital-onset probable healthcare-associated – first positive specimen date 8–14 days after admission to Trust (RCA required)*
Indeterminate (HO.iHA): *hospital-onset indeterminate healthcare-associated – first positive specimen date 3–7 days after admission to Trust*
Community Onset (CO*) - positive specimen date <=2days after hospital admission or hospital attendance.*

Cases of hospital-onset, healthcare associated COVID-19 infection were lower than in 2022/23 with 226 cases meeting the Hospital onset, definite healthcare associated case definition compared to 432 in 2022/23, a decrease of 48%.

A number of changes to IP&C guidance and testing measures were implemented in 2023/24, to align with national guidance, including:

- April 2023 : removal of the routine requirement to wear facemasks within our hospital sites (with some exceptions).
- April 2023: changes in requirements to staff symptomatic testing.
- March 2024: review of management of COVID-19 contacts and implementation of revised guidance whereby,with the exception of adult cancer care, patients who have been in contact with a confirmed positive case of COVID-19 will no longer be quarantined (isolated/cohorted).

Respiratory Virus Outbreaks

UHS surveillance data continues to be used to facilitate early warnings of increased rates of infection enabling us to identify both outbreaks and PIIs/clusters (detection of unexpected, potentially linked cases) of infection amongst patients. Close liaison between the Infection Prevention Team and clinical teams remains in place to support identification, investigation and management of increased incidence of infection.

	Number of COVID-19 Outbreaks	Total Number of Positive Patients
Q1	7	47
Q2	12	81
Q3	8	33
Q4	11	67
Total	**38**	**228**

	Number of Influenza Outbreaks	Total Number of Positive Patients
Q1 & 2	0	0
Q3	1	3
Q4	0	0
Total	**1**	**3**

All outbreaks have been managed by the Infection Prevention Team, with target control measures implemented as required, with ongoing monitoring until 14 days following the last confirmed case.

Key themes/ learning from outbreaks

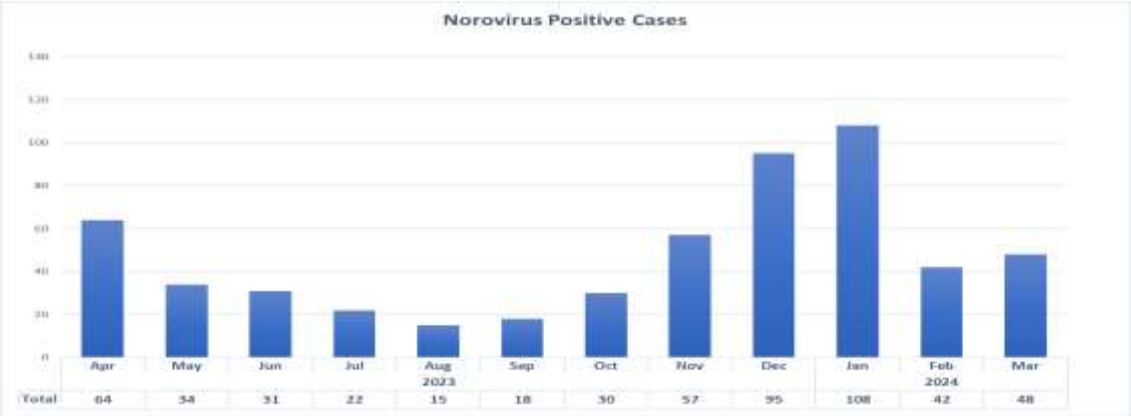
As a result of changes to testing and other IP&C measures as part of the ongoing transition to living with COVID-19 it is often now often difficult to determine specific factors that have resulted in acquisition or outbreaks of COVID-19 occurring. The virus itself remains highly transmissible and key themes contributing to this remain largely unchanged from 2022/23 including:

- Risks associated with the physical environment, particularly lack of mechanical ventilation and difficultly in achieving good airflow by natural ventilation (due to lack of windows/ inability to open windows in some areas) and risks related to the physical environment (including the lack of bathroom/toilet facilities on some wards resulting in a high number of patients sharing facilities or difficulty in allocating dedicated facilities for patients with known or suspected infection).
- Challenges with confused and wandering patients, complex patients with significant physical or mental health needs and individual inpatients frequently leaving the ward for non-clinical/treatment reasons (e.g. to meet others in retail outlets/outside) increasing the risk for transmission of infection.
- Visitors attending the hospital/visiting wards with respiratory virus symptoms or reporting symptoms a short period after visiting indicating that they may have been incubating a respiratory virus at the point of visiting.

2.3 Viral Gastroenteritis including Norovirus.

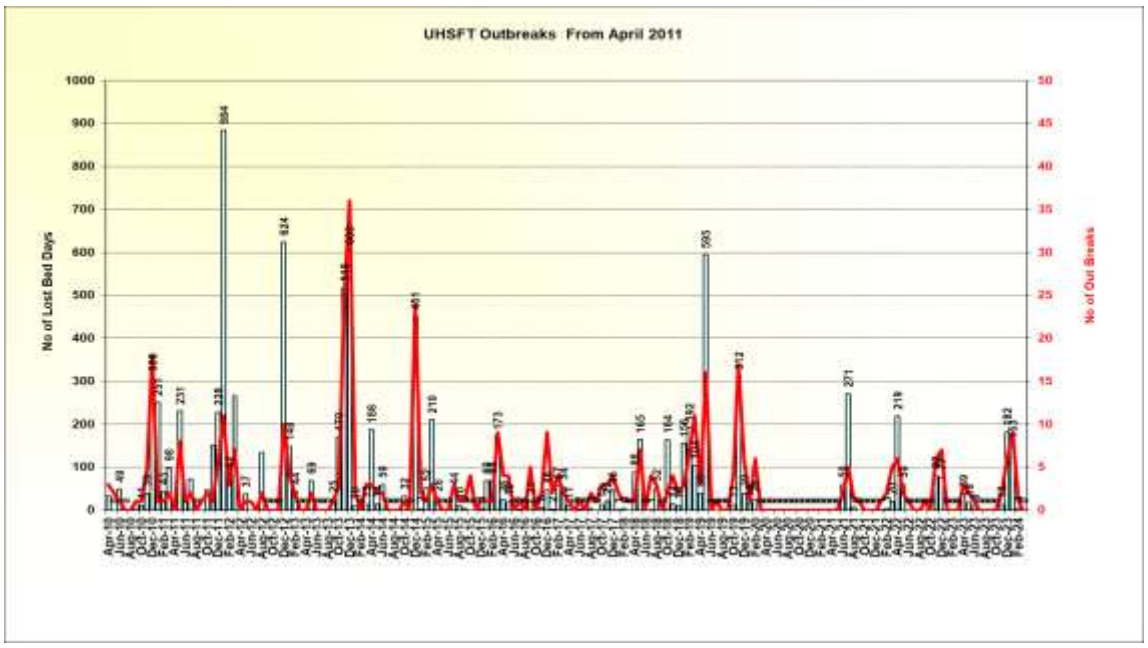
The Trust experienced a significant increase in Norovirus activity in both April 2023 and over winter 2023/24 with an increased number of outbreaks resulting in bay/ward closures. This is in the context

of a significant rise in cases both locally and nationally.



	No. of outbreaks	Cause	No of Bed Days Lost	No of Pts	No of Staff	No of Bays Closed	Wards closed
Q1	6	Norovirus	66	28	0	7	1
Q2	0	Norovirus	9	7	0	7	0
Q3	8	Norovirus	181	54	5	6	4
Q4	14	Norovirus	221	57	8	12	4
Total	**28**		**477**	**146**	**13**	**32**	**9**

In 2023/24 9 wards and 32 bays were closed due to outbreaks of Norovirus affecting 146 patients and resulting in 477 lost bed days.



Year	Bed days lost due to bay/ward closures
2019-2020	1039
2020-2021	0
2021-2022	361
2022-2023	503
2023-2024	477

Summary of key themes/learning from Norovirus outbreaks included:

- Ensuring early identification, assessment, and management of patients with unexpected/unexplained diarrhoea and/or vomiting, including the management of patients with type 5 stools and sending samples in a timely manner.
- Ensuring accurate documentation of patient's bowel movements.
- Ensuring that PPE is worn in closed bays and removed when exiting the bay.
- The need to decontaminate hands with soap and water.
- Ensuring that waste is disposed of into the correct waste stream.
- Ensuring that the closed ward is not used as an exit route by staff from neighbouring wards.
- The potential risk of transmission associated with parents/families interacting with each other and their children e.g. caring for each other's babies including changing nappies; using shared facilities on the ward.

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

2.4 Actions to support prevention and control of respiratory viruses and Norovirus.

Actions and strategies to support prevention and control of respiratory viruses (including COVID-19) and Norovirus and reduce risk of in-hospital transmission and associated outbreaks, along with planning for potential increases in cases, remain in place and under ongoing review. Actions taken throughout 2023/24 included:

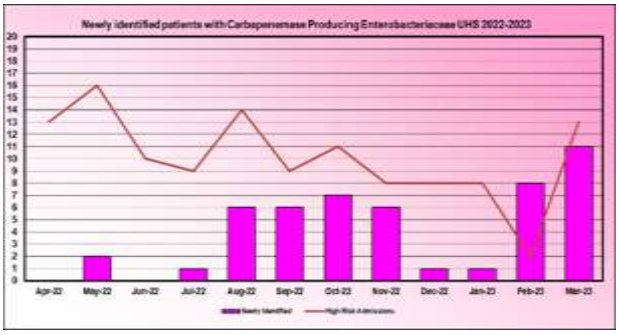
- Promotion of the annual flu and COVID-19 booster vaccination for staff and patients.
- Screening and triaging of all patients either prior to arrival to a care area, or as soon as possible on arrival, to allow early recognition of patients presenting with symptoms of infection or at high risk of infection.
- Testing of patients with symptoms suggestive of respiratory viruses and viral gastroenteritis to facilitate early identification and placement of positive cases:
  - Ongoing use of rapid in-lab testing for respiratory viruses (SARS-CoV-2, Influenza and RSV) for symptomatic patients in admission pathways and for in-patients who develop symptoms.
  - Ongoing use of rapid in-lab diagnostic testing for gastrointestinal (GI) pathogens (including Norovirus and *C. difficile*) for symptomatic patients (those with potentially infective diarrhoea) on admission in AMU and MOAS and, led by the IPT within ward bays throughout the hospital.
- Isolation or cohorting of symptomatic patients who have a positive respiratory virus test (COVID--19 and influenza) or Norovirus and quarantine of patient contacts where required.
- Review of IP&C guidance for the care of patients with respiratory viruses, including personal protective equipment (PPE), with the decision to maintain the requirement for use of FFP3 masks for the care of patients with COVID-19 and other defined respiratory viruses (above current national guidance) based on the evidence of modes of transmission (aerosol and droplet) and the lack of ventilation in many of our wards.

- Ongoing review of IP&C guidance/control measures and implementation of additional measures where required e.g. short term re-introduction of universal mask wearing in response to rising levels of infection/outbreaks within the hospital
- Education & training activities including a winter virus awareness campaign led by the IPT.
- Proactive focus on bed planning and management with collaborative discussions amongst key stakeholders, including the Infection Prevention Team, to manage and reduce overall risk to the organisation.
- Monitoring and focus on infection prevention and control practices in clinical areas.
- Active deployment of portable air-purification units to wards/bays deemed to be at high risk of respiratory virus transmission/outbreaks.
- Ongoing focus on effective management of existing isolation capacity within UHS to ensure optimal use and explore longer term options to increase isolation capacity.
- Use of trust wide communications prior to and during outbreaks – communication cascades/alerts relating to rising levels of infection, expected IP&C practices, situational updates.

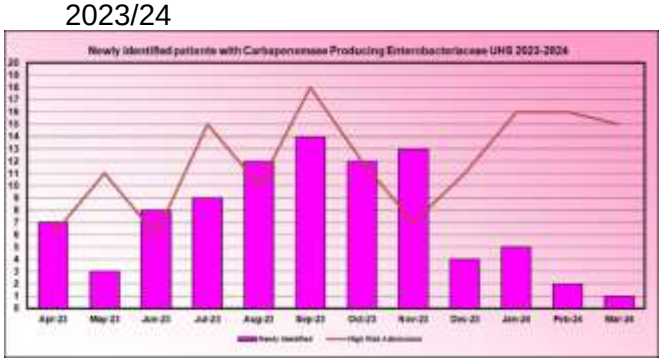
Planning and preparedness for potential future pandemics remains a key area of focus for the Trust and the Trust Pandemic Plan has undergone a full review and update in 2023/24.

2.5 Carbapenemase-producing Gram negative bacteria.

2022/23



2023/24



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

- 90 newly identified CPE cases in were identified in 2023/24 compared to 49 in 2022/23, an increase of 46%
- 143 high risk patients were admitted to UHS in 2023/24 compared to 111 in 2022/23 , an increase of 22%

Cluster of identical CPE producing *Klebsiella pneumoniae*

5 patients tested positive for CPE producing *Klebsiella pneumoniae* between the beginning of November and the of end December 2024. 4 of the patients were identified as positive via rectal screening, undertaken as part of routine CPE testing requirements, and 1 patient was tested following contact with a confirmed positive case. Typing of the isolates subsequently confirmed that all cases were of an identical strain indicating likely transmission within UHS.

A review of the cases was undertaken by the Infection Prevention Team including timeline, location, investigations/procedures undertaken. No one common link, location or speciality could be identified. 2 of the patients had spent time in endoscopy within 3 days of each other (although different rooms and different clinicians carrying out procedure).Ongoing actions in response to the review include:

- Review of scopes/decontamination processes related to endoscopy plus focus on optimising IP&C knowledge and practices,
- Focus on IP&C practices in all clinical areas including hand hygiene, cleaning & decontamination of equipment, correct use of PPE - as part of ongoing improvement focus across the Trust.
- Any further CPE producing *K. pneumoniae* cases will be sent for typing to monitor if there is a wider problem within the Trust.

Key actions to reduce risk and transmission from CPE:

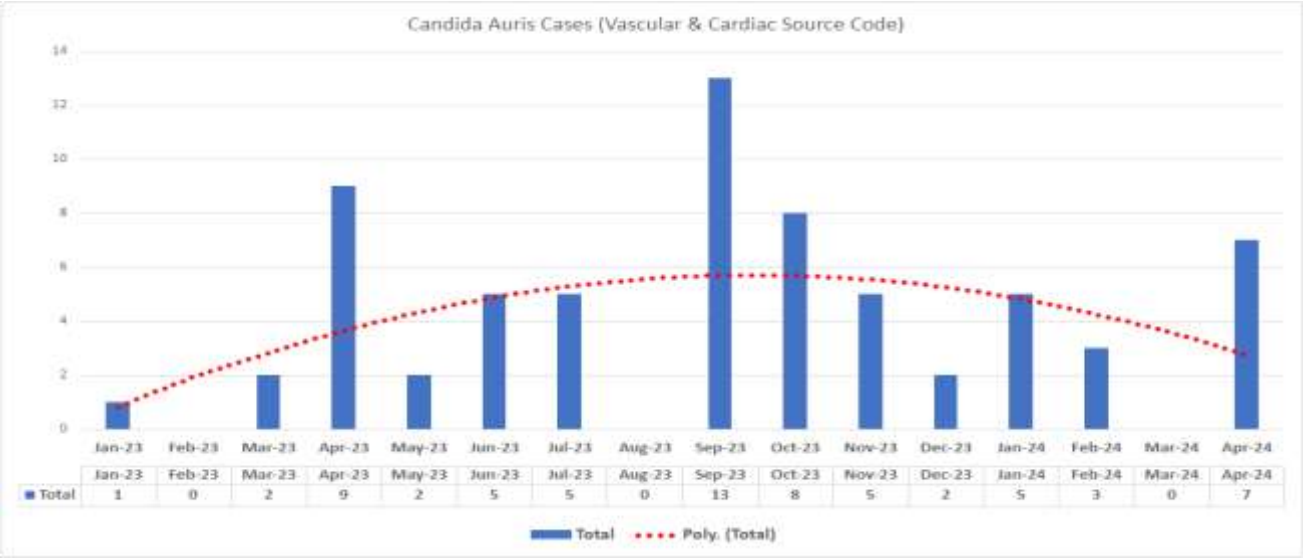
- Enhanced focus on antimicrobial stewardship to reduce use of broad-spectrum antibiotics especially carbapenem group of antibiotics (e.g. Meropenem).
- To continue to undertake extensive screening for CPE including patients admitted that meet the high-risk criteria for CPE carriage and patients on carbapenems.
- Ensuring consistent application of high standards of infection prevention practices.

2.6 *Candida auris outbreak*

Since March 2023 there has been an ongoing *Candida auris* outbreak, centred on D4 Vascular ward at UHS. This also impacts on Trusts within the region whose patients access the UHS Vascular service.

Candida auris is a fungal pathogen first identified as a novel species in 2009. This yeast can colonise the skin and cause infection in both adult and paediatric populations. *C. auris* is readily transmitted between patients, and the clinical environment, including via multi-use equipment.

To date (end of March 2024) 60 cases of *Candida auris* have been confirmed in patients who have spent some time as an inpatient on D4 ward or linked to cases who have spent time on D4. Many of the patients have complex vascular problems including diabetic foot ischaemia and/or infection. Whilst the large majority of patients have been identified via surveillance screening within UHS, a small number have subsequently tested positive after discharge from D4 ward, at other hospitals in the region.



A wide range of control measures have been implemented which remain under constant review, with guidance and support from regional and national colleagues from UKHSA:

- Ongoing review, monitoring and focus on IP&C practice and cleanliness standards on ward D4.
- Enhanced PPE (long sleeve gown and gloves) with hand hygiene, after contact with the patient and patient's environment, with soap and water, followed by alcohol gel.
- Infection alerts for individual patient 'C. auris' cases and 'C. auris contacts' created on Camis.

- Isolation in side-rooms or quarantine in *C. auris* designated positive bay(s) on D4 for all confirmed positive cases for the duration of their admission and for any subsequent re-admission.
- Isolation in side-rooms or quarantine of *C. auris* contacts (patients who have shared a bay with a confirmed case, for any time, no matter how short).
- Increased frequency of environmental cleaning on ward D4.
- Routine use of UVC disinfection technology following terminal clean of single rooms/bays occupied by confirmed *C. auris* cases.
- Switch from Chlorine based liquid cleaning product, to use of Clinell Universal Cleaning wipes for multi-use patient equipment.
- Review of all shared patient equipment with increased focus on cleaning between patient use plus introduction of some items of single patient use equipment e.g. single patient use BP cuffs.
- *C.auris* screening programme for all patients accessing the UHS Vascular service (all inpatients tested via axilla, groin and wound swabs on admission, weekly and on discharge) adopted by UHS, HHFT, PHU and Isle of Wight.
- Review and monitoring of IP&C practices and cleanliness standards in other linked areas e.g. cardiac catheter labs and theatres and other wards within CV&T where vascular patients may be placed.
- Environmental sampling of equipment/surfaces on D4 and other linked areas.
- Review of antimicrobial usage on ward D4 and review/update of prescribing guidelines for vascular patients.
- Review and monitoring of the general environment on D4.
- Review and assurance on IP&C practices within community podiatry/diabetic foot clinics.

To date *C. auris* has been detected (cultured) from environmental swabs on inner windowsills, and a patient wheelchair (accessible touch surfaces for patients and staff) which confirms that the organism can persist, remain viable in the ward environment/on equipment and is potentially transferrable from any fomite (inanimate surface or piece of equipment) to the hands or other body areas of an individual touching that fomite. Sampling was also undertaken in a single room (where a positive case had been accommodated) prior to and after the room had received a terminal clean followed by UVC decontamination . Prior to cleaning *C. auris* was found on the wheel of the patient wheelchair but this was not present after completion of the terminal clean/UVC decontamination cycle, thus providing assurance of the effectiveness of the terminal room cleaning process.

<u>Factors which may be contributing to the ongoing outbreak</u>

- D4 ward environment
    - high ambient temperature.
    - poor ventilation (no mechanical ventilation and limited natural ventilation).
    - aging and deteriorating ward infrastructure (e.g. floor and ceiling tiles) compromising the ability to effectively clean the ward environment.
    - limited space, cluttered and crowded ward environment making effective cleaning challenging.

  Previous concerns relating to the ward environment outlined in previous reports in 2023/24 have subsequently been addressed:
    - internal building works causing further disruption, are now complete.
    - recurrent and frequent sewage leaks affecting D4's limited number of side rooms leading to their closure on multiple occasions, have resolved.
    - extensive and prolonged external building works immediately outside the ward (close to the external windows, which can and are opened at times and building materials stored close to external ward windows), are now complete.
- Patient group - national experts have noted that vascular patients in diabetic foot clinics have been a part of other *C. auris* outbreaks in the UK, so this may be a relevant risk factor for acquiring *C. auris*. Review of IP&C practices in outpatient diabetic foot/podiatry clinics including those in the community have therefore been undertaken by community/ICB colleagues. These patients, particularly when admitted and receiving inpatient care for complications of diabetic foot, frequently require antibiotics (often broad spectrum) to treat severe polymicrobial skin and

soft tissue infection and/or osteomyelitis. Prolonged antibiotic courses (e.g. 6 weeks for osteomyelitis) may be indicated. It is possible that antibiotic exposure may lead to a higher colonisation bioburden of yeasts, including *C. auris* on the skin of an already colonised individual, potentially increasing the likelihood of transmission to the environment or directly to other individuals.

- There is no evidence based intervention e.g. topical antimicrobial decolonisation regimen that results in clearance of colonisation with this organism. There is no robust evidence on the prevalence of asymptomatic colonisation with this organism either in the UK or internationally. There is limited evidence on the usual duration of colonisation with *C. auris*; an individual may remain colonised for many months, and expert opinion is that colonisation may potentially persist for years or even lifelong. Expert opinion also points to the possibility that skin colonisation with *C. auris* may fluctuate between being detectable on screening swabs and undetectable. Hence, cryptic undetectable ongoing low-level colonisation may be a confounder in IPC management of *C. auris* outbreaks. This includes the potential for ongoing but unidentified risk of transmission to other patients and challenges in confidently de-alerting and declaring individual patients formally cleared of colonisation.

Regular outbreak/incident meetings remain in place to review the situation and control measures, with representation from HHFT, PHU, IOW, HIOW ICB, UKHSA, SCAS, Solent and Southern Health. Local UKHSA colleagues are feeding back learning/interventions from this outbreak to support development of updated national guidance for *Candida auris*.

Additional control measures have been explored/recommended to reduce the risk of transmission of *C. auris* from potentially high risk patients being admitted to D4 (i.e. any patient who has a history of being an inpatient D4 since March 2023 to be isolated in a single room on subsequent admission until results of admission screening are known). However, to date the ward/care group have been unable to implement this due to the ongoing operational pressures within CV&T and the Trust.

In addition, vascular patients are not in frequently outlied to wards other than D4 (e.g. D2, D3, E3, CHDU and E4). The inability to achieve ward segregation of patients on the vascular pathway represents a significant ongoing risk of the outbreak expanding to involve other groups of patients and wards, where vascular patients share wards, notably those on cardiac/cardiothoracic pathways. During this outbreak, transmission to a small number of cardiac patients has already occurred. Overall the risk of adverse clinical consequences of *C. auris* in this ongoing outbreak have been low, but colonisation with this organism can and does occasionally result in sepsis from candidaemia (candida blood stream infection) which can be fatal. Patients who are at additional risk of poor outcome from *C. auris* colonisation include complex patients requiring vascular grafts and cardiothoracic patients who ae vulnerable to deep sternal wound infections.

2.7 Other infections

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

<u>Salmonella Montevideo</u>

In February 2024 an inpatient in the Childrens Hospital tested positive for Salmonella Montevideo and the Trust were advised by UKHSA that the case was the 9th case over a period of 10 years with the same 5-SNP address on whole genome sequencing (the only cluster of this type in the UK), therefore likely linked to the previous cases and to UHS. Of the previous cases, 5 occurred in 2013, 1 in 2016, 1 in 2019 and 1 in 2023.

The initial 5 cases were extensively investigated in 2013 by UHS with the support of the local health protection team (then PHE) including review of IP&C practices, the environment and environmental

sampling. Environmental sampling at the time identified the presence of Salmonella Montevideo in a sink in PMU and the sink/pipework were subsequently replaced.

Following notification of the case in February 2024, further investigations have been undertaken and remain ongoing to determine potential links/source of the organism including:

- Review of the location of patients whilst in UHS to determine any common bed spaces or bays with subsequent environmental sampling to ensure they are not a source of S. Montevideo.
- Extensive environmental sampling (undertaken by Porton FWE (Food, Water and Environmental) laboratory of sinks and aspirate from U-bends on all of the sinks that were common to all of the children from the last 3 cases (samples taken from G2N, PICU, PHDU and E1) plus sinks and surfaces within the milk kitchen.
- Review of the practice of preparation of PEG/other feeds undertaken in the milk kitchen.
- Investigation of pre-prepared feeds.
- Review of the general environments, including sinks in all areas.
- Review of general IP&C practices by staff and parents.
- Introduction of a lower threshold for salmonella testing in the Children's hospital.

Environmental sampling found Salmonella species (subsequently confirmed as Salmonella Montevideo) in two sinks in G2 Neuro, which is where the February 2024 case had cared for. On receipt of the results, the affected sinks were taken out of use and portable sinks were provided. UHS Estates team removed & replaced plumbing (U-bend and the lower piping) and the whole drain system was thermally and chemically disinfected with a chlorine-based product.

The significance of these positive samples from the sink is not clear and not conclusive to indicate that the sinks were the source of the organism in the latest case. There is a high probability that salmonella was introduced into the sink/plumbing through staff/parent care activities/practices.

Increases in cases of Measles and Pertussis.

Nationally, cases of measles and pertussis have been rising in 2023/24 which is also reflected locally. Whilst the majority of cases have been seen within the community, a number of cases have presented in our childrens and adult emergency pathways (e.g. emergency dept) or required admission to UHS. For a small proportion of these it has been necessary to undertake a contact tracing exercise following confirmation of a positive test result, to determine if any staff or patients were exposed to the individual whilst in UHS; their individual immune status and whether actions such as exclusion from work (e.g. until evidence of immune status is known); isolation in single room (inpatients) whose immune status is unknown/not immune; or post-exposure prophylaxis (PEP) is required. All relevant staff/patient contacts are sent a warn & inform letter. The Infection Prevention Team, Occupational Health, Virology/Microbiology Consultants have jointly undertaken this exercise when required but this has and continues to be extremely resource intensive for all involved.

2.8 Surgical Site Infections

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

PERIOD	UHS SSI INCIDENCE HIP REPLACEMENT	UHS SSI INCIDENCE KNEE REPLACEMNT
Q4 – October – December 2023	(0)66 = 0.0% Other participating hospitals with post discharge questionnaires = 0.2%	(0)33 = 0.0% 1 x Patient reported SSI. Patient had a 2 week course of antibiotics in the community. Wound swab grew MSSA. Other participating hospitals with post discharge questionnaires = 0.2%

2.9 Assurance of Infection Prevention Practice standards, including environmental cleaning

Infection Prevention Practice standards
The Trust annual infection prevention audit programme has remained in place for 2023/24 to monitor infection prevention and control practice standards in clinical and non-clinical areas

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

	Month	Element	% Standards met
Urinary Catheter Care	May 2023	Insertion	99%
		Ongoing Care	93%
	Nov 2023	Insertion	99%
		Ongoing Care	87%
Central Venous Catheter Care	June 2023	Insertion	93%
		Ongoing Care	94%
	Dec 2023	Insertion	100%
		Ongoing Care	94%
Peripheral Intravenous Cannula Care	June 2023	Insertion	95%
		Ongoing Care	95%
	Dec 2023	Insertion	99%
		Ongoing Care	94%
Surgical Site Infection	Aug 2023	Pre-Operative	98%
		Intra-Operative	93%
		Post-Operative	98%
	Feb 2024	Pre-Operative	99%
		Intra-Operative	99%
		Post-Operative	100%
Care of Ventilated Patients	Aug 2023		100%
	Feb 2024		95%

Hand Hygiene

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

Monitoring and assurance of hand hygiene practice for inpatient areas in 2023/24 consisted of:

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

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

- peer audits only

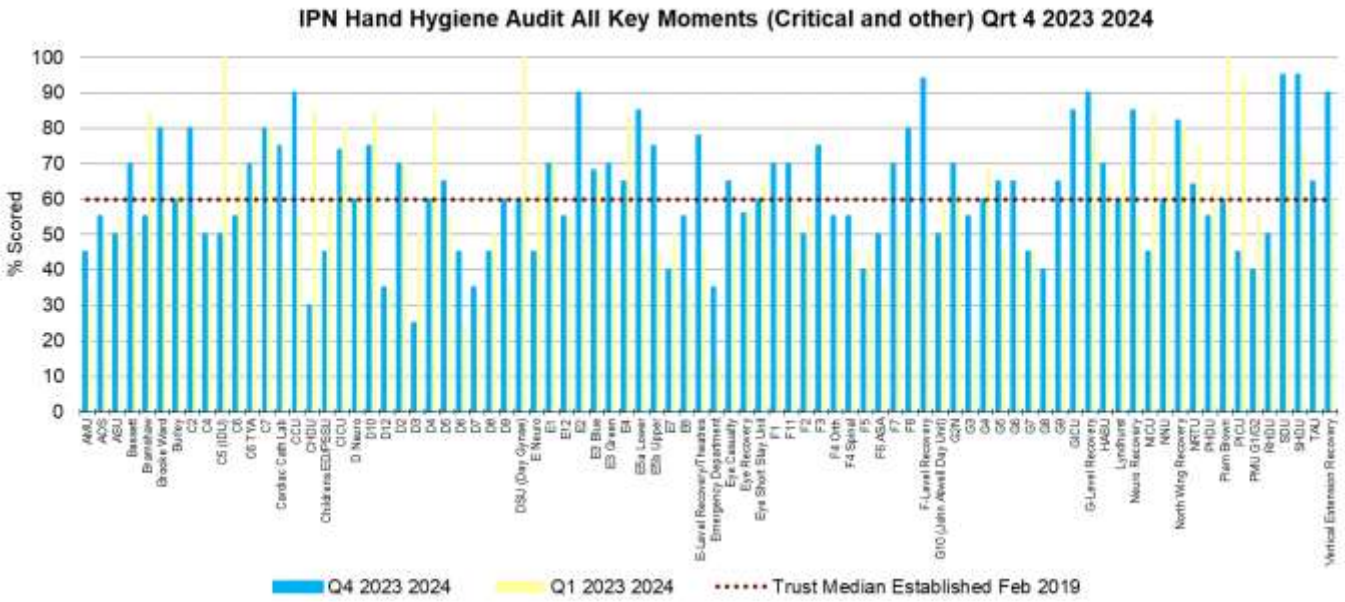
Audit type	Month	% Standards met	
Inpatient areas (self-assessed)	July 2023	92%	
	January 2024	93%	
Outpatient areas (self-assessed)	July 2023	98%	
	January 2024	98%	
Surgical Scrub Audit	July 2023	100%	
	January 2024	100%	
Inpatient areas (covert audit undertaken by Infection Prevention Nurses)	Q1 -All inpatient areas Q2 - reaudit of areas who did not achieve the trust median score in Q1 audits.	Q1 overall trust median score = 58%. Overall trust median score following re-audits = 61%	Against a performance improvement target of 60% (the trust median score established following February 2019 covert audits).
	Q4 -All inpatient areas	Q4 overall trust median score = 62%	

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

Of the 84 areas audited in Q4.

- 50 areas (60%) achieved on or above the Trust median score of 60%, an increase of 12 areas compared to 38 areas (45%) in Q1 2023/24.
- 34 areas (40%) achieved below the Trust median score of 60%.

Areas not achieving expected standards are required to implement actions to improve practice. The Infection Prevention Team continue to work with ward leaders and matrons to improve hand hygiene practice. Additional focus is also required to improve standards of hand hygiene practice amongst medical staff and other staff groups.



Improving standards of hand hygiene practice will remain an ongoing area of focus in 2024/25 with the need to have a rolling programme of education and awareness to achieve consistent practice. With improvements seen in the overall Trust median score in Q1/2 and Q4 audits, the performance improvement target of 60% (the trust median score established following the first covert audits undertaken in February 2019) will be increased to 62% for 2024/25.

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

Audit	Month	% Standards met	
Hand Hygiene Facilities	April 2023	97%	
Cleaning and Decontamination	Sept 2023	Non-Infected	92%
		Infected	95%
	March 2024	Non-Infected	96%
		Infected	97%
Standard Precautions	October 2023	97%	
Sharps Safety	May 2023	98%	
	November 2023	98%	
PPE (Clinical Areas)	September 2023	98%	
	March 2024	98%	
PPE (Infection Prevention)	Q1 2023 2024	97%	
Isolation Audit	April 2023	97%	
	October 2023	98%	

Areas/wards who do not achieve the expected audit standards are required to identify actions for improvement and are offered support and input from the Infection Prevention Team.

Processes are in place for regular review of areas not achieving expected standards. Performance in relation to audit standards has been reviewed monthly by the Infection Prevention Team in order to identify areas of concern/those requiring additional support to improve practice standards. 3 areas were contacted in relation to their performance and requested to implement actions for improvement and offered support and education from the IPT.

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

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

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

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

Infection Prevention Ward Accreditation 2023/24

Target**:** All areas to achieve full accreditation at year end 2023/24.

Accreditation status for each clinical area is calculated based on self-reported performance in audits undertaken as part of the Infection Prevention Audit Programme (high impact intervention audits hand hygiene, miscellaneous audits), IPN Hand Hygiene Audits and Clinical Cleaning scores as detailed below:

- Self-assessed Audits: scores achieved across all audits. Non submission of an audit scores 0
- IPN hand hygiene audits -score achieved across both audits in the year.
- Clinical cleaning scores: scores consistently achieved against national cleaning standards.

End of year outcome (144 areas)

- 55 areas achieved Full accreditation (38%)
- 42 areas achieved Partial accredited (29%).
- 47 areas did not achieve accreditation (33%).

Of the 89 areas who did not achieve full accreditation 48 (54%) of the areas were due to non-submission of audits and 36 (40%) due to both non-submission of audits and areas not meeting expected audit/practice standards.

Actions to improve accreditation status in 2024/25

1. Divisions and Care Groups to review and discuss the detailed ward accreditation report and take action to improve performance, including ensuring that required audits are submitted as per the annual infection prevention audit programme.
2. The Infection Prevention Team will continue to work with areas to support achievement of full accreditation for 2024/25.
3. Performance for individual clinical areas will continue to be subject to monthly review by the IPT as part of a continual improvement process.
4. Actions to improve audit submissions:
    - An email reminder on the audits due for submission is sent on the 1st working day of each month to all ward leaders, theatre leads, matrons and infection prevention link staff.
    - Audit reports detailing non submissions are sent to all ward leaders, theatre leads and matrons and uploaded to staffnet.
    - Infection prevention nurses linking with the ward leaders within their divisions to highlight audit non submissions.
    - List of areas that have not submitted the previous months audits will be communicated via the Infection Prevention Link Staff Microsoft Teams Group.

Environmental Cleaning

Monitoring of environmental cleaning standards (domestic and clinical) continued to be undertaken by the environmental monitoring team and Serco in 2023/2024.

During this period, the EMT have established themselves as a team with a new Clinical Education Lead to support with engagement with clinical teams and education for the Serco team. Levels of audits has remained consistent, ensuring all areas of the hospital are being assured for cleanliness.

Serco have seen some inconsistency with audit outcomes in the last 12 months, with 5 months not meeting the national target of 98%. The average score of audits per month is 99%. The Trust are continuing to work with Serco on ensuring they meet the national standard across both sites.

Over the last 12 months a total of 20,664 terminal cleans have been completed at an average of 1,722 per month, this is a slight reduction on last year.

Clinical cleaning has also seen inconsistency with audit outcomes in the last 12 months, with an average score of 97%. The introduction of the clinical education lead has seen relationships between EMT and the clinical teams improve with much better engagement around clinical cleaning.

The New National Standards for Healthcare Cleanliness (2021) were fully implemented in May 2023, with cleanliness charters and Star rating posters being displayed in all patient facing areas. The responsibility framework is in its final stages of completion and efficacy audits are due to be implemented later this year.

Infection Prevention and Control Board Assurance Framework.

NHSE/I developed a Board Assurance framework in 2021 with a number of subsequent updates to enable a self- assessment of compliance with UKHSA COVID-19 related infection prevention and control guidance, to identify risks, to act as an improvement tool and to assure trust boards. This was further updated in September 2022 to enable a self-assessment of compliance with the new National Infection Prevention and Control Manual (NIPCM) and other related infection prevention and control guidance to identify risks associated with infectious agents, gaps in assurance and actions to mitigate/control risks. The UHS self-assessment against the framework previously noted good evidence and overall assurance of compliance with national IP&C guidance and a further review/update will be undertaken in early 2024/25.

2.10 Antimicrobial Stewardship.

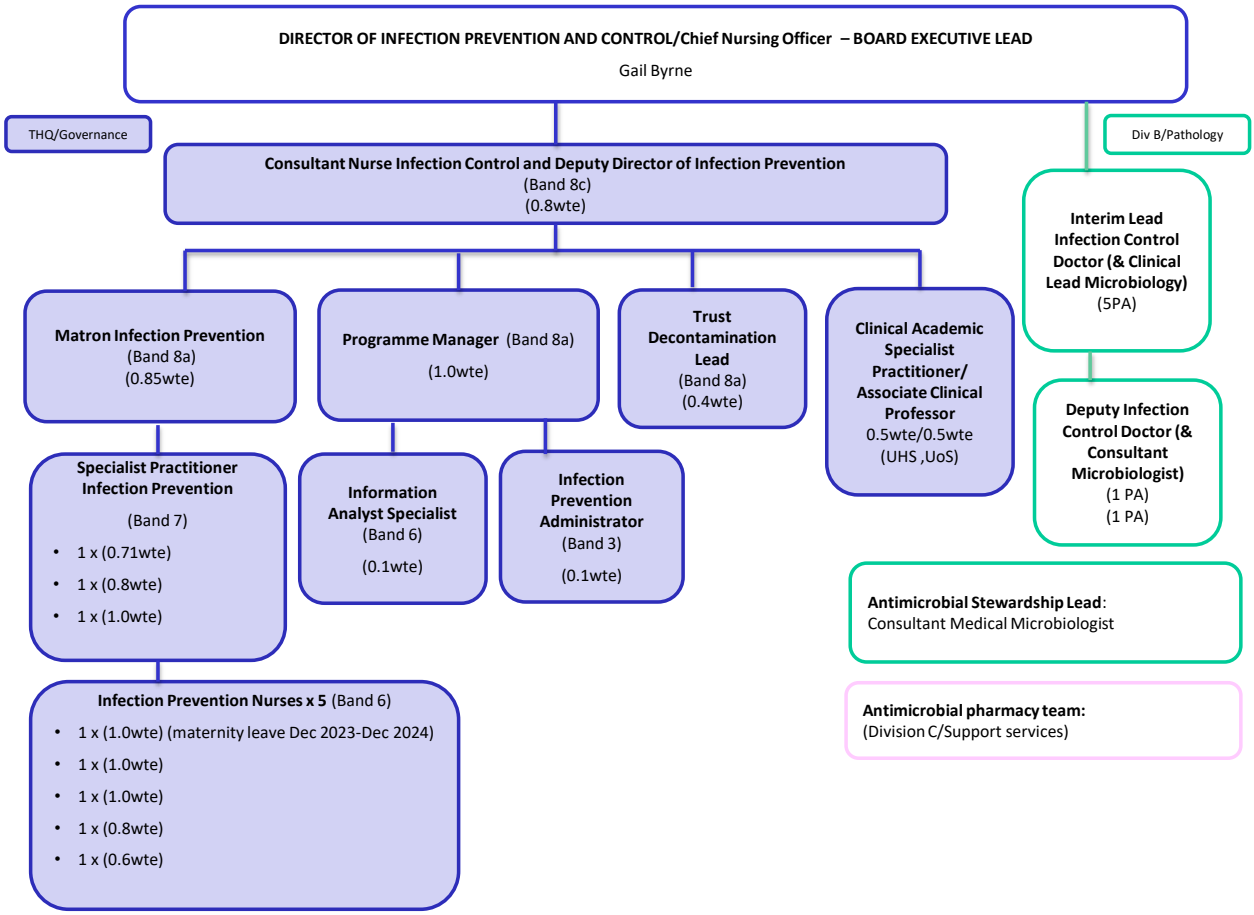
Antimicrobial stewardship, along with the focus on infection prevention and control, is a key component in reducing antimicrobial resistance and is a key requirement within the Health and Social Care Act 2008 : Code of Practice for health and adult social care on the prevention and control of infections and related guidance (updated 2022), with a requirement for registered healthcare providers to demonstrate appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance

Appendix 1 provides a full report on antibiotic usage/consumption within UHS and performance against NHS contractual requirements and CQUIN outcomes (Note – full data for Q4 not yet available).

Formal antimicrobial stewardship (AMS) activity and strategic development at UHS continues to be led by a small team comprising a consultant medical microbiologist (only 1.4PAs per week allocated to AMS activity) and a small pharmacy anti-infectives team. Activities are limited by resource with targeted stewardship rounds not covering all areas of the Trust and limited educational activities. Without adequate resource the Trust will remain at high risk of continuing to fail to meet nationally set AMS targets and there is a need to ensure that the UHS AMS team is adequately resourced to support the Trust's antimicrobial stewardship programme/strategy and national AMR agenda moving forward.
Further resourcing (both medical and pharmacy) staffing of the AMS team will allow for increased educational activity and targeted stewardship rounds.

2.11 Infection Prevention Team/Service

Resource



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

A range of activities have been undertaken throughout the year focused on preventing and controlling infection and a programme of IP&C policy reviews has re-commenced to ensure that UHS policies are aligned with the National Infection Prevention & Control Manual that was published in 2022. The team have continued to support Divisions in the prevention and control of infection as well as providing expert advice/input into other services such as estates, cleaning, waste, procurement.

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

Supporting environmental sustainability and the UHS Green Plan
The IPT are actively engaged in projects and initiatives to support environmental sustainability and the UHS Green Plan. Examples include:

- Launch and rollout of the 'Give up the gloves' campaign across the trust (following a successful pilot in the surgical care group) with the aim of reducing the number of non-sterile gloves used resulting in a reduction in single-use plastics and reduction in waste.
- Supporting safe reduction of use of other PPE by reviewing and updating PPE guidance (e.g. use of masks and long sleeve gowns) and promoting the correct use of PPE.
- Working with the procurement team to explore options for use of re-usable products instead of single use products e.g. exploring option of re-usable tourniquets to replace single use.
- Supporting the waste transformation project.
- Supporting the theatres sustainability group

2.12 Estates & the Built Environment

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

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

Concerns continue to be highlighted in relation to the existing environment in many areas of our hospital sites (e.g. ventilation, lack of toilet/bathroom facilities, lack of isolation facilities, general repair of ward/outpatient environments) and the impact on preventing & controlling infection. A number of reviews undertaken by the IPT, in response to specific incidents/clusters/outbreaks of infection, have identified concerns related to the environment. A specific example of this relates to Ward D4 as outlined in section 2.6 of this report and in previous reports.

IPT spotlight reviews of the environment, cleanliness and practice undertaken in 2023/24 in maternity inpatient areas and outpatient areas on SGH, PAH & RSH sites also highlighted a wide range of issues associated with the general fabric/repair of the environment which can have an impact on the ability to effectively prevent and control infection e.g. damage to the fabric of the environment which can provide a reservoir for harbouring micro-organisms and cannot be cleaned effectively.

Processes and mechanism are place to report these back to the EFCD team to address and some progress has been made in addressing a number of the findings e.g. actions taken to address concerns with mould growing around the window frames/windows in some of the rooms on labour ward.

Water Quality

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

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

- Provide clear direction and oversee the strategic and operational implementation of water safety and hygiene management throughout the Trust.
- Support and steer action on water safety and hygiene to meet Trust objectives and local and national targets and statutory compliance.
- Ensure action is taken across the Trust to minimise the risk of infection emanating from water and 'wet' systems supporting the improvement in patient safety and the patient experience.
- Review of the programme and outcomes of monitoring of sampling for Legionella and Pseudomonas; review of risks and actions required/taken; review of water safety risk assessments for Legionella/Pseudomonas.

Good progress continues to be made in addressing pseudomonas in our water systems (as demonstrated by an ongoing reduction in positive water samples) and in completing remedial works required to improve water hygiene.

A review of the findings from the Water Safety Audit undertaken by the Trust Appointed Authorising Engineer (AE) was undertaken by the Water Safety Group in March 2024 with key areas for action identified as:

- Appointment of relevant responsible persons for Water following changes in the EFCD personnel.
- Review and update of the Trust Water Safety plan to ensure it has a tailored, risk-based approach, while acknowledging areas of expected non-compliance, with a focus on priorities.

Air Quality/Ventilation

Providing a clean environment, including fresh air, is considered essential to the healthcare environment. Good ventilation is an important line of defence for controlling transmission of infection which has been highlighted further during the COVID-19 pandemic, where the association between transmission/outbreaks and poor ventilation in a range of settings (healthcare and non-healthcare) was established.

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

Currently, the risk relating to poor/lack of ventilation in inpatient ward areas continues to be managed by the careful placement of portable air purification units which are likely to play an essential role in risk mitigation. Air purification units continue to be actively deployed to wards/bays deemed to be at high risk of respiratory virus transmission/outbreaks and high risk areas such as admission units. However, use of these units is only a temporary short-term solution.

Options for a medium-term solution to improve the ventilation on some of the highest risk wards on F Level East Wing (Orthopaedics) were identified by the Estates team in collaboration with the Infection Prevention Team in late 2022 and installation of wall mounted mechanical heat recovery

ventilation(MHRV) units into 8 bays within the T&O wards was completed in Spring/Summer 2023. These bays were assessed by the IPT/DHN/Matrons as highest risk for outbreaks of COVID-19 (F2 & F1 trauma bays) (based on UHS outbreak data with multiple outbreaks in these areas) with subsequent disruption to operational capability due to bay/ward closures. Efficacy of the installation of these units has been reviewed by Estates & the IPT who have determined that they have had a positive impact on infection rates within the wards. A recommendation has subsequently been made for consideration, as a medium-term solution, to roll out MHRV units to other non-ventilated wards that are considered at high risk of infection outbreaks e.g. other wards on F-level West wing and D4. The limiting factor however being electrical supply and funding.

Long term solutions to improve/install mechanical ventilation in existing inpatient wards will require a large scale of work with potential disruption and significant investment. Long term solutions to install ductwork will be scheduled in line with future ward refurbishment programmes. Newly built inpatient wards will (and have) been designed with mechanical ventilation e.g. D12 and E12.

Focus on ventilation in the built environment may further reduce the risk from many other healthcare associated infections such Norovirus, MRSA and multi-drug resistance organisms. Ventilation remains on the estates risk register and is identified as one of estates highest priorities for addressing. It continues to be included in the backlog maintenance replacement programme but requires funding.

3.0 Operational and financial impact of Healthcare Associated Infection

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

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

4.0 Appendices

Appendix 1 : Pharmacy Anti-infectives Team Report
Appendix 2 : Q4 Division A Matron and CGCL Report
Appendix 3: Q4 Division B Matron and CGCL Report
Appendix 4: Q4 Division C Matron and CGCL Report
Appendix 5: Q4 Division D Matron and CGCL Report

Appendix 1

Pharmacy Anti-infectives Team Report to Infection Prevention Committee and TEC
May 2024 (Covering 2023-24)

Introduction

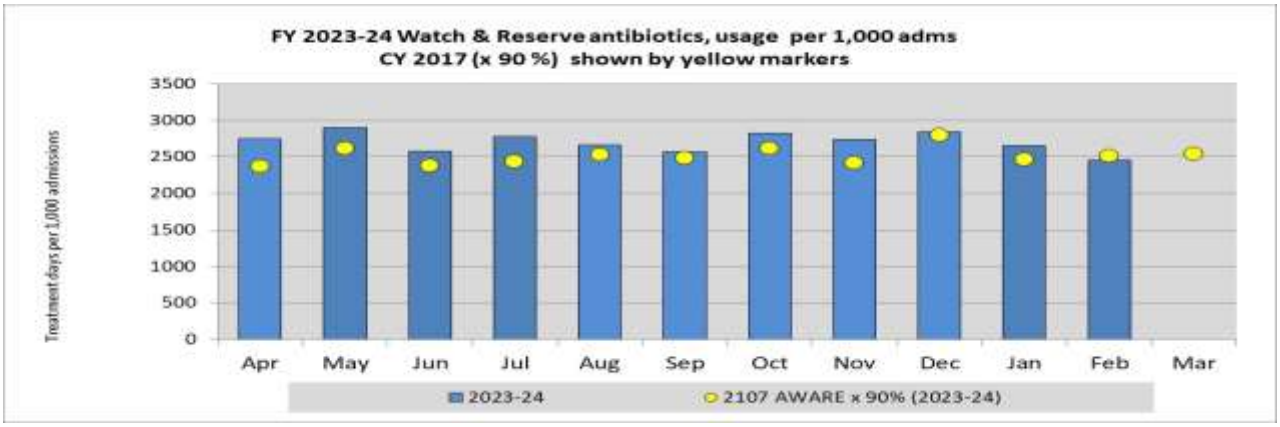
Antimicrobial stewardship (an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness) features in the Health and Social Care Act 2008. To comply with the terms of the code of practice the trust needs to ensure: Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.
Antimicrobial stewardship functions well when there is strong leadership across clinical specialities.
At UHS oversight is provided by the antimicrobial stewardship committee reporting via this medium to TEC. Stewardship work focuses on national targets and CQUIN schemes as well as review and update of antimicrobial guidelines. A full antimicrobial stewardship strategy is planned when resources allow. The medical microbiologists provide speciality-based stewardship rounds and advice although there are gaps in this provision.

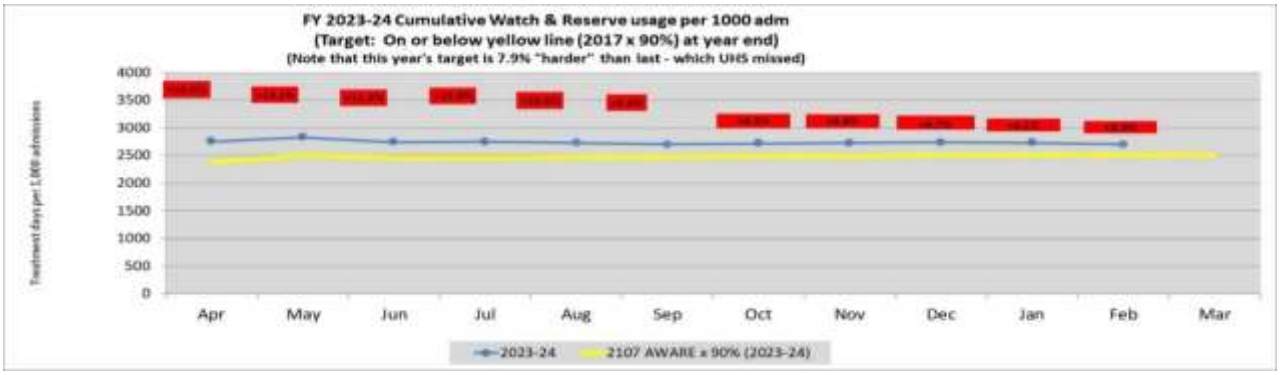
1. Total Antibiotic Consumption

a. Internal performance

The NHS standard contract 2023-24 requires a reduction of 10% in the use of WHO AWaRe programme "Watch" and "Reserve" antibiotics for FY 2023-24 when compared to calendar year 2017 (watch and reserve antibiotics include as examples co-amoxiclav and piperacillin-tazobactam).

Consumption data is shown in the charts below. To meet the target the blue line need to be on or below the yellow line. Data up to February 2024 strongly suggests that UHS is ***unlikely to meet this target***. To meet our contractual target there needs to be a wholesale change in practice surrounding use of antibiotics in the trust and even that would likely be insufficient for the current year.
(Bed activity data is only available around 6 weeks after the end of the month so March 2024 data is unavailable.)

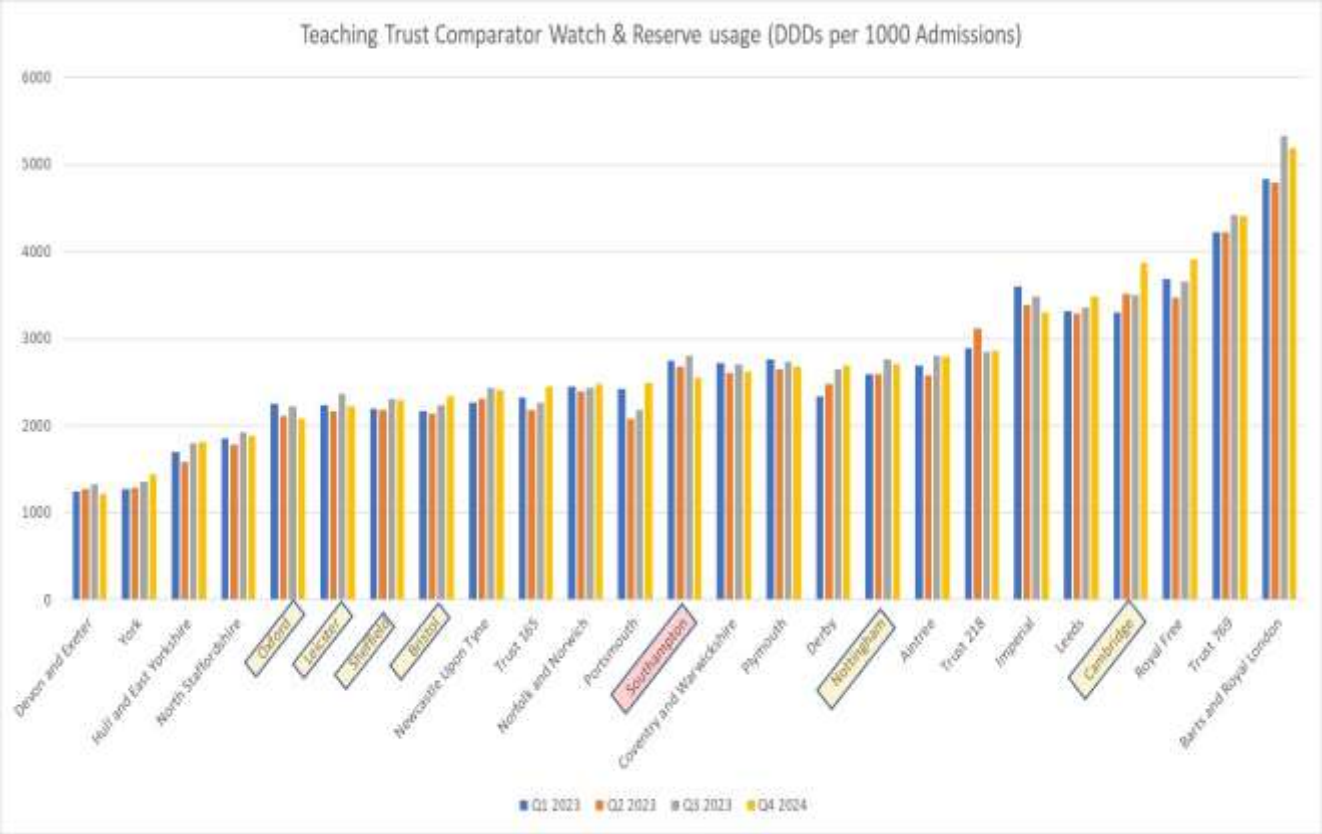




Ref: Internal reporting; source data from https://www.rx-info.co.uk/ (Refine)

b. National comparators

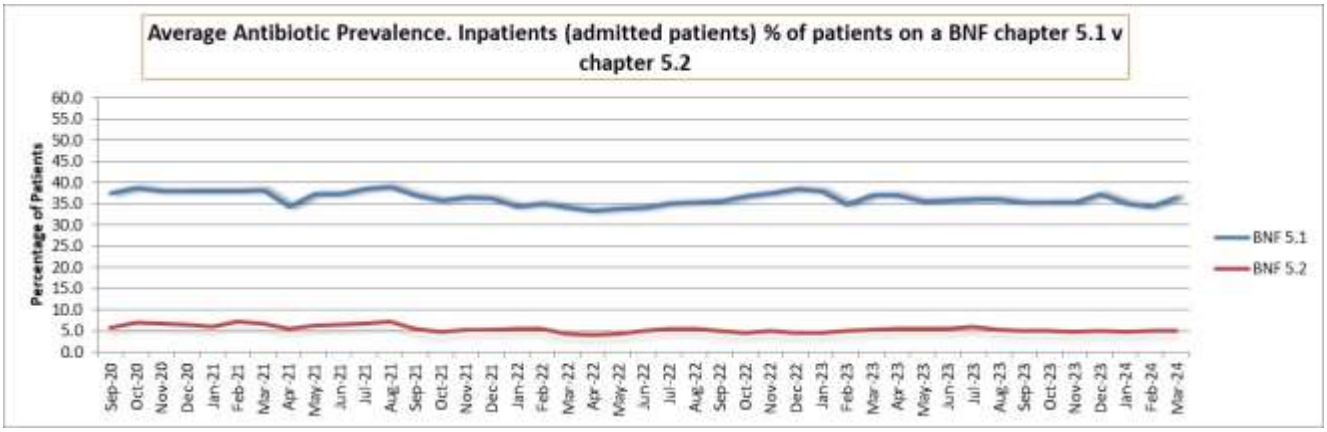
The following chart shows how UHS compares to other teaching trusts. We do not have full trust identifiers as seen with the codes; our peer comparator trusts are identified by the y-axis boxes. When the average of our peer comparator trusts is calculated Southampton usage is 9% (Q3) above the mean. (Note, numbers alter slightly each time refine is accessed for the previous 6 months as admissions data is finalised)



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

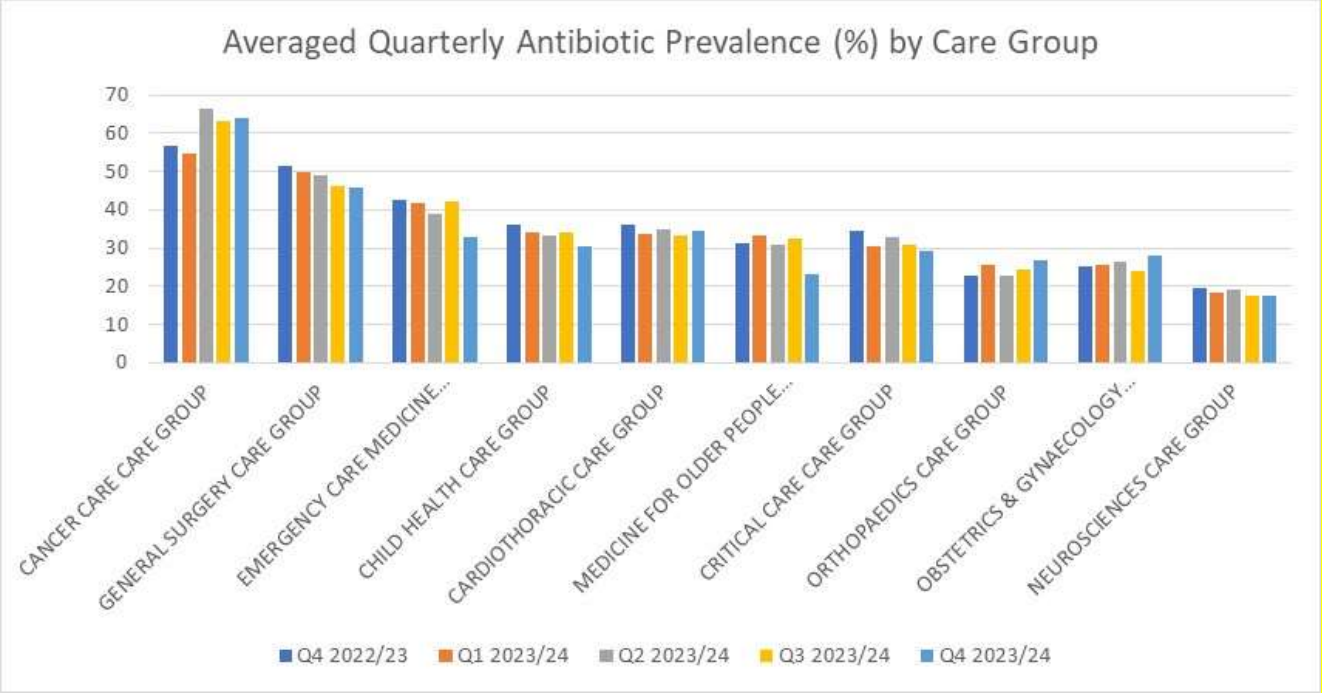
c. Proportion of Patients on Antibiotics

At UHS there continues to be approximately 39-42% of patients on antimicrobials at any one time.



Ref: Reporting data from JAC prescribing system

This can be broken down by speciality; quarterly usage. Note this is prevalence (patients on an antibiotic) and not adjusted for usage/admissions.



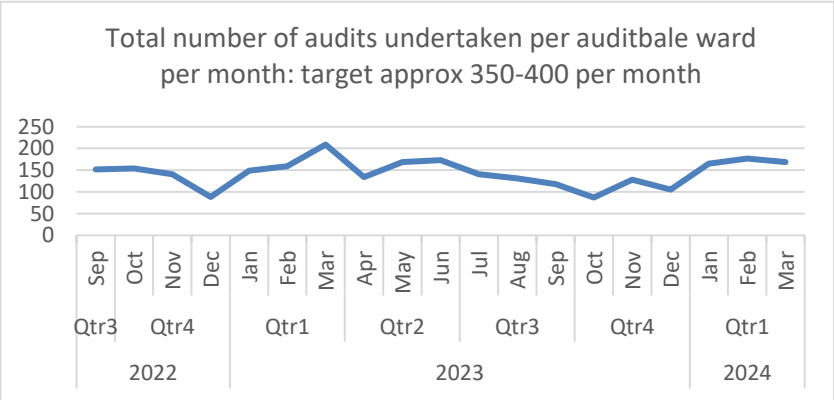
Ref: Reporting data from JAC prescribing system

d. HAPPI Audits

Hospital Antibiotic Prudent Prescribing Indicators (HAPPI) audits have been re-introduced (September '22) to gain information on appropriateness of antimicrobial prescribing. They allow UHS to fulfil its obligation as per the H&SC Act 2008 to monitor the use of antimicrobials to ensure inappropriate and harmful use is minimised.

The aim is for 5 audits to be completed each month for each ward by the ward pharmacists.

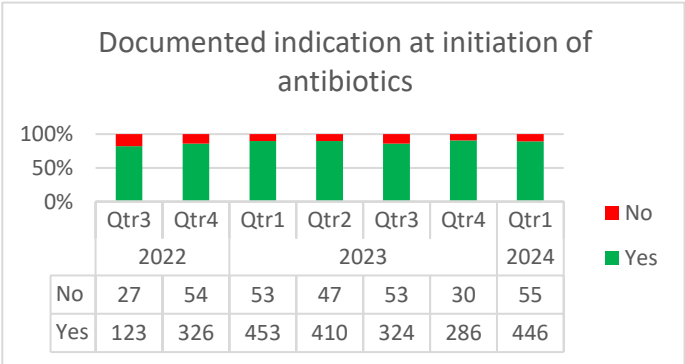
Note that patients are NOT selected randomly, making selection bias a possibility.

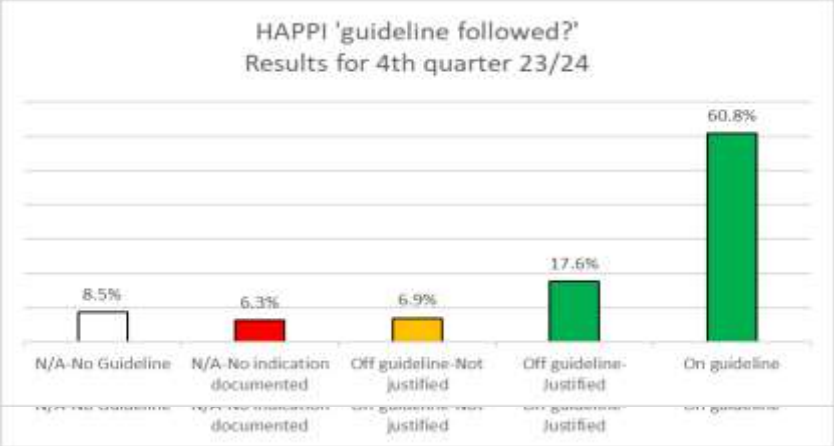


In view of the decline in audits we instituted a training package, particularly focussing on new pharmacists, to encourage awareness and quality data collection in autumn 2023, the outcome appears to be an increase in audit completion to consistently more than 40% of target number for the final quarter of 2023/4 – see chart left. This training will continue.

Audit results for Q4 2023/4:

- Of auditable cases, 10.9% did NOT have a documented indication at the time of prescribing, this shows sustained improvement since lowest measures of 14% in Q4 2022 and Q3 2023 (chart right). This can be improved upon further as one in ten prescriptions do not have indication documented at time of initiation.





- Guidelines were followed (or justifiably deviated from) in around 78% of cases, leaving 8.5% of infections with "no applicable guideline" and then 13.2% either NOT followed or not auditable due to having no stated indication, (image left). This has declined from 83% guideline followed or justified off guideline use for the previous quarter.

- Of auditable cases we record the number that had a documented review and management plan at 48-72hr: the improvement to 83% from 79% in the succeeding two quarters has been sustained for this quarter achieving 83.9%. Optimising these reviews will improve IVOST (see below

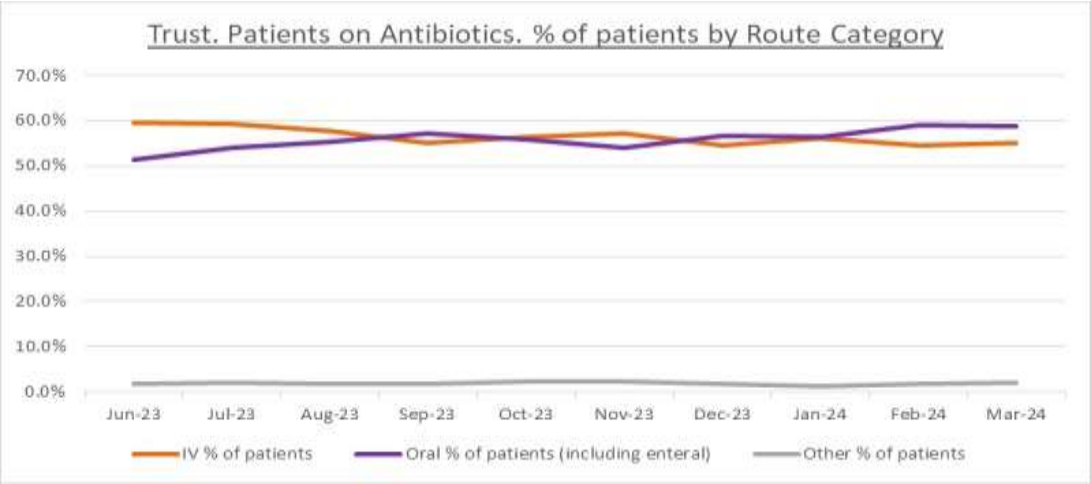
2. CQUIN: Timely IV to Oral Antibiotic Switching (IVOST)

Target: Of audited patients receiving IV antibiotics, fewer than 40% shall be found to have been eligible for oral switching at time of audit; this is a cumulative target for the year. One hundred patients are audited per quarter. The CQUIN has been fully met for 2023-24.

Quarterly results are recorded in the table below:

	Non-compliant %	Compliant %	CQUIN target: ≤ 40% non-compliant
Q1 (April-June)	22	78	Met
Q2 (July-September)	22	78	Met
Q3 (October-December)	19	81	Met
Q4 (January-March)	19	81	Met

No real change in practice has been seen from the audit data collected however this is a small sample size.
Internal reporting data suggests a trend to this change in practice starting to be seen which is encouraging.



Ref: Reporting data from JAC prescribing system

Switching to oral from IV has numerous associated benefits including saving nursing time and reduction in length of stay as well as reducing healthcare associated infection and reducing plastic waste. As this stewardship activity has added value we will continue to promote this over the next year. Of note a 20% non-compliance rate offers a potential £250k saving in drug costs per annum and nursing time saved equating to 15 WTE.

Appendix 2

Division A Q4 Matron and CGCL Report

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

Matrons: Kerry Rayner, Kate Stride, Jake Smokcum, Charlie Morris, Lisa Turnbull, Linda Monk, Michaela Jones. Ryan Bird, Leah Marriott, Tracy Richards, Mitzi Garcia, Raquel Domene Luque and Fretzie Condevillamar, Neil Sabarre.

Clinical Lead: John Knight, Aris Konstantopoulos and Aby Jacob

Date of Report: April 2024

Author: Colette Perdrisat

Performance Quarter 4 – 1st January to 31st March 2024

Key Indicator	Division A	Limit	Trust Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 3** (HOHA +COHA)
***Clostridium difficile* diarrhoea**	**2**	**Trust Limit 15**	**Trust Total 24** (HOHA + COHA)
E. coli (HOHA)	**4**	**Trust Limit of 30**	**Trust Total 32** (HOHA + COHA)
Pseudomonas (HOHA)	**0**	**Trust Limit of 9**	**Trust Total 6** (HOHA + COHA)
Klebsiella (HOHA)	**3**	**Trust Limit of 15**	**Trust Total 16** (HOHA + COHA)
MSSA Bacteraemia	**3**	**No Limit**	
GRE	**3**	**No Limit**	

Incidents / Outbreaks of Infection and PIIs	
C.difficile Period of Increase Incidence on GICU	Three patients testing positive on GICU within 28 days. Learning: • Dirty commode found in C Zone • 5 bags of used PPE directly below PPE dispenser.
Decontamination of scopes on Urology Day Unit.	Investigation around scope being used twice without being cleaned. Learning: • Skin prep to be reviewed to check it is flowing nice guidelines. • Scopes used on 2 different patient -with no decontamination between patients

Performance Year to Date: 1st April 2023 – 31st March 2024

Key Indicator	Division A	Limit	Trust Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 7** (COHA)
***Clostridium difficile* diarrhoea**	**14**	**Trust Limit 60**	**Trust Total 105** (HOHA + COHA)
E. coli (HOHA)	**25**	**Trust Limit of 120**	**Trust Total 147** (HOHA + COHA)
Pseudomonas (HOHA)	**2**	**Trust Limit of 33**	**Trust Total 24** (HOHA + COHA)
Klebsiella (HOHA)	**16**	**Trust Limit of 56**	**Trust Total 58** (HOHA + COHA)
MSSA Bacteraemia	**9**	**No Limit**	
GRE	**5**	**No Limit**	

Key Learning from Investigation of Infections and Deaths:

Critical Care

CICU – 1 x C.Diff case in January**.** One orange bag hanging from PPE trolley outside the room with packaging from gowns, and others, requested this to be removed and substituted for a bin with a black general waste bag. Staff are choosing to wear long sleeve gowns.

GICU 2 x C.Diff cases (start of PII) in February – (1) Medical equipment ontop of domestic waste bin meaning handtowels were disposed of in clinical infectious waste. Staff wearing long sleeve gown and gloves although not required. Minimum PPE required is gloves & apron. Consider use of longsleeve gown if at risk of uniform contamination. Patient has flexiseal insitu. Cubicle has an ensuite toilet door not labelled as a toilet please ensure- daily flushing as not all staff were aware that the cubile had an ensuite. (2) Three commodes were checked, and were all clean but only 2 had clean indicator stickers. Pillow on top of domestic waste bin. Patients offered hand hygiene before meals, after toileting etc.

GICU 2 x C.Diff (therefore PII extended) in March – (1) No issues raised.(2) Delay in moving patient to isolation room (patient transferred from GICU 12.03, started with symptoms on 09.03 sample sent on 12.03 only transferred to side room in GICU on 12.03 once sample result known). C.diff pathway not started in GICU. Staff wearing long sleeve gowns. Patient not offered hand hygiene before meals, after toileting etc. as patient currently confused with RMN – advised to encourage to clean hands.

GICU C.Diff PII visits: 1st - dirty commode in C Zone sluice, 2nd - no practice issues observed, 3rd - no practice issues observed, 4th - no practice issues observed, 5th - dirty commodes and I am clean sticker from previous day, bags of dirty linen piled up below clean PPE I have done 4 visits and unfortunately, will have to extend the monitoring as we have had 2 new cases acquired on GICU.

GICU – feedback received from MSSA in December. Actions noted and fedback to GICU - When reviewing central or peripheral access – please continue to record the CADI and VIPS 8 hourly, medical teams to remember to document whether lines are still required and anyone accessing IV lines if blocked/ difficult to flush please consider removal as intraluminal clots will increase risk of line infection.

Teaching on MSD and monthly newsletter regarding investigations and learning/ actions required. Action plans written and cascaded to relevant clinical staff on units.

Surgery

F11 learning from increase in line infection led to focus on hand hygiene and PN practice.

Theatres

Ongoing instigations theatre K, ceiling, and laminar flow. No outcome or learning identified as yet.

Progress and Success:

Critical Care

GICU – Hand hygiene audit 95%, reaudit CVC ongoing care 100%, VAP 100%, SSI post op 100%, PPE 96%, cleaning & decontamination 100%
CICU - reaudit CVC ongoing care 100%, VAP 100%, SSI post op 100%, PPE 96%, cleaning & decontamination 100%
NICU - VAP 100%, SSI post op 100%,
SHDU – Hand hygiene audit (local) 100% (UHS covert) 95%, SSI post op 100%, PPE 100%, cleaning & decontamination 100%

Ophthalmology

Audits:
Eye Theatres: Surgical site 100%
Eye Recovery: IPN HH 56% - only 1 individual audited
Eye Casualty: IPN HH 65% - missed opportunities across a range of professions
Eye Short Stay: IPN HH 60%
Eye Casualty: Outpatient HH compliance 90%
Eye Outpatients: Outpatient HH compliance 70%

Cleaning audits:
Eye Casualty: 17/01/24 – 98%
Injection suite: 02/04/24 – 99%
Injection suite: 25/03/24 – 97%
Injection suite: 19/03/24 – 98%
Injection suite: reaudit: 24/02/24 – 98%
Injection suite: 19/02/24 – 98%
Injection suite: 16/02/24 – 99%
Injection suite: 05/02/24 – 94% - due to domestic score
Injection suite: 29/01/24 – 100%
Injection suite: 25/01/24 – 98%

Eye Theatres: 25/03/24 – 98%
Eye Theatres: 20/03/24 – 99%
Eye Theatres: 13/03/24 – 99%
Eye Theatres: 04/03/24 – 100%
Eye Theatres: 27/02/24 – 99%

Eye Theatres: 21/02/24 – 98%
Eye Theatres: 16/02/24 – 95%
Eye Theatres: 06/03/24 – 96%
Eye Theatres: 29/01/24 – 97%
Eye Theatres: 26/01/24 – 99%
Eye Theatres: 09/01/24 – 99%
Eye Theatres: 05/01/24 – 100%

Surgery

Walk through/talk through of flexible cystoscopy process has been undertaken in urology centre to identify learning following double scope use incident. Current investigation being written, this will allow trust wide learning.

F11 have undertaken a hand hygiene focus week following an increase in line infections.
This involved staff attending microbiology lab with Nitin and shared learning achieved.

Theatres

Number of failed clinical clean audits across theatres- action plans produced, and improvements seen as result. Senior member of cleaning services coming to speak on theatre education mornings to give update, guidance and take Q&A

Continued education and walk abouts from matron team.

Estates walk around happening monthly with UEL and Theatre Matron team.

Successful matrons walk about in several theatre specialities, supporting infection prevention measures. Working on theatre specific CAS

Ongoing Challenges:

Critical Care

CICU – hand hygiene audit (local) 85% after patient contact, after contact with patients' surroundings and reaudit 85%, 74% (UHS covert) staff walking around with gloves on, no HH after removal of gloves and before and after touching patient.

GICU – hand hygiene audit (UHS covert) 85% same gloves worn for multiple tasks, cardigan sleeves down in clinical area including around bedspace.

NICU - Hand hygiene audit (local) 92% before ANTT, before patient contact (UHS covert) 45% general lack of hand decontamination prior to glove use, domestic not cleaning hands between glove changing, not before or after patient contact, or after glove use; PPE 91% aprons not worn as single use items and lack of eye protection; cleaning & decontamination 85% lack of documentation e.g. I am clean stickers identifying if equipment is clean.

General reminders to follow policy and WHO key moments for hand hygiene in CC with ongoing surveillance and audit. Other reminders include the correct use of PPE including visors and masks.

CICU Staff wearing surgical masks inappropriately below nose and on chin highlighted during covert hand hygiene audit when it was mandatory for staff to wear surgical masks, this is no longer the case and therefore staff choosing to wear masks are wearing them correctly. However, staff that are advised to wear face covering for risk of splash to face there is still some reluctance to wearing visors despite education and having several options available (all Critical Care (CC)). A small amount of antiglare visors are available for medical team who insert CVADs but there has been not requests for them other than within the technician team for PICC insertion. Some flip up

visors are also available on GICU left over from pre-Covid but these cannot be used when in contact with a patient with a confirmed respiratory virus or when an AGP is being carried out.

Lack of housekeeping staff on GICU due to sickness, and therefore allocation to alternative staff when able otherwise many tasks including tap flushing and commode and environment checking is being missed. Encouraging all staff to clean commodes thoroughly after use especially on GICU due to PII.

Environmental audits from EMT regarding unclean beds particularly underside of rails – often arriving from ward areas unclean and CC not noticing immediately on arrival to unit or not having the time to thoroughly clean or escalate to prior ward on arrival , and consequently being picked up by EMT during weekly audits. Staff encouraged to check, report by informing ward staff and/or complete AERs. Beds will still need to be cleaned if present on CC otherwise risk of infection risk to patients and repeated failed audits from EMT.

Ophthalmology

Inconsistent audit results especially around hand hygiene. Challenges with embedding the good practice that is demonstrated from one audit to the next

Clinical cleans in Eye Theatres inconsistent. Refocus undertaken and changes made to departmental cleaning records. Thus far this has produced improved results.

Theatres

Issue with estates acting in a prompt manner. Theatre U laminar flow has been out of action for 10 weeks. Care group managing through scheduling and moving of theatre workload.

Issue with implementation of new sharps bins and lack of provision for appropriate holders. Will potentially result in additional UEL cost pressure of in excess of £24,000.

One staff member with pertussis-incident- No risk identified to patient of staff. Meetings being held to manage with care group and IP.

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

Critical Care

Rollout of gloves off campaign in NICU and continued education regarding the same in remainder of CC however IP link days to promote campaign, education and audits have been removed on Neuro ICU to support financial controls. There remains one Critical Care IP link sister present to support all units and complete observations of practice and surveillance to ensure staff are following policy and providing assurance that infection prevention practices are adhered to. Information is cascaded via newsletter, emails and one to one education whilst in the clinical areas. Focus will continue with hand hygiene, documentation and highlighting actions/ lessons learnt following post infection reviews.

Theatres

Issue with laminar flow in theatre K and with break in ceiling. This has been escalated to infection prevention and estates. Issue now fixed by estates. Flow up in progress with patient safety team, IP,

estates, and clinical team. Potential risk that fragments from ceiling could have dropped into operating field. No support required from DMT or wider. No evidence that harm has occurred.

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

Theatres Issue with estates acting in a prompt manner. Theatre U laminar flow has been out of action for 10 weeks. Care group managing through scheduling and moving of theatre workload.

Date this report will be an agenda item at Care Group Governance Meeting	**Date this report will be an agenda item at Divisional Governance Meeting**
January 2024	January 2024

Appendix 3

Division B Q4 Matron and CGCL Report

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

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

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

Date of Report: April 2024

Author: Suzy Pike

Performance Quarter 4 – 1st January to 31st March 2024

Key Indicator	Division B	Limit	Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 3** (COHA)
***Clostridium difficile* diarrhoea**	**5**	**Trust Limit 15**	**Trust Total 24** (HOHA + COHA)
E. coli (HOHA)	**9**	**Trust Limit of 30**	**Trust Total 32** (HOHA + COHA)
Pseudomonas (HOHA)	**1**	**Trust Limit of 9**	**Trust Total 6** (HOHA + COHA)
Klebsiella (HOHA)	**3**	**Trust Limit of 15**	**Trust Total 16** (HOHA + COHA)
MSSA Bacteraemia	**3**	**No Limit**	
GRE	**1**	**No Limit**	

Incidents / Outbreaks of Infection and PIIs	
Influenza Outbreak on Bassett Ward	3 x cases of influenza A on Bassett Learning: • Delay in testing • Early sampling of symptomatic patients
Isolation of CPE contacts on F7	Patient high risk of CPE, and ?TB, not isolated, left in an open bay, with standard precautions. Learning: • Patient had been identified as query TB and high-risk CPE, and staff were not aware how the patient should be managed • Isolation risk assessment was not completed. • Delay in isolation due lack of appropriate escalation
MDRO in Bay on D8	Patient with MDRO placed in a bay Learning: • Staff were not aware that patient had MDRO. • Capacity to isolate the patient has not been escalated appropriately which has led to long delay in isolation. • Isolation risk assessment not completed. • Contacts were not managed with appropriate precautions. • Lack of communication between shifts about the closed bay

C.difficile Period of Increase Incidence on G8	2 patients tested C.difficile positive in the last 28 days Learning: • Staff -noted to be wearing false nails in the clinical area. • Staff found not bare below the elbow in the bay • Staff wearing gloves to doing a drug and carry out patient observations round not required. • Isolation risk assessment not completed. • Missing day of documentation on C diff pathway. • Dirty commode found during visit today.
Pertussis In ED/PMU	2 x patient confirmed pertussis. Learning: • Incorrect PPE worn with a patient with suspected whooping cough.
CPE In MAOS	CPE positive patient admitted to bay on MAOS. Learning: • Staff not checking patients alerts before admission 3 incidents (C. Auris, CPE and a VRE).

Performance Year to Date: 1st April 2023 – 31st March 2024

Key Indicator	Division B	Limit	Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 7** (COHA)
***Clostridium difficile* diarrhoea**	**36**	**Trust Limit 60**	**Trust Total 105** (HOHA + COHA)
E. coli (HOHA)	**37**	**Trust Limit of 120**	**Trust Total 147** (HOHA + COHA)
Pseudomonas (HOHA)	**3**	**Trust Limit of 33**	**Trust Total 24** (HOHA + COHA)
Klebsiella (HOHA)	**9**	**Trust Limit of 56**	**Trust Total 58** (HOHA + COHA)
MSSA Bacteraemia	**8**	**No Limit**	
GRE	**4**	**No Limit**	

Key Learning from Investigation of Infections and Deaths:

Emergency Medicine

- Staff knowledge and awareness of correct PPE required for suspected Whooping cough. Refocus and training required, particularly across nursing staff group.

Cancer Care

- Checking of alerts in admitting areas (AOS) to avoid cross infection and creating contacts. Need to enhance staff compliance as part of admitting process.

- Daily use of Bactroban, and how to obtain when stock levels are low. Use of patient information leaflet. Requires a refocus.

Medicine/MOP

- Checking CPI Alerts as part of admission process. Need to enhance staff compliance.
- Adherence to trust uniform policy, in particular wearing of jewellery and long-sleeved fleeces on shift. G8 Commended for their focus on this.
- Timely testing of symptomatic patients (Flu). Refresh required on managing respiratory viruses.

- F7 learning centred around communication between wards, IPT and flow team. Patient identified but no follow up from IPT, and no escalation from ward team.

Specialist Medicine

- Not applicable

Progress and Success:

Emergency Medicine

- All staff have been informed of the correct PPE.
- Isolation scoring table has been printed and laminated for quick reference guide.
- Promoted the whopping cough vaccine.

Cancer care

- Productive performance review on C4 with IPT, action plan initiated including teaching sessions from IPT.
- Change in contact requirements in cancer care, has reduced the need to isolate thus slightly reducing the pressure on side rooms.
- Currently reviewing mask wearing in the care group, plan to change current requirements in certain areas.

Medicine/MOP

- C.Diff reviews recently have not needed action plans, but hand hygiene before patient contact and food were themes, picked up.
- Consistent sharing of IPC reports and guidance within the medicine and MOP governance structures.
- Managing multiple infections, combined with need to isolate patients due to behaviour has been done well.

Specialist Medicine

- Plans regarding PPE management handed back to unit teams. Some areas sharing the ordering of PPE due to infrequent use of some items.
- All areas within Spec Med compliant with weekly environmental cleaning audit.

Ongoing Challenges:

Emergency Medicine

- There is limited side room capacity if a patient need admitting.

Cancer Care

- Results of cleaning audits – areas of concerns regularly highlighted are dusty fans, blood fluids on underside of bedrails and sharps trolleys.
- Side room capacity has been helped by contact changes but remains a pressure.
- Ongoing review of practices to improve audit results.

Medicine/MOP:

- Hand hygiene across the MDT.
- Side room capacity – competing demand infections/ end of life/ mental health.

- Adherence to uniform policy
- High volume of staff/visitors across D-level and G-level especially leads to crowded environments.

Specialist Medicine:

1. Dermatology- TB clinic runs within medical outpatient's department and to date no risk of active TB patients attending have been raised. During April, active TB patient brought to the clinic and due to changes in staffing, staff member in medical outpatients was not mask fit tested. Action taken to ensure all staff who cover medical outpatient are fit tested and their masks available for use. Discussion ongoing with clinical team regarding this clinic.
2. Endoscopy scored 74% on PPE audit and 70% on cleanliness audit in March 2024- action plan and re-audit in Progress, to be shared with next quarter report. CF, TRC and Derm scored 100% on both audits.
3. Some areas of non-submission with monthly IPT audits addressed with nursing team at clinical team meetings and through 1:1s. Some areas noted to have combined audits (such as Rheumatology and Managed Care) which are deemed appropriate, and environment is shared.

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

Emergency Medicine

- Ongoing with Hand hygiene. New infection control link nurse allocated.

Cancer Care

- Constantly reviewing our Covid guidelines to reduce restrictions during this period of low prevalence.

Medicine/MOP:

- Hand Hygiene is our current focus on the back of failings in the audit. Peer review audits are happening with the focus on before patient contact and before food as these are themes picked up across all areas.
- Current focus is to continue to manage multiple infections across multiple wards.
- Use of side rooms, and balancing different requirements

Specialist Medicine

- Infection prevention reports included within local governance reports and highlighted areas of success and areas for improvement within governance meetings.

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

None to note.

Date this report will be an agenda item at Care Group Governance Meeting	**Date this report will be an agenda item at Divisional Governance Meeting**
May 2024	May 2024

Appendix 4

Division C Q4 Matron and CGCL Report

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

Matrons: Karen Elkins (PAH), Victor Taylor (Neonates), Lucy Price (Maternity), Lorna St John (PICU), Felicity Oldman (Divisional) and Catherine Roberts (Child Health).

Clinical Lead: Balamurugan Thyagarajan and Charlie Keys

Date of Report: April 2024

Author: Louisa Green, Emma Northover

Performance Quarter 4 – 1st January to 31st March 2024

Key Indicator	Division C	Limit	Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 3** (COHA)
***Clostridium difficile* diarrhoea**	**3**	**Trust Limit 15**	**Trust Total 24** (HOHA + COHA)
E. coli (HOHA)	**2**	**Trust Limit of 30**	**Trust Total 32** (HOHA + COHA)
Pseudomonas (HOHA)	**2**	**Trust Limit of 9**	**Trust Total 6** (HOHA + COHA)
Klebsiella (HOHA)	**2**	**Trust Limit of 15**	**Trust Total 16** (HOHA + COHA)
MSSA Bacteraemia	**3**	**No Limit**	
GRE	**0**	**No Limit**	

Incidents / Outbreaks of Infection and PIIs	
CPE Contact on E1	Patient was admitted and the ward, staff had not realised that the patient had been in a hospital in Romania in the last 12 months. Learning: • Patient should have been isolated and screened as per policy.
Scabies on Burley Ward	Woman admitted to a maternity ward. Potential staff contacts sent to Occupational health. Learning: • Rash should have been assessed. • Correct contact precaution should have been implemented. • Correct PPE should have been worn.
Norovirus on PMU	2 Norovirus acquired on the ward with further staff and parent cases. Learning: • x3 medical staff found to be bare below elbow wearing wrist watches. • Inaccurate stool chart records, only ticking boxes no stool type specified.

Performance Year to Date: 1st April 2023 – 31st March 2024

Key Indicator	Division C	Limit	Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 7** (COHA)
***Clostridium difficile* diarrhoea**	**9**	**Trust Limit 60**	**Trust Total 105** (HOHA + COHA)
E. coli (HOHA)	**9**	**Trust Limit of 120**	**Trust Total 147** (HOHA + COHA)
Pseudomonas (HOHA)	**6**	**Trust Limit of 33**	**Trust Total 24** (HOHA + COHA)
Klebsiella (HOHA)	**6**	**Trust Limit of 56**	**Trust Total 58** (HOHA + COHA)
MSSA Bacteraemia	**11**	**No Limit**	
GRE	**0**	**No Limit**	

Key Learning from Investigation of Infections and Deaths:

CPE investigation on E1 found that staff missed that the patient had been an inpatient in hospital in Romania and had not been isolated and screened as per policy. Staff reminded to check where patients are admitted from and their travel history in the last 2 weeks. Education reminder on CPE policy. Audit to be undertaken to ensure practice is embedded.

Norovirus on PMU investigated, and findings showed that the cases of D&V occurred over a weekend. The immediate management of the outbreak was thorough and escalated appropriately, cleaning was carried out promptly and social areas closed. PMU was able to be reopened by the Monday morning.

The investigation into scabies on Burley found that initially the patient was not isolated and midwives were not wearing PPE. This was due confusion amongst staff regarding whether the patient had active lesions (active mites). Maternity have circulated the IP policy for scabies and action flow chart reminding staff of the process. All staff members who were in contact with the patient without PPE were informed and were contacted by occupational health.

Progress and Success:

Childrens Hospital

Following a case of Salmonella within Child Health, the prompt and correct procedures were followed, and temporary estate measures were implemented. A permanent solution of new sinks has now resolved this situation. Following cases of Pertussis, MRSA and Rota Virus status the common theme with all was an education focus for all staff around correct use of PPE and ensuring infection status is checked on admission to an area whether it be from the community or another inpatient area. Regular audits undertaken to ensure there is continued improvement in identifying infection status of patients.

PICU

100% achieved in PVC, CVC, Surgical site audits. There has been marked improvement with documentation on Meta vision. PICU have worked alongside the environmental monitoring Team, updating both bedside and Metavision cleaning guidance, this has resulted in improved environmental monitoring cleaning scores and have met the required

standard consistently over the last couple of months. PICU continue to work closely with the EMT to ensure these standards are maintained.

PICU had a known MRSA patient prior to admission. The correct isolation and screening procedures were followed, as well as correct decontamination regimen followed. Feedback given to staff caring for patient regarding the correct use of aprons/gowns.

Neonates

SOP for Incubator cleaning approved by governance. Neonate business case to SCBU to increase capacity within NNU.

Clinical Support

100% achieved in PPE audit compliance and 100% with cleaning and contamination.

Women's Health

Inpatient and outpatient services have scored high in audits. With improvement seen in Theatres when previously had a had failed audits.

Maternity

Consistently achieved green in environmental and cleaning audits.

Ongoing Challenges:

Childrens Hospital

Sewage leaked into the walls of cubicle on PMU. Room closed for 7 days whilst specialist treatment carried out and problem resolved.

Child health Infection Prevention team have begun training staff to Fit Mask Testing, this is due to the trusts central FIT mask testing hub being closed. Therefore, staff are asked to continue with the mask that they have been tested on in the last 2 year as advise trust wide.

There is a focus on nothing below the elbow for all multidisciplinary staff following the infection prevention team identifying staff wearing watches on ward rounds.

PICU

Ongoing leaks exacerbated due to recent weather conditions. There are 2 separate leaks identified Sky light in Sluice room and patient accommodation, this has been mitigated by placing a diverter and a quote for repair is being drawn up. The 2nd Leak is in PICU storeroom and is associated with the M&S leak and there are plans for this to fixed in the forthcoming weeks.

45% scored on a covert hand hygiene audit, action plans and reauditing completed. Enhanced education being delivered and more on spot feedback carried out.

There has been a focus on waste management streams for correct waste disposal, regular walk arounds implemented on PICU to determine where improvements are required.

Inconsistencies found amongst nursing and medical staff when requesting and sending weekly swabs for catheter urine and any wound/PEG/line swabs. Swabs not being sent on the designated days. On the spot feedback given to appropriate members of the team and relevant educational posters made available on PICU to remind staff of correct process and correct days, this will be audited to confirm compliance.

Neonates

Challenging staffing levels leading to increased workload and pressures on staff, making compliance of infection control practices more challenging. Due to the environmental factor's incubator decontamination was being undertaken in the sluice, therefore to mitigate this a toilet has been isolated elsewhere and the fluid waste disposal point is currently out of action. There is ongoing work to relocate the incubator decontamination area as part of the SOP.

Clinical Support

A shortage of sterile water bottles has impacted the use of bubble PEP devices, liaised with infection prevention who have agreed drinking water can continued to be used.

Women's Health

Bramshaw ward had a covert hand hygiene audit that scored 45%. Education focus being carried out with light box and target education including on the spot feedback. Reaudit will be carried out. 1 new case of Cdiff found to be unavoidable by infection prevention, all infection prevention procedures carried out correctly.

Maternity

Windows

The Princess Anne Hospital had a window replacement scheme. Not all the hospital windows were replaced, and this includes all the windows on Broadlands Birth Centre and the majority on Labour Ward. The windows that were not been replaced have recurring issues with mould, damp and poor insulation.

The mould around the windows has been identified as a risk to patients and staff with asthmatics who are sensitive to mould spores. The mould has also been identified by the infection prevention team as a source of a potential infection breakout for staff and patients.

The poor insulation around the windows is a risk to babies becoming cold. Several AERs regarding cases in which babies and women have become cold have already been completed. The issue with the windows has been added to the risk register.

Remedial works have commenced to remove the mould however this is likely to reoccur until the windows are replaced. This risk is on the register 786.

Fabrics and flooring

The general fabric and flooring within the Maternity Wards are poor. This was identified at our Spotlight reviews on Labour Ward, Burley, Lyndhurst, and Broadlands. Due to the size and constant use of our birthing rooms we would benefit from white rock to protect the paint work and walls. There is cosmetic damage to paintwork across the wards. Flooring joints and sealants are starting to crack, and we would benefit from new flooring. Following the Spotlight review some flooring was condemned and this triggered an urgent repair.

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

There is a focus on hand hygiene across the division.

Childrens Hospital

Education focus around audits, correct isolation, hand hygiene and ANTT. Work continuing around improving maintenance/estates. Infection Prevention meetings within Child Health are having a relaunch.

PICU

Education and training provided on risk assessments for use of PPE in the clinical environment, VAP and oral hygiene and hand hygiene. Continue to work with environmental monitoring team to maintain high standards.

Neonates

The Infection Prevention team have also implemented a Newsletter. Incubator SOP has been approved by governance. Expansion continues however currently awaiting building work regulations approval. There is continuing development with the metavision team to improve documentation regarding equipment changes. Clarification from infection control team is being sort regarding appropriate taping and dressings for UVCs. Rationale for tape and dressing for these lines is not to keep the line clean but is used further up the line to keep the line secure.

Women's Health Within PAH there has been a marked improvement in cleaning in theatres however a decrease in hand hygiene practice on Bramshaw education focus implemented.

Maternity

Ongoing issues with estates, fabric, and mould around windows. This has all been escalated with estates and central Infection Prevention. Remedial work on mould on labour ward commenced on 8th April. Estate issues remain on risk register. Risk Number :786.

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

Difficulty in obtaining access to mask fit testing appointments resulting in many staff currently requiring re-testing. This is due to the main FIT mask testing hub being closed. Focus to be carried out across the division to get education teams and education links trained to be train the trainers for FIT mask testing.

Date this report will be an agenda item at Care Group Governance Meeting	Date this report will be an agenda item at Divisional Governance Meeting
January 2024	January 2024

Appendix 5

Division D Q4 Matron and CGCL **Report to TEC**

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

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

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

Date of Report: April 2024

Author: Natasha Watts

Performance Quarter 4 – 1st January to 31st March 2024

Key Indicator	Division D	Limit	Status
MRSA Bacteraemia	**2**	**Trust Limit 0**	**Trust Total 3** (COHA)
***Clostridium difficile* diarrhoea**	**5**	**Trust Limit 15**	**Trust Total 24** (HOHA + COHA)
E. coli (HOHA)	**6**	**Trust Limit of 30**	**Trust Total 32** (HOHA + COHA)
Pseudomonas (HOHA)	**1**	**Trust Limit of 9**	**Trust Total 6** (HOHA + COHA)
Klebsiella (HOHA)	**3**	**Trust Limit of 15**	**Trust Total 16** (HOHA + COHA)
MSSA Bacteraemia	**1**	**No Limit**	
GRE	**0**	**No Limit**	

Incidents / Outbreaks of Infection and PIIs	
Measles in ED, AMU and E4	Positive Measles case who was in ED ,AMU3 and E4 contacts also in X-ray. Learning: • Patient was not identified as being a case of measles until day 2.
C.difficile Period of Increase Incidence on F4	2 patients positive for C. difficile on F4 within 28 days. Learning: • Medical member of staff eating an apple at nursing station. • Missing ceiling tiles in bay A from leak. • Staff not aware of PII and cleaning equipment with actichlor plus. • An improvement plan from the findings of the IP&C team on their visits was completed by the Ward Manager and the Infection Control Link Nurse. Action steps included: 1. Staff awareness to adhere to hand hygiene before and after removal of gloves. 2. Ensure compliance to performing an isolation risk assessment for patients who are ESBL gentamycin sensitive. 3. Use of appropriate products for environmental cleaning.

C. difficile Period of increased incidence on Ward F3	2 patients thought to have acquired C. difficile on Ward F3 within 28 days. The 2 cases had different Ribotype which indicated that onward transmission had not occurred. The following gaps in IP practice were observed by the IP&C team during their visit: 1. Inappropriate PPE worn. Issue addressed. 2. Some staff need teaching on appropriate use of environmental cleaning products. 3. Proper storage of clean linen.

Performance Year to Date: 1st April 2023 – 31st March 2024

Key Indicator	Division D	Limit	Status
MRSA Bacteraemia	**6**	**Trust Limit 0**	**Trust Total 7** (COHA)
***Clostridium difficile* diarrhoea**	**20**	**Trust Limit 60**	**Trust Total 105** (HOHA + COHA)
E. coli (HOHA)	**19**	**Trust Limit of 120**	**Trust Total 147** (HOHA + COHA)
Pseudomonas (HOHA)	**5**	**Trust Limit of 33**	**Trust Total 24** (HOHA + COHA)
Klebsiella (HOHA)	**10**	**Trust Limit of 56**	**Trust Total 58** (HOHA + COHA)
MSSA Bacteraemia	**12**	**No Limit**	
GRE	**2**	**No Limit**	

Key Learning from Investigation of Infections and Deaths:

T&O-C-diff monitoring after 2 cases has just completed on F3. No further actions.

Progress and Success:

T&O

Links made again with theatres and anaesthetic lead to review and audit intra-operative temperature recording.

Neuro

Wards are continuously striving to ensure that hand hygiene audits are achieved. This was discussed regularly in HOD's and at ward level. Focus on ward areas have included spot checks, refresher teaching, re-education and regular meetings to ensure that the MDT (Medical, Nursing, AHP and other clinical staff) have been reminded of good hand hygiene and resolve the poor standards. The last audit showed significant improvements with most of the neuro wards achieving the target.

Hyper Acute Stroke unit have been commended with their good practice with a patient with C. Diff. The review highlights showed HASU has adhered to all correct practices.

Recent Infection Prevention Ward accreditation showed D Neuro, F8 and Neuro OPD received Full accreditation. Whilst C Neuro, E Neuro and F4 Spinal are partially accredited.

Ongoing Challenges:

T&O

Sudden rise in T&O of Covid cases to 7 from one ward area. All symptomatic requiring testing. Challenge to source appropriate side rooms within speciality. This is part of NICE recommendations.

Neuro

Continuous staff engagement for education, training and refreshing of Hand Hygiene.

Spot checks are continuously done.

Glowbox is used to do further refresh good hand hygiene technique.

Posters, social media interactive apps have been set up for Neuro staff as part of the re-education and refresher.

Cvt

Outstanding Candida Auris guidance to transport, antibiotics and timeframe between transitioning contacts and testing positive (Initial 8 weeks has been considered to be 3 weeks).

Failure to submit timely audit in the last quarter because of reducing WLS and Admin days to support staffing. Action plan in place to reinstate audit completion with the current workforce strategy.

Further meeting planned to review new cases .

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

Neuro

Current Focus on hand hygiene in the clinical area and audits have been reiterated.

Spot checks, refresher education and posters have been set up on each ward area.

Trust guidelines for mask wearing has been changed, so staff are encouraged to do risk assessments as necessary.

We will discuss in HOD's action plan to receive full accreditation of the Neuro wards who has not receive this.

Candida auras remains a concern within vascular service. A MDT meeting has been arranged to review recent cases and to discuss next steps.

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

None

Date this report will be an agenda item at Care Group Governance Meeting	**Date this report will be an agenda item at Divisional Governance Meeting**
January 2024	January 2024

Report to the Trust Board of Directors				
Title:	**Learning from Deaths 2023-24 Quarter 4 Report**			
Agenda item:	**5.11**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Author:	**Jenny Milner Head of Patient Experience** **Alex Woodhead, Mortality and Data Insight Coordinator**			
Date:	**6 June 2024**			
Purpose:	**Assurance or reassurance** **x**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	This report ensures that mortality reporting in relation to deaths, reviews, investigations, and learning is regularly provided to the board. The report also provides an update on the development and effectiveness of the medical examiner service.			
Response to the issue:	The National Guidance on Learning from Deaths sets out expectations that: *Boards must ensure robust systems are in place for recognising, reporting, reviewing, or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care. Providers should ensure such activities are adequately resourced*. This paper sets out a plan to meet these requirements more fully.			
Implications: (Clinical, Organisational, Governance, Legal?)	1. The Trust does not reduce avoidable deaths in our hospitals. 2. The Trust does not promote learning from deaths, including relating to avoidable deaths and good and poor quality of care. 3. The Trust does not promote an open and honest culture and support for the duty of candour.			
Summary: Conclusion and/or recommendation	• Q4 has seen an increase in deaths compared to previous Q4, this is in line with national increases and our gross mortality numbers show no significant trends. • Baby funeral contract reviewed and out to tender as service not to the quality we expect for our families. • 60% of community practices now onboarded for examination of death in line with statutory changes.			

1. Introduction

The learning from deaths report sets out to satisfy the requirements within the NHS Learning from Deaths framework. Data is presented from UHS data sources, NHS England and data collected by Medical Examiners Southampton.

In addition to the quantitative data presented, learning is presented from UHS sources such as 'adverse event reports', complaints, and mortality review bodies.

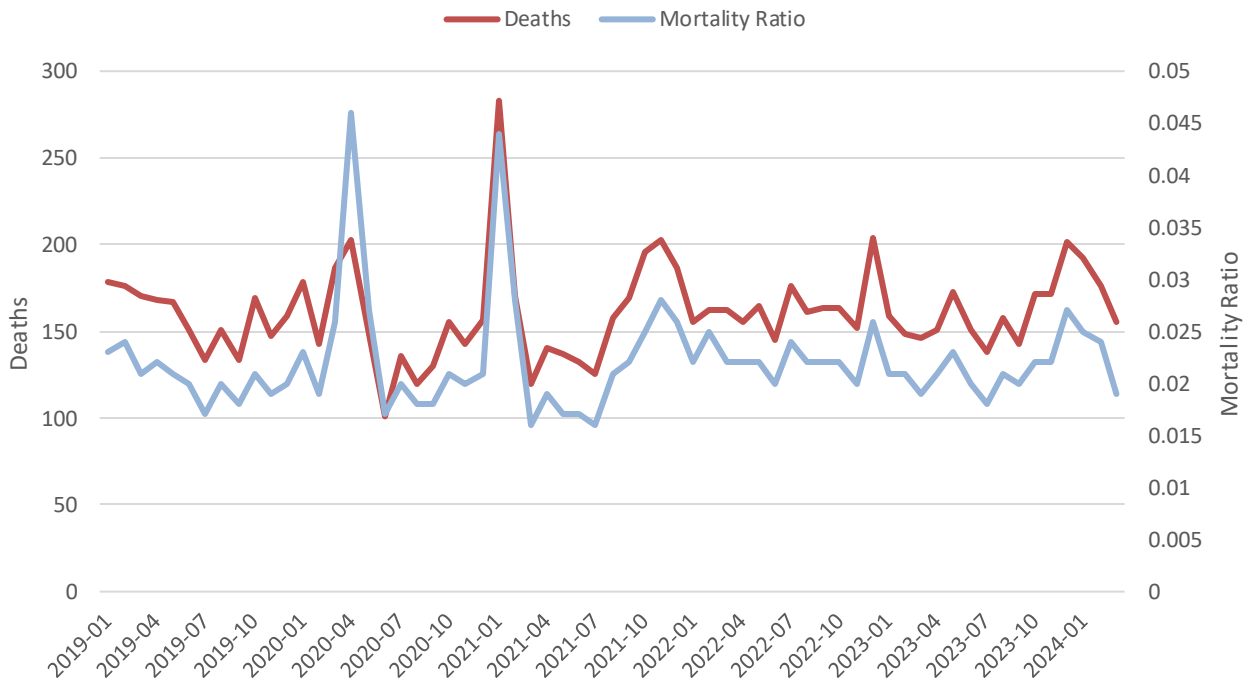
Morbidity and mortality meetings remain a focus for the improvement of data capture and availability, such that learning identified in these meetings can be shared both in this report and across the trust.

2. Analysis and Discussion

2.1 Deaths at UHS

Quarter	2019-2020	2020-2021	2021-2022	2022-23	2023-24
Q1	485	540	483	504	512
Q2	416	516	591	526	471
Q3	474	599	651	565	578
Q4	506	644	537	489	558
Total	1881	2299	2262	2084	2119

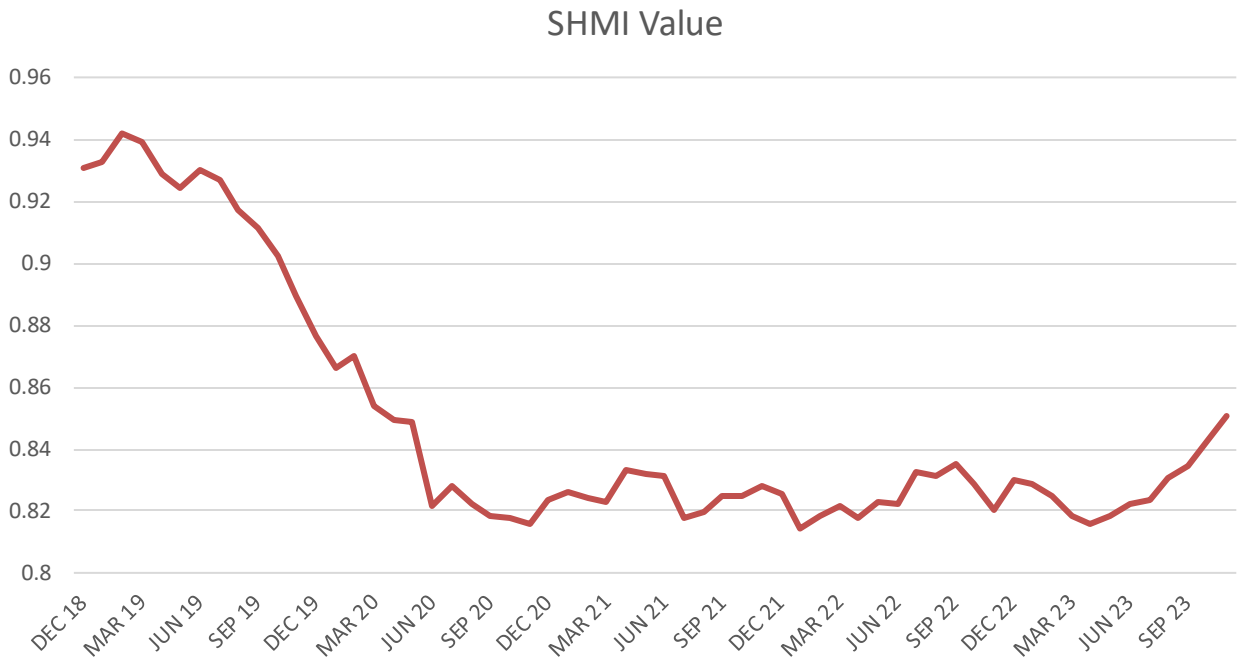
The fourth quarter of 2023-24 saw 558 deaths at UHS sites, compared to 565 in Q4 2023-24.



Gross mortality numbers remain steady with no significant trends present in the monthly aggregated data. The crude mortality ratio (admissions/deaths) remains consistent with monthly values between 0.02 & 0.03.

2.2 **SHMI (replacing HSMR)** (Calculated by NHSE)

SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated here.



SHMI remains in the 'lower than expected' range at 0.85 for the 12 months to November 2023, however over the previous 7 months there is an upward trend in the data that should be noted.

SHMI values are calculated on a diagnosis level for the following diagnosis groups:

DIAGNOSIS_GROUP_DESCRIPTION	SHMI_VALUE	SHMI_Banding_Text
Septicaemia (except in labour), Shock	0.8323	As Expected
Cancer of bronchus; lung	0.6782	Lower Than Expected
Secondary malignancies	0.6087	Lower Than Expected
Fluid and electrolyte disorders	0.4771	Lower Than Expected
Acute myocardial infarction	0.7587	Lower Than Expected
Pneumonia (excluding TB/STD)	0.9601	As Expected
Acute bronchitis	0.7322	As Expected
Gastrointestinal haemorrhage	0.8613	As Expected
Urinary tract infections	0.8164	As Expected
Fracture of neck of femur (hip)	0.8065	As Expected

For the 12 months to November 2023 6 diagnosis level values are in the 'As Expected' range, 4 are in the 'Lower than Expected' range.

2.3 Medical Examiner Reviews

In Q4 the Medical Examiner Service reviewed 863 deaths of which 534 occurred at UHS acute sites, 329 occurred in the community. This compares to 699 deaths reviewed in Q4 of 2022/23 which is an increase of 23%.

2.4 Referrals to M&M

5 cases were referred to speciality M&Ms by MES. 2 of these cases are yet to be discussed. 2 cases have been discussed and found no learning.

The final case, discussed in the GICU & Respiratory M&Ms identified the need to consider the suitability of patients for level 2 care in RHDU where difficulties with intubation are anticipated.

2.5 Referrals to Patient Safety

3 cases were referred to Patient Safety by the Medical Examiners. Of these, one was closed with no further investigation, one was referred to Divisional Governance by Patient Safety and one is awaiting investigation.

1 Q3 investigation was ongoing at the time of the Q3 report, this has now concluded. This case was referred to Patient Safety as the Medical Examiner felt that this patient's death may have been avoidable with more frequent observations and prompt recognition of their deterioration.
The Patient Safety investigation echoed this and prompted additional training for the staff on the ward with the intention to deepen the understanding and compliance with timely observations, and prompt identification and management of deterioration.

2.6 UHS 'End of Life' Incident Reports

25 adverse event reports were submitted in the quarter relating to end-of-life. Recurrent themes from these include:

Lack of out of hours paediatric palliative care service commissioning for the Wessex region. Advice is currently provided on a good will basis with medical and nursing staff giving up personal time to ensure appropriate care can be provided to children at the end of their lives.

Lack of staffing in bereavement care due to recruitment freeze. This has resulted in decreased standard of service being delivered to bereaved families. Often bereavement care is unable to facilitate viewings for bereaved families, find themselves working alone in an area that is frequently visited by members of the public, and are unable to make or return phone calls to families.

Various issues involving incorrect, incomplete paperwork or processes for end of life not being correctly followed when patients are transferred to the mortuary from wards. In the worst instances this could result in misidentification of patients. Causes of these incidents are broadly, time pressures on wards and lack of training for ward staff.

2.7 UHS Complaints relating to End-Of-Life Care

One formal complaint relating directly to end-of-life care. In this case the bereaved family received incorrect information from the ward that resulted in the family not being able to spend the time that they would have liked with the deceased after they passed. This was found to be due to poor communication between the ward staff and the family.

Following this the family found that communication with bereavement care was challenging and therefore struggled to arrange a viewing while the patient was in the mortuary. This was due to staffing pressures in the department.

Complaints about the quality of provision of baby funerals have been received, the contract with current funeral director is due for renewal and the Experience of Care team have decided alongside the Maternity team to go to tender for another service provider.

3. Morbidity and Mortality Data Capture & Standardisation

The trial of the standardised M&M meeting recording application is reaching its conclusion, and a final round of feedback is currently being sought from participants. The trial has involved 8 of the ~50 M&M meetings from across the trust.

While some specialities have integrated the app very successfully into their reviews, other areas have experienced challenges in adopting the app for the recording of their M&M reviews.

The final round of feedback will be used to address as many of these challenges as possible before the app design is finalised for roll out to all M&Ms.

Strategy and timelines for the wider roll out will be decided upon in Q1 2024/25.

4. Medical Examiner Service Update

Medical Examiner Southampton continues to progress toward its statutory status due 9 Sept 2024. It is fully staffed for the review of all death both UHS and community. It has onboarded 60% of the community GP practices.

90% of families are contacted by the service.

In Q4 57% of MCCDs were completed by day 3.

22% of deaths were referred to the Coroner (HMC) with 10% cases being taken on for further investigation.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Freedom to Speak Up Report**			
Agenda item:	**5.12**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Christine Mbabazi, Freedom to Speak Up Guardian**			
Date:	**6 June 2024**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** ✓
Issue to be addressed:	To provide an update on the Freedom to Speak Up (FTSU) agenda, cases, themes and actions taken and lessons learnt from the concerns raised.			
Response to the issue:	Trust Board is asked to: • Note the number of FTSU cases received to date. • Note the lessons learnt from concerns raised. • Note staff survey results 2023 and ER/FTSU recommendations.			
Implications: (Clinical, Organisational, Governance, Legal?)	1. Mechanism to support a culture where staff feel safe and can speak up about concerns. 2. Compliance with the raising concerns policy for the NHS following the recommendations made by Sir Robert Francis after the enquiry into Mid Staffordshire NHS Foundation Trust. 3. Compliance with the Public Interest Disclosure Act 1998.			
Risks: (Top 3) of carrying out the change / or not:	1. Failure to keep improving services for patients and the working environment for staff. 2. Failure to support a culture based on safety, openness, honesty and learning. 3. Failure to comply with NHS requirements and best practice and commissioning contracts.			
Summary: Conclusion and/or recommendation	Trust Board is asked to note this report.			

1. Executive Summary / Purpose

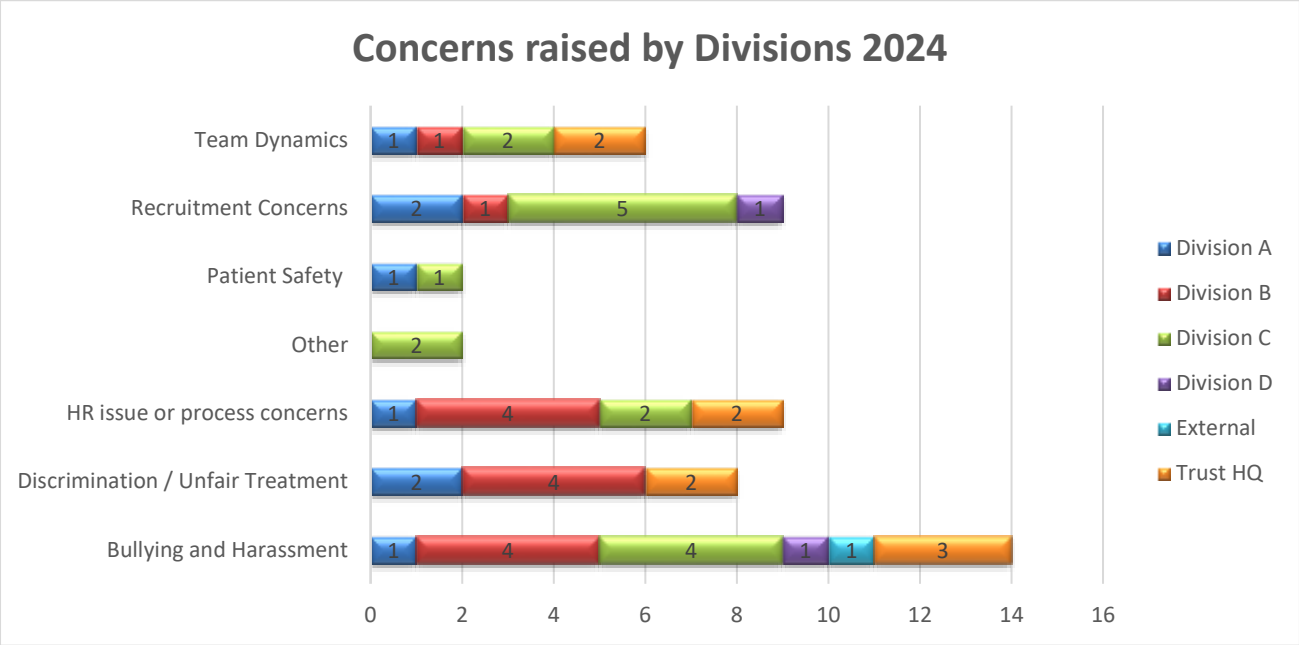
To provide an update following the last report written in November 2023. This report provides an update on the Freedom to Speak Up (FTSU) agenda, and actions taken. In addition, it also makes note of the lessons learnt from concerns raised to the FTSU guardian.

2. Key Issues

Case Update

From 13th November 2023 – 13th May 2024 the Trust has received 56 FTSU cases compared to 44 cases received in the same period last year (13th November 2022 – 13th May 2023).

The graph below shows concerns raised in 2024 by Division.



The case key themes are bullying and harassment, HR issues or HR process concerns and recruitment concerns. The recent recruitment concerns have been due to AHP international recruits that have joined the Trust and are going through a probation period. Some needing support from FTSU champions, some do contact FTSU when they feel they have not been heard or feel the process has not been fair to them.

3. Progress on the FTSU Agenda

3.1 Update following Facebook comments in June 2023

On 21st June 2023, concerns were anonymously raised on a private Facebook group regarding bullying and harassment in the Trust. In addition to the details of bullying and concerns about culture, the subsequent threads of conversation and themes that arose questioned the robustness of processes regarding HR handling of complaints and how raising concerns are handled by the Freedom to Speak Up office.

3 broad areas of action were taken which were as follows:

1) Commissioning an external learning review of employee relations and Freedom to Speak Up processes to seek assurance on their effectiveness and identify any learning.
2) A continued focus on listening to the experiences of people and drawing a thematic analysis for issues raised.
3) Accelerate local action being taken in known areas of bullying concern and poor staff experience.

The learning review led to the following recommendations:

Employee Relations	To develop a communications strategy to raise the profile of the ER team and its work within the Trust, including its collaborative work with the FTSU Guardian in ensuring that concerns raised via that route are addressed
	To work with the FTSU Guardian to produce statistics for the Trust Board showing activity related to addressing concerns about bullying
	To create a standard acknowledgement response to queries arriving via the ER mailbox
	To set indicative timescales on casework and enhance communications with involved parties about progress towards completion, and to review response performance through the ER Performance Board
	To consider the arrangements for chairing the ER Performance Board to ensure continued robust scrutiny.
FTSU	To enhance reporting of FTSU cases and outcomes to the Trust Board and the wider staff body
	To ensure that FTSU Champions do not engage directly in casework in that capacity but focus instead on promoting FTSU and signposting concerns
	To ensure a comprehensive communication strategy including updating the FTSU leaflet to reflect the new FTSU policy
	To update the FTSU process flowchart to include reference to the Chief Financial Officer and Counter Fraud
	To consider adapting the Chief Registrar role to include FTSU Champion responsibilities in order to strengthen medical staff engagement with FTSU.

The FTSU team are currently working with the ER team on the recommendations made in the report. An update on the progress of the recommendations will be included in the next ER report to the OD and People Committee in Q2.

3.2 Lessons learnt from concerns raised with the FTSU Guardian

If done in the right way and acted upon speaking up can increase feelings of connectedness and relatedness. But the act of speaking up itself is almost always uncomfortable because of feelings tied to social threat (Cobbett, 2022). After reviewing the Trust's cases there have been certain commonalities and lessons learnt:

- Communication

  We have learnt that how we communicate determines how we make people feel hence the outcome, we have also learnt that face to face communication is very valid in certain situations and nothing else is best. Going back to the basics of honest conversations has led to clarity

in some cases even solved them. Being human and actively listening helps put things in perspective when it comes to conflict resolution hence better outcomes. The importance of apologising where things have gone wrong.

- The power of validation.

  Validation is particularly important during emotionally charged situations. This means you believe their experience or statement is valid, and you don't intend to change their point of view. Validation is about showing you really hear someone and understand why they feel the way they feel. Most people who reported about not being valued, when validated felt heard and listened to. Again, the importance of apologising when things have gone wrong was a good starting point on resolving the conflict or issue after validation.

- Recruitment practices:

  Significant changes have been made in response to feedback from FTSU and other channels for example section 4 and section 10 of the current UHS recruitment guidance as stated below:

4. Advertising Fairly

All vacancies should be advertised internally and externally simultaneously for 14 days via the TRAC recruitment management system as standard, except in the following limited circumstances:

- Where staff are identified as being 'at risk' through organisational change, as a result of the ending of a fixed term contract or redundancy programmes.
- Where staff are identified as being in a formal redeployment process due to ill health or an employee relations matter.
- Where a post has been identified as part of a formal retire and return process in accordance with the Retirement Policy.
- Where there is an **exceptional and short term (3 months or less) requirement** for an existing staff member to provide interim cover, which requires specific skills and experience. This will be in exceptional circumstances only, see section 6.

In the above circumstances identified individuals will be given prior consideration for any vacant posts which may or may not have been advertised. Limited competition situations may arise where more than one 'at risk' employee is identified as suitable for an existing vacant post. Please refer to the Organisational Change Policy for further information regarding prior consideration status and limited competition situations.

10. Interviews and Assessments (non-consultant posts)

It will be mandatory for there to be an independent panel member on interviews where there are internal candidates. Independent panel members must be someone outside of the reporting line for the role and ideally from a completely different area. The independent panel member will need to play an active part in the selection process and decision making and therefore should be part of the required panel and not added as an additional panel member.

- Leadership and management behaviours:

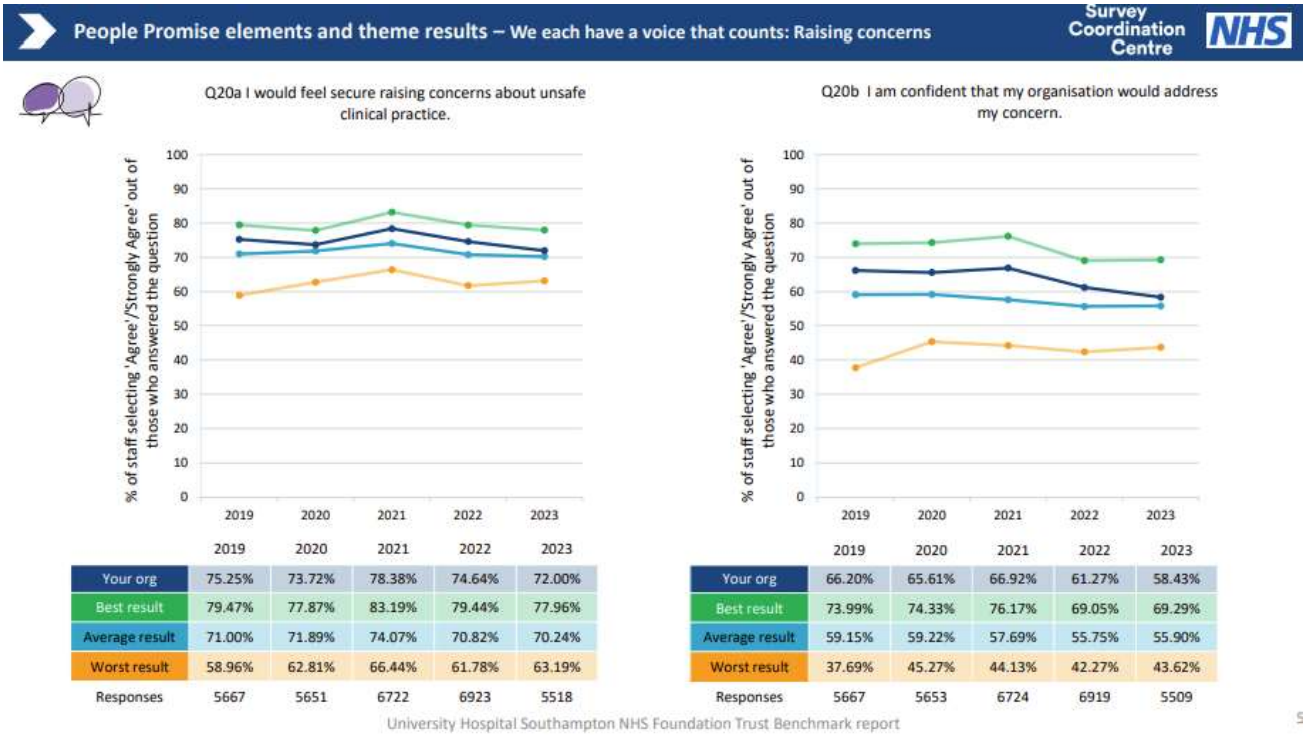
  This is important in developing the culture of the organisation hence in areas of the organisation that behaviours have not been reflective of the UHS values, the organisation development team and HR have been involved in working with these teams.

- Doctors in training speaking up

  Following the GMC survey, doctors in training chose to raise concerns using the survey rather than raising the concerns internally, how do we get them to raise concerns internally and safely why is it they chose that route. Is this something we have to look into? We have for the above reason asked for doctors in training to volunteer and we have so far received 4 application forms from doctors to join the FTSU champion team.

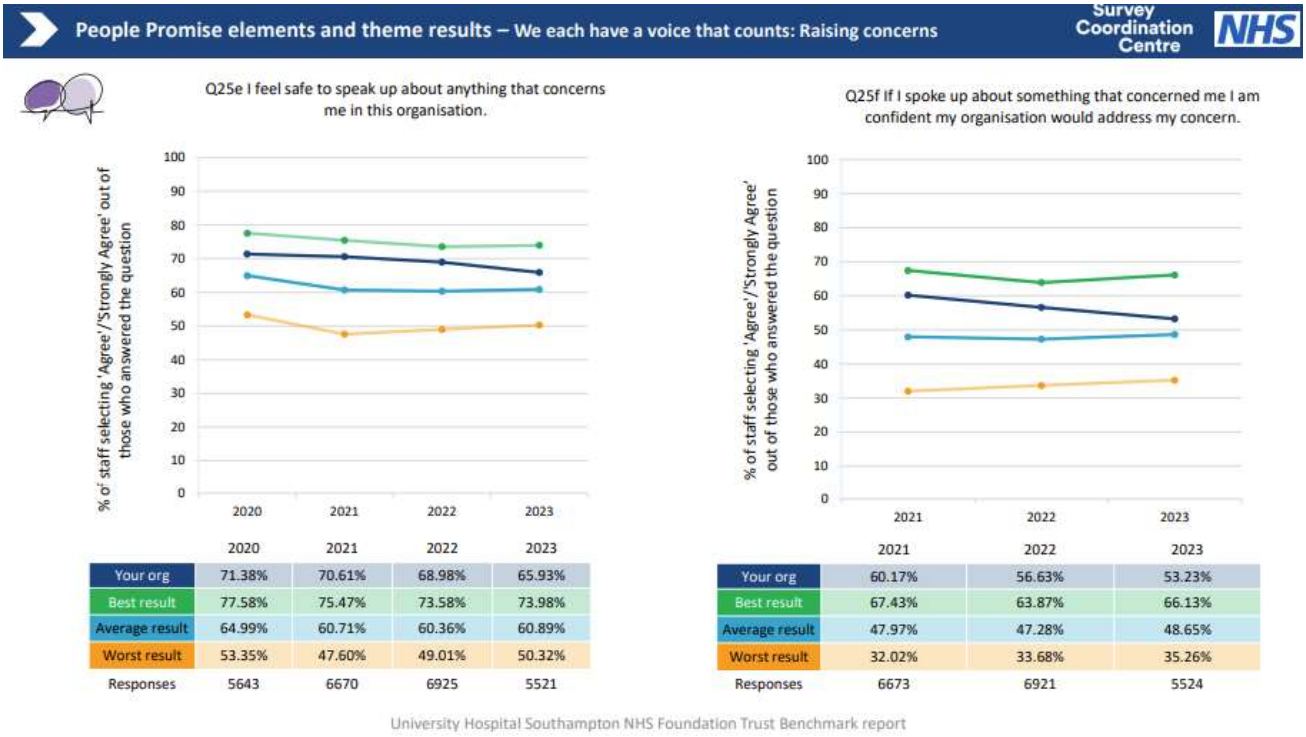
3.3 Staff Survey Results

In the staff survey results for 2023, the National Guardian office looks at 4 questions in the staff survey. Questions 20a, 20b and Questions 25e and 25f. UHS scored in the top 20 Acute and Acute Community NHS Trusts and below are the results:



	2019	2020	2021	2022	2023
Your org	75.25%	73.72%	78.38%	74.64%	72.00%
Best result	79.47%	77.87%	83.19%	79.44%	77.96%
Average result	71.00%	71.89%	74.07%	70.82%	70.24%
Worst result	58.96%	62.81%	66.44%	61.78%	63.19%
Responses	5667	5651	6722	6923	5518

	2019	2020	2021	2022	2023
Your org	66.20%	65.61%	66.92%	61.27%	58.43%
Best result	73.99%	74.33%	76.17%	69.05%	69.29%
Average result	59.15%	59.22%	57.69%	55.75%	55.90%
Worst result	37.69%	45.27%	44.13%	42.27%	43.62%
Responses	5667	5653	6724	6919	5509



The Trust's FTSU Guardian has been working with different departments targeting areas with low positive responses to these questions We continue to recruitment FTSU champions and to also engage with the management teams to consider what measures can be implemented to give staff more confidence in raising concerns about unsafe clinical practice and being assured that the Trust would address those concerns.

4. Next Steps / Way Forward / Implications / Impact

The FTSU Guardian and Champion network will continue to work with different teams to achieve the recommended actions from the external report above. The importance of doing this is to ensure that we create a culture where patients and staff safety are at the centre of what we do, as has been noted by the National Guardian Office and CQC.

5. Recommendation

Trust Board is asked to:

- Note the number of FTSU cases received to date.
- Note the lessons learnt from concerns raised.
- Note staff survey results 2023 and ER/FTSU recommendations.

Appendix A – FTSU CASES 11/11/2023 – 13/05/2024

Yea	Qtr	Date Concern Raised	Month Rais	Department	Contact Method (Internal / Extern	Trust Board Summary
2023	Q3	11/11/2023	November	THQ	Internal	Bullying and Harassment
2023	Q3	21/11/2023	November	THQ	Internal	Discrimination / Unfair treatment
2023	Q3	28/11/2023	November	Division A	Internal	HR issue or process concerns
2023	Q3	08/12/2023	December	Division D	Internal	HR issue or process concerns
2023	Q3	14/12/2023	December	Division A	Internal	HR issue or process concerns
2024	Q4	04/01/2024	January	Division C	Internal	HR issue or process concerns
2024	Q4	04/01/2024	January	Division C	Internal	HR issue or process concerns
2024	Q4	06/01/2024	January	Division C	Internal	Recruitment Concerns
2024	Q4	17/01/2024	January	THQ	Internal	HR issue or process concerns
2024	Q4	18/01/2024	January	Division B	Internal	HR issue or process concerns
2024	Q4	19/01/2024	January	Division A	Internal	Patient Safety
2024	Q4	05/02/2024	February	THQ	Internal	HR issue or process concerns
2024	Q4	06/02/2024	February	THQ	Internal	Discrimination / Unfair treatment
2024	Q4	06/02/2024	February	THQ	Internal	Discrimination / Unfair treatment
2024	Q4	09/02/2024	February	Division B	Internal	Team Dynamics
2024	Q4	11/02/2024	February	Division D	Internal	Bullying behaviour of consultant
2024	Q4	12/02/2024	February	Division A	Internal	Team Dynamics
2024	Q4	14/02/2024	February	Division B	Internal	HR issue or process concerns
2024	Q4	14/02/2024	February	Division A	Internal	Recruitment Concerns
2024	Q4	15/02/2024	February	Division B	Internal	Recruitment Concerns
2024	Q4	16/02/2024	February	Division C	Internal	Recruitment Concerns
2024	Q4	16/02/2024	February	Division A	Internal	Bullying and harassment
2024	Q4	18/02/2024	February	Division B	Internal	Bullying and harassment
2024	Q4	19/02/2024	February	Division C	Internal	Recruitment Concerns
2024	Q4	22/02/2024	February	THQ	Internal	Bullying and harassment

Yea	Qtr	Date Concern Raised	Month Rais	Department	Contact Method (Internal / Extern	Trust Board Summary
2024	Q4	22/02/2024	February	Division B	Internal	HR issue or process concerns
2024	Q4	23/02/2024	February	Division C	Internal	Bullying and harassment
2024	Q4	23/02/2024	February	Division C	Internal	Team Dynamics
2024	Q4	27/02/2024	February	Division C	Internal	Bullying and harassment
2024	Q4	24/02/2024	February	Division B	Internal	Discrimination / Unfair treatment
2024	Q4	29/02/2024	February	THQ	Internal	Bullying and harassment
2024	Q4	06/03/2024	March	THQ	Internal	Team Dynamics
2024	Q4	07/03/2024	March	Division A	Internal	Discrimination/ Unfair treatment
2024	Q4	07/03/2024	March	Division A	Internal	Recruitment Concerns
2024	Q4	13/03/2024	March	Division C	Internal	Team Dynamics
2024	Q4	13/03/2024	March	External	External	Bullying and harassment
2024	Q4	13/03/2024	March	Division B	External	Discrimination / Unfair treatment
2024	Q4	21/03/2024	March	Division C	Internal	Other
2024	Q4	22/03/2024	March	Division A	Internal	HR issue or process concerns
2024	Q4	23/03/2024	March	Division B	Internal	Discrimination / Unfair treatment
2024	Q4	04/04/2024	April	Division C	Internal	Other
2024	Q4	06/04/2024	April	Division B	Internal	Discrimination / Unfair treatment
2024	Q4	10/04/2024	April	Division B	Internal	Bullying and harassment
2024	Q4	11/04/2024	April	Division C	Internal	Bullying and harassment
2024	Q4	22/04/2024	April	Division C	Internal	Patient Safety
2024	Q4	17/04/2024	April	THQ	Internal	Bullying and harassment
2024	Q4	25/04/2024	April	Division A	Internal	Discrimination /Unfair treatment
2024	Q4	29/04/2024	April	Division B	Internal	Bullying and harassment
2024	Q4	29/04/2024	April	Division B	Internal	Bullying and harassment
2024	Q4	30/04/2024	April	Division C	Internal	Bullying and harassment
2024	Q4	03/05/2024	May	Division D	Internal	Recruitment Concerns
2024	Q1	09/05/2024	May	Division B	Internal	HR issue or process concerns
2024	Q1	09/05/2024	May	Division C	Internal	Recruitment Concerns
2024	Q1	09/05/2024	May	Division C	Internal	Recruitment Concerns
2024	Q1	09/05/2024	May	Division C	Internal	Recruitment Concerns
2024	Q1	13/05/2024	May	THQ	Internal	Team Dynamics

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Fuller Inquiry Report**			
Agenda item:	**5.13**			
Sponsor:	**David French, Chief Executive Officer**			
Author:	**Gavin Hawkins, Divisional Director Operations**			
Date:	**6 June 2024**			
Purpose:	**Assurance or reassurance** x	**Approval**	**Ratification**	**Information** x
Issue to be addressed:	Update Trust Board with the Trust's response relating to the recent Fuller inquiry on mortuary security arrangements.			
Response to the issue:	This report.			
Implications: (Clinical, Organisational, Governance, Legal?)	Organisational Governance Legal			
Risks: (Top 3) of carrying out the change / or not:	1. Inadequate security arrangements for the mortuary 2. Failure to comply with expected standards 3. Reputational risk and cessation of post-mortem works			
Summary: Conclusion and/or recommendation	The Trust has considered and responded to the recommendations of Phase One of the Fuller Inquiry and the HTA self-assessment questionnaire. The Board will be updated when a) the Phase Two report is published and b) following the upcoming HTA inspection, scheduled for August 2024. The Trust considers there is appropriate governance in place to monitor mortuary security and access controls. The Board is asked to note this report.			

Background of the Fuller Inquiry and Main Recommendations

An independent inquiry was established in November 2021 to investigate how an NHS estates member of staff (David Fuller) was able to carry out inappropriate and unlawful actions in the mortuary of Maidstone and Tunbridge Wells NHS Trust (MTW) and to understand how and why his activity went unnoticed for so long.

The inquiry was to issue a Phase One report on the specific MTW matters, with Phase Two looking at the broader, national picture and the practices / procedures in place to protect the deceased in the NHS and other settings to be published later (sometime in 2024).

The Phase One report was published in November 2023. The report made 17 recommendations with the aim of preventing anything similar happening again at MTW.

The main recommendations for MTW were:

1) the Trust must ensure all non-mortuary staff are accompanied by another staff member, including all work tasks to be undertaken by staff in pairs;

2) the Trust must assure itself that all regulatory requirements and standards relating to the mortuary are met and that the practice of leaving deceased people out of mortuary fridges overnight, or while maintenance is undertaken, does not happen;

3) the Trust must review its policies to ensure that only those with appropriate and legitimate access can enter the mortuary;

4) CCTV cameras must be installed in the mortuary and the post mortem room. The footage must be reviewed regularly, alongside records of who is accessing the mortuary and how often; and

5) the Trust Board must review its governance structures to make sure that the Board has greater oversight and assurance of legally regulated activity in the mortuary. The Trust must treat the deceased with the same due regard to dignity and safeguarding as it does its other patients.

The UHS Response

In terms of overall trust governance, the Mortuary Operations Manager attends monthly Pathology Governance meetings which report to Division B Divisional Governance meetings, where any areas of concern regarding the mortuary are raised formally.

In October 2021 the Trust was asked to provide assurance to NHSE that our mortuary and body store complied with existing guidance and requested we took additional steps to ensure security measures were in place.

These additional steps were:

i. controlled access using swipe care security (we decided to use proximity cards);
ii. CCTV coverage in all areas which should be reviewed on a regular basis by an appropriately trained and authorised individual;
iii. documented risk assessment of the facilities regarding operation, security and construction of the mortuary and body store area;
iv. consistent application of DBS check for all Trust and contracted employees.

We were also advised to review Human Tissue Authority (HTA), the regulator overseeing the licensing and inspection of post-mortem facilities, guidance including security arrangements.

On receipt of this request, a self-assessment document was generated in November 2021 with the involvement of estates, mortuary team and Head of Security. This document then became the team's mechanism to monitor progress on the measures where we had identified gaps in our assurance.

The main actions were to increase our CCTV coverage, upgrade some of the existing systems and ensure our processes were compliant and documented appropriately. This work has subsequently been completed.

In April 2024, the Trust was asked to complete a questionnaire to support the Phase 2 report of the Fuller Inquiry. We understand the responses to the questionnaire are to be used to determine whether procedures and practices in NHS hospital settings are sufficient to prevent inappropriate access and opportunity to abuse the deceased.

The completion of this questionnaire was led by Tania Fernandes, UHS Mortuary Operations Manager and was submitted following the approval of David French, UHS CEO. We anticipate the Phase 2 report of the inquiry to be published sometime later in 2024.

In May 2024, the Trust was also asked to complete and return a self-assessment by the HTA focussed on mortuary access security and associated questions to provide assurance on our processes. This exercise has highlighted the following areas of focus:

- Review the body store facility held in the Princess Anne Hospital (PAH) as currently the CCTV system is inoperative.
- Consider the requirement for CCTV coverage for the public areas access to the mortuary viewing room and the public gallery.
- Security arrangements for the post-mortem room.

Separately and unrelated, the mortuary team are looking at options to remove the temporary external body storage facility (the Dawson Unit) whilst maintaining total overall capacity.

We have subsequently been advised of an on-site HTA inspection date scheduled for 22nd August 2024, although we do not believe the inspection date has been driven by our responses to the self-assessment questionnaire.

Conclusion and recommendation

The Trust has considered and responded to the recommendations of Phase One of the Fuller Inquiry and the HTA self-assessment questionnaire. The Board will be updated when a) the Phase Two report is published and b) following the upcoming HTA inspection, scheduled for August 2024.

The Trust considers there is appropriate governance in place to monitor mortuary security and access controls.

The Board is asked to note this report.

Report to the Trust Board of Directors				
Title:	**CRN Wessex: 2023-24 Annual Performance Report**			
Agenda item:	**6.1**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Author:	**Clare Rook, Network Director, RRDN South Central** **Graham Halls, Business Intelligence Manager, CRN Wessex**			
Date:	**17 May 2024**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **x**
Issue to be addressed:	• This report covers Clinical Research Network (CRN) Wessex's performance in the 2023/24 financial year (April 2023 to March 2024) against the Department of Health and Social Care's (DHSC) high level objectives (HLOs) for research and other local metrics.			
Response to the issue:	• The Wessex region's contribution to national DHSC ambitions to deliver over eighty per cent of open studies to target and on time was not met. Wessex was close to meeting this ambition for non-commercial studies (seventy-eight per cent). Both England and Wessex did not achieve this for commercial studies. • Wessex has met the DHSC objective to deliver sufficient responses to the National Institute of Health and Care Research's (NIHR) Participant in Research Experience Survey (PRES), with over 1,600 people responding with generally favourable feedback. • Early concerns raised by the CRN Executive Group about low predicted Wessex recruitment in the 2023/24 financial year were addressed by the efforts of CRN Wessex partner organisations.			
Implications: (Clinical, Organisational, Governance, Legal?)	• All NHS organisations have a duty to their local population to participate in and support health and care research. The NIHR provides service support and grant funding to facilitate research activity within Wessex. Therefore, CRN Wessex and its partner organisations must ensure the funding is used effectively.			

Risks: (Top 3) of carrying out the change / or not:	• CRN Wessex maintains a risk register, which can be found in Appendix One. The main identified risks are:
	  ○ Winter pressures
	  ○ End of LCRN contract September 2024
	  ○ Strike actions.
	• Please review the risk register in Appendix One for details of the already underway or planned responses.			

Summary: Conclusion and/or recommendation	• While Wessex did not fully meet the study delivery high level objective, it surpassed expectations in participant experience, with positive feedback from research participants. CRN Wessex and its partner organisations will aim to improve performance for study delivery in the first half of the 2024/25 financial year, leading up to the transition to the South Central Regional Research Delivery Network (SC RRDN) in October 2024. • Wessex partner organisations have recruited 45,287 participants on to 720 research studies, at 270 sites and in all thirty specialties. This is a fifteen per cent increase on the previous financial year, representing an additional 6,000 participants who were able to take part in research. • Total recruitment in 2023/24 was projected to be 27,700 at the beginning of the financial year, significantly below the average of 40,000 participants. This was due to an unbalanced research portfolio, skewed towards smaller interventional studies. Partner organisations rose to this challenge by accelerating recruitment on existing studies, bringing new studies to the region and reducing the time taken to open locally led research. This happened with support from the CRN Wessex team, who identified both new study opportunities and new sites on existing studies, via the region's established research network. • The Board will continue to be updated on performance quarterly.

NIHR | Clinical Research Network Wessex

CRN Wessex 2023/24 Annual Performance Report

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

May 2024

Introduction

This report informs the UHS Board of Directors of the clinical research activities within the Wessex region. The report covers the performance against the National Institute of Health and Care Research's (NIHR) high level objectives, as well as general research activity in Wessex during the 2023/24 financial year (April 2023 to March 2024), unless otherwise stated.

Key issues

National areas of strategic focus for health research

The Department of Health and Social Care (DHSC) and the National Institute of Health and Care Research (NIHR) published seven areas of strategic focus for the NIHR in a paper titled *Best Research for Best Health: The Next Chapter* (listed in Figure 1). These focus areas guide how the CRN, and its partner organisations deliver NIHR-supported research activities in Wessex.

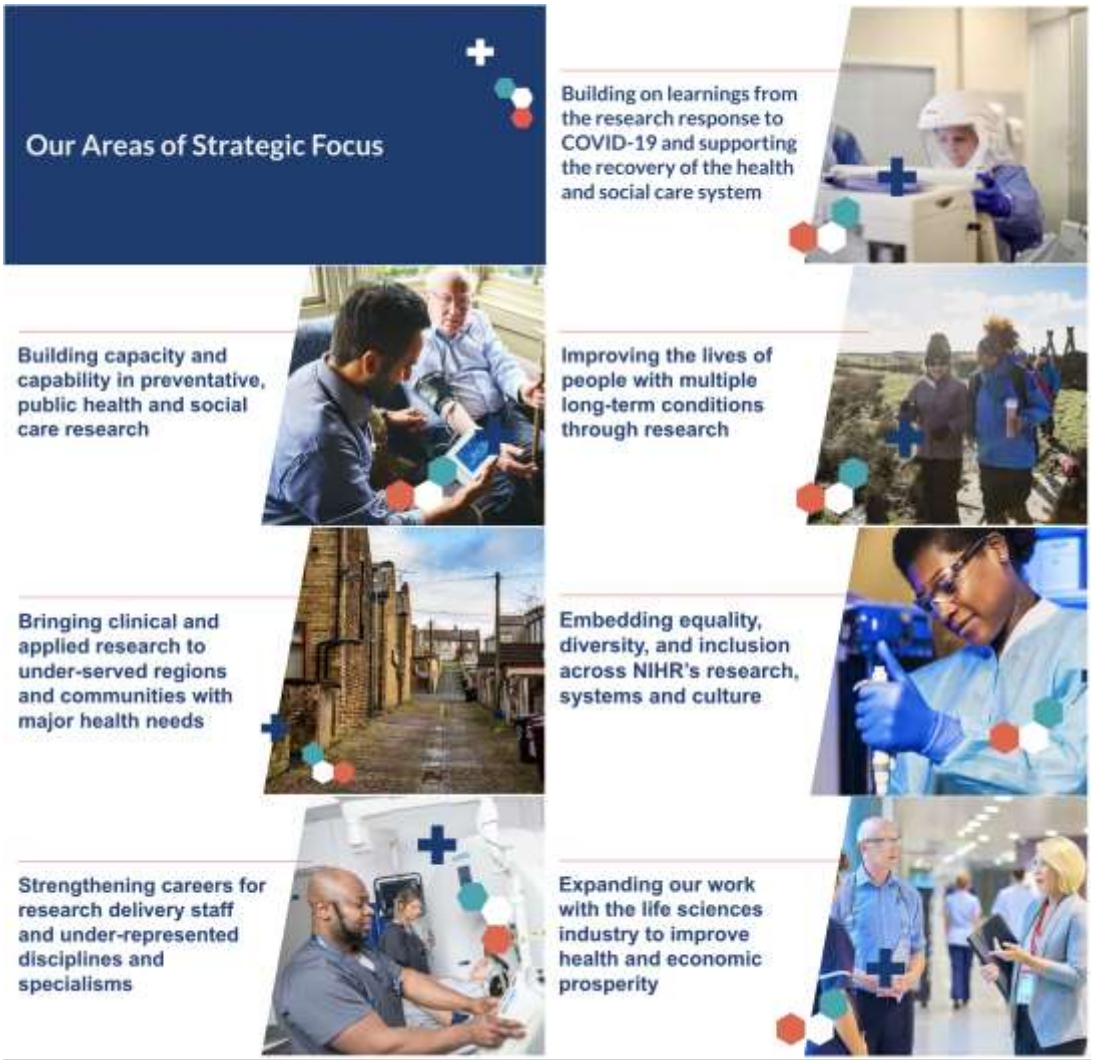


Figure 1 - NIHR Areas of strategic focus from Best Research for Best Health: The Next Chapter.

DHSC & NIHR Clinical Research Network high level objectives (HLOs) for 2023/24

The purpose of the NIHR CRN is to provide efficient and effective support for initiating and delivering funded research in the NHS and other health and care settings. In addition, the NIHR CRN should demonstrate to NIHR-supported research participants that their input is valued by gathering their feedback and using it to improve research delivery. The performance of the NIHR CRN in meeting these purposes is measured using the HLOs. These are expanded in Figure 2, with current Wessex and English (all local CRNs combined) performance linked to ambitions agreed with the DHSC.

Objective		Measure	Ambition	Wessex	England
Study delivery	Support sponsors to deliver NIHR CRN Portfolio studies to recruitment target	Percentage of **open to recruitment commercial** contract studies which are predicted to achieve their recruitment target	80%	65% (26/40 open Wessex-led studies)	71%
		Percentage of **open to recruitment non-commercial** studies which are predicted to achieve their recruitment target	80%	78% (100/129 open Wessex-led studies)	82%
Participant experience	Demonstrate to participants in NIHR CRN supported research that their contribution is valued through collecting their feedback and using this to inform improvement in research delivery	Number of NIHR CRN Portfolio study participants responding to the **Participant Research Experience Survey**	1,237	1,619 (131%)	18,000 ambition (the total national responses received to date is to be announced)

Figure 2 – Local and national performance for the DHSC & NIHR CRN High Level Objectives for the 2023/24 financial year.

Wessex did not meet the *Study Delivery* objective in 2023/24. England as a whole fell short of the eighty per cent ambition for commercial contract studies but met the objective for non-commercial studies. The high level objectives are set and measured nationally in agreement with the DHSC and the NIHR. CRN Wessex's role is to support the delivery of this objective for the studies that have sponsors or study chief investigators located in this region. Study sites nationwide contribute to the performance of these studies. Influencing their recruitment is therefore challenging when balanced against the rest of their research portfolio and

other NHS pressures. To enable performance management of the Wessex-led studies, monthly performance reports are sent to the Wessex organisations that sponsor and/or employ the chief investigator.

The NIHR Research Delivery Network (RDN) is currently transitioning from the NIHR Clinical Research Network. The RDN established its coordinating centre on 1 April 2024. Part of the RDN's Springboard programme of work will be to improve the processes behind study site identification and selection. When the planned improvements are in place, it is anticipated that this will lead to faster site selection and study delivery, therefore improving performance on the *Study Delivery* objective if it continues into the 2024/25 financial year and beyond. Studies will open research sites where the participants live, therefore increasing the efficiency of recruitment and delivering research where it is most needed. Further information on Springboard is available at: https://sites.google.com/nihr.ac.uk/rdn/rdn-transformation/springboard.

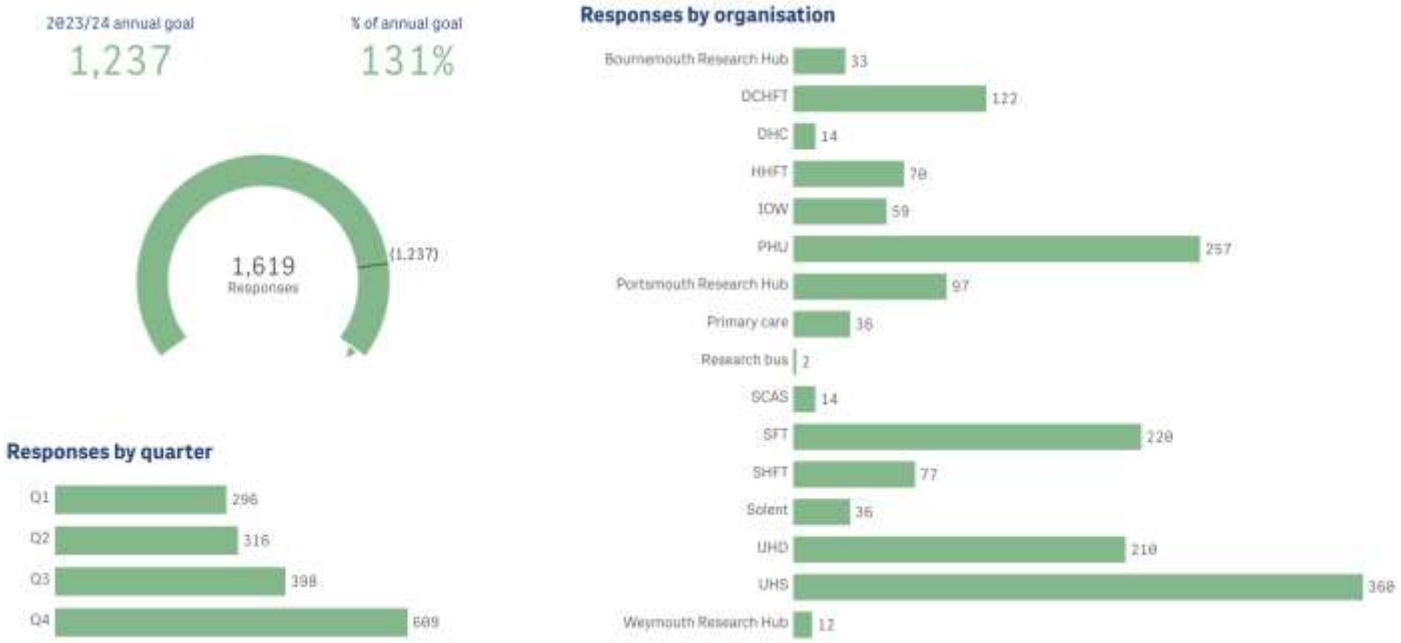


Figure 3 - Participant in research experience survey responses in Wessex in the 2023/24 financial year. The glossary in appendix two contains expanded organisation acronyms.

The ambition for the *Participant Experience* objective in Wessex was 1,237 completed Participant Research Experience Surveys (PRES). This ambition was met by the end of January, with a total of 1,619 responses in 2023/24 (Figure 3). Overall, participants in Wessex research projects have reported positive experiences (Figure 4). Lower scored aspects, such as staying informed and receiving study outcomes, are primarily controlled by the sponsor's study design and the ethical guidelines governing participant communication. Wessex organisations are encouraged to incorporate regular communication into local research protocols and ethical applications. The findings from the PRES are consolidated in a Summer annual report and are used to make improvements to the research service in the region. The PRES process is overseen by a regional working group comprising representatives from Wessex health and care organisations and research participants.

Figure 4 - Summary of the Participant in research experience survey results in Wessex in the 2023/24 financial year.

Research activity in Wessex

COVID-19 activity

In 2023/24, COVID-19 studies accounted for only four per cent of Wessex recruitment and took place across all four quarters (Figure 5). The largest studies were investigating new COVID-19 vaccines, the long term effects and how to stratify clinically vulnerable people for the disease.

In response to the pandemic, most non-COVID-19 research was paused across the UK. In 2022, the DHSC launched the Research Reset programme. The programme's aim was to make portfolio delivery achievable within planned timelines and sustainable within the resource and capability currently available in the NHS. As a result of this process, the Wessex Portfolio of open studies is around sixteen per cent smaller than before the pandemic (Figure 6), but this capacity has been made available to offer more participants access to health and care research.

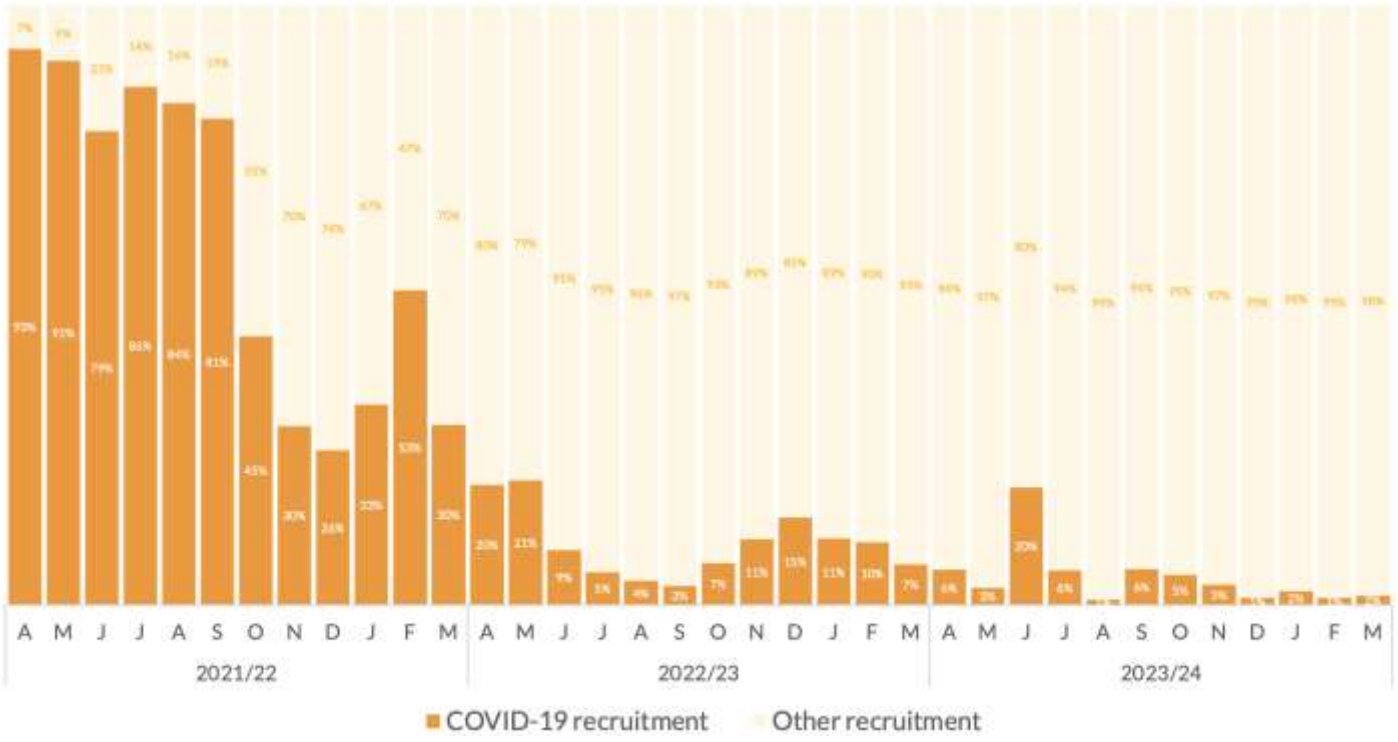


Figure 5 - COVID-19 recruitment as a proportion of Wessex activity between April 2021 and March 2024.

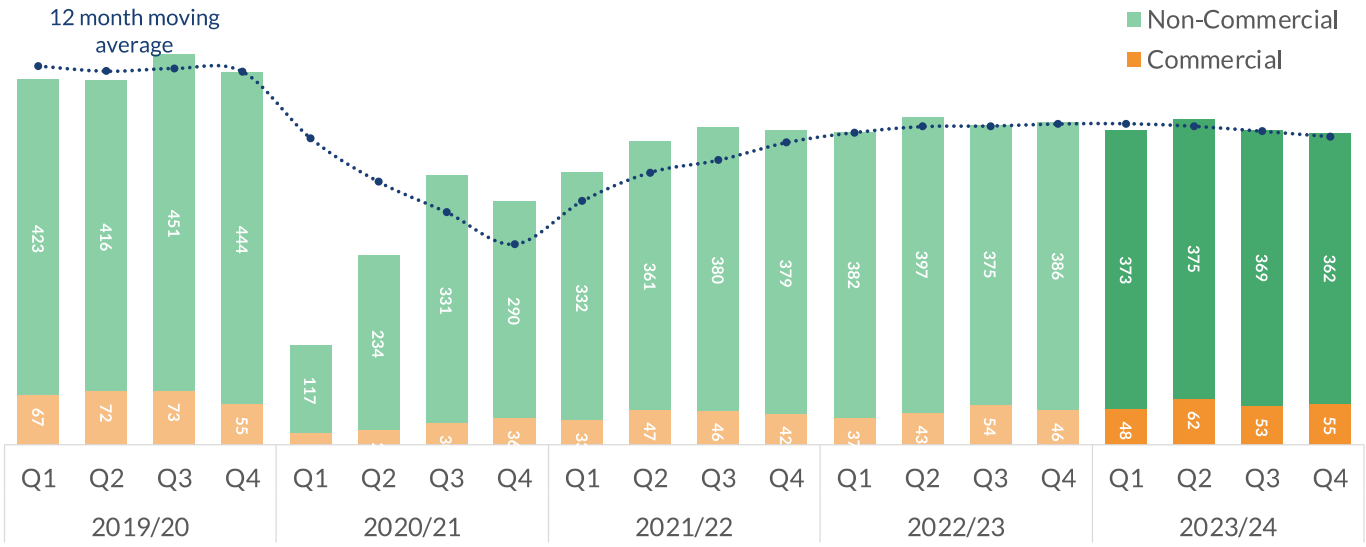


Figure 6 - Recruiting studies in Wessex by funding type in the last five financial years (April 2019 to March 2024).

All research activity

The CRN Wessex Executive Group track recruitment benchmarked both against the region's previous activity and the current recruitment in the fourteen other CRN regions in England. In the first two months, Wessex was averaging recruitment of around 2,300 participants per month. Based on historic averages, Wessex would expect to recruit approximately 3,333 participants per month.

Compared to England as a whole, the Wessex study portfolio was unevenly balanced towards smaller, interventional research taking place in only a few sites. The way that recruitment takes place influences

performance, as well as the eligibility criteria for studies. For example, Portsmouth Hospitals NHS Trust introduced a successful a 'core studies' approach where projects were identified that could be delivered rapidly by a central group of multi-specialty staff. At several points during the 2023/24 financial year, this group recruited hundreds of participants in a month on to relatively few studies. This happened alongside the more traditional model of hospital departments operating their own studies with specialised staff, which is necessary to deliver more complicated studies. CRN Wessex considers both approaches to have a place in a balanced research portfolio.

The CRN Wessex Executive Group requested that action was taken to increase recruitment to match or exceed historical averages for the remainder of the financial year (and beyond). A plan was agreed with CRN partner organisations and specialty leads to prioritise the recruitment opportunities for research participants. CRN Wessex specialty leads and research delivery teams encouraged new Wessex sites to open on existing studies. New studies were identified that had higher recruitment potential and that could open before the end of the financial year. Wessex sponsors opened studies that had been in development, with the largest of these starting in the late Autumn of 2023. The effect of this collaboration between Wessex partner organisations on accelerating recruitment can be clearly seen in Figure 7.

Figure 7 - Cumulative recruitment in Wessex during 2023/24 compared to an early prediction of the year-end total.

Wessex's marked increase in average monthly recruitment was the opposite of England's in the second half of the 2023/24 financial year (Figure 8). In March 2024, the end of the financial year, Wessex was ranked

seventh of fifteen local clinical research network regions for recruitment (Figure 9). Wessex has approximately five per cent of England's population, and the region would expect to be ranked around eighth with five per cent of average English recruitment. When the size of the population is factored in (recruitment per million population), Wessex was ranked second in March 2024 (Figure 10).

Wessex partner organisations have exceeded recruitment expectations in the latter months of the financial year, when benchmarked against England's recruitment. This restored position has continued into the start of the 2024/25 financial year so far. Performance will be reported for this period in the quarter one report to the UHS Board.

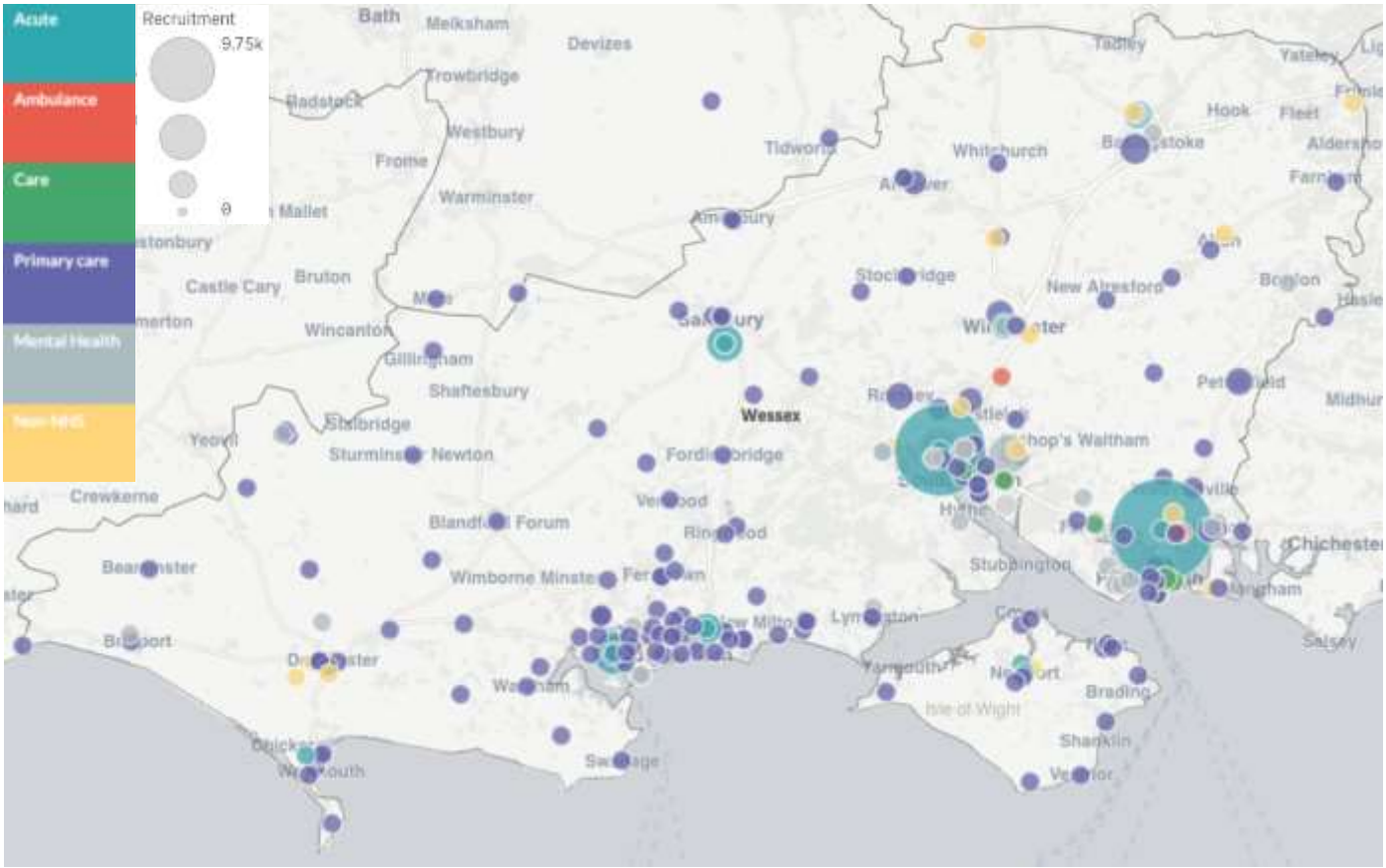
Figure 8 - Wessex research recruitment benchmarked against England since April 2022.

Month	A	M	J	J	A	S	O	N	D	J	F	M
Wessex rank	14	15	12	15	15	15	13	9	9	12	10	7

Figure 9 - Wessex's recruitment rank within each month of the 2023/24 financial year, compared to the fifteen local clinical research network regions in England.

Figure 10 - Wessex's recruitment per million population rank within each month of the 2023/24 financial year, compared to the fifteen local clinical research network regions in England.

Figure 11 shows how research activity is distributed across the Wessex region. Activity has taken place in all types of organisation across 720 studies, 270 sites and all thirty specialties. Recruitment in primary care has reached its highest levels in over a decade, experiencing growth in both participant numbers and recruitment sites since the onset of the COVID-19 pandemic. Sixty-nine percent of GP practices in Wessex participated in research, marking the highest level of participation ever recorded. For further reference, Figure 12 provides quarterly organisation recruitment grouped by their type in the 2023/24 financial year.



Organisation type	Trusts	Recruiting sites	Recruitment	Recruiting studies	% of organisations recruited this year
Acute	7	27	30,163	595	100% (ambition 100%)
Ambulance	1	6*	931	10	100%

11

					(ambition 100%)
Care	1	15	614	38	100% (ambition 100%)
Primary care	*N/A*	169	10,375	62	69% (ambition 100%)
Mental Health	2	33	2,979	53	100% (ambition 100%)
Non-NHS	*N/A*	21	225	22	N/A

*Activity happens across Wessex but is primarily recorded at the SCAS Trust Headquarters in Oxfordshire.

Figure 11 – Research activity in Wessex by organisation type during the 2023/24 financial year.

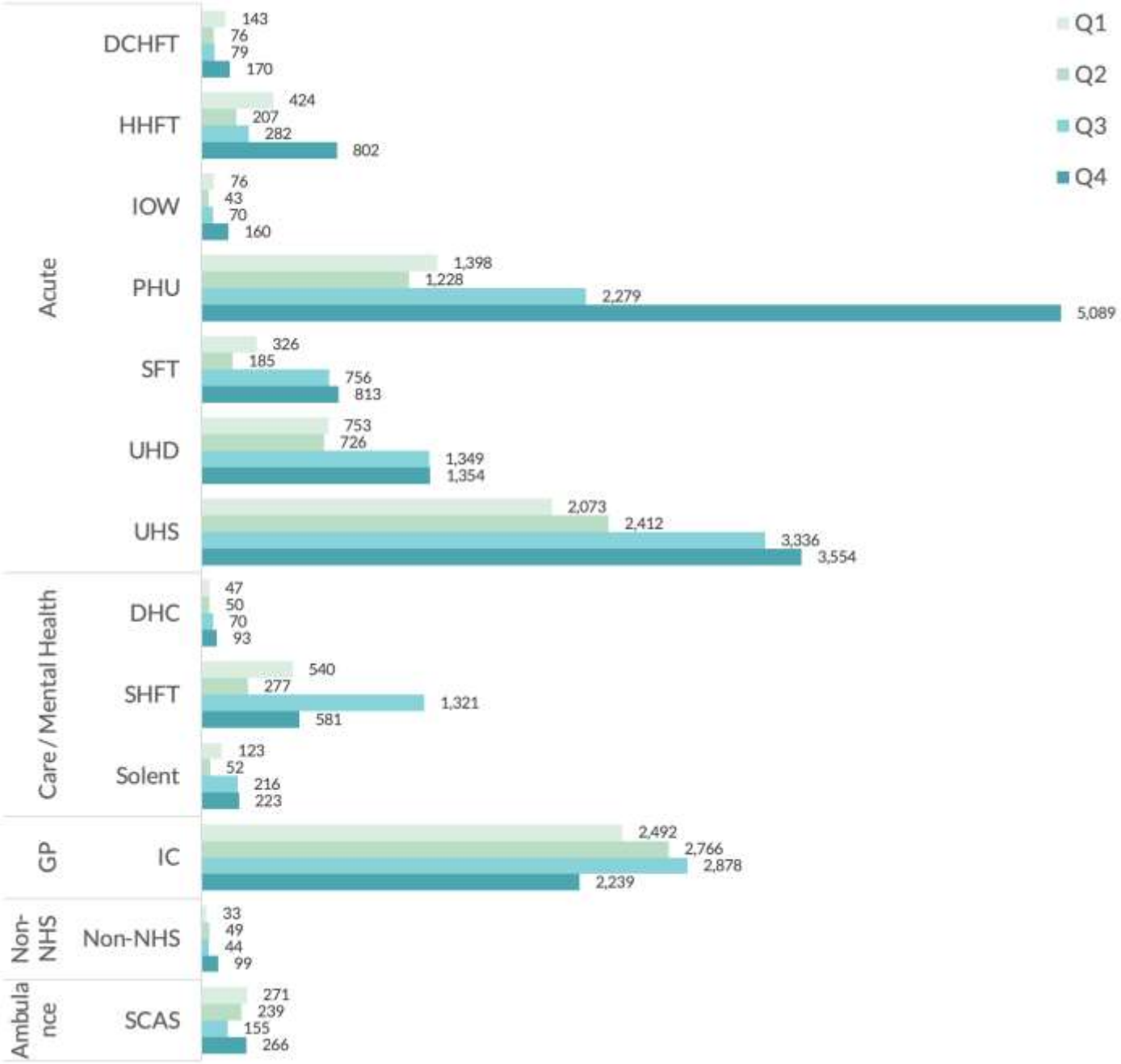


Figure 12 – Quarterly CRN Portfolio study recruitment by organisation type in Wessex in the 2023/24 financial year.

Commercial research activity in Wessex

Commercial research, funded and sponsored by the life sciences industry, is important to the Wessex region and is a priority area for the DHSC and the NIHR. It provides novel treatment options for patients, supports the expansion of research infrastructure and often generates savings on treatment costs for participating organisations.

The high level objectives focus on studies led by each region, but site performance on commercial studies led from any region is also monitored by CRN Wessex (Figure 13). In 2023/24, Wessex study sites have not

achieved the internal ambition of eighty per cent closing having met the recruitment target assigned by the sponsor. Performance increased slightly on the previous financial year, with a notable increase in study sites that were close to achieving their recruitment target when closed (thirteen per cent). Sites are regularly informed of their performance in CRN Wessex monthly reports to partner organisations.

Recruitment for commercial studies typically represents less than four percent of the annual research activity. In 2023/24 this proportion increased significantly to twenty percent. On the largest study, which took place primary care, an average of over 750 participants per month have joined Omnigen Biodata Ltd.'s Discover Me personal genetics testing study (https://www.discovermestudy.com/). Excluding the Discover Me study, commercial recruitment in the region has remained just below the five-year average, which includes the very large COVID-19 vaccine trials that took place in the 2020/21 and 2021/22 financial years. Quarterly commercial recruitment figures by Wessex organisation are provided in Figure 14.

Figure 13 - Percentage of Wessex-led commercial studies that closed each financial year meeting their recruitment target assigned by the sponsor.

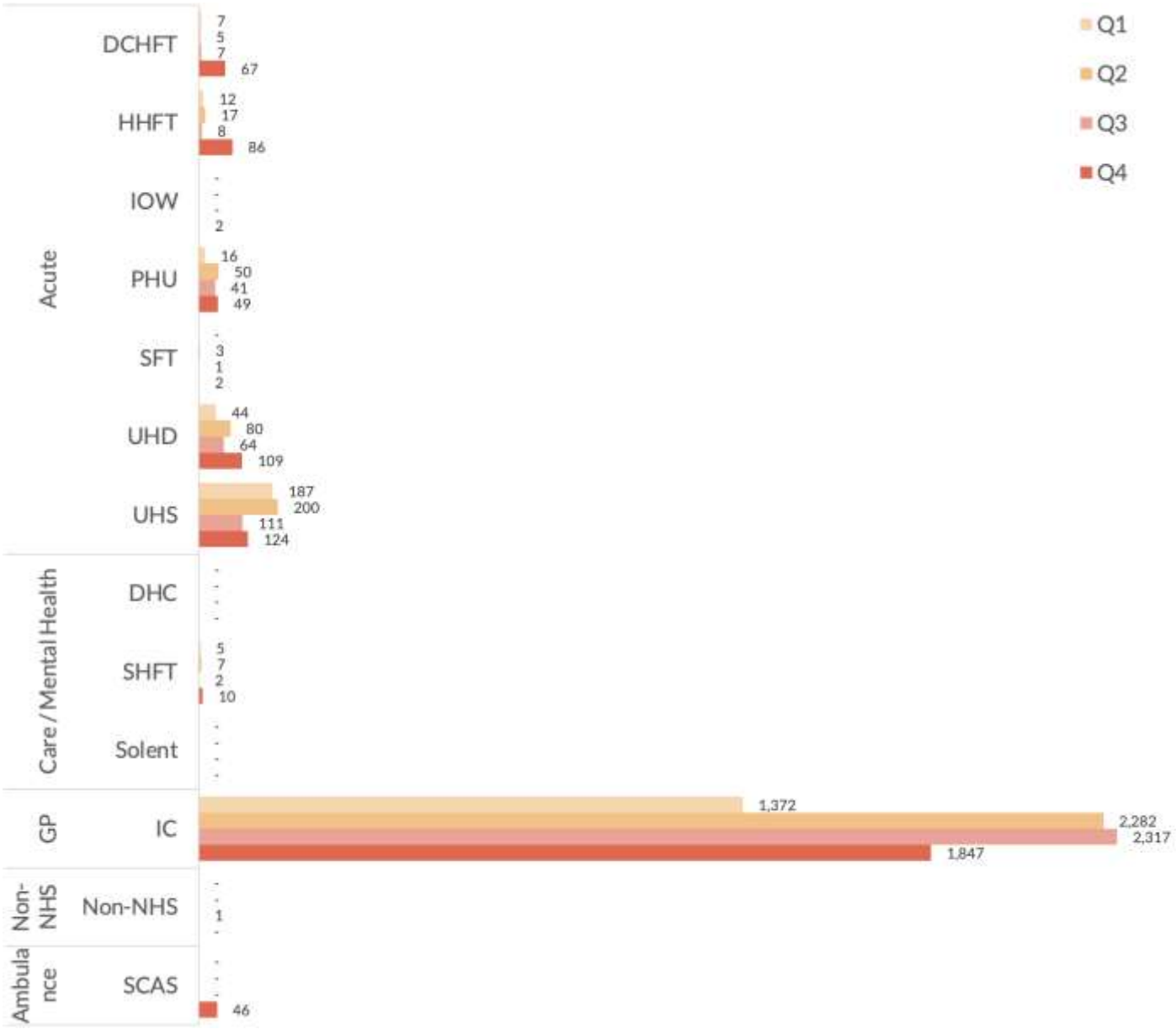


Figure 14 – Quarterly commercially funded and sponsored CRN Portfolio study recruitment by organisation type in Wessex in the 2023/24 financial year.

Lord O'Shaughnessy's 2023 review of commercial clinical trials in the UK recommended many improvements to the system. Among other planned actions, the UK Government's response to the review included reducing set up times from the original application for regulatory approvals through to recruiting the first UK participant, as well as more than doubling the current UK recruitment by 2025. CRN Wessex will provide support to sponsors and our partner organisations and will be proactive in bringing commercial research to the region.

Appendix

Appendix 1 – CRN Wessex Risk Register

PRE-RESPONSE (INHERENT)									POST RESPONSE (RESIDUAL)							
Risk ID	Primary category	Date raised	Risk Owner	Risk Description (to include cause/event, and effect)	Probability	Impact	Value (Pxi)	Proximity	Response Actions	Action owner(s)	Action status	Probability	Impact	Value (Pxi)	Risk status (open or closed date)	Trend (since last reviewed)
CRN 06	Performance	Jun-20	CDs/COO	**Cause: Future waves of Covid-19 pandemic** **Event:** Leading to a **reduction in research capacity** in NHS and social care **Effect:** Meaning **recruitment** to all studies, including priority studies, may be **detrimentally affected** by future waves of Covid infections. In *extremis* CRN funded staff may be redeployed to clinical duties and shortages in staffing will be exacerbated by staff sickness, sheilding and isolating.	3	3	9	Current	1. Agile staff deployment supported by contractual arrangements between partners and the host. 2. Strong clinical leadership to motivate staff and provide first-hand intelligence to the partners 3. Wessex workforce campaign to recruit additional staff to DDT 4. Active support for POs to restart non UPH studies e.g two-weekly calls with POs 5. Core team returning to 40/60 split of office/home January 2022	WFD Lead / COO / SSS Lead	All - ongoing	2	2	4	Open	Decreased
CRN 06	Workforce	Aug-21	CDs/COO	**Cause: Lack of availability of registered nurses** **Event: Leading to a shortfall in registered staff qualified to deliver clinical trials** **Effect: Meaning that fewer clinical trials are delivered**	3	4	12	Current	1. DDT based from research hubs to relieve trust based research nurses 2. Recruit band 3 CTAs and train up to band 4 level to relieve existing nursing staff of some duties 3. Recruit CRPs to relieve existing nursing staff of some duties 4. Recruitment campaign to attract graduates to research delivery careers	WFD Lead/COO	All - ongoing	2	2	4	Open	Decreased
CRN 7	Workforce	Aug-21	CDs/COO	**Cause: Staff burnout** **Event: Lack of registered staff to deliver clinical trials** **Effect: Meaning that fewer clinical trials are delivered**	2	3	6	Current	1. Ongoing recruitment to the direct delivery team 2. Reinvestment of hub income to increase head count 3. Wellbeing programme established for the team and delivered by the team	WFD/COO	All - ongoing	2	2	4	Open	Decreased
CRN 8	Performance	Mar-22	CDs/COO	**Cause: Fuel prices/fuel shortage** **Event: Cost of fuel becomes prohibitively expensive/fuel shortages prevent core delivery team travel across the region to deliver trials** **Effect: Meaning that fewer clinical trials are delivered**	2	3	6	Current	1. DDT based nearer hub locations could pick up some work 2. Look for opportunities for remote trial delivery	COO/DCOO	All - ongoing	2	2	4	Open	Decreased
CRN 9	Performance	Mar-22	CDs/COO	**Cause: Supply chain issues** **Event: Cost of fuel becomes prohibitively expensive/fuel shortages impact on supply chain for drugs and consumables required for trial delivery** **Effect: Meaning that fewer clinical trials are delivered**	2	3	6	Current	1. Raise locally and nationally for advice on prioritisation of key activities/studies	COO/DCOO	All - ongoing	2	3	6	Open	Decreased

PRE-RESPONSE (INHERENT)									POST RESPONSE (RESIDUAL)							
Risk ID	Primary category	Date raised	Risk Owner	Risk Description (to include cause/event, and effect)	Probability	Impact	Value (Pxi)	Proximity	Response Actions	Action owner(s)	Action status	Probability	Impact	Value (Pxi)	Risk status (open or closed date)	Trend (since last reviewed)
CRN 10	Workforce	Sep-22	CDs/COO	**Cause: End of LCRN contract September 2024** **Event: Existing staff may leave for other roles in the system to avoid uncertainty, leading to a depleted team and difficulty delivering to the POF. Difficulty recruiting into vacant posts for the final 'transition' year (2023/24)**	4	4	16	Current	1. Raise locally and nationally for advice on prioritisation of key activities/studies 2. Implement staff transition survey to gather opinions and suggestions 3. Involve staff in wellbeing initiatives to support through the transition 4. Work with UHS transition leads and HR to keep staff up to date with process to support transition to new roles and services	COO/DCOO	All - ongoing	3	4	12	Open	Static
CRN 11	Performance	Oct-22	CDs/COO	**Cause: Winter pressures** **Event: Staff shortages due to sickness impacting on delivery, pharmacy, imaging: redeployment of research staff to clinical services**	4	4	16	Current	1. Raise locally and nationally for advice on prioritisation of key activities/studies	COO/DCOO	All - ongoing	4	4	16	Open	Static
CRN 14	Performance	March	CDs/COO	**Cause: Junior doctor strike action** **Event: Redeployment of clinical staff to cover emergency care leading to lack of staff to deliver clinical trials**	4	3	12	Current	1. Raise locally and nationally for advice on prioritisation of key activities/studies	COO/DCOO	All - ongoing	4	3	12	Open	Static
CRN 15	Performance	March	CDs/COO	**Cause: Consultant strike action** **Event: Redeployment of clinical staff to cover emergency care leading to lack of staff to deliver clinical trials**	4	3	12	Current	1. Raise locally and nationally for advice on prioritisation of key activities/studies	COO/DCOO	All - ongoing	4	3	12	Open	Static
CRN16	Workforce	Dec-23	CDs/COO	**Cause: RRDN transition** **Event: CRN Wessex host organisation and incoming South Central RRDN host, UHS, has placed a recruitment freeze on the CRN Wessex team. This is currently impacting the agile clinical delivery team that has 6 vacancies and a further 5 team members going on mat leave in the new year. A lack of registered staff in the team has been highlighted as a risk by CRN Wessex chief research nurse**	4	3	12	Current	1. Raise locally and nationally for advice on prioritisation of key activities/studies 2. With support of CRN Wessex chief nurse, quantify the level of WTEs missing from the team and impact on skill mix required to deliver the upcoming portfolio	COO/DCOO	All - ongoing	3	3	9	Open	Static
CRN17	Workforce	Apr -24		**NHS Handbook staff mileage cap < 3500 annual mileage restrictions impacting agile delivery team capacity to travel across the region to deliver research to communities currently under-served by research opportunities**	3	3	9	Current	1. Raised locally with HR and nationally through CC	COO/DCOO	All-ongoing	3	3	9	Open	Static

Appendix 2 - Glossary

Partner organisation abbreviations used by CRN Wessex:

- DCHFT Dorset County Hospital NHS Foundation Trust
- DHC Dorset HealthCare University NHS Foundation Trust
- HHFT Hampshire Hospitals NHS Foundation Trust
- IOW Isle of Wight NHS Trust
- IC Independent contractors, typically primary care practices
- Non-NHS Organisations linked to the NHS, such as universities, care homes etc.
- PHU Portsmouth Hospitals University NHS Trust
- SFT Salisbury NHS Foundation Trust
- Solent Solent NHS Trust
- SCAS South Central Ambulance Service NHS Foundation Trust
- SHFT Southern Health NHS Foundation Trust
- UHD University Hospitals Dorset NHS Foundation Trust
- UHS University Hospital Southampton NHS Foundation Trust

Local clinical research network or devolved nation abbreviations and their 2023/24 financial year population:

East Midlands	EM	4,605,206
East of England	EoE	3,891,262
Greater Manchester	GM	3,029,318
Kent, Surrey and Sussex	KSS	4,654,474
North East and North Cumbria	NENC	2,963,018
North Thames	NT	5,757,668
North West Coast	NWC	3,950,452
North West London	NWL	2,075,696
South London	SL	3,285,629
South West Peninsula	SWP	2,304,291
Thames Valley and South Midlands	TVSM	2,397,813
Wessex	Wessex	2,793,224
West Midlands	WM	5,860,706
West of England	WoE	2,490,339
Yorkshire and Humber	YH	5,560,334
Northern Ireland	NI	1,870,800
Scotland	Scotland	5,424,800
Wales	Wales	3,125,200

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Board Assurance Framework (BAF)**			
Agenda item:	**6.2**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Lauren Anderson, Corporate Governance & Risk Manager** **Craig Machell, Associate Director of Corporate Affairs and Company Secretary**			
Date:	**6 June 2024**			
Purpose:	**Assurance or reassurance** ✔	**Approval**	**Ratification**	**Information** ✔
Issue to be addressed:	The Board Assurance Framework (BAF) provides assurance against the achievement of our strategic objectives; highlighting those that are at risk of not being delivered. The BAF provides evidence to support the annual governance statement and is a focus of CQC and audit scrutiny. This report sets out the strategic risks, control framework, sources of assurance and action plans. The BAF is a dynamic document that will reflect the Trust's changing strategic position.			
Response to the issue:	The BAF has been developed with input from responsible executives and relevant stakeholders. It satisfies good governance requirements on information and scoring. The report has been updated following discussions with the relevant executives and their teams.			
Risks: (Top 3) of carrying out the change / or not:	The ability of the Board to effectively manage strategic risk is fundamental to the delivery of the Trust's strategic objectives and is a core element of the CQC's 'well led' inspection process. An organisation that does not monitor its strategic risk through a Board Assurance Framework or similar document may not be aware of key risks, or may not understand failures in the control environment and actions planned to address these failures.			
Summary: Conclusion and/or recommendation	The Board is asked to note the updated Board Assurance Framework and information contained within this report.			

1. Purpose

1.1. The University Hospital Southampton Board Assurance Framework (BAF) identifies the strategic ambitions and the key risks facing the organisation in achieving these ambitions. The full BAF is provided as appendix A.

1.2. This document seeks to provide assurance to the Board that the Trust is appropriately sighted on, and working to mitigate, key strategic risks through an appropriate governance structure. Each risk detailed within the BAF is overseen by a sub committee of board.

1.3. When reviewing the BAF the Board are asked to consider:

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

2. Key updates

2.1. The board last received the BAF in March 2024. Since then all risks have been reviewed by the responsible executive(s) and updated where appropriate.

2.2. Key changes to individual strategic risks are shown within the current assurances and updates on each risk within the BAF.

2.3. The risk rating for one risk has altered since the committee last reviewed the risk in March. This is 5b (Estates) which has increased from 16 (4 x 4) to 20 (4 x 5) to reflect the accumulative level of risk across the estate which continues to increase without sufficient funding available to address this.

2.4. At present there are 5 risks which sit outside of the Trust's stated risk appetite, however all of them have target ratings which do sit within either the tolerable or optimal appetite, along with actions identified to achieve this.

2.5. Work has progressed to embed the risk appetite within the organisation:

- All critical (red rated risks) have been audited against the risk appetite with the results shared through TEC. Those risks where there is not a clear plan to manage the risk in line with appetite are being reviewed by the divisional management and governance teams.
- A process is being developed for escalation of risks outside of appetite.
- A training presentation is being developed with dates secured to share this at all 4 divisional governance groups in June 2024.

2.6. Work has progressed to create stronger connections between the operational risk register and BAF with all critical risks mapped to a strategic risk. The digital system, Ulysses Safeguard, which holds the risk register has now been updated to reflect the current strategic risks and allow digital coding and reporting. Further work is planned to introduce an intermediary level of risk which collates the operational risks into a collective divisional oversight framework.

UHS Board Assurance Framework (BAF)

Updated May 2024

The Board Assurance Framework (BAF) is a dynamic document which provides assurance against the achievement of our strategic objectives, highlighting those risks that may threaten delivery.

The risks are grouped according to the Trust's key strategic themes:

1. Outstanding patient outcomes, safety, and experience

- 1a: Lack of capacity to appropriately respond to emergency demand, manage the increasing waiting lists for elective demand, and provide timely diagnostics, that results in avoidable harm to patients.
- 1b: Due to the current challenges, we fail to provide patients and their families / carers with a high-quality experience of care and positive patient outcomes.
- 1c: We do not effectively plan for and implement infection prevention and control measures that reduce the number of hospital-acquired infections and limit the number of nosocomial outbreaks of infection.

2. Pioneering research and innovation

- 2a: We do not take full advantage of our position as a leading University teaching hospital with a growing, reputable, and innovative research and development portfolio, attracting the best staff and efficiently delivering the best possible treatments and care for our patients.

3. World class people

- 3a: We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles.
- 3b: We fail to develop a diverse, compassionate, and inclusive workforce, providing a more positive staff experience for all staff.
- 3c: We fail to create a sustainable and innovative education and development response to meet the current and future workforce needs identified in the Trust's longer-term workforce plan.

4. Integrated networks and collaboration

- 4a: We do not implement effective models to deliver integrated and networked care, resulting in sub-optimal patient experience and outcomes, increased numbers of admissions and increases in patients' length of stay.

5. Foundations for the future

- 5a: We are unable to deliver a financial breakeven position, resulting in: inability to move out of the NHS England Recovery Support Programme, NHS England imposing additional controls/undertakings, and a reducing cash balance impacting the Trust's ability to invest in line with its capital plan, estates/digital strategies, and in transformation initiatives.
- 5b: We do not adequately maintain, improve, and develop our estate to deliver our clinical services and increase capacity.
- 5c: Our digital technology or infrastructure fails to the extent that it impacts our ability to deliver care effectively and safely within the organisation
- 5d: We fail to prioritise green initiatives to deliver a trajectory that will reduce our direct and indirect carbon footprint by 80% by 2028-2032 (compared with a 1990 baseline) and reach net zero direct carbon emissions by 2040 and net zero indirect carbon emissions by 2045.

Executive Summary

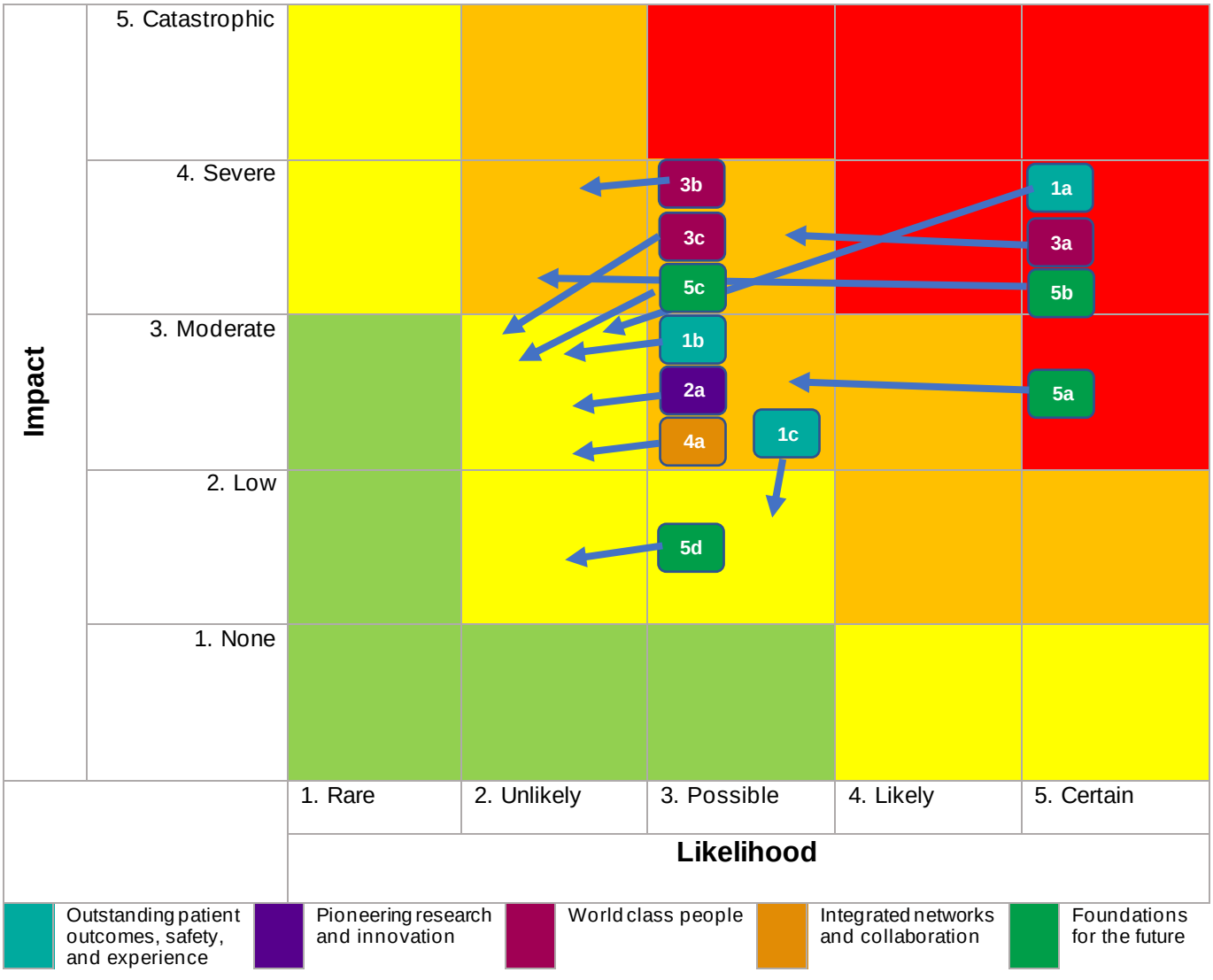
There are 4 critical strategic risks with a red risk rating above 15. These are:

- 1a) Capacity (4 x 5 = 20)
- 3a) Staffing (4 x 5 = 20)
- 5a) Finances (3 x 5 = 15)
- 5b) Estates (4 x 5 = 20)

At present there are 5 risks with a current risk rating outside of the optimal or tolerable appetite. These are: 1a, 1c, 3a, 5a, and 5b. All of these risks are being actively treated with the aim of reducing the risk score and all risks set out within the BAF have a target risk rating which sits within the optimal or tolerable risk appetite.

Trajectory

The heatmap provided below demonstrates the current risk rating based on the impact and likelihood, along with an arrow illustrating the target score to be achieved through implementation of planned actions and mitigations.



Outstanding patient outcomes, safety, and experience

1a) Lack of capacity to meet current demand resulting in avoidable patient harm

Monitoring committee: Quality Committee	**Executive leads:** COO, CMO, CNO

Cause	Risk	Effect
If there is inadequate capacity due to increasing demand, suboptimal flow, and limited resources (including funding, workforce, estate, and equipment);	This could lead to an inability to respond to emergency demand in a safe, timely and appropriate manner, delays in elective admissions and treatment, and delays in timely diagnostics;	Resulting in avoidable harm to patients and increased incidents, complaints, and litigation.
Category	**Appetite**	**Status**
Safety	Minimal *The current risk rating is outside of the stated risk appetite. The target risk rating is within the tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 5 20	April 2022	4 x 5 20	May 2024	3 x 2 6	April 2025

Risk progression: (previous 12 months)	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24
	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20

Current assurances and updates

- Inpatient flow and discharge programme established within Transformation with clear objectives set to significantly reduce length of stay and to improve home before lunch rates to at least 25%. This is governed through the Inpatient Steering Group (IPSG) with senior clinical and non-clinical leadership including the CNO, deputy CMO, and deputy COO. Targeted workstreams underpinning the objectives include criteria led discharge and discharge lounge use.
- From a planned care perspective the outpatients and operating services programmes have been established for 2024/25 with clear targets for improving utilisation of our existing capacity including for outpatients the implementation of new ways of working to reduce demand.
- As part of these programmes above each Care Group across the Trust has clear improvement plans to support the delivery of improvement across UHS in 24/25 supported by the GIRFT programme metrics (Getting It Right First Time)
- An external visit from the Emergency Care Intensive Support Team took place in February 2024 and we have now received their report with findings and recommendations to review and implement. The Emergency Department Team have clear actions to take forward as well as some Trust wide schemes.
- Managing risk around urgent care remains a key priority as we continue to see high demand for services, and challenges discharging patients without a criteria to reside (medically fit). This results in queuing within the emergency department and a higher number of ambulances waiting outside than usual.
- UEC standards have been developed and implemented with guidance for site management to ensure that we admit the right patient to the right place. Monitored through patient flow programme board.
- There is a current increased focus on home before lunch, flow, and utilisation of discharge lounges.
- Waiting lists for elective care have stabilised Although we have seen increases again in the last 2 months.
- An additional £2m of capital has been secured due to ED performance in March 24 which will enable new Same Day Emergency Care (SDEC) facilities to be implemented to reduce demand on our Emergency Department and reduce admissions to the hospital.
- New capacity is being implemented in 24/25 including 2 new theatres, a new MRI suite and later in the year a community diagnostic centre.

Key controls	Gaps in controls
Clinical Prioritisation Framework. Triage of patient lists based on risk of harm with consultant led flagging of patients of concern. Capacity and demand planning, including plans for surge beds and specific seasonal planning. Patient flow programme to reduce length of stay and improve discharge. Outpatient transformation programme focused on reducing follow up demand. Operating services transformation programme to improve theatre utilisation / treat more patients. Use of independent sector to increase capacity. Urgent and Emergency Care Board established to drive improvements across UEC pathways. UEC recovery plan to support improvements across UEC pathways. Rapid Improvement Plans to support improvements across cancer pathways.	Excess demand in community and social care combined with cuts to Hospital Discharge Funding may further increase the number of patients in hospital not meeting the criteria to reside. Limited funding, workforce, and estate to address capacity mismatch in a timely way. Lack of local delivery system response and local strategy to manage demand in our emergency department as well as to address delays in discharge from the acute sector. Challenges in staffing ED department during periods of extreme pressure. Ongoing industrial action through 23-24 and into 24-25 presents significant risk to the Trust's ability to meet ongoing demand on our services. Staff capacity to engage in quality improvement projects due to focus on managing operational pressures. Workforce and recruitment controls result in ward leaders working within the safe staffing numbers as opposed to in a solely supervisory capacity reducing their ability to plan discharges and oversee flow.
Key assurances	**Gaps in assurances**
Clinical Assurance Framework, reported quarterly to the executive. Reported bi-weekly via CPRP. Harm reviews identifying cases where delays have caused harm. Weekly divisional performance meetings with a particular focus on cancer and long waiting patients. Live monitoring of bed occupancy and capacity data. Monitoring and reporting of waiting times. Implementation of PSIRF with oversight of red incidents at TEC. Transformation programme work plans.	Local system plans to reduce patients without a criteria to reside are emerging but currently lack detail to provide assurance.
Key actions	
Establish local delivery system plan for reducing delays throughout the hospital. Deliver ERF targets for 2024/25 to secure additional funding and address waiting lists. Deliver plans to hit the trajectory of no patients waiting over 65 weeks by September 2024. Community Diagnostic Hub opening in Q4 2024/5 to provide additional diagnostic capacity. Previously scheduled for 2023/4 however this has been delayed following redesign. New theatres and MRI suite open in 2024. Engagement in the NHSE Further Faster programme for elective care. Delivery of improvement work in 2024/25 on patient flow, and optimising operating services and outpatients.	

Linked operational risks				
No.	**Title**	**Current risk rating**	**Target risk rating**	**Target Date**
74	If there is a continued demand for SDU bed Capacity for inpatients there will be an impact on elective admission flow, patient experience, financial cost and staff well-being	3 x 5 = 15	3 x 3 = 9	31/08/2024
95	Delays in discharge of children and young people with acute mental illness or behavioural disturbance may impact on capacity within the Children's hospital.	3 x 5 = 15	2 x 3 = 6	31/12/2024
187	Inability to deliver critical services within the emergency department due to increased demand, overcrowding and inadequate flow out of the department, which is resulting in harm to patients.	5 x 5 = 25	4 x 3 = 12	28/11/2024
218	Patients will experience loss of vision if additional outpatient follow up capacity is not identified.	5 x 3 = 15	4 x 3 = 12	30/06/2024
259	Capacity and Demand in Maternity Services	4 x 4 = 16	2 x 2 = 4	31/07/2024
470	Risk to reputation and patient safety due to insufficient theatre capacity across Child Health, resulting in long waiting times for surgery.	4 x 4 = 16	3 x 2 = 6	30/09/2024
652	Prostate cancer capacity	4 x 4 = 16	3 x 2 = 6	31/07/2024
687	Impact on patient care due to delayed recovery discharges, because of lack of patient flow throughout the hospital.	3 x 5 = 15	3 x 1 = 3	31/12/2024
697	Delays in surgery for paediatric congenital cardiac patients due to lack of capacity and a growing waiting list	5 x 4 = 20	3 x 2 = 6	26/04/2024
766	Inability to deliver a critical service to those with a life threating illness/injury due to our resuscitation bays being overcrowded. Compromised ability to function as the Regional Major Trauma Centre.	5 x 5 = 25	4 x 2 = 8	30/06/2024
788	Elective caesarean section list capacity	3 x 5 = 15	2 x 2 = 4	21/09/2024
804	Congenital cardiac (adult & paeds) surgery demand	4 x 4 = 16	4 x 2 = 8	01/09/2024
814	Inability to provide a safe pleural service	4 x 4 = 16	2 x 2 = 4	01/01/2025
816	Inability to discharge patients due to non-criteria to reside status and/or ineffective processes will compromise effective flow and result in patient harm, a suboptimal patient experience, and insufficient admitting capacity	5 x 4 = 20	3 x 2 = 6	31/03/2025

Outstanding patient outcomes, safety and experience

1b) Due to the current challenges, we fail to provide patients and their families / carers with a high-quality experience of care and positive patient outcomes

Monitoring committee: Quality Committee	**Executive leads:** COO, CMO, CNO

Cause	Risk	Effect
If demand outstrips capacity, and/or we have insufficient workforce to meet the demand,	This could result in an inability to provide a fully comprehensive, and exceptional, experience of care,	Resulting in not fully meeting the needs of our patients and their families and carers, which may lead to an increase in complaints and poor feedback. Additionally, patents may suffer delays, complications, poorer outcomes, and longer lengths of stay if their needs are not addressed at the earliest opportunities.

Category	Appetite	Status
Experience	Cautious *The current risk rating is within the tolerable risk appetite and the target risk rating is within the optimal risk rating.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
3 x 3 9	April 2022	3 x 3 9	May 2024	3 x 2 6	December 2024

Risk progression: (previous 12 months)	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24
	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9

Current assurances and updates

- There has been a recent increase in pressure ulcers. This is under review with actions focussed on how we safely manage a reduction in bank staff to support tasks such as turnaround.
- Shortage of staff in maternity continues to be a challenge, with continuity of care team members being pulled into birthing activity to meet demand. Comprehensive oversight of this risk including at board level by the maternity safety champions.

Key controls	Gaps in controls
Trust Patient Safety Strategy and Experience of care strategy. Organisational learning embedded into incident management, complaints and claims. Learning from deaths and mortality reviews. Mandatory, high-quality training. Health and safety framework. Robust safety alert, NICE and faculty guidance processes. Integrated Governance Framework. Trust policies, procedures, pathways and guidance. Recruitment processes and regular bank staff cohort. Culture of safety, honesty and candour. Clear and supportive clinical leadership. Delivery of 23/24 Always Improving Programme aims.	No agreed funding for the quality of outcomes programme to go forward beyond this year. Staff capacity to engage in quality improvement projects due to focus on managing operational pressures . Reduction in head count (decreased bank utilisation) due to the measures taken because of financial challenges. Reduction in SDM delivery team due to financial challenges and temporary vacancies/sickness.

Involvement of patients and families through our Quality Patient Safety Partners (QPSPs) in PSSG, SISG and Quality Improvement projects. Implementation of PSIRF. Patient Involvement and engagement in capital build projects Working with communities to establish health inequalities and how to ensure our care is accessible and equitable.	
Key assurances	**Gaps in assurances**
Monitoring of patient outcomes. CQC inspection reporting: Good overall. Feedback from Royal College visits. Getting it right first time (GIRFT) reporting to Quality Committee. External accreditations: endoscopy, pathology, etc. Kitemarks and agreed information standards. Clinical accreditation scheme (with patient involvement). Internal reviews into specialties, based on CQC inspection criteria. Current and previous performance against NHS Constitution and other standards. Matron walkabouts and executive led back to the floor. Quality dashboard, KPIs, quality priorities, clinical audits and involvement in national audits. Performance reporting. Governance and oversight of outcomes through CAMEO and M+Ms Patient Safety Strategy Oversight Committee Transformation Oversight Group (TOG) including TOG dashboard to oversee impact. Established governance oversight and escalation from ward to board through care group and divisional governance groups, as well as the Quality Governance Steering Group and the Quality Committee (sub committee of the board). Providing other avenues of FFT feedback that suits the needs of our demographic, or example SMS surveys, ensuring our care is informed by ours patients voice	Ongoing industrial action through 22-23 and 23-24, and into 24-25 presents risk to the Trust's ability to meet ongoing demand on our services
Key actions	
Introducing a robust and proactive safety culture: Implement plan to enable launch of PSIRF in Q3 2023/24 and continued implementation and embedding into 2024/25. Embed learning from deaths lead & lead medical examiner roles (primary and secondary care) and develop objectives and strategy. Introduce thematic reviews for VTE. Implement the second round of Ockenden recommendations – completed. **Empowering and developing staff to improve services for patients** Ongoing completion of SDM project, data analysis and formulate plan for ongoing roll-out, predominantly focussed on specialist services. Engagement and rollout within adult congenital heart disease, head and neck cancer, and also orthopaedics across the ICS. To embed as business as usual from April 2024. Baseline assessments and two quarters' submissions have completed and this will form part of the CQINN this year.	

Always Improving programme

Delivery of 23/24 aims of patient flow, outpatient and optimising operating services programmes and associated quality, operational and financial benefits (incl. Outpatient follow-up reduction).

Further development of our continuous improvement culture to ensure a sustained focus on quality and outcomes.

Increase specialties contributing to CAMEO. We are developing a new strategy linking outcomes, transformation, and safety.

Actively managing waiting list through points of contact, escalating patients where changes are identified. Ongoing harm reviews for p2s and recurring contact for p3 and p4 patients.

Always Improving self assessment against NHSE guidance to be taken to Trust Board in December.

Fundamentals of care programme roll out across all wards.

Patient experience initiatives

Roll out of SMS and other feedback mechanisms, offering clinical teams targeted response surveys to ensure specific care needs are not only identified they are also addressed.

Experience of Care team to provide meaningful patient feedback to individual services through Div Gov and local level groups to disseminate and support service improvement through codesign and patient experience.

We are Listening events – held in local community areas to capture protected characteristic patients that may not explore traditional complaint routes into the Trust.

Measures in place to identify and share thematic learning.

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
38	Timeliness of screening for sickle cell and thalassaemia in early pregnancy	3 x 5 = 15	2 x 2 = 4	31/12/2024
440	Children and young people with acute mental illness or behavioural disturbance will be at increased risk of harm if there are no dedicated CAMHS facilities and insufficient CAMHS staffing at Southampton Children's Hospital; this risk will be exacerbated if there are also delays in their discharge.	4 x 5 = 20	2 x 3 = 6	28/06/2024
645	Increase in mental health patients and ligature risk in ED and AMU	3 x 5 = 15	2 x 2 = 4	30/06/2024
765	Risk to patient safety and patient experience due to a lack of plasma exchange provision for children at UHS	4 x 4 = 16	4 x 2 = 8	31/01/2024
815	Poor compliance with NICE guidance for antenatal bookings	3 x 5 = 15	2 x 2 = 4	31/12/2024

Outstanding patient outcomes, safety and experience

1c) We do not effectively plan for and implement infection prevention and control measures that reduce the number of hospital acquired infections and limit the number of nosocomial outbreaks of infection

Monitoring committee: Quality Committee	**Executive leads:** CNO, COO

Cause	Risk	Effect
If there are gaps in compliance with IPC measures and policy, either due to increased working pressures, or a lack of awareness or understanding,	Patients may acquire a new infection whilst in hospital and there may be nosocomial outbreaks of infection,	Resulting in patient harm, longer lengths of stay, a detrimental impact to patient experience if visiting restrictions are necessitated, and an operational impact as bays and wards are closed.

Category	Appetite	Status
Safety	Minimal *The current risk rating is outside of the stated risk appetite. The target risk rating is within the tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
3 x 3 9	April 2022	3 x 3 9	May 2024	2 x 3 6	April 2025

Risk progression: (previous 12 months)	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24
	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9

Current assurances and updates

- There has been an increased numbers of patients presenting to ED with measles, with initial cases generating high numbers of contacts who were sent 'warn and inform' letters. Subsequently 2 staff members were confirmed positive for measles following exposure and this has been reported to the HSE as RIDDOR reportable events. Processes to manage measles cases have been implemented quickly with the ability to bypass ED and admit patients directly into an isolation area, greatly reducing the number of contacts generated.
- Guidance disseminated around identifying potential cases of measles and pertussis and monitoring symptoms, supported by national messaging and encouragement of vaccinations.
- Ongoing review of IP&C guidance, including PPE, including launch of a reduced glove usage campaign plus review of required PPE as part of the update of the Trust Isolation Policy.
- Ongoing focus on hand hygiene by the IPT and Divisions/Care groups – improvements starting to be seen in hand hygiene practice (as demonstrated in audits) and evidence of ongoing focus within clinical areas to drive improvements in practice.
- Education and support provided to clinical areas not meeting expected cleanliness standards, providing by EMT and external providers.
- The fundamentals of care continue to be rolled out which includes embedding expected IPC measures This also addresses learning from the recent MRSA BSIs and other infections e.g. risk reduction measures for MRSA, focus on hand hygiene practice and correct PPE.

Key controls	Gaps in controls
Annual estates planning, informed by clinical priorities. Digital prioritisation programme, informed by clinical priorities. Infection prevention & control agenda, annual work plan, audit programme. Local infection prevention support provided to clinical teams.	Transmissibility of respiratory virus infections (e.g. COVID-19, Influenza, RSV), Norovirus and other infections. Resurgence of infections such as measles and pertussis plus emergence of newer infections e.g.

Compliance with NHSIE Infection Prevention & Control Assurance Framework. Focused IP&C educational/awareness campaigns e.g. hand hygiene, 'Give up the gloves' winter virus. campaigns. Digital clinical observation system. Implementation of My Medical Record (MMR). Screening of patients to identify potential transmissible infection and HCAIs. Programme of monitoring/auditing of IP&C practice and cleanliness standards. Review of incidents/outbreaks of infection and sharing learning and actions. Risk assessments in place for individual areas for ventilation, bathroom access, etc. to ensure patient safety.	candida Auris and increased national prevalence of multi-drug resistant organisms such as CPE. Familiarisation with response to resurgence of infections such as norovirus, measles, pertussis plus new infections. Challenges in the ability to isolate patients presenting with suspected infection due to limited infrastructure in some areas e.g. limited single rooms/demand on single rooms. IPC measures are reliant on people and their actions will be influenced by human factors, therefore 100% compliance cannot be enforced.
Key assurances	**Gaps in assurances**
Infection Prevention Committee and IP&C Senior Oversight Group. Hand hygiene, IP&C and cleanliness audits. Patient-Led Assessment of the Care Environment. National Patient Surveys. Capital funding monitored by executive. NHSE/I infection prevention & control assurance framework compliance reporting to executive, Quality Committee and Board. Clinical audit reporting. Internal audit annual plan and reports. Finance and Investment Committee oversight of estates and digital capital programme delivery. Digital programme delivery group meets each month to review progress of MMR. Quarterly executive monitoring of Estates KPIs (maintenance, cleanliness, fire safety, medical devices, etc.).	Ward and bay closures due to norovirus outbreaks. Increase in cases of C.Diff , MRSA BSIs (blood stream infections) and other gram negative BSI above national set thresholds. Not all areas consistently submitting IP&C audits to demonstrate assurance of expected IP&C practices.
Key actions	
Ongoing programme of IP&C policy review to ensure alignment with national infection prevention & control manual for England. e.g. Isolation policy. Ongoing focused IP&C education and awareness campaigns supported by internal and external communications plan. Re-enforce processes to ensure all areas submit required audits to demonstrate assurance of IP&C practice standards and follow up/support provided by the IPT. Delivery of IPT work plan to support improvements in practice (MRSA focus in Q1, Isolation care focus in Q2). Follow-up/review of all new cases of Cdifficile & MRSA for assurance that expected standards are in place to reduce risk of onward transmission. Monthly Infection Prevention Newsletter to provide updates/education and share learning – May 2024 covered performance & learning from 2023/24 and focus on hand hygiene.	

Pioneering research and innovation

2a) We do not take full advantage of our position as a leading university teaching hospital with a growing, reputable, and innovative research and development portfolio, attracting the best staff and efficiently delivering the best possible treatments and care for our patients

Monitoring committee: Trust Board	**Executive leads:** CMO

Cause	Risk	Effect
If there is: • insufficient research workforce and limited capacity in clinical support services; • an organisational culture which does not encourage and support staff to engage with research and innovation.	This could lead to: • an inability to set-up and deliver research studies in a safe and timely manner; • a lack of development opportunities for staff which impacts the next generation of researchers and innovators.	Resulting in: • failure to deliver against existing infrastructure awards; • impact our national ranking; • reduced access for patients to innovative new treatments; • reputational damage to our university teaching hospital status and ability to secure funding awards in the future.

Category	Appetite	Status
Technology & Innovation	Open *Both the current and target risk ratings are within the optimal risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 2 8	April 2022	3 x 3 9	May 2024	3 x 2 6	January 2025

Risk progression: (previous 12 months)	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24
	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9

Current assurances and updates

- Impact of recruitment processes on vacancy rates in research workforce and clinical support services starting to impact performance, with 10% vacancy rates across research delivery teams. Some recruitment now proceeding and appointment to vacancies, with an agreed pathway for research posts going forward.
- Processes being streamlined and new digital tools being adopted to increase clinical research delivery efficiency.
- R&D Trust Board KPI's being monitored closely to benchmark our performance nationally. In 24/25 we are seeing the impact of the focus on our recruitment with improvement in our national performance.
- Joint Research Vision, developed with University of Southampton, going to Senior Operational Group for review in June 2024, before being finalised by Joint Research Strategy Board in July 2024.
- UHS will be leading on a regional bid for an NIHR Commercial Clinical Research Delivery Centre which would consolidate the collaborative working across organisational boundaries, and secure access to future commercial clinical trial pipeline.
- Seeking funding from Wessex Health Partners to take forward outputs from Innovation workshop - to develop processes for UHS/UoS partnership and in longer term a UHS innovation strategy.
- Meeting with Solent Academy of Research & Improvement to share learning.

Key controls	Gaps in controls
Research strategy, approved by Board and fully funded. Always improving strategy, approved by the board and detailing the UHS improvement methodology. Partnership working with the University and other partners.	Operational pressures, limiting time for staff to engage in research & innovation. Limited capacity to support new studies and research areas, relating to hard to recruit areas, turnover, and existing clinical priorities. Research priorities with partners not necessarily led by clinical or operational need.

Clinical academic posts and training posts supporting strategies. Secured grant money. Host for new regional research delivery network, supporting regional working. Local ownership of development priorities, supported by the transformation team.	No overarching strategy to support innovation.
Key assurances	**Gaps in assurances**
Governance structure surrounding University partnership. Board to Council meetings. Joint Senior operational group. Joint Research Strategy Board. Joint executive group for research. Joint executive group for innovation. Joint Innovations and Commercialisation Group – UHS/UoS. Monitoring research activity funding and impact at R&D steering group. MHRA inspection and accreditation. Strategy and transformation process. CQC review of well-led criteria, including research and innovation.	Limited corporate approach to supporting innovation across the Trust. National benchmarking: previously ranking was below optimal although improvements are being seen since September 2023. Action plan underway.
Key actions	
Staff survey to test staff engagement and understanding of innovation at UHS. Deliver R&I Investment Case. Ongoing work to review investment and return. International Development Centre, attracting external funding to support staff in pursuing innovation. Execute an agreed joint programme of work with partners through establishing executive group for education. Maximise the benefits of the newly established Wessex Health Partnership as a founding member. Supporting departments in increasing recruitment and retention through work with R&D to create innovative roles. Review the Trust's approach to corporate-wide innovation.	

World class people

3a) We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles

Monitoring committee: People & Organisational Development Committee | **Executive leads:** CPO

Cause	Risk	Effect
Nationally directed financial restraints limiting workforce size and growth pose a risk, and this is compounded in some hard to fill professions and specialities by national and international shortages;	This could result in an inability to recruit the number and skill mix of staff required to meet current demand;	This may result in a suboptimal patient care and experience and may be damaging to staff engagement and morale.

Category	Appetite	Status
Workforce	Open *The current risk rating is outside of the stated risk appetite. The target rating is within the tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 4 16	April 2022	4 x 5 20	May 2024	4 x 3 12	March 2026

Risk progression: (previous 12 months)	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24
	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20

Current assurances and updates

- There are extensive recruitment controls in place presently which have been necessary to slow overall headcount growth in light of nationally directed financial pressures. However, this results in a tension between current clinical and operational demand and the workforce available.
- Affordable workforce limits are being agreed with all divisions and THQ.
- Workforce plan for 2024/25 submitted to ICB.
- Current turnover rate is acceptable at 11.5% and we are meeting the sickness target (rolling average of 3.8%).
- Plan for nursing recruitment agreed for 2024/25 including overseas recruitment, newly qualified recruitment, and domestic recruitment to ensure the overall nurse vacancy position is sustained.

Key controls	Gaps in controls
New 5-year People Strategy and clear objectives for Year 2 monitored through POD. Recruitment and resourcing processes. Workforce plan and overseas recruitment plan. General HR policies and practices, supported by appropriately resourced HR team. Temporary resourcing team to control agency and bank usage. Overseas recruitment including a reduced level of nurse vacancies. Recruitment campaign. Apprenticeships. Recruitment control process to ensure robust vacancy management against budget.	Completion and sign off of divisional and THQ affordable workforce limits underway. Completion of objectives for South-East temporary collaborative for 2024/25. People report for Board to be refreshed.

Workforce reviews to respond to specific recruitment and retention issues (e.g. the ACP review). Improved data reporting.	
Key assurances	**Gaps in assurances**
Fill rates, vacancies, sickness, turnover and rota compliance . NHSI levels of attainment criteria for workforce deployment. Annual post-graduate doctors GMC report. WRES and WDES annual reports - annual audits on BAME successes. Gender pay gap reporting. NHS Staff Survey results and pulse surveys. Joint finance and Workforce working group on data assurance. Temporary staffing collaborative diagnostic analysis on effectiveness.	Universal rostering roll out including all medical staff. Review of implications for education and training infrastructure from national workforce plan.
Key actions	
Approval of Year 3 objectives supporting delivery of the Trust's People Strategy. Deliver workforce plan for 2024/25 including increasing substantive staff in targeted areas offset by reducing temporary agency spend. To develop and implement Divisional Workforce Plans. Completion of objectives for South-East temporary collaborative for 2024/25. To implement a range of programmes to ensure turnover remains below 13.6%. To implement a range of measures to ensure our staff absence remains below 3.9%. To implement a range of measures to improve medical deployment. Ensure accuracy of leave allocation and recording for medical staff via Health roster for all care groups. Increase use of Health roster across medical staff groups.	

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
258	Maternity Staffing during peaks of activity	4 x 5 = 20	5 x 1 = 5	31/10/2024
578	Impact of reduced critical care outreach team service due to vacancy rate and skill mix on patient safety for adult deteriorating patients and ward based teams across UHS and personal health and wellbeing impact on CCOT ACPs.	4 x 4 = 16	2 x 2 = 4	31/12/2024
677	Workforce Resourcing - Insufficient resilience in the UHS network team to support mission critical infrastructure.	5 x 3 = 15	2 x 3 = 6	31/03/2024
705	Significant Risk to Service Provision for Neuroradiology	4 x 5 = 20	3 x 3 = 9	31/05/2024
746	Risk of harm to patients on a suspected cancer pathway if they are not triaged appropriately (PSC)	4 x 4 = 16	5 x 1 = 5	27/09/2024

World class people

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

Monitoring committee: People & Organisational Development Committee	**Executive leads:** CPO

Cause	Risk	Effect
If longstanding societal and NHS wide challenges surrounding inclusion and diversity, and current operational pressures on the NHS post covid, are not mitigated;	There is a risk that we will not recruit a diverse workforce with a range of skills and experience, and that we will not develop and embrace a positive and compassionate working culture where all staff feel valued;	Resulting in a detrimental impact to staff morale, staff burnout, higher absence and turnover, and the potential for reputational risk and possible litigation. This in turn has an impact on our patients when staff capacity cannot match clinical requirements, as we need to look after our staff to enable them to look after our patients.
Category	**Appetite**	**Status**
Workforce	Open *The current risk rating is within the tolerable risk appetite and the target risk rating is within the optimal risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 3 12	April 2022	4 x 3 12	May 2024	4 x 2 8	March 2027

Risk progression: (previous 12 months)	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24
	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12

Current assurances and updates

- Staff survey was published in March 2024 and results have been shared with TEC, People Board, and Trust Board. Areas of concern and required improvement reflected in People objectives for 2024/25.
- NHSE review of surgical training has resulted in enhanced monitoring from the GMC. Full action plan being implemented including completion of workshops with all consultants working within the area.
- Year 1 of the inclusion and belonging strategy complete; year 2 objectives set out for 2024/25 to be implemented.

Key controls	Gaps in controls
Great place to work including focus on wellbeing UHS wellbeing plan developed. Guardian of Safe Working Hours. Re-launched appraisal and talent management programme. Comprehensive employee recognition programme embedded including monthly staff spotlight and annual awards. **Building an inclusive and compassionate culture** Inclusion and Belonging Strategy signed off at Trust Board. Creation of a divisional steering group for EDI. FTSU guardian, local champions and FTSU policies. Diversity and Inclusion Strategy/Plans.	Ensure each network has dedicated leadershi to continue to support well-functioning and thriving networks. Coverage of allyship training to increase to 80% compliance by 31/03/2025. Launch of digital appraisal process. Improving implementation of national improving working lives actions for junior doctors following national letter May 2024.

Collaborative working with trade unions. Launch of the strategic leaders programme with a cohort of 24 across UHS. Senior leader programme launched. Positive action programme completed. Nurse specific positive action programme also launched. All leadership courses now include management of EDI issues and allyship training has been rolled out across the organisation with good uptake.	
Key assurances	**Gaps in assurances**
Great place to work including focus on wellbeing Annual NHS staff survey and introduction of quarterly pulse engagement surveys. Guardian of Safe Working Hours report to Board. Regular communications monitoring report Wellbeing guardian. Staff Networks. Exit interview process. Wellbeing Guardian and wellbeing champion. **Building an inclusive and compassionate culture** Freedom to Speak Up reports to Board. Qualitative feedback from staff networks data on diversity. Annual NHS staff survey and introduction of quarterly pulse engagement. Listening events with staff, regular executive walkabouts, talk to David session. Insight monitoring from social media channels. Allyship Programme. Gender Pay Gap reporting. External freedom to speak up and employee relations review.	Maturity of staff networks Maturity of datasets around EDI, and ease of interpretation
Key actions	
Building an inclusive and compassionate culture Deliver year 2 objectives of the Inclusion and Belonging strategy by March 2025: This includes: • To get to 85% of all staff having completed the Actional Allyship Training by March 2025. • To implement the 1st phase recommendations of the Inclusive Recruitment Programme • To deliver improvement plan in terms of experience of people with disabilities and long-term illness. • To deliver a programme of work to meet the NHSE Sexual Safety Charter standards and increase sexual safety at UHS. • Refresh the underpinning behaviours of our Trust Values and produce a new behaviours framework. This will underpin future leadership development and OD interventions.	

World class people

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

Monitoring committee: People & Organisational Development Committee	**Executive leads:** CPO

Cause	Risk	Effect
If there is: • Limited ability to recruit staff with suitable skills to support education; • Lack of current national education financing and changes in the way the education contract will function; • Inflexibility with apprenticeship regime;	This may be: • A lack of development for staff affecting retention and engagement; • Reduced staff skills and competencies; • Inability to develop new clinical practices.	This could result in: • An adverse impact of quality and effectiveness of patient care and safety; • An adverse impact on our reputation as a university teaching hospital; • Reduced levels of staff and patient satisfaction.

Category	Appetite	Status
Workforce	Open *The current risk rating is within tolerable appetite and the target risk rating is within optimal appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Long term target (I x L)	
3 x 3 9	April 2022	4 x 3 12	May 2024	3 x 2 6	March 2025

Risk progression: (previous 12 months)	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24
	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12

Current assurances and updates

- New national education funding contract published for consultation 29 Feb. Reduced resources and higher levels of control included.
- Reported inability of staff to participate in statutory, mandatory, and other training opportunities.
- TNA process completed for 2024/25. Allocations will be made when funding confirmed.

Key controls	Gaps in controls
Education Policy	Quality of appraisals
New leadership development framework, apprenticeships, secondments	Limitations of the current estate and access to offsite provision
In-house, accredited training programmes	Access to high-quality education technology
Provision of high quality clinical supervision and education	Estate provision for simulation training
Access to apprenticeship levy for funding	Staff providing education being released to deliver education, and undertake own development
Access to CPD funding from NHSE WTE and other sources	Releasing staff to attend core training, due to capacity and demand
Leadership development talent plan 2024/25	Releasing staff to engage in personal development and training opportunities
Executive succession planning	Limited succession planning framework, consistently applied across the Trust.
VLE relaunched to support staff to undertake self-directed learning opportunities.	Areas of concern in the GMC training survey

Key assurances	Gaps in assurances
Annual Trust training needs analysis reported to executive Trust appraisal process GMC/NETs Survey Education review process with NHSE WTE. Utilisation of apprenticeship levy. Talent development steering group People Board reporting on leadership and talent, quarterly	Need to develop quantitative and qualitative measures for the success of the leadership development programme Review of implications for education and training infrastructure from national workforce plan.

Key actions

To increase the proportion of appraisals completed and recorded to 85%, and increase staff quality perceptions on appraisal by March 2025.

Take specific targeted action to improve areas of low satisfaction in the GMC survey.

To continue to build the education strategic partnerships and capacity for delivery of the NHS workforce plan and UHS People Strategy Including:

- Continuing to develop our formal partnership with the new UTC
- Developing a partnership agreement with South Hampshire Colleges Group
- Developing a stronger partnership with Solent University
- Reviewing the education infrastructure requirements to support increases in placement capacity and quality (including T Level placements), preceptorship, apprenticeships and internationally educated registrants.
- Preparing UHS for changes to the national apprentice model in 25/26

To continue to develop the skills and capability of line managers through roll out of the leadership and management framework. Specifically to:

- Deliver a second year of leadership development framework including Strategic and Senior Leaders programmes, Operational Leaders and Implement Team Leaders Programmes.
- Run 2nd cohort of Human Leaders and integrate psychology and trauma informed approaches to leadership programmes.
- Roll out of a targeted programme of development for Care Group Clinical Lead

Integrated networks and collaboration

4a) We do not implement effective models to deliver integrated and networked care, resulting in suboptimal patient experience and outcomes, increased numbers of admissions, and increases in patients' length of stay

Monitoring committee: Quality Committee	**Executive leads:** CEO, CMO, Director of Networks & Strategy

Cause	Risk	Effect
Historical structures and culture have not encouraged or enabled collaborative networked pathways.	Growth in benign non-specialist activity could prevent UHS capacity being available for tertiary activity which can only be done at UHS.	Waiting times and outcomes for our tertiary work would be adversely impacted. Efficiencies arising from consolidation of specialities would not be realised.
Category	**Appetite**	**Status**
Effectiveness	Cautious *The current risk rating sits within the tolerable risk appetite and the target risk rating sits within the optimal risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Long term target (I x L)	
3 x 3 9	April 2022	3 x 3 9	May 2024	3 x 2 6	April 2025

Risk progression: (previous 12 months)	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24
	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9

Current assurances and updates

Participation in the Tim Briggs 'Further Faster' initiative is helpfully facilitating clinically led discussions with increased pace for dermatology, orthopaedics, ENT, spinal and ophthalmology. The primary purpose of the initiative is to increase productivity by, for example, increasing the number of cataracts performed on a list, but discussion for several specialties includes where services should be delivered. The UHS CEO is the SRO for this project and is ensuring alignment with UHS and overall ICB strategy.

The strategic intent is to bring the two ISTCs (RSH and St Mary's) back into NHS control when the current contracts with PPG expire. Commissioners are aligned and will support the change contractually.

Elsewhere, discussions with UHD regarding UGI surgery are ongoing. Practical implementation of new pathways and working arrangements, eg UHD surgeons operating in Southampton is, as always, difficult to achieve. Network arrangements in Urology, pelvic floor and plastics have also been prioritised for focus during 2024/25. The ICB and NHSE South East region have also requested that UHS work in collaboration with Portsmouth in consideration to upper GI.

A new programme oversight role has been appointed to the ICB to enable progress on clinical networks. We are engaging with this post; sharing priorities, opportunities and challenges with a view moving forward networks within HIOW ICB.

Key controls	Gaps in controls
Key leadership role within local ICS Key leadership role within local networked care and wider Wessex partnership UHS strategic goals and vision Establishment and development of Hampshire and Isle of Wight Acute Provider Collaborative (HIoW APC) Establishment of UHS Integrated Networks and Collaboration Board focussing on delivery of the four network types, (Integrated community, Hospital	Potential for diluted influence at key discussions Arrangements for specialised commissioning – delegated from centre to ICS – historically national and regional, rather than local Form and scope of role for HIoW APC in relation to ICS and other acute provider collaboratives Work to develop a shared pharmacy model with Portsmouth has been delayed, and the Trust is looking at alternative options.

networks, Specialised services and Diagnostic networks)	The costs associated with the Elective Hub in Winchester may have been underestimated. Additional funding sources may need identifying. Engagement and pace from organisations we are looking to partner with is not within our control.
Key assurances	**Gaps in assurances**
CQC and NHSE/I assessments of leadership CQC assessment of patient outcomes and experience National patient surveys Friends and Family Test Outcomes and waiting times reporting Integrated networks and collaborations Board set up for regular meetings at executive level	Trusts all under significant operational and financial pressure which is challenging prioritisation on elective networking. Specialised Commissioning budget delegation deferred until April 2024. Ability to network is difficult and manifests in capacity challenges.

Key actions

Integrated Networks and Collaboration

Urology Area Network plan agreed. Progress had stalled due to lack of programme management resource and clinical lead stepping down. This programme has now picked up again and new workstreams have been agreed. Challenges to moving forward related to aligning clinician's availability across multiple organisations.

Support for networks from clinical programme team continues. This is challenging due to lack of resources from other organisations and constrained resource within the UHS team. Integrated networks and collaboration project management post recruited to.

Business case for future working of the Southern Counties Pathology Network due for consideration by Trust Board in Q1 of 2024/25.

Business case development for aseptic services and elective hub by HIoW APC has been approved and is moving into the implementation phase.

Further development of HIoW APC to drive improvements in outcomes

Clinical leaders ICS forum has been started, this group is an opportunity to gain clarity on board level agreement on network opportunities and ways forward.

NHSE has approved the business case for the Elective Hub, this is a significant step forward and now moving ahead.

Tim Briggs, National Director of Clinical Improvement, and team supporting HIOW on 'Further Faster' programme.

Mr AK, Ophthalmology clinical lead, leading improvement work focussed on theatre productivity and point of access for cataract referral.

ICS agreement on clinical specialty focus including dermatology, ophthalmology, UGI and pelvic floor.

Funding for dermatology AI pathway secured.

HIOW ICS have recruited a new interim programme lead for clinical networks. We are engaging with this programme to support our networking ambitions.

A high level options paper has been developed for Upper GI across UHS and UHD, this will be coming to executives for review before development into a full case.

We have agreed to join in a collaborative with Salisbury NHSFT, enabling joint governance of clinical networking arrangements between our two organisations and regular review of opportunities. Principles for collaboration and TORs for a board have been developed. We are waiting on Salisbury's response on these to move forward with arranging regular board meetings.

A Pelvic floor networks away day has been booked for end of May, with attendees across acute, primary and community care and the ICB.

Work has begun on reviewing the Plastics model for UHS and Salisbury. A detailed review has been completed of activity against plan for all plastics services. An away day has been booked to review opportunities to improve services across both sites.

Planning underway to increase performance and meet targets for the Elective Recovery Fund supported by a common assumption across the system and leadership from David French for the ICS elective programme.

Foundations for the future

5a) We are unable to deliver a financial breakeven position resulting in:

- **Inability to move out of the NHS England Recovery Support Programme.**
- **NHS England imposing additional controls/undertakings.**
- **A reducing cash balance impacting the Trust's ability to invest in line with its capital plan, estates/digital strategies, and in transformation initiatives.**

Monitoring committee: Finance & Investment Committee	**Executive leads:** CFO

Cause	Risk	Effect
Due to existing and growing financial pressures including unfunded activity growth, system pressures (NCtR), workforce growth above funded levels, and challenges with the NHS payment infrastructure.	There is a risk that we will be unable to deliver a financial breakeven position;	This may result in the measures outlined above regarding the Recovery Support Programme, and the Trust's inability to invest and grow due to a reducing cash balance.
Category	**Appetite**	**Status**
Finance	Cautious *The current risk rating sits outside of the stated risk appetite, however the target risk rating is within the tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		**Current risk rating (I x L)**		**Long term target (I x L)**	
4 x 5 20	April 2022	3 x 5 15	May 2024	3 x 3 9	April 2025

Risk progression: (previous 12 months)	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24
	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	3 x 5 15	3 x 5 15	3 x 5 15

Current assurances and updates

- The risk rating remains unchanged, with a reduced risk score targeted by April 25 should we be successful in delivering our operation plan.
- Controls and assurances have been updated to reflect changes as we move into a new financial year.
- There is a lack of assurance over system-wide plans to deliver reductions in NCTR, mental health and corporate collaborations, worth £14m within our plan submission.
- System transformation programmes are currently forming new Delivery Units within each organisation. We have updated controls, but also reflected an assurance concern that this may divert resource away from existing trust-led initiatives.

Key controls	Gaps in controls
Internal • Financial strategy and Board approved financial plan. • Trust Savings Group (TSG) oversight of CIP programme. • Transformation Oversight Group (TOG) overseeing delivery of transformation programmes including financial benefits. • Implementation of revised recruitment controls, including setting revised divisional Affordable Workforce Limits • Robust business planning and bidding processes	**Internal** • Remaining unidentified and high-risk schemes within CIP programme. • Ability to control and reduce temporary staffing levels. **System wide/external** • Elements of activity growth unfunded via block contracts. • Lack of progress with out of hospital model to support reductions in NCTR and Mental Health.

• Robust controls over investment decisions via the Trust Investment Group and associated policies and processes • Monthly VFM meetings with each Care Group **System wide/external** Financial Recovery Programmes / Transformation Programmes: • Planned Care • Urgent & Emergency Care • Discharge • Local Care • Workforce • Mental Health Formation of new Delivery Units & mapping of UHS resources to support delivery. Improved "grip and control" measures with consistent application across all organisations.	
Key assurances	**Gaps in assurances**
• Regular finance reports to Trust Board & F&IC • Divisional performance on cost improvement reviewed by senior leaders – quarterly. • Trust Savings Group oversight of financial recovery plan and CIP programme actions • F&IC visibility and regular monitoring of detailed savings plans • Capital plan based on cash modelling to ensure affordability. • Regular reporting on movements in overall productivity.	• Current short-term nature of operational planning • No detailed system-wide plan yet produced to deliver reductions in NCTR or Mental Health. • Lack of reporting on system transformation initiatives to individual Trust Boards. • Concern over any further industrial action not incorporated into plan. • Concern that pay awards will not be fully funded. • Formation of Trust delivery units may take resource away from Trust programmes / lack of additional resource to deliver programmes.
Key actions	
• Finalise 24/25 plan to be agreed with NHSE. • Set Divisional/Directorate budgets and ensure appropriate sign-off of budgets, inclusive of revised AWL limits. • Reset CIP and transformation programmes based on 24/25 targets. • Review formation of Delivery Units to support system transformation programmes. • Reset organisational focus onto flow, theatres and outpatients' transformation programmes.	

Foundations for the future

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

Monitoring committee: Finance & Investment Committee	**Executive leads:** COO

Cause	Risk	Effect
If the cost of maintenance of our estate outweighs the available funding or does not offer value for money, or the works are too extensive to be able to complete without disruption to clinical services;	There is a risk that our estate will prohibit delivery and expansion of clinical services;	Resulting in an inability to meet the growing needs of our patients and potential health and safety risks to patients, staff and visitors if the estate is not fit for purpose.

Category	Appetite	Status
Effectiveness	Cautious *The current risk rating sits outside of our stated risk appetite. The target risk rating sits within our tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Long term target (I x L)	
4 x 4 16	April 2024	4 x 5 20	May 2024	4 x 2 8	April 2027

Risk progression: (previous 12 months)	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24
	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16

Current assurances and updates

- The risk rating has been reviewed and increased from 16 (4 x 5) to 20 (4 x 5) on the basis that the accumulative level of risk relating to the estate continues to increase without a sufficient level of funding available to address this. Therefore the likelihood of the impact materialising has been increased to certain. This, in conjunction with the recent (March) extension to the target date to mitigate this risk (from April 2025 to April 2027), evidences how significant the gap is between the level of risk we are holding at present and the level of risk we wish to reduce this to.
- The annual six facet survey has recently been completed and is being used to facilitate risk-based prioritisation of funding through the Trust Investment Group (TIG). This has highlighted 17 new operational risks which are being assessed ahead of addition to the operational risk register.
- Key areas of concern are an insufficient electrical supply, aged electrical systems, inadequate and aged ventilation systems, and aged water and sewage distribution.

Key controls	Gaps in controls
Multi-year estates planning, informed by clinical priorities and risk analysis	Missing funding solution to address identified gaps in the critical infrastructure.
Up-to-date computer aided facility management (CAFM) system	Missing funding solution to address procurement of new system.
	Timescales to address risks, after funding approval.
	Continuing revenue budget pressures to reduce costs as infrastructure is getting more costly to maintain
Asset register (90% in place)	Operational constraints and difficulty accessing parts of the site affecting pace of investment including refurbishment.
Maintenance schedules	Lack of decant facilities
Trained, accredited experts and technicians	Requires new CAFM system installing to fully understand gaps and address outstanding assets.

Asset replacement programme Construction Standards (e.g. BREEM/Dementia Friendly Wards etc.) Six Facet survey of estate informing funding and development priorities Estates masterplan 22-23 approved. Clear line of sight to Trust Board for all risks identified.	Reactive system requires re-prioritisation review. Planned maintenance will drop out of the asset register work. Recruitment controls inhibiting recruiting to key roles. Derogation policy to be introduced. Lack of Estates strategy for the next 5 years Missing process to highlight all 12+ risks from the six facet survey. Missing funding solution to deliver strategy.
Key assurances	**Gaps in assurances**
Compliance with HTM / HBN monitored by estates and reported for executive oversight Patient-Led Assessments of the Care Environment. Reported to QGSG. Statutory compliance audit and risk tool for estates assets Monitoring at Finance and Investment Committee, including progress of capital investment and review of critical infrastructure risk and updates to Six Facet survey Quarterly updates on capital plan and prioritisation to the Board of Directors	Derogation policy to be introduced. Gap in funding to respond to issues. Funding streams to be identified to fully deliver capacity and infrastructure improvements
Key actions	
Commence work on the estates strategy following the finalisation and agreement of the estates masterplan, including engagement with all clinical and non-clinical divisions. Being developed alongside the ICB infrastructure plan. Currently paused as funding has been withdrawn. Identify future funding options for additional capacity in line with the site development plan. Delivery of 2024/25 capital plan Implement the HIOW elective hub. Deliver £4.2m of critical infrastructure backlog maintenance. £3.5m in 2025/26. Agree plan for remainder of Adanac Park site Site development plan for Princess Anne hospital.	

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
34	Imminent failure of the pharmacy logistics robot	3 x 5 = 15	2 x 2 = 4	31/10/2024
260	Insufficient space in the induction of Labour Suite.	4 x 4 = 16	3 x 1 = 3	31/12/2024
262	Insufficient space on Maternity Day Unit	4 x 4 = 16	5 x 1 = 5	31/12/2024
489	Inadequate Ventilation in in-patient facilities	5 x 3 = 15	5 x 1 = 5	31/10/2024
548	HV West side transformer circuit breaker trip not operating	4 x 4 = 16	4 x 1 = 4	31/08/2024
817	Lack of UPS backup on power failure	5 x 3 = 15	5 x 1 = 5	30/09/2024

Foundations for the future

5c) Our digital technology or infrastructure fails to the extent that it impacts our ability to deliver care effectively and safely within the organisation

Monitoring committee: Finance & Investment Committee	**Executive leads:** COO

Cause	Risk	Effect
If there are inhibitors to implementing and sustaining digital technology either due to funding, capacity, technology, or resource constraints	This could mean that our digital technology or infrastructure is unable to support the Trust in delivering clinical, financial, or operational objectives	Resulting in an inability to deliver the right level of patient care required in line with Trust strategy
Category	**Appetite**	**Status**
Technology & Innovation	Open *The current risk rating is within the tolerable risk appetite and the target risk rating is within the optimal risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
3 x 4 12	April 2022	4 x 3 12	May 2024	3 x 2 6	March 2025

Risk progression: (previous 12 months)	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24
	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12

Current assurances and updates

- This risk has been reviewed in conjunction with the Chief Information Officer to identify the specific risks underpinning the overarching strategic risk and distinguish the key assurances (and gaps) for each:

- **The Trust suffers a significant cyber attack**.
  Investment in cyber infrastructure delivered to the Trust. Key cyber roles within Trust recruited (one remaining for recruitment).

- **There is a loss of access to critical IT systems**.
  Backups of systems, and network resilience, have been carefully considered and implemented. There is robust testing of developments, and a weekly departmental change control process to structure change.

- **There is a failure in physical network infrastructure**.
  The current Data Centre is end of life and requires a capital plan for replacement. There is currently no phased replacement of switch and network equipment.

- **Single points of failure in staffing**.
  Digital workforce plan created. Some critical posts filled. However, some areas – such as networking – do not have adequate rota cover.

Key controls	Gaps in controls
• Cyber security infrastructure in place. • Staff training on cyber risks, with regular refreshers and clear policies. • Absolute back ups of data created. • Business continuity plans developed for Digital team and Wards. • Robust system and regression testing completed on system developments. • Partial implementation of Digital workforce plan.	• Ability to enforce more robust training due to lack of time for staff training. • Penetration testing contract expires in October 2024, with no funding to renew until 2025/26. • Ability to implement workforce plan to retain staff needed to underpin strategy. • Cyber security and recovery capability requires ongoing investment and development. • Time to fully stress test business continuity plans.

• Inpatient noting for nursing has been rolled out to all appropriate wards. • New cyber infrastructure (firewall and email gateway) has been delivered. • All digital UPS tested.	
Key assurances	**Gaps in assurances**
Monthly executive-led digital programme delivery group meeting Finance oversight provided by the Finance and Investment Committee Quarterly Digital Board meeting, chaired by the CEO	Funding to cover the development programme, improvements, and clinical priorities Difficulties in understanding benefits realisation of digital investment. ICB outline business case funding for EPR
Key actions	
• Ongoing recruitment of key Digital resource to mitigate operational risk. • Inpatient noting for doctors scheduled for 24/25 • Replacement of key clinical systems to more modern systems: OpenEyes, LIMS, Alcidion scheduled in 24/25 • Development of Single EPR across HIOW to provide a more modern EPR • Identify opportunities for funding for digital transformation and programmes.	

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
650	Accommodation / Infrastructure - The trust's data and communications centre facilities are no longer suitable for supporting mission-critical IT services. There is an element of resilience across the network but all of the facilities described have significant problems.	4 x 4 = 16	3 x 1 = 3	31/03/2024
677	Workforce Resourcing - Insufficient resilience in the UHS network team to support mission critical infrastructure.	5 x 3 = 15	2 x 3 = 6	31/03/2024

Foundations for the future

5d) We fail to prioritise green initiatives to deliver a trajectory that will reduce our direct and indirect carbon footprint by 80% by 2028-2032 (compared with a 1990 baseline) and reach net zero direct carbon emissions by 2040 and net zero indirect carbon emissions by 2045

Monitoring committee: Trust Executive Committee	**Executive leads:** CMO

Cause	Risk	Effect
If we fail to deliver the current decarbonisation plan and build upon it to meet 2032 target.	This could lead to increased costs, reputational damage and potentially subject UHS to national scrutiny.	Resulting in higher costs, reduced national standing and reduced resilience
Category	**Appetite**	**Status**
Technology & Innovation	Open *Both the current and target risk rating is within the optimal risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Long term target (I x L)	
2 x 3 6	April 2022	2 x 3 6	May 2024	2 x 2 4	December 2024

Risk progression: (previous 12 months)	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24
	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6

Current assurances and updates

- Current decarbonisation plan does not complete journey to Net Zero and further steps will require funding to be sourced but continuing to identify opportunities, such as PSDS R5a expected October 24.
- Progress EPC Works – Veolia on site, established, met year one programme which lines us up to meet interim benefits in year 2.
- Secured £823k funding from the National Energy Efficiency Fund (NEEF) and have now nearly relaced all lights in Princess Anne to with LEDs, dramatically reducing energy consumption,
- Travel plans progressing well nearing final draft, and sustainable travel promotions through various avenues.
- Funding bid submitted to the Salix Low Carbon Skills fund, expecting confirmation of success by end July 24.
- Clinical Sustainability plan yet to be completed though several actions underway, including improvements to medical gas management and waste minimisation.
- Have now developed a dashboard-based set of metrics reporting to sustainability board.
- Develop metrics and establish governance processes in respect of the Trust's Green Plan and other related strategies.
- Progress being made to improve compliance with clinical waste

Key controls	**Gaps in controls**
Governance structure including Sustainability Board (with patient representation), Sustainability Delivery Group and Clinical Sustainability Group Appointment of Executive Lead for Sustainability Green Plan	Clinical Sustainability Plan/Strategy (CSP) Sustainable Development Management Plan (SDMP) Long-term energy/decarbonisation strategy Communications plan
Key assurances	**Gaps in assurances**
Progress against the NHS direct emission net zero target by 2040, with an ambition to reach an 80% reduction by 2028 to 2032. Progress against the NHS indirect emissions target to be net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.	Definition of and reporting against key milestones

Quarterly reporting to NHS England and NHS Improvement on sustainability indicators. Green Plan and Clinical Sustainability Programme has been approved by Trust Investment Group and Trust Board.	

Key actions
Agree funding requirements to commence the delivery of the strategies
Progress improvements to the Trust's estate and energy supply, including use of funding from the Public Sector Decarbonisation Scheme.
Develop metrics and establish governance processes in respect of the Trust's Green Plan and other related strategies.
Review green energy ambitions following extreme rises in electricity costs.
Forward plans to review energy contract.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Register of Seals and Chair's Actions**			
Agenda item:	**7.2**			
Sponsor:	**Jenni Douglas-Todd, Trust Chair**			
Date:	**6 June 2024**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification** **Y**	**Information**
Issue to be addressed:	This is a regular report to notify the Board of use of the seal and actions taken by the Chair in accordance with the Standing Financial Instructions and Scheme of Delegation for ratification.			
Response to the issue:	The Board has agreed that the Chair may undertake some actions on its behalf. There have been no Chair's actions since the last report.			
Implications: (Clinical, Organisational, Governance, Legal?)	Compliance with The NHS Foundation Trust Code of Governance (probity, internal control) and UHS Standing Financial Instructions and Scheme of Delegation.			
Risks: (Top 3) of carrying out the change / or not:				
Summary: Conclusion and/or recommendation	The Board is asked to **ratify** the application of the seal.			

1 Signing and Sealing

1.1 **Agreement** pursuant to Section 106 of the Town and Country Planning Act 1990 and other powers between Southampton City Council (the Council) and University Hospital Southampton NHS Foundation Trust (the Owner) relating to the Oncology Department Levels D & E at Southampton General Hospital, Tremona Road, Southampton, SO16 6YD. Seal number 273 on 26 April 2024.

1.2 **Agreement** pursuant to Section 106 of the Town and Country Planning Act 1990 and other powers between Southampton City Council (the Council) and University Hospital Southampton NHS Foundation Trust (the Owner) relating to the Blue Car Park, Southampton General Hospital, Tremona Road, Southampton, SO16 6YD. Seal number 274 on 26 April 2024.

1.3 **HM Land Registry Transfer** of whole of registered title(s) of 89 Laundry Road, Southampton SO16 6AQ (Property) from Christopher Andrew Hobbs and Valerie Mary Goodwin acting as Executors of the late Betty Kathleen Hobbs (Transferor) to University Hospital Southampton NHS Foundation Trust (Transferee). Seal number 275 on 7 May 2024.

2 Recommendation

The Board is asked to ratify the application of the seal.