University Hospital Southampton
NHS Foundation Trust

# Agenda Trust Board – Open Session

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| **Date** | 13/05/2025 |
| **Time** | 9:00 - 13:00 |
| **Location** | Conference Room, Heartbeat Education Centre |
| **Chair** | Jenni Douglas-Todd |
| **Apologies** | Keith Evans, Alison Tattersall |
| **In attendance** | Helena Blake, Head of Clinical Quality Assurance (shadowing Gail Byrne)<br>Raquel Domene Luque, Interim Lead Matron, Ophthalmology (shadowing Gail Byrne) |

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|---|---|---|
| **1** | 9:00 | **Chair's Welcome, Apologies and Declarations of Interest**<br>Note apologies for absence, and to hear any declarations of interest relating to any item on the Agenda. |
| **2** | | **Patient Story** *(This item has been postponed until the next meeting)*<br>The patient story provides an opportunity for the Board to reflect on the experiences of patients and staff within the Trust and understand what the Trust could do better. |
| **3** | | **Minutes of Previous Meeting held on 11 March 2025**<br>Approve the minutes of the previous meeting held on 11 March 2025 |
| **4** | | **Matters Arising and Summary of Agreed Actions**<br>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**<br>Quality includes: clinical effectiveness, patient safety, and patient experience |
| **5.1** | 9:10 | **Briefing from the Chair of the Audit and Risk Committee**<br>Keith Evans, Chair |
| **5.2** | 9:15 | **Briefing from the Chair of the Finance and Investment Committee**<br>Dave Bennett, Chair |
| **5.3** | 9:20 | **Briefing from the Chair of the People and Organisational Development Committee**<br>Jane Harwood, Chair |
| **5.4** | 9:25 | **Briefing from the Chair of the Quality Committee**<br>Tim Peachey, Chair<br>including Maternity and Neonatal Safety 2024-25 Quarter 3 Report |

**5.5** **Chief Executive Officer's Report**

9:30 Receive and note the report
Sponsor: David French, Chief Executive Officer

**5.6** **Performance KPI Report for Month 12**

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

**5.7** **Break**

10:40

**5.8** **Finance Report for Month 12**

10:55 Review and discuss the report
Sponsor: Ian Howard, Chief Financial Officer

**5.9** **ICS Finance Report for Month 12**

11:05 Receive and discuss the report
Sponsor: Ian Howard, Chief Financial Officer

**5.10** **People Report for Month 12**

11:10 Review and discuss the report
Sponsor: Steve Harris, Chief People Officer

**5.11** **UHS Annual Staff Survey Results 2024 Report**

11:20 Discuss and note the report
Sponsor: Steve Harris, Chief People Officer
Attendees: Ceri Connor, Director of OD and Inclusion/Sophie Limb, HR Project Manager

**5.12** **Guardian of Safe Working Hours Quarterly Report**

11:30 Receive and discuss the report
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Diana Hulbert, Guardian of Safe Working Hours and Emergency Department Consultant

**5.13** **Learning from Deaths 2024-25 Quarter 3 and 4 Reports**

11:40 Review and discuss the reports
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Jenny Milner, Associate Director of Patient Experience

**6** **STRATEGY and BUSINESS PLANNING**

**6.1** **Corporate Objectives 2024-25 Quarter 4 Review**

11:50 Review and feedback on the corporate objectives
Sponsor: David French, Chief Executive Officer
Attendees: Martin De Sousa, Director of Strategy and Partnerships/Kelly Kent, Head of Strategy and Partnerships

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

12:00 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

**6.3** **South Central Regional Research Delivery Network (SC RRDN) 2024-25 Annual Performance Review and 2025-26 Annual Plan**

12:10 Receive and note the annual report and plan
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Clare Rook, Chief Operating Officer, CRN: Wessex

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

**7.1** **Feedback from the Council of Governors' (CoG) meeting 29 April 2025 (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: 15 July 2025**

**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**

12:40

University Hospital Southampton NHS
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# Agenda links to the Board Assurance Framework (BAF)

13 May 2025 – Open Session

## Overview of the BAF

| Risk | Appetite (Category) | Current risk rating | Target risk rating | |
|---|---|---|---|---|
| 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. | Minimal (Safety) | 4 x 5 20 | 4 x 2 6 | Apr 27 |
| 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. | Cautious (Experience) | 3 x 3 9 | 3 x 2 6 | Mar 26 |
| 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. | Minimal (Safety) | 4 x 4 16 | 2 x 3 6 | Apr 27 |
| 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. | Open (Technology & Innovation) | 3 x 3 9 | 3 x 2 6 | Dec 25 |
| 3a: We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles. | Open (workforce) | 4 x 5 20 | 4 x 3 12 | Mar 26 |
| 3b: We fail to develop a diverse, compassionate, and inclusive workforce, providing a more positive staff experience for all staff. | Open (workforce) | 4 x 3 12 | 4 x 2 8 | Mar 27 |
| 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. | Open (workforce) | 4 x 4 16 | 3 x 2 6 | Mar 29 |
| 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. | Cautious (Effectiveness) | 3 x 3 9 | 3 x 2 6 | Dec 25 |
| 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. | Cautious (Finance) | 4 x 5 20 | 3 x 3 9 | Apr 30 |
| 5b: We do not adequately maintain, improve and develop our estate to deliver our clinical services and increase capacity. | Cautious (Effectiveness) | 4 x 5 20 | 4 x 2 8 | Apr 30 |
| 5c: Our digital technology or infrastructure fails to the extent that it impacts our ability to deliver care effectively and safely within the organisation, | Open (Technology & Innovation) | 3 x 4 12 | 3 x 2 6 | Apr 27 |
| 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. | Open (Technology & Innovation) | 2 x 3 6 | 2 x 2 4 | Dec 27 |

## Agenda links to the BAF

| No | Item | Linked BAF risk(s) | Does this item facilitate movement towards or away from the intended target risk score and appetite? | | |
|---|---|---|---|---|---|
| | | | Towards | Away | Neither |
| 5.6 | Performance KPI Report for Month 12 | 1a, 1b, 1c | | | X |
| 5.8 | Finance Report for Month 12 | 5a | | | X |
| 5.9 | ICS Finance Report for Month 12 | 5a | | | X |
| 5.10 | People Report for Month 12 | 3a, 3b, 3c | | | X |
| 5.11 | UHS Staff Survey Results 2024 Report | 3b | X | | |
| 5.12 | Guardian of Safe Working Hours Quarter 3 Report | 3b, 3c | X | | |
| 6.1 | Corporate Objectives 2024-5 Quarter 3 Review | All | | | X |
| 6.3 | South Central Regional Research Delivery Network Annual Performance Review and 2025-26 Annual Plan | 1b, 2a | X | | |

University Hospital Southampton
NHS Foundation Trust

# Minutes Trust Board – Open Session

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|---|---|
| **Date** | 11/03/2025 |
| **Time** | 9:00 – 13:00 |
| **Location** | Conference Room, Heartbeat/Microsoft Teams |
| **Chair** | Jenni Douglas-Todd (JD-T) |
| **Present** | Dave Bennett, NED (DB)<br>Gail Byrne, Chief Nursing Officer (GB)<br>Jenni Douglas-Todd, Chair (JD-T)<br>Diana Eccles, NED (DE)<br>Keith Evans, Deputy Chair and NED (KE)<br>David French, Chief Executive Officer (DAF)<br>Paul Grundy, Chief Medical Officer (PG)<br>Steve Harris, Chief People Officer (SH)<br>Jane Harwood, NED/Senior Independent Director (JH)<br>Ian Howard, Chief Financial Officer (IH)<br>Duncan Linning-Karp, Interim Chief Operating Officer (DL-K)<br>David Liverseidge, NED (DL)<br>Tim Peachey, NED (TP)<br>Alison Tattersall, NED (AT) |
| **In attendance** | Martin De Sousa, Director of Strategy and Partnerships (MDeS)<br>Craig Machell, Associate Director of Corporate Affairs and Company Secretary (CM)<br>Lauren Anderson, Corporate Governance and Risk Manager (LA) (item 6.2)<br>Kelly Kent, Head of Strategy and Partnerships (KK) (item 6.1)<br>2 members of the public (item 2)<br>5 governors (observing)<br>7 members of staff (observing)<br>1 members of the public (observing) |



**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.

**2. Patient Story**

Gregg and Serra [SURNAME] were invited to present their experience as the parents of a child who underwent successful open-heart surgery at Southampton General Hospital in September 2024, having been diagnosed with an atrioventricular septal defect in 2023. It was noted that:

- The care provided by the Trust's staff had been exceptional, including for being able to put matters into layman's terms to assist understanding.
- The interaction between staff and the child patient was also praised, with the parents reporting that their child had been viewed first of all as a person, rather than as simply another patient.

**3. Minutes of the Previous Meeting held on 7 January 2025**

The draft minutes tabled to the meeting were agreed to be an accurate record of the meeting held on 7 January 2025.

**4. Matters Arising and Summary of Agreed Actions**

An update was provided in respect of the following actions:

- 1200: it was noted that discussions had been had with Natasha Watts and Jenny Milner and the action was ongoing.
- 1201: it was noted that an update would be presented in the closed session of the meeting.
- 1202: the Trust had written to the Integrated Care Board.
- 1203: it was noted that a meeting had been arranged to discuss Freedom to Speak Up on 21 March 2025.

**5. QUALITY, PERFORMANCE and FINANCE**

**5.1 Briefing from the Chair of the Audit and Risk Committee**

The chair of the Audit and Risk Committee was invited to present the Committee Chair's Report in respect of the meeting held on 20 January 2025, the content of which was noted. It was further noted that:

- The committee considered the accounting policies and management judgements for the 2024/25 annual accounts.
- The committee reviewed the Trust's compliance with the Code of Governance for NHS Provider Trusts, noting that the Trust was compliant in all areas or had appropriate explanations for the few areas of non-compliance.
- The committee had received a report on cyber risk, noting that the main risk was from suppliers not having adequate protection and the Trust's operations being impacted as a result of the loss of service.
- The committee considered a report in respect of the risk of individuals impersonating agency staff and noted the Trust's controls to mitigate against this risk.

**5.2 Briefing from the Chair of the Finance and Investment Committee**

The chair of the Finance and Investment Committee was invited to present the Committee Chair's Reports in respect of the meetings held on 27 January and 24 February 2025, the content of which was noted. It was further noted that:

- The committee reviewed the Finance Report for Month 10 (item 5.8), noting that the Trust was forecasting a year-end deficit of £17.65m and delivery of £76m in efficiencies under the Cost Improvement Programme.
- It was further noted that the Trust was anticipating that it would have carried out c.£40m of unpaid activity by the end of the year.
- The committee considered a draft of the Trust's annual plan submission, noting that 2025/26 would present a significant challenge.

**5.3 Briefing from the Chair of the People and Organisational Development Committee**

The chair of the People and Organisational Development Committee was invited to present the Committee Chair's Reports in respect of the meetings held on 24 January and 24 February 2025, the content of which was noted. It was further noted that:

- The committee reviewed the People Report for Month 10 (item 5.10), noting that whilst the Trust was forecasting to be 125 whole-time-equivalents (WTE) above its 2024/25 plan, the total substantive workforce would be 50 WTE lower than in March 2024.
- There had been high levels of sickness absence over the period, which had resulted in increased use of bank staff. Concern was expressed in respect of the low uptake rate for vaccinations by staff compared to previous years.

- Appraisal rates were lower than anticipated, but it was possible that this was due to issues with the transfer of recording of appraisals to the Virtual Learning Environment system.

**5.4 Briefing from the Chair of the Quality Committee**

The chair of the Quality Committee was invited to present the Committee Chair's Report in respect of the meeting held on 27 January 2025, the content of which was noted. It was further noted that:

- The committee had received an update in respect of the 'Fundamentals of Care' programme and noted that the programme was progressing well.
- The committee reviewed the progress of the Always Improving outpatients and discharge programmes.
- The committee reviewed the interim Maternity and Neonatal Safety Report, noting that there was nothing to escalate to the Board.

**5.5 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:

- There had been significant changes in the leadership of NHS England with effectively all executive directors having resigned. Furthermore, there were expected to be significant reductions in the NHS England workforce and changes in the relationship between NHS England and the Department for Health and Social Care.
- The Trust had received a request to provide feedback on a proposed management and leadership standard for the NHS. The Trust intended to respond to the consultation.
- Concerns had been raised in respect of the Trust's adult cardiac waiting list due to a mismatch in referrals against operations performed, which had resulted in an improvement plan being submitted to NHS South East Region and a quality visit on 4 February 2025. The Trust's congenital cardiac team was also under pressure due to insufficient capacity.
- Positive feedback had been received following a visit to the Trust's maternity services by NHS South East Region and the Local Maternity and Neonatal System team.
- On 28 February 2025, the Trust had announced the opening of the refurbished Muslim prayer room facilities.
- The Trust's mechanical thrombectomy service was now a 24/7 service and that it was expected that the service would treat up to 1,200 patients a year over the next five years.
- Dr Stephen Harden, a consultant in cardiothoracic radiology at the Trust, had been elected as the incoming president of the Royal College of Radiologists for a three-year term commencing on 1 September 2025.

**5.6 Performance KPI Report for Month 10**

Duncan Linning-Karp was invited to present the Performance KPI Report for Month 10, the content of which was noted. It was further noted that:

- The Emergency Department remained under significant pressure due to the level of attendances (11,728 during January 2025), with performance against the four-hour wait target being 61% in January 2025 and 55% in February 2025.
- The average number of patients having no criteria to reside was 232 during January 2025.
- The Trust's performance in respect of the 62- and 28-day cancer targets remained high at 79.1% and 83.6% respectively for December 2024. The

Trust's performance in these areas was higher than the national targets for March 2026.

- Compared to equivalent teaching hospitals, the Trust was second in the country for 65-week waits and joint first in the country for 78-week waits. It was expected that the outstanding 65-week wait patients at March 2025 would be limited to those awaiting material for corneal transplants, of which there was a national shortage, and a small number of complex patients.
- The Trust's mortality rate had fallen as expected and the Trust was ranked as having one of the lowest mortality rates in England.
- There had been an increase in the number of incidents of pressure ulcers during January and February 2025. It was noted that often there was an increased number of patients with co-morbidities during the winter months, who were at greater risk of developing pressure ulcers.
- Whilst staffing levels had been problematic during September and October 2024 in the Maternity service, the situation had since improved as newly-qualified nurses became substantive.
- Further work was ongoing to promote wider use of virtual clinics as an alternative to face-to-face appointments.
- The Trust was intending to spend £1.5m on hardware by the end of the year to address the issues caused by the average age of the Trust's IT estate.

**Action**
Craig Machell agreed to add A/I to a future Trust Board Study Session agenda.

Gail Byrne agreed to present a deep-dive on pressure ulcers to the Quality Committee.

**5.7 Break**

**5.8 Finance Report for Month 10**
Ian Howard was invited to present the Finance Report for Month 10, the content of which was noted. It was further noted that:

- The Trust had been working with system partners to agree a 'landing plan' for the system for 2024/25 to deliver a break-even position. The Trust's forecast was for a year-end deficit of £17.65m.
- The Trust had recorded a £7.5m in-month surplus and a year-to-date deficit of £15.2m, £11.8m behind its plan. However, there remained an underlying deficit of c.£6.5m, which would pose a significant challenge for 2025/26.
- The Trust was forecasting to have insufficient cash in May 2025 and therefore would require additional cash support. It was noted that cash support would require certain commitments from applicants and that requests were not always fulfilled.
- The messaging from NHS England appeared to be that difficult decisions would be required to deliver a financially sustainable NHS and that there would be no additional funding. It was noted that a number of these decisions would be better made at a national level to ensure consistency across the country.

**5.9 ICB Finance Report for Month 10**
The ICB Finance Report for Month 10 was noted.

**5.10 People Report for Month 10**
Steve Harris was invited to present the People Report for Month 10, the content of which was noted. It was further noted that:

- Unison had put an offer to its members to resolve the dispute over Band 2/3 pay. It was expected that the vote would conclude at the end of March 2025.
- The consultation in respect of the transfer of staff to UHS Estates Limited had progressed well, with the transfer expected to take place on 1 April 2025.
- Progress continued to be made in respect of the action plan agreed with portering staff.
- The Trust had exceeded its workforce plan by 153 whole-time-equivalents (WTE) at the end of January 2025. There had been a significant increase in use of bank staff due to continued high levels of sickness absence and the need to open surge capacity.
- It was forecast that the Trust would be 125 WTE above its plan for 2024/25. It was noted that the Trust had anticipated a reduction in staffing numbers of c.220 WTE due to reductions in patients having no criteria to reside and delivery of system transformation programmes. However, these assumptions had not materialised.

**5.11 Mortuary Standards Compliance Update**

Gail Byrne was invited to provide an update in respect of the actions required following the Fuller Inquiry, the content of which was noted. It was further noted that:

- The action plan and outputs from the Fuller Inquiry had been presented to the Board at its meeting held on 6 June 2024.
- It was noted that all the actions identified had been completed.

**6. STRATEGY and BUSINESS PLANNING**

**6.1 Corporate Objectives 2024-25 Quarter 3 Review**

Martin De Sousa and Kelly Kent were invited to present the 'Corporate Objectives 2024-25 Quarter 3 Review', the content of which was noted. It was further noted that fifty per cent of objectives were on track to be delivered in full (a reduction compared to the second quarter), 37.5% were amber and 12.5% were red.

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

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

- There were six risks rated as 'critical' (i.e. 15 or above), with one risk (risk 3c) having been upgraded from 12 due to increased likelihood given reductions in the available funding and workforce.
- The target dates for six risks had also been extended, including two out to April 2030 due in part to uncertainty in respect of funding availability.

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

**7.1 Feedback from the Council of Governors' (CoG) meeting 29 January 2025**

The Chair presented a summary of the Council of Governors' meeting held on 29 January 2025. It was noted that the meeting had considered the following matters:

- Chief Executive Officer's Performance Report

- Chair and Non-Executive Director Appraisal Process
- Audit and Risk Committee Terms of Reference
- Governors' Nomination Committee Terms of Reference
- Annual Business Plan
- Noting the appointment of David Liverseidge following the original approval given in 2024.
- Governor Attendance
- Membership Engagement

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

The paper 'Register of Seals and Chair's Actions Report' was presented to the meeting, the content of which was noted. It was further noted that the following items had been sealed on 7 March 2025:

- TP1 Land Registry between University Hospital Southampton NHS Foundation Trust and Prime Infrastructure Management Services 4 Limited (the Transferor) and University Hospital Southampton NHS Foundation Trust (Transferee) relating to Land forming part of an accessway adjoining Plot 2, Bargain Farm, Frogmore Lane, Nursling, Southampton, Hampshire SO16 0XS. Seal number 291 on 7 March 2025
- TP1 Land Registry between University Hospital Southampton NHS Foundation Trust and Prime Infrastructure Management Services 4 Limited (Transferor) and University Hospital Southampton NHS Foundation Trust (the Transferee) relating to Land forming part of an accessway adjoining Plot 2, Bargain Farm, Frogmore Lane, Nursling, Southampton, Hampshire SO16 0XS. Seal number 292 on 7 March 2025.
- Underlease between Just Retirement Limited (the Landlord) and University Hospital Southampton NHS Foundation Trust (the Tenant) relating to Aseptic Pharmacy and Offices on the Ground, 1st and 2nd Floors at Plot 2 Adanac Health and Innovation Campus, Nursling, Southampton, Hampshire SO16 0XS. Seal number 293 on 7 March 2025.
- Reversionary Underlease between Just Retirement Limited (the Landlord) and University Hospital NHS Foundation Trust (the Tenant) relating to Ground and first Floor Sterile Services Unit and Offices at Plot 2 Adanac Health and Innovation Campus, Nursling, Southampton, Hampshire SO16 0XS. Seal number 294 on 7 March 2025.
- Underlease between Just Retirement Limited (the Landlord), IHSS Limited (the Tenant) and University Hospital Southampton NHS Foundation Trust (the Trust) relating to Ground and first Floor Sterile Services Unit and Offices at Plot 2 Adanac Health and Innovation Campus, Nursling, Southampton, Hampshire SO16 0XS. Seal number 295 on 7 March 2025.
- Sub-Underlease between University Hospital NHS Foundation Trust (Landlord) and UHS Estates Limited (Tenant) of Aseptic Pharmacy and Offices on the Ground, 1st and 2nd Floors at Plot 2 Adanac Health and Innovation Campus, Nursling, Southampton, Hampshire SO16 0XS. Seal number 296 on 7 March 2025.

**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' and in respect of the items listed above.

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

Craig Machell was invited to present the proposed changes to the Audit and Risk Committee's Terms of Reference, the content of which was noted. It was further noted that:

- The Audit and Risk Committee had reviewed its terms of reference at its meeting on 20 January 2025, following which input had been sought from the Council of Governors at its meeting held on 29 January 2025.
- It was proposed to amend a reference in paragraph 10.2 and to update Appendix A.

**Decision**
Having considered the proposed amendments to the Audit and Risk Committee's Terms of Reference, the Board approved the changes.

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

Craig Machell was invited to present the proposed changes to the Finance and Investment Committee's Terms of Reference, the content of which was noted. It was further noted that:

- The Finance and Investment Committee had reviewed its terms of reference at its meeting on 27 January 2025.
- It was proposed to update Appendix A.

**Decision**
Having considered the proposed amendments to the Finance and Investment Committee's Terms of Reference, the Board approved the changes.

**7.5 Quality Committee Terms of Reference**

Craig Machell was invited to present the proposed changes to the Quality Committee's Terms of Reference, the content of which was noted. It was further noted that:

- The Quality Committee had reviewed its terms of reference at its meeting on 27 January 2025.
- It was proposed to amend a reference in paragraph 10.2 and to update Appendix A.

**Decision**
Having considered the proposed amendments to the Quality Committee's Terms of Reference, the Board approved the changes.

**7.6 Remuneration and Appointment Committee Terms of Reference**

Craig Machell was invited to present the Remuneration and Appointment Committee's Terms of Reference, the content of which was noted. It was further noted that:

- The Remuneration and Appointment Committee had reviewed its terms of reference at its meeting on 11 March 2025.
- No changes were proposed.

**Decision**
Having considered the Remuneration and Appointment Committee's Terms of Reference, the Board approved the terms of reference.

**7.7 Trust Executive Committee Terms of Reference**

Craig Machell was invited to present the proposed changes to the Trust Executive Committee's Terms of Reference, the content of which was noted. It was further noted that:

- The Trust Executive Committee (TEC) had reviewed its terms of reference at its meeting on 12 February 2025.
- It was noted that the most significant amendments were in respect of the following:
    - Introduction of the pre-TEC process for business cases requiring additional expenditure;
    - The role of the TEC as a forum for discussion of significant strategic matters;
    - The TEC's role in identification of opportunities for system collaboration;
    - Updates to reflect the current role of the Trust Investment Group and the TEC under the Standing Financial Instructions; and
    - Other amendments to add clarity about the TEC's operation and reports received.

**Decision**
Having considered the proposed amendments to the Trust Executive Committee's Terms of Reference, the Board approved the changes.

**8. Any other business**

There was no other business.

**9. Note the date of the next meeting: 13 May 2025**

**10. Items circulated to the Board for reading**

The item circulated to the Board for reading was noted. There being no further business, the meeting concluded.

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

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

The meeting was adjourned.

List of action items

| Agenda item | | Assigned to | Deadline | Status |
|---|---|---|---|---|
| Trust Board – Open Session 25/07/2024 5.4 Briefing from the Chair of the Quality Committee (Oral) | | | | |
| 1163. | Impact of technology | Machell, Craig | 03/06/2025 | Pending |
| | *Explanation action item*<br>Craig Machell agreed to add an item covering the impact of technology over the next 5-10 years to a future Trust Board Study Session agenda.<br><br>Update: Item deferred to Study Session on 03/06/2025. | | | |
| Trust Board – Open Session 07/01/2025 5.13 Infection Prevention and Control 2024-25 Quarter 2 Report | | | | |
| 1204. | Infection prevention | Byrne, Gail | 03/06/2025 | Pending |
| | *Explanation action item*<br>Gail Byrne agreed to include an item on infection prevention control at a future Trust Board Study Session to include details of an Australian study, point of care testing, and progress on the roll out of the Fundamentals of Care programme.<br><br>Update: Item tentatively scheduled for TBSS on 03/06/2025. | | | |
| Trust Board – Open Session 11/03/2025 5.6 Performance KPI Report for Month 10 | | | | |
| 1217. | Artificial Intelligence (A/I) | Machell, Craig | 03/06/2025 | Pending |
| | *Explanation action item*<br>Craig Machell agreed to add A/I to a future Trust Board Study Session agenda.<br><br>Update: Tentatively scheduled for TBSS on 03/06/2024. | | | |

| Agenda item | | Assigned to | Deadline | Status |
|---|---|---|---|---|
| Trust Board – Open Session 11/03/2025 5.6 Performance KPI Report for Month 10 | | | | |
| 1218. | Pressure ulcers | Byrne, Gail | 13/05/2025 | Pending |
| | *Explanation action item*<br>Gail Byrne agreed to present a deep-dive on pressure ulcers to the Quality Committee. | | | |

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**Agenda item 5.1**

| **Committee Chair's Report to the Trust Board of Directors 13 May 2025** | | | |
|---|---|---|---|
| **Committee:** | **Audit & Risk Committee** | | |
| **Meeting Date:** | **17 March 2025** | | |
| **Key Messages:** | • The committee considered the going concern assessment for the 2024/25 accounts and agreed that the accounts should be prepared on a 'going concern' basis.<br>• The external auditor reported that there had been no significant issues resulting from the transfer to a new finance system.<br>• The committee received a report on losses and special payments during 2024/25 and noted that the levels were similar to previous years. These payments were generally related to lost patient property.<br>• The committee reviewed the Trust's Treasury Policy, confirmed the current bank mandate and approved certain minor changes to the Treasury Policy.<br>• An update was received in respect of Information Governance. It was noted that the Trust – in common with most others – was not expected to meet the standards set out in the Data Security and Protection Toolkit for 2024/25 due to the introduction of the Cyber Assurance Framework. The Trust had reported six breaches to the Information Commissioner since 1 January 2024, but none of the incidents resulted in further action on the part of the regulator.<br>• The committee agreed the Fraud team's work plan for 2025/26. | | |
| **Assurance:** *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)* | **6.2 Board Assurance Framework (BAF) Update** | ***Assurance Rating:*** **Substantial** | ***Risk Rating:*** **N/A** |
| | • All risks had been reviewed with the relevant executive director(s).<br>• It was suggested that Risk 3c should be reconsidered in terms of what the main risk was given the increase in risk rating to 16, particularly whether the main concern was running out of trained staff as opposed to being unable to deliver training and development. | | |
| **Any Other Matters:** | • The committee reviewed the outputs from the internal audit reports in respect of rostering, the discharge process, and core financial controls noting that there was nothing significant which required escalation to the Board. | | |

## Assurance Rating:

| | |
|---|---|
| **Substantial Assurance** | There is a robust series of suitably designed internal controls in place upon which the organisation relies to manage the risk of failure of the continuous and effective achievement of the objectives of the process, which at the time of our review were being consistently applied. |
| **Reasonable Assurance** | There is a series of controls in place, however there are potential risks that may not be sufficient to ensure that the individual objectives of the process are achieved in a continuous and effective manner. Improvements are required to enhance the adequacy and effectiveness of the controls to mitigate these risks. |
| **Limited Assurance** | Controls in place are not sufficient to ensure that the organisation can rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Significant improvements are required to improve the adequacy and effectiveness of the controls. |

| | |
|---|---|
| **No Assurance** | There is a fundamental breakdown or absence of core internal controls such that the organisation cannot rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Immediate action is required to improve the adequacy and effectiveness of controls. |
| **Not Applicable** | Where assurance is not required and/or relevant. |

**Risk Rating:**

| | |
|---|---|
| **Low** | Based on the report considered by the committee, there is little or no concern that the Trust will be unable to meet its stated objectives and/or plans. |
| **Medium** | There is some concern that the Trust might not be able to fully meet its stated objectives and/or plans based on the information contained in the report considered by the committee. |
| **High** | There is a significant risk that the Trust will not be able to meet its stated objectives and/or plans based on the information contained in the report considered by the committee. |
| **Not Applicable** | Where risk rating is not relevant. |

University Hospital Southampton
NHS Foundation Trust

**Agenda Item 5.2 i)**

| **Committee Chair's Report to the Trust Board of Directors 13 May 2025** | |
|---|---|
| **Committee:** | **Finance & Investment Committee** |
| **Meeting Date:** | **24 March 2025** |
| **Key Messages:** | • The committee received an update in respect of the Trust's 2025/26 annual plan. It was noted that the NHS in England was forecasting a deficit of £6.6bn, which had resulted in significant intervention by Government, including the abolition of NHS England and 50% reductions in integrated care boards' costs. These reductions would be supplemented by a national mutually agreed resignation scheme.<br>• The Trust anticipated running out of cash in May 2025, but it was understood that cash support would no longer be provided.<br>• The Hampshire and Isle of Wight Integrated Care System was aiming to reach a breakeven position in 2025/26. This would necessitate additional controls on recruitment and 5-10% reductions in expenditure/headcount as well as achievement of challenging Cost Improvement Programme targets.<br>• The committee reviewed the Finance Report for Month 11. It was noted that the Trust had recorded an in-month surplus of £8.2m due to a number of one-off items. There had been an increase in the use of bank staff due to the need to open surge capacity and the demand resulting from patients with mental health issues.<br>• The committee received an update in respect of the transformation plans regarding the 'living within our means', urgent and emergency care, and elective care recovery workstreams.<br>• The committee reviewed the quarterly update from Estates, Facilities and Capital Development. It was noted that there was a plan for removal of all reinforced autoclaved aerated concrete (RAAC) on the Southampton General Hospital site. It was further noted that the steam ducts on the site continued to be an issue and there was a risk that the Trust was at the limit for electricity usage on the site. |
| **Assurance:** *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)* | N/A |
| **Any Other Matters:** | The committee considered a business case in respect of a Hampshire and Isle of Wight Elective Hub in Winchester. It was noted that this proposal was reviewed and approved at the Trust Board meeting on 25 March 2025. |

## Assurance Rating:

| | |
|---|---|
| **Substantial Assurance** | There is a robust series of suitably designed internal controls in place upon which the organisation relies to manage the risk of failure of the continuous and effective achievement of the objectives of the process, which at the time of our review were being consistently applied. |

| | |
|---|---|
| **Reasonable Assurance** | There is a series of controls in place, however there are potential risks that may not be sufficient to ensure that the individual objectives of the process are achieved in a continuous and effective manner. Improvements are required to enhance the adequacy and effectiveness of the controls to mitigate these risks. |
| **Limited Assurance** | Controls in place are not sufficient to ensure that the organisation can rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Significant improvements are required to improve the adequacy and effectiveness of the controls. |
| **No Assurance** | There is a fundamental breakdown or absence of core internal controls such that the organisation cannot rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Immediate action is required to improve the adequacy and effectiveness of controls. |
| **Not Applicable** | Where assurance is not required and/or relevant. |

**Risk Rating:**

| | |
|---|---|
| **Low** | Based on the report considered by the committee, there is little or no concern that the Trust will be unable to meet its stated objectives and/or plans. |
| **Medium** | There is some concern that the Trust might not be able to fully meet its stated objectives and/or plans based on the information contained in the report considered by the committee. |
| **High** | There is a significant risk that the Trust will not be able to meet its stated objectives and/or plans based on the information contained in the report considered by the committee. |
| **Not Applicable** | Where risk rating is not relevant. |

University Hospital Southampton
NHS Foundation Trust

**Agenda Item 5.2 ii)**

<table>
<tr><td colspan="4">Committee Chair's Report to the Trust Board of Directors<br>13 May 2025</td></tr>
<tr><td>Committee:</td><td colspan="3">Finance and Investment Committee</td></tr>
<tr><td>Meeting Date:</td><td colspan="3">28 April 2025</td></tr>
<tr><td>Key Messages:</td><td colspan="3">• The committee reviewed the Finance Report for Month 12 (see below).<br>• The committee received an update in respect of the Trust's cash position, noting that the Trust's cash position had been relatively stable during the fourth quarter due to receipt of additional one-off funding and careful supplier payment management. However, the Trust was highly likely to require cash support in either Q1 or Q2.<br>• The committee noted the report from the Trust's digital services, noting the successful negotiation of a discount for purchasing new laptops due to the number required. In addition, there had been a leak in GICU which had impacted the switch network, but which had since been rectified. It was further noted that, during the first months of the year, the Trust had blocked more attempted cyber attacks than in the whole of 2024.<br>• It was noted that trusts had been set challenging targets for reducing the size of their corporate services, and as such were expected to reduce the size of these services by 50% of the growth since 2018/19.<br>• The committee received an update on the Trust's 2025/26 capital plan, noting that the plan was under review owing to the Trust's cash position. In addition, it had been agreed to prioritise maintaining the Trust's level of expenditure on strategic maintenance and to defer the refurbishment of the neuro theatres.<br>• The committee reviewed the update from the Trust's commercial team, including in respect of private and overseas patients, the proposed private patient unit, and Adanac Park.<br>• The committee supported the Trust's participation in the proposed Elective Hub at Winchester.</td></tr>
<tr><td rowspan="5">Assurance:<br>(Reports/Papers reviewed by the Committee also appearing on the Board agenda)</td><td>5.8 Finance Report for Month 12</td><td>Assurance Rating:<br>Substantial</td><td>Risk Rating:<br>High</td></tr>
<tr><td colspan="3">• The Trust had successfully ended the year at where it expected to do so with a deficit of £7m at year end.<br>• The Trust's underlying position remained a concern with a £6.9m deficit recorded during the month.<br>• The committee reviewed the high use of bank staff during months 8 to 12, noting that the Trust had opened surge capacity during this period and was experiencing significant demand.<br>• The Trust had achieved 127% elective recovery performance against the national target of 113%, and had also delivered its 2024/25 Cost Improvement Programme target in full (£85m).<br>• The Trust had also spent £96m of capital during 2024/25.</td></tr>
<tr><td>6.2 Board Assurance Framework (BAF) Update</td><td>Assurance Rating:<br>Substantial</td><td>Risk Rating:<br>N/A</td></tr>
<tr><td colspan="3">• Risks 5a, 5b and 5c have been updated, following discussions with the respective Executive Director(s).</td></tr>
</table>

| | |
|---|---|
| | • The committee discussed whether the 2030 target for risk 5b was realistic and whether the rating to be achieved by 2030 should be increased. |
| **Any Other Matters:** | N/A |

## Assurance Rating:

| | |
|---|---|
| **Substantial Assurance** | There is a robust series of suitably designed internal controls in place upon which the organisation relies to manage the risk of failure of the continuous and effective achievement of the objectives of the process, which at the time of our review were being consistently applied. |
| **Reasonable Assurance** | There is a series of controls in place, however there are potential risks that may not be sufficient to ensure that the individual objectives of the process are achieved in a continuous and effective manner. Improvements are required to enhance the adequacy and effectiveness of the controls to mitigate these risks. |
| **Limited Assurance** | Controls in place are not sufficient to ensure that the organisation can rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Significant improvements are required to improve the adequacy and effectiveness of the controls. |
| **No Assurance** | There is a fundamental breakdown or absence of core internal controls such that the organisation cannot rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Immediate action is required to improve the adequacy and effectiveness of controls. |
| **Not Applicable** | Where assurance is not required and/or relevant. |

## Risk Rating:

| | |
|---|---|
| **Low** | Based on the report considered by the committee, there is little or no concern that the Trust will be unable to meet its stated objectives and/or plans. |
| **Medium** | There is some concern that the Trust might not be able to fully meet its stated objectives and/or plans based on the information contained in the report considered by the committee. |
| **High** | There is a significant risk that the Trust will not be able to meet its stated objectives and/or plans based on the information contained in the report considered by the committee. |
| **Not Applicable** | Where risk rating is not relevant. |

University Hospital Southampton
NHS Foundation Trust

**Agenda Item 5.3 i)**

| **Committee Chair's Report to the Trust Board of Directors 13 May 2025** | | | |
|---|---|---|---|
| **Committee:** | **People & Organisational Development Committee** | | |
| **Meeting Date:** | **24 March 2025** | | |
| **Key Messages:** | • The committee reviewed the People Report for Month 11. It was noted that February 2025 had continued to be challenging due to high sickness rates, with the Trust close to calling a critical incident. This had driven much higher bank rates. There had been a lower than forecast number of leavers during the month (44 whole-time-equivalents (WTE) against a forecast of 100). The Trust was 267 WTE above its plan.<br>• The Trust's draft Workforce Plan for 2025/26 was reviewed. The Trust was required to deliver a breakeven plan. Accordingly, the Trust was anticipating a freeze on all non-clinical vacancies and holding 30% of clinical vacancies. In addition, there would potentially be a target to reduce headcount by 5-10% as well as additional reductions in use of bank and agency staff. It was further proposed to reorganise the four existing Divisions into three in order to deliver efficiencies. It was noted that even if the Trust achieved fully against all performance targets and implemented the restrictions and reductions above, there would still be a deficit. | | |
| **Assurance:** *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)* | **5.11 UHS Staff Survey Results 2024 Report** | ***Assurance Rating:*** **Reasonable** | ***Risk Rating:*** **Low** |
| | • The committee reviewed the Staff Survey results for 2024.<br>• The Trust had maintained its above average position across all of the People Promise domains.<br>• The Trust's results remained broadly similar to those in 2023, although there had been improvements in some areas, such as satisfaction with immediate managers, flexible working, appraisals, and confidence in reporting unsafe practice, violence, bullying and harassment.<br>• The participation rate was low at 39%, which gave rise to some concern about how reflective of the workforce the results were. A significant difference in engagement between non-clinical and clinical staff was noted. | | |
| | **6.2 Board Assurance Framework Update** | ***Assurance Rating:*** **Substantial** | ***Risk Rating:*** **N/A** |
| | • Risks 3a, 3b and 3c had been updated, following discussions with the respective Executive Director(s).<br>• Risk 3c had been upgraded from 12 to 16 to reflect the reduction in national funding for education and training and the more restrictive funding framework. In addition, it was noted that the intended reduction in NHS corporate infrastructure would impact training and development staff.<br>• The committee agreed to review the Board Assurance Framework again once the 2025/26 plan had been approved. | | |
| **Any Other Matters:** | • The committee received an update in respect of the Band 2/3 pay dispute and in respect of the portering department. | | |

## Assurance Rating:

| | |
|---|---|
| **Substantial Assurance** | There is a robust series of suitably designed internal controls in place upon which the organisation relies to manage the risk of failure of the continuous and effective achievement of the objectives of the process, which at the time of our review were being consistently applied. |
| **Reasonable Assurance** | There is a series of controls in place, however there are potential risks that may not be sufficient to ensure that the individual objectives of the process are achieved in a continuous and effective manner. Improvements are required to enhance the adequacy and effectiveness of the controls to mitigate these risks. |
| **Limited Assurance** | Controls in place are not sufficient to ensure that the organisation can rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Significant improvements are required to improve the adequacy and effectiveness of the controls. |
| **No Assurance** | There is a fundamental breakdown or absence of core internal controls such that the organisation cannot rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Immediate action is required to improve the adequacy and effectiveness of controls. |
| **Not Applicable** | Where assurance is not required and/or relevant. |

## Risk Rating:

| | |
|---|---|
| **Low** | Based on the report considered by the committee, there is little or no concern that the Trust will be unable to meet its stated objectives and/or plans. |
| **Medium** | There is some concern that the Trust might not be able to fully meet its stated objectives and/or plans based on the information contained in the report considered by the committee. |
| **High** | There is a significant risk that the Trust will not be able to meet its stated objectives and/or plans based on the information contained in the report considered by the committee. |
| **Not Applicable** | Where risk rating is not relevant. |

**Agenda Item 5.3 ii)**

| **Committee Chair's Report to the Trust Board of Directors 13 May 2025** | | | |
|---|---|---|---|
| **Committee:** | **People & Organisational Development Committee** | | |
| **Meeting Date:** | **25 April 2025** | | |
| **Key Messages:** | • The committee reviewed the People Report for Month 12 (see below).<br>• The committee noted the significant challenges for 2025/26 in delivering the Trust's Annual Plan and the implications for its workforce. In particular, the Trust was anticipating having to reduce its overall workforce by 6% during the year, coupled with a 20% reduction in bank staff and 30% reduction in agency staff. It was noted that the organisational changes would need to happen at pace, but that there was not presently central funding to support this.<br>• The Trust had implemented strict recruitment controls, including a freeze on all non-clinical recruitment and would hold 30% of clinical vacancies.<br>• Delivery of the Trust's 2025/26 plan also assumed significant reductions in the numbers of mental health patients and in patients having no criteria to reside.<br>• It had been announced that the Trust would be restructuring its divisions, reducing from four to three. It was anticipated that this would be completed by 1 July 2025. Furthermore, the Trust had a medium- to long-term objective of developing and implementing shared services with other organisations in the Hampshire and Isle of Wight Integrated Care System.<br>• The organisational and workforce changes envisaged were to be supported by both an equality and a quality impact assessment process.<br>• The committee agreed to review its agenda going forward to ensure that it was focusing on the most appropriate areas, especially those relating to the intended organisational changes and the delivery of the Trust's 2025/26 workforce plan. | | |
| **Assurance:** *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)* | **5.10 People Report for Month 12** | ***Assurance Rating:*** **Substantial** | ***Risk Rating:*** **High** |
| | • The Trust was above its 2024/25 workforce plan by 373 whole-time-equivalents (WTE) and there had been high numbers of bank staff during March 2025.<br>• The committee discussed in detail the reasons for the high level of use of bank staff during March 2025, noting that it was likely driven by staff taking annual leave before the year end and due to the number of patients with enhanced care needs.<br>• The People Report was to be amended to include additional information in respect of nursing fill rates, annual leave utilisation data, and the basis of the forecast numbers was to be reviewed. | | |
| **Any Other Matters:** | • The committee received a further update in respect of the Band 2/3 pay dispute and in respect of the portering department. | | |

## Assurance Rating:

| | |
|---|---|
| **Substantial Assurance** | There is a robust series of suitably designed internal controls in place upon which the organisation relies to manage the risk of failure of the continuous and effective achievement of the objectives of the process, which at the time of our review were being consistently applied. |
| **Reasonable Assurance** | There is a series of controls in place, however there are potential risks that may not be sufficient to ensure that the individual objectives of the process are achieved in a continuous and effective manner. Improvements are required to enhance the adequacy and effectiveness of the controls to mitigate these risks. |
| **Limited Assurance** | Controls in place are not sufficient to ensure that the organisation can rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Significant improvements are required to improve the adequacy and effectiveness of the controls. |
| **No Assurance** | There is a fundamental breakdown or absence of core internal controls such that the organisation cannot rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Immediate action is required to improve the adequacy and effectiveness of controls. |
| **Not Applicable** | Where assurance is not required and/or relevant. |

## Risk Rating:

| | |
|---|---|
| **Low** | Based on the report considered by the committee, there is little or no concern that the Trust will be unable to meet its stated objectives and/or plans. |
| **Medium** | There is some concern that the Trust might not be able to fully meet its stated objectives and/or plans based on the information contained in the report considered by the committee. |
| **High** | There is a significant risk that the Trust will not be able to meet its stated objectives and/or plans based on the information contained in the report considered by the committee. |
| **Not Applicable** | Where risk rating is not relevant. |

**Agenda Item 5.4 i)**

<table>
<tr><td colspan="4">Committee Chair's Report to the Trust Board of Directors<br>13 May 2025</td></tr>
<tr><td>Committee:</td><td colspan="3">Quality Committee</td></tr>
<tr><td>Meeting Date:</td><td colspan="3">17 March 2025</td></tr>
<tr><td>Key Messages:</td><td colspan="3">• In its review of the Quality Indicators, it was noted that there had been one Never Event in January 2025. There had been a significant increase in the number of category 2 pressure ulcers. It was also noted that there had been six C-diff cases, 12 instances of Ecoli and one case of MRSA.<br>• The Trust was continuing to experience significant pressure in its Emergency Department, which necessitated caring for patients in corridors.<br>• The Trust was commissioning a full-service review of its cardiac surgery team by the Royal College.<br>• The committee reviewed the Trust's performance against its 2024/25 Quality Priorities. It was noted that the Trust had achieved all but one of its Quality Priorities.<br>• The committee reviewed the Maternity and Neonatal Safety Report for Quarter 3 as well as an update following the inspection of the Trust's maternity and midwifery service by the CQC in May 2023. It was noted that the Trust continues to conduct thematic reviews around third and fourth degree tears. The Trust had experienced higher than expected levels of post-partum haemorrhage. However, in part this was likely due to transitioning from estimating to using a machine to measure blood loss, which was known to cause an increase in the recorded rate during the first months of adoption.<br>• The visit by the NHS South East region to the Princess Anne Hospital had resulted in some positive feedback about the service.<br>• The committee received an update in respect of the Trust's implementation of the national standards for surgical procedures (NatSSIPS), noting that there had been some delays due to insufficient resources.<br>• The committee received the Medicines Management Audit and Assurance Report. Walkarounds had been conducted across 48 wards focusing on assessing the current state of medication management. Controlled drugs were generally well-managed, but a number of issues had been identified with respect to security. An action plan had been developed to address the issues identified.<br>• The committee noted the improvement in response times in respect of patient complaints.<br>• The committee reviewed the Patient Safety 2024-25 Quarter 3 Report, noting that there had been five Never Events during the period.</td></tr>
<tr><td rowspan="2">Assurance:<br>(Reports/Papers reviewed by the Committee also appearing on the Board agenda)</td><td>5.13 Learning from Deaths 2024-25 Quarter 3 Report</td><td>Assurance Rating:<br>Substantial</td><td>Risk Rating:<br>Medium</td></tr>
<tr><td colspan="3">• The Trust benchmarked well compared to other Trusts in respect of having a lower than expected death rate (12 out of 119).<br>• The lack of available side-rooms continued to be an issue, with patients dying on wards rather than in a more private setting.</td></tr>
</table>

| | |
|---|---|
| **Any Other Matters:** | There number of Inquests had increased, with Coroners' expectations increasing in terms of the numbers of witnesses. |

## Assurance Rating:

| | |
|---|---|
| **Substantial Assurance** | There is a robust series of suitably designed internal controls in place upon which the organisation relies to manage the risk of failure of the continuous and effective achievement of the objectives of the process, which at the time of our review were being consistently applied. |
| **Reasonable Assurance** | There is a series of controls in place, however there are potential risks that may not be sufficient to ensure that the individual objectives of the process are achieved in a continuous and effective manner. Improvements are required to enhance the adequacy and effectiveness of the controls to mitigate these risks. |
| **Limited Assurance** | Controls in place are not sufficient to ensure that the organisation can rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Significant improvements are required to improve the adequacy and effectiveness of the controls. |
| **No Assurance** | There is a fundamental breakdown or absence of core internal controls such that the organisation cannot rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Immediate action is required to improve the adequacy and effectiveness of controls. |
| **Not Applicable** | Where assurance is not required and/or relevant. |

## Risk Rating:

| | |
|---|---|
| **Low** | Based on the report considered by the committee, there is little or no concern that the Trust will be unable to meet its stated objectives and/or plans. |
| **Medium** | There is some concern that the Trust might not be able to fully meet its stated objectives and/or plans based on the information contained in the report considered by the committee. |
| **High** | There is a significant risk that the Trust will not be able to meet its stated objectives and/or plans based on the information contained in the report considered by the committee. |
| **Not Applicable** | Where risk rating is not relevant. |

| **Agenda item 4.5 Report to the Quality Committee, 17 March 2025** | |
|---|---|
| **Title:** | Maternity and Neonatal Safety 2024-25 Quarter 3 Report |
| **Sponsor:** | Gail Byrne, Chief Nursing Officer |
| **Author:** | Emma Northover, Director of Midwifery<br>Alison Millman, Quality Assurance and Safety Midwifery Matron<br>Jessica Bown, Quality Assurance and Safety Midwifery Matron<br>Hannah Mallon, Quality Assurance and Safety Neonatal Matron<br>Marie Cann, Maternity and Neonatal Safety Lead |

**Purpose**

| (Re)Assurance | Approval | Ratification | Information |
|---|---|---|---|
| x | x | | x |

**Strategic Theme**

| Outstanding patient outcomes, safety and experience | Pioneering research and innovation | World class people | Integrated networks and collaboration | Foundations for the future |
|---|---|---|---|---|
| x | | | | |

**Executive Summary:**

NHS Resolution (NHSR) requires that the Maternity & Neonatal (MatNeo) Service reports to our Trust Quality Committee each time it meets. This Quarter 3 (Q3) 24-25 MatNeo Service safety report will continue to be adapted and responsive to safety concerns or issues within our service providing assurance around safety improvements impacting our families, services, and staff. The information provided is for assurance and reassurance, whilst meeting the requirements of NHSR Maternity Incentive Scheme (MIS)Year 6 and highlights the safety improvement work and learning from all aspects of the services. We ask members to continue to support the MatNeo Service and provide monitoring and scrutiny as required.

**Contents:**

This report provides an update in relation to the following areas for Quarter 3 2024/25:

| **Risk(s):** | |
|---|---|
| The risk implications for the UHS Trust and MatNeo Services sit within several frameworks including:<br>• **Reputational** – Safety concerns can be raised by the public to both NHS Resolution and the CQC.<br>• **Financial** – Compliance with NHS Resolution Maternity Safety Actions to meet all ten safety actions remains to be an expectation for maternity safety requirements.<br>• **Governance** – Safety concerns can be escalated to the Care Quality Commission for their consideration and to NHS England, the NHS Improvement Regional Director, the Deputy Chief Midwifery Officer, the Regional Chief Midwife.<br>• **Safety** - Non-compliance with requirements or recommendations would have a detrimental impact on the women and their families leading to increased poor outcomes and staff wellbeing. MNSI can raise concerns regarding the safety of MatNeo Service and instigate reviews. | |
| **Equality Impact Consideration:** | N/A |

## 1. Perinatal Quality Surveillance – Maternity & Neonatal full Dashboard

The red flag exceptions can be found here 1a. UHS Maternity Dashboard - December 2024.xlsx, most of these remain known to the Quality Committee with no 'new exceptions', key areas to note are:

### 1.1 Scheduled Caesarean Section Capacity

This remains a significant challenge for our service with additional requests for LSCS occurring late in pregnancy or just prior to an induction of labour process creating difficulties in scheduling when lists are full. It remains on our risk register (RISK 788 High RED).

### 1.2 Post Partum Haemorrhage (PPHs)

The OBS UK study is up and running within Maternity with the 3 key elements being a RAG rated proforma combined with ongoing measured blood loss (MBL) and the use of a TEG (thomboelastography) machine. The Study Team performed a site visit in January and, despite the study being in its infancy, reported being very impressed by how motivated the teams were and how well embedded new practices were already observed to be. The visiting team from OBS Cymru (based in Cardiff) were clear that earlier adopters of the study often saw their PPH rate data increase initially due to stopping the practice of estimating blood loss with the longer-term observation being a reduction in major PPH rates due to earlier detection of emerging coagulopathies and awareness of escalating blood loss.

### 1.3 Episiotomy

The episiotomy rate is related to all births at UHS, this in combination with the 3rd and 4th degree tears is an area requiring focused improvement work, with the Trust implementing the RCOG Obstetric Anal Sphincter Injury (OASI) care bundle.

### 1.4 3rd and 4th Degree Tears

The Maternity Service continues to conduct thematic reviews around these and are moving forwards with adopting the RCOG OASI bundle to seek to reduce these obstetric injuries, with an MDT stakeholder group. This area has senior oversight, seeking to respond and identify areas for improvement.

### 1.5 ITU Transfers

There were 4 ITU transfers in Q3 2024/25 compared to 5 in Q2. All ITU admissions are reviewed through Clinical Events Review with an ITU Consultant present to identify any learning.

### 1.6 Apgar's <7 at 5 minutes

NMPA targets for Apgar's <7 at 5 minutes is <1.1%. UHS MatNeo Service has consistently sat above this, see **Appendix 1.1** for a deeper dive.

*Q3 Summary:* 39 babies were born with an Apgar of <7 at 5 mins, 1 resulted in a neonatal death following a category 1 emergency LSCS from the Maternity Day Assessment Unit, this had a full review and can be found as part of **Appendix 2** report (*PMRT number 95525*).

*Mode of delivery*

- Caesarean birth (Emergency 22 & planned elective 8) = 30
- Spontaneous vaginal birth = 3
- Forceps = 5
- Breech = 1

12 (31%) of the babies were born following a general anaesthetic, a known complication for delayed/poor transition and a lower Apgar score. All 12 had a caesarean birth, 3 planned and 9 emergencies.

19 (49%) had an Apgar of 7 or > at 10mins.
Further work is planned with the fetal monitoring leads to see if there is any learning around timing of delivery and fetal monitoring in the cases where delivery was due to fetal heart rate/CTG concerns (11 cases).

### 1.7 Stillbirths per 1000 births - (see slide) Appendix 1.2

In Q3 24-25 the MatNeo Service saw a stillbirth rate of 4.03%, National target set in 2021 was to aim for 4.1 per 1,000 births of less. Stillbirths (as rate per 1000) is closely monitored, as a Trust there has been some variation month on month, yet locally we have consistently been <4.1 per 1000 births in the calendar year for 2022 and 2023. Learning from stillbirths is included in **Appendix 1.2** for more information, this is also shared with the LMNS and the safety forum.

### 1.8 Public Health Outcomes – Smoking Rates

Reducing smoking during pregnancy is still a key workstream for our Public Health Team. There is ongoing recruitment for an additional Tobacco Dependency Advisor (TDA) who, with the specialist input, will be able to offer our service users, and their families targeted interventions to support with becoming smoke free.

### 1.9 Booked Continuity of Carer (CoC)

Our NEST case loading teams are now booking all IMD1 pregnant service users under a case loading model. Further development of case loading other higher risk groups is a service priority. Particularly focusing on our global majority families, as our MBRRACE reportable cases reflect that of the National picture when drilling down in the patient demographic.

### 1.10 FFT Recommenders as % of Responders

Overall, for Q3 24-25 the % of responders that would recommend our service was 85%, just below the 90% target. Our MNVP chair is working with the clinical areas, our patient experiences lead and engaging with service users and their families to better understand how as a service we can improve their experiences.

### 1.11 Maternity Opel 4 Escalations/Diverts

For Q3 24-25 the Maternity Service saw us escalate to Opel 4 divert on 7 occasions, October – 6, November – 1 and December – 0. With the recent intake of new starters, operational pressures around staffing have significantly reduced. As such, the Maternity Service has seen less escalations and overall, an improving picture for frontline clinicians.

## 2. Maternity and Newborn Safety Investigations (MNSI), Patient Safety Incident Investigations (PSII) and PMRT cases

**Appendix 2** provides assurance to the members that the appropriate reporting has taken place for Q3. The report includes all new MNSI cases, of which there was 1, and any PSII cases. Also providing an update on all cases closed within the same period, together with any thematic learning identified.

Information will also be included which relates to new and closed perinatal mortality cases even where there are no patient safety care concerns for the service to continue to be transparent. **Appendix 2** also includes a summary of the moderate incidents reported in Q3. To note, the Maternity Service has reviewed the way that we report our Opel 4 escalations, to ensure a more robust scrutiny for the Opel 4 diverts that directly involve patients. Therefore, it might appear that there have been a greater number of moderate incidents reported in Q3.

There was 1 MNSI case closed in Q3, and the learning slide is featured within the appendix:

- MNSI 037018 / PMRT case 92625

**2.1** **Appendix 3** is to provide some assurance to the committee around the 2 Maternity Never Event incidents and the actions that are in place. **Appendix 3** is the action plan agreed from the first never event and outlines our status with these actions.

## 3. Perinatal Mortality Review Tool Learning and Themes

A summary of PMRT Reviews of Q3 PMRT cases and learning are noted within **Appendices 2 and 4. Appendix 4** also includes the ethnicity and IMD decile of the women and birthing people, as well as whether they were initially booked to birth at PAH. The MatNeo Service can confirm that there is high

level oversight of reported and processed cases to ensure reviews and feedback from and to families are captured within appropriate timeframes.

Case information is reviewed at a level where the service can look to identify any themes or vulnerable groups. Learning has been identified within the information and is shared with our LMNS.

## 4. ATAIN Update – see Appendix 5

There has been a slight increase in term admissions for Q3 (45) compared to Q2 (41), however the unexpected term admissions as a percentage of the total birth rate continues to be below target (5%). The most common reason for admission continues to be for respiratory related reasons or poor perinatal adaptation. There has been an increase in babies admitted following elective caesarean sections, however, there has been an overall increase in babies born via elective caesarean section which could account for this rise.

## 5. Midwifery Workforce Update

UHS Maternity Services have welcomed a total of 34 x B5 newly qualified midwives, 4 x Internationally trained midwives and 11 x B6 midwives since October 2024. This significant increase in staff has lifted our workforce and the difference in morale is palpable on a day-to-day basis. In addition to midwives, we have also successfully recruited x 6 B3 maternity support workers which sees us now fully recruited to this vital role. As a direct result, we have seen a staggering reduction in escalations to Opel 4 with just x 3 in the last 3 months. A remarkable difference to last quarter where our service was strained and under significant pressure.

Listening to the feedback from our 2023 cohort of newly qualified midwives, we heard how traumatised and significantly impacted these members of staff have been in terms of their experiences at work over the last year. This issue has been compounded by the level of high acuity across the service, together with significant gaps within the workforce and a perceived lack of available senior midwifery support.

In response to this, and to support our new starters, we have looked to run their introduction to UHS Maternity Services differently this year by enabling an extended period of protected rotation across all the clinical areas. The fundamentals of this change is that all band 5 midwives will work in a provisional capacity in their first 4 months which will aim to support the development of their clinical autonomy whilst recognising their continued need for pastoral support and education. It is also hoped that this extended period of protected practice will afford them a greater resilience than our previous cohorts and in turn, reduce staff sickness rates and increase our retention rates.

Significant investment has also been made in respect to our more experienced staff members. We have learnt in previous years that having the right number of band 6 midwives across the clinical areas greatly enhances the support and expertise available to our preceptees and influences their wellbeing and learning within their first year post qualification. From April 2025 we will start to see shifts staffed at full complement as our preceptors transition and begin to be counted in the clinical establishment.

We have been fortunate to have received some external funding from the national team which has been drawn down to support our internationally trained midwives. We have adapted our successful and highly regarded preceptorship programme to incorporate additional learning opportunities tailored to their needs. Clinical experience varies across our international workforce therefore we have incorporated a high level of support and additional teaching, particularly around high-risk maternity care, recognising that exposure to these cases previously, will be low. Feedback on this programme is very positive so far.

To ensure that we continue to think strategically around midwifery recruitment, we have sought high level approval to forward plan based on our predicted rate of leavers across the year. As our establishment drops and staff vacancies naturally occur, we have mapped a band 5 / 6 rolling recruitment strategy to ensure that we respond quickly and avoid a large vacancy again.

Finally, in response to our staffing crisis last year, we gratefully received mutual aid from the corporate nursing team at UHS. UHS Maternity Services welcomed x 11 B5 registered nurses across all clinical areas on a 6 month secondment between September 2024 and March 2025.

The support they have provided us has been invaluable and it has taught us a great deal about how valuable a nursing workforce can be across Maternity Services. Feedback from the nurses involved has also been overwhelmingly positive.

## 6. Triangulation of Incidents, Claims & Complaints

The Quality Assurance Matron Team have met with NHS Resolution to review the Trust claims scorecard for obstetrics and neonatology. It was discussed how best to triangulate this information for greatest impact on service safety and improvement. **Appendix 6** aims to triangulate incidents, claims and complaints and identify and thematic learning. To note, this scorecard does not include claims registered under the NHS Resolution Early Notification Scheme and there were 0 claims in the last 2 years.

## 7. 3 Year Delivery Plan Benchmarking & Action Plan

We are now in the 2nd year of the 3 year delivery plan, as a service we have completed a benchmarking exercise to review our progress against current delivery of the standards set out. See **Appendix 7** for an action plan for those that are partially/not yet met. As a Trust, we are committed to this action plan, which will improve safety but also patient experience and equity of care for our service users. We will continue to update via this report our progress and any challenges in relation to this key maternity driver.

## 8. CQC Maternity Survey 2024 Action Plan

Please see **Appendix 8** for the 2024 Maternity Survey, the key highlights from this action plan are:

- Partners staying/visiting hours
- Delays in discharge
- Access to a midwife during the postnatal period.

As a service we aim to be responsive to feedback, whilst ensuring safety for all is at the forefront of changes and improvement plans. We will continue to work with our MNVP to ensure service users are heard and involved in any changes.

The 2025 posters are up, triangulated with local population top 10 languages from 2024, to ensure equity in the accessibility for our service users. These results will be available towards the end of 2025.

## 9. SCORE Survey

Due to significant challenges our MatNeo Service faced over the latter part of 2024, there is ongoing work to be done around the Perinatal Culture and Leadership Programme (SCORE Survey), to ensure that together we work to improve the culture and safety of our service. This workstream is key for the leadership team and we will continue to update with any new developments.

## 10. Patient Voice and Progress with MNVP

November 2024 saw the arrival of our ICB appointed Maternity and Neonatal Voices Partnership Chair, Frankie Snow. Frankie has already attended our Women and Newborn Governance Meeting, met with our patient experience lead for Maternity and presented at our most recent LMNS insight visit. A family from one of our MNSI cases co-presented their experience at our MatNeo M and M Education Meeting. This was very well received. Our Birth Reflections Team have secured the offer of further involvement of this nature from another service user who had a challenging experience which has already changed practice at her GP surgery.

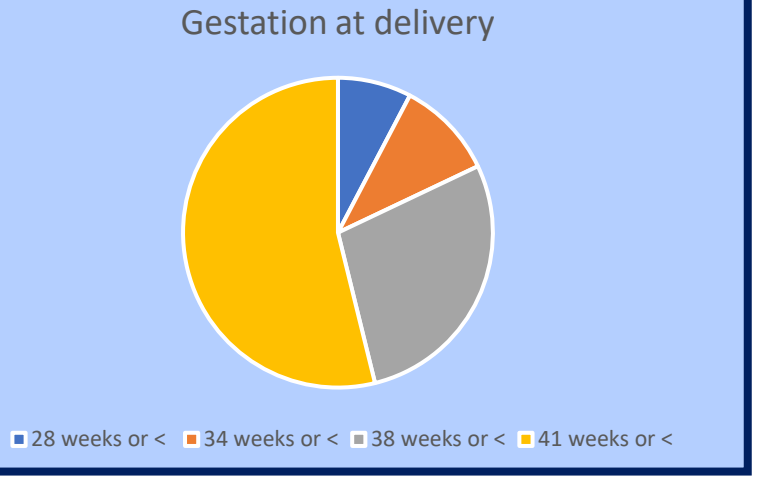
## 11. NHS Resolutions Maternity Incentive Scheme Year 6 Update

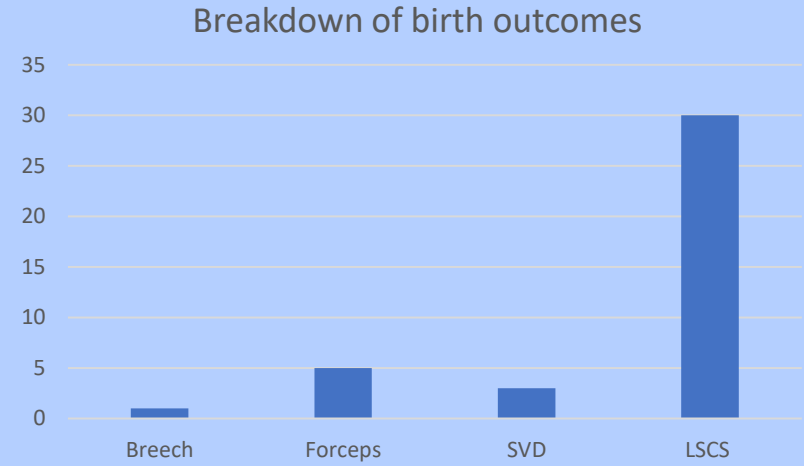
The MatNeo Service were able to present evidence supporting compliance with all 10 safety actions to the Trust Board in December 2024. The ICB Executive Board have considered the same evidence of compliance in February 2025. The ICB have aligned with our Board in agreeing that the QA Team will submit the jointly signed declaration of compliance to NHS Resolutions prior to midday on 3 March 2025.

# Appendix 1.1 Apgar's <7 at 5 mins

University Hospital Southampton NHS Foundation Trust

**Q3 24-25:** 39 born with Apgar's <7 at 5 mins
1 NND (Cat 1 LSCS from MDAU due to FHR concerns).



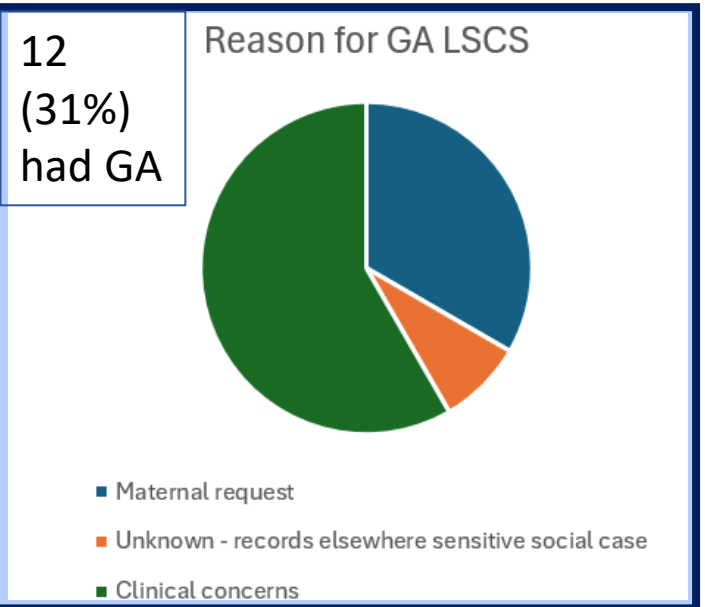

## Apgar's

49% had improved by 10mins

Apgar 7 or > at 10 mins = 19

6 birthing people Global Majority ethnicity.

12 (31%) had GA




## Category of LSCS

| | |
|---|---|
| Cat 1 | 4 |
| Cat 2 | 15 |
| Cat 3 | 3 |
| Cat 4 | 8 |

Delivery due to fetal distress/CTG concerns = 11

**Ongoing work planned**

- Review PIL for GA at EL LSCS
- Fetal monitoring leads to review CTG's where EM LSCS due to CTG concerns
- Reminder/education around calculating APGAR score.

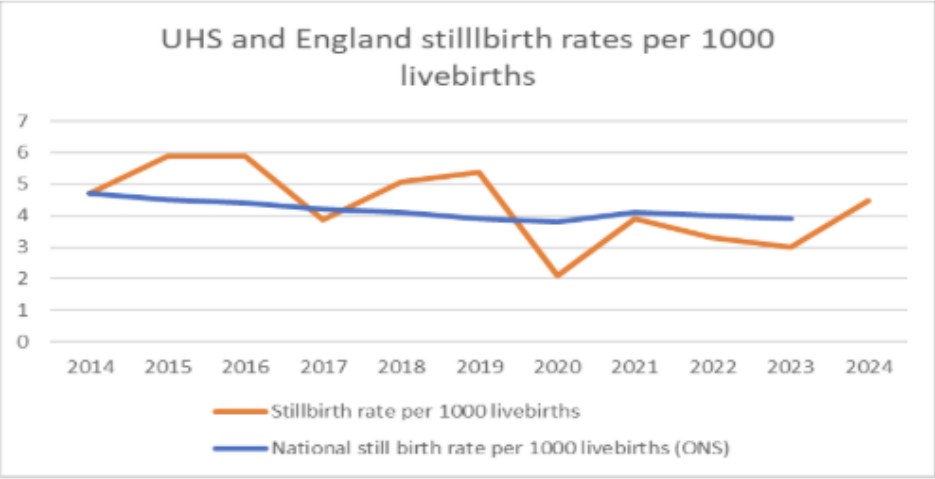
Appendix 1.2

University Hospital Southampton NHS Foundation Trust

# Outcomes

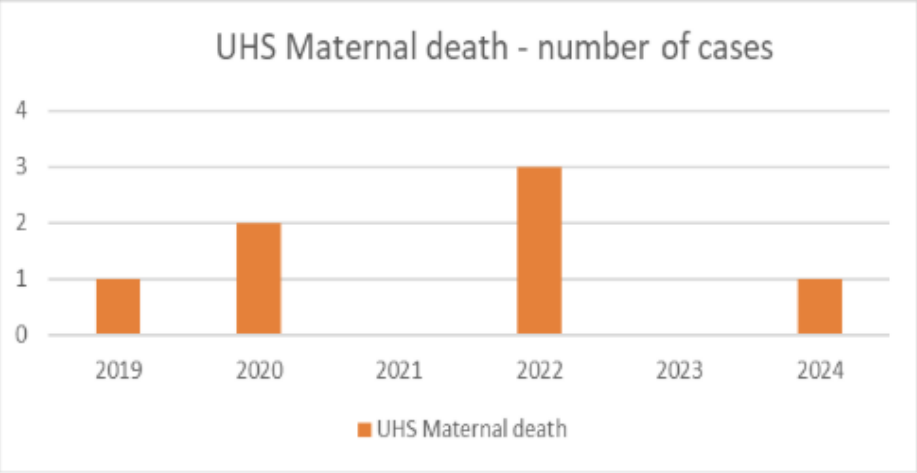
## Stillbirths

2024 – 22 stillbirths. Total stillbirth rate 0.45% of UHS births
Rate per 1000 livebirths 4.47



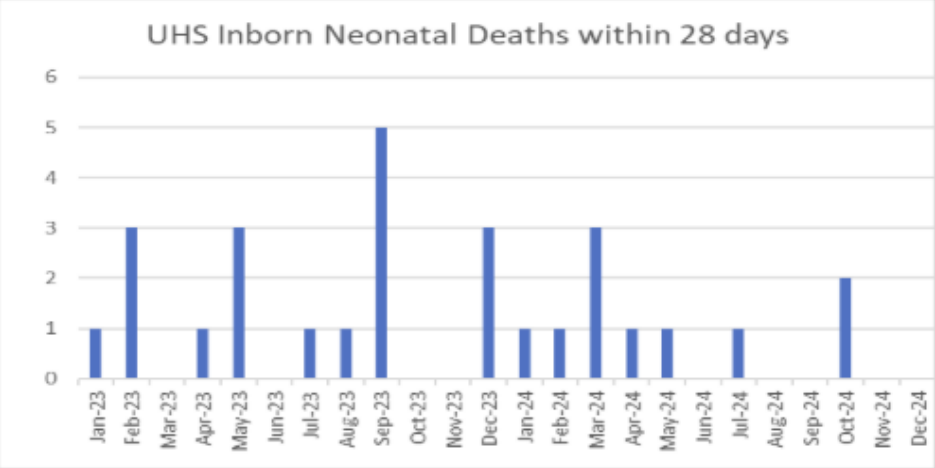

## Maternal deaths

2024 – 1 maternal death



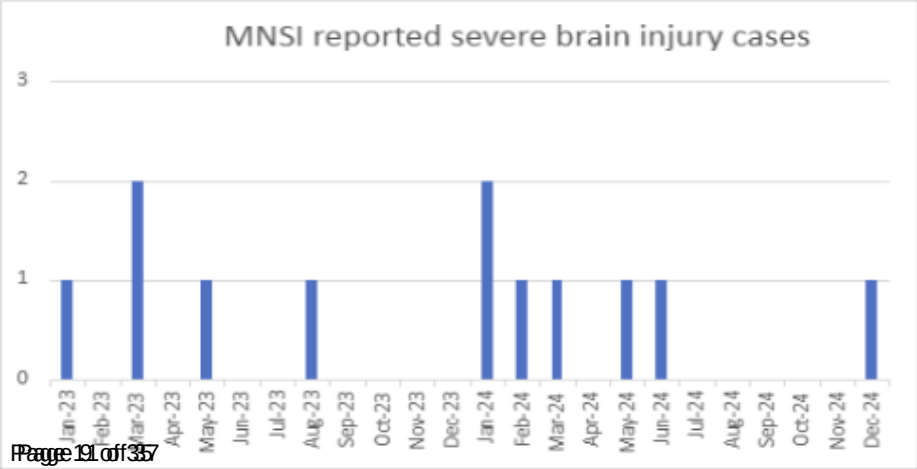

## Neonatal deaths

2024 – 10 NNDs within 28 days, 3 after 28 days.




## Brain injury

7 cases reported to MNSI during 2024



**Appendix 2**

**Maternity and Newbon Safety Investigations (MNSI), Patient Safety Incident Investigations (PSII) and PMRT cases – Quarter 3 2024/25**

**New Patient Safety Cases**

| Case type MNSI / PMRT etc | Incident form | Log Date | Incident Trigger | Summary of incident | Outcome of incident |
|---|---|---|---|---|---|
| MNSI | MI-039127 / 9988425 | 05/12/2024 | Therapeutic hypothermia | Baby born at 40+1 weeks gestation following Category 2 caesarean section for failed induction and fetal monitoring concerns. Low risk pregnancy. Thick meconium present at delivery. Baby born in poor condition requiring resuscitation. He was transferred to Neonatal Intensive Care Unit (NICU) intubated and ventilated. Therapeutic hypothermia was commenced at 3 hours of age. He had an MRI scan at 7 days of age which was verbally reported as essentially a normal MRI. | Reviewed through Clinical Events Review (CER) and Neonatal M&M meeting.<br>Initial learning identified relating to escalation of concerns (during handover), communication between teams post-delivery of decision to cool and documentation of decision-making regarding decision to cool.<br>Reported to MNSI and accepted for investigation. |
| Patient Safety | 9988433 | 18/12/2024 | Retained swab | Patient delivered her baby on 20/11/2024 via vaginal delivery. She had an episiotomy and second-degree tear and was sutured following delivery. She presented on 06/12/2024 with a retained vaginal swab which was removed. | Patient safety review meeting held and decision to log as Never Event and plan for Patient Safety Incident Investigation (PSII).<br>It was discussed that the learning from this incident is similar to the previous Never Event logged in June 2024 (incident 9976595). Therefore, it is likely that the action plan will be the same. |

**New PMRT cases**

*(to note some cases have been opened and closed in this time period)*

| PMRT number | Log Date | Incident Trigger | Summary of incident | Outcome of incident |
|---|---|---|---|---|
| 95426 (being led by the Children's Hospital) | 03/10/2024 | Neonatal death | Term birth at 38+2. Represented to QAH on day 1 and retrieved by PICU. Died on PICU on day 2 of life. Blood cultures grew Strep pneumoniae. | Reported to PMRT.<br>PMRT ongoing within timeframe.<br>Reported to MNSI, however rejected by MNSI and to be investigated / logged under QAH.<br>Heard through Child Death and Deterioration (CDAD) meeting and PICU Child Death Review Meeting (CDRM).<br>No learning identified for UHS. Awaiting completion of MNSI report before grading. |
| 95525 | 08/10/2024 | Neonatal death | Term baby at 41+5. Due to come in for IOL at 6pm. Presented with absent fetal movements for approx. 18 hours. On admission to MDAU, CTG commenced, and decision made for Cat 1 Section. Baby girl born in poor condition requiring resuscitation. ROSC at 22mins of age. Admitted to NICU however cranial ultrasound scan showed severe HIE. She developed multi organ failure despite maximal treatment. Decision made with parents to redirect care. Died on day 1 of life. | Reported to PMRT and closed. Grading A / B / A.<br>Heard through CER and Neonatal CDRM.<br>Learning identified relating to ETCO2 colourimeters and that there will be no colour change if no cardiac output. |
| 95534 | 10/10/2024 | Antepartum stillbirth | Presented at 26+2 with absent fetal movements for approx 24 hours. IUD confirmed. Baby girl stillborn at 26+6 weeks. | Reported to PMRT. Review to be closed with grading B / A.<br>Heard through CER and Perinatal Mortality Review Group (PMRG).<br>There was a missed opportunity for a referral to fetal growth restriction clinic, however it was felt unlikely that this would have had an impact on the outcome. |
| 95617 | 14/10/2024 | Antepartum stillbirth | Transfer to PAH from Jersey where IUD had been confirmed due to placenta acreta. | Reported to PMRT. Review to be closed with grading A / B.<br>Heard through CER and PMRG.<br>Learning identified for UHS relating to memory making discussions and communication between teams. |

| | | | | |
|---|---|---|---|---|
| 95675 | 19/10/2024 | Neonatal death | Born at 25+2 weeks with severe IUGR in Poole due to maternal hypertension and fetal bradycardia. Transferred to PAH ex utero (maternity services on Opel 4 and therefore unable to facilitate IUT). She developed a large left intracranial haemorrhage. Discussions were held with the family and the decision made for comfort focussed care. She died on day 3 of life. | Reported to PMRT and closed. Grading C / B / B.<br>Heard at Neonatal CDRM with representatives from Poole present.<br>Local learning identified as well as learning for UHS.<br>Issue identified at UHS with blood grouping for maternal samples being provided when mum is not yet an inpatient. There had also been a national change to the Crem 1 form, and the family had initially signed an old form. |
| 95987 (being led by the Children's Hospital) | 10/11/2024 | Neonatal death | Born at 39+4 weeks gestation. Out of hospital arrest at home. Retrieved by SORT. Sadly died on PICU on day 5 of life. Coroners case & JAR. | Reported to PMRT.<br>PMRT ongoing within timeframe.<br>Reported to MNSI, however rejected by MNSI as plans to be investigated / logged under Reading. However, due to an ongoing police investigation, this is not being investigated by MNSI.<br>To be reviewed jointly with Royal Berkshire Hospital (where the mother delivered). |
| 96022 | 09/11/2024 | Antepartum stillbirth | Presented at 22+2 following private scan showing no fetal heartbeat. IUD confirmed. Recent FM scan showed SGA with cystic kidneys. Delivered at 22+5 weeks. | Reported to PMRT.<br>PMRT ongoing within timeframe.<br>Heard at CER. No learning identified. |
| 96024 | 09/11/2024 | Antepartum stillbirth | Presented at 36+1 weeks to MDAU with RFM. Under care in Falklands (arrived in UK on 06/11/24) - was receiving twice weekly CTGs as concerns with growth. Delivered at 36+2 weeks. | Reported to PMRT.<br>PMRT ongoing within timeframe.<br>Heard at CER. Waiting for further information from Falkland Islands. |
| 96093 (being led by the Children's Hospital) | 18/11/2024 | Neonatal death | Born at 39+0 weeks. Postnatal collapse and diagnosis of pulmonary atresia (at 2 days of age). Retrieved by PICU. Underwent pulmonary valve ablation which was complicated with cardiac tamponade. Transferred to E1. Following day, he had a PEA cardiac arrest on the ward. Clot++ evacuation in theatre and commenced ECMO. HIE identified on MRI. Care redirected and baby boy died at 24 days of life. | Reported to PMRT.<br>PMRT ongoing within timeframe.<br>Heard at CDAD and Patient Safety Case Review meeting held. No care concerns identified and no further patient safety investigation.<br>To be reviewed through PICU CDRM. |

| | | | | |
|---|---|---|---|---|
| 96183 | 23/11/2024 | Antepartum stillbirth | Presented at 32+5 weeks to MDAU with absent fetal movements. IUD confirmed. Delivered at 32+6 weeks. Under care of NEST team due to her ethnicity (Bangladeshi). | Reported to PMRT.<br>PMRT ongoing within timeframe.<br>Heard at CER. Missed opportunity identified to have a face-to-face visit postnatally. Interpreters were also not always used; however, it was not clearly documented how good communication was with the family and if they were needed or not. |
| 96475 | 16/12/2024 | Neonatal death | Presented at 22+4 weeks to Poole (on holiday from Manchester - booked to Tameside). Rapid labour and delivery. Transferred to PAH ex utero. Maximal intensive care support was given; however it was felt that there was no further scope to increase his support. Discussion was had with family and care was redirected. Baby boy died on day 1 of life. | Reported to PMRT. Review to be closed with grading A / B / C.<br>Heard at Neonatal CDRM with presence from Poole and Tameside. Learning identified re. education for support staff at UHS when there has been a bereavement, and a baby is being cared for in a cold cot in a room with the family. |

## Closed Cases

| Case type MNSI / PMRT etc | Incident form | Log Date | Incident Trigger | Summary of incident | Outcome of incident |
|---|---|---|---|---|---|
| MNSI / PMRT | MI – 037018 / 92625 | 29/03/2024 | Intrapartum stillbirth | Presented in labour with reduced fetal movements. Unable to locate fetal heart. Labour progressed quickly. Baby born with no heart rate. Resuscitation commenced but no response after approximately 25 minutes. Decision made to stop resuscitation with the family. | Reported to PMRT and MNSI. Reviewed through Clinical Events and PMRG. PMRT closed with grading B / C. Learning identified relating to lack of privacy screens for resuscitation and issues with communication to Health Visiting team. Learning also related to FSE leads and ensuring that the correct FSE leads are available for the CTG machine. See lessons learned slide. |
| Patient safety | 9978989 | 13 – 14/07/2024 | Maternity Services on Opel 4 alert >24 hours | Maternity Services was on Opel 4 alert from 13 – 14/07/2024. | Harm tool to be completed. Closed at Patient Safety Steering Group (PSSG) in January 2025. No new learning identified. Thematic review of Opel 4 alerts shared with the LMNS. |
| Patient safety | 9979945 | 29 – 31/07/24 | Maternity Services on Opel 4 alert >24 hours | Maternity Services was on Opel 4 alert from 29 – 31/07/2024. | |
| Patient safety | 9983770 | 27/09/24 | Maternity Services on Opel 4 alert >24 hours | Maternity Services was on Opel 4 alert from 27 – 28/09/2024. | |
| PMRT | 93219 | 06/05/2024 | Neonatal Death | Baby born at 24+1 weeks gestation. Transferred to QAH and remained on the unit until he developed NEC. Transferred to PAH as surgical uplift. Care redirected 2 days later due to extensive NEC. | Reported to PMRT and closed. Grading A / B / A. Heard at CDRM, no learning identified for UHS. |
| PMRT | 93507 | 26/05/2024 | Late Neonatal Death | Baby born at 35+4 weeks gestation. Transferred to PAH for cardiac management. Diagnosed with Phelan McDermid Syndrome. Died at 2 months of age. | Reported to PMRT and closed. Grading B / B / B. Heard at CDRM, learning has been identified regarding the neonatal symptom management plan and communications from another Trust post death. |

| | | | | | |
|---|---|---|---|---|---|
| PMRT | 94119 | 02/07/2024 | Neonatal Death | Baby born at 27+5 weeks gestation. Known fetal hydrops. Born in reasonable condition, required high pressures to support with chest movement. NLS management including CPR continued for 67 mins. Agreed with parents for CPR to cease and baby given to mum to cuddle. | Reported to PMRT and closed. Grading B / A / B. Heard at CDRM, learning identified re. maternal thyrotoxicosis and a delay in treatment, there was also no evidence of offer or parallel care ACP plan on counselling antenatally. There was also a lack of coordinated bereavement care and she felt overwhelmed by contact / correspondence after baby died. |
| PMRT | 94518 (led by the Children's Hospital) | 29/07/2024 | Late Neonatal death | Born at 29+4 weeks on IOW. Transferred via SONeT to QAH. Transfer to PAH due to postnatal diagnosis of TAPVD, ASD and VSD. Discharged to PICU at 39+2 weeks. Under care of E1 / PICU. Died on PICU. | Reported to PMRT and closed. Grading B / A / A. Heard at PICU CDRM. No learning identified for UHS. |
| PMRT | 94525 | 30/07/2024 | Antepartum stillbirth | Attended MDAU at 39+3 with reduced fetal movements (first episode in 3 weeks). IUD confirmed in MDAU. Baby girl delivered stillborn at 39+5 weeks. | Reported to PMRT and closed. Grading B / B. Heard at CER and through PMRG. Missed opportunity for a scan when there was an issue with serial fundal height measurements. There was also an issue related to communication re. handover of transfer of the baby to the holding room. |
| PMRT | 94951 | 29/08/2024 | Stillbirth | Perimortem CS in ED at 36+4 due to suspected maternal brain aneurism. Booked under QAH. Born with no signs of life. | Reported to PMRT and closed. Grading A / A. Maternal death under investigation via MNSI. Patient Safety Case Review held and case discussed through PMRG. Incidental learning identified relating to equipment available in the neonatal resuscitation grab bag taken to the delivery in the Emergency Department. |
| PMRT | 95320 | 24/09/2024 | Stillbirth | Known to fetal medicine with likely diagnosis of T13. Attended MDAU at 30+5 weeks with RFM for 24 hours. IUD confirmed and baby delivered stillborn. | Reported to PMRT and closed. Grading B / B. Heard through CER and PMRG. Learning related to analgesia during labour and the family did not have anything to dress the baby in (i.e. angel gown) when she was born. |

| | | | | | |
|---|---|---|---|---|---|
| PMRT | 95321 | 25/09/2024 | Stillbirth | Attended MDAU at 39+3 with absent fetal movements. IUD confirmed and baby delivered stillborn. | Reported to PMRT and closed. Grading B / A. Heard through CER and PMRG. Learning related to urinalysis result not captured. The family have also raised some concerns and complaints regarding her care and decisions made and referrals they feel should have been made. |

**Moderate or above incidents**

| Incident Date/Number | Type of Incident | Summary of incident | Outcome of incident |
|---|---|---|---|
| 01/10/24 9983983 | Moderate | Ureteric injury noted after vaginal birth. | Reviewed through CER and closed as moderate harm incident, with potential to upgrade to severe following patient follow up appointment. Missed opportunities were identified relating to bedside review by an Obstetrician and bladder care (2 hourly reviews). There are currently new bladder care guidelines in development. |
| 01/10/24 9983984 | Moderate | Maternity services escalated to Opel 4 due to increased activity and reduced staffing. | 5 patients were diverted to other units in labour. The Opel 4 alert lasted less than 24 hours. |
| 02/10/24 9984062 | Moderate | Patient readmitted 2 days post-partum with severe ano rectal pain following Neville Barnes forceps delivery + episiotomy repair. On examination, suture palpable in anal canal. Patient underwent a surgical repair where a 3b tear was also identified and sutured. | Reviewed through CER and closed as moderate harm. Patient safety case review undertaken alongside incident 9986961 to identify if there is any thematic learning related to suturing. No further investigation required. |
| 07/10/24 9984393 | Catastrophic | Term baby born at 41+5. Due to come in for IOL at 6pm. Presented with absent fetal movements for approx. 18 hours. On admission to MDAU, CTG commenced, and decision made for Cat 1 Section. Baby girl born in poor condition requiring resuscitation. ROSC at 22mins of age. Admitted to NICU however cranial ultrasound scan showed severe HIE. She developed multi organ failure despite maximal treatment. Decision made with parents to redirect care. Died on day 1 of life. | Reported to PMRT (see new PMRT cases above). |
| 10/10/24 9984579 | Moderate | Maternity services escalated to Opel 4 due to reduced staffing and increased labour care. | 2 patients were diverted in labour. The Opel 4 alert lasted less than 24 hours. |
| 12/10/24 9984748 | Moderate | Escalated to Opel 4 due to activity and staffing. | 1 patient was diverted in labour. The Opel 4 alert lasted less than 24 hours. |

| | | | |
|---|---|---|---|
| 15/10/24<br>9985296 | Moderate | 11-week-old baby admitted via ED following collapse at home. Baby has several fractures and a brain injury. Non accidental injury remains the most likely cause and parents are currently under police investigation.<br>Mother of infant was known to be a frequent attender to maternity during pregnancy and was known to neonatal services. This case has been referred to the local learning and enquiry group. A brief review of this case identifies that there may have been some missed opportunities to share information. | This was reviewed and closed as moderate incident. There were full discussions with the named midwife and safeguarding team around actions and potential missed opportunities. A safeguarding referral was completed by midwife appropriately, but it was unclear whether safeguarding process was completed fully and whether a MASH referral should have been completed. Learning points identified. |
| 16/10/24<br>9987170 | Moderate incident | Maternity services escalated to Opel 4 due to increased activity. | 1 patient was diverted to Chichester in labour. The Opel 4 alert lasted less than 24 hours. |
| 20/10/24<br>9987171 | Moderate incident | Maternity services escalated to Opel 4 due to capacity and acuity. | 1 patient was diverted to Salisbury in labour. The Opel 4 alert lasted less than 24 hours. |
| 25/10/24<br>9985616 | Moderate | Maternity service escalating to Opel 4 for capacity and activity | 1 patient was diverted in labour. The Opel 4 alert lasted less than 24 hours. |
| 13/11/24<br>9986961 | Moderate | Perineal repair incomplete following vaginal delivery – homeostasis not initially achieved. Further repair involving transfer to theatre required, existing repair noted to be inadequate and re-repaired.<br><br>Initial blood loss 1500, total blood loss 2000. Delay in re-suturing due to acuity. | Reviewed through CER and Patient Safety Case Review alongside incident 9984062. No further investigation required. Closed as moderate incident. |
| 05/12/24<br>9988384 | Moderate | Swelling on baby's right hand noticed on 3/12/24 (last cannula from the right hand removed 27/11/24 according to MetaVision). Reviewed by medical team hand elevated. Ultrasound scan confirms foreign object present 9mm in length – likely cannula tubing. | Reviewed through Neonatal Risk meeting and Patient Safety Case Review held 24/12/25. Learning shared with Neonatal Services related to ensuring tubes / lines removed from patients are intact. To take to Neonatal M&M and include learning around cannulation. Learning also shared within the Neonatal ODN. No other similar incidents reported. |

| | | | |
|---|---|---|---|
| 05/12/24<br>9988425 | Moderate | Baby born at 40+1 weeks gestation following Category 2 caesarean section for failed induction and fetal monitoring concerns. Low risk pregnancy. Thick meconium present at delivery. Baby born in poor condition requiring resuscitation. He was transferred to Neonatal Intensive Care Unit (NICU) intubated and ventilated. Therapeutic hypothermia was commenced at 3 hours of age. He had an MRI scan at 7 days of age which was verbally reported as essentially a normal MRI. | Reported to MNSI and reviewed through CER (see new Patient Safety cases section above). |
| 06/12/24<br>9988433 | Moderate | Patient delivered her baby on 20/11/2024 via vaginal delivery. She had an episiotomy and second-degree tear and was sutured following delivery. She presented on 06/12/2024 with a retained vaginal swab which was removed. | Patient Safety Case Review held 18/12/24. For PSII utilising action plan from previous retained swab incident (see new Patient Safety cases section above). |
| 17/12/24<br>9989838 | Moderate | Patient admitted to Lyndhurst following the pre-term birth of her babies. She had a complex medical plan from her home trust, and was requesting access to the treatment plan for this (Cannulation and IV fluids and anti-emetics). This plan is clearly documented on Badgernet and eDocs. All teams (obstetric and anaesthetic) were busy in theatre, so unable to review, although the obstetric team were planning to when able. The request for cannulation was declined by the anaesthetic team (for the second time, it had previously been declined the night before also). It was reported to us as having been declined due to 'drug seeking behaviours' and this lead to an escalation in the challenging behaviour of the patient. She was seen in person by a member of the anaesthetic team on the evening of the 16/12 who said they would return once they had spoken to their senior - they did not return, and the decision to decline cannulation was passed as a message through the midwifery team, which lead to the first deterioration in her behaviour. As a result of this she took a large dose of her Amitriptyline to effectively sleep through the pain she was in. | Reviewed through CER. It was noted that this occurred at a weekend where there was less cover around. There were communication issues between the teams and a lack of ability to provide support with mental health. There was also a missed opportunity to discuss with the Maternal Medicine team. |

| | | | |
|---|---|---|---|
| 23/12/24<br>9990902 | Severe / Major | Unbooked pregnancy, patient informs pregnancy as a result of repeated rapes and imprisonment, took medication for MTOP. Positive urine toxicology for cocaine. Presents likely at term with pre-eclampsia. Undergoes Cat 2 CS with PPH 1200ml under general anaesthetic due to patient distress at hearing baby cry. Day 2 post CS ?ileus and positive for influenza A, transferred to surgical ward. Decompressive colonoscopy 13/12/24. Deterioration 20-23/12/24 and bowel perforation confirmed 23/12/24 via laparotomy and stoma formed. | To be reviewed through Patient Safety Case Review. |
| 29/12/24<br>9990120 | Moderate | Twin 2 baby born at 36+5 weeks gestation. Required initial resuscitation/support at delivery. I-gel inserted as unable to get chest wall movement. Subsequently recovered and stayed with mother and twin on postnatal ward. Reported to have increased work of breathing and with gurgling noises and reviewed a few times. Nasal suction performed at least twice. Poor feeding so nasogastric tube (NGT) placed. Unable to get an aspirate but bloody/milky secretions aspirated. NGT not used as no aspirate and removed. Admitted to Neonatal Intensive Care Unit (NICU) due to increased WOB. Diagnosed with oesophageal perforation, likely iatrogenic. | Reviewed through Neonatal M&M held 15/01/25. It was felt likely that the perforation was due to NG tube insertion and not the LMA. It is a recognised complication of NG tube insertion, although it is noted that it is not part of routine risks given to families prior to NG tube insertion. Initial Duty of Candour occurred. Named consultant to feedback following M&M meeting. |

**Lessons Learned Slide – MI – 037018 / PMRT case 92625**

# The Patient Safety Incident Response Framework (PSIRF) Learning Slide

The mother had an uncomplicated pregnancy, despite having a low-lying placenta initially on scan. At 40+2 weeks she contacted MTL reporting signs of labour and she also stated that she was unsure of baby's fetal movements. Enroute to the hospital she experienced SROM and the liquor was noted to be clear. On arrival to the Labour and her liquor was clear. On arrival at the hospital, she was found to be in advanced labour and an attempt was made to auscultate her baby's heartbeat. The baby was born vaginally after 20 minutes, during which time the midwives were unable to find/record a fetal heart rate. The baby received resuscitation for 27 minutes following birth ,however at no point made any attempt to breathe. At 28 mins resuscitation was stopped. On initial examination of the placenta ,it was noted that there were clinical signs of placental abruption, separation of placental lobes and a 500ml retroplacental clot

## Questions from family

Parental engagement was sought however there was no response from the family

## Organisation Learning

The investigation learned that there are several different makes and models of continuous electronic fetal monitoring machines in use on the labour ward, and that the fetal scalp electrode leads are not universally compatible. This led to a delay in obtaining the correct lead and a delay in attempting to record the Baby's heart rate.

## External Learning

Equipment issues relating to FSE leads

## Tools & Technology Learning

- Equipment issues

## Local Learning

Dopplers/CTG machines with the relevant FSE attachments, to ensure that presence of FH is confirmed prior to commencing intrapartum fetal monitoring (whether than be IA or CTG).

## Task Learning

For all staff to ensure that appropriate FSE leads are in situ when commencing their shift and making initial equipment checks.

## Person Learning

ALWAYS use IA prior to using CTG
Ensure equipment is in situ at the start of your shift

**Appendix 3**

University Hospital Southampton NHS
NHS Foundation Trust

# Patient safety incident investigation (PSII) report

| | |
|---|---|
| Incident ID number: | 9976595 |
| Patient initials and Hospital number | GA<br>3371545 |
| Division and Care Group | Div C Women and Newborn |
| Date incident occurred: | 10th June 2024 |
| Report approved date: | UHS 30th January 2025<br>St Mary's and Mulberry Surgery (GP) 20th January 2025 |
| Date Approved by PSIIOG: | 06/02/2025 |

Feb 2025.

## Safety action summary table

| Area for improvement: Improve the use of NatSSIPs in maternity | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Safety action description** ***(SMART)*** | **Safety action owner** ***(role, team directorate)*** | **Target date for implementation** | **Current Progress** **Updated Feb 2025.** | **Tool/ measure** | **Measurement frequency** ***(eg daily, monthly)*** | **Responsibility for monitoring/ oversight** ***(eg specific group/ individual, etc)*** | **Planned review date.** ***(eg annually)*** |
| 1. | Improve the use of the Labour ward whiteboards, as per NatSSIP's for documentation of swab/needle counts and blood loss.<br><br>The LW Co-Ord/OPCO to exception report via AER if whiteboards / pens not available in intrapartum areas. | JB Audit / QS Matron<br><br>PF Birth environments Matron | April 2025 | Feb 25 spot check completed and boards available in all areas.<br>Short term solution: send out a theme of the week for the use of whiteboards.<br>Communication sent to the OPCO's and Co-ord's to report AER's. | Exception report via an AER | Quarterly | Women and Newborn Clinical Governance steering group | April 2026 |
| 2. | Review the guidelines (Labour care/perineal repair/assisted birth) to ensure STOP POINTS FOR SAFETY (NatSSIPs) | JB Audit midwife | April 2025 | QA Matron team to write a local guideline/policy | Audit of compliance with STOP POINTS FOR | 6 months following implementation of new guidance and | Women and Newborn Clinical Governance steering group | January 2026 |

Feb 2025.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | included to ensure standardisation of the process for checking swab / needle counts post-delivery. Supported by guidance and video simulation (PE team) that standardises the STOP POINT actions and the language | MD Maternity Education team lead<br><br>PF Birth environments Matron | | for Swab counts in maternity.<br>CH is linking with Chris Elston on the roll out of NatSSIP's. | SAFETY (NatSSIPs) | simulation then as any occurring incident. | | |
| 3. | Improve compliance with appropriate staff group training for the organisation wide NatSSIPs review. | MD Maternity Education team lead. | April 2025 | CH linking with the trust lead for NatSSIP's to organise roll out in Maternity. | Evidence of training numbers | Quarterly | Women and Newborn Clinical Governance steering group | January 2026 |
| 4 | Improve the use of NatSSIPs through a quality improvement approach, within the maternity service by clinical staff in the prevention of retained swabs. | MD Maternity Education team lead. | April 2025 | CH linking with the trust lead for NatSSIP's to organise roll out in Maternity. | Evidence of training numbers | Quarterly | Women and Newborn Clinical Governance steering group | January 2026 |
| 5. | Improve the system functionality within the Badgernet system to allow only one location to upload swab counts, to improve record keeping. This will enable greater ability to undertake a review of cases in real- | UHS Digital Team | June 2025 | Ongoing – to form part of new guideline/process.<br>Linking with trust/main theatres to | Audit of data capture | Annually | Women and Newborn Clinical Governance steering group | June 2025 |

Feb 2025.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | time to ensure swab count is correct. | | | ensure consistent. | | | | |

| **Area for Improvement: Requirement for clear oversight and handover** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Safety action description**<br><br>***(SMART)*** | **Safety action owner**<br><br>***(role, team directorate)*** | **Target date for implementation** | **Date Implemented** | **Tool/measure** | **Measurement frequency**<br><br>***(eg daily, monthly)*** | **Responsibility for monitoring/ oversight**<br><br>***(eg specific group/ individual, etc)*** | **Planned review date.**<br><br>***(eg annually)*** |
| 6. | Ensure there is clear clinical oversight for all patients. | GV Obstetric clinical lead | February 2025 | Link with OBS team | Monitor incidents reported via AER when staffing deemed inadequate. | Routine checking of incident forms | Women and Newborn Clinical Governance steering group | January 2026 |
| 7. | Improve the use of approved and agreed clinical handover tools i.e. SBAR in line with current guidance. | GV Obstetric clinical lead<br><br>MD Maternity Education team lead. | February 2025 | SBAR tools form part of PROMPT MDT training | Monitor incidents reported via AER when staffing deemed inadequate. | Routine checking of incident forms | Women and Newborn Clinical Governance steering group | January 2026 |

Feb 2025.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 8. | Planned Quality Improvement project to 're-launch' the role of a second midwife for all deliveries/clinical procedures to ensure appropriate checks/procedures are completed as per NatSSIP's. | PF Birth environments Matron | February 2025 | Planned QI project with the Intrapartum matron – In progress | Quality improvement project to include agreed STOP POINTS for safety in birthing environments (as per NatSSIP's) | Annually | Women and Newborn Clinical Governance steering group | January 2026 |
| 9. | Decrease the barriers to safe swab/needle counts and improve the escalation for support if barriers are present | PF Birth environments Matron | February 2025 | Safety huddle responses regularly reviewed. | 11am safety huddle question captures any concerns or barriers to two-person swab/needle counts. | Quarterly Audit of documentation around swab and needle counts post-delivery and suturing. | Women and Newborn Clinical Governance steering group | February 2026 |
| 10. | Review of medical staffing to ensure adequate safety and training. | GV Obstetric Care group Lead/SEW – Obstetric Rota Co-ordinator | February 2025 | Link with OBS team | Monitor incidents reported via AER when staffing deemed inadequate. | Exception report when this is deemed not accurate. | Women and Newborn Clinical Governance steering group | February 2026 |

| | |
|---|---|
| R | Red: Immediate remedial action required to progress this activity |
| A | Amber: Action required for successful delivery of this activity |
| G | Green: Complete |

Feb 2025.

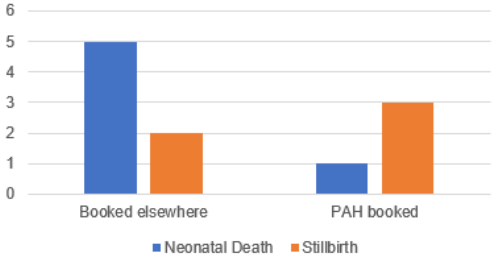
**Appendix 4**

# PMRT cases for Q3 2024/25

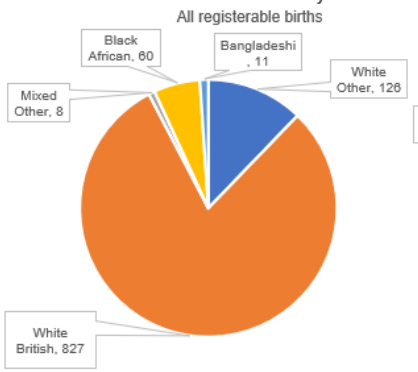
University Hospital Southampton NHS Foundation Trust

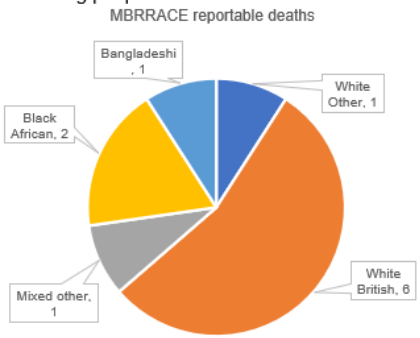
Eligible cases for PMRT = 11

- Stillbirth = 5
- Neonatal death = 6

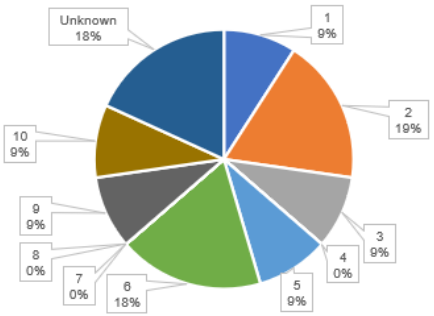



Ethnicity of women / birthing people




IMD deciles of women / birthing people of the MBRRACE reportable deaths




**Learning points / Actions:**

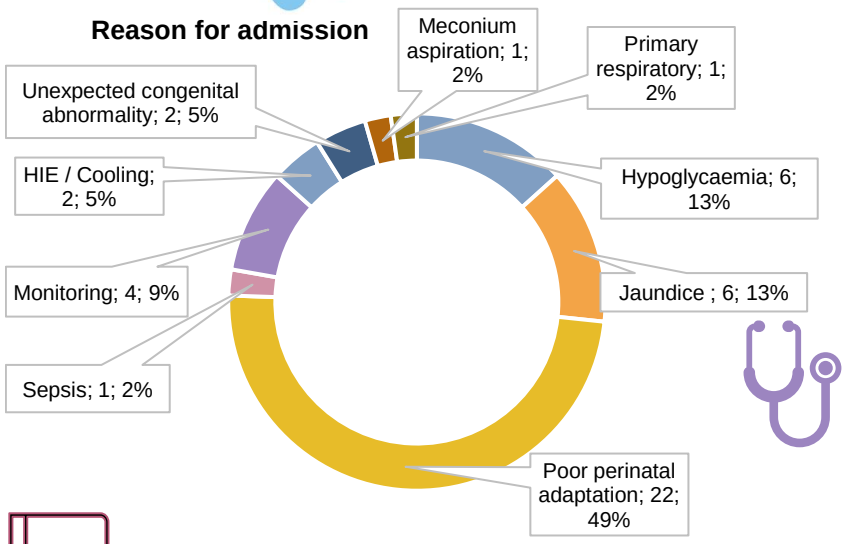
- Reminder to staff that there is no colour change in ETCO2 if there is no cardiac output.
- Issues with maternal blood sampling for mothers who are not inpatients. Followed up with the lab team who have confirmed the process which has been shared with the doctors.
- Cremation 1 form had been changed, and the team were unaware of this.
- Missed opportunity to refer to FGR clinic.
- Difficulty in booking appropriate theatre space and contacting the IR team out of hours.
- Documentation around need for interpreters.
- Missed opportunity for postnatal visits.

# ATAIN

**Qtr. 3 2024/25** – 45 unexpected term admissions

University Hospital Southampton NHS Foundation Trust

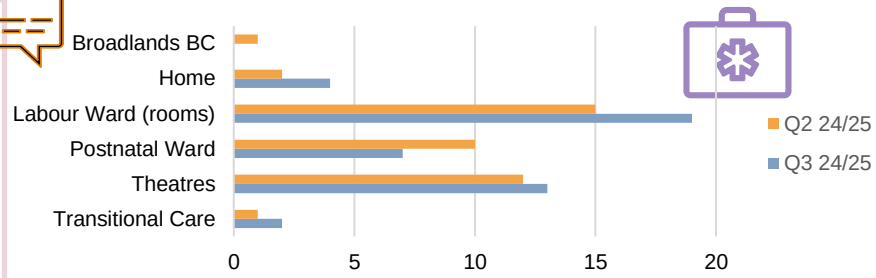
## Reason for admission



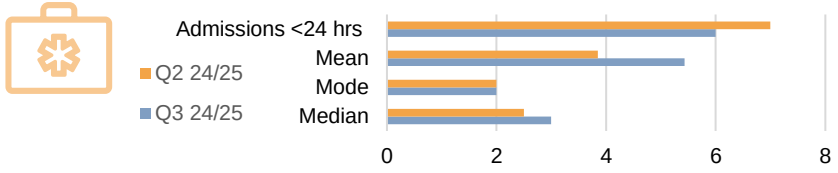

## Learning identified

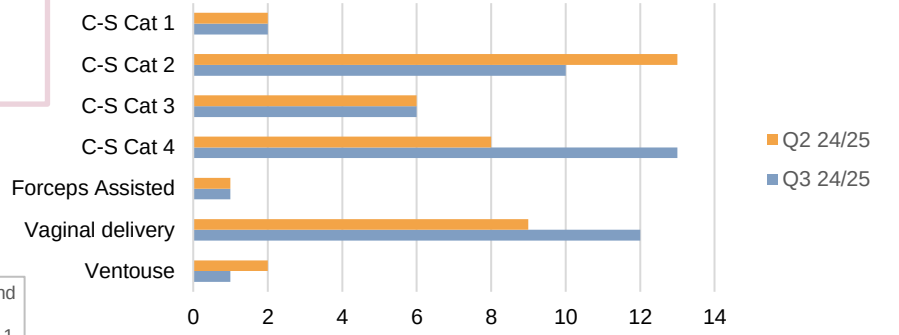
- 22 cases identified for review
- 13 reviews completed
- 1 case deemed avoidable admissions
- Themes/issues highlighted:
  - Documentation
  - Fetal monitoring
  - Use of in reach nurse could have benefitted
  - Prolonged length of stay
  - Escalation
  - Communication
  - Review for Cat 3 sections

## Admission from

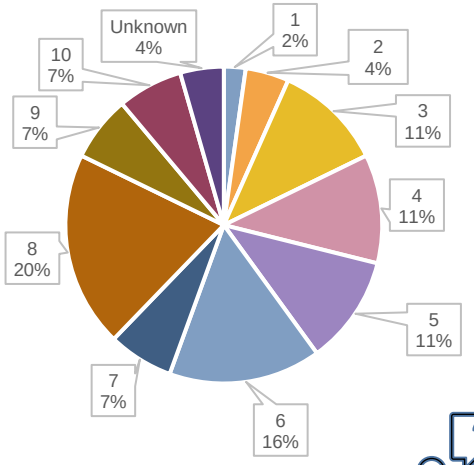



## Average length of stay



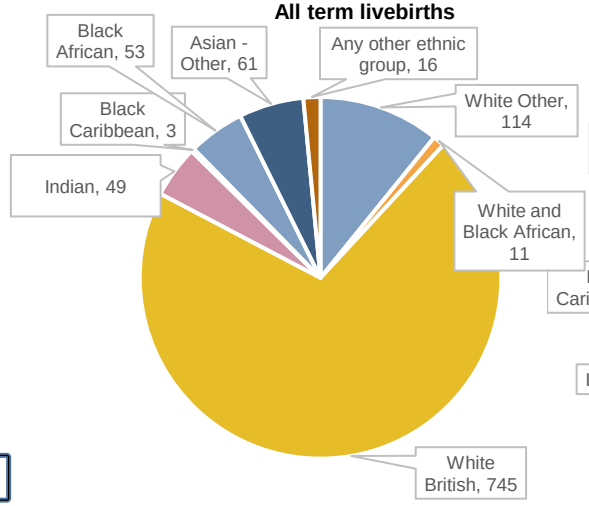




## IMD deciles of women / birthing people

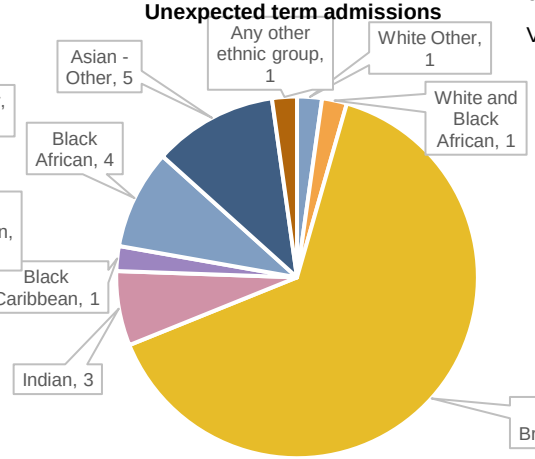


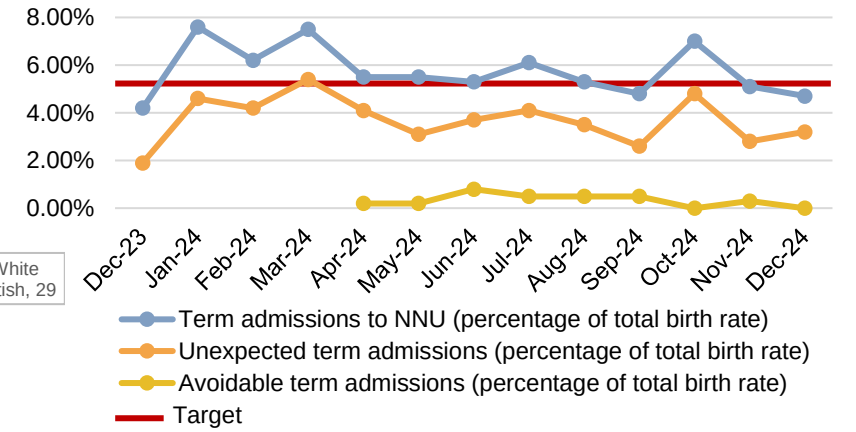

## Ethnicity of women / birthing people

### All term livebirths




### Unexpected term admissions



University Hospital Southampton NHS Foundation Trust

# Appendix 6 UHS Maternity/Obstetric Triangulation of claims, incidents and complaints data Q3 24-25

*No New claims in Q3 2024-2025.*

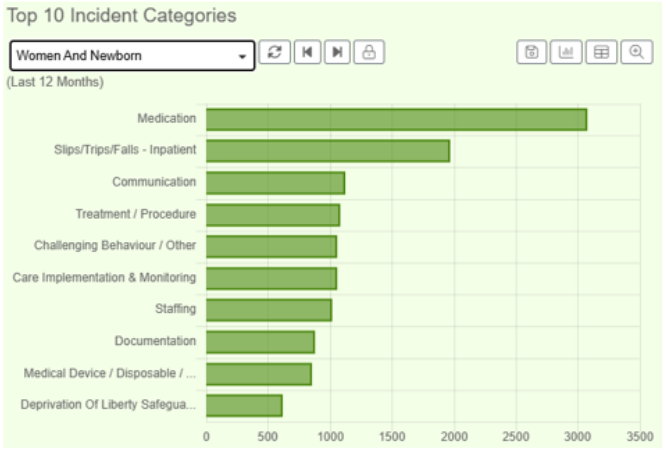
**Themes from Maternity reported incidents (AER's)**

*Maternal*

- *Specialist referrals/blood test & results*
- *Medication errors*

*Baby*

- *Newborn observations (not being completed as per protocol)*
- *Heel prick samples*




**Themes & learning identified from PMRT**

- Bereavement support in the community (NEST Teams)
- Management of FGR referral process
- Transfer of care when transferring in from Jersey.

**Complaints Q3 24-25**

8 new cases opened
3 cases closed
0 upheld, 1 not upheld & 2 partially upheld.

**Themes**

- Communication
- Patient care/mismanagement/clinical treatment/delay/failure to diagnose
- Staffing/lack of trained staff impact on patient care
- Medication/prescribing
- Values/behaviours

**Commonalities**

- Failure to follow process
- Communication
- Clinical care/treatment
- Treatment/procedure/medication error

University Hospital Southampton NHS Foundation Trust

## Background

NHS England has engaged a wide range of stakeholders who supported the development of this plan. This includes women and families who have used or are using maternity and neonatal services, members of the maternity and neonatal workforce, leaders and commissioners of services, NHS systems and regional teams, and representatives. The Plan requires Mat Neo services to focus on the following requirements,

- Listening to and working with women and families, with compassion
- Growing, retaining, and supporting our workforce
- Developing and sustaining a culture of safety, learning, and support
- Standards and structures that underpin safer, more personalised, and more equitable care.

**NB – the below actions does not contain all actions, those completed are excluded**

| Recommendation | Action / Improvement | Who will be responsible | Current Compliance | Completion | Comments |
|---|---|---|---|---|---|
| **1: Listening to and working with women and families with compassion** | | | | | |
| Achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding, or an equivalent initiative, by March 2027. | To achieve full BFI accreditation by 2026 | Infant Feeding Team | Currently at stage 2 achieved May 2024 | March 2026 | On track for 2026 delivery |
| Provide services that meet the needs of local population, with a focus on health inequalities. Ensure interpreter services and all standards are adhered to. | Full review of all patient information including digital systems has been undertaken | Patient Experience Lead | Digital website has been made available in a number of formats and can be translated | Continual review of patient information as part of the Trust Consensus System | As information expires and is reviewed changes are being made |

| | | | | | |
|---|---|---|---|---|---|
| | Ensure that we have gathered feedback from families where English is not their first language | Patient Experience Lead | Review of patient information is in process with paper converted to digital to ensure it can be translated. | Continual review of patient information as part of the Trust Consensus System | Oversight and review by the Divisional Team |
| | | | Audit of Interpretation services to ensure usage levels | Audit quarterly | Current audits demonstrate that Mat Neo services are the highest user of Interpretation services |
| | | | Work collaboratively with the MNVP chair to reach communities | End of quarter 2 2025 | MNVP chair now recruited and workstreams being developed |
| Collect & disaggregate local data & feedback by population groups to monitor differences in outcomes. | Continue to gather information from our digital systems to disaggregate data to population groups and other vulnerable groups | Digital Team<br>Specialist Midwives<br>QA Matrons | Continual review of local data and information from IT systems and feedback through to specialist midwives | Continual review of business intelligence information | This has achieved for the<br>Public Health Midwife service<br>Infant feeding Team |
| Involve services users in quality, governance and co-production when planning the design and delivery of maternity and neonatal services | CQC Maternity Survey action plan in place and regular monitoring. | Patient Experience Lead | To ensure development of action plan to address areas for improvement | End of quarter 2 2025 | |
| | MNVP & Patient Experience lead to support service developments | Patient Experience Lead & MNVP | MNVP working in collaboration in the development of services | End of quarter 2 2025 | |
| **2: Growing, retaining and supporting our workforce** | | | | | |
| Provide administrative support to free up pressured clinical time | Continued review of systems and processes to identify | Digital Team<br>QI team | | End of quarter 2 2025 | |

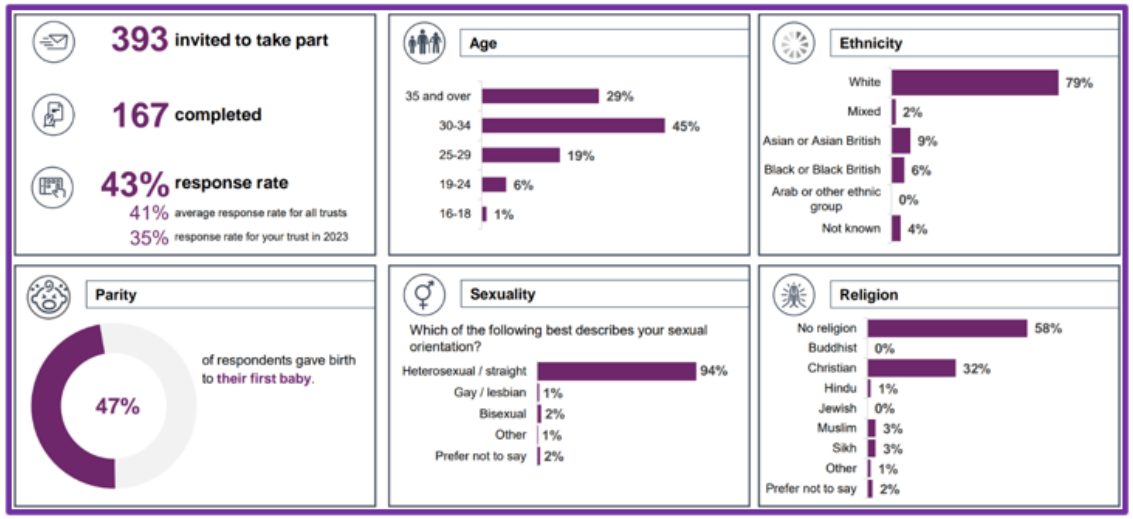
| | | | | | |
|---|---|---|---|---|---|
| | efficiencies in clinical time | | | | |
| Identify and address local retention issues affecting the maternity and neonatal workforce in a retention improvement action plan | Recruitment of a Recruitment & Retention Midwife | Director of Midwifery<br>Consultant Midwife Practice Education lead | Recruitment to role in place for appointment to Band 7 position | End of quarter 2 2025 | |
| Implement equity and equality plan actions to reduce workforce inequalities. | Align all with the Trust overarching Equity & Inequality policies | Recruitment of a Recruitment & Retention Midwife Workforce leads<br>Head of Midwifery | Recruitment to role in place for appointment to Band 7 position | Dec 2025 | |
| Create an anti-racist workplace, acting on the principles set out in the combatting racial discrimination against minority ethnic nurses, midwives | Align all with the Trust overarching Equity & Inequality policies and review of staff surveys | Recruitment of a Recruitment & Retention Midwife Workforce leads<br>Head of Midwifery | Priorities from the staff survey to be implemented by the Head of Midwifery | Dec 2025 | |
| Identify and address issues highlighted in student and trainee feedback surveys, such as the National Education and Training Survey | Ongoing feedback sessions taking place over the next months | Chief Nurse<br>Director of Midwifery Practice Education lead | Action plan to address any areas of concern | Dec 2025 | |
| Develop future leaders via succession planning, ensuring this pipeline reflects the ethnic background of the wider workforce | NHS People Plan compliance supported by the TNA & compliance monitoring | Practice Education lead Service leads | Agreed TNA | Annually completed | |
| **3: Developing and sustaining a culture of safety, learning and support** | | | | | |
| Understand ‘what good looks like’ to meet the needs of their local populations and learn from when things go well and when they do not. | Continual review of the data to establish the needs of the population and staff alongside the MNVP | Patient Experience Lead & MNVP<br>Head of Midwifery | Support in lace to implement PSIRF in the service | End of quarter 2 2025 | |

| | | | | | |
|---|---|---|---|---|---|
| | with full review of staff surveys and CQC patient surveys | | | | |
| Respond effectively and openly to patient safety incidents using PSIRF. | PSIRF has been implemented within the trust and used within Mat Neo services. | QA Matrons<br>Div Governance team | Support in place to implement PSIRF in the service | Dec 2025 | |
| | 4 x Safety Specialists within the Mat Neo service | Safety Specialists | Support in lace to implement PSIRF in the service and the wider Trust | Dec 2025 | |
| Time & structure in place to review & share learning, ensure actions are implemented within agreed timescales | Governance framework restructuring - 2025 | Div Governance team | | Dec 2025 | |
| Establish and maintain effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care. | Implementation of Martha's Law – QI project alongside the pilot programme.<br><br>Working alongside the AHSN to assist in implementation. | Inpatient Matron<br>QUAD team | QUAD team in place to drive actions<br><br>Inpatient Matron Implementing Marthas Law | Dec 2025 | |
| Act, alongside leaders, on outcomes data, staff and MNVP feedback, audits, incident investigations, and complaints, as well as learning | Support the implementation of PSIRF in the service and the wider Trust with the MNVP. Consider Safety & Quality Specialist | QA Matrons<br>Div Governance team | Audits, incident investigations, and complaints, as well as learning take place | Dec 2025 | |
| Involve the MNVP in developing the trust's complaints process, and in the quality safety and surveillance | MNVP & Patient Experience lead to support service developments | Patient Experience Lead & MNVP | MNVP now recruited<br>FTSU champions within the Mat Neo service<br>Focused meetings with the Trust | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | Complaints team including opportunities to undertake face to face resolution meetings | | |
| **4: Standards and structures that underpin safer, more personalised, and more equitable care** | | | | | |
| Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024 and adopt the national MEWS and NEWTT-2 tools by March 2025 | Full compliance and implementation remain in progress. Reviewed quarterly by the LMNS quality team. Significant improvement made over 2024 Implementation of Mews & NEWT remains in progress | QA Matron Audit Midwife | Oversight by the LMNS with ongoing local actions<br><br>Working alongside the AHSN to assist in implementation. | NEWTT- 2 by March 2025 Meows by June 2025 | |
| Review available data to draw out themes and trends and identify and address areas of concern including consideration of the impact of inequalities | MNVP & Patient Experience lead to support service developments | Patient Experience Lead & MNVP R&R lead midwife | Align all with the Trust overarching Equity & Inequality policies | Dec 2025 | |

# Maternity National Survey 2024 – Appendix 8

The survey was completed by 120 trusts involving 18,951 women and pregnant people who gave birth in February 2024




## Areas where we could improve

- Partners or someone close staying as long as the service user liked-
- Being able to speak to a midwife whenever they wanted after birth
- Help & advice from Health Professional in the 4 weeks after birth
- Delays in the discharge process
- Support with feeding baby in the 4 weeks after birth Improvement plan in progress for all areas

## Areas where we did well

- Involved in decision to be induced.
- Any concerns were taken seriously.
- Information on where to have baby.
- HP aware of medical history.
- Being asked about mental health by midwife.

## What Good Looks Like.....and what Are We doing

### Antenatal Education

- We have reviewed & updated all information and awaiting workforce provision to work with both our MNVP and Digital Teams to launch a new delivery of our Antenatal Education.

### Listening to women

- We review all FFT /Gather information and look at themes.
- New MNVP chair to be our listening ear and help us to improve our services
- Birth Reflections services expanded to meet the demand of families
- 'Intentional Rounding' takes place & Appreciative Enquiry used

### Consent

- All incidents, claims or complaints reviewed for this (1 x complaint in last month) – we are exploring Digital solutions for consenting

### Safe working environment

- BirthRate Plus completion 2024 – future planning underway

### Postnatal Care

- WLS roles and new Matron leadership for the ward environments
- Women increased access to good feeding support – Paid BFN support

### Partners

- We have introduced extended visiting in the form of 'Quiet time' for families in response to feedback asking for increased visiting for partners now 07.30-23.00

### Equity

- Trust policies in place for staff and patient support & guidance in place
- MatNeo are the highest user of the interpreting service in the Trust
- Information in different languages available on website

University Hospital Southampton
NHS Foundation Trust

**Agenda Item 5.4 ii)**

| **Committee Chair's Report to the Trust Board of Directors 13 May 2025** | | | |
|---|---|---|---|
| **Committee:** | **Quality Committee** | | |
| **Meeting Date:** | **28 April 2025** | | |
| **Key Messages:** | • The committee noted that there had been a further never event in Dermatology and that there had been an increase in the number of C-Diff cases. The committee also considered the plans in respect of the safety procedures to be introduced for the helicopter landing pad.<br>• In its thematic review of never events, the committee noted that the Trust had reported ten never events during 2024 (down from 12 in 2023), of which 50% related to wrong-site surgery.<br>• The Quality Governance Steering Group informed the committee that during December/January, 30% of the calls under the 'call for concern' (Martha's Rule) procedure had related to discharges. It was noted that the Trust was experiencing significant capacity challenges during this period and work was ongoing to roll out a discharge checklist and to update the Trust's policy.<br>• The committee received an update in respect of the 'Fundamentals of Care' programme, noting that an engagement event had been held with community carers to obtain feedback regarding the discharge experience. The Digital team had also agreed to increase the prioritisation of the work required to adapt the inpatient noting system. A clear structure had also been implemented for matrons' walkabouts.<br>• The committee noted that the Trust continued to experience significant challenges due to the number of patients with mental health issues, who would be better cared for by alternative care providers.<br>• An equality and quality impact assessment process to support the decisions required during 2025/26 was shared with the committee. | | |
| **Assurance:** *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)* | **6.2 Board Assurance Framework (BAF) Update** | ***Assurance Rating:*** **Substantial** | ***Risk Rating:*** **N/A** |
| | • All risks had been reviewed by the relevant Executive(s) and there had been no changes to ratings or target dates. | | |
| **Any Other Matters:** | The committee reviewed the interim Maternity and Neonatal Safety Report, noting that there was nothing requiring escalation to the Board. | | |

## Assurance Rating:

| | |
|---|---|
| **Substantial Assurance** | There is a robust series of suitably designed internal controls in place upon which the organisation relies to manage the risk of failure of the continuous and effective achievement of the objectives of the process, which at the time of our review were being consistently applied. |
| **Reasonable Assurance** | There is a series of controls in place, however there are potential risks that may not be sufficient to ensure that the individual objectives of the process are achieved in a continuous and effective manner. Improvements are required to enhance the adequacy and effectiveness of the controls to mitigate these risks. |
| **Limited Assurance** | Controls in place are not sufficient to ensure that the organisation can rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Significant improvements are required to improve the adequacy and effectiveness of the controls. |

| | |
|---|---|
| **No Assurance** | There is a fundamental breakdown or absence of core internal controls such that the organisation cannot rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Immediate action is required to improve the adequacy and effectiveness of controls. |
| **Not Applicable** | Where assurance is not required and/or relevant. |

**Risk Rating:**

| | |
|---|---|
| **Low** | Based on the report considered by the committee, there is little or no concern that the Trust will be unable to meet its stated objectives and/or plans. |
| **Medium** | There is some concern that the Trust might not be able to fully meet its stated objectives and/or plans based on the information contained in the report considered by the committee. |
| **High** | There is a significant risk that the Trust will not be able to meet its stated objectives and/or plans based on the information contained in the report considered by the committee. |
| **Not Applicable** | Where risk rating is not relevant. |

University Hospital Southampton
NHS Foundation Trust

| **Agenda Item 5.5 Report to the Trust Board of Directors, 13 May 2025** | |
|---|---|
| **Title:** | Chief Executive Officer's Report |
| **Sponsor:** | David French, Chief Executive Officer |
| **Author:** | Craig Machell, Associate Director of Corporate Affairs |

**Purpose**

| (Re)Assurance | Approval | Ratification | Information |
|---|---|---|---|
| | | | x |

**Strategic Theme**

| Outstanding patient outcomes, safety and experience | Pioneering research and innovation | World class people | Integrated networks and collaboration | Foundations for the future |
|---|---|---|---|---|
| x | x | x | x | x |

**Executive Summary:**

The CEO's Report this month covers the following matters:

- NHS England Reorganisation
- Model Integrated Care Boards
- British Social Attitudes Survey
- Board Member Appraisal Guidance
- NHS Performance Assessment Framework Consultation
- Spring Statement
- Advice and Guidance Scheme
- NHS Cancer Vaccine Launch Pad

**Contents:**

Chief Executive Officer's Report

**Risk(s):**

N/A

| **Equality Impact Consideration:** | N/A |
|---|---|

# Chief Executive Officer's Report

## NHS England Reorganisation

On 13 March 2025, the Government announced its intention to abolish NHS England and bring its functions back into the Department of Health and Social Care in a reversal of the reforms carried out in 2012 which had introduced a degree of operational independence for the NHS. It is anticipated that headcount across the two current organisations will be reduced by 50%

Integrated Care Boards have also been instructed to reduce their running costs, based on a target running cost per head of population (£18.76) compared to the current national average of nearly double that. There is significant variation in running costs across the ICBs, some of which is associated with lack of scale. I understand that a population size of 2-3m is emerging as the appropriate scale and that consequently there is likely to be a reduction in the number of ICBs through consolidation or boundary shifts.

Trusts have been instructed to make significant reductions in their corporate services budgets, with targets based on the headcount growth since 2019. This target, combined with the Trust's overall financial settlement for 25/26, translates into a challenging Cost Improvement Programme target of £110m, including a headcount reduction of 780 FTEs during the year.

Having announced this to staff, we chose to issue a press release, and I agreed to be interviewed by the BBC in respect of how the cost-saving measures would impact the Trust. The story was covered responsibly by the BBC, and we were able to deliver our message that the Trust's priority will be to protect frontline services, continue to deliver outstanding care and support our staff through what will undoubtedly be a very difficult time.

## Model Integrated Care Boards

On 2 May, NHS England published a blueprint document setting out the proposed re-modelling of the current Integrated Care Boards (ICBs) to define their focus, role and function. This follows the outputs of the Darzi review, which noted a lack of clarity around the role of ICBs and inconsistency. Furthermore, the blueprint is intended to lay the foundations for the expected 10-Year Health Plan as well as to help ICBs deliver their cost savings.

The core functions of ICBs are stated as being:

- Understanding local context
- Developing long term population health strategy
- Delivering the strategy though payer functions and resource allocation
- Evaluating impact

It is suggested that ICBs grow or invest in eleven functions, such as those concerning population health management, health inequalities and commissioning in order for ICBs to be able to deliver against their purpose and objectives. At the same time, ICBs should selectively retain and adapt six core functions, such as governance, core organisational operations and quality management, and review, with the potential to transfer, eighteen other functions such as oversight of provider performance, local workforce development and training, research and development, digital, data collection, infection prevention and control, safeguarding, and estates.

It is proposed that some responsibilities, including primary care operations and transformation, will transfer to neighbourhood health providers, whose remit is not completely defined, but is likely to include primary care, community, mental health and the voluntary sector.

For NHSE, regions, ICBs and trusts to achieve the headcount reduction targets, further iteration of the model is likely needed to determine what activities currently undertaken can be stopped rather than redistributed to other bodies.

NHS Providers has published a briefing note, together with the blueprint document. These can be accessed at:

68490_model-icb-blueprint---may-2025.pdf

Model Integrated Care Board – Blueprint v1.0

**British Social Attitudes Survey**
Based on the British Social Attitudes survey for 2024, 59% of people said that they were 'very' or 'quite' dissatisfied with the NHS, an increase from 52% in 2023. The survey has been carried out every year since 1983 by the National Centre for Social Research, with questions relating to public views of health and care sponsored by the King's Fund and Nuffield Trust.

The survey was carried out in September and October 2024 and documents the lowest levels of satisfaction with the NHS on record. Public satisfaction with accident and emergency services has fallen sharply from 31% to 19%. Dissatisfaction with waiting times and the ability to get an appointment was widespread with 65% of respondents dissatisfied with the length of time it took to get hospital care and 69% saying that they were dissatisfied with accident and emergency waiting times.

However, inpatient and outpatient hospital care was the part of the NHS with the highest levels of satisfaction, with 32% saying they were satisfied and only 28% dissatisfied. Similarly, a majority (51%) of the public said that they were satisfied with the quality of NHS care. Seventy-two per cent of respondents disagreed with the statement that 'there are enough staff in the NHS these days', and 69% believed that the Government did not spend enough money on the NHS.

The report can be read at:
https://a.storyblok.com/f/256914/x/e2d53af58e/public_satisfaction_nhs_social_care_2024_bsa_2025.pdf?cv=1743525036900

**Board Member Appraisal Guidance**
NHS England published new board member appraisal guidance on 1 April 2025, alongside forms for completion, gathering stakeholder feedback, and for the appraisee to use to prepare.

The guidance sets out NHS England's expectations and recommendations for the completion of board member appraisals. It sets out a number of 'what' principles focused on what the appraisal should contain, and 'how' principles focused on how it should be undertaken.

The guidance also incorporates the NHS leadership competency framework domains and fit and proper persons test requirements.

The guidance can be read at: https://www.england.nhs.uk/publication/board-member-appraisal-guidance/

If appraisals have been completed or are underway, they do not need to be redone. The UHS process for annual appraisals was already underway so this new framework will be used for the next round in 2026. The Chief People Officer will work with the Chair and CEO to implement the new framework as appropriate.

**NHS Performance Assessment Framework Consultation**
On 27 March 2025, NHS England published an updated NHS performance assessment framework for 2025/26 to be consulted on between 2 – 23 May 2025. It is intended to publish the final framework at the end of the first quarter, with the first formal segmentation of all trusts and integrated care boards (ICBs) being undertaken in July 2025.

This new draft framework reflects the response to the consultation previously carried out in 2024 as well as a number of other changes announced in late 2024. It also provides clarity about the roles and responsibilities of providers, integrated care boards and NHS England.

Providers and ICBs will be assessed against an agreed set of metrics by NHS England. The actions then taken to secure improvement will be informed by the organisation's capability assessment. The approach to capability assessment is being finalised but is expected to use qualitative information including reports from regulators. The extent to which providers are effectively collaborating and supporting system working is also expected to form part of the assessment.

NHS England will also assess the leadership capability of providers and ICBs to direct performance improvement activities. Providers will be measured against the six domains of the insightful provider board, using a combination of self-assessment, third party information and measures of their track record.

Each trust and ICB will continue to be assigned a segment ranging from 1 (high performing) to 4 (low performing), with 4 triggering a diagnostic review. Organisations with the most intense support needs will enter the recovery support programme and will be allocated a segment of 5.

The proposed NHS Performance Assessment Framework can be read at:
https://www.england.nhs.uk/wp-content/uploads/2025/03/6-the-nhs-performance-assessment-framework-annex.pdf

**Spring Statement**
The Chancellor presented her Spring Statement on 26 March 2025, accompanied from the main findings from the Office for Budget Responsibility's (OBR) forecast on the UK economy.

The key points from the OBR's forecast were:
- Since October 2024, the economic outlook has worsened.
- Real GDP growth was expected to be 1% in 2025, half of the October 2024 forecast.
- Interest rate expectations have risen since October, with the Bank Rate projected to decrease from 4.5% to 3.8% by mid-2026.
- Annual Consumer Prices Index (CPI) inflation was expected to rise to 3.2% in 2025.

Whilst the Government intends to outline its spending plans and key public sector reforms at the Spending Review which will conclude on 11 June 2025, it was confirmed that the Resource Departmental Expenditure Limits envelope will grow at 1.2% in real terms per year from 2025/26 to 2029/30. Government departments will be expected to reduce their administrative budgets by 15% by the end of the decade to deliver at least £2.2bn of savings on back-office functions.

The revised Department of Health and Social Care budget is set out below:

| | **2023/24 (outturn)** | **2024/25 (plans)** | **2025/26 (plans)** |
|---|---|---|---|
| **DHSC Revenue Budget (£bn)** | 177.9 | 193.3 | 202.0 |
| **Of which NHSE (£bn)** | 171.0 | 183.6 | 193.4 |

**Advice and Guidance Scheme**
On 17 April 2025, the Government announced an extension of the 'advice and guidance' scheme to enable General Practitioners to provide care and advice to patients without increasing hospital waiting lists. The scheme links GPs and hospital specialists before patients are referred onto waiting lists, so that tests and treatments can be delivered at the most convenient place.

The scheme is supported by £80m of funding with the ambition of helping two million people receive faster and more convenient care in their local community by the end of 2025/26. GPs are able to claim £20 for each episode of care.

**NHS Cancer Vaccine Launch Pad**

It was announced on 14 April 2025 that patients with advanced skin cancer were set to be included in trials of a new cancer vaccine. This follows the extension of a Southampton-run national programme.

The NHS Cancer Vaccine Launch Pad, run by the Southampton Clinical Trials Unit, aims to speed up the development of potentially ground-breaking cancer treatments, including through personalised cancer vaccines. Health Minister Karin Smyth visited UHS, meeting R&D staff and a patient, which was covered positively by the BBC.

University Hospital Southampton
NHS Foundation Trust

| Agenda Item 5.6 | Report to the Trust Board of Directors, 13 May 2025 |
|---|---|
| **Title:** | Performance KPI Report 2024-25 Month 12 |
| **Sponsor:** | David French, Chief Executive Officer |
| **Author:** | Sam Dale, Associate Director of Data and Analytics<br>Emily Wright, Mental Health Service Manager |

**Purpose**

| (Re)Assurance | Approval | Ratification | Information |
|---|---|---|---|
| x | | | |

**Strategic Theme**

| Outstanding patient outcomes, safety and experience | Pioneering research and innovation | World class people | Integrated networks and collaboration | Foundations for the future |
|---|---|---|---|---|
| x | x | x | x | x |

**Executive Summary:**

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

**Contents:**

The content of the report includes the following:

- An 'Appendix,' which presents monthly indicators aligned with the five themes within our strategy
- An overarching summary highlighting any key changes to the monthly indicators presented and trust performance indicators which should be noted.
- An 'NHS Constitution Standards' section, summarising the standards and performance in relation to service waiting times

**Risk(s):**

Any material failures to achieve Trust performance standards present significant risks to the Trust's long-term strategy, patient safety and staff wellbeing.

| Equality Impact Consideration: | NO |
|---|---|

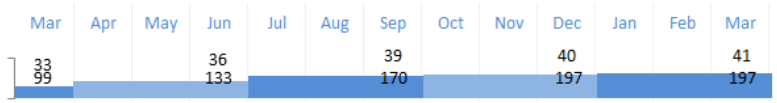
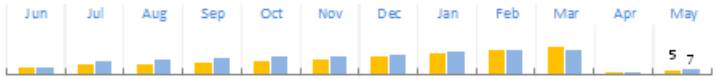
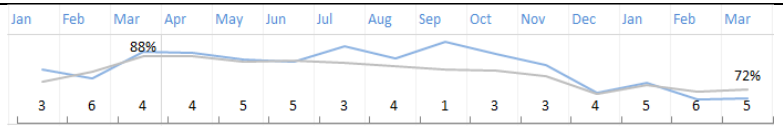
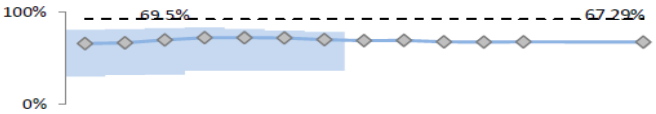
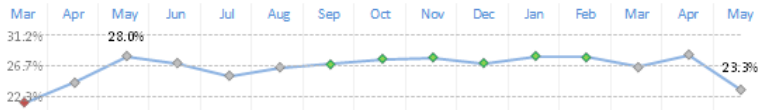
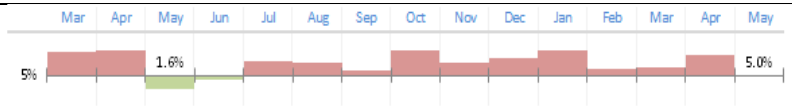
University Hospital Southampton NHS
NHS Foundation Trust

# Performance KPI Board Report

## Covering up to
## March 2025

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 prepared for the Trust Board members 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.

# Summary

This month's spotlight report explores UHS recent performance for patients attending the Trust with mental health needs.

The report highlights that:-

- The Trust has seen an increase in the volume of patients attending UHS with enhanced care needs and those who receive a decision to admit to a mental health bed.
- The establishment of the Virtual Enhanced Care Group is proving successful which now incorporates the Alcohol Care Team, Dementia and Delirium Team, Enhanced Care Mental Health Team, Learning Disabilities and Autism Team an Mental Health Operations Team.
- The trust has established improved data collections and a mental health dashboard to improve patient monitoring and management alongside early visibility of capacity and staffing pressures.
- The service is facing financial barriers particularly driven by the cost of the agency staffing required to ensure appropriate enhanced care observations for patients.
- The team has plans to expand a programme of training and support to UHS staff on key areas such as suicide and self-harm awareness, violence and aggression reduction and staff wellbeing.

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

1. Performance against the emergency access target continues to be challenging with attendances growing by 3.2% compared to the previous financial year. In March 2025, 57.2% of patients spent less than four hours in the main ED department which places the trust in the third quartile when compared to peer teaching hospitals.
2. There is significant focus on improving this, with the plan based on two areas; improving decision making speed within the Emergency Department and improving timely flow from the department when patients need admission. The former is looking at consistency of practice, speciality in-reach into the department, and ensuring rotas reflect known peaks in attendance. The latter is looking at enhanced access, and increased pathways, to same day emergency care, flow and discharge throughout the hospital and embedding internal professional standards.
3. Whilst the trust continues to deliver more elective activity year on year, the RTT (referral to treatment) waiting list has continued to climb in each month of quarter four peaking at 61,686 at the end of the financial year. Despite this the organisation has maintained performance of 62% for the percentage of patients on the waiting list who are below 18 weeks.
4. The hospital reported just one patient waiting over 78 weeks in March 2025 due to the continued national delays for corneal tissue release. There were 21 patients waiting over 65 weeks - whilst some were also corneal transplant patients, others were services impacted by the prioritisation of urgent cancer patients or services managing emergency demand.
5. The trust has maintained its strong performance against the 28 day faster diagnosis standard for cancer across quarter four, consistently hitting the target and benchmarking in the top quartile compared to peer teaching hospitals across the country. Diagnostic capacity and the impact of provider

referrals into UHS specialised services impacted our 62 day performance in February (72.1%) but unvalidated data provides assurance that the position has recovered to above 80% in March 2025.

6. There were zero cases of MRSA BSI attributed to UHS in March 2025 and just one case across the quarter. This case underwent a detailed concise review led by the Infection Prevention Team, an after-action review (AAR) with the relevant clinical teams to identify learning and areas for improvement and a final HCAI review with Chief Nursing Officer and Chief Medical Officer.
7. The Trust reported zero Patient Safety Investigations (PSIIs) and zero Never Events in March 2025.
8. The HSMR statistics have now been refreshed for the January 2025 position and UHS continues to reflect better than expected survival.

**Ambulance response time performance**

The latest unvalidated weekly data is provided by the South Central Ambulance Service (SCAS). In the week commencing 21st April 2025, our average handover time was 17 minutes 25 seconds across 756 emergency handovers and 18 minutes 31 seconds across 42 urgent handovers. There were 62 handovers over 30 minutes and 11 handovers taking over 60 minutes within the unvalidated data. Across April the average handover time was 16 minutes 36 seconds.

# Spotlight: Mental Health Patient Cohort

In 2020 the CQC (2020) identified that acute hospitals need to do more in collaboration with their mental health Trust partners, to support vulnerable people who have mental health needs whilst they are attending acute hospital emergency departments and receiving in-patient care. Many of these patients will have a physical health need that has led them to acute hospital care setting. This may be as a direct result of a mental health crisis or may be a primary physical health need with an added complexity because of on-going mental health needs. There are numerous physical health conditions that can lead to an increased incidence of mental health issues impacting engagement with treatment and care and increasing length of stay and creating poorer outcomes if not effectively prevented or supported whilst the patient is in the acute hospital NICE 2009.

With an increasing number of patients with mental health needs attending the Trust the aim of this paper is to provide an overview on the current performance, the challenges and successes for this cohort of patients at University Hospital Southampton NHS Foundation Trust.

This report includes a summary of the pressures and plans in place alongside analysis on the following themes:

1. Patients who receive a decision to admit to a mental health unit while at University Hospital Southampton NHS Foundation Trust (UHS)
2. Patients who are referred to Adult/Older Persons Mental Health Liaison Team Service
3. Patients who are detained to UHS under the Mental Health Act
4. Patients who are brought to UHS ED as a hospital-based place of safety detained under Section 136
5. Costs for patients who are medically optimised for discharge (MOFD) and are allocated enhanced care staff

## 1. Patients who receive a decision to admit while at University Hospital Southampton NHS Foundation Trust (UHS)

A **Mental Health Emergency Department breach** occurs twelve hours following the decision to admit. This is the only national reportable performance data requirement from the Mental Health Operational Team at UHS.

- The clock starts at the date and time when the Mental Health Act Assessment or Gatekeeping Assessment has a clearly documented decision that the patient requires admission to a Psychiatric hospital while in the Emergency Department.
- The clock stops once the:
  - patient is transferred to an inpatient bed (mental health or a UHS bed) or
  - patient absconds from ED or
  - patient decides if informal that they wish to go home for treatment, or
  - psychiatry team deems that they no longer required inpatient admission within ED

If admitted to a UHS ward, the date and time of the clock stop is when they are transferred. If admitted to a Mental Health bed, the date and time of the clock stop is when they are discharged from ED. If the clock exceeds 12 hours or more this is reported monthly to NHSE.

UHS also monitor what we refer to as **hidden breaches**, these are patients whose wait for a Mental health bed extends beyond 12 hours but is not NHSE reportable. There are two reasons why the breach in not reportable:

1. In the absence of a psychiatric bed the patient is admitted to UHS with no physical need, either to facilitate flow in the ED and/or for the safety and dignity of the patient.
2. The patient has been admitted for inpatient physical health care, have a decision to admit as their discharge destination and wait more than 12 hours for transfer once medically optimised for discharge from UHS.

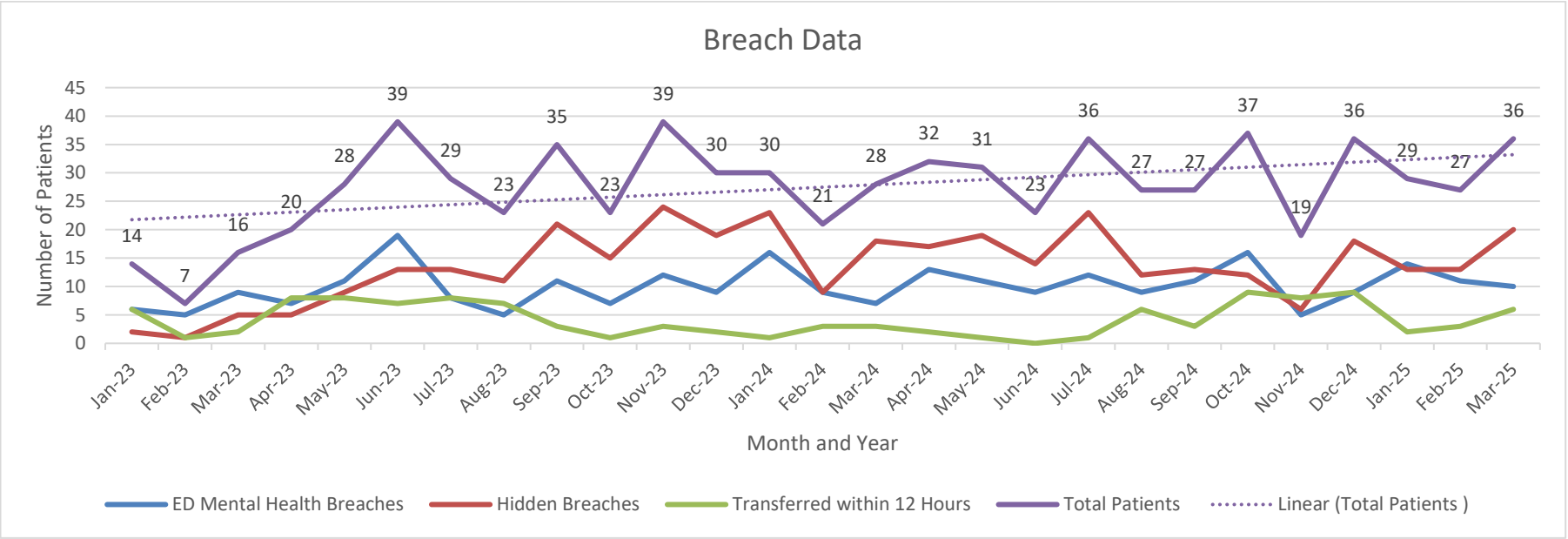
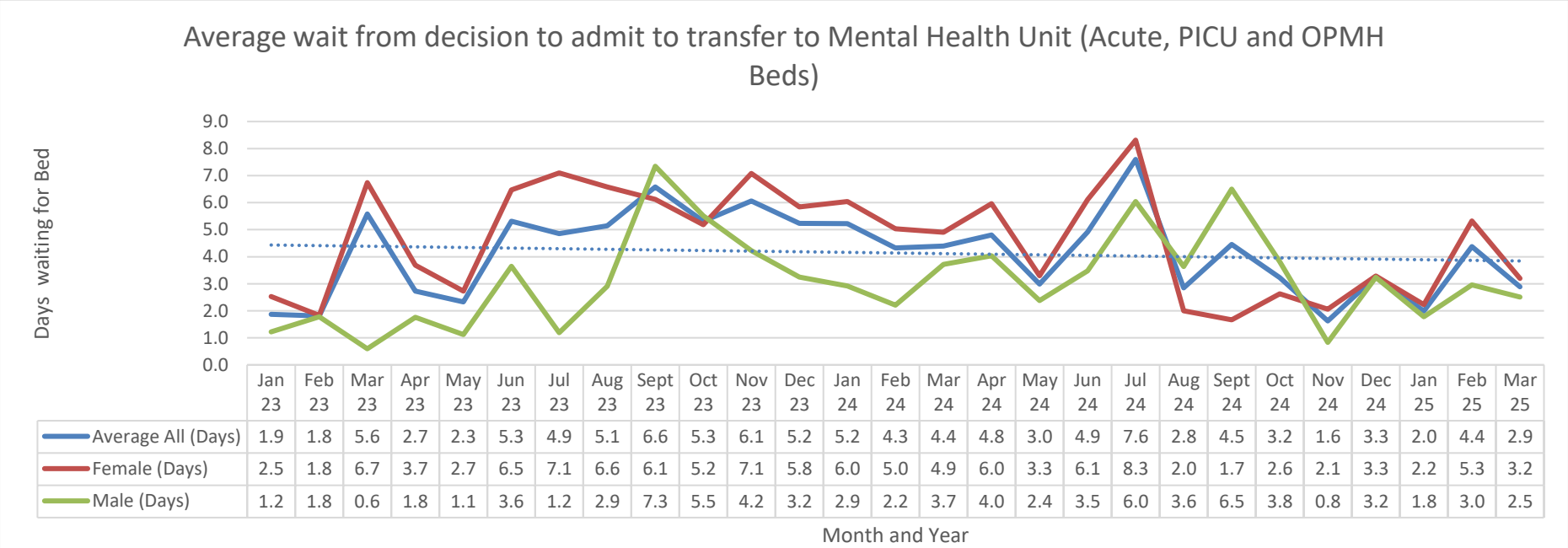



**Figure 1. UHS Breach data including 12 Hour NHSE reportable breaches and hidden breaches from 1st January 2023 to 31st March 2025.**

In 2023, a total of 303 patients had a decision to admit to a mental health bed whilst at UHS. Fifty-six (18.5%) patients were transferred within the expected standard (12 hours from their decision to admit) and there were 109 NHSE reportable Mental Health Breaches in ED. In 2024, 347 patients had a decision to admit to a mental health bed whilst at UHS, reflecting a 14.5% annual growth rate. There have been forty-six (13.2%) patients who

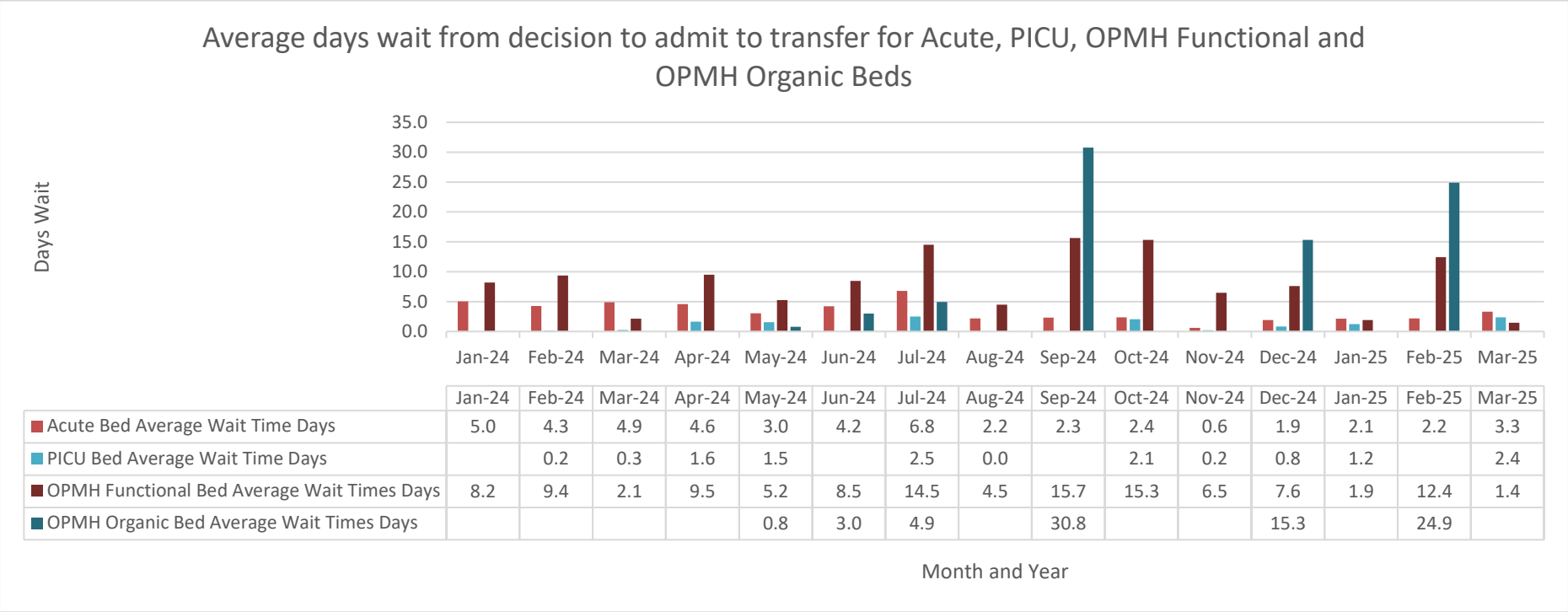
transferred within the expected 12 hours from their decision to admit. There were 127 (37%) NHSE reportable Mental Health Breaches in UHS ED a 16.5% increase compared to 2023. In Q1 of calendar year 2025, 92 patients had a decision to admit to a mental health bed whilst at UHS. If numbers remain consistent for the rest of 2025, a growth rate of 6% 2024-2025 is expected.




| | Jan 23 | Feb 23 | Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sept 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sept 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 | Feb 25 | Mar 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Average All (Days) | 1.9 | 1.8 | 5.6 | 2.7 | 2.3 | 5.3 | 4.9 | 5.1 | 6.6 | 5.3 | 6.1 | 5.2 | 5.2 | 4.3 | 4.4 | 4.8 | 3.0 | 4.9 | 7.6 | 2.8 | 4.5 | 3.2 | 1.6 | 3.3 | 2.0 | 4.4 | 2.9 |
| Female (Days) | 2.5 | 1.8 | 6.7 | 3.7 | 2.7 | 6.5 | 7.1 | 6.6 | 6.1 | 5.2 | 7.1 | 5.8 | 6.0 | 5.0 | 4.9 | 6.0 | 3.3 | 6.1 | 8.3 | 2.0 | 1.7 | 2.6 | 2.1 | 3.3 | 2.2 | 5.3 | 3.2 |
| Male (Days) | 1.2 | 1.8 | 0.6 | 1.8 | 1.1 | 3.6 | 1.2 | 2.9 | 7.3 | 5.5 | 4.2 | 3.2 | 2.9 | 2.2 | 3.7 | 4.0 | 2.4 | 3.5 | 6.0 | 3.6 | 6.5 | 3.8 | 0.8 | 3.2 | 1.8 | 3.0 | 2.5 |

**Figure 2: Waiting times in days from decision to admit/ patient becoming medically optimised for discharge, to transfer to specialist bed (Acute, PICU and OPMH Beds only) between 1st January 2023 to 31st March 2025.**

This is the time from when a patient received a decision to admit or if the patient had a decision to admit when not MOFD the time from when declared MOFD. Wait times for admission have remained a consistent average for 2023-2024 as per trend line below. There continues to be long waits for patients over the age of 65, who require admission to a ward for older people.




| | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Acute Bed Average Wait Time Days | 5.0 | 4.3 | 4.9 | 4.6 | 3.0 | 4.2 | 6.8 | 2.2 | 2.3 | 2.4 | 0.6 | 1.9 | 2.1 | 2.2 | 3.3 |
| PICU Bed Average Wait Time Days | | 0.2 | 0.3 | 1.6 | 1.5 | | 2.5 | 0.0 | | 2.1 | 0.2 | 0.8 | 1.2 | | 2.4 |
| OPMH Functional Bed Average Wait Times Days | 8.2 | 9.4 | 2.1 | 9.5 | 5.2 | 8.5 | 14.5 | 4.5 | 15.7 | 15.3 | 6.5 | 7.6 | 1.9 | 12.4 | 1.4 |
| OPMH Organic Bed Average Wait Times Days | | | | | 0.8 | 3.0 | 4.9 | | 30.8 | | | 15.3 | | 24.9 | |

**Figure 3: wait time in hours per month relating to the bed patients require**

There continue to be extremely long waits for patients over the age of 65, who require admission to a ward for older people. Figure 3 depicts the average wait time in days per month relating to the type of bed a patient requires. Acute beds are for patients aged 18-65, PICU beds (Psychiatric Intensive Care Unit) are for patients who require a higher level of care due to their risk/ health, OPMH Functions beds are for patients over 65 with a mental health issue which is not organic in cause such as schizophrenia, OPMH Organic beds are for patients over 65 with a cognitive condition such as dementia.

The data in figure 4 was taken from all patients who received a decision to admit at UHS in 2024, the data looks at what need the patient had on arrival to UHS ED and whether they were admitted for a health care need or other reason. 49% of people who attended the Trust with a patient journey resulting in a decision to admit had no physical health need to attend the Emergency department.

On review of the time patients attended ED, 41% of those attending with no physical health need attended at the same time a local haven was open between 16.30-22.30, it may have been that these patients were brought to ED by Ambulance/ Police or were too unwell to self-present to a haven.

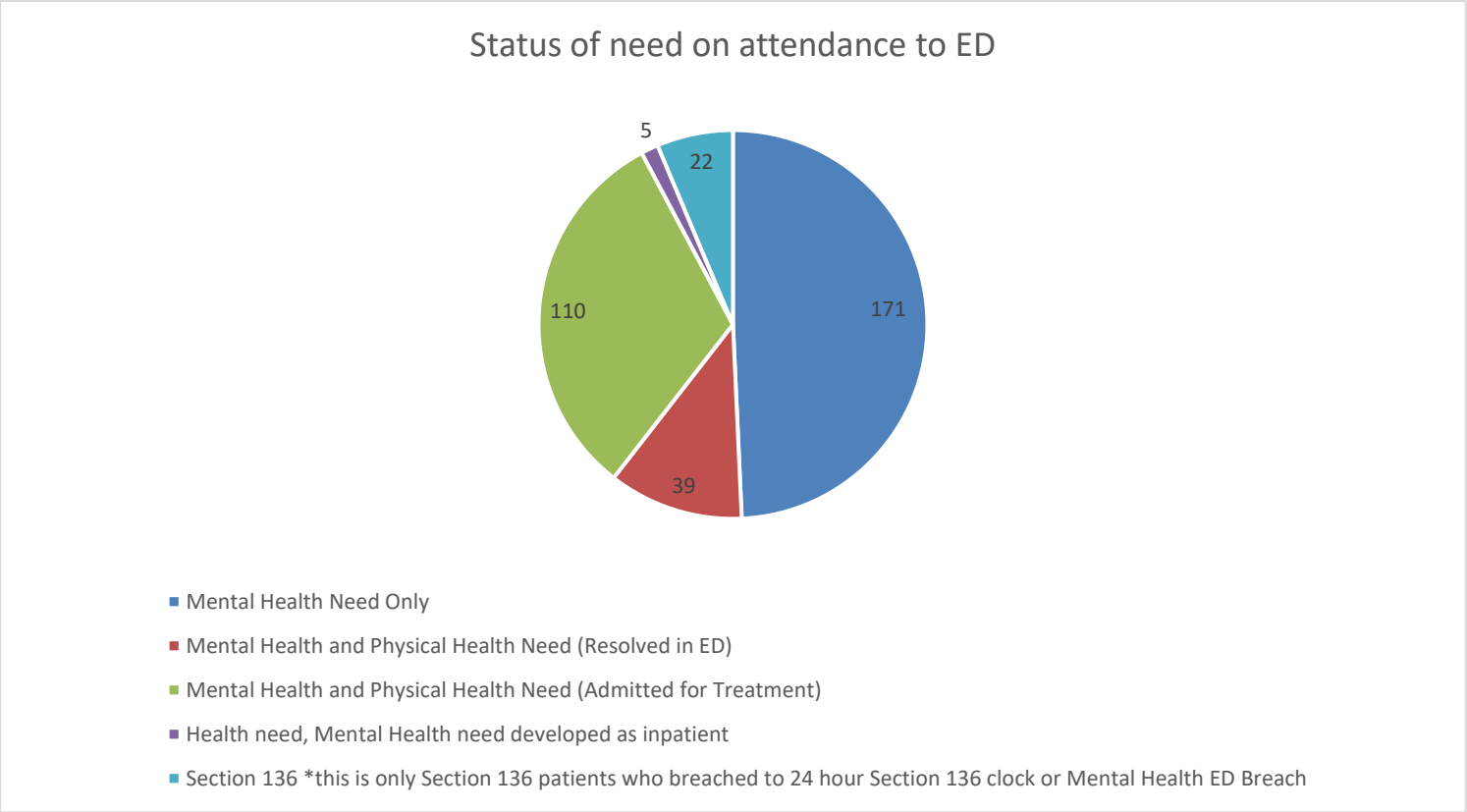



**Figure 4: Status of need on attendance**

Only 2% of patients (6 patients) admitted for a health treatment reason were transferred within 12 hours of becoming MOFD compared to 31% of patients who were a hidden and unreported breach as they waited longer than 12 hours on an inpatient ward after becoming MOFD. 28% of patients were admitted to UHS with no health need but because there was no mental health bed available for the patient. 32% patients were transferred from UHS ED.

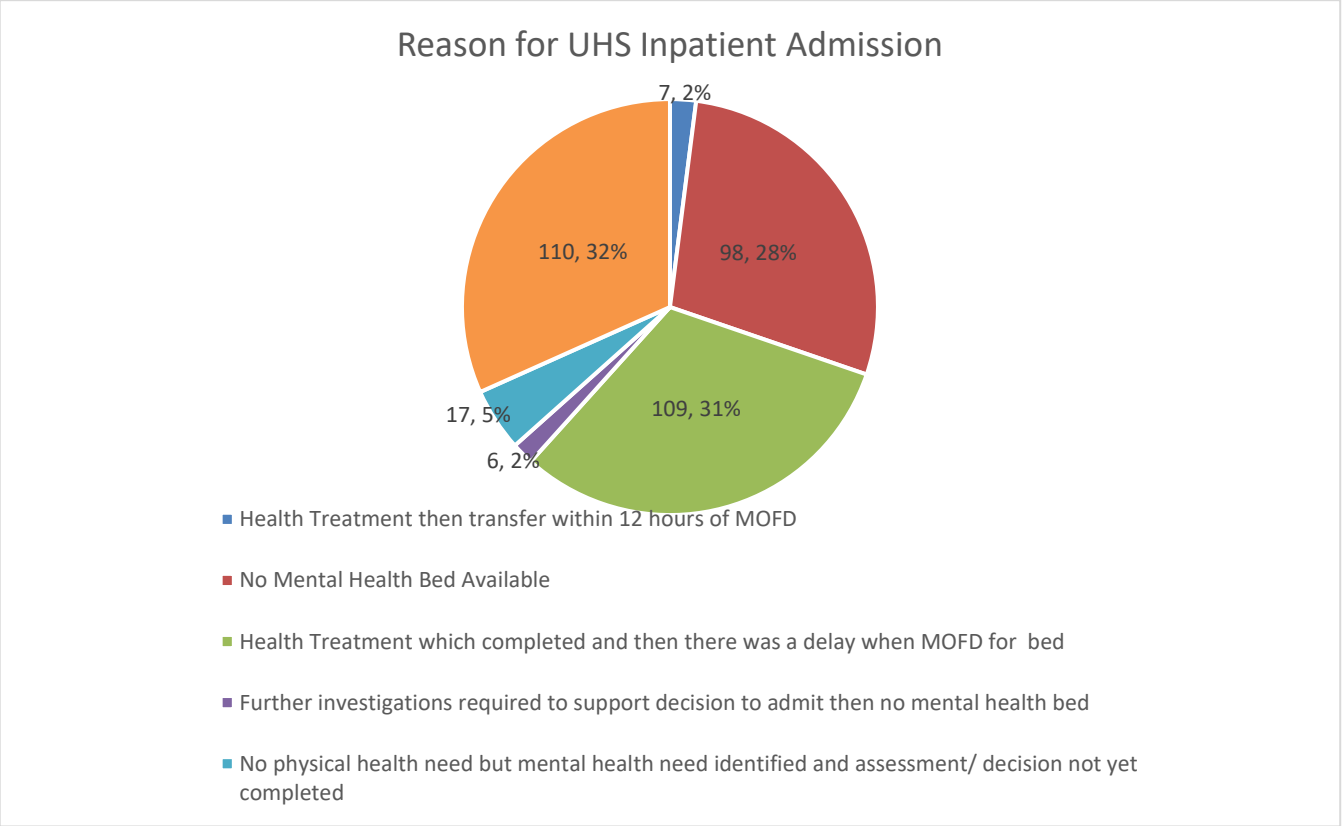



**Figure 5 - Reasons for admission into UHS split by number & percentage**

**2. Patients who are referred to Adult/ Older Persons Mental Health Liaison Team Service**

The data below (figure 6) was collated for all patients 18+ who were referred to the Mental Health Liaison Team, Hampshire and Isle of Wight Healthcare NHS Foundation Trust from January 2022 to December 2024. This graph highlights that that the referral numbers were highest in 2024, on 60% of the months out of the year, in comparison to previous years.

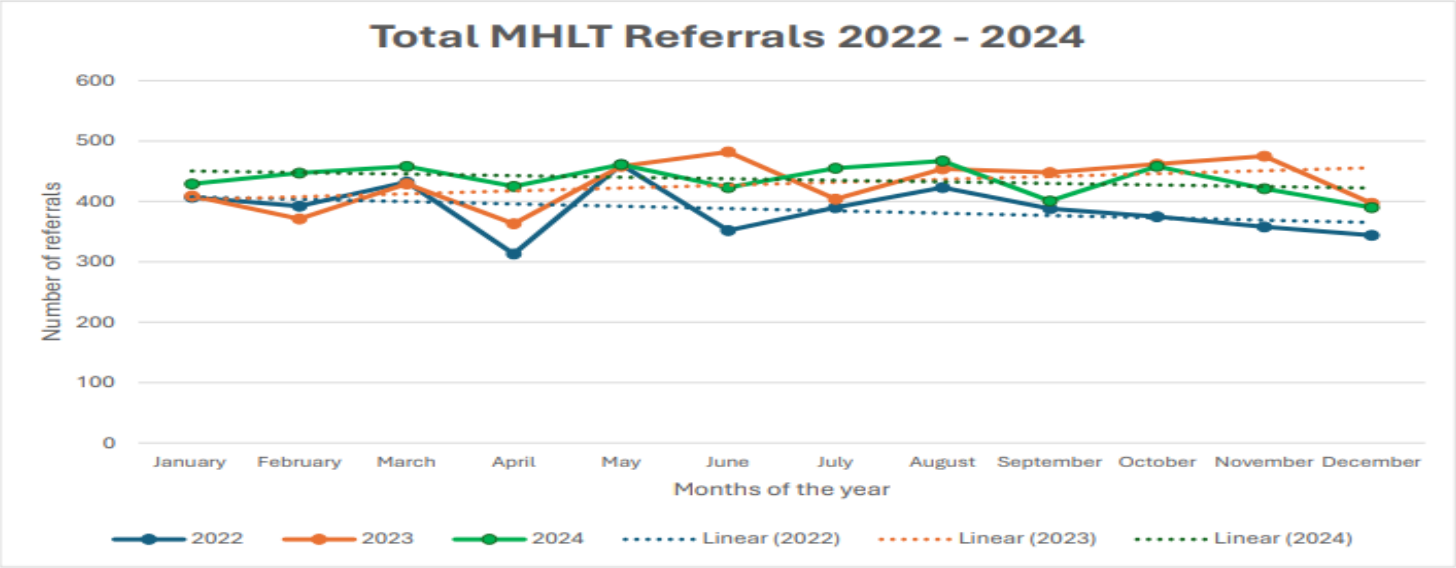


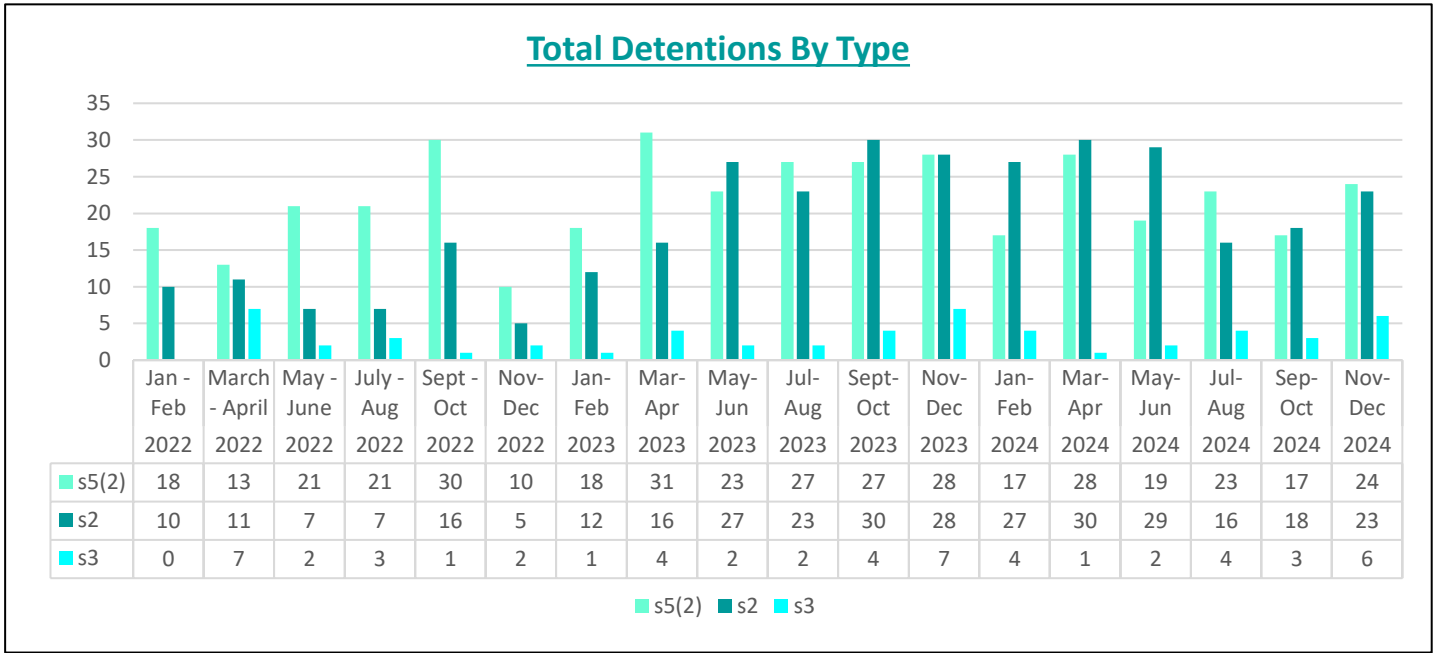

Figure 6 – Mental Health Referral Trends

In 2022, the total referrals across Adult Mental Health (AMH) and Older Persons Mental Health (OPMH) were 4,635 (AMH – 3,602 and OPMH – 1,033). This number increased by 11% in 2023, rising to 5,125 referrals (AMH – 4,147 and OPMH – 1,005). This number of referrals increased again leading into 2024 by a further 2% with the service receiving 5,235 referrals (AMH – 4,144 and OPMH – 1,091). This is a 13% referral increase over the course of 3 years.

The average number of referrals for AMH has increased from 300 in 2022 to 345 in 2024. The average yearly number of referrals for OPMH has also risen from 86 in 2022 to 91 by 2024. So far in 2025, the monthly referral numbers for both AMH and OPMH are in keeping with the average number of referrals received in 2024, with a predicted increase based on historical demand figures.

## 3. Patients who are detained to UHS under the Mental Health Act

UHS is registered with the CQC for the provision of the Mental Health Act. People do need to be detained to UHS and as such we are the authority in charge of this detention and must ensure that our legal duties are carried out, including ensuring the detention is lawful and ensuring that all of the patient's rights are provided to them.




| | Jan - Feb 2022 | March - April 2022 | May - June 2022 | July - Aug 2022 | Sept - Oct 2022 | Nov-Dec 2022 | Jan-Feb 2023 | Mar-Apr 2023 | May-Jun 2023 | Jul-Aug 2023 | Sept-Oct 2023 | Nov-Dec 2023 | Jan-Feb 2024 | Mar-Apr 2024 | May-Jun 2024 | Jul-Aug 2024 | Sep-Oct 2024 | Nov-Dec 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| s5(2) | 18 | 13 | 21 | 21 | 30 | 10 | 18 | 31 | 23 | 27 | 27 | 28 | 17 | 28 | 19 | 23 | 17 | 24 |
| s2 | 10 | 11 | 7 | 7 | 16 | 5 | 12 | 16 | 27 | 23 | 30 | 28 | 27 | 30 | 29 | 16 | 18 | 23 |
| s3 | 0 | 7 | 2 | 3 | 1 | 2 | 1 | 4 | 2 | 2 | 4 | 7 | 4 | 1 | 2 | 4 | 3 | 6 |

**Figure 7 - Patients detained under the Mental Health Act from January 2022 to December 2024.**

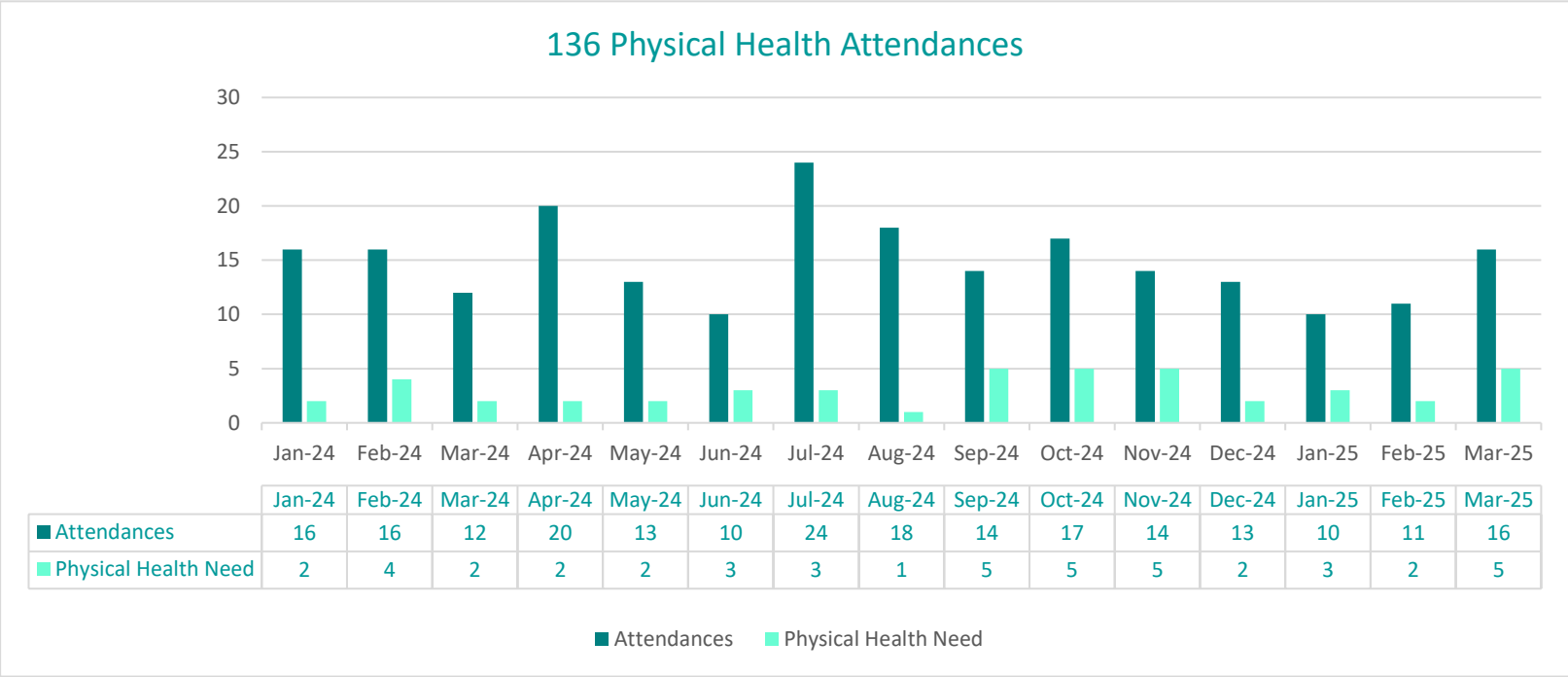
The data above shows November to December 2024 as the highest number of detentions since May and June 2024.
This is an increase after lower numbers for the past four months.

There were consistent numbers of patients detained under Section 5(2) (a holding power which last for 72 hours) and Section 2 (which last 28 days).
However, there was a marked increase in the number of patients detained under Section 3 (which can last up to 6 months) towards the end of 2024.

It could be presumed that the reason for these figures is due to an increase in patients with complex physical health needs requiring longer stays within the General Hospital setting. This would need further investigation on a case-by-case basis.

## 4. Patients who are brought to UHS ED as a hospital-based place of safety detained under Section 136

Section 136 is a holding power used by police officers to remove a person who appears to have a Mental Health disorder and is acting in a manner that is unsafe for that person or for others around them to a place of safety. For this purpose, there are a number of 136 suites attached to Mental Health Units. Once a patient is brought to a place of safety, they must be assessed within 24 hours to determine if further detention under the Mental Health Act is necessary. If all the 136 Suites are full or the person requires medical attention, then the A&E Department can be used as a place of safety.



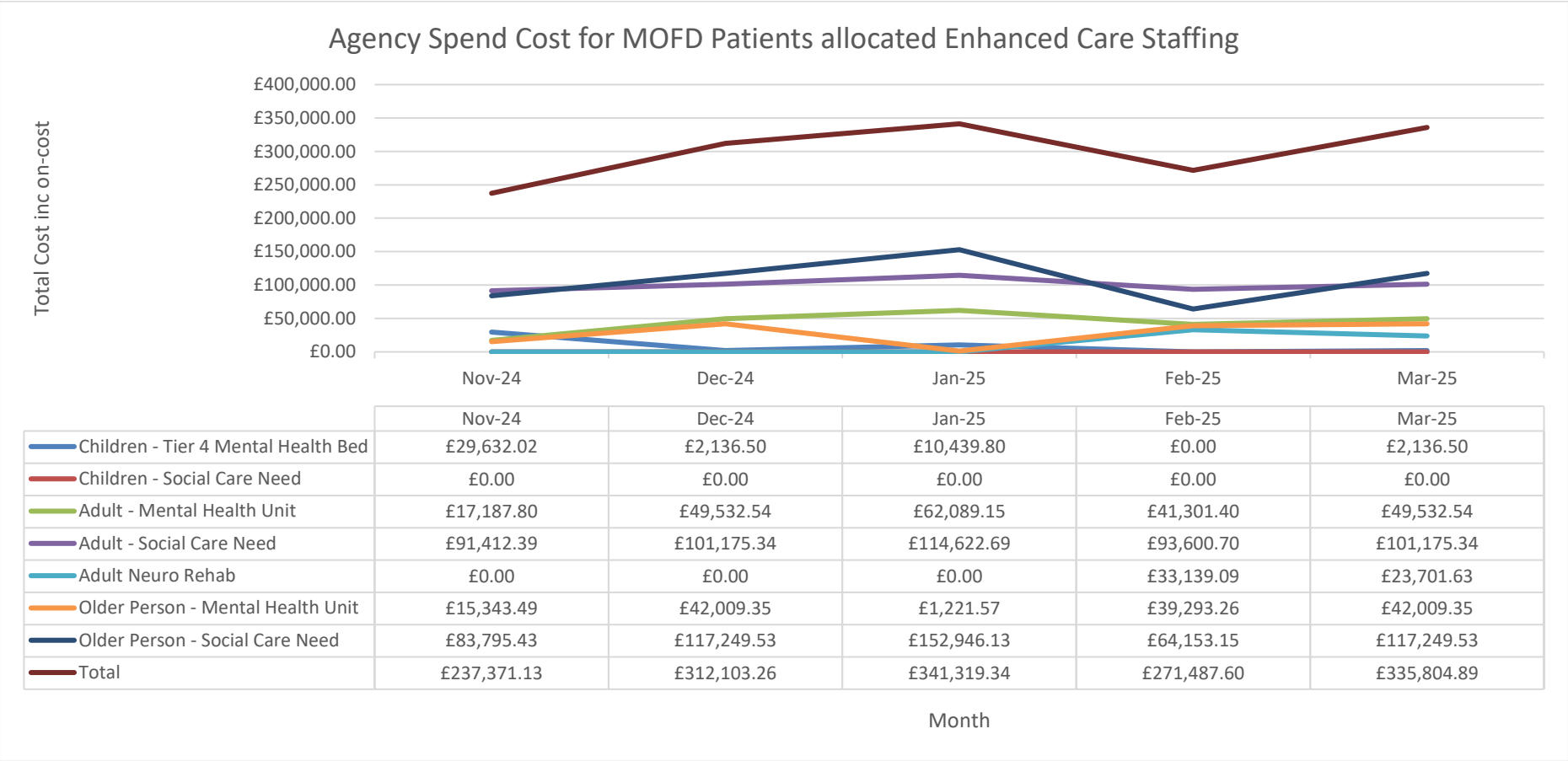

| | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Attendances | 16 | 16 | 12 | 20 | 13 | 10 | 24 | 18 | 14 | 17 | 14 | 13 | 10 | 11 | 16 |
| Physical Health Need | 2 | 4 | 2 | 2 | 2 | 3 | 3 | 1 | 5 | 5 | 5 | 2 | 3 | 2 | 5 |

**Figure 8 – Section 136 attendances volumes**

January and February 2025 (as seen in figure 8 above) saw the lowest figures since January 2023, this improvement was down to a change in the provider of secure transport. However, on average only 22% of the patients that are brought to UHS have a physical health need to do so. This means 78% of patients brought to ED are due to a lack of available 136 Suite.

**5. Costs for patients who are MOFD and are allocated enhanced care staff**

This data (figure 9) has been manually collated since November 2024-February 2025 and relates to patients who had no reason to remain at UHS. All patients were MOFD and allocated an RMN (Registered Mental Health Nurse Band 5) or CSW03 (Mental Health Support Worker) from staffing hub (NHSP workforce) who remained at UHS while awaiting mental health bed or social care discharge plans (i.e. Package of Care, Care Home, Nursing Home etc.).




| | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
|---|---|---|---|---|---|
| Children - Tier 4 Mental Health Bed | £29,632.02 | £2,136.50 | £10,439.80 | £0.00 | £2,136.50 |
| Children - Social Care Need | £0.00 | £0.00 | £0.00 | £0.00 | £0.00 |
| Adult - Mental Health Unit | £17,187.80 | £49,532.54 | £62,089.15 | £41,301.40 | £49,532.54 |
| Adult - Social Care Need | £91,412.39 | £101,175.34 | £114,622.69 | £93,600.70 | £101,175.34 |
| Adult Neuro Rehab | £0.00 | £0.00 | £0.00 | £33,139.09 | £23,701.63 |
| Older Person - Mental Health Unit | £15,343.49 | £42,009.35 | £1,221.57 | £39,293.26 | £42,009.35 |
| Older Person - Social Care Need | £83,795.43 | £117,249.53 | £152,946.13 | £64,153.15 | £117,249.53 |
| Total | £237,371.13 | £312,103.26 | £341,319.34 | £271,487.60 | £335,804.89 |

**Figure 9 – Agency Spend Analysis**

Costs did decrease in February 2025. This can be attributed to the reduced number of days in the month, no bank holiday pay rates within the month and one complex care patient prescribed 2:1 staffing a reduction from 3:1/4:1 in December and January. It has since increased in March25 however, the number of patients who attended UHS receiving a decision to admit has increased and therefore this could be attributed to this alongside a 31 day month.

The Enhanced Care Mental Health Team provide support to patients, temporary resource staff and the staffing hub by supporting with the distribution and prioritisation of staff, reviewing patient and co-creating personalised Enhanced Care Observation Plan with patients which share information to support the staff to care for the patient receiving enhanced observations. In the last rolling 12 months the team have seen over 555 patients with 2,149 patient contacts during this time.

When comparing data of the validated MOFD patient data and the total spend of mental health agency staff per month, it shows that on average over the past 4 months (figure 10), 62% of total cost was for staff caring for patients were MOFD.


| | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
|---|---|---|---|---|---|
| Total Cost for patients | £461,327.55 | £502,073.85 | £496,854.47 | £421,560.82 | £518,831.40 |
| Cost for MOFD | £237,371.13 | £312,103.26 | £341,319.34 | £271,487.60 | £335,804.89 |

**Figure 10 – Cost of Mental Health Temporary Staffing**

## 6. Key Issues, Successes and Next Steps.

Pressures raised in previous reports to Quality Committee and Mental Health Board still remain and in summary these are:-

- Attendance growth – An increase in the amount of patients attending UHS who receive a decision to admit to a mental health bed.
- Delays in transfers – Once a decision to admit is made and a patient is medically optimised for discharge the delay in the allocation of an appropriate bed from the community mental health Trusts can be significantly delayed. Only 15% of patients since January 2023 have transferred within the 12 hour KPI. This is the fundamental underlying issue and we need to continue to work collaboratively with Hampshire and Isle of Wight Healthcare NHS Foundation Trust to reduce these delays where we can.
- Continued rise in patients with enhanced care needs and mental health attendances and the associated length of stay in the ED but also the knock-on impact on assessment areas and downstream wards.
- Cost of agency staffing cohort to provide enhanced care observations for patients within this care cohort.
- Poor patient and staff experience, lack of parity of esteem.
- Lack of Liaison Psychiatrist to cover Responsible Clinician duties for adult inpatients detained under the Mental Health Act with reliance on Older adult consultant and/ or CMHT consultants.
- The cost and quality of the enhanced care staffing is known within the Trust and is an active workstream led by the Chief Nurse and Deputy Chief Nurse with significant input from the VECG at all levels both clinically and operationally.

## 7. Conclusion

UHS has made significant strides in better understanding the scale of the problem through improved collection and use of data. This also allows better decision making about when and where enhanced care is needed, what level is needed and what risk the organisation is holding at any time. We have also continued to work closely with our community partners Hampshire and the Isle of Wight Healthcare NHS Foundation Trust (formerly Southern and Solent) to try to improve the care these patients are offered, when they do not need to remain in an acute trust. Nevertheless, it remains true that a significant number of patients are brought to UHS when they do not have a physical health need because of lack of S136 capacity or mental health beds, and frequently they then remain at UHS for far too long. This is fundamentally because of a lack of admitting capacity for mental health beds and will only be resolved by a reduction on demand (either through admitting fewer patients or reducing length of stay in those beds, or n-ctr) or an increase in capacity.

# 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

| | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Monthly target | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 31 | % Patients on an open 18 week pathway (within 18 weeks )<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 17) | 75% | | 61.5% | | | | | | | | | | | | 62.6% | ≥92% | 63.0% |
| | | 50% | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | | |
| | | | 4 | 4 | 4 | 4 | 4 | 4 | 3 | 4 | 4 | 3 | 5 | 5 | 5 | 7 | | |
| 39 | Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below)<br>UHSFT<br>Teaching hospital average (& rank of 19)<br>South East average (& rank of 17) | 100% | | 83.7% | | | | | | | | | | | | 72.1% | ≥70% | 77.8% |
| | | 40% | 4 | 3 | 7 | 4 | 6 | 5 | 5 | 4 | 3 | 5 | 4 | 4 | 2 | 10 | | |
| | | | 2 | 1 | 3 | 1 | 4 | 3 | 3 | 2 | 2 | 2 | 1 | 2 | 2 | 4 | | |
| 39 - As of April 2024, YTD and Monthly targets changed from 85% to 70% in line with latest operational guidance | | | | | | | | | | | | | | | | | | |
| 28 | Patients spending less than 4hrs in ED - (Type 1)<br>UHSFT<br>Teaching hospital average (& rank of 16)<br>South East average (& rank of 16) | 95% | | 71.7% | | | | | | | | | | | | 57.2% | ≥95% | 62.8% |
| | | 30% | 4 | 4 | 4 | 9 | 6 | 8 | 6 | 10 | 6 | 6 | 12 | 15 | 9 | 16 | 14 | |
| | | | 2 | 3 | 2 | 5 | 2 | 4 | 5 | 6 | 4 | 4 | 9 | 12 | 6 | 12 | 12 | |
| 37 | % of Patients waiting over 6 weeks for diagnostics<br>UHSFT<br>Teaching Hospital average (& rank of 20)<br>South East Average (& rank of 18) | 40% | | 7.8% | | | | | | | | | | | | 11.3% | ≤5% | 12.14% |
| | | 0% | 7 | 5 | 5 | 5 | 4 | 5 | 5 | 5 | 5 | 6 | 6 | 6 | 6 | 6 | | |
| | | | 5 | 5 | 4 | 5 | 5 | 5 | 6 | 6 | 6 | 8 | 9 | 8 | 9 | 6 | | |
| 37 - As of April 2024, YTD and **Monthly Target changed from 1% to 5%** to reflect latest guidance | | | | | | | | | | | | | | | | | | |

| **Outcomes** | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | HSMR (Rolling 12 Month Figure) - **UHS**<br>HSMR (Rolling 12 Month Figure) - **SGH** | 95.0<br>89.9<br>88.6<br>75.0 | | | | | | | | | | | | 86.3<br>84.6 | | | ≤100 | 88.0 | ≤100 |
| 2 | HSMR - Crude Mortality Rate | 3.0%<br>2.7%<br>2.2% | | | | | | | | | | | | 2.2% | | | <3% | 2.2% | <3% |
| 3 | Percentage non-elective readmissions within 28 days of discharge from hospital | 15%<br>12.5%<br>10% | | | | | | | | | | | | 12.4% | | | - | 12.1% | - |
| | | Q1 2023/2024 | | | Q2 2023/2024 | | | Q3 2024/2025 | | | Q4 2024/2025 | | | Q1 2024/2025 | | | Quarterly target | | |
| 4 | **Cumulative Specialties** with Outcome Measures Developed (Quarterly) | 78<br>76<br>74<br>75 | | | 76 | | | 76 | | | 76 | | | 76 | | | +1 Specialty per quarter | | |
| 5 | Developed Outcomes RAG ratings (Quarterly)<br>Red<br>Amber<br>Green | 100%<br>75%<br>50%<br>41<br>62<br>334 | | | 36<br>77<br>342 | | | 39<br>79<br>319 | | | 36<br>76<br>317 | | | 36<br>88<br>309 | | | - | | |

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 | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6 | Cumulative Clostridium difficile<br>Most recent 12 Months vs. Previous 12 Months | 9 | 12 | 14 | 19 | 22 | 29 | 27 | 36 | 37 | 49 | 47 | 59 | 55 | 69 | 60 | 79 | 69 | 88 | 79 | 94 | 85 | 112 | 93 | 120 | ≤9 | 120 | ≤99 |
| 7 | MRSA bacteraemia | 2 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | | | | | | | | | | | |
| 8 | Gram negative bacteraemia | 22 | 19 | 16 | 31 | 25 | 25 | 29 | 22 | 34 | 23 | 29 | 31 | 20 | 35 | 18 | ≤19 | 322 | ≤219 |
| 9 | Pressure ulcers category 2 per 1000 bed days | 0.20 | | | | | | | | | | | | | | 0.17 | <0.3 | 0.17 | <0.3 |
| 10 | Pressure ulcers category 3 and above per 1000 bed days | 0.17 | | | | | | | | | | | | | | 0.17 | <0.3 | 0.17 | <0.3 |
| 11 | Medication Errors (severe/moderate) | 5 | | | | | | | | | | | | | | 3 | ≤3 | 24 | 36 |
| 12 | Watch & Reserve antibiotics, usage per 1,000 adms<br>Most recent months vs. 2023/24 | 2,356 | | | | | | | | | | | | | | 2,354 | <2630 | 2,607 | <2578 |

12 - Beginning June 2024, target and comparison changed in accordance with National Action Plan.

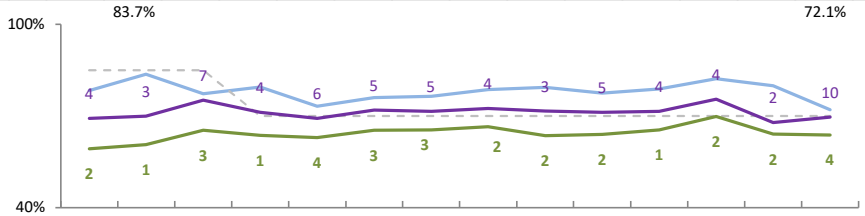
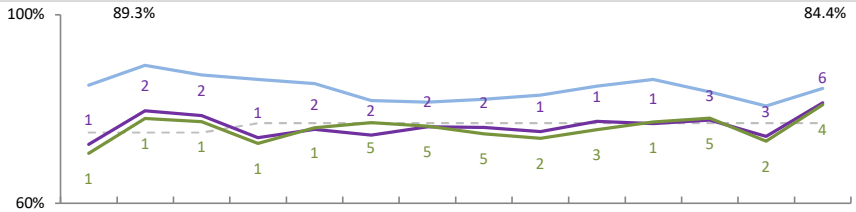
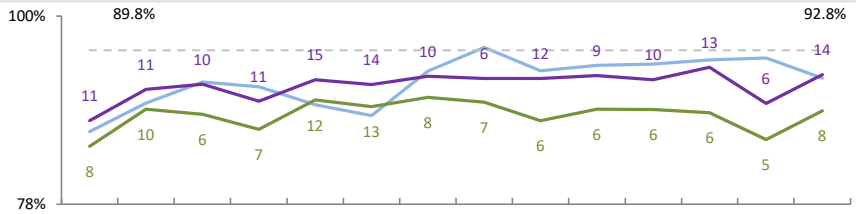
| **Safety** | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 13 | Patient Safety Incident Investigations (PSIIs) (based upon month reported, excluding Maternity) | | | 2 | | | | | | | | | | | | 0 | - | 9 | - |
| 13a | Never Events | | | 1 | | | | | | | | | | | | 0 | 0 | 10 | 0 |
| 14 | Patient Safety Incident Investigations (PSIIs)- Maternity | | | 0 | | | | | | | | | | | | 0 | - | 0 | - |
| 15 | Number of falls investigated per 1000 bed days | | | 0.16 | | | | | | | | | | | | 0.21 | - | 0.13 | - |
| 16 | % patients with a nutrition plan in place (total checks conducted included at chart base) | | | 92.8% | | | | | | | | | | | | 93.4% | ≥90% | 94% | ≥90% |
| | | | | 962 | 961 | 1,012 | 930 | 973 | 977 | 930 | 869 | 826 | 964 | 961 | 828 | 901 | 989 | 965 | |
| 17 | Red Flag staffing incidents | | | 41 | | | | | | | | | | | | 18 | - | 214 | - |
| **Maternity** | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Monthly target | YTD | YTD target |
| 18 | Birth rate and Bookings<br>Birth Rate - total number of women birthed<br>Bookings - Total number of women booked | 406 | 401 | 428 | 411 | 415 | 379 | 390 | 400 | 410 | 438 | 392 | 396 | 395 | 372 | 410 | - | - | - |
| | | 483 | 429 | 409 | 448 | 633 | 517 | 501 | 480 | 403 | 523 | 451 | 467 | 496 | 466 | 494 | | | |
| 19 | Staffing: Birth rate plus reporting / opel status - number of days (or shifts) at Opel 4. | 4 | 0 | 6 | 0 | 3 | 8 | 8 | 2 | 12 | 6 | 1 | 0 | 1 | 1 | 1 | - | - | - |
| 20 | Mode of delivery<br>% number of normal birthed (women)<br>% number of caesarean sections (women) | 47.29% | 50.62% | 46.73% | 45.99% | 46.51% | 53.03% | 44.80% | 44.25% | 43.90% | 41.10% | 46.68% | 40.91% | 47.85% | 47.85% | 48.54% | - | - | - |
| | | 39.16% | 38.90% | 40.89% | 43.80% | 39.04% | 35.88% | 44.40% | 43.00% | 42.44% | 48.40% | 41.07% | 47.47% | 42.03% | 42.47% | 40.98% | | | |

| **Patient Experience** | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 21 | FFT Negative Score - Inpatients | 3% | | 0.2% | | | | | | | | | | | | 2.0% | ≤5% | 0.9% | ≤5% |
| | | 0% | | | | | | | | | | | | | | | | | |
| 22 | FFT Negative Score - Maternity (postnatal ward) | 10% | | 3.3% | | | | | | | | | | | | 0.7% | ≤5% | 2.1% | ≤5% |
| | | 0% | | | | | | | | | | | | | | | | | |
| 23 | Total UHS women booked onto a continuity of carer pathway | 30% | | 12.2% | | | | | | | | | | | | 15.3% | ≥35% | 14.4% | ≥35% |
| | | 0% | | | | | | | | | | | | | | | | | |
| 24 | Total BAME women booked onto a continuity of carer pathway | 100% | | 9.1% | | | | | | | | | | | | 21.7% | ≥51% | 20.1% | ≥51% |
| | | 0% | | | | | | | | | | | | | | | | | |
| 25 | % Patients reporting being involved in decisions about care and treatment | 100% | | 90.1% | | | | | | | | | | | | 87.7% | ≥90% | 87.6% | ≥90% |
| | | 80% | | | | | | | | | | | | | | | | | |
| 26 | % Patients with a disability/reporting additional needs/adjustments met (total questioned at chart base) | 100% | | 91.4% | | | | | | | | | | | | 86.3% | ≥90% | 87.7% | ≥90% |
| | | 80% | 272 | 304 | 268 | 339 | 340 | 280 | 258 | 317 | 221 | 353 | 247 | 296 | 323 | 273 | 483 | | |
| 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) | 100 | | 67 | | | | | | | | | | | | 97 | - | 794 | - |
| | | 0 | | | | | | | | | | | | | | | | | |

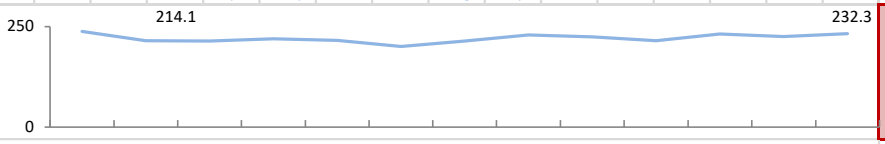
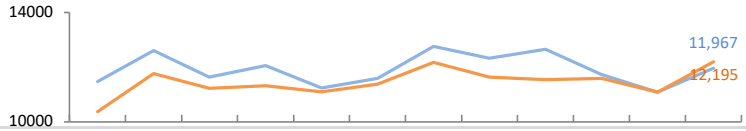
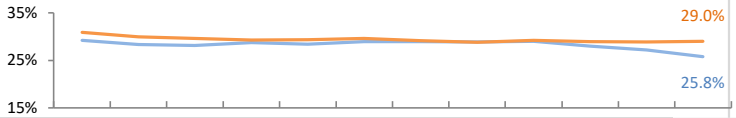
| **Access Standards** | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 28 | Patients spending less than 4hrs in ED - (Type 1)<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 16) | 71.7% | | | | | | | | | | | | | | 57.2% | ≥95% | 62.8% | ≥95% |
| | | 4 | 4 | 4 | 9 | 6 | 8 | 6 | 10 | 6 | 6 | 12 | 15 | 9 | 16 | 14 | | | |
| | | 2 | 3 | 2 | 5 | 2 | 4 | 5 | 6 | 4 | 4 | 9 | 12 | 6 | 12 | 12 | | | |
| 29 | Average (Mean) time in Dept - non-admitted patients | 03:08 | | | | | | | | | | | | | | 03:26 | ≤04:00 | 03:19 | ≤04:00 |
| 30 | Average (Mean) time in Dept - admitted patients | 05:37 | | | | | | | | | | | | | | 06:30 | ≤04:00 | 05:41 | ≤04:00 |
| 31 | % Patients on an open 18 week pathway (within 18 weeks )<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 18) | 61.5% | | | | | | | | | | | | | | 62.6% | ≥92% | 63.0% | ≥92% |
| | | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | | | |
| | | 4 | 4 | 4 | 4 | 4 | 4 | 3 | 4 | 4 | 3 | 5 | 5 | 5 | 7 | | | | |
| 32 | Total number of patients on a waiting list (18 week referral to treatment pathway) | 58435 | | | | | | | | | | | | | | 61686 | - | 61,686 | - |
| 33 | Patients on an open 18 week pathway (waiting 52 weeks+ )<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 18) | 1880 | | | | | | | | | | | | | | 1147 | 0 | 1147 | 0 |
| | | 2 | 3 | 3 | 4 | 3 | 2 | 2 | 2 | 2 | 2 | 3 | 3 | 3 | 3 | | | | |
| | | 10 | 9 | 10 | 10 | 10 | 9 | 9 | 8 | 9 | 8 | 9 | 9 | 10 | 9 | | | | |

| | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 34 | Patients on an open 18 week pathway (waiting 65 weeks+ )<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 18) | 49 | | | | | | | | | | | | | | 21 | 0 | 21 | 0 |
| 35 | Patients on an open 18 week pathway (waiting 78 weeks+ )<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 18) | 18 | | | | | | | | | | | | | | 1 | 0 | 1 | 0 |
| 35a | Patients on an open 18 week pathway (waiting 104 weeks+ )<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 18) | 0 | | | | | | | | | | | | | | 0 | 0 | 0 | 0 |
| 36 | Patients waiting for diagnostics | 8655 | | | | | | | | | | | | | | 10409 | - | 10,409 | - |
| 37 | % of Patients waiting over 6 weeks for diagnostics<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 18) | 7.8% | | | | | | | | | | | | | | 11.3% | ≤5% | 12.1% | ≤5% |

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

| | | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 39 | Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below)<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 18) |  | | | | | | | | | | | | | | | | ≥70% | 77.8% | ≥70% |
| 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.<br><br>As of April 2024, YTD and Monthly targets changed to 70% in line with latest operational guidance | | | | | | | | | | | | | | | | | | | | |
| 40 | Cancer 28 day faster diagnosis Percentage of patients treated within standard<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 18) |  | | | | | | | | | | | | | | | | ≥77% | 83.5% | ≥77% |
| 40 - As of April 2024, YTD and monthly targets changed from 75% to 77% in line with latest operational guidance | | | | | | | | | | | | | | | | | | | | |
| 41 | 31 day cancer wait performance - decision to treat to first definitive treatment (Most recently externally reported data, unless stated otherwise below)<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 18) |  | | | | | | | | | | | | | | | | ≥96% | 83.5% | ≥96% |

| R&D Performance | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 43 | Comparative CRN Recruitment Performance - non-weighted | 15 | 15 | 15 | 9 | 7 | 6 | 9 | 9 | 8 | 10 | 8 | 8 | 9 | 10 | 11 | Top 10 | - | - |
| 44 | Comparative CRN Recruitment Performance - weighted | 11 | 11 | 11 | 6 | 8 | 9 | 10 | 10 | 10 | 10 | 10 | 12 | 12 | 12 | 12 | Top 5 | - | - |
| 45 | Study set up times - 80% target for issuing Capacity & Capability within 40 Days of Site Selection | 55% | 50% | 64% | 50% | 55% | 47% | 100% | 44% | 38% | 78% | 36% | 70% | 44% | 47% | 44% | - | - | - |
| 46 | Achievement compared to R+D Income Baseline<br>Monthly income increase %<br>YTD income increase % | 65.2% | 157.6% | 75.0% | 26.8% | 119.5% | 70.7% | 51.2% | 90.2% | 80.5% | 26.8% | 80.5% | 61.0% | 80.5% | 80.5% | 163.4% | ≥5% | - | - |
| | | | | 6.2% | | | | | | | | | | | | 13.6% | | | |

| **Local Integration** | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 47 | Number of inpatients that were medically optimised for discharge (monthly average) |  | | | | | | | | | | | | | | | ≤80 | 225 | - |
| 48 | Emergency Department activity - type 1<br>This year vs. last year |  | | | | | | | | | | | | | | | - | 143,096 | - |
| 49 | Percentage of virtual appointments as a proportion of all outpatient consultations<br>This year vs. last year |  | | | | | | | | | | | | | | | ≥25% | 28.3% | ≥25% |

| **Digital** | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 50 | My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month) | | | 195541 | | | | | | | | | | | | 238521 | - | 238,521 | - |
| 51 | My Medical Record - UHS patient logins (number of logins made within each month) | | | 34470 | | | | | | | | | | | | 39153 | - | 449,596 | - |
| 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<br>Distribution of computers per age in years | 14: 0 | 13: 21 | 12: 11 | 11: 26 | 10: 54 | 9: 151 | 8: 431 | 7: 620 | 6: 957 | 5: 2260 | 4: 2840 | 3: 1810 | 2: 1910 | 1: 200 | | - | - | - |
| 53 | CHARTS system average load times<br>- % pages loaded <= 5s<br>- % pages loaded <= 3s | 99.8% | 99.8% | 99.8% | 99.3% | 99.2% | 99.3% | 99.3% | 99.4% | 99.4% | 99.4% | 99.3% | 99.3% | 99.3% | 99.3% | 99.3% | | | |
| 53 - From **April 2024** , metric was changed from % loading time**s under 5s** to % loading times **under 3s** | | | | | | | | | | | | | | | | | | | |

University Hospital Southampton
NHS Foundation Trust

| Agenda Item 5.8 Report to the Trust Board of Directors, 13 May 2025 | |
|---|---|
| **Title:** | Finance Report 2024-25 Month 12 |
| **Sponsor:** | Ian Howard, Chief Financial Officer |
| **Author:** | Philip Bunting, DoOF and Anna Schoenwerth, ADOF |

**Purpose**

| (Re)Assurance | Approval | Ratification | Information |
|---|---|---|---|
| | | | x |

**Strategic Theme**

| Outstanding patient outcomes, safety and experience | Pioneering research and innovation | World class people | Integrated networks and collaboration | Foundations for the future |
|---|---|---|---|---|
| | | | | x |

**Executive Summary:**

The Trust monthly finance report provides insight and awareness of the financial position and the key drivers for any variance to plan. It also provides commentary around future risks and opportunities. This covers the three key domains of income and expenditure, capital and cash.

The headlines for the March report are as follows:

- As noted last month, UHS worked with system partners to agree a HIOW ICS "landing plan" for 2024/25. As a result, UHS improved its forecast to £7.0m deficit at year-end. The Trust identified a series of non-recurrent improvements to the position and have also been supported by additional cash from HIOW ICB.
- The Trust has reported a breakeven position in month and a £7.0m deficit for the year (subject to audit). This is in line with the forecast submitted to NHS England and is in line with the HIOW ICB 'landing plan'.
- UHS continues to deliver significant levels of financial savings (£85.3m in 24/25 achieving the required plan), from UHS transformation programmes on patient flow, theatres and outpatients.
- UHS benchmarks as providing good value for money across a wide range of metrics.
- One of the main underlying deficit drivers continues to be the non-delivery of system transformation initiatives, in particular Non-Criteria to Reside (NCTR).
- The Trust continues to overtrade – undertaking activities beyond funding received.
- Additional rigour continues to be applied around financial grip and governance ensuring strong controls are in place. This includes a weekly FIG (Finance Improvement Group) being supported by the Financial Improvement Director with attendance from all divisions and directorates. The Trust also continues to work with Deloitte around savings opportunities.
- Cash has increased to £16.9m in month, as per forecast. There is a significant risk in Q1 2025/26 that cash will reduce close to zero and mitigations are currently being explored.
- The Trust's capital programme ended the year as per the required forecast, with £45m spent in M12 to deliver this. Capital expenditure totalled £96m in 2024/25.

**Contents:**

Finance Report.

**Risk(s):**

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.

| **Equality Impact Consideration:** | N/A |
|---|---|

# UHS Finance Report – M12

## Headlines

As reported in previous months, following the receipt of £11.2m of deficit support funding in October, UHS is now being measured against an annual plan of £3.3m deficit.

The below table illustrates both the in-month and YTD reported I&E position against the revised annual plan:

| Financial Position - After Deficit Support | M12 | YTD |
|---|---|---|
| Re-set Plan | 0.0 | (3.3) |
| Actual Surplus / (Deficit) | 0.0 | (7.0) |
| Variance | 0.0 | (3.7) |

In month a series of one-off benefits has meant the trust has reported a breakeven position. These include:

- £4.1m of confirmed additional non recurrent ICB income
- £2.2m of other one-off benefits

The Trust's underlying position has increased over the previous few months and is now at £6.9m in M12. This has been driven by the uptick in workforce numbers, equating to additional staff costs of £0.8m per month. This is driven by a combination of pay pressures (B2/B3), mental health demand and winter demand driving additional surge capacity being open. Month 12 also saw an increase in bank usage with a 90wte increase when compared to previous months. This is expected to reduce back to previous levels in the coming months.

## "Landing Plan" Forecast

UHS has worked with partners across HIOW ICS to agree a "landing plan" for 2024/25. As part of this, UHS submitted a revised forecast deficit of £7m. Improvements have been identified within the UHS financial position from one-off benefits and additional funding from HIOW ICB and NHSE. To deliver this position UHS was required to report a breakeven position in M12 which has been achieved (subject to audit). The system forecast for the full year is at a breakeven level which has also been achieved (subject to audit).

## Financial Improvements

The Trust is continuing to substantively deliver on financial improvements from its savings and transformation programmes. For example:

- The Trust has delivered length of stay improvements for P0 patients of 5%.
- We have delivered a significant improvement to our outpatient ratio, undertaking more first appointments, procedures and advice & guidance.
- The Trust has implemented new workforce controls embedded within Divisions, which have been widely supported. We are below our pay expenditure plan YTD (excluding the impact of system NCTR reductions) with all divisions operating within workforce control totals.
- We are currently utilising agency for 0.5% of our total workforce, significantly below the national target of 3.2%.
- UHS is performing well on ERF activity through transformation programmes and other initiatives, with YTD performance at 127% of baselines, above the overall national target of 107% (although below our internal plan target of 133%).
- UHS has delivered £85.3m (>6% of addressable spend) of CIP by M12, which is above the trajectory from 23/24.

- Since March 24, our ERF performance has increased by 9%, and at the same time our staffing stayed broadly flat.
- The Trust has recently received benchmarking information which highlights its relative efficiency, notably:
    - National Cost Collection score of 89 – 11% more efficient than national average.
    - Model Hospital data for 23/24 – further improvement to 15th national performance, above peer organisations.
    - Back-office benchmarking highlighting efficient use of resources.

**Key Drivers**

The key drivers for the underlying deficit are as follows:

- System Transformation programmes targeted delivery of reductions to Non-Criteria to Reside (NCTR) and Mental Health numbers attending the hospital. Despite best endeavours of UHS and system partners, patient numbers remain above planned levels, meaning the Trust continues to incur additional temporary staffing costs and is maintaining additional bed capacity above funded levels. Savings of £14m have not been delivered across all system transformation schemes.
- Final elements of the pay award have been made to resident doctors and Band 8+ staff on the November payroll (taxes were paid in December). The combined impact of pay awards is confirmed to have an in-year funding shortfall of c£2m.
- The UHS ERF target with Specialised Commissioning was increased by £1.2m after the plan was submitted (£1.0m YTD). This was related to movement in the target of another Trust. This was challenged but upheld by NHS England.
- Non pay cost pressures including the impact of inflation above planned levels continues to cause pressure.
- The Combined Heat and Power (CHP) units have broken down on several occasions, meaning electrical power is imported from the national grid at a higher cost. This has had an in-year impact of £1.4m. One of the units has recently been serviced with the aim of reducing the number of breakdowns.
- Non-Elective growth and staffing challenges have resulted in under-performance against our elective income plan in Cardiac Surgery.
- Pay is £16m adverse to plan YTD after removing the impact of the pay award and year end pension provisions. After having an underspend in the first half of the year, an overspend has prevailed as planned system transformation savings have not been achieved in addition to recent workforce pressures.

**Other Headlines**

Income performance increased in month with Elective Recovery Fund (ERF) performance increasing to 127% of 19/20 levels. This is in line with the YTD average of 127% driven by consistent performance in month. ERF overperformance has generated income of £29m of additional income for the trust in year.

Pay expenditure increased in month by £0.9m to £66.9m in M12. WTEs increased by 92 overall which is predominantly in the bank workforce (90). Low levels of leavers were noted in the month.

Non pay expenses (excluding pass through) are reporting a £33.9m adverse variance YTD with the majority of this relating to unidentified CIP that was planned for within this category (£20m FY). In M12 there was additional non-operating expenditure which is removed totalling £10.2m. Savings have however been

achieved in other areas partially offsetting this variance. We are also currently working with Deloitte to review and implement non pay savings opportunities.

The underlying position, removing all further one-off items of income and expenditure, totals £6.9m in month deficit. The underlying trend continues to be refreshed for any backdated costs and benefits.

An assessment of YTD performance highlights that the Trust delivered over £34.4m of valued activity above block contracts in months 1 - 12. Some areas of additional funding for Urgent and Emergency care have been forthcoming for 2025/26 albeit this has only been agreed non recurrently. Contracts have yet to be signed for 2025/26 with active dialogue underway with both key commissioners.

**Cash**

A separate paper was presented to Finance & Investment Committee on this topic. The Trust cash position is highlighting that cash support is likely to be required in either Q1 or Q2 of 2025/26. We are currently exploring potential mitigations with HIOW ICB prior to engaging with NHS England. It is therefore imperative that financial savings are delivered in early 2025/26 as outlined in our plan.

**Capital**

Capital expenditure totalled £96m for the full year, which was in line with the forecast previously agreed with the ICB and NHSE.

All major projects delivered as per forecast including completing the Aseptic facility at Adanac park with the lease signed in March. The decarbonisation project also capitalised £17m in year linked to additional grant funding from Salix.

**Agenda Item 5.9**

**NHS Hampshire and Isle of Wight Integrated Care Board**
**Report to: ADD HERE**
**Paper title: ADD HERE**

NHS Hampshire and Isle of Wight

| | | | |
|---|---|---|---|
| **Report To** | Board meeting in Public | | |
| **Title of Paper** | *ICS Public Board System Report – Financial year end (March 2025)* | | |
| **Purpose of Paper** | For information | **Date of Meeting** | 24 April 2025 |
| **Author** | *Lindsay Jones* | **Agenda Item** | *Item no. will be added by Governance team* |
| **Executive Sponsor** | Martin Sheldon, Chief Finance Officer<br>*Your paper must be signed off by this Director before submission* | **Clinical Sponsor** | *If applicable* |

| **Prior Discussion** | | |
|---|---|---|
| **Meeting Name** | **Meeting Date** | **Recommendations/Comments** |
| | Click or tap to enter a date. | |
| **Future Discussion** | | |
| **Meeting Name** | **Meeting Date** | **Recommendations/Comments** |
| | Click or tap to enter a date. | |

**Executive Summary**

The purpose of the Month 12 (M12) System Report for Hampshire & Isle of Wight Integrated Care System (ICS) is to provide details of the final pre-audited financial position for the ICS as at the end of March 2025, alongside key information on system transformation and quality.

At M12, the Hampshire and Isle of Wight system in-month position is a surplus of £12.4m compared to a planned surplus of £4.5m, a positive variance to plan of £7.9m.

The ICS is reporting a year-end surplus of £0.1m at the end of March 2025, compared to a planned year-to-date breakeven of £0m, so a positive variance to plan of £0.1m at financial year end.

| | |
|---|---|
| **Recommendations** | 1. *Each Board needs assurance that their organisation has delivered on their organisation's 2024/25 financial landing plan*<br>2. *Each Board needs assurance that their organisation has robust plans for delivery of their 2025/26 operating plan* |

| **Governance and Compliance Obligations** | |
|---|---|
| **Relation to Strategic Objectives** | *Please select which of the following strategic objectives this paper addresses:*<br>☐ 1) Improve outcomes and reduce inequalities for the people of Hampshire and Isle of Wight<br>☒ 2) Work with partners to transform the local NHS into an effective and sustainable system<br>☐ 3) Continuously improve the quality of and access to services for the people of Hampshire and Isle of Wight<br>☒ 4) Make best use of our resources by living within our means |

| | |
|---|---|
| | ☐ 5) Be an organisation that is a meaningful and fulfilling place to work. |
| **Risk or Board Assurance Framework** | *Does this paper create any new risk?*<br><br>*Please select which of the following BAF risks relate to your paper:*<br>☐ 1A) There is a risk that the Integrated Care Board is unable to embed focus to address inequalities in population health outcomes.<br>☐ 1B) There is a risk that there will be a greater burden of ill-health and reduced healthy life expectancy if the delivery of prevention is not accelerated.<br>☐ 1C) There is a risk that mental health illness will increase across our population and widen the inequalities in outcomes if the system does not improve access, quality and experience of mental health services.<br>☐ 1D) There is a risk that the Integrated Care Board does not continuously improve and fails to support local research and innovation.<br>☐ 2A) There is a risk that the Integrated Care Board and its partners do not have clear, quantified and timebound plans for system transformation.<br>☐ 2B) There is a risk that the Integrated Care Board is unable to fully realise the opportunities of partnership working required to achieve the aims of the Integrated Care Partnership and our ambitions for Hampshire and the Isle of Wight.<br>☐ 2C) There is a risk that the Integrated Care Board is unable to access and effectively utilise joined up, robust and timely data and information.<br>☐ 2D) There is a risk that the Integrated Care Board and its partner organisations have insufficient capacity to focus on transformation.<br>☐ 3A) There is a risk that the Integrated Care Board's transformation programmes do not deliver improvement, quality and access to services for our populations.<br>☐ 3B) There is a risk that quality standards of experience and safe care will not be met.<br>☐ 3C) There is a risk that the Integrated Care Board will fail to engage and collaborate with service users and providers.<br>☐ 4A) There is a risk that the current financial plans are insufficient or do not deliver as planned to achieve the Integrated Care Board's financial plan.<br>☒ 4B) There is a risk that the Integrated Care System's NHS financial plans are insufficient or do not deliver as planned to achieve the individual organisation and/or system financial plans. |

| | |
|---|---|
| | ☐ 5A) There is a risk that the Integrated Care Board fails to reorganise its people effectively and create an inclusive workforce that feel valued, have a sense of belonging, and are undertaking work that has purpose and is fulfilling.<br>☐ 5B) There is a risk that the Integrated Care Board fails to enable coordination of a system-wide workforce plan, incorporating the Transformation workforce priorities.<br><br>*Please elaborate how the BAF risks you have selected relate to this paper, do they have a negative/positive impact and why?* |
| **Regulatory and Legal Implications** | *The system remains in System Oversight Framework (SOF) 4 as a result of our financial and operational performance* |
| **Financial Implications** | *As described in the executive summary and paper* |
| **Communications and Stakeholder or Staff Engagement Implications** | |
| **Patient or Staff Implications** | *All decisions arising from our financial recovery process were subject to assessment of their impact on quality across the system and appropriate organisational and system governance.* |
| **Equality Impact Assessment** | *As above* |
| **Quality Impact Assessment** | *None* |
| **Data Protection Impact Assessment** | |
| **Appendices or Supporting Information** | |

## 1. Purpose

1.1 The purpose of the Month 12 (M12) Finance Report for Hampshire & Isle of Wight Integrated Care System (ICS) is to provide an overview of the final pre-audited financial position for NHS organisations within the Hampshire and Isle of Wight ICS as at the end of financial year 2024/25.

1.2 This report has been shared with all NHS organisations in the system, to ensure Boards are able to gain assurance and hold their organisation(s) to account for delivery of their operating plan as well as their contribution to recovery of the whole system.

## 2. Background

2.1 The final agreed system plan for 2024/25 was a £70.0m deficit, consisting of a £9.6m surplus plan for NHS Hampshire and Isle of Wight (the Integrated Care Board), and a combined provider deficit plan of £79.6m. This plan was agreed on the basis that NHS England would provide £70.0m of non-recurrent deficit support funding, enabling our plan to reduce to £0 (breakeven).

2.2 In month 6, NHS England confirmed the anticipated £70m in non-recurrent deficit support. This support requires a matching improvement in our plan, and took the Hampshire and Isle of Wight system plan to a combined £0 breakeven plan for the financial year. The £70m cash support is repayable as part of national business rules on repayment of deficits and will not reduce the Hampshire and Isle of Wight system historic deficit.

2.3 At the close of Month 6, Southern Health NHS Foundation Trust and Solent NHS Trust merged into a new organisation called NHS Hampshire and Isle of Wight Healthcare Foundation Trust.

2.4 At month 10, following agreement with NHS England, the Hampshire and Isle of Wight system moved its forecast to a combined deficit of £18.5m by financial year end.

2.5 At month 11 the ICS revised its forecast further and moved to a combined £0 breakeven position by financial year end. Forecasts were then fixed for this financial year.

2.6 The whole system continues to be in the NHS England (NHS E) Recovery Support Programme (RSP). This requires additional assurance and reporting requirements to NHSE as well as controls around decision making.

## 3. Discussion

### 3.1 Integrated Care System Financial Overview

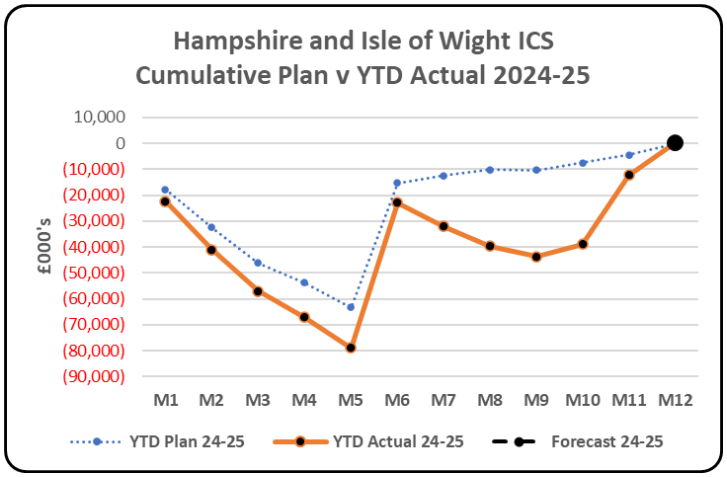
3.1.1 The table below summarises the final pre-audited ICS financial position reported at month 12 (March 2025). In March itself, the ICS reported a surplus of £12.4m against a planned surplus of £4.5m, so a positive variance to plan of £7.9m.

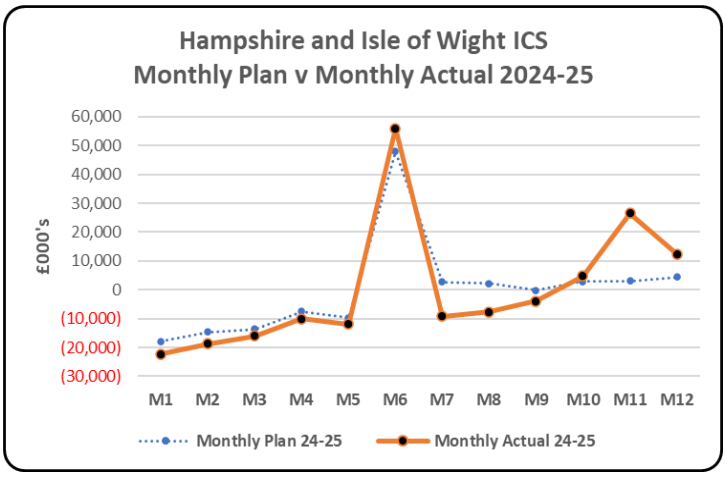
| Organisation | In Month | | | Year to date | | | Forecast Outturn | | |
|---|---|---|---|---|---|---|---|---|---|
| | In Month Plan £'000 | In Month Actual £'000 | Variance £'000 | YTD Plan £'000 | YTD Actual £'000 | Variance £'000 | Annual Plan £'000 | Forecast Outturn £'000 | Variance £'000 |
| Hampshire and Isle of Wight ICS Total | £4,488 | £12,403 | £7,915 | £0 | £83 | £83 | £0 | £83 | £83 |

3.1.2 The system reported a final year-end surplus of £0.1m compared to a planned £0m breakeven, therefore a £0.1m positive variance to plan.

3.1.3 The ICS will continue to prioritise the implementation of the agreed system plan and transformation programmes to support the achievement of our financial plan in the financial year 2025/26.

3.1.4 The graphs below summarise the ICS position reported at financial year-end 2024/25:




### 3.2 System Actions to Support Financial Recovery

3.2.1 In 2023/24, additional controls were required by NHS England as a consequence of our deficit plan. Individual providers may also have had enhanced conditions as described in undertakings letters and where revenue or capital cash support was required, additional conditions will apply, including assessment of affordability of capital plans. All our existing system business rules, conditions and controls remained extant in 2024/25.

3.2.2 System financial recovery and delivery of our system transformation programmes was overseen by a monthly System Recovery and Transformation Board, which was attended by all Provider Chief Executives and chaired by the ICB Chief Finance Officer and Deputy CEO.

3.2.3 System leaders agreed additional steps in 2024/25 that strengthened our delivery of plans, including:

- A system vacancy control panel, to review all proposed external recruitment and identify opportunities to recruit to roles from within the existing NHS workforce
- Chief Executive-level leadership for each system transformation programme
- Organisation and system-level delivery units focused on our system transformation programmes, coordinated by a system Programme Management Office (PMO).

3.2.4 Additional external support was commissioned for some organisations within the local system, either to support delivery of their 2024/25 plan, or to support recovery where organisations were already materially off-plan.

## 3.3 System Transformation Programmes

3.3.1 Our system plan for 2024/25 intended to address the challenges impacting our financial position that required a system response. Together we identified six key programmes for corrective action to reduce our system deficit in 2024/25 and enable delivery of each organisation's operating plan. Our 2024/25 system transformation programmes were:

| Programme | Lead Chief Executive | Lead ICB Executive |
|---|---|---|
| Discharge | Penny Emerit | Caroline Morison |
| Local Care | Alex Whitfield | Lara Alloway |
| Urgent and Emergency Care | David Eltringham | Nicky Lucey |
| Mental Health | Ron Shields | Nicky Lucey |
| Planned Care | David French | Lara Alloway |
| Workforce (including Corporate Right-Sizing) | David French | Danny Hariram |

3.3.2 Each transformation programme reports on progress and key metrics into the monthly System Recovery and Transformation Board, which is attended by all provider Chief Executives. Reporting is supported by a system Programme Management Office.

## 3.4 Elective Recovery Fund

3.4.1 The Elective Recovery Fund (ERF) aims to increase elective activity in the NHS by providing additional funding to Integrated Care Boards (ICBs). The

funding was initially uncapped meaning that additional funding would be given to ICBs and NHS Providers that over performed and exceeded their individual targets.

3.4.2 In December/January 2025 it was confirmed that there would be a ceiling on ERF funded activity for 2024/25 and that there would be no reconciliation of adjustments for 2024/25 overperformance in 2025/26. The ceiling has been confirmed by NHS England and remains fixed for this financial year.

3.4.3 Prior to the introduction of the ceiling, each organisation had a specific target level of activity growth (compared to 2019/20) above which additional income was earned. For Hampshire and Isle of Wight as a whole, our target level was 108.7% of 2019/20 activity, but our operating plans for 2024/25 were based on achieving 120.5%. At Month 12, initial data estimates show achievement of 122.7%, although it is important to note that all ERF funding has been fully transacted following the introduction of the ERF funding ceiling.

## 4. Quality

### 4.1 Regulatory

**Care Quality Commission**: during March 2025, five Care Quality Commission inspection outcomes were published – three were rated Good and two were rated as Requires Improvement and all related to care homes. One provider showed a worsening position (from Good overall to Requires Improvement overall) and one showed an improving position (from Requires Improvement overall to Good overall).

Care Homes fall under the responsibility of the Local Authority and NHS Hampshire and Isle of Wight support quality elements with the Local Authority as residents placed in the facilities may have primary health funding.

**Quality Assurance and Improvement Levels**: all providers, apart from one remain in the routine quality assurance and improvement level. One provider is in the Intensive level of quality assurance and improvement and will stay there whilst they remain in the National Recovery Support Programme (RSP).

### 4.2 Patient Experience

**Friends and Family Test Performance**: the latest data relates to January 2025. One Trust that is not meeting/exceeding the national positive rate for Accident and Emergency feedback is also showing a declining variation. In March 2025, there was one online NHS.UK review of this department, the service user rated the department as 5* and whilst long waits were noted, the person highlight that they were impressed by the medical and reception staff and their ‘thorough and professional abilities’.

**ADVISE Mixed-Sex Accommodation Breaches (January 2025):** a mixed-sex accommodation breach refers to all patients in sleeping accommodation who have been

admitted to hospital. Sleeping accommodation includes all areas where patients are admitted and cared for on beds or trolleys, even when they do not stay overnight. The guidance states that:

- A breach occurs at the point a patient is admitted to mixed-sex accommodation outside the guidance.
- Patients should not normally have to share sleeping accommodation with members of the opposite sex.
- Patients should not have to share toilet or bathroom facilities with members of the opposite sex.
- Patients should not have to walk through an area occupied by patients of the opposite sex to reach toilets or bathrooms; this excludes corridors.
- Women-only day rooms should be provided in mental health inpatient units.

Across Hampshire and Isle of Wight there were 180 mixed-sex accommodation breaches (rate 3.1) during January 2025. The number of breaches reported by providers ranged from 2 to 144.

The January 2025 performance data represent an increase from December 2024 (128/rate 2.4).

Trusts manage their breaches, aiming to rectify them as soon as possible and ensuring patient privacy and dignity. Several factors impact the number of breaches a hospital reports, including the hospital estate, for examples those estates with bays within wards and which include en-suite facilities are less likely to incur breaches. There are some clinical circumstances where mixing can be justified, for example, patients who need highly specialised care, such as that delivered in critical care units. However, once it is deemed the patient's care can be stepped down (e.g. they become 'ward able'). if the patient does not transfer to another area within four hours they are breaching.

## 4.3 Safety

**Infection Prevention and Control Metrics (current)**

| March 2025 (accurate at the time of recording – likely to change in month): | | |
|---|---|---|
| **Methicillin-resistant Staphylococcus aureus (MRSA) Blood Stream Infections** | | |
| Total number of cases financial year to date | | Performance against 2024/25 trajectory (annual) |
| 32 | | +32 |
| **Clostridium difficile infections** | | |
| Number of cases reported* in month | Total number of cases financial year to date* | Performance against 2024/25 trajectory (annual)* |
| 45 | 587 | +52 |
| **Escherichia coli (E. coli) bloodstream infections** | | |
| Number of cases reported* in month | Total number of cases financial year to date* | Performance against 2024/25 trajectory (annual)* |
| 97 | 1377 | +158 |

**SO40a Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infections**: 2023/24 saw an increase in Methicillin-resistant Staphylococcus aureus (MRSA) Blood Stream Infection (BSI), in particular healthcare associated cases. We are predicted to finish the year with five cases above the number of MRSA BSI in 2023/24.

The overall trend is encouraging, however, there is concern that some Trusts are not impacting their numbers as much as others. NHS Hampshire and Isle of Wight Infection Prevention and Control team continue to link with the Trusts for oversight and to support improvements through the sharing of learning from themes.

**S041a: Clostridium difficile infection rate:** the monthly trajectory for Clostridium difficile is 44.5 cases; at the time of writing, NHS Hampshire and Isle of Wight have had 45 cases in March 2025.

The January 2025 oversight framework metrics show a significant improving trend when compared to the oversight framework metrics in March 2024 (20/42). We will finish the year above threshold; however we have significantly improved our ranking position compared to 2023/24.

Since 2021/22, NHS Hampshire and Isle of Wight has seen a 9-18% year-on-year increase in clostridium difficile infection cases; this annual increase is predicted to be reduced this year to 5.2% against and NHS England average increase of 16.5.

**SO42a Escherichia coli (E. coli) bloodstream infections (BSI):** the monthly trajectory for Escherichia coli (E. coli) bloodstream infections is 102 cases. We will finish the year above threshold.

Support is being provided to those Trusts that have exceeded their 5% trajectory for the month and learning from the cases is shared across the System. The main change seems to be associated with

Community Onset, Healthcare Associated cases, however the reason for this is unknown. NHS Hampshire and Isle of Wight is assured that very few cases are associated with initial treatment failures in primary care. The majority are spontaneous events.

**Never Events:** in March 2025, three Never Events were reported by two acute providers.

A Never Event deep dive into the 2024/25 incidents will be undertaken and shared with providers via the System Quality Group to support their improvement work in relation to safer invasive procedures.

**Hampshire and Isle of Wight Report Under Regulation 28 process:** there were no new Reports under Regulation 28 relating to our providers during March 2025.

### 4.4 Clinical Effectiveness

**Standardised Hospital-level Mortality Indicator (SHMI) – November 2023 - October 2024:** all providers are reporting 'as expected' (band 2) or 'lower than expected' (band 3) mortality rates, with two Trusts showing improving variation and two Trusts showing normal variation.

**National Hip Fracture database – hours to operation (March 2025):** early surgery for hip fractures has been shown to reduce mortality rates and surgical complications. The national target is for patients to have surgery within 36 hours, this is because delays beyond this are shown to have increased mortality.

Within Hampshire and Isle of Wight one Trust continued to be the only Trust to meet this target, with the other three Trusts performing above the national rate. Two Trusts are showing a declining variation, and one is showing an improving variation.

### 4.5 Quality Impact Assessments

NHS Hampshire and Isle of Wight have a weekly panel in place which reviews all Quality Impact Assessments that are linked to our financial recovery (i.e., not linked to a usual business case) and financial recovery savings that exceed £50,000 requiring higher level Integrated Care Board or potential Integrated Care System scrutiny. The panel reviews all Quality Impact Assessments that meet the above criteria and makes recommendations based on the information presented.

During March 2025, two Quality Impact Assessments which had been formally submitted to the Hampshire and Isle of Wight panel for review were moved to the decision-making stage of the process.

## 5. Recommendations

5.1 Each Board needs assurance that their organisation has delivered on their organisation's 2024/25 financial landing plan

5.2 Each Board needs assurance that their organisation has robust plans for delivery of their 2025/26 operating plan

University Hospital Southampton
NHS Foundation Trust

| Agenda item 5.10 | Report to the Trust Board of Directors, 13 May 2025 |
|---|---|
| **Title:** | People Report 2024-25 Month 12 |
| **Sponsor:** | Steve Harris, Chief People Officer |
| **Author:** | Matthew Kelly, Interim Head of Workforce |

**Purpose**

| (Re)Assurance | Approval | Ratification | Information |
|---|---|---|---|
| x | | | |

**Strategic Theme**

| Outstanding patient outcomes, safety and experience | Pioneering research and innovation | World class people | Integrated networks and collaboration | Foundations for the future |
|---|---|---|---|---|
| | | x | | |

**Executive Summary:**

Whilst the substantive workforce fell in March, the overall workforce increased, driven by high bank usage in March. Substantive workforce reduced by 11 WTE to 12,690. The level of leavers was again lower than forecast and much lower than levels that would normally be seen in March. UHS finished above its NHSE workforce plan for 24/25. 218 WTE was linked to system wide changes and reductions in NCTR and mental health presentation which have not materialised. NCTR has remained stubbornly high (at between 220 – 260 patients) due to a continuing lack of onward capacity within social care settings. This has meant UHS was unable to close ward capacity as intended as part of its plan.

All surge areas remained open during March. Whilst sickness fell, overall annual leave was higher as staff utilised leave prior to year-end. This, combined with a spike in mental health, drove the higher level of bank. We are re-reviewing bank controls again in line with the increased target reduction for 2025/26 and proposals is being considered through financial improvement group (FIG). Early data in April has shown that bank has fallen again which is positive.

Turnover at year-end was 10.1%, significantly below the target of 13%. The sickness rate has fallen back below the target in March as winter illness has reduced. UHS continues to benchmark well on absence, and our policy and practice is being used as good practice across HIOW as part of a system wide project to improve attendance.

Focused has moved to the implementation of the 25/26 WF plan with increased recruitment controls in place. The NHSE plans set out a net workforce reduction 785 WTE. To facilitate this a range of ICB wide workforce controls have been put in place, including a freeze on recruitment to NHS infrastructure (non-clinical recruitment). Clinical recruitment is being reduced to 70% of previous levels in line with ICB requirements. Divisions and THQ functions are reviewing costs against targets for WTE reduction, with plans being reviewed in April and May. Trade unions have been briefed on the scale of the challenge, and UHS continues to be transparent with its staff through a range of mechanisms. Forecasting for 25/26 is being recalibrated based on the workforce controls and new NHSE plan.

**Contents:**

The report contains workforce data and reporting set out against our People Strategy, Thrive, Excel and Belong pillars.

| **Risk(s):** | |
|---|---|
| 3a: We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles.<br>3b: We fail to develop a diverse, compassionate, and inclusive workforce, providing a more positive staff experience for all staff.<br>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. | |
| **Equality Impact Consideration:** | EQIA assessments undertaken as required for specific streams within the People Strategy |

# UHS People Report

WORLD CLASS PEOPLE

March 2025

THRIVE EXCEL BELONG

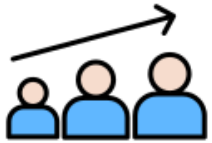
# Summary

# PEOPLE REPORT OVERVIEW: 2024/25 M12 (MAR-25)

In-month sickness is currently 3.7%, which is 0.2% below target (3.9%).

Appraisal completion rates in March remains at 75% same level as February

R12m turnover rate (10.1%), which is below target (13.6%).



Substantive workforce is above NHSE 24/25 workforce plan.

Bank usage increased from prior month and is now 170 WTE above plan.

Increase in agency staffing usage. Agency remains under plan.

Decrease in patient safety incidents from 83 to 74 in March

Pulse Survey for Q4 shows a stable engagement score

## Executive Summary

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# Overall Position

# WTE Movement (M11 to M12)

## Total Workforce

The total workforce **increased by 92 WTE** to 13,651 WTE from M11 (13,559) to M12.

During this period, the substantive workforce decreased by **11 WTE**, while the total temporary staffing increased by **103 WTE.**

As of M12, the Trust is **over the total plan** (by 373 WTE).

## Substantive WTE

**Substantive WTE decreased** by **11 WTE** between end of February and end of March.

The biggest decrease was in the Nursing and Midwifery Registered staff group, decreasing by 18 WTE from M11 to M12.

Substantive workforce position has been adjusted and corrected to fully exclude the clinical research network (CRN - a network fully funded and hosted) which has expanded following a TUPE transfer. This was previously only partially excluded in our workforce numbers.

## Bank & Agency WTE

**Total Bank and Agency** usage increased by 103 WTE in March 2025.

**Bank** usage **increased** in March by 24% (805 to 895 WTE; 90 WTE increase).

**Agency** usage **increased** in March by 24% compared to February 2025 (53 to 66 WTE).

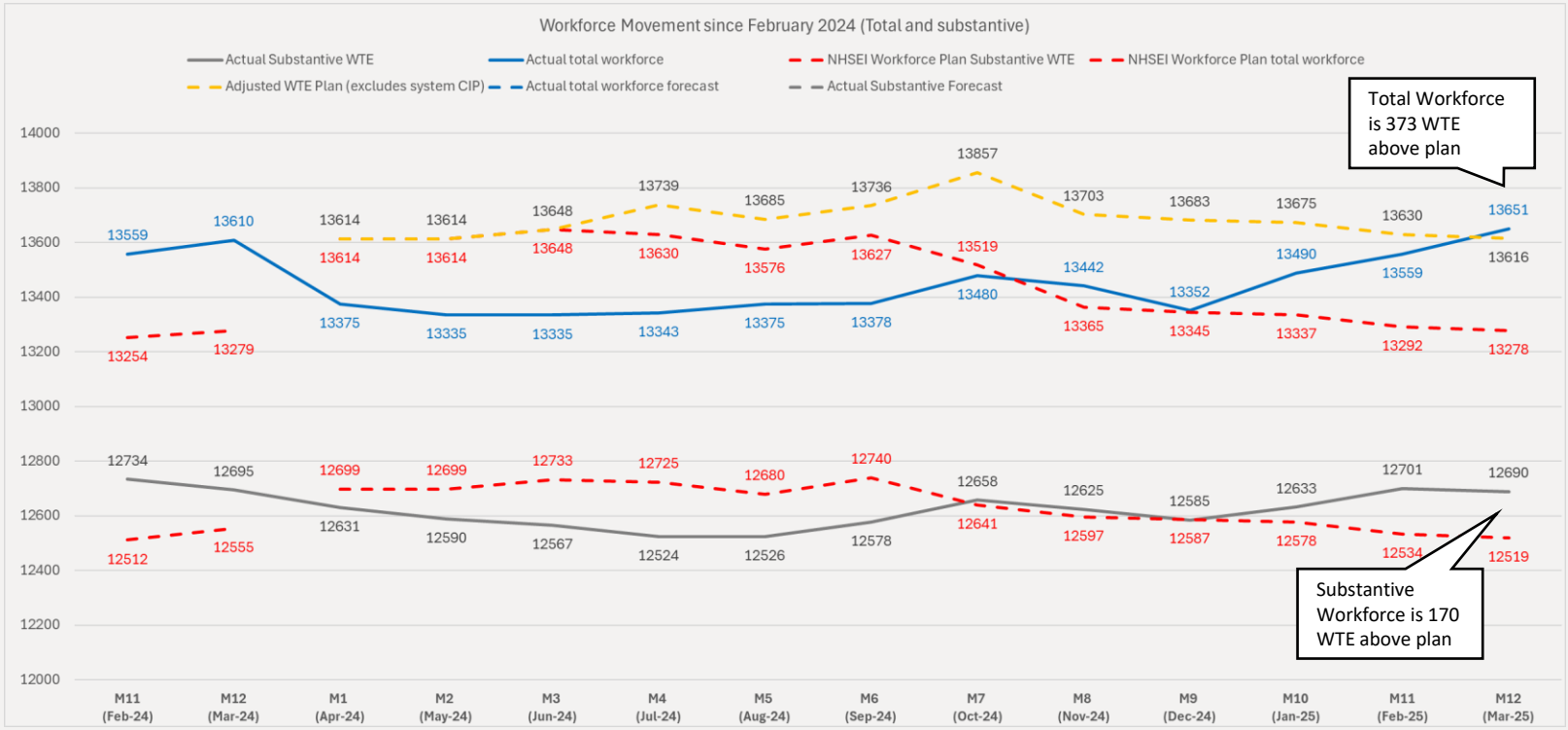
**Key Challenges & Actions:**

**Ongoing Pressures:** Mental health demand continues to create safety, quality, and financial challenges for the Trust. UHS is escalating concerns to the ICB and pushing for broader system solutions.

**Active Workforce Management:** The staffing hub team maintains a detailed record of requests, ensuring all the information is collated from patients being supported with 1:1 Enhanced Care staffing.

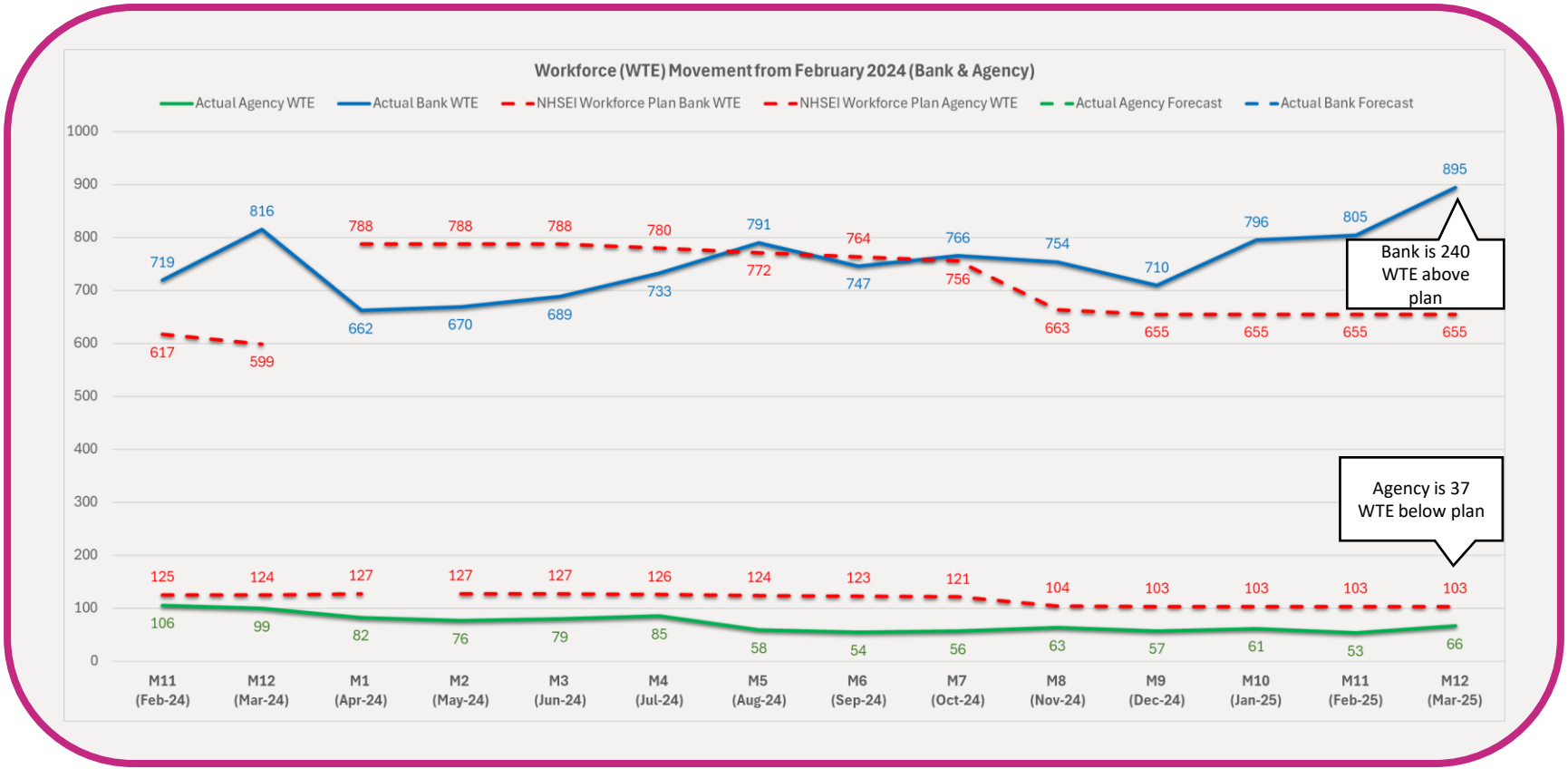
**Shift from Agency to Bank Staff:** Agency shift fill rates dropped to 34% in March 2025 from 57% in March 2024, as NHSP continues to migrate MH workers to bank roles. Agency MH HCA turned off on 1st April 2025.

# Workforce Trends: Total & Substantive




Source: ESR as of March 2025.
NB: Please note that the hosted service criteria in 2024/25 is the same as in 2023/24 We have adjusted our substantive position to account for the full exclusion of the CRN (Clinical Research network – A hosted and external funded network) now this transfer has completed. This has reduced A&C by 34 WTE in November.

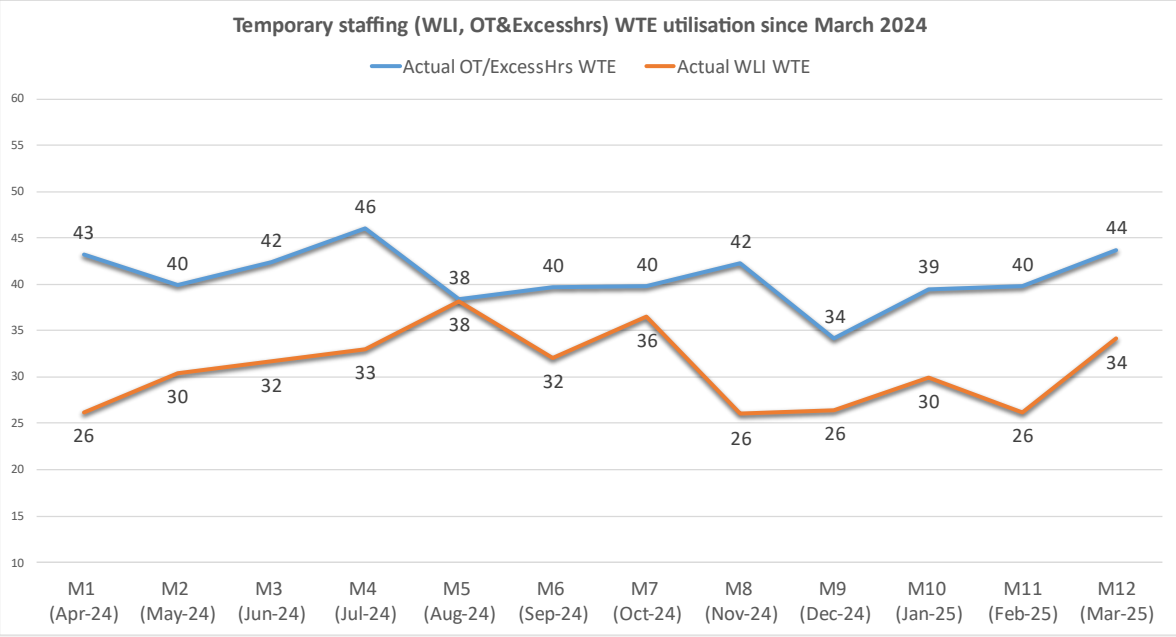
# Workforce Trends: Bank & Agency




Source: NHSP Bank + THQ Medical Bank & Agency (NHSP Agency & 247 Agency) as of March 2025

# Workforce Trends: WLI and Overtime

| WLI Movement | M1 – M2 | M2 - M3 | M3 - M4 | M4 - M5 | M5 - M6 | M6 - M7 | M7 - M8 | M8 - M9 | M9 - M10 | M10 - M11 | M10 - M12 | M1 - M12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 5 | 2 | 0 | 5 | -7 | 5 | -11 | 0 | 4 | -4 | 8 | **-6** |




Source: Healthroster as of March 2025; retrospective WLI figures have been updated M11 to M12 movement.

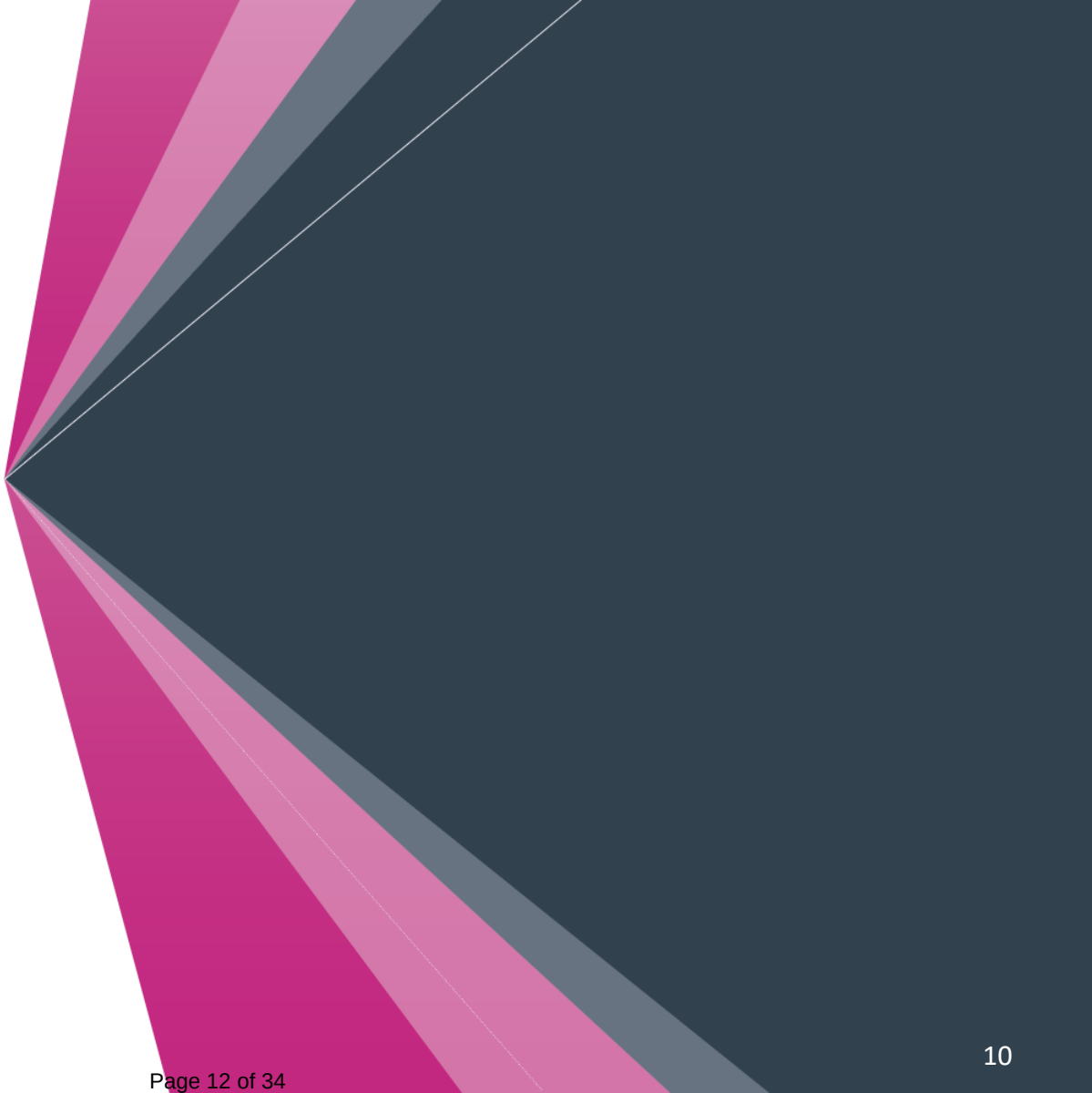
# Quarterly People Heatmap – 2024/25 Q4

THRIVE EXCEL BELONG

| | AWL as of M12 (Mar 25) | % Turnover | Vacancy Rate (AWL - WTE Worked) | Apprentice numbers (WTE) | Appraisals completed | Sickness absence | % Flexible working requests approved | Pulse Survey - Recommendation as a place to work | Pulse Survey - Staff Engagement | Pulse survey - sense of belonging | % of staff at Band 7 and above (BAME) | % of staff band 7 and above LID |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **UHS Overall** | **13329** | **10.15%** | **232** | **688.8** | **74.9%** | **3.7%** | **88.5%** | **64.1%** | **6.84** | **65.2%** | **12.0%** | **13.1%** |
| **Division A Overall** | 2529 | 9.3% | -8 | 103.9 | 72.4% | 3.8% | 92.7% | 57.3% | 6.56 | 61.8% | 14.7% | 12.5% |
| **Critical Care** | 658 | 9.3% | -30 | 22.4 | 73.8% | 3.0% | 92.7% | 72.6% | 6.75 | 65.9% | 7.8% | 9.1% |
| **Ophthalmology** | 334 | 11.4% | 29 | 13.7 | 77.9% | 4.5% | 100.0% | 54.8% | 6.72 | 67.1% | 14.3% | 7.1% |
| **Surgery** | 594 | 10.0% | -7 | 24.4 | 79.0% | 3.3% | 88.9% | 51.6% | 6.34 | 56.4% | 7.7% | 15.4% |
| **Theatres & Anaesthetics** | 924 | 8.1% | -1 | 43.3 | 65.8% | 4.4% | 77.8% | 53.2% | 6.51 | 58.8% | 33.9% | 16.1% |
| **Division B - Overall** | 3507 | 9.7% | -59 | 143.9 | 72.7% | 4.0% | 83.7% | 61.9% | 6.73 | 60.9% | 13.4% | 14.2% |
| **Cancer Care** | 746 | 11.0% | 14 | 32.3 | 67.6% | 4.0% | 93.2% | 53.2% | 6.31 | 51.6% | 18.3% | 17.5% |
| **Emergency Care** | 715 | 11.0% | -39 | 18.6 | 70.1% | 4.3% | 75.2% | 57.9% | 6.30 | 56.4% | 10.1% | 21.5% |
| **Medicine** | 814 | 9.6% | 1 | 47.8 | 86.9% | 4.1% | 100.0% | 73.6% | 7.22 | 71.9% | 25.6% | 7.0% |
| **H&IOWAA** | 0 | 16.4% | 0 | 0.0 | 37.0% | 2.3% | 100.0% | - | - | - | 0.0% | 10.7% |
| **Pathology** | 605 | 8.3% | -5 | 39.9 | 63.6% | 4.3% | 82.8% | 60.2% | 6.71 | 61.0% | 12.2% | 9.9% |
| **Specialist Medicine** | 607 | 8.2% | -2 | 5.2 | 76.3% | 3.1% | 91.7% | 64.1% | 7.03 | 64.7% | 9.7% | 12.5% |
| **Division C - Overall** | 2872 | 10.9% | 84 | 160.9 | 74.1% | 3.7% | 91.1% | 63.6% | 6.79 | 63.5% | 9.8% | 12.4% |
| **Child Health** | 918 | 9.6% | 24 | 40.9 | 74.6% | 3.5% | 92.3% | 60.4% | 6.72 | 61.7% | 4.3% | 13.6% |
| **Clinical Support** | 904 | 13.7% | 37 | 92.1 | 76.2% | 2.3% | 89.7% | 68.6% | 6.86 | 65.3% | 13.2% | 10.3% |
| **Women & Newborn** | 876 | 7.1% | 26 | 27.9 | 73.6% | 5.0% | 90.9% | 60.2% | 6.75 | 63.0% | 5.5% | 17.8% |
| **Division D - Overall** | 2575 | 10.3% | 82 | 114.7 | 79.1% | 3.6% | 97.0% | 66.6% | 6.90 | 70.1% | 15.5% | 13.7% |
| **CV&T** | 977 | 10.4% | 18 | 52.4 | 76.5% | 3.6% | 100.0% | 73.6% | 7.12 | 72.0% | 18.7% | 15.8% |
| **Neuro** | 493 | 10.9% | 8 | 24.9 | 77.1% | 4.1% | 100.0% | 57.6% | 6.69 | 65.2% | 19.4% | 13.9% |
| **Radiology** | 530 | 10.0% | 44 | 18.3 | 84.7% | 2.6% | 92.3% | 68.6% | 6.84 | 75.4% | 7.3% | 9.8% |
| **T&O** | 469 | 10.3% | 3 | 19.1 | 81.6% | 3.6% | 90.7% | 64.4% | 6.89 | 67.0% | 20.0% | 10.0% |
| **THQ - Overall** | 1736 | 10.6% | 133 | 165.5 | 79.4% | 3.1% | 100.0% | 67.3% | 7.07 | 69.2% | 10.2% | 13.3% |
| **Chief Finance Officer** | 119 | 12.0% | -3 | 15.0 | 83.3% | 1.6% | - | 64.3% | 7.17 | 73.3% | 9.5% | 14.3% |
| **Chief Operating Officer** | 87 | 11.2% | -1 | 1.0 | 62.8% | 5.1% | - | 66.7% | 7.02 | 66.7% | 11.1% | 7.4% |
| **Clinical Development** | 85 | 15.8% | -9 | 2.0 | 80.0% | 2.9% | 100.0% | 66.7% | 7.15 | 71.1% | 10.9% | 26.1% |
| **Estates** | 364 | 10.4% | 48 | 49.0 | 86.4% | 4.5% | 100.0% | 56.6% | 6.63 | 61.0% | 2.2% | 10.9% |
| **Informatics** | 276 | 4.6% | 17 | 27.1 | 66.3% | 2.8% | 100.0% | 66.2% | 6.99 | 68.5% | 16.0% | 7.4% |
| **People / HR** | 172 | 17.0% | 16 | 20.1 | 88.8% | 2.1% | 66.7% | 74.3% | 7.31 | 71.1% | 2.7% | 18.9% |
| **R&D** | 409 | 13.3% | 20 | 14.3 | 87.1% | 2.6% | 92.3% | 75.3% | 7.21 | 72.7% | 14.8% | 11.1% |
| **Training & Education** | 223 | 5.8% | 9 | 37.0 | 83.1% | 3.7% | 88.9% | 79.4% | 7.61 | 70.6% | 10.5% | 10.5% |

NB: Care groups and THQ departments of < 50 WTE have been excluded from the above

# THRIVE

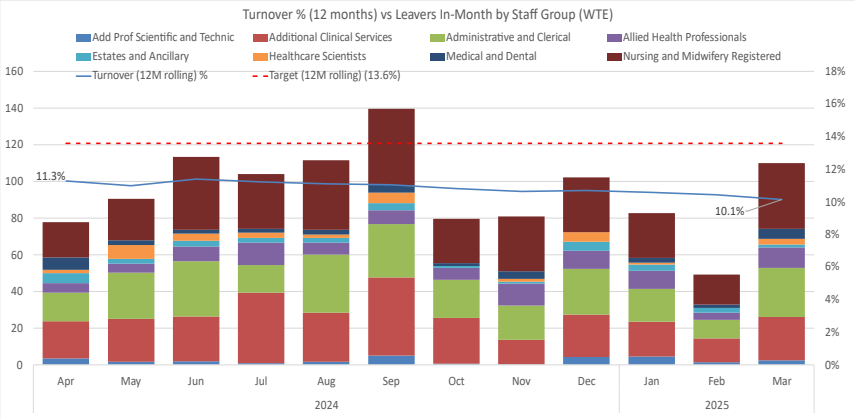


# Substantive SIP by Staffing Group

| Substantive Monthly Staff in Post (WTE) for last 12 months | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2024/25 M1 (Apr) | 2024/25 M2 (May) | 2024/25 M3 (Jun) | 2024/25 M4 (Jul) | 2024/25 M5 (Aug) | 2024/25 M6 (Sep) | 2024/25 M7 (Oct) | 2024/25 M8 (Nov) | 2024/25 M9 (Dec) | 2024/25 M10 (Jan) | 2024/25 M11 (Feb) | 2024/25 M12 (Mar) | M11 to M12 movement |
| Add Prof Scientific and Technic | 397 | 400 | 396 | 396 | 401 | 301 | 301 | 300 | 295 | 294 | 297 | 302 | **5** |
| Additional Clinical Services | 2135 | 2134 | 2130 | 2117 | 2099 | 2098 | 2088 | 2091 | 2078 | 2097 | 2104 | 2107 | **3** |
| Administrative and Clerical (Divisions) | 1304 | 1292 | 1279 | 1271 | 1268 | 1261 | 1252 | 1231 | 1216 | 1228 | 1237 | 1241 | **4** |
| Administrative and Clerical (THQ) | 999 | 997 | 970 | 959 | 955 | 954 | 947 | 970 | 983 | 992 | 994 | 996 | **2** |
| Allied Health Professionals | 703 | 700 | 699 | 688 | 686 | 808 | 815 | 813 | 805 | 806 | 820 | 816 | **-5** |
| Estates and Ancillary | 374 | 372 | 373 | 376 | 373 | 370 | 373 | 375 | 374 | 374 | 377 | 378 | **1** |
| Healthcare Scientists | 499 | 495 | 498 | 496 | 497 | 495 | 504 | 510 | 509 | 512 | 518 | 521 | **4** |
| Medical and Dental | 2165 | 2163 | 2161 | 2155 | 2217 | 2240 | 2244 | 2241 | 2233 | 2239 | 2256 | 2248 | **-8** |
| Nursing and Midwifery Registered | 4052 | 4039 | 4030 | 4025 | 3998 | 3998 | 4055 | 4038 | 4035 | 4035 | 4028 | 4010 | **-18** |
| Students | 58 | 58 | 58 | 58 | 58 | 58 | 58 | 56 | 56 | 56 | 69 | 69 | **0** |
| Grand Total | **12685** | **12649** | **12593** | **12540** | **12550** | **12583** | **12635** | **12625** | **12585** | **12633** | **12701** | **12690** | **-11** |

Source: ESR substantive staff as of March 2025; includes consultant APAs and junior doctors' extra rostered hours, excludes CLRN, Wessex AHSN, UEL and WPL (same criteria as 23/24). Numbers relate to WTE, not headcount.

# Turnover



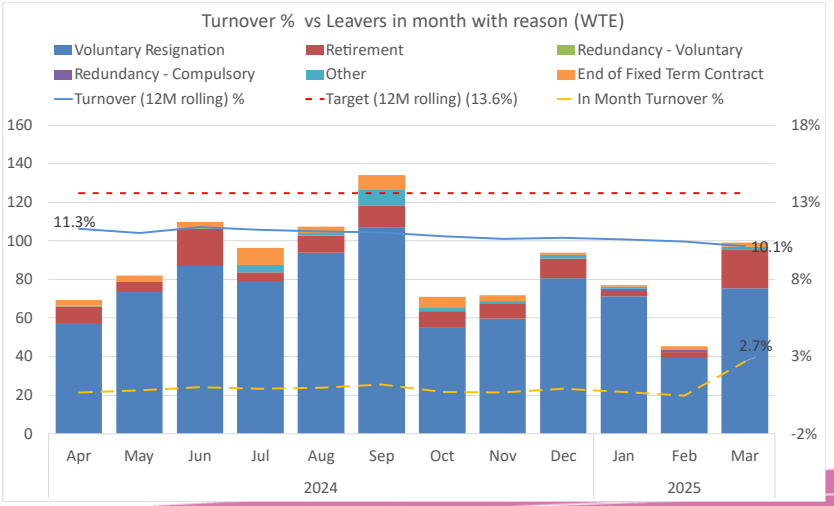

In March 2025, there was a total of 109 WTE leavers, 64.1 WTE more than February 2025 (44.9 WTE). Division B recorded the highest number of leavers (29 WTE). Within Division B, Nursing and Midwifery Registered staff group had the highest number of leavers (11 WTE), followed by the Additional Clinical Services staff group at 8 WTE.

Divisions C and A had the second and third highest number of leavers (24 and 22 WTE respectively); with the largest numbers being the Nursing and Midwifery Registered staff group for Div C (7 WTE), and Nursing and Administrative and Clerical staff group for Div A (7 WTE).

Total leavers by division are as follows:

- **Division A: 22 WTE leavers**
- **Division B: 29 WTE leavers**
- **Division C: 24 WTE leavers**
- **Division D: 19 WTE leavers**
- **THQ: 15 WTE leavers**

| Staffing group | Leavers (WTE) in month | Turnover In-Month | Turnover 12m rolling % |
|---|---|---|---|
| Add Prof Scientific and Technic | 2.4 | 0.8% | 8.7% |
| Additional Clinical Services | 22.7 | 1.1% | 14.1% |
| Administrative and Clerical | 26.7 | 3.4% | 11.3% |
| Allied Health Professionals | 11.2 | 1.4% | 12.0% |
| Estates and Ancillary | 1.6 | 31.7% | 9.5% |
| Healthcare Scientists | 3.1 | 0.6% | 6.2% |
| Medical and Dental | 5.5 | 0.6% | 4.5% |
| Nursing and Midwifery Registered | 35.8 | 0.9% | 9.1% |
| **UHS total** | **109.0** | **2.7%** | **10.1%** |

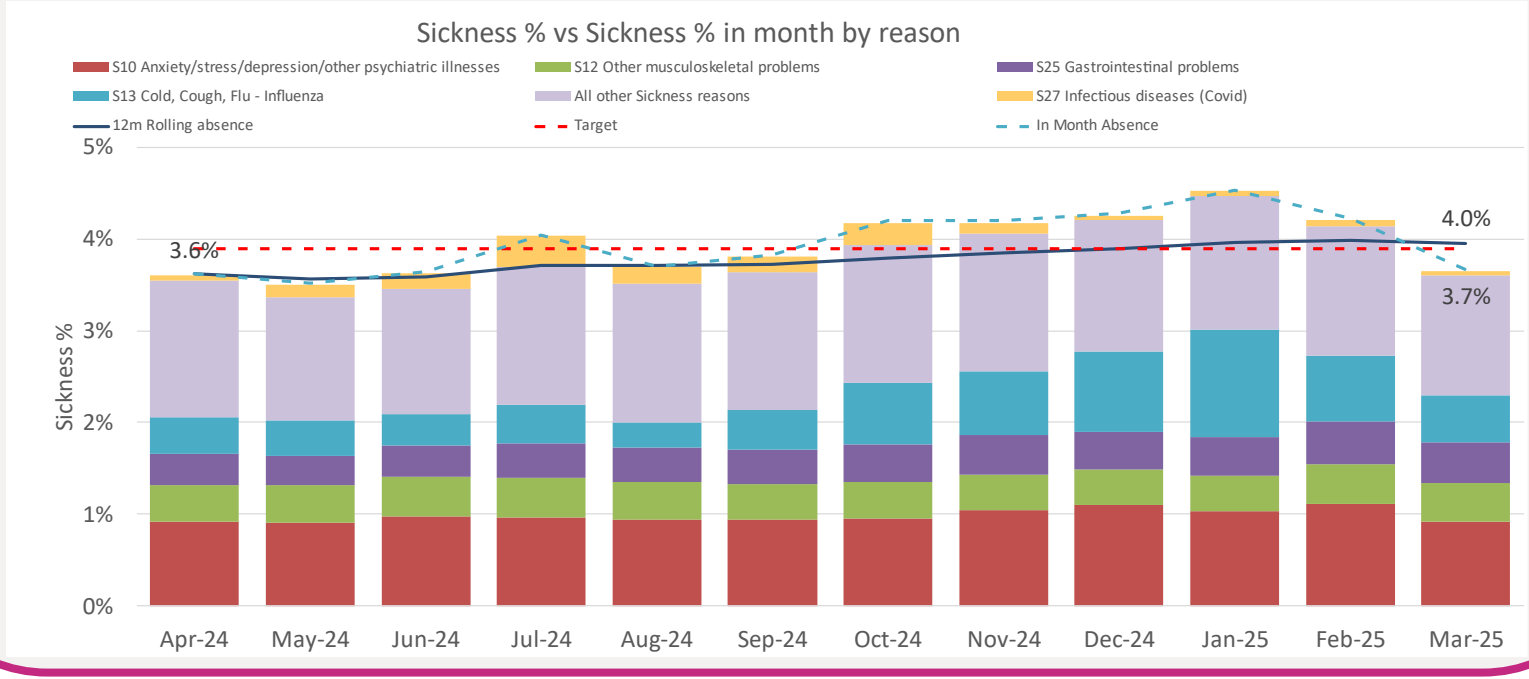



Source: ESR – Leavers Turnover WTE, ESR Staff Movement March 2025 (excludes junior doctors & hosted services)

# Sickness

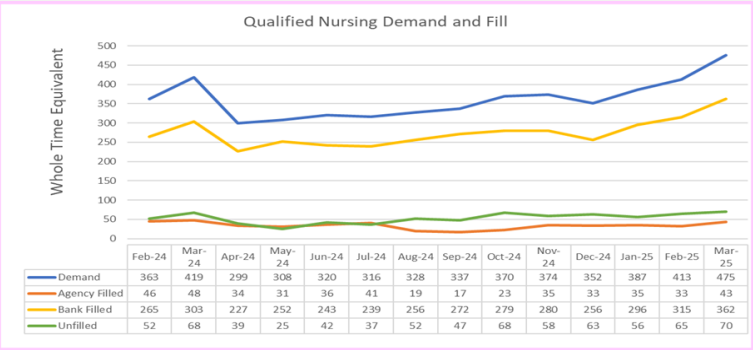
**Current in-month sickness: 3.7% | Rolling 12-month sickness: 4.0%**

Current in month sickness is at the lowest since June 2024.

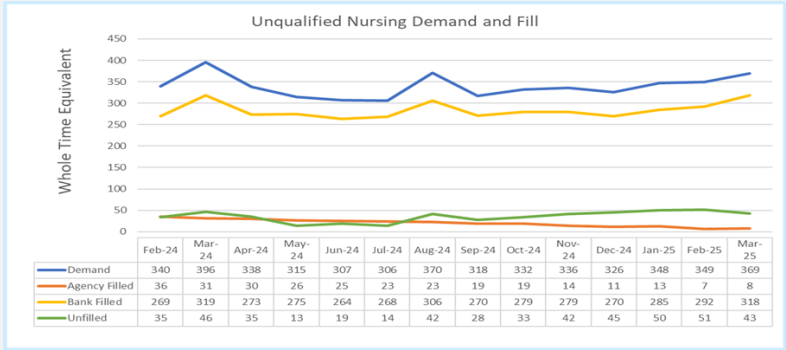



Source: ESR – March 2025

# Temporary Staffing




| | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Demand | 363 | 419 | 299 | 308 | 320 | 316 | 328 | 337 | 370 | 374 | 352 | 387 | 413 | 475 |
| Agency Filled | 46 | 48 | 34 | 31 | 36 | 41 | 19 | 17 | 23 | 35 | 33 | 35 | 33 | 43 |
| Bank Filled | 265 | 303 | 227 | 252 | 243 | 239 | 256 | 272 | 279 | 280 | 256 | 296 | 315 | 362 |
| Unfilled | 52 | 68 | 39 | 25 | 42 | 37 | 52 | 47 | 68 | 58 | 63 | 56 | 65 | 70 |




| | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Demand | 340 | 396 | 338 | 315 | 307 | 306 | 370 | 318 | 332 | 336 | 326 | 348 | 349 | 369 |
| Agency Filled | 36 | 31 | 30 | 26 | 25 | 23 | 23 | 19 | 19 | 14 | 11 | 13 | 7 | 8 |
| Bank Filled | 269 | 319 | 273 | 275 | 264 | 268 | 306 | 270 | 279 | 279 | 270 | 285 | 292 | 318 |
| Unfilled | 35 | 46 | 35 | 13 | 19 | 14 | 42 | 28 | 33 | 42 | 45 | 50 | 51 | 43 |

**Qualified nursing demand/fill (WTE) status:**

- **Demand increased from 413 to 475 in March (+62).**
- **Bank filled** 362 WTE(+47 from previous month) and Agency filled 43 WTE (+10 from the previous month).
- **Unfilled shifts:** 70 WTE remained unfilled (+5 on previous month).
- **Year-on-year demand increase:** 56 WTE higher than March 2024.

**Actions:**

- **Agency Rate Reduction Plan**: Further reduction in ED, CC and PICU planned for 1st April 2025 to align to SE Ceilings.
- **SE Collaborative Bank Rate Project**: Review of current nursing rates at UHS as part of this initiative and wider to meet bank and agency reduction targets..

**HCA demand/fill (WTE):**

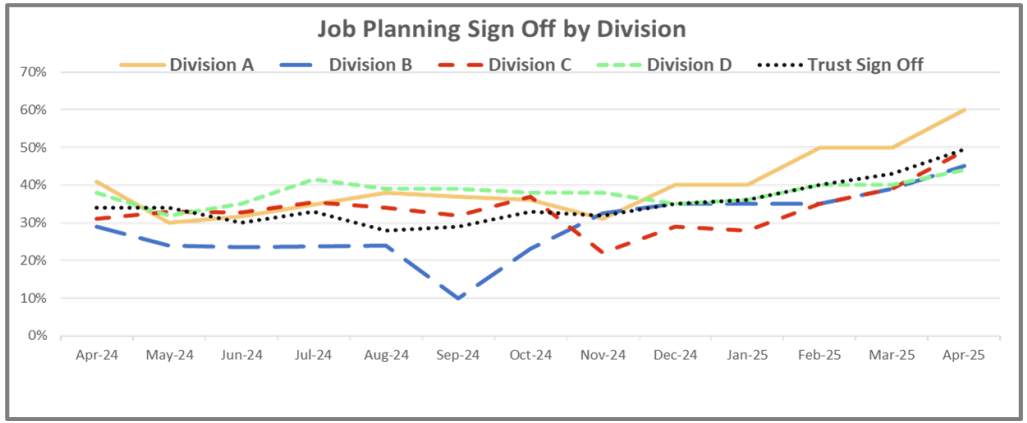
- **Demand increased** from 349 to 369 in March (+20).
- **Bank filled 318** WTE (+26)
- **Agency filled** 8 WTE (all MH HCAs) (+1)
- **Unfilled shifts:** 43 remained unfilled (down 8 on prior month)
- **Year-on-year demand increase:** 27 WTE lower than March 2024.

**Actions:**

- **Band 2/3 bank review:** Process for mapping the Band 2/3 work for NHSP
- **Agency switch off Band 2:** all band 2 agency has been removed from 1st April 2025

Source: Temporary Resourcing - March 2025

# Workforce: Medical Rostering and Planning

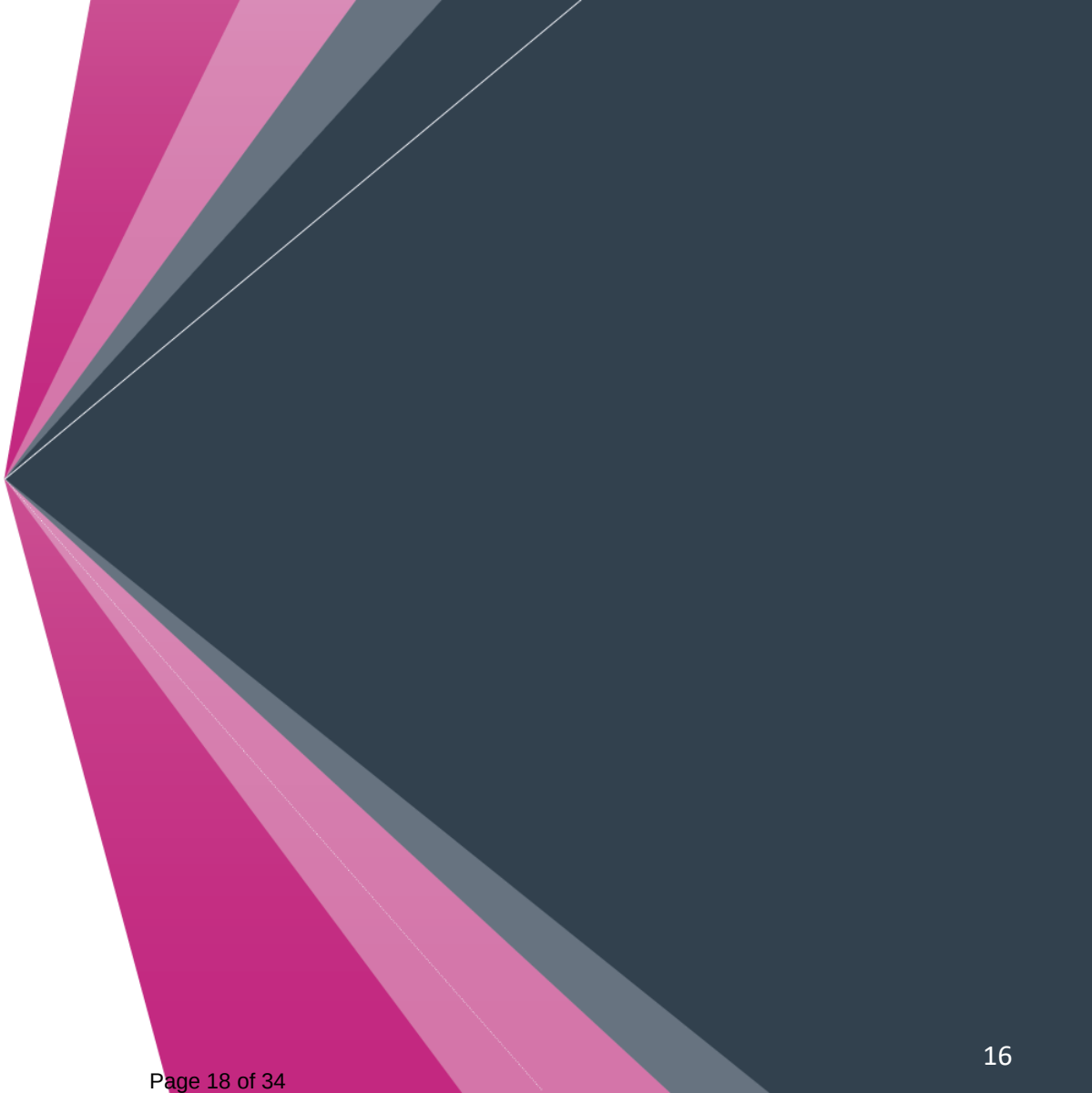


Signed off Job Plans


Active Job Plans

- Job planning sign off levels up 6.5% to 49.5%
- Active Job Plans up 2% to 90%
- 81% of Cancer, Acute Med and Specialist Medicine relevant Job plans extended

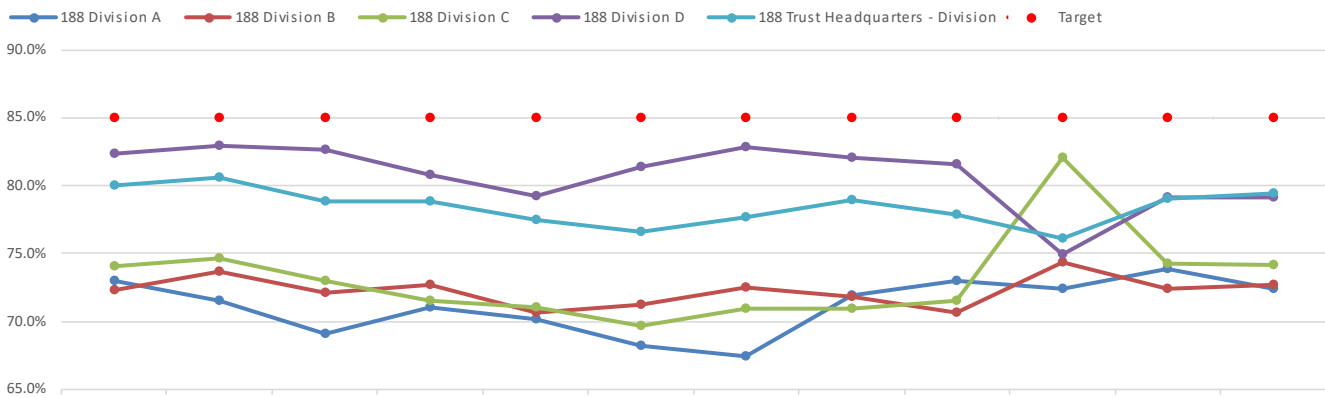
# EXCEL



# Appraisals

## Summary

**The Trust's appraisal completion rate is 75% as of March 2025, same level as February 2025.**

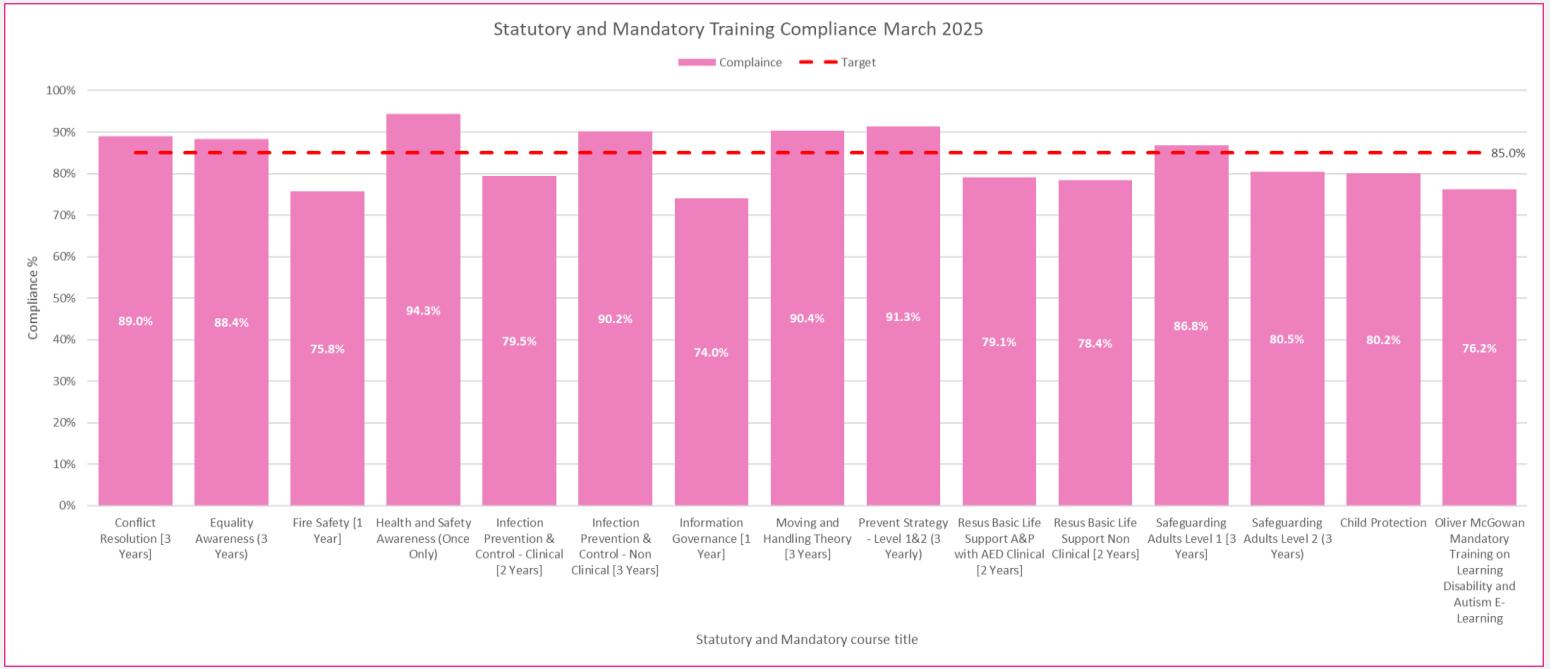



| | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
| 188 Division A | 73.0% | 71.6% | 69.1% | 71.0% | 70.1% | 68.2% | 67.4% | 71.9% | 73.0% | 72.3% | 73.9% | 72.4% |
| 188 Division B | 72.3% | 73.6% | 72.1% | 72.7% | 70.6% | 71.2% | 72.5% | 71.8% | 70.6% | 74.3% | 72.4% | 72.7% |
| 188 Division C | 74.0% | 74.7% | 73.0% | 71.5% | 71.1% | 69.7% | 70.9% | 71.0% | 71.5% | 82.0% | 74.3% | 74.1% |
| 188 Division D | 82.4% | 83.0% | 82.7% | 80.8% | 79.2% | 81.4% | 82.8% | 82.1% | 81.6% | 74.9% | 79.2% | 79.1% |
| 188 Trust Headquarters - Division | 80.0% | 80.6% | 78.9% | 78.8% | 77.4% | 76.6% | 77.7% | 78.9% | 77.9% | 76.1% | 79.0% | 79.4% |
| Target | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |

Source: ESR & VLE – Appraisal data for Divisions A, B, C, D and THQ only (excluding Medical and Dental staff group) March 2025

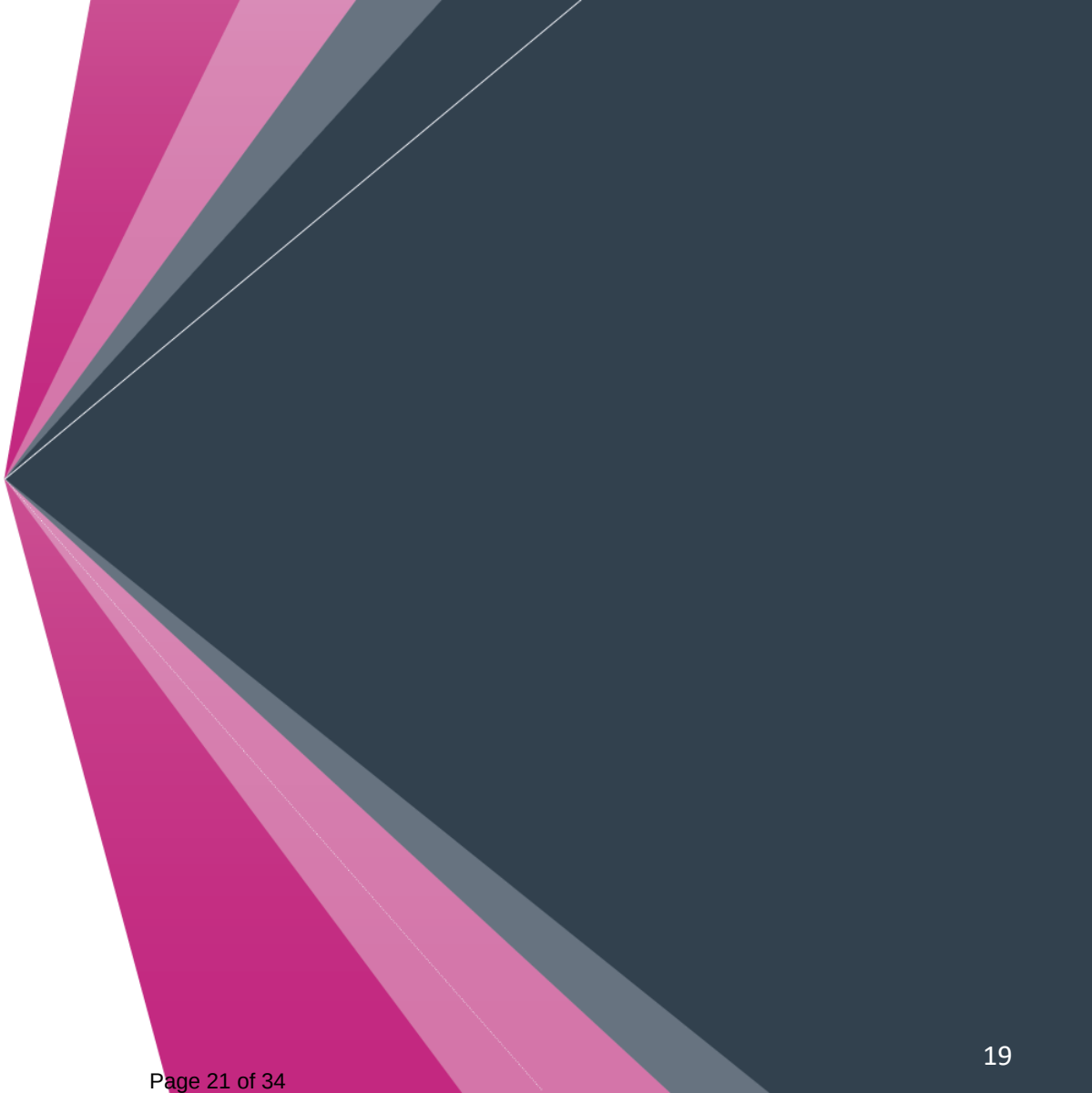
# Statutory & Mandatory Training

**The Trust's average completion rate for March 2025 is 83%, 1% higher than February 2025 at 82% with 7 of 15 measures above the 85% target. Please note that the audiences for both Safeguarding Adults and Children is currently under review.**

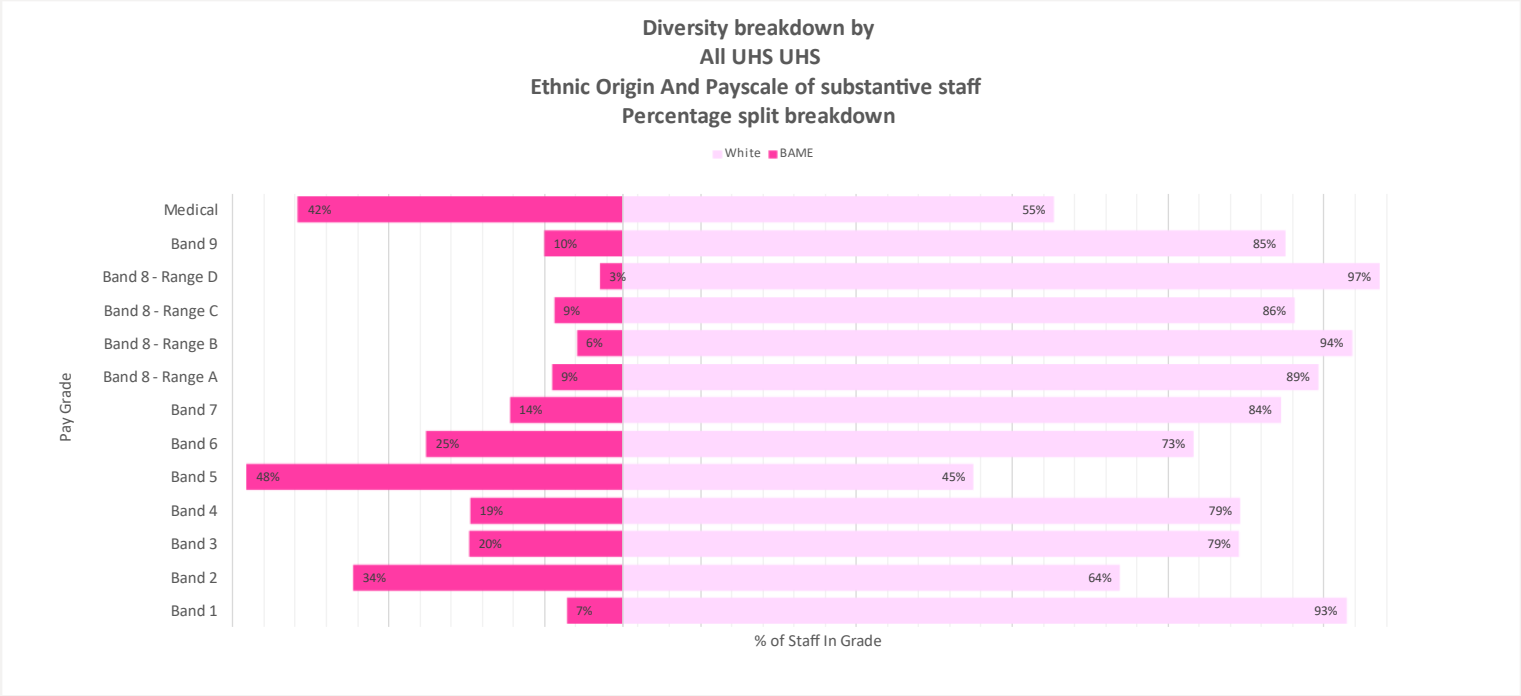



Source: Virtual Learning Environment (VLE) March 2025

# BELONG

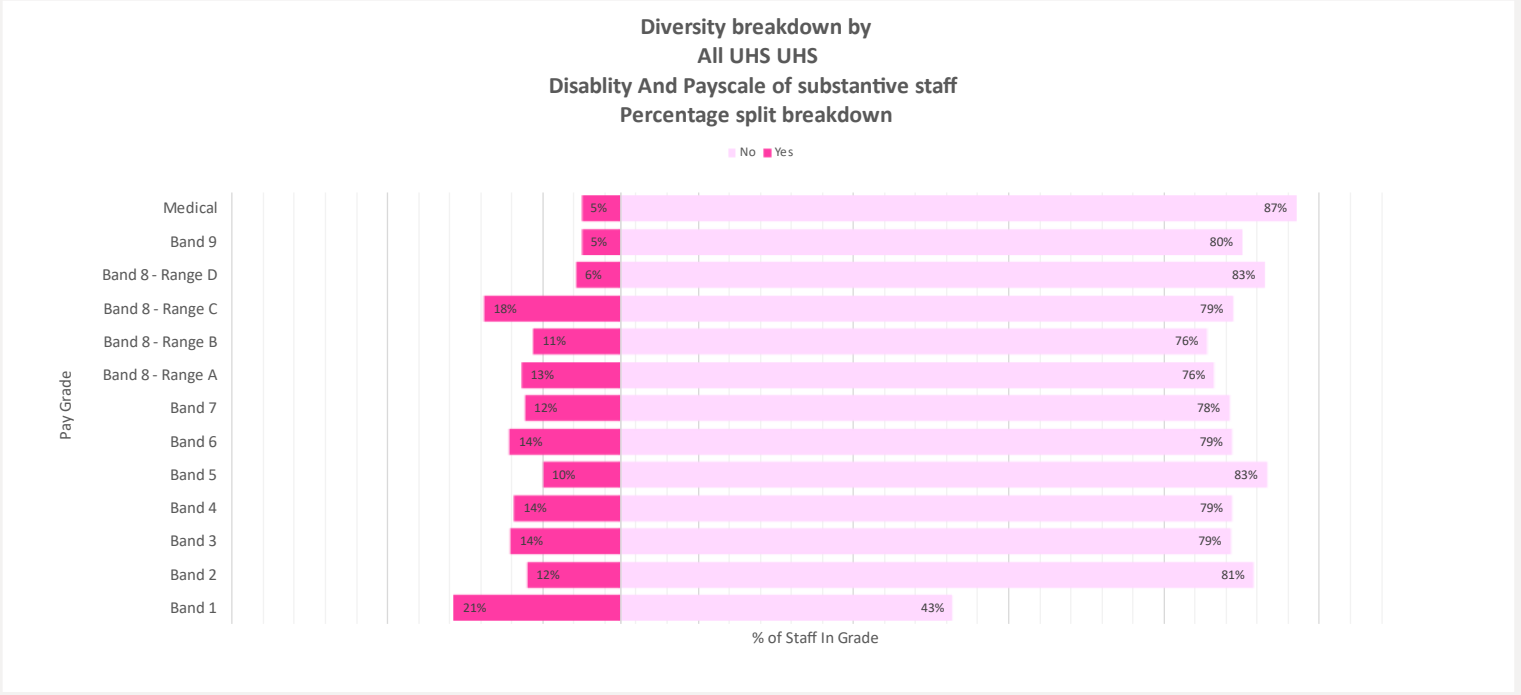


# Staff in Post - Ethnicity



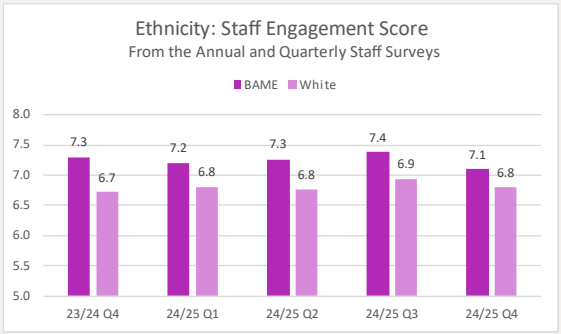

Source: ESR – March 2025

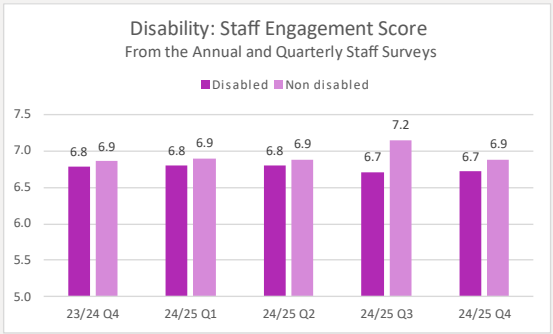
# Staff in Post – Disability Status

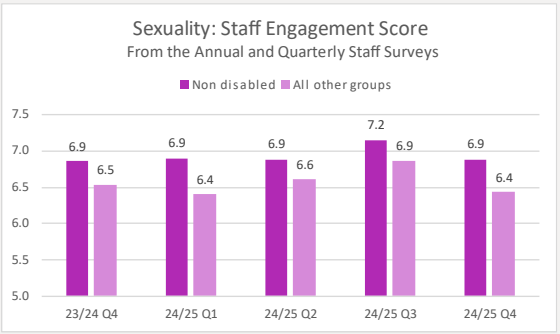


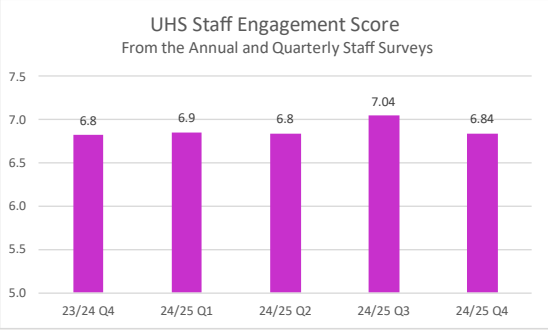

Source: ESR – March 2025

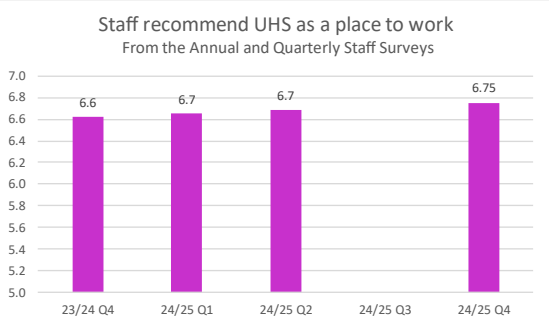
# Pulse Survey – 2024/25 (Q3 and Q4 Updated)



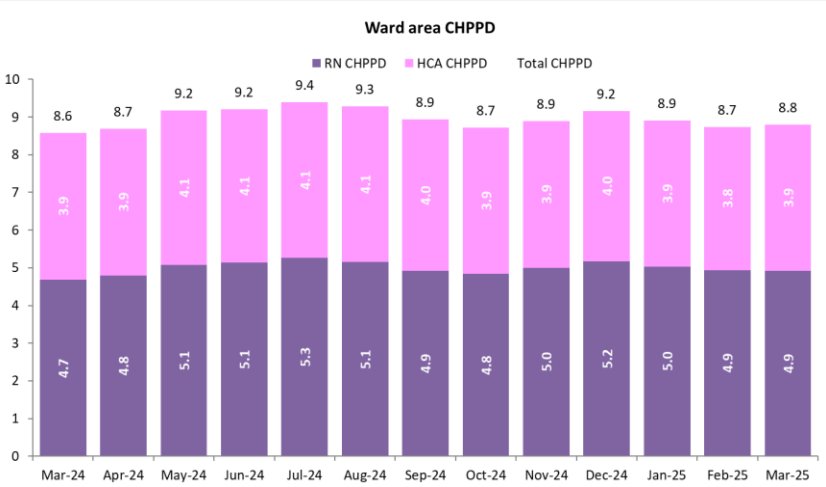



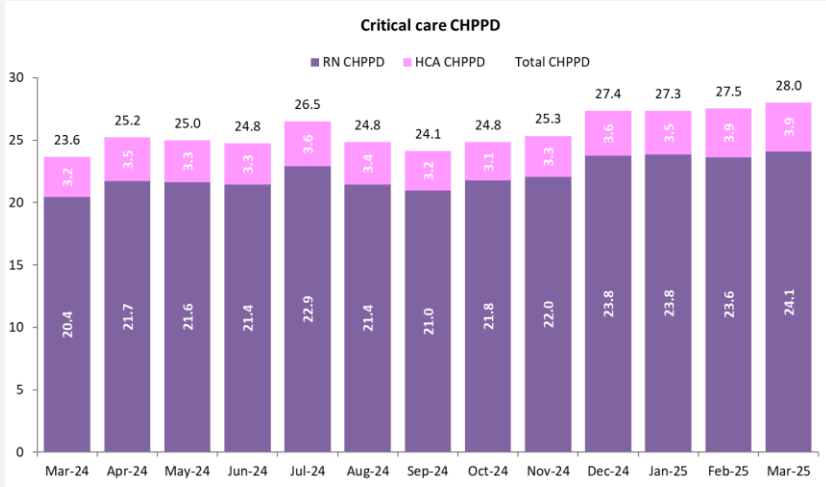




Source: Picker (Qualtrics)

# CHPPD



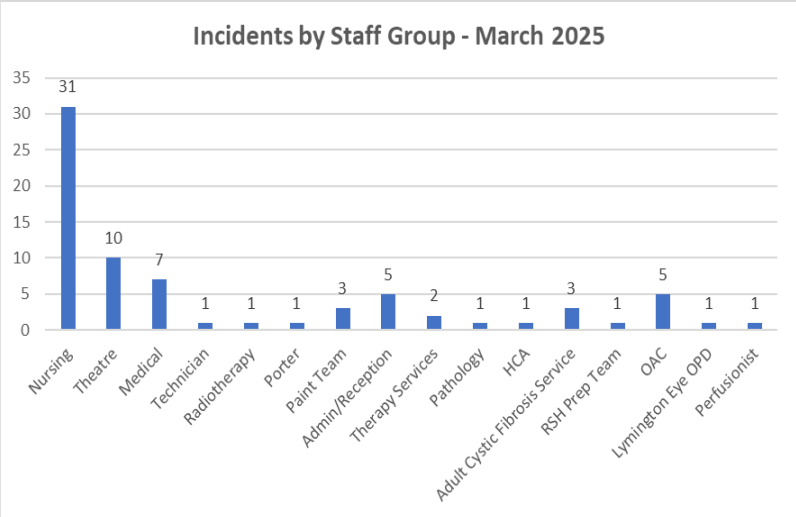

The Ward areas CHPPD rate in the Trust for RN's remained flat at 4.9, same as February 2025 while HCA increased to 3.9 (previously 3.8) overall 8.8 (previously 8.7)

The CHPPD rate in Critical care has increased overall from last month. RN 24.1 (previously 23.6), HCA remained flat at 3.9, while the overall CHPPD for Critical Care increased to 28 (previously 27.5)

Source: HealthRoster, NHSP & eCamis – March 2025

# Patient Safety – Staffing Incidents & Red Flags

In total 74 incident reports were received in March 2025 which cited staffing. This is a slight decrease on the 83 reported in February and represents a continued fall on the elevated level of 109 reported in March 2024.




**Incidents by Division March 2025 vs February 2025**

| Month Incident occurred | Division A | Division B | Division C | Division D | THQ | Trust total |
|---|---|---|---|---|---|---|
| March 2025 | 24 | 16 | 23 | 10 | 1 | 74 |
| Total | 24 ↑ 19 | 16 ↓ 20 | 23 ↔ 23 | 10 ↓ 17 | 1 ↓ 4 | 74 ↓ 83 |

| Month Incident occurred | Division A | Division B | Division C | Division D | THQ | Trust total |
|---|---|---|---|---|---|---|
| February 2025 | 19 | 20 | 23 | 17 | 4 | 83 |
| Total | 19 ↑ 14 | 20 ↑ 15 | 23 ↑ 19 | 17 ↑ 11 | 4 ↑ 3 | 83 ↑ 62 |

Source: Safeguard System March 2025

# Patient Safety – Staffing Incidents & Red Flags cont.

**DIVISIONAL BREAKDOWN:**

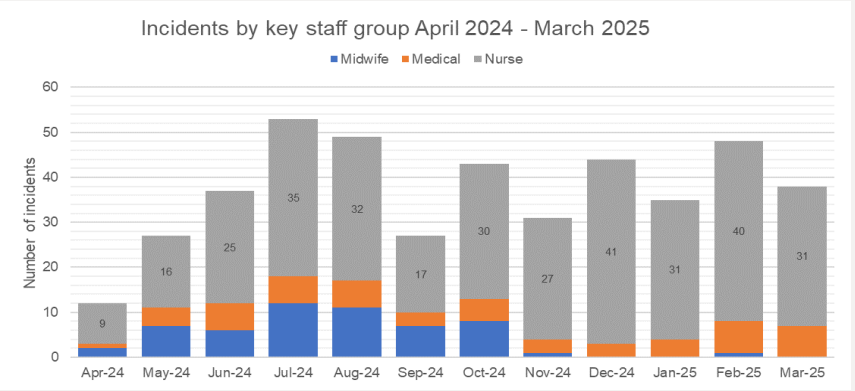
**Div A:**
Twenty-four incidents reported in March 2025, up on the 19 in the previous month. Red Flags were up from 3 to 4.

**Div B:**
Sixteen incidents were reported in March 2025 (a drop from 20 in the previous month). Red flags were up from 0 to 13 and were spread evenly across all 4 reported categories.

**Div C:**
Twenty-three incidents reported in March 2025 (same level as the previous month). There were no red flags reported.

**Div D:**
Ten incidents reported in March 2025 (down from 17 in the previous month). Red flags decreased, with 5 reported (down from 13 in the previous month).

**THQ:**
One incident reported in March 2025 (down from 4 in the previous month). The incident was reported from Portering.

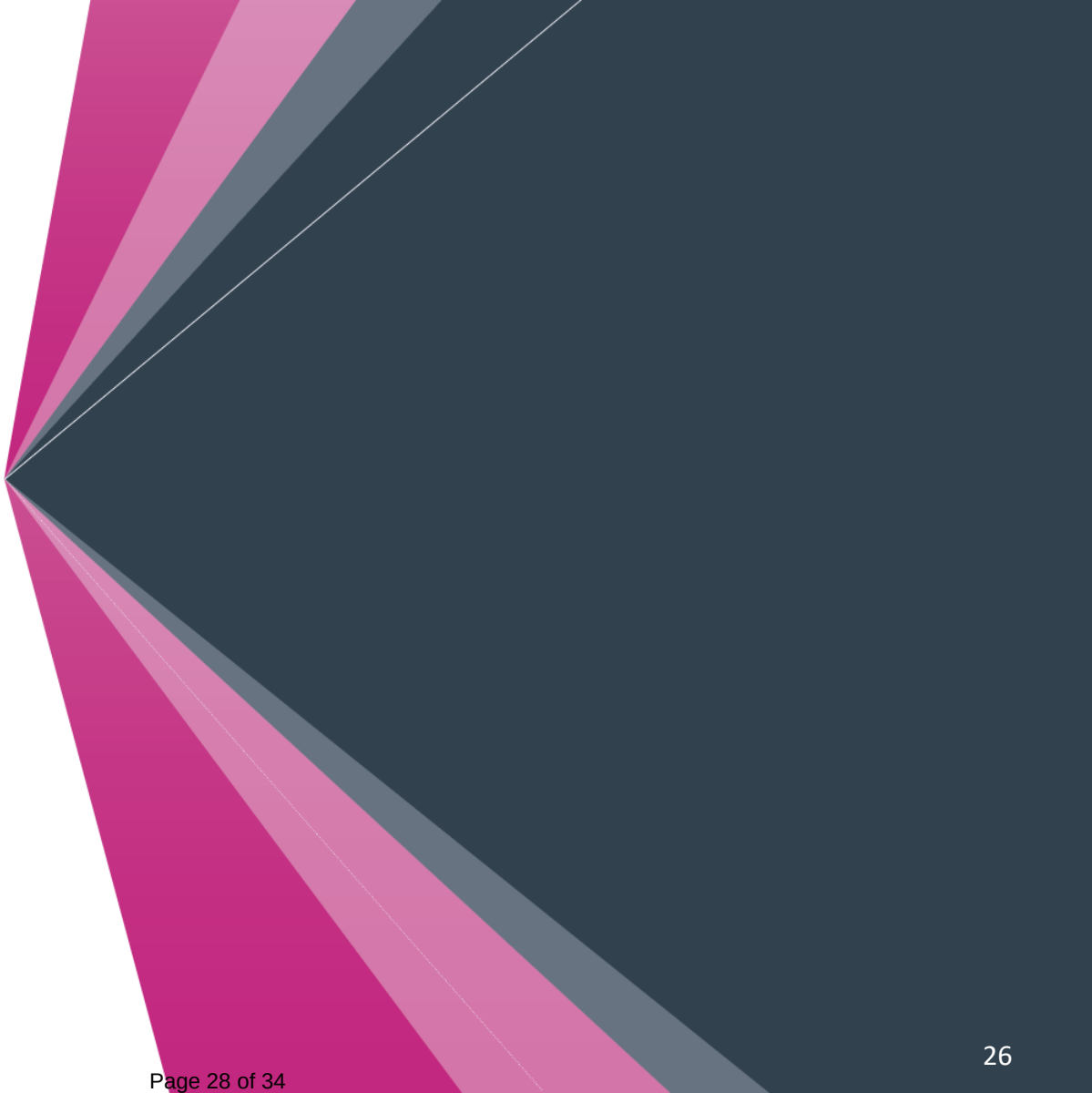



| March 2025 | Red flag category | Number of reports | Div A | Div B | Div C | Div D |
|---|---|---|---|---|---|---|
| | Delay in medication | 6 | 2 | 3 | 0 | 1 |
| | Delay in pain relief | 6 | 0 | 4 | 0 | 2 |
| | Delay in observations | 5 | 1 | 3 | 0 | 1 |
| | Less than 2 registered | 5 | 1 | 3 | 0 | 1 |
| | **Total** | **22** | **4** | **13** | **0** | **5** |

| February 2025 | Red flag category | Number of reports | Div A | Div B | Div C | Div D |
|---|---|---|---|---|---|---|
| | Delay in medication | 3 | 0 | 0 | 1 | 2 |
| | Delay in pain relief | 6 | 1 | 0 | 0 | 5 |
| | Delay in observations | 4 | 1 | 0 | 0 | 3 |
| | Less than 2 registered | 4 | 1 | 0 | 0 | 3 |
| | **Total** | **17** | **3** | **0** | **1** | **13** |

Source: Safeguard System March 2025

# 2025/26 Workforce Plan



# Workforce Plan 25/26

UHS has submitted its workforce plan for 25/26 to NHSE. This sets out a challenging reduction target as part of the Trust's requirement to deliver a balanced financial position as part of the national planning guidance. Overall, the plan sets out a net reduction of 785 WTE (6%) in total workforce and this is phased over the year.

Overall, the breakdown of the net planned reductions is as follows:

- Substantive reductions – 620 WTE (5%)
- Bank reductions – 145 WTE (20%)
- Agency reductions – 20 WTE (30%)

**Delivery risks**

There are a number of key risks to the delivery of the plan which have been discussed and appropriate mitigation factors being considered:

- **Impact on quality and safety** – workforce proposals will have a full QIA process for changes. A QIA committee has been set up as a reporting subgroup to the Financial Improvement Group (FIG) Chaired by the Chief Nurse.
- **Reduced Turnover** – plans are reliant on natural attrition, which is slowing in the local health system and wider local economy. Slowing attrition rates will be a risk to plan delivery.
- **Severance payments** – Cost of significant severance payments without external cash support. Our cash position will limit the ability to make a high volume of exits.
- **Temporary staffing** – reductions in temporary staffing are linked to closure in capacity, including improvements in mental health and NCTR. System schemes designed to support improvements in out-of-hospital capacity are key.

# Workforce Plan 25/26

## How will we deliver the plan

| Trust Action | Detail | Timescale |
|---|---|---|
| Vacancy Management | • All Trust in Hampshire and Isle of Wight IBC have implemented a freeze on external non-clinical recruitment<br>• Trust are also only recruiting to 70% of clinical leavers<br>• Limited internal recruitment permitted to support organisational movement and redeployment as required | In place |
| Clinical Divisional Structure | • Consolidation from four clinical divisions to three aligned to national planning priorities<br>• Focus on overall reduction in divisional infrastructure and move to a consistent leadership blueprint<br>• Consultation with affected groups and change management during May and June | Divisions to go live 1 July |
| Divisional and THQ pay cost base reductions | • Divisional teams reviewing plans to reduce overall pay costs by 5%<br>• THQ teams have been set a target overall reduction of 10%<br>• Executive reviews of plans taking place in May. Change management to take place in May onwards<br>• Focus on substantive and temporary staffing expenditure | Reviews May |
| MARS | • A second MARS scheme to be run following NHSE approval<br>• Applications open to wider pool of people with process to be advertised in May<br>• Case by case review applications against service requirements and affordability at CFO and CPO level with trade unions. | May |

**Change management process**

- Changes managed in line with the Trust's organisational change procedures. Focus on redeployment as a priority supported through vacancy management.
- Consultation with unions has commenced on overall level of change required. Weekly union meetings in place.
- Transparent ongoing communication with staff through range of mediums including CEO led 'connect' sessions with staff across the Trust

# UHS Workforce Plan 2025/26

**WTE Movement Summary**

Total reduction of 785 WTE
Substantive reduction of 620 WTE
Bank reduction of 145 WTE
Agency reduction of 20 WTE

**KPIs**

Sickness – **3.7%**
Turnover – **10%**

**Governance**

Via the People Board, Trust Savings Group, FIG, PODC, TEC

## Substantive

Substantive WTE planned baseline is **12,654** WTE and is projected to be 12,034 WTE by March 2026 (a **net reduction of 620 WTE**).

## Bank

Bank WTE planned baseline is 769 WTE and is projected to be 624 WTE by March 2026 (**a net reduction of 145 WTE**). Bank increased in March 2025, but has fallen again in April.

## Agency

Agency WTE baseline is 63 WTE and is projected to be 43 WTE by March 2026 (a **reduction of 20 WTE**). Agency WTE throughout 2024/25 has reduced steadily the Trust closed agency under plan for the 2024/25 financial year.

## Total WTE

By March 2026, there will be a total WTE **net reduction of 785 WTE** from the baseline of 13,486 WTE (M12) to 12,701 WTE. Substantive, bank and agency are expected to reduce, with a bigger focus on temporary resourcing.

**Risks**

Focusing on safety and quality
Affordability of workforce versus patient demand
Turnover levels to enable reductions
Improvements in NCTR and Mental Health

## Assumptions

National assumption of low/no Covid impact and low/negligible industrial action impact. Assumes continued levels of turnover. NCTR reductions are linked to the success of wider system programmes on discharge and frailty.

# Appendices

# Data Sources

| Metric | Data Source | Scope |
|---|---|---|
| **Industrial Action** | HealthRoster | All staff rostered for strike action during IA periods |
| **Substantive Staff in Post (WTE)** | ESR (Month-end contracted staff in post; consultant APAs; junior doctors' extra rostered hours) | For 24/25 Exclusions: Honorary contracts; Career breaks; Secondments; WPL, CLRN, Wessex AHSN and list of Hosted networks within Divisions. |
| **Additional Hours (WTE)** | Overtime & Excess Hours; WLIs; Extra Duty Claims; non-contracted APAs | For 24/25 Exclusions: WPL, CLRN, Wessex AHSN and list of Hosted networks within Divisions. |
| **Temporary Staffing (WTE)** | Bank: NHSP; MedicOnline<br><br>Agency: Allocate Staff Direct (Medical & Non-medical); all other framework and non-framework agencies | Exclusions: Vaccination activity |
| **Turnover** | ESR (Leavers in-month and last 12 months) | Trainee/junior doctors excluded |
| **Sickness** | ESR (Sickness absence in-month and last 12 months) | No exclusions |
| **Appraisals** | ESR (Appraisals completed in-month and last 12 months) | AfC staff only |
| **Statutory & Mandatory Training** | VLE | No exclusions |
| **Staff in Post (Ethnicity & Disability)** | ESR | No exclusions |
| **Pulse Survey** | Picker (Qualtrics) | No exclusions |
| **Care Hours PER Patient Day (CHPPD)** | HealthRoster (In-month shifts)<br>eCamis (In-month daily patient numbers) | Clinical inpatient wards, Critical Wards, and ED only |


WORLD CLASS PEOPLE

University Hospital Southampton NHS Foundation Trust

| Agenda Item 5.11 | Report to the Trust Board of Directors, 13 May 2025 |
|---|---|
| **Title:** | UHS Annual Staff Survey Results 2024 Report |
| **Sponsor:** | Steve Harris, Chief People Officer |
| **Author:** | Ceri Connor, Director of OD, Bridie Moore, Head of OD |

**Purpose**

| (Re)Assurance | Approval | Ratification | Information |
|---|---|---|---|
| x | | | x |

**Strategic Theme**

| Outstanding patient outcomes, safety and experience | Pioneering research and innovation | World class people | Integrated networks and collaboration | Foundations for the future |
|---|---|---|---|---|
| x | | x | | |

**Executive Summary:**


The Staff Survey paper provides the results of the 2024 annual NHS staff survey. It provides interpretation of the results relating to engagement, morale, advocacy and sentiment towards the organisation, and assesses the impact on organisational culture specifically on speaking up, inclusion, patient safety, transformation, leadership and management, and wellbeing of our staff.

The 2024 survey headlines are as follows:

- Trust wide, we have maintained our above average position across all the People Promise domains.
- Our national ranking for **Recommendation as a place to work** has improved four places from last year, we now rank 18th out of 122 trusts, compared to 22nd in 2023.
- Participation rate has continued to decline to 39% from 41% in 2023, a 15% drop since 2022. Total participation of 5410 people out of a total eligible of 13,795 including subsidiaries.
- Our results are broadly unchanged from 2023 across all questions, with minimal improvements or declines which would be considered statistically significant.
- Year-on-year results over a three-year period, there have been continued improvements in relation to satisfaction with immediate managers, opportunities for flexible working, appraisals, and increased confidence in reporting of incidences of unsafe practice, violence, bullying and harassment.
- We continue to see downward trends associated with civility and respect, and team dynamics which align to the themes in recent patient safety events and F2SU themes.
- The challenging working environment continues to impact on staff wellbeing, stress, and burnout.

Recommendations in the paper aim to respond to the broader themes detailed above, slightly different in approach from previous years, specific focus on the conditions which impact on our trend results, and maximising corporate team resources within 25/26 objectives.

The paper has already been shared and discussed at Trust Executive Committee and People and OD Committee. A trust board study session took place in April where the paper was debated.

| **Contents:** |
| --- |
| Survey report, pages 3-13<br>Appendices:<br>1: People Promise RAG by Care Group 2024, page 15<br>2: Engagement score comparison 2023 to 2024, page 15<br>3: Participation by Division and Staff Group, page 16-17<br>4: Violence, aggression, bullying, harassment and speaking up comparison 2020 – 2024, page 18<br>5: Estates improvement example, page 19 |
| **Risk(s):** |
| 3a: We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles.<br>3b: We fail to develop a diverse, compassionate, and inclusive workforce, providing a more positive staff experience for all staff.<br>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. |

| | |
| --- | --- |
| **Equality Impact Consideration:** | Annual staff survey results contribute to the annual WRES and WDES which is reported as per the national cycle in September. Any areas of disparity in relation to equity or experience will be addressed in those papers and action plans. |

## 1 Purpose and context

1.1 The national NHS staff survey is conducted annually between September and November, it measures the **satisfaction of employees** across the seven domains of the **NHS People Promise**, in addition the survey results contribute to the Workforce Race Equality Standards (WRES) and the Workforce Disability Equality Standards (WDES).

1.2 The annual staff survey is a critical data set for NHS organisations, the singular methodology for **large scale, multi professional feedback** enabling benchmarking to other trusts nationally.

1.3 Survey results are recognised as an **indicator of organisational performance** in terms of staff **engagement and satisfaction**. The survey outcomes support decision making regarding our People Priorities going forward, and helps to provide a strategic picture of engagement, morale, and culture at UHS.

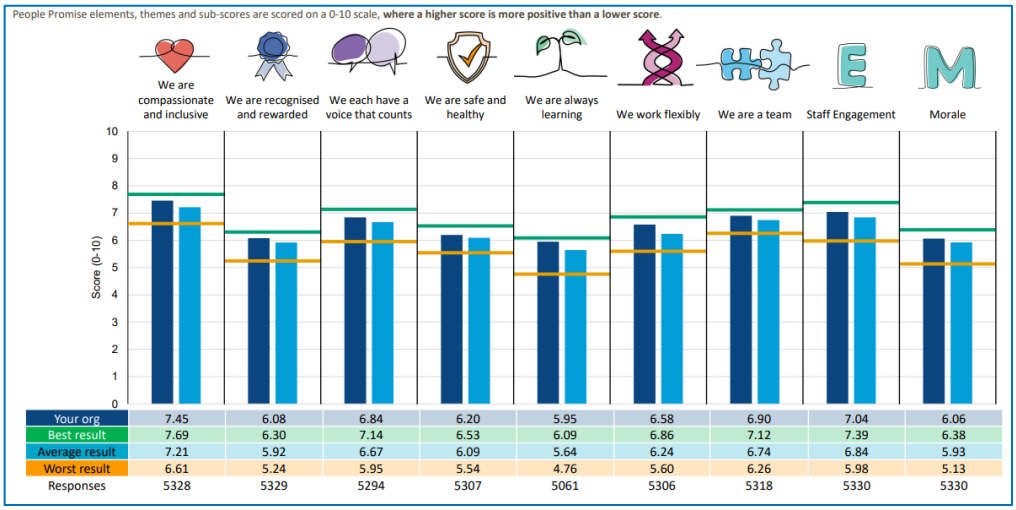
1.4 To achieve **a holistic and accurate picture** of the organisational culture, triangulation of other intelligent information such as, themes from exit surveys, incidents, friends and family surveys, Freedom to Speak Up, employee relations, and workforce indicators should all be used. Also, valuable feedback from the voices of staff; within leadership programmes, team interventions, listening events, senior leader walk arounds, staff networks, etc.

1.5 With the backdrop of **unprecedented financial constraints**, and as we embark on **significant organisational change**, this paper will make recommendations to respond to the drop in survey engagement and engagement more broadly and respond to some of the indicators relating to safety to speak up, team effectiveness, team behaviours, and continue to support capability of leaders and managers. This paper will suggest a set of priorities which will shape the work of the Organisational Development (OD) team, in collaboration with HR Business Partners, Patient Safety team, and aligned to Transformation team workstreams in 2025/26.

## 2. Survey headlines for 2024

2.1 We remain **above average in the acute and acute community group (122 trusts)** across all People Promise domains - Fig 1. At the time of writing the national embargo is still in place, therefore we are unable to provide performance comparisons to other like for like trusts nationally.

**Fig 1. People Promise elements and themes 2024**




| | We are compassionate and inclusive | We are recognised and rewarded | We each have a voice that counts | We are safe and healthy | We are always learning | We work flexibly | We are a team | Staff Engagement | Morale |
|---|---|---|---|---|---|---|---|---|---|
| Your org | 7.45 | 6.08 | 6.84 | 6.20 | 5.95 | 6.58 | 6.90 | 7.04 | 6.06 |
| Best result | 7.69 | 6.30 | 7.14 | 6.53 | 6.09 | 6.86 | 7.12 | 7.39 | 6.38 |
| Average result | 7.21 | 5.92 | 6.67 | 6.09 | 5.64 | 6.24 | 6.74 | 6.84 | 5.93 |
| Worst result | 6.61 | 5.24 | 5.95 | 5.54 | 4.76 | 5.60 | 6.26 | 5.98 | 5.13 |
| Responses | 5328 | 5329 | 5294 | 5307 | 5061 | 5306 | 5318 | 5330 | 5330 |

2.2 Comparison of People Promise results by **Division and Care group** can be found in Appendix 1.

2.3 Our position broadly remains **unchanged** from 2023 across most questions. There have been improvements on 6 questions, declines on 5 questions, and remained the same on 89, out of 119 questions.

2.4 Our **Staff Engagement score remains at 7.0.** There have been **no significant changes** to the sub scores on Motivation and Involvement. Year on year comparison can be found in Appendix 2. We are now ranked 23rd out of 122 trusts nationally.

2.5 For **Recommendation as a place to work** we now rank 18th out of 122 trusts, an improvement of 4 places from our ranking of 22nd in 2023.

2.6 There was a **3% increase in advocacy** in terms of *If a friend or relative needed treatment, staff would be happy with the standard of care provided* and we managed to sustain satisfaction relating to *Care of patients/service users is my organisation's top priority* which is **unchanged from 2023** at 79%.

2.7 Fig 2 below shows our **most improved and most declined** scores. It is pleasing to see improvements in scores relating to the reporting incidents of violence, harassment, and bullying. The trust wide investment into our allyship programme, and the significant support from nursing and clinical leaders to encourage a culture of reporting and just culture within services has seen in the result and we hope this will continue be an improving picture in 2025.

**Fig 2 – Most improved and most declined scores**

| Most improved scores | Org 2024 | Org 2023 |
|---|---|---|
| q13d. Last experience of physical violence reported | 74% | 69% |
| q14d. Last experience of harassment/bullying/abuse reported | 53% | 49% |
| q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours | 68% | 65% |
| q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours | 52% | 49% |
| q14c. Not experienced harassment, bullying or abuse from other colleagues | 84% | 82% |

| Most declined scores | Org 2024 | Org 2023 |
|---|---|---|
| q11a. Organisation takes positive action on health and well-being | 59% | 61% |
| q3h. Have adequate materials, supplies and equipment to do my work | 55% | 57% |
| q13a. Not experienced physical violence from patients/service users, their relatives or other members of the public | 85% | 87% |
| q7e. Enjoy working with colleagues in team | 81% | 83% |
| q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work | 79% | 81% |

## 3. Participation and Engagement

3.1 The 2024 survey results are dominated by another **drop in participation**. We have seen a continued downward trend in participation, now at 39% from 54% in 2021, a 15% decline over three survey years.

3.2 UHS participation is now **9% below the Picker average of 48%,** and 8% below the national acute and acute community benchmark group average of 49%. **Participation by division** can be found in Appendix 3.

3.3 In 2024 there have been some examples of excellent leadership with regard to engagement with staff and prioritise actions that will lead to improvement in morale and staff satisfaction. This has resulted in increased participation in the survey in those areas.

3.4 **Healthcare Scientists** as a professional group have undertaken a significant amount of work in 2024 to engage staff on career pathways, and have focussed on their identify, strategy and vision, this has translated into a small increase in participation of 1%. The positive efforts from **Estates, Facilities and Capital Development** have resulted in an **overall increase of 8.7%** in the Estates and Ancillary staff group. EFCD saw increases in many indicators across the survey following on from programmes of work around career and personal development, and increased leadership in this area.

3.5 **Division D** have seen some increases in participation (2.8%) as a result of targeted engagement undertaken in summer 2024.

3.6 There are contextual factors behind some of the declines in Divisions when comparing to 2023.

3.7 To improve participation, **the Emergency Department** piloted a change from digital to paper completion in 2024. This proved not as successful as hoped, resulting in an 8% drop in participation, this contributed to the overall decline in Division B.

3.8 **Division D** undertook purposeful staff events to improve participation in 2024, which resulted in a 2.8% increase from 2023.

3.9 **THQ were the most engaged group in the survey**, this can be attributed to several factors, most likely access to laptops and regular access to individual email accounts as part of their roles, also greater flexibility in their working pattern which makes it easier to complete the survey.

3.10 Appendix 3 shows the **participation by staff group**, with Admin and Clerical and Nurses and Midwives having the largest participation in the survey as a whole with 28% respectively.

3.11 However, when you convert this to **engagement in the survey** by the total eligible within the staff group, this provides a different picture. With 37% of **eligible nurses and midwives** engaged in the survey, compared to **60% of the total eligible admin and clerical group**. Evidencing that the admin and clerical staff group are significantly more engaged in participating in the survey than Nurses and Midwives.

3.12 Engagement from **Allied Health Professional, and Additional Professional Scientific and Technical Groups** has declined year on year since 2022, the same year on year decline has occurred for Admin and Clerical, albeit they remain the **highest engaged** staff group in the survey.

3.13 Despite attempts to remove **barriers to participation** (access to laptops, enabling dedicated time, survey drop-in sessions) the reasons given anecdotally to those promoting the survey, to why some staff have not completed the survey are varied:

- Impact on morale due the recruitment restrictions in 2023 and general disengagement in the survey.
- High demand and pressure on staff, no time during working day to complete the survey.
- High levels of cynicism linked to the impact of feedback and change that can happen as a direct result of completing the survey; a "what's the point" attitude.
- Managers saying that they have not encouraged staff to complete the survey as they feel unable to respond positively to any of the feedback or lead positive change as a result.
- Continued feedback on lack of access to emails in clinical areas, staff often use of shared log ins, or shared computers.
- Continued concerns about anonymity and lack of psychological safety surrounding the survey, that any negative feedback given will have a personal impact.

**4 Results in detail**

4.1 We have seen continued improvements where effort and investment aligned to the People Strategy in relation to:

- Flexible working opportunities.
- Satisfaction with pay (although overall satisfaction remains low at 30.4% of our respondents).
- Satisfaction with immediate managers, specifically in terms of managers caring about their staff, supporting staff during challenges, and listening to concerns.
- % of staff experiencing discrimination based on ethnicity, sexual orientation, gender and disability from a manager, team leader or colleague.
- Appraisal helping people to have clear objectives and helping people to do their job.

**4.2 Inclusion, belonging and wellbeing**

4.2.1 The Trusts Inclusion and Belonging Strategy, launched in April 2023 has delivered a range of interventions and actions, however cultural changes of this nature take 3-5 years to be evidenced.

4.2.2 We are pleased to see some improvements in questions relating to areas covered in this strategy:

- 61.2% of respondents agreeing that UHS acts **fairly** in relation to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age which is broadly unchanged from 2021, and is higher than the Picker comparator group average.
- We continue to see small, year on year improvements on whether people feel a sense of belonging at UHS. 70.1% of participants said yes, they always or sometimes feel a sense of belonging at UHS, 12.6% were unsure, and 17.2% said not really or at all.

4.2.3 30.4% of participants said they could **regularly** take positive steps towards managing their health and wellbeing, this was 5% point improvement from 2023. 49% said they were **sometimes** able to take positive steps, 9% were unsure, and 10.3% said not really or not at all.

4.2.4 Indicators on burnout and remain broadly unchanged from 2023, all just above the national average:

- 42% of participants said they often or always feel exhausted after a working day/shift
- 31% of participant said they find work emotionally exhausting.
- 32% saying they often or always find work frustrating.
- 41% of participants said they felt unwell due to work related stress in the preceding 12 months.
- 51% said they had come into work despite not feeling well enough in the preceding 12 months.

### 4.3 Violence, aggression, bullying, harassment, and abuse at work

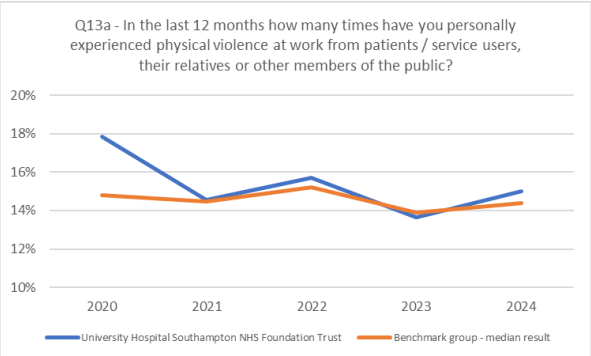
4.3.1 Overall, those who completed the survey in 2024 said they are still **experiencing violence at work:**

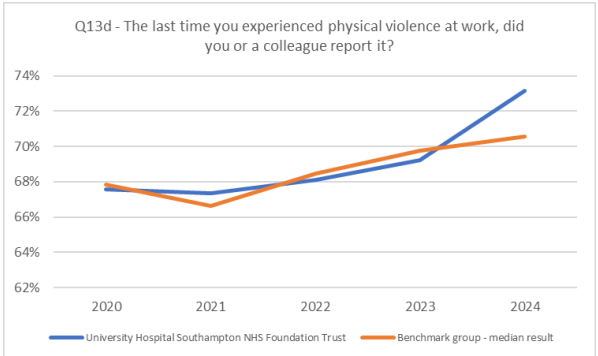
- 14% saying they have experienced violence from patients and service in the last 12 months.
- 1% saying they have experienced violence from managers.
- 2% saying they have experienced it from colleagues.

4.3.2 When reviewing the overall trust results in terms of bullying, harassment and violence at work, it is important to investigate what is happening in the locality **areas of known high risk,** as this demonstrates as different picture, as below:

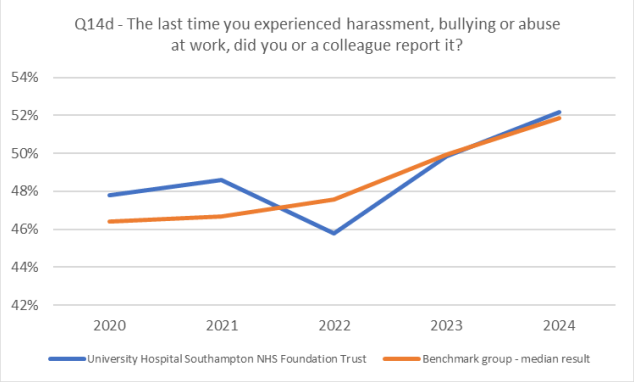
| Locality/Service | % of staff saying they **have** experienced violence or aggression from patients/members of the public in the last 12 months. |
|---|---|
| ED | 61.7% |
| Neuro | 46.5% |
| Critical Care (L2) | 46.5% |
| T&O | 47.3% |
| General ICU (L3) | 72.1% |

4.3.3 The graphs below show a positive improvement in people, trust wide, **reporting** their last experience of physical violence.



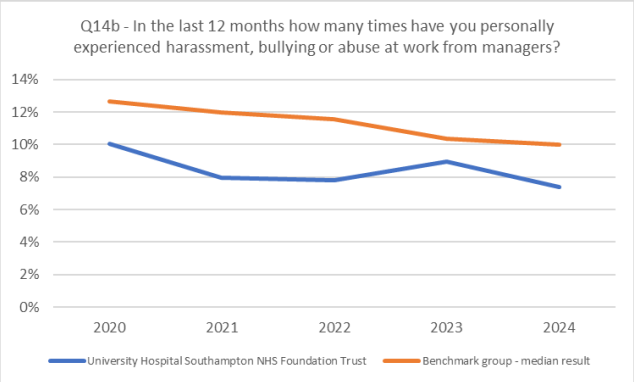



4.3.4 Our work on allyship and encouraging people to report bullying and harassment has seen a positive impact, a continued **upward trend since 2022** can be seen in the graph below:




4.3.5 The positive impact of the investment allyship, and leadership and management development has continued, the number of people who reported **bullying and harassment from their managers** has decreased to 7.4%, a recovery of the decline we saw in 2023. Bullying and harassment from colleagues has also decreased to 15.7%, returning closer to our position held in 2021.

4.3.6 In 2024 an independent review of our employee relations and F2SU processes took place, and positive changes have been made as a result.

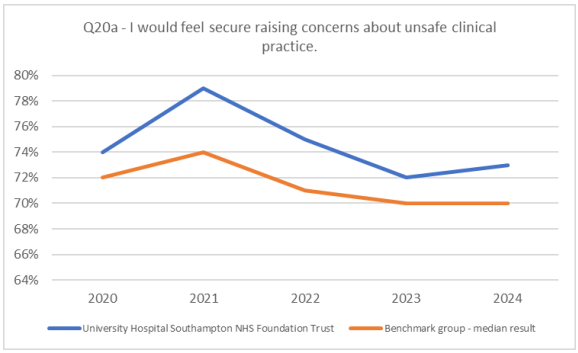


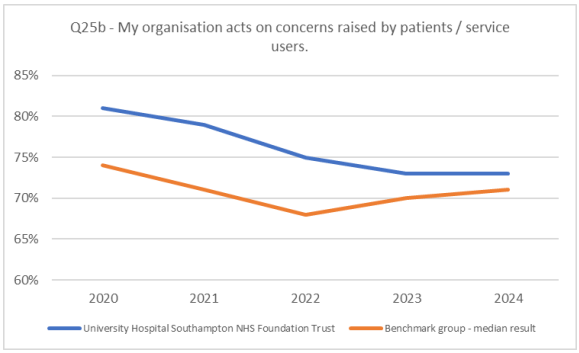

4.3.7 Whilst it is positive to see improvements there is a significant amount of work still to do to ensure our staff are safe at work, to reduce the instances of **violence, aggression, bulling and harassment at work,** and for people to be trained correctly, to have quick support "in the moment" and debriefing afterwards. The Violence and Aggression Steering Group is leading the improvement plan with the support of divisional and THQ leaders and managers.

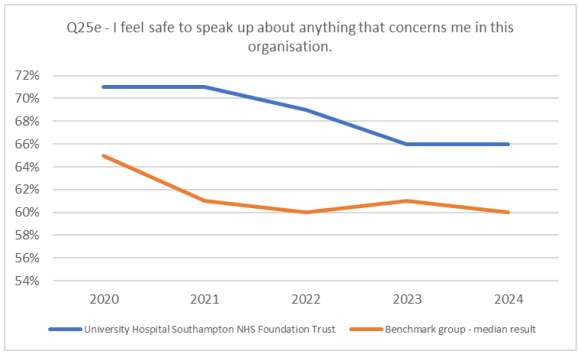
### 4.4 Speaking up culture, team dynamics and patient safety

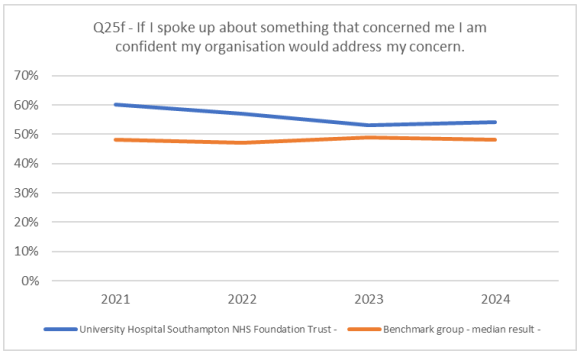
4.4.1 There is significant evidence to link **patient outcomes, patient safety**, with levels of **staff engagement, team effectiveness, safety to speak up, and inclusive cultures**. We have seen recent increase in Never Events at UHS, analysis of themes relating to these include the need to strengthen confidence to speak up, optimise team dynamics, increase levels of trust and civility.

4.4.2 Survey indicators relating to staff **confidence to speak up**, and confidence that the **organisation would take action as a result of speaking up**, have declined over the last four year in the staff survey. Full year on year data can be seen in Appendix 4.

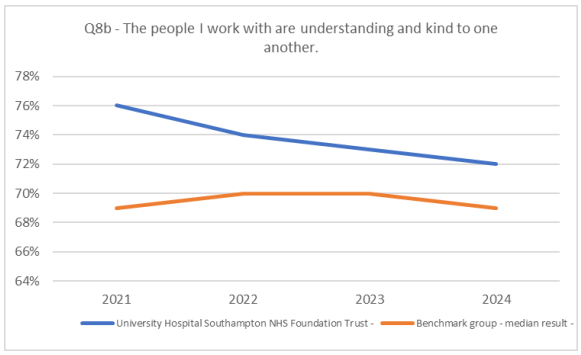


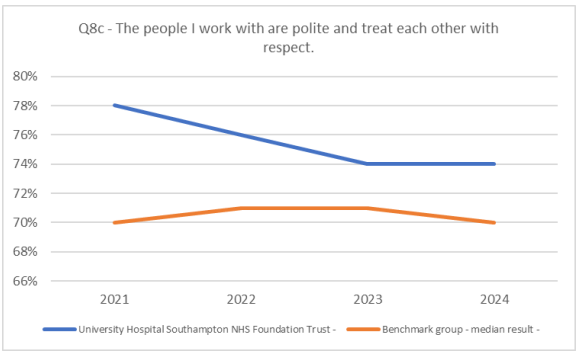



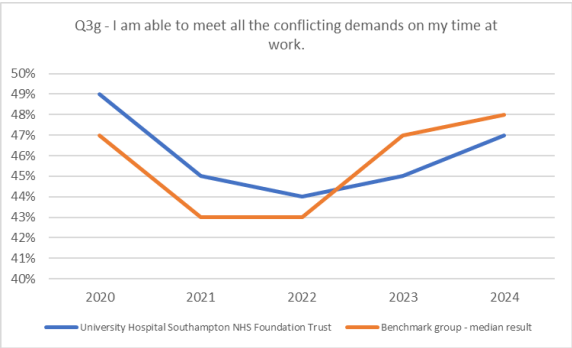

4.4.3 Graphs below relate to **civility** at UHS. Both indicators are demonstrating a downward trend since 2021.

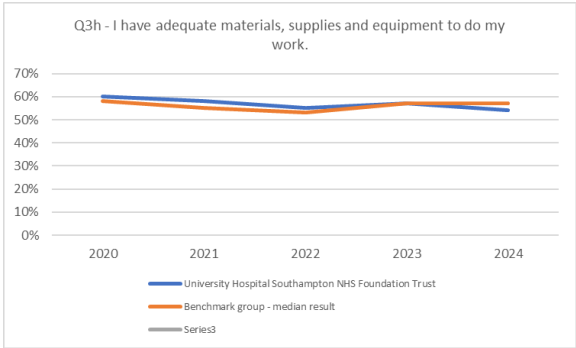


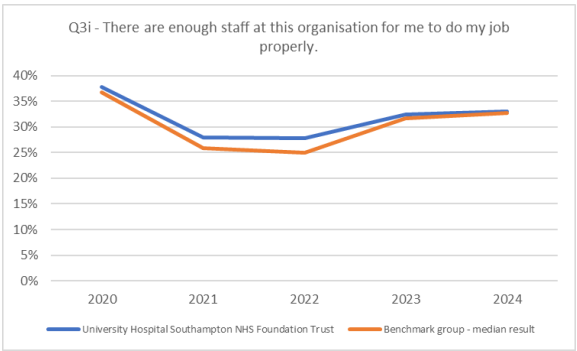




4.4.4 The **Freedom to Speak up** themes for 2024, in the graph below, correlate with the themes analysed through Patient Safety events, and themes being supported by the OD team in the same period, specifcally on team dynamics and behaviours.


4.4.5 The questions that measure safety in relation to staff capacity show a mixed response since 2020.

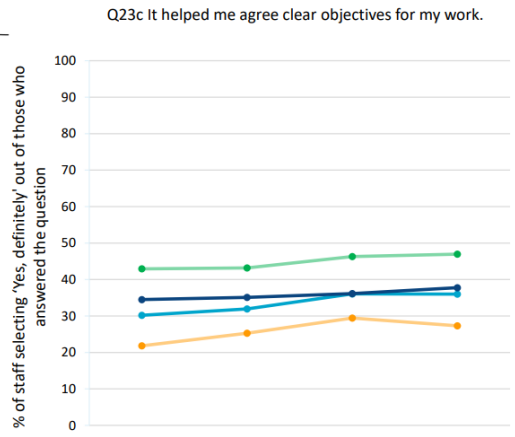


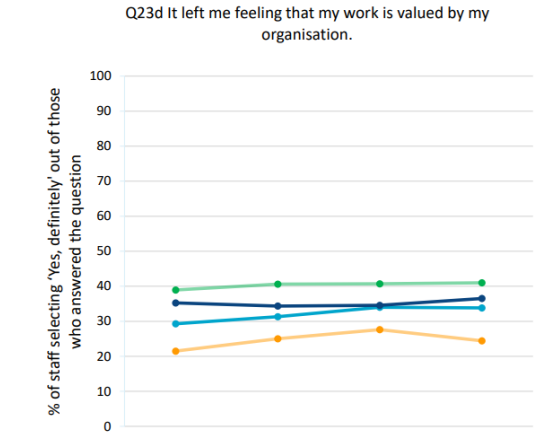




## 4.5 Appraisal, line managers and recognition

4.5.1 There continues to be small year on year improvements in effectiveness of appraisal, our work on improving the appraisal experience has continued to make a difference.



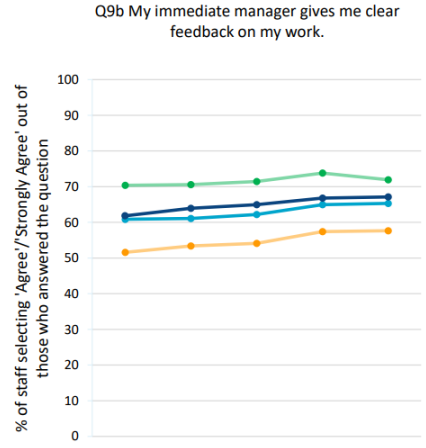

| | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|
| Your org | 34.50% | 35.10% | 36.13% | 37.76% |
| Best result | 42.92% | 43.18% | 46.31% | 46.95% |
| Average result | 30.19% | 31.93% | 36.06% | 36.01% |
| Worst result | 21.81% | 25.28% | 29.43% | 27.28% |
| Responses | 5486 | 5635 | 4495 | 4489 |



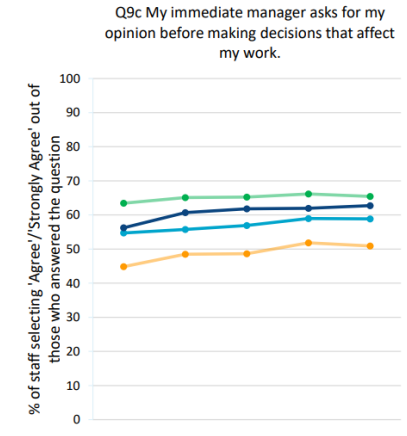

| | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|
| Your org | 35.22% | 34.33% | 34.55% | 36.49% |
| Best result | 38.93% | 40.59% | 40.69% | 40.97% |
| Average result | 29.27% | 31.30% | 33.99% | 33.79% |
| Worst result | 21.48% | 25.03% | 27.61% | 24.42% |
| Responses | 5486 | 5634 | 4502 | 4489 |

4.5.2 We have maintained our **above average position on people feeling that there are opportunities for learning and development** and feeling supported to reach their potential at 64% and 61% respectively however these are unchanged over the last three years.

4.5.3 We have **improved on all ten questions** relating specifically to immediate manager indicators, our continued investment in leadership and management capability and skills continues to make a difference. Improvements seen across all questions on how managers are giving **clear feedback** and **involving people in changes that affect their work,** managers taking an interest in **staff wellbeing**, immediate managers listening to the **challenges people face**, and managers being approachable in terms of **flexible working.**




| | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| Your org | 61.82% | 63.92% | 64.97% | 66.77% | 67.12% |
| Best result | 70.38% | 70.55% | 71.44% | 73.80% | 71.93% |
| Average result | 60.86% | 61.06% | 62.20% | 64.95% | 65.31% |
| Worst result | 51.58% | 53.40% | 54.10% | 57.39% | 57.64% |
| Responses | 5734 | 6784 | 6927 | 5533 | 5316 |

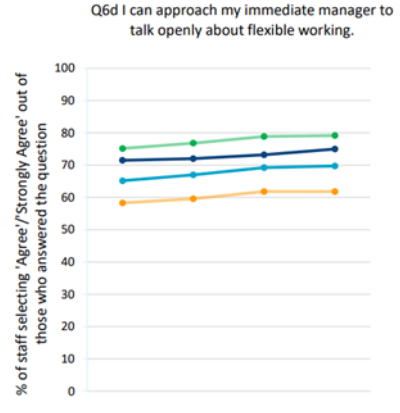



| | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| Your org | 56.24% | 60.69% | 61.80% | 61.94% | 62.74% |
| Best result | 63.45% | 65.11% | 65.23% | 66.16% | 65.47% |
| Average result | 54.73% | 55.75% | 56.93% | 58.97% | 58.84% |
| Worst result | 44.85% | 48.47% | 48.62% | 51.84% | 50.94% |
| Responses | 5730 | 6785 | 6939 | 5542 | 5316 |

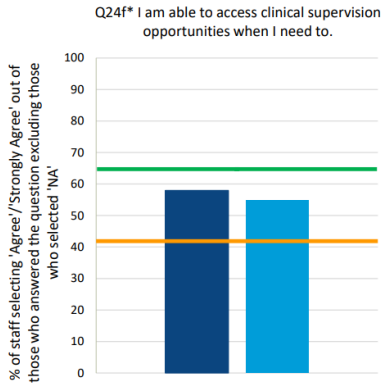
4.5.4 The **Estates team** are an exemplar of improvements across all Immediate Manager scores, seeing some significant improvements in 2024, resulting from targeted and purposeful actions from leaders, and focus on **career development, appraisals, and more visible leadership**, see Appendix 5.

4.5.5 We continue to see improvements in terms of **flexible working**. 74% of staff agree or strongly agree that they can approach their manager to discuss flexible working, continuing to increase year on year.

4.5.6 Satisfaction with opportunities for flexible working patterns also continue to make incremental improvements, increasing to **62% in 2024 from 58% in 2022.**




| | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|
| Your org | 71.48% | 72.01% | 73.22% | 74.98% |
| Best result | 75.16% | 76.80% | 78.85% | 79.16% |
| Average result | 65.17% | 66.99% | 69.24% | 69.74% |
| Worst result | 58.30% | 59.57% | 61.83% | 61.80% |
| Responses | 6869 | 6940 | 5544 | 5323 |




| | 2024 |
|---|---|
| Your org | 57.95% |
| Best result | 64.73% |
| Average result | 54.75% |
| Worst result | 41.87% |
| Responses | 4306 |

4.5.7 **54**% of participants said **they can access clinical supervision opportunities** when they need to, above the national average of 54.75%. This was a new question in the 2024 survey.

4.5.8 The People Promise domain on **"recognised and rewarded"** focuses on how the organisation and manager values participants work, recognition achieved for good work, appreciation shown to one another, and levels of pay. These have remained largely unchanged except for a slight increase in satisfaction in pay, which is just below the national average.

4.5.9 Triangulation to the quarterly exit interview themes across Q1 – Q3 2024, shows **not feeling valued or recognised** was consistently in the top two reasons for leaving. Therefore, in terms of our retention, the efforts on reward and recognition trust wide through staff awards, WeAreUHS week, and other initiatives, also reinforcing the importance of everyday recognition at individual and team level remains a priority and will be reinforced within all our leadership and management interventions in 2025/26.

**5. Free text feedback**

5.1 Participants are given the option to provide **free text** comments prior to the completion of the survey. These are provided to UHS separately to the main report, text is not edited but any personal identifiers/names are deleted by Picker prior to sending. Free text comments are not identifiable by division or professional group although if these are included in the original comment, they are provided unedited.

5.2 **1024 comments** were provided. Analysis of themes using key words, and "mild" or "strong" sentiments has been carried out with the following themes:

- 93% of comments were **"mildly positive"** indicating general satisfaction rather than strong enthusiasm.
- 39% of negative feedback was considered **"strongly negative"** highlighting deep frustration.
- Fewer than 40 comments were strongly positive.

### 🔷 What Differentiates Positive from Negative Feedback?

| Aspect | Positive Feedback | Negative Feedback |
|---|---|---|
| **Workload** | "Manageable workload most of the time." | "Constant pressure and unachievable targets." |
| **Management Support** | "Some managers really care about us." | "Management ignores concerns and is out of touch." |
| **Career Growth** | "Good training programs available." | "No career progression opportunities." |
| **Team Collaboration** | "Great colleagues make a difference." | "Lack of teamwork due to high stress and workload." |

### ✅ Positive Sub-Themes

| Theme | Example Quote |
|---|---|
| **Teamwork & Support** | *"I love working with my colleagues; we always support each other."* |
| **Flexible Work Arrangements** | *"Hybrid working helps me balance my job and personal life."* |
| **Good Patient Care** | *"Despite challenges, we always do our best for the patients."* |
| **Job Satisfaction in Some Areas** | *"I feel like my role is valued and makes an impact."* |
| **Training Opportunities** | *"Some training programs are excellent and help us grow."* |

### ❌ Negative Sub-Themes

| Theme | Example Quote |
|---|---|
| **Severe Understaffing** | *"We are always short-staffed, and it's causing burnout."* |
| **Leadership & Management Issues** | *"Management doesn't listen to our concerns."* |
| **Workload & Time Pressure** | *"Unrealistic deadlines make it impossible to do a quality job."* |
| **Lack of Career Progression** | *"No clear promotion path, so many leave for better opportunities."* |
| **Poor Communication** | *"Departments don't talk to each other, which causes confusion."* |

5.3 The word **"staff"** was mentioned 712 times, and **"work"** 568 times, demonstrating that either celebration or concern about staff at UHS was significantly prevalent in the free text comments.

## 6 Conclusions and Recommendations for 2025/2026

6.1 The annual survey and quarterly pulse surveys are valuable indicators of staff satisfaction, morale, and sentiment and a national benchmarking tool. Staff engagement, and motivation has a direct

correlation to performance and therefore to patient experience and patient outcomes. Highly engaged and motivated staff are more likely to deliver our operational targets, achieve our transformation goals and be more productive. Organisations with Outstanding CQC ratings are those with higher engagement in the staff survey.

6.2 We have remained above average on all People Promise themes, however, we have seen a decline in our national rankings for the last two years, and we are significantly below average in terms of our participation. The survey results provide valuable insight and feedback from staff who participate, but this year we have not had feedback from over 60% of our staff.

6.3 With existing capacity challenges and requirements on Trusts to implement further reductions in NHS Infrastructure in 2025/26, it is recommended that we take a **collaborative and highly focused** approach to the response this year which will shape the priorities of the OD team staff facing psychology, HR team and alongside patient safety and transformation colleagues:

- Provide support to leaders and managers implementing **organisational change priorities.**
- Implement a programme of team support aimed at strengthening the **speaking up culture, promote psychological safety** and embed **Human Factors** approaches – collaboration between patient safety, OD, and psychology.
- Continue to focus on **capability, skills and confidence of leaders and managers**. With particular focus on transformation and change, supporting people to thrive in changing and demanding environments, personal resilience, and adaptive thinking.
- Focus resources on improving team effectiveness and team dynamics, focus on conflict and behaviours. Support for teams who are experiencing significant and complex challenges.
- Refresh templates, communication and engagement in the annual and quarterly surveys to maximise the impact of the feedback given and aim to recover participation levels to above 40%.
- Continue work on addressing violence and aggression through the Violent and Aggression group.

6.4 A review of all existing **OD interventions** has already started, working with other teams to reshape priorities and form a programme implementation plan and timeline. This will be monitored via the People governance structure throughout 2025/26.

**April 2025**

## Appendix 1 - People Promise Themes by Care Group – 2024

| Key |
|---|
| Same/within 0.3ppt |
| <0.4ppt below |
| >0.4ppt above |

| Care Group | Responses | We are compassionate and inclusive score | We are recognised and rewarded score | We each have a voice that counts score | We are safe and healthy score | We are always learning score | We work flexibly score | We are a team score | Staff Engagement Score | Morale score |
|---|---|---|---|---|---|---|---|---|---|---|
| UHS Overall | 5410 | 7.5 | 6.1 | 6.9 | 6.2 | 6.0 | 6.6 | 6.9 | 7.0 | 6.1 |
| **Division A** | | | | | | | | | | |
| Critical Care | 244 | 7.3 | 5.7 | 6.7 | 5.9 | 6.0 | 6.7 | 6.9 | 7.0 | 6.1 |
| Ophthalmology | 191 | 7.5 | 5.9 | 6.8 | 6.2 | 5.4 | 6.4 | 6.9 | 7.0 | 6.1 |
| Surgery | 196 | 7.3 | 5.8 | 6.5 | 5.8 | 5.7 | 6.5 | 6.7 | 6.8 | 5.8 |
| Theatres & Anaesthetics | 284 | 7.1 | 5.5 | 6.6 | 6.0 | 5.9 | 6.3 | 6.4 | 6.8 | 5.8 |
| **Division B** | | | | | | | | | | |
| Cancer Care | 224 | 7.2 | 5.7 | 6.5 | 5.9 | 5.2 | 6.1 | 6.4 | 6.7 | 5.5 |
| Emergency Care | 133 | 7.0 | 5.6 | 6.5 | 5.2 | 5.9 | 6.4 | 6.6 | 6.8 | 5.6 |
| Medicine | 226 | 7.4 | 6.2 | 7.1 | 6.1 | 6.6 | 6.5 | 7.1 | 7.3 | 6.3 |
| Pathology | 230 | 7.1 | 5.6 | 6.5 | 5.8 | 5.0 | 5.8 | 6.3 | 6.7 | 5.5 |
| Specialist Medicine | 249 | 7.4 | 6.1 | 6.7 | 6.2 | 5.8 | 6.3 | 6.8 | 7.0 | 6.1 |
| **Division C** | | | | | | | | | | |
| Child Health | 320 | 7.7 | 6.2 | 7.1 | 6.1 | 6.1 | 6.5 | 7.1 | 7.2 | 6.1 |
| Clinical Support | 427 | 7.6 | 6.2 | 6.9 | 6.1 | 5.9 | 6.4 | 7.1 | 7.1 | 5.9 |
| Women & Newborn | 303 | 7.4 | 5.9 | 6.6 | 6.0 | 5.9 | 6.4 | 6.7 | 6.9 | 5.9 |
| **Division D** | | | | | | | | | | |
| CV&T | 296 | 7.6 | 6.1 | 7.0 | 6.1 | 6.3 | 6.4 | 7.0 | 7.3 | 6.2 |
| Neuro | 284 | 7.3 | 5.9 | 6.7 | 5.7 | 6.1 | 6.6 | 6.7 | 6.9 | 5.9 |
| Radiology | 201 | 7.5 | 6.2 | 6.9 | 6.6 | 6.2 | 6.6 | 6.9 | 7.0 | 6.5 |
| T&O | 186 | 7.3 | 5.9 | 7.0 | 5.9 | 6.2 | 6.6 | 6.8 | 7.0 | 6.0 |
| **THQ** | | | | | | | | | | |
| Chief Finance Officer | 104 | 7.7 | 6.9 | 7.1 | 6.6 | 5.8 | 7.1 | 7.2 | 7.3 | 6.3 |
| Clinical Development | 128 | 7.7 | 6.7 | 7.1 | 6.6 | 6.3 | 7.3 | 7.5 | 7.4 | 6.3 |
| Estates | 217 | 7.3 | 6.1 | 6.7 | 6.6 | 5.9 | 6.9 | 6.8 | 6.9 | 6.1 |
| Digital | 201 | 7.8 | 6.6 | 7.1 | 7.1 | 6.1 | 7.6 | 7.3 | 7.1 | 6.6 |
| People | 141 | 8.0 | 6.7 | 7.5 | 6.8 | 6.3 | 7.1 | 7.6 | 7.5 | 6.4 |
| R&D | 251 | 7.9 | 6.7 | 7.2 | 7.1 | 6.4 | 7.1 | 7.4 | 7.4 | 6.7 |
| THQ Other Services | 93 | 7.6 | 6.7 | 7.0 | 6.8 | 5.9 | 7.3 | 7.4 | 7.3 | 6.4 |

## Appendix 2 – Engagement score comparison 2023 and 2024

| Area | Question | UHS 2023 | UHS 2024 | Difference |
|---|---|---|---|---|
| Motivation | Often/always look forward to going to work | 55.8% | 55.3% | -0.5% |
| | Often/always enthusiastic about my job | 69.1% | 68.0% | -1.1% |
| | Time often/always passes quickly when I am working | 71.6% | 71.7% | 0.1% |
| Involvement | Opportunities to show initiative frequently in my role | 76.0% | 75.3% | -0.7% |
| | Able to make suggestions to improve the work of my team/department | 73.3% | 73.5% | 0.2% |
| | Able to make improvements happen in my area of work | 58.4% | 57.9% | -0.2% |
| Advocacy | Care of patients/service users is organisations top priority | 80.1% | 79.3% | -0.8% |
| | Would recommend organisation as a place to work | 67.7% | 68.3% | 0.6% |
| | If a friend/relative needed treatment would be happy with standard of care provided by organisation | 76.4% | 79.3% | 2.9% |
| | Engagement score | 7.0 | 7.0 | - |

## Appendix 3 – Participation rate by Division and Staff Group

When analysing survey results, it is important to consider two elements:

- The % completion vs the total number of respondents (5410)
- The conversation to engagement, the % completions within the eligible in the staff group.

**Fig 3 – Participation rate by Division compared vs total completion (5410 people)**

| Division | Number of respondents | % of total Trust respondents |
|---|---|---|
| **Division A** | 927 | 17.1% |
| **Division B** | 1109 | 20.5% |
| **Division C** | 1139 | 21.1% |
| **Division D** | 986 | 18.2% |
| **Hosted Services** | 114 | 2.1% |
| **THQ** | 1135 | 21.0% |
| **Trust Total** | **5,410** | **100%** |

**Fig 4 - Participation rate by Division from 2022 – 2024 vs total eligible in the division (conversion to engagement)**

| Division | Participation rate 2022 | Participation rate 2023 | Eligible headcount number 2024 | Participation headcount 2024 | Participation rate 2024 | % difference +ve/-ve from 2023 |
|---|---|---|---|---|---|---|
| **Division A** | 56.6% | 39.1% | 2525 | 927 | 36.7% | -2.4% |
| **Division B** | 49.2% | 36.0% | 3567 | 1109 | 31.1% | -4.9% |
| **Division C** | 54.9% | 38.6% | 3085 | 1139 | 36.9% | -1.7% |
| **Division D** | 48.7% | 36.8% | 2488 | 986 | 39.6% | +2.8% |
| **Hosted Services** | 52.4% | 54.7% | 296 | 114 | 38.5% | -16.2% |
| **THQ** | 68.7% | 61.8% | 1834 | 1135 | 61.9% | +0.1% |

**Fig 5. Participation rates by Staff Group from 2024 compared to total completion (to measure participation)**

| Division | Number of respondents | % of total Trust respondents |
|---|---|---|
| **Additional Professional scientific and technical** | 149 | 2.7% |
| **Additional clinical services** | 827 | 15.2% |
| **Admin and clerical** | 1544 | 28.5% |
| **Allied Health Professionals** | 356 | 6.5% |
| **Estates and ancillary** | 241 | 4.5% |
| **Healthcare Scientists** | 261 | 4.8% |
| **Medical and Dental** | 379 | 7% |
| **Nursing and Midwifery** | 1653 | 28.8% |
| **Trust Total** | **5,410** | **100%** |

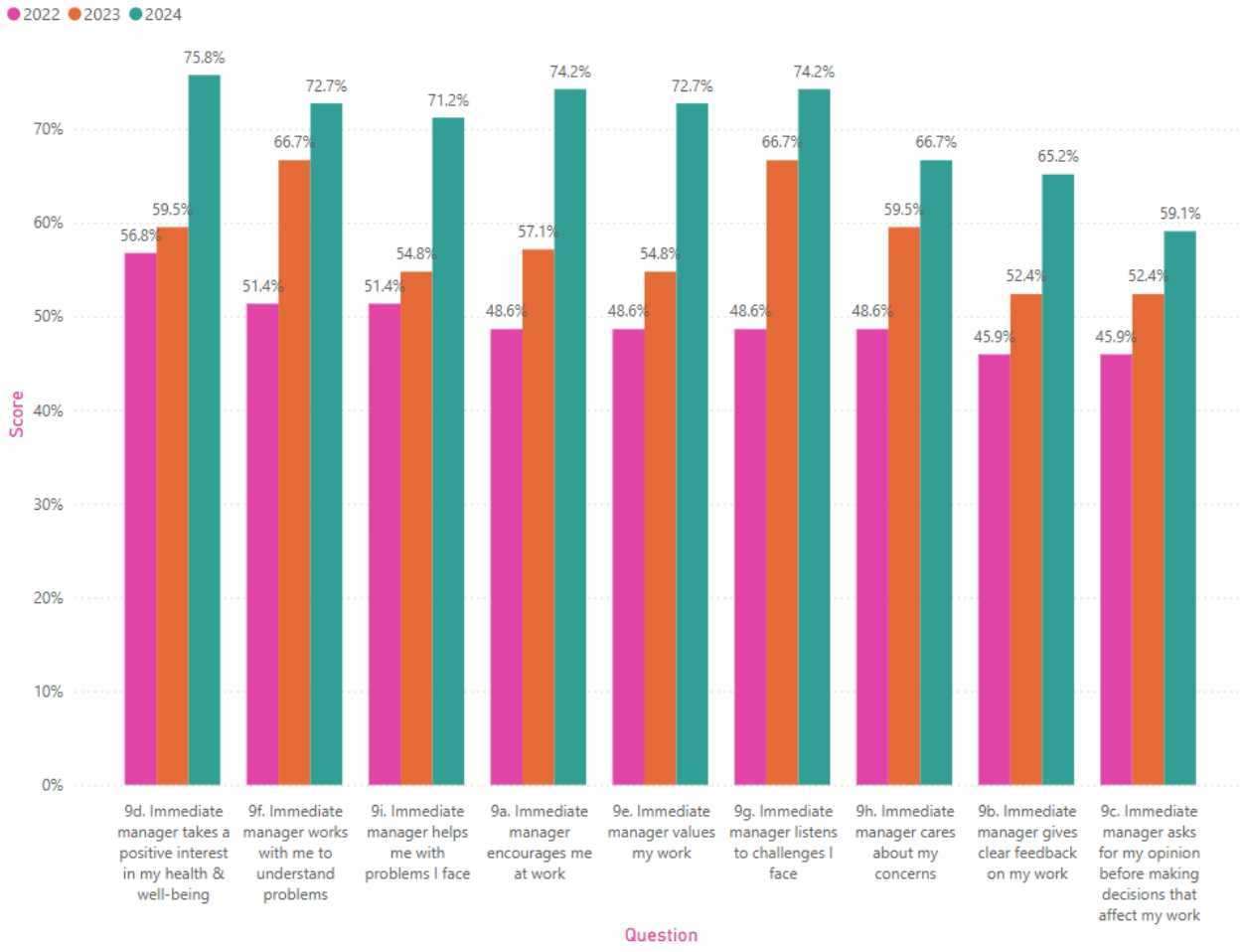
**Fig 6. Participation rates by staff group 2022-2024 compared to the eligible number in the staff group (to measure engagement)**

| Staff Group | Participation Rate 2022 | Participation Rate 2023 | Eligible headcount 2024 | Participation headcount 2024 | Participation Rate 2024 | % difference +ve/-ve from 2023 |
|---|---|---|---|---|---|---|
| Add prof scientific and technic | 65.9% | 49.7% | 336 | 149 | 44.3% | -5.4% |
| Additional clinical services | 49.6% | 36.0% | 2434 | 827 | 34.0% | -2% |
| Administrative and clerical | 74.2% | 63.4% | 2575 | 1544 | 60.0% | -3.4% |
| Allied health professionals | 65.5% | 46.1% | 886 | 356 | 40.2% | -5.9% |
| Estates and ancillary | 40.4% | 39.6% | 499 | 241 | 48.3% | +8.7% |
| Healthcare scientists | 63.2% | 47.4% | 538 | 261 | 48.5% | **+1.1%** |
| Medical and dental | 32.6% | 21.6% | 2087 | 379 | 18.2% | **-3.4%** |
| Nursing and midwifery registered | 54.2% | 37.6% | 4437 | 1653 | 37.3% | **-0.3%** |

**Appendix 4 – Violence, aggression, bullying, harassment, and abuse comparison 2020-2024**

| | | Picker Average 2024 | 2024 | 2023 | 2022 | 2021 | 2020 |
|---|---|---|---|---|---|---|---|
| Q | Questions | | | | | | |
| q13a | Not experienced physical violence from patients/service users, their relatives or other members of the public | 85.7% | 85.2% | 87.4% | 83.9% | 85.4% | 81.8% |
| q13b | Not experienced physical violence from managers | 99.1% | 99.3% | 99.4% | 99.4% | 99.3% | 99.2% |
| q13c | Not experienced physical violence from other colleagues | 98.0% | 98.3% | 98.6% | 98.5% | 98.4% | 98.3% |
| q13d | Last experience of physical violence reported | 71.4% | 73.7% | 69.5% | 68.4% | 67.2% | 67.5% |
| q14a | Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public | 75.6% | 76.7% | 75.4% | 75.0% | 77.4% | 73.8% |
| q14b | Not experienced harassment, bullying or abuse from managers | 90.3% | 92.6% | 90.6% | 92.2% | 92.0% | 89.9% |
| q14c | Not experienced harassment, bullying or abuse from other colleagues | 81.7% | 84.3% | 81.6% | 83.4% | 84.8% | 81.5% |
| q14d | Last experience of harassment/bullying/abuse reported | 52.5% | 52.7% | 49.1% | 46.0% | 48.2% | 47.7% |
| q15 | Organisation acts fairly: career progression | 57.0% | 61.2% | 61.3% | 62.4% | 62.4% | 62.8% |
| q16a | Not experienced discrimination from patients/service users, their relatives or other members of the public | 91.3% | 90.8% | 91.9% | 91.4% | 92.5% | 91.3% |
| q16b | Not experienced discrimination from manager/team leader or other colleagues | 91.0% | 92.1% | 91.9% | 92.0% | 92.3% | 92.6% |
| q17a | Not experienced unwanted behaviour of a sexual nature from patients/service users, their relatives or members of the public | 92.1% | 91.7% | 91.1% | * | * | * |
| q17b | Not experienced unwanted behaviour of a sexual nature from other colleagues | 96.5% | 96.7% | 96.0% | * | * | * |
| q18 | Not seen any errors/near misses/incidents that could have hurt staff/patients/service users | 65.7% | 65.6% | 65.7% | 63.3% | * | * |
| q19a | Staff involved in an error/near miss/incident treated fairly | 58.7% | 64.0% | 63.4% | 64.1% | * | * |
| q19b | Encouraged to report errors/near misses/incidents | 86.0% | 86.5% | 86.6% | 86.9% | * | * |
| q19c | Organisation ensure errors/near misses/incidents do not repeat | 66.9% | 68.9% | 69.5% | 70.1% | * | * |
| q19d | Feedback given on changes made following errors/near misses/incidents | 59.9% | 62.1% | 61.5% | 62.8% | * | * |
| q20a | Would feel secure raising concerns about unsafe clinical practice | 70.0% | 72.9% | 72.0% | 74.9% | 78.5% | 73.9% |
| q20b | Would feel confident that organisation would address concerns about unsafe clinical practice | 55.1% | 59.4% | 58.7% | 61.1% | 66.7% | 65.5% |
| q25b | Organisation acts on concerns raised by patients/service users | 68.6% | 73.5% | 72.7% | 74.6% | 79.1% | 80.5% |
| q25e | Feel safe to speak up about anything that concerns me in this organisation | 60.5% | 66.4% | 66.2% | 68.9% | 70.6% | 71.3% |
| q25f | Feel organisation would address any concerns I raised | 48.0% | 54.3% | 53.6% | 56.4% | 60.0% | * |

**Appendix 5 – Estates Improvement Journey**


2022
2023
2024
Score
70%
60%
50%
40%
30%
20%
10%
0%
75.8%
59.5%
56.8%
72.7%
66.7%
51.4%
71.2%
54.8%
51.4%
74.2%
57.1%
48.6%
72.7%
54.8%
48.6%
74.2%
66.7%
48.6%
66.7%
59.5%
48.6%
65.2%
52.4%
45.9%
59.1%
52.4%
45.9%
9d. Immediate manager takes a positive interest in my health & well-being
9f. Immediate manager works with me to understand problems
9i. Immediate manager helps me with problems I face
9a. Immediate manager encourages me at work
9e. Immediate manager values my work
9g. Immediate manager listens to challenges I face
9h. Immediate manager cares about my concerns
9b. Immediate manager gives clear feedback on my work
9c. Immediate manager asks for my opinion before making decisions that affect my work
Question

| Agenda item 5.12 Report to the Trust Board of Directors, 13 May 2025 | |
|---|---|
| **Title:** | Guardian of Safe Working Hours Quarterly Report |
| **Sponsor:** | Paul Grundy Chief Medical Officer |
| **Author:** | Dr Diana Hulbert Guardian of Safe Working Hours |

**Purpose**

| (Re)Assurance | Approval | Ratification | Information |
|---|---|---|---|
| | | | x |

**Strategic Theme**

| Outstanding patient outcomes, safety and experience | Pioneering research and innovation | World class people | Integrated networks and collaboration | Foundations for the future |
|---|---|---|---|---|
| | | x | | x |

**Executive Summary:**

In March 2024 NHS England issued the Priorities and National planning Guidance for 2024/25. This included the changes expected to be made to improve the working live of our staff, including the resident doctors.

A letter was sent to all NHS People Leaders in April 2024 regarding a number of actions expected for all Trusts to take in relation to Residents. At UHS we established a group to deliver these actions.

There are currently 79 Resident Doctor posts vacant which is in keeping with previous years.

The amount spent on locums covers both short-term vacancies and longer-term gaps in the rotas. The controls on the locum request process reflect a need for clear financial governance around staffing spending and is seen in all NHS trusts.

The Exception Reporting system reveals the self-reported hours worked above those contracted and also highlights missed educational opportunities.
In the last four months there have been 271 reports received.

**Contents:**



**Risk(s):**

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.

| Equality Impact Consideration: | N/A |
|---|---|

Quarterly Report - Guardian of Safe Working Hours

Employment

In April 2025 the vacancy rate for resident and local employed doctor posts across the Trust was 7.85 %.
Recruitment continues for current approved vacancies and Medical HR continues to work with departments to plan for future gaps. (Appendix 1)
The present financial situation of the NHS is a cause for concern; there is a recruitment freeze which will inevitably impact both directly and indirectly on the Resident Doctor workforce. There have been clear steps taken to keep the Resident Doctors regularly informed of the situation and at the next forum there will be a presentation and an opportunity for discussion with a member of the Executive.

Exception reporting

There were 707 exception reports received over last 12 months, which is an average of 59 per month:

Exception reporting over the four months has been highest in General Medicine

The most common reason for the submission of an exception report is additional working hours and the most common resolution is additional payment for the additional hours worked.

The overall cost of exception reporting to UHS continues to remain low despite previous breaches of hours which are clearly important. We shall continue to ensure transparent scrutiny of the rotas, exception reporting and working practices in conjunction with support for all the clinical teams.

As has always been the case the majority of the exception reports received are from FY1 Doctors.

Self-Development Time (SDT)

All doctors are given two hours of dedicated SDT each week to be used in addition to their formal training hours; this is recorded in the doctors' work schedules.

UHS encourages the use of the exception reporting mechanism to raise concerns when SDT has been missed on at least 25% of occasions over a 12-week period. This allows us to review and adjust rotas accordingly.

In the last 12 months we have received 5 exception reports stating missed SDT.

Activity

The Resident Doctor Executive Committee, led by the Chief Registrar, meets quarterly to bring together representatives of the Residents from all the care groups, the Guardian, the DME and members of the UHS Executive. These meetings facilitate discussion between the Residents (via their representatives) with senior figures in the Trust who can help explain current operational policy and be part of open discussions to effect useful change.

The Resident Doctor Forum, also led by the Chief Registrar, meets monthly and acts as an open and informal meeting to allow easy communication between the Residents, the Chief Registrar, the Guardian, the DME, and the Medical Workforce Team. We are encouraging in-person meetings for this forum to generate more open discussions.

The Guardian and Medical Workforce Team attend monthly Trust inductions to ensure that all the Residents who join UHS feel connected to the team and can ask for help and advice.

Our present Chief Registrar, Dr Guendalina Bonifacio (a senior doctor in training in neurology), is currently on maternity leave until March 2026.
After a highly competitive process we are delighted to have appointed a Chief Registrar to cover this leave; Dr Genevieve Southgate is a senior doctor in training in paediatric palliative care.
Genevieve is taking on several projects during her year in post. These include the continuation of the project to provide a management teaching programme for the Registrars at UHS, the organisation of Doctors' Awards (taking place on 15th May) and an on-going review of non-clinical space.
I am delighted that UHS continues to support this role which is invaluable for Resident engagement and representation.

## Challenges

### Rota Gaps

The vacancy rate for Resident Doctors is 7.85% which is similar to previous years.
The impact of staff sickness continues to be sigificant, particularly with recent flu and norovirus cases, and rotas can be over-stretched. It is not only medical staff sickness that impacts medical rotas; shortages in other professional groups have a significant effect on Residents' work patterns as the hospital becomes inefficient and doctors take on tasks usually carried out by other members of the MDT. This tends to particularly impact the out of hours work burden for some Residents.

### Locums

The use of the Medical Locum Bank system has led to more efficient and timely coverage of short-term rota gaps. In addition, specialties with significant challenges are becoming easier to identify earlier, allowing more effective intervention.

The significant expenditure on locums suggests that regular reviews of medical and non-medical staffing is required to ensure appropriate staffing levels are maintained.
Any uplift in the workforce will need innovative solutions for staffing patterns and recruitment but would undoubtedly help retention.
However, this is a huge challenge in the present financial crisis and this inevitably is a cause for concern amongst all professional groups at UHS.

A variable pay rate for locums was put into place some years ago which allowed the traditionally "hard-pressed" specialties such as Emergency Medicine, Anaesthetics and Paediatrics to pay a higher hourly rate. The prevailing feeling was that work intensity was not equal between specialties and the Resident doctor workforce agreed with this position. This agreement has now ended and there is a suggestion that the rates will be the same for all specialties. This may result in difficulty filling locum cover in hard-pressed specialties.
We need to re-discuss this in the contact of the competing interests of patient care and spending restrictions.
It will be particularly important to review the needs of these specialties by assessing the regularity with which exceptional payments are requested, the number of unfilled locums and the number of exception reports.

In the last two years there has been greater transparency, more consistency, and a better understanding of rotas and rota gaps at UHS and I am hopeful that a mutually acceptable outcome will be reached.

Workforce Evolution

There remains a need to discuss the evolution of the workforce. Work is being carried out around the role of Residents, advanced nurse practitioners, physician assistants and a range of non-clinical roles. The is controversy surrounding many of these roles and we at UHS must actively engage in the debate to get the best solutions.

Exception Reporting

Engagement with the exception reporting system remains variable; whilst it has highlighted some areas that need review, it is unlikely that this system reflects the true situation across the hospital. A true understanding of most of the areas of concern has come from direct discussion with teams in various departments.

The most fruitful discussions which generate the best understanding of the challenges and offer some solutions come from informal meetings with the Residents themselves.

This workforce is bright, engaged and innovative and able to ask to solve problems in a practical and informed way. I suspect it is an untapped source of solutions.

In September there will be significant national changes to the Exception Reporting System. These changes are being discussed currently and will provide some challenges for UHS. I shall discuss these changes and our plans to manage them in my next Trust Board Report.

Local Induction

The challenge of effective local induction for the Trust is regularly highlighted as an area of concern by the Residents; I shall be discussing this with the new DME in June.

Provision of Non-Clinical Space

Members of the Executive are helping Kate Nash and I review the provision of non-clinical spaces alongside our Chief Registrar. The scoping exercise has revealed a number of challenges in many areas of the hospital for many colleagues. In most areas of the Trust the lack of space impacts all sectors of the workforce and solutions have to be inventive.

Improving the Working Lives of Residents at UHS

Following the paper from NHS E in April 2024 the Task and Finish group set up at UHS has explored the three domains:

Increase choice and flexibility

Reduce duplicative inductions and pay errors

Create a sense of value and belonging for our Doctors

This is an on-going piece of work; we have ensured wide representation in the group including the Chief Resident and an F1 and we have made progress in all three domains.

I hope to report to the Trust Board in the next six months with the further outcomes of this group. (Appendix 2)

I still passionately believe that we need to better understand the unique challenges and expectations of Resident doctors.

Many doctors at UHS embark on a new career in an unfamiliar city (sometimes in an unfamiliar country) in a big Trust where they know no one, have no support system and may be working an antisocial shift system. Some residents in this situation may only have four months to understand, assimilate and succeed before moving on to another team. We expect them to manage their job and their life with relatively little practical support at a time when they are isolated socially and new to everything in their professional and private life.

The NHS can be complex for all of us but there is a unique challenge in being in a short-term post dictated by career necessity and not by choice.

It is the provision of compassionate support in all its forms that will determines these doctors' ability to thrive.

These problems are national; I am confident that the divisional management and executive teams are aware of these issues and open to discussion and solutions.

I would be delighted to take part in future Study Days for members of the Executive and Non-Executive Boards to allow a light to be shed on the lives of Residents in 2025. The lived experience of the Residents is particularly valuable and gives a real insight into the highs and lows of the working lives of Residents at UHS.

I would like to conclude by offering huge thanks to the Becci Mannion, Lynne Stassen and their team who work so hard to provide rotas, support and in-depth knowledge, which is so effective for the doctors, and therefore all members of the multidisciplinary teams and the patients at UHS.

Great thanks also to Guendalina Bonifacio and Genevieve Southgate who are superb in their roles as UHS Chief Residents.

Final thanks to the Executive team (particularly Paul and Steve) who continue to positively engage with the challenges facing these doctors and who remain consistently supportive in these complex times.

Appendix 1 Vacancy data

| Division | Care Group | Cost centre | No of posts | Fill rate as of 2/4/25 | Number of Vacancies |
|---|---|---|---|---|---|
| A | Critical Care | Anaesthetics | 73 | 83.56% | 11 |
| A | Critical Care | CICU | 11 | 100.00% | 0 |
| A | Critical Care | GICU | 48 | 83.33% | 6 |
| A | Critical Care | NICU | 12 | 100.00% | 0 |
| A | Critical Care | SHDU | 10 | 100.00% | 0 |
| A | Ophthalmology | Ophthalmology | 28 | 96.43% | 1 |
| A | Surgery | ENT | 16 | 100.00% | 0 |
| A | Surgery | General Surgery | 50 | 96.00% | 2 |
| A | Surgery | OMFS | 10 | 80.00% | 2 |
| A | Surgery | Urology | 13 | 92.31% | 1 |
| B | Cancer Care | Clinical Oncology | 18 | 100.00% | 0 |
| B | Cancer Care | Haematology | 23 | 100.00% | 1 |
| B | Cancer Care | Medical Oncology | 19 | 89.47% | 2 |
| B | Cancer Care | Palliative Care | 9 | 77.78% | 2 |
| B | Cancer Care | Acute Oncology | 3 | 66.67% | 1 |
| B | Emergency | Acute Med | 23 | 100.00% | 1 |
| B | Emergency | Acute Med OOH | 6 | 100.00% | 0 |
| B | Emergency | ED | 70 | 95.71% | 3 |
| B | Emergency | PHEM | 2 | 100.00% | 0 |
| B | MOP | MOP | 44 | 97.73% | 2 |
| B | Pathology | Chemical Pathology | 2 | 50.00% | 1 |
| B | Pathology | Microbiology | 13 | 76.92% | 3 |

| | | | | | |
|---|---|---|---|---|---|
| B | Pathology | Histopathology | 24 | 58.33% | 10 |
| B | Specialist Med | Allergy/Respiratory | 28 | 100.00% | 0 |
| B | Specialist Med | Clinical Genetics | 4 | 100.00% | 1 |
| B | Specialist Med | Dermatology | 11 | 100.00% | 0 |
| B | Specialist Med | Endo/Diabetes | 4 | 100.00% | 0 |
| B | Specialist Med | General Medicine | 14 | 92.86% | 1 |
| B | Specialist Med | GI Renal | 33 | 93.94% | 1 |
| B | Specialist Med | Rheumatology | 4 | 100.00% | 0 |
| C | Child Health | Paediatric Cardiology | 14 | 92.86% | 1 |
| C | Child Health | Paediatrics | 57 | 94.74% | 6 |
| C | Child Health | Paeds ED | 13 | 100.00% | 1 |
| C | Child Health | PICU | 18 | 100.00% | 0 |
| C | W&N | Neonates | 27 | 77.78% | 5 |
| C | W&N | O&G | 36 | 94.44% | 0 |
| D | CV&T | Cardiology | 38 | 97.37% | 1 |
| D | CV&T | Cardiothoracic Surgery | 35 | 100.00% | 0 |
| D | CV&T | Vascular Surgery | 12 | 91.67% | 1 |
| D | Neurosciences | Neurology | 22 | 81.82% | 5 |
| D | Neurosciences | Neurophysiology | 2 | 50.00% | 1 |
| D | Neurosciences | Neurosurgery | 25 | 88.00% | 3 |
| D | Neurosciences | Stroke | 8 | 100.00% | 0 |
| D | T&O | Spinal Surgery | 3 | 100.00% | 0 |
| D | T&O | T&O | 58 | 93.10% | 3 |
| | | **Total** | **993** | 92.15% | 79 |

Appendix 2: Improving the Lives of Residents at UHS - Gap Analysis

How we are delivering against the NHS England set of standards as per 2024/25 planning guidance and letter of 25 April 2024

| Objective | Standard | UHS progress to date | RAG | Future actions based on discussion 09/12/2024 |
|---|---|---|---|---|
| **Increase choice and flexibility** | (1) Provide work schedules at least eight weeks in advance<br><br>(2) Finalised duty rosters provided six weeks in advance | There is an internal target of 80% of work schedules to be issued to Medical HR at the 10-week deadline.<br><br>Late information from the doctors themselves and from the Deanery impacts our ability to meet this target. KN has raised our concerns with the Deanery, but there is limited scope for UHS to influence their timescales.<br><br>May 2025 - 88% of doctors issued with their work schedule 10weeks before they began their posts.<br><br>Bespoke work schedules are received for people working LTFT | | DH has arranged meetings for clinical rota leaders to understand the issues they face. Attendance has been variable with some areas not engaging.<br><br>**KN raised with DCDs at medical education and workforce meeting. LS provided list of leads who have yet to meet. DH to hold one more round of meetings to ensure full engagement from all the rota leads by August 2025.**<br><br>**LS provides data to Medical Education & Workforce Meeting on deadline achievements of Work schedules** |

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| | Improve rota management and move to self-rostering. Where rota changes are required with less than six weeks' notice, the resident doctors impacted should be involved in creating the new rota. In such situations all pre-existing leave arrangements must be accommodated | Preferential rostering rather than self-rostering allows for service and training demands to be met. This is in place, with bespoke rotas for service and training provided for many.<br><br>LTFT have bespoke schedules and rotas from the start<br><br>ED and CED are already self-rostering<br><br>The named medical administrator and clinical rota lead for each doctor is shared at local inductions and they should be contacted by the residents in the first instance regarding leave requests. Names are added to work schedule templates. | | LS – interfacing of rotas is a work in progress. Workforce/IT teams continue working towards arranging IT access to be available 6 weeks in advance. This will allow access to systems on Loop when switching organisations<br><br>Some IT issues have occurred<br><br>DH will coordinate the writing and publication of a brief practical guide for resident doctors. Hopefully the first edition will be ready for August 2025 |

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| **Reduce duplicative inductions and pay errors** | Pay specific attention to payroll accuracy for all staff, particularly doctors who rotate | There is an average of 9 errors per month (1.2% of total trainees). Peak rotational months see higher errors due to volume of entry changes and late work schedules or changes. Pay errors are often related to departmental recording for maternity leave and sick leave<br><br>A Teams group has been established for updates, communications and reminders for medical administrators<br><br>The underpayment / overpayment process is reviewed monthly<br><br>Individuals must be responsible for checking their own pay slips and raising any concerns and or inaccuracies<br><br>An example of both substantive and bank contract payslips and their components will be shared at Trust induction and on Staffnet.<br><br>BM gave a presentation on understanding payslips at the resident doctor forum. | | Work is mostly complete<br>Outstanding task is to produce a video on payslips and how to exception report -BM to arrange |
| | Develop local SLAs to include timescales for dealing with individual payroll errors so payroll queries are handled swiftly by the end of July 2024 and implement a board governance framework for monitoring and reporting payroll errors for all staff by the end of July 2024 | We rectify the problems immediately (as soon as feasible)<br><br>Payroll queries are dealt with rapidly and there are none outstanding currently<br><br>Payroll maintin a list of all errors and corrections for all staffing groups<br><br>Overarching policies are already in place that outline procedures for all staff in the Trust | | |

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| **Create a sense of value and belonging for our doctors** | Protect training time for both learners and educators. For example, no member of staff should have to do mandatory training in their own time | Self-development and MAST training is carried out in work time<br><br>SDT is added to contract and included in roster summary with the work schedule<br><br>This is 2 hours a week or approximately one day a month<br><br>Recording of lost SDT is positive at UHS and encouraged by the exception reporting system<br><br>Clarity of definitions of study leave and SDT are included in trust induction slides | | |

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| | Address the unique issues caused by rotations, such as reviewing on-boarding processes, and other practical steps to help foster a sense of wellbeing and belonging such as reviewing the application processes for lockers or car parking spaces, the availability of facilities and inclusion in team photos etc | There is good feedback from residents for the on-boarding processes. The processes and timelines and regularly reviewed.<br><br>On-call rooms are constantly used by all staff groups. Managed by estates<br><br>Too tired to drive home charter is in place. Rooms currently available 9am-12pm<br>If no room available, or room required for longer after twilight etc – escalation to site to manage with availability of a taxi home<br><br>There is a lack of office space and desks.<br>There are IT limitations<br><br>KN and DH have joined a UHS Estates group.<br><br>IT rollout project commenced August 2023<br><br>Doctors are informed of how to raise IT issues with laptops. | Green<br><br>Red for estates | On call rooms– working with mess president on recent reports of misuse of rooms and hospital bedding.<br>Propose a culture piece defining expectations regarding on call and shift rotas<br><br>Small group to include DH and GB to meet the Junior doctors' mess team.<br>DH and BM have met with the facilities manager to ensure availability of the rooms.<br>DH to meet with site team to ensure that their role is explicit<br><br>Chief reg/estates walkabouts ongoing – T&O, oncology, neurosciences, D level medicine completed. Feeling that any spending needs to be seen to have equity e.g. by division?<br><br>Discussed at estates and facilities group – further discussion required regarding prioritisation. Aim for equity where possible e.g. one area in each division first. Continue walkabouts and define priority list. Hoping to spend money in 25/26<br><br>Still red for lockers – need to take up with estates team KN/DH.<br><br>Ongoing work required outside of this main meeting (KN/DH/GB)<br><br>KN/DH sit on estates and facilities meeting and therefore felt that estates representation in this group is not required<br><br>PAH resident doctors' room might be improved with c £15k funding |

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| | Align to the latest Core Skills Training Framework (CSTF) by the end of June 2024, confirming with NHS England when your organisation has done so | National programme of work on Statutory & Mandatory training ongoing with more changes expected in January 2025.<br><br>Local team is reviewing S&M. UHS are partially aligned (and not a statistical outlier). Ongoing dialogue about what training is mandatory<br><br>KN is a member of SMOG | | **https://www.e-lfh.org.uk/programmes/statutory-and-mandatory-training/**<br><br>The UK Core Skills Training Framework (CSTF) sets out 11 statutory and mandatory training topics for all staff working in health and social care settings<br><br>Ongoing review required as further information provided on National programmes |
| | Use the free eLearning for Healthcare packages and shorter e-assessments by the end of October 2024 | TBC | | **Resus is the only e-assessment outstanding for eLfH due to the number of courses within resuscitation e-learning** |
| | Adopt the NHS Digital Staff Passport at the earliest opportunity | HR digital passport – been involved in multiple versions. Will roll out when released nationally. | | Tracking this but nothing issued or confirmed nationally<br><br>Piloted in the north of England; awaiting a national update on this programme<br><br>LB confirmed that UHS are involved in shaping this programme of work |
| | Take action to improve the experience of trainees by ensuring the National Training and Education Survey and GMC Survey are treated in the same way as the National Staff Survey results, with reviews by trust boards supported by clear action plans | As a trust we present at a variety of forums<br><br>NETS went to People Board on 15 May for wide discussion<br><br>GMC NTS is subject to extensive analysis and presented to TEC. DME team review concerns with local areas and work with them to create action plans towards resolving issues.<br><br>Targeted intervention is undertaken where there are free text concerns or other areas requiring extra scrutiny, with close liaison with the NHS-E quality teams | | |

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| | Identify a senior, named individual to oversee the implementation of these actions and be accountable to the trust board | Paul Grundy is the executive lead | | |

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| | Consider BMA wellbeing guidance recently published and implementation at local level | Karen M wellbeing induction and support networks<br><br>DH has joined the UHS Wellbeing Group<br>Five priorities for improving wellbeing in the workplace (BMA)<br><br>1. On-call designated parking spaces*<br>2. Self-directed learning time to commensurate the training needs of each individual (in place for Deanery and LEDs)<br>3. The right to work from home to undertake portfolio and self-directed learning (in place)<br>4. Mess, rest facilities and lockers included in all hospitals including any new hospital builds*<br>5. Access to an out-of-hours menu 24/7 that includes a hot meal and cold snacks for staff (vending machines and microwaves are available on General and PAH sites) | | All to read /review for future discussion<br><br>We need to have resident doctor participation in this group – GB is on maternity leave so DH has invited the new chief resident.<br><br>Could there be funding allocated to rest facilities?<br><br>Progress outlined above.<br>DH/KN now on Estates group, hopefully will assist with ensuring space is included in new builds |

*Reviewed on 14 May 2024.*
*Updated with further actions on 15 July 202416 August 2024, 16 September 2024, 9 December 2024, 10th March and 12th April 2025*

University Hospital Southampton NHS Foundation Trust

| Agenda Item 5.13 | Report to the Trust Board of Directors, 13 May 2025 |
|---|---|
| **Title:** | Learning from Deaths 2024-25 Quarter 3 Report |
| **Sponsor:** | Paul Grundy, Chief Medical Officer |
| **Author:** | Jenny Milner, Associate Director of Patient Experience<br>Lauren Kennedy, Lead Medical Examiner Officer |

**Purpose**

| (Re)Assurance | Approval | Ratification | Information |
|---|---|---|---|
| x | x | | |

**Strategic Theme**

| Outstanding patient outcomes, safety and experience | Pioneering research and innovation | World class people | Integrated networks and collaboration | Foundations for the future |
|---|---|---|---|---|
| x | | | | |

**Executive Summary:**

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.

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.

1. The Trust reduces avoidable deaths in our hospitals.
2. The Trust promotes learning from deaths, including relating to avoidable deaths and reviews quality of end-of-life care.
3. The Trust promotes an open and honest culture and support for the duty of candour.

**Contents:**

N/A

**Risk(s):**

Risk 828 – Bereavement Services (reduced risk rating to 9 due to successful recruitment)

| Equality Impact Consideration: | N/A |
|---|---|

# 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 the Medical Examiners Southampton (MES) service.

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, so 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

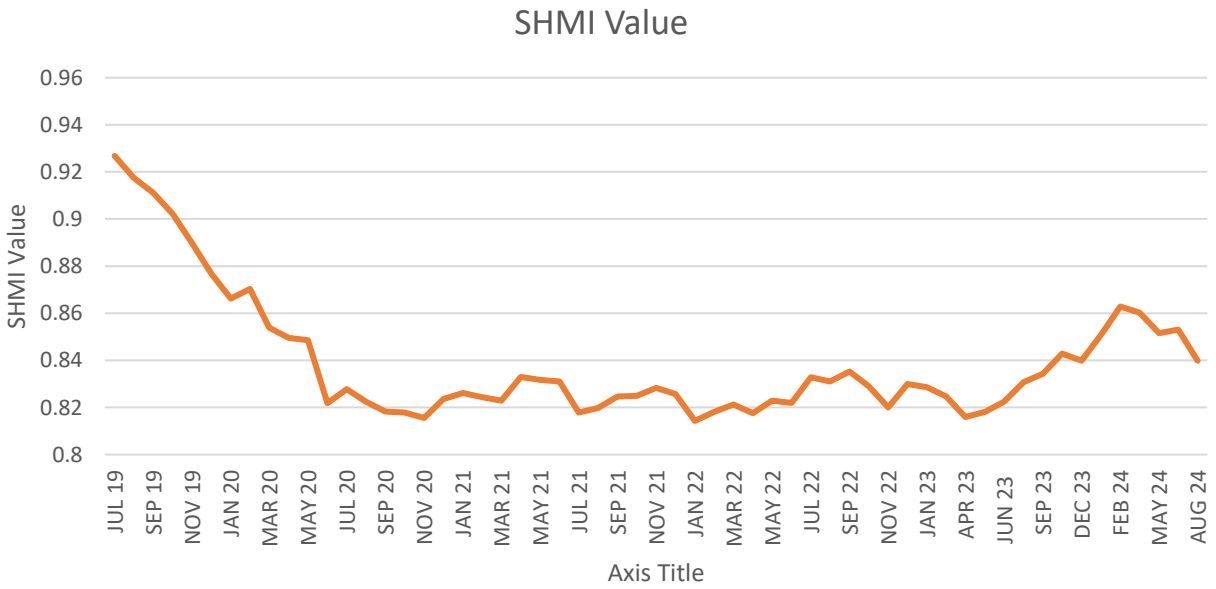
| Quarter | 2019-20 | 2020-21 | 2021-22 | 2022-23 | 2023-24 | 2024-25 |
|---|---|---|---|---|---|---|
| Q1 | 485 | 540 | 483 | 504 | 512 | 466 |
| Q2 | 416 | 516 | 591 | 526 | 471 | 446 |
| Q3 | 474 | 599 | 651 | 565 | 578 | 498 |
| Q4 | 506 | 644 | 537 | 489 | 558 | - |
| Total | 1881 | 2299 | 2262 | 2084 | 2119 | |

Q3 of 2024-25 saw 498 deaths at UHS sites, compared to 578 in Q3 2023-24.

21 of Q3 deaths at UHS are recorded as occurring in the Emergency Department and the remainder were inpatients.

## 2.2 **SHMI (replacing HSMR)** (This is calculated by NHSE)

SHMI (Summary of Hospital Level Mortality Indicator) is the ratio between the 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 August 2024. However, over the latest 11 SHMI reports there has been an upward trend in the data that should be noted. This upward trend is in line with national trends.

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

| Diagnosis Group | SHMI Value | SHMI Banding |
|---|---|---|
| Septicaemia (except in labour), Shock | 1.0007 | As expected |
| Cancer of bronchus; lung | 0.8878 | As expected |
| Secondary malignancies | 0.6506 | Lower than expected |
| Fluid and electrolyte disorders | 0.5773 | Lower than expected |
| Acute myocardial infarction | 0.7501 | Lower than expected |
| Pneumonia (excluding TB/STD) | 0.9596 | As expected |
| Acute bronchitis | 0.6375 | Lower than expected |
| Gastrointestinal haemorrhage | 0.8467 | As expected |
| Urinary tract infections | 0.6446 | Lower Than expected |
| Fracture of neck of femur (hip) | 0.9739 | As expected |

For the 12 months to August 2024, 5 diagnosis level values are in the 'as expected' range, 5 are in the 'lower than expected' range. Banding for cancer of bronchus; lung, has changed from 'lower than expected' to 'as expected'. The rest of the diagnosis groups remain the same as they were in the May 2024 data publication.

NHSE statistics for deaths following a time in hospital were published during Q3. UHS continues to sit alongside only 12 trusts out of 119 with 'lower than expected' death outcomes.

### 2.3 Medical Examiner reviews

In Q3 the MES reviewed 1217 deaths, of which 461 occurred at UHS acute sites and 756 occurred in the community. This compares to 791 deaths reviewed in Q2. There was an increase of 103% in community referrals compared to Q2. This is due to the medical examining system becoming statutory, whereby all non-coronial deaths must be reviewed by a medical examiner before registration can occur.

76 acute UHS deaths were referred to the coroner, 58% of these were taken for further investigation through a coroner postmortem or inquest. These figures remain consistent from the previous quarter.

#### 2.3.1 Referrals to M&M and learning

8 cases were referred to speciality M&Ms by MES, 2 of which are still to be reviewed. Referrals were made to the following specialities: Respiratory, Trauma and Orthopaedics, Dietetics, Hepatology, GI and Renal and Cardiology and AMU.

In all cases that were reviewed, it was felt that patients were managed appropriately, and outcomes were mostly unavoidable.

In one case, it was recognised the patient should have been offered an earlier follow-up appointment after starting diuretics, as a result a system has now been implemented where patients started on diuretics are reviewed in the SMDU (day unit) within one week of initiation.

One case identified TAVI (Transcatheter aortic valve implantation) capacity as a potential concern, and it was noted that this would be taken for discussion in the respective care group governance meeting. A patient was referred for TAVI but did not receive this before they died. The medical care was noted to be excellent and that the death was "possibly avoidable but not likely" considering the co-morbidities. The delays for TAVI were related to logistical limitations.

### 2.3.2 Referrals to Patient Safety

1 death with a concern related to a missed referral opportunity was referred to the Patient Safety Team by MES and was subsequently triaged to the Complaints team to resolve. This case was also referred to the coroner, but they found no duty to investigate due to the death being of natural causes.

## 2.4 UHS 'End of Life' incident reports

For Q3, there were a total of 20 incidents reported relating to end-of-life care.

Overall, the main themes of the incidents were related to:

- Safe transfer of patients, communication, documentation, implanted medical devices.
- Communication and documentation among clinical staff and support staff (for example, the signing of EOLCP or documentation of implants).
- The incorrect transfer of deceased patients including incorrect identification and notice of deaths.
- End of life care management, with regards to anticipatory medication.

- Funding out of hours paediatric palliative care consultants being contacted out of hours to support end of life children symptom control.
- Patients receiving end of life care in bays as side rooms are unavailable.

In all incidents where possible, staff were given feedback on incidents and advised of correct processes and procedures.

## 2.5 Learning from UHS complaints relating to End-of-Life care

There was one complaint from a deceased patient's family regarding feeling uninformed about the associated risks with the patient's condition. At the time there were no widely available websites of patient information leaflets available for laryngeal papillomatosis. There were no NICE guidelines to specify management, and care was tailored to the individual. The death was discussed at the departmental mortality and morbidity (M&M) meeting. During this, the following actions were proposed:

- Establishing a dedicated airway emergency list to ensure a patient has rapid access to care, co-ordinated by a nurse practitioner.
- Exploring the potential of HPV typing (a test that identifies the type of Human Papillomavirus that a patient has) as a tool to assist in managing similar conditions.

- Developing patient information leaflets, noting that such resources are currently unavailable through major surgical societies, such as ENT UK.
- Creating a database of patients with laryngeal papillomatosis to improve tracking and co-ordination of care.
- Recent recruitment of a locum consultant will support sharing the responsibility for managing airway patients, addressing the current reliance on a single person.

## 3. Morbidity and Mortality data capture & standardisation

Three external programmes have been explored and compared for the data capture of M&M. One programme has created examples of what a potential data capture could look like, and this is currently being reviewed and likely to be adopted.

There is a drive for M&M outcomes with learning to be shared at divisional governance with the option of escalation if shared learning is appropriate for across the organisation. This will help to ensure that M&M recording is consistent across the Trust and outcomes can be shared more widely for learning.

## 4. Medical Examiner Service update

This is the first full quarter of the medical examiner system being statutory. Community referrals for MES have increased by 103%, increasing the demand on medical examiners and medical examiner officers. Acute deaths remain consistent with seasonal expectation.

In Q3 for acute deaths occurring at UHS, 95% of families were contacted by the service to ask if they had concerns about care, an improvement compared to 93% in Q2. Reasons for non-contact were that there was no informant, or the informant declined to be involved.

16% of Medical Certificate of Cause of Death (MCCD) were sent to the registry office by day 3 from date of death, compared to 41% in Q2. This decrease could be attributed to the introduction of additional steps in the process since becoming statutory and the delay in referrals received to MES after a patient death, via a deceased patient referral. 33% of MCCD's were sent within 3 days of the referral being received.

At the start of Q3 MES has also introduced an 'on call' Medical Examiner, available on weekends and bank holidays for two hours, providing guidance and advice on whether an urgent release of a body can be facilitated, for paediatric and faith deaths, or if organ retrieval can happen if no referral to the coroner is required. MES has received four out of hours calls, two resulted in successful organ retrieval.

## 5. Supportive and Palliative Care update

- The UHS 'End of Life Care Strategy' is ready launch during Q4, in which a host of new resources will be provided. It aims to provide good end of life care information for adult patients and families.

- During Q3, the HPCT (Hospital Palliative Care Team) conducted a 4-week pilot of pro-active working named APPLE (Acute Proactive Palliative Liaison Evaluation). The pro-active approach was centred around 'flagging' of patients known to hospices and

community palliative teams when presenting as an acute admission into UHS (ED, AMU, ASU).

Out of 108 flagged patients, the HPCT were able to intervene earlier for 47 patients, of which 5 patients were directly discharged back home. This proactive review of dying patients was triggered by preliminary NACEL (National Audit of Care at the End of life) 2024 data that indicated a difference between documentation of care which appeared to be “good” and the lived experience of family which showed inconsistency in terms of their observations relating to symptom control, communication, and care of family.

University Hospital Southampton NHS Foundation Trust

| Agenda Item 5.13 ii) Report to Trust Board of Directors, 13 May 2025 | |
|---|---|
| **Title:** | Learning from Deaths 2024-25 Quarter 4 Report |
| **Sponsor:** | Paul Grundy, Chief Medical Officer |
| **Author:** | Jenny Milner, Associate Director of Patient Experience<br>Lauren Kennedy, Lead Medical Examiner Officer |

**Purpose**

| (Re)Assurance | Approval | Ratification | Information |
|---|---|---|---|
| x | x | | |

**Strategic Theme**

| Outstanding patient outcomes, safety and experience | Pioneering research and innovation | World class people | Integrated networks and collaboration | Foundations for the future |
|---|---|---|---|---|
| x | | | | |

**Executive Summary:**

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.

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.

1. The Trust reduces avoidable deaths in our hospitals.
2. The Trust promotes learning from deaths, including relating to avoidable deaths and reviews quality of end-of-life care.
3. The Trust promotes an open and honest culture and support for the duty of candour.

**Contents:**

N/A

**Risk(s):**

Risk 828 – Bereavement Services (closed during Q4 due to being fully recruited)

| Equality Impact Consideration: | N/A |
|---|---|

# 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 the Medical Examiners Southampton (MES) service.

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, so 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

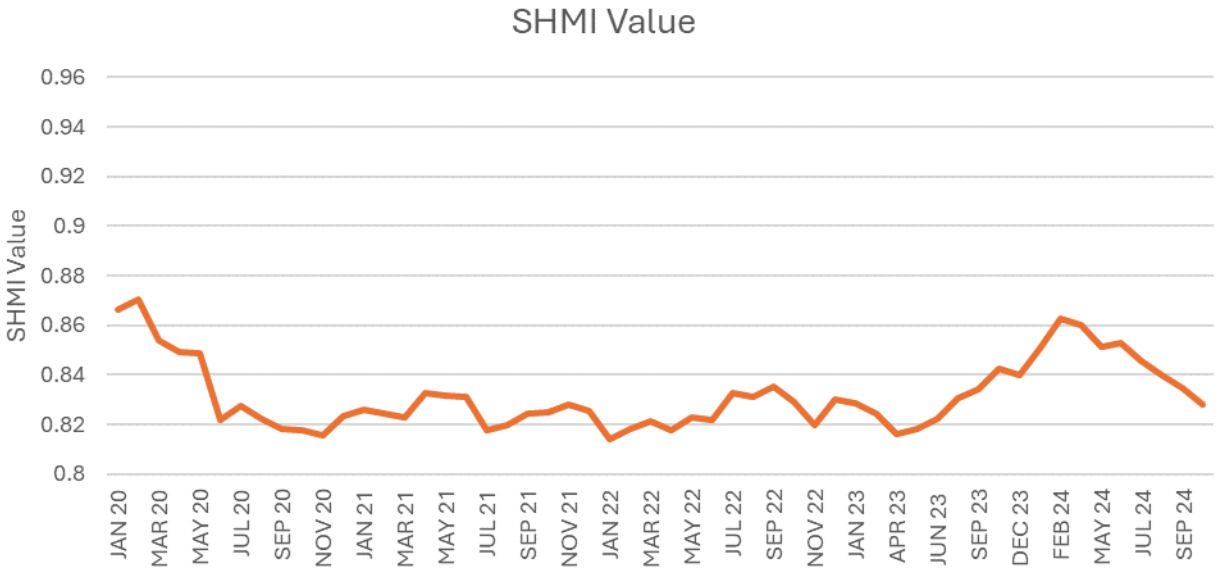
| Quarter | 2019-20 | 2020-21 | 2021-22 | 2022-23 | 2023-24 | 2024-25 |
|---|---|---|---|---|---|---|
| Q1 | 485 | 540 | 483 | 504 | 512 | 466 |
| Q2 | 416 | 516 | 591 | 526 | 471 | 446 |
| Q3 | 474 | 599 | 651 | 565 | 578 | 498 |
| Q4 | 506 | 644 | 537 | 489 | 558 | 552 |
| Total | 1881 | 2299 | 2262 | 2084 | 2119 | 1962 |

Q4 of 2024-25 saw 552 deaths at UHS sites.

25 of Q4 deaths at UHS are recorded as occurring in the Emergency Department and the remainder were inpatients.

## 2.2 SHMI (replacing HSMR) (This is calculated by NHSE)

SHMI (Summary of Hospital Level Mortality Indicator) is the ratio between the 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 0.828 for the 12 months to November 2024.

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

| Diagnosis Group | SHMI Value | SHMI Banding |
|---|---|---|
| Septicaemia (except in labour), Shock | 1.0244 | As expected |
| Cancer of bronchus; lung | 0.9106 | As expected |
| Secondary malignancies | 0.6184 | Lower than expected |
| Fluid and electrolyte disorders | 0.5677 | Lower than expected |
| Acute myocardial infarction | 0.8485 | As expected |
| Pneumonia (excluding TB/STD) | 0.96 | As expected |
| Acute bronchitis | 0.5975 | Lower than expected |
| Gastrointestinal haemorrhage | 0.733 | Lower than expected |
| Urinary tract infections | 0.627 | Lower than expected |
| Fracture of neck of femur (hip) | 0.8041 | As expected |

For the 12 months to November 2024, 5 diagnosis level values are in the 'as expected' range, 5 are in the 'lower than expected' range. Banding for acute bronchitis has changed from 'as expected' to 'lower than expected' and acute myocardial Infarction has changed from 'lower than expected' to 'as expected'. The rest of the diagnosis groups remain the same as they were in the August 2024 data publication. There are no groups which feature higher than expected bandings.

NHSE statistics for deaths following a time in hospital were published during Q4. UHS continues to sit alongside 12 trusts out of 119 with 'lower than expected' death outcomes.

### 2.3 Medical Examiner reviews

In Q4, the MES reviewed 1301 deaths, 491 occurred at UHS sites, and 810 were community deaths. This compares to 1217 deaths reviewed in Q3. There was a slight increase in deaths occurring compared to the previous quarter which is a seasonal expectation.

53 UHS acute deaths were referred to the coroner, 56% of these were taken for further investigation through a coroner postmortem or inquest. These figures remain consistent from the previous quarter.

#### 2.3.1 Referrals to M&M and learning

3 deaths were referred to speciality M&Ms by MES in Q4. Referrals were made to the following specialities: Surgery, Cardiology and Medicine for Older People (MOP). One case has not yet been reviewed.

In both cases that were reviewed, the questions raised by the ME (Medical Examiner) would not have changed clinical outcomes for these patients. In the case referred to MOP, the clinical team felt the death was not appropriate for a full M&M. The ME had highlighted that in the written notes it stated that a positive for Covid-19 test was 'missed'. The medical team advised that this was documented by an out of hours doctor, the patient was frail and had multiple comorbidities and it was unclear what additional treatment the patient could have had. The patient was already on supportive management of symptoms for a respiratory infection. The medical team stated that with drug interactions and need for patient specific prescribing, the patient may still not have received Paxlovid.

### 2.3.2 Referrals to Patient Safety

MES referred 7 deaths to the Patient Safety Team (PST) to complete LeDeR (Learning from Lives and Deaths – People with a Learning Disability) referrals and review the deaths. The PST identified some challenges in communication and recognising the soft signs of deterioration displayed by these vulnerable group of patients. Concerns regarding one case are currently being investigated by a patient safety incident review and findings will be shared trust-wide and in the Q1 25/26 'Learning from Death' report. This learning triangulates with quality concerns regarding the care of learning disability patients escalated by the Experience of Care Team. There are plans to hold an urgent review of 3 cases in which there were quality care concerns.

There were no referrals made specifically for patient safety review in Q4.

## 2.4 UHS 'End of Life' incident reports

For Q4, there were a total of 27 incidents reported relating to end-of-life care.

Overall, the main themes of the incidents were related to:

- Patients dying in bays and not side rooms.
- Equipment availability, safe transfer of patients, documentation, particularly around implanted medical devices.
- Documentation among clinical staff and support staff (for example, of implants).
- The improper transfer of deceased patients including missing identification and notice of deaths.
- End of life care management, with regards to anticipatory medication. One incident described the unavailability of a syringe driver on the acute medical unit. The team tried to source one from MOP wards and likely wards to have one, but with no avail so a syringe pump was used as an alternative. The patient's care was not delayed however it was suggested that a review of available equipment or access to a tracking system would be useful. In another incident on a neuro ward, staff had used a 50ml syringe with the syringe driver. This was practice when they previously did not have access to the equipment library, these incidents highlight the need for education of staff on using the equipment library and the correct items and procedures for EOL medication.

13 incidents were reported where patients died in bays and not in private rooms. The reason given for this was limited availability of side rooms within care groups, further impacted by infection control. This is an ongoing issue that has been raised with care group management teams, the end-of-life facilitator and the specialist palliative care team and has been escalated to trust management.

One incident related to restricted visiting, the bereaved family raised concerns with regards to being unable to visit the dying patient, due to diarrhoea and vomiting outbreaks and ward closure. This was distressing to the family and sadly they were unable to visit the patient, who died alone. The family were called after the death and informed they could visit. The ward recognised the missed opportunity to allow the family to visit the patient during their deterioration and this learning was discussed at a multi-disciplinary meeting.

The PST investigated the continued pressures in the emergency department, including the death of a patient in a corridor. The patient had received good care from the department and did not die because of being in the corridor, but this strongly highlighted the challenges with maintaining a

patient's dignity when being cared for in this environment, and the impact this has on staff should not go unnoticed.

In all incidents where possible, staff were given feedback on incidents and advised of correct processes and procedures.

### 2.5 Learning from UHS complaints relating to End-of-Life care

There have been two complaints relating to end-of-life care in Q4. Both complaints are still under investigation and therefore no learning has yet been identified. Any identified learning after investigation will be reported in Q1 2025/26.

## 3. Morbidity and Mortality data capture & standardisation

Of the three external programmes that were compared for the data capture of M&M, the Ulysses mortality module was recently shown to M&M leads, the PST and the lead for clinical effectiveness. Further meetings are being organised to finalise the decision, specifically to explore how another comparable trust has used the same module and if we can identify any learning from their use. There is also work required with linking the trusts digital team with the Ulysses team to explore how this can be developed to suit needs.

There is a drive for M&M learning outcomes to be a standing agenda item at care group and divisional governance with the option of trust wide escalation if shared learning is appropriate. This will help to ensure that M&M recording is consistent across the Trust and outcomes can be shared more widely for learning.

## 4. Medical Examiner Service update

The statutory medical examiners service continues to review all non-coronial deaths occurring in Southampton and the surrounding areas. The volume of work seen in Q3 was maintained into Q4, with 1302 deaths being reviewed by the MES, 38% of which occurred at UHS sites, consistent with seasonal expectation.

In Q4 for acute deaths occurring at UHS, 96% of families were contacted by the service to ask if they had concerns about care. 6% of bereaved families reported concerns with care which were then appropriately communicated onwards.

In Q4, the MES were working under significant pressure with the winter high volumes of death which resulted in delays in the overall process. It took an average of 7 days (*including weekend days*) from receiving the referral from the medical team and sending a Medical Certificate of Cause of Death (MCCD) to the registry office.14% of MCCD's were sent within 3 days of the referral being received by the medical team. Towards the end of Q4 this has started to improve. The average number of days has now reduced to 6, which is expected to continue to improve into Q1 2025/2026.

On average, it took 2.5 days for the MES to receive a referral from the UHS medical team when an inpatient died. The MES has been exploring opportunities to improve referral rates and the timely completion of the MCCD by reaching out to ward teams, attending teaching sessions and advising on live timescales for the management of family expectations and updating available information on Staffnet. The MES will be escalating delays to the DCD, CGCL and CGM and will

raise AERs for any significant delays in referrals or completion of paperwork to hasten the process and highlight areas for improvement.

The MES continues to hold monthly case review and learning meetings, enabling discussion about complex cases, such as decisions to refer to the coroner, complex causes of death, or where learning could be implemented for the service.

## 5. Supportive and Palliative Care update

Q4 saw many instances of excellent person-centred care with prioritisation on patient and family experience.

A dying patient on AMU was recognised to have spiritual needs that the family were not familiar with and felt unsure how to meet them. Working together, the palliative care team and EOL educator were able to ensure the chaplaincy were contacted, information relating to the Hindu faith was printed from Staffnet and shared with the family and ward staff. The medical team were also involved to ensure a timely pre-emptive referral to the MES. The family shared how supported they felt in achieving what was most important to their mother.

Feedback shared about G7 demonstrated the impact of shared decision making and excellent patient experience; *"The ward made us feel welcome, they didn't just look after my wife/mum they looked after us. The nurses felt like family. The ward supported my dad when mum was dying, they did not mind explaining everything multiple times. The ward leader prepared us before the decision to stop treatment was made, this gave us time to talk things through which made making difficult decisions easier".*

One instance of excellent multi-disciplinary working on C2 saw a patient who was transferred from abroad with metastatic cancer. Their family were unaware of how ill the patient was and sadly they deteriorated just over a week after their arrival. Nursing, medical, therapy and the supportive and palliative care teams brought the patient and their family to a point of understanding the reality and an exceptional level of support was shown in these extremely challenging circumstances. This patient declined hospice transfer as they felt so well cared for at UHS and trusted the team here.

University Hospital Southampton
NHS Foundation Trust

| Agenda Item 6.1 Report to the Trust Board of Directors, 13 May 2025 | |
|---|---|
| **Title:** | Corporate Objectives 2024-25 Quarter 4 Review |
| **Sponsor:** | David French, Chief Executive Officer |
| **Author:** | Kelly Kent, Head of Strategy and Partnerships |

**Purpose**

| (Re)Assurance | Approval | Ratification | Information |
|---|---|---|---|
| x | | | |

**Strategic Theme**

| Outstanding patient outcomes, safety, and experience | Pioneering research and innovation | World class people | Integrated networks and collaboration | Foundations for the future |
|---|---|---|---|---|
| x | x | x | x | x |

**Executive Summary:**

This paper provides an update regarding progress against our Corporate Objectives for Quarter 4 for 2024-25 and a summary of year end.

During Q4, the number of objectives on track and therefore completed in full by year end was 50%. With 37.5% of objectives remaining amber having been partially achieved or with minor delays, and 12.5% or 2 objectives remaining red.

The organisation has worked hard through an extremely challenging 12 months to achieve many of the annual corporate objectives. Balancing the desire to maintain quality, outcome, and experience against demand during a year of rapid political evolution and stark financial challenges.

A scoring summary of progress is below:

| Ref | Corporate ambition | Leads | No. of Objectives for 2024/25 | Q3 Green | Q3 Amber | Q3 Red | Q4 Green | Q4 Amber | Q4 Red |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Outstanding patient outcomes, safety and experience | COO/CNO | 4 | 2 | 2 | 0 | 3 | 1 | 0 |
| 2 | Pioneering research and innovation | CMO | 2 | 2 | 0 | 0 | 2 | 0 | 0 |
| 3 | World class people | CPO | 3 | 1 | 2 | 0 | 1 | 1 | 1 |
| 4 | Integrated networks and collaboration | COO/CMO | 2 | 1 | 1 | 0 | 0 | 2 | 0 |
| 5 | Foundations for the future | CFO/CEO/CNO/CMO | 5 | 2 | 1 | 2 | 2 | 2 | 1 |
| Totals | | | 16 | 8 | 6 | 2 | 8 | 6 | 2 |
| | | | % against 16 | 50.0% | 37.5% | 12.5% | 50.0% | 37.5% | 12.5% |

| RAG Rating for corporate objectives updates | In Year Updates | Q4 Update |
|---|---|---|
| Green | On track to be delivered in full | Achieved in Full |
| Amber | Minor Delays/or shortfall in target | Partially Achieved |
| Red | Significant delays/or shortfall in target | Not Achieved |

**Contents:**

Summary of progress.
Appendix 1-5 Updates in full by strategic theme.

**Risk(s):**

Objectives relate directly to all BAF risks.

| Equality Impact Consideration: | NO |
|---|---|

**Background**
The 2024/25 Corporate Objectives were approved by the UHS Board in April 2024 and were noted to be highly focused and within the confines of the overall financial position.

**Quarter 4 Update and Year End Summary**
This paper provides an update regarding achievements of Quarter 4 and a concluding summary for 2024-25 objectives at year end.

During Q4, the number of objectives to remain 'on track' and therefore completed at the end of 2024-25 has remained at 50%. With 37.5% remaining as amber, noted as partially achieved or with minor delays. As forecasted two objectives (12.5%) have remained red rated at year end.

As the year has drawn to a close the objectives which have been achieved in full are as follows: -

**Outstanding Patient outcomes, safety and experience** delivered well on reducing long waiters with only twenty-three patients waiting over 65 weeks. Comparatively UHS is above average against the national picture. Likewise, UHS has successfully reduced length of stay by 5.26% across the year outperforming the target of 5%- this has been achieved through successful delivery of the inpatient flow transformation programme.

Patient experience has also achieved the implementation of the 'Fundamentals of Care' programme - this saw the pilot of 'What matters to me' being launched with great success and upon further funding, which is due in June, it is anticipated this will be rolled out further.

Progress has been achieved toward an integrated approach to quality management by review of UHS governance structures, however a lack of resources and competing priorities has resulted in a delay in establishing a quality dashboard - this objective remains amber.

**Pioneering research and innovation** have delivered successfully on both their objectives through 24/25. Over the past year R&D have successfully delivered year 4 of the research and innovation investment plan which has seen cohort four of the Research Leaders Programme start and tracking of the return of investment on cohort one through the appointment of a new project manager. Planning is now underway for implementation of year 6.

In addition, year 2 of the five-year R&D strategy implementation plan has been progressed, developing initiatives to recognise staff engaging in research, identifying and tracking clear returns on investment from the research leaders programme and working collaboratively with University of Southampton.

**World class people** have seen achievements in reducing turnover to 10.1% at year-end against a target of 13% and absences has fallen below the 4% target, with UHS benchmarking well nationally, and our policies and practices recognised and used across Hampshire and the Isle of Wight.

In what has been an incredibly challenging financial year, UHS has also made progress against delivery of the UHS People Strategy and the Belonging and Inclusion Strategy. UHS has seen the continued investment in leadership and management development programmes, and positive action leadership programmes for staff. UHS was in receipt of 250K of charity funding which has led to numerous staff wellbeing opportunities to be realised throughout the year such as improvements to the chapel, staff room refurbishments, staff recognition and celebration events.

UHS also experienced an industrial dispute around portering services which required considerable time and resourcing to successfully resolve and overcome. In addition, the annual survey although broadly static in results, did show a downturn in participation from 41% to 39%, demonstrating further work is required to engage our workforce.

**Integrated Networks and Collaboration** has seen progress made in developing the identified priority clinical networks (e.g. Plastics, Neurology etc). UHS continues to strengthen its relationships with other hospitals such as Hampshire Hospitals and Salisbury.

However, UHS continues to face challenges in reducing No Criteria to Reside (nCTR) patients and continues to work with the local delivery system in identifying support and actions to actively reduce numbers. Work is continuing to improve processes particularly across the “pathway one” patient group. Moving into the new year the ICB are resetting the discharge programme, with a renewed focus on internal standards and process improvements.

**Foundations of the future** has seen particular success in all three of the transformation programmes, with successful achievement leading to increases in patients treated by the hospital. UHS has also successfully delivered on the Trust’s capital programme with £45 million spent in M12 and a total of £96 million for 2024-25.

The overall PTL growth throughout the year has been slowed due to improved demand and capacity balance in a number of areas as well as an increase in referral rejections. There has been an increase in the last quarter attributed to waiting list growth in dermatology, clinical genetics, cardiology, gynaecology, and gastroenterology. Monitoring of these areas will highlight if there is an ongoing trend.

Lastly year 2 of the public sector decarbonisation scheme has had a challenging year which saw significant disruption to the programme due to the issues around the low temperature water systems which facilitates de-steaming. Although not all programmes are fully achieved, resolutions have been identified and programmes are back on track with the heat pump facility progressing well and installation of solar panels commencing from May 2025.

The areas with the highest number of objectives outstanding or greatest risks were:

- World Class People
- Foundations of the future

***World Class People***: The most challenged objective in this area was achievement of our workforce plan, which ended the year 373 WTE over plan. This was predominantly because of the lack of delivery within system programmes related to reducing nCTR and mental health demand. All surge areas also remained open during March due to ongoing high emergency demand.

The Trust has set out and agreed its workforce plan for 25/26. Increased recruitment controls have been implemented including a significant reduction of non-clinical recruitment and targeting recruitment to 70% of replacement clinical posts.

Divisions have been asked to review opportunities for 5% pay cost savings, and THQ functions have been asked to review 10% as part of achieving the 25/26 plan.

***Foundations of the Future:*** The most challenged objective in this area was achievement of the financial plan for 2024/25.

UHS ended 24/25 with a £7.0m deficit for the year. This is in line with the forecast submitted to NHS England and is in line with the HIOW ICB ‘landing plan.’

UHS continues to deliver significant levels of financial savings (£85.3m in 24/25 achieving the required plan), from UHS transformation programmes on patient flow, theatres, and outpatients.

One of the main underlying deficit drivers continues to be the non-delivery of system transformation initiatives, in particular, non-criteria to reside (NCTR) and mental health support.

The Trust continues to overtrade – undertaking activities beyond funding received. Additional rigour continues to be applied around financial grip and governance ensuring strong controls are in place. This includes a weekly FIG (Finance Improvement Group) being supported by the Financial Improvement Director with attendance from all divisions and directorates. The Trust also continues to work with Deloitte around savings opportunities.

There is a significant risk in Q1 2025/26 that cash will reduce close to zero and mitigations are currently being explored and the subject of separate discussions.

**Summary**

The Board is asked to note the progress that was made in delivering the corporate objectives for 2024/25, particularly considering the political contextual issues and ongoing financial challenges.

**The table below shows only Q3 and Q4 updates against each objective for ease of reading.**

**Outstanding patient outcomes, safety, and experience**

| Ref | Lead | Objective | Q3 Update | Q4 Update |
|---|---|---|---|---|
| 1(a) | CNO | Establish an integrated approach to quality management through review of current governance structures, aligning work in the domains of safety, outcomes, experience, and improvement and consolidation of management information in a quality dashboard. | Partially achieved: Work continues on the integrated quality report expected to be tabled at TEC in Q4 and a workshop is planned to create a specification for a revised quality dashboard across the quality teams however both of these items have been delayed from Q2 and Q3. Engagement and learning from others continues with Royal Berkshire and Salisbury to inform future approaches. | Partially achieved: Working group established to develop an integrated quality dashboard that will work throughout 25/26. Integrated quality governance will now be a consideration within the divisional restructure process and an EQIA panel is being formed to manage the quality impacts of our financial improvement work. |
| Ref | Lead | Objective | Q3 Update | Q4 Update |
| 1(b) | COO | Treat patients according to need but aim to meet national target of zero 65 week waiters by end of September 2024, and continued reduction of longer waiters subsequent to this. | The positive work in this area continues, although there has been a very slight increase in outstanding 65 week waiters with the current total being 56. The majority of which are with ophthalmology and surgery. | As the positive work continues this can be seen by the waiting list dropping to 23 for outstanding 65 week waiters and is above average comparatively across the country. |

| Ref | Lead | Objective | Q3 Update | Q4 Update |
|---|---|---|---|---|
| 1(c) | COO | Reduce length of stay across elective and non-elective pathways by focusing on inpatient flow improvement | On plan: Length of Stay reduced by 4.65% this year against 5% target. However, sustained high attendances in the emergency department couple with non-criteria to reside patients still averaging 225 each day is impacting patient flow. A discharge week followed by a complex discharge workshop with system partners was held in December to agree a shared action plan on nCTR. | Delivered: Length of Stay reduced by 5.26% this year exceeding the 5% target. Following the discharge week and workshop in Q3, Pathway 1-3 LoS reduced by 2.37% on the year. However, sustained high winter attendances in the emergency department and persistent non-criteria to reside patients still averaging 225 each day impacted patient flow and ED performance. |

| Ref | Lead | Objective | Q3 Update | Q4 Update |
|---|---|---|---|---|
| 1(d) | CNO/ CMO | Improve patient experience and outcomes through continued implementation of the 'Fundamentals of Care' programme. | As a key Fundamentals of Care workstream 'What Matters to Me' pilot was started on F7 and G7 but due to volunteer recruitment challenges this is on pause until Volunteering for Health funding is released from a regional partnership in April 2025.<br>The campaign remains successful with some work on sharing the messaging at local universities, alongside different internal platforms. Project Manager engaged to embed the FoC into the new Clinical Quality Dashboard for effective monitoring of developments and progress. Links built with existing Proportionate Care workstream to build the Enhancing Safe Movement work and support a reduction of length of stay in collaboration with AHP teams. | 'What Matters To Me' is paused currently due to challenges with the pilot and lack of funding from the Volunteering For Health big. Funding due to come in June 2025 to provide a volunteer coordinator to support this project.<br>Collaboration has started successfully with the Head of Clinical Quality Assurance in aligning the FoC plan for 2025 with matron's walkabout and CAS. This embeds the FoC into the Matron's Walkabout and CAS processes with monthly focusses and have started with Patient Weights, Infection Prevention, Patient Safety and will include Skin Integrity, Diabetes and End of Life care in the next quarter.<br>Establishing stronger relationships with nursing/care homes, community care providers and unpaid carers through a FoC and discharge focussed engagement event which took place on the 1st May 2025 as part of Patient Experience Week 2025 and saw 25 representatives of the caring community representing their voice. |

**Research and Innovation**

| Ref | Lead | Objective | Q3 Update | Q4 Update |
|---|---|---|---|---|
| 2(a) | CMO | Deliver year 4 of the research and innovation investment plan, including the Southampton Emerging Therapies and Technologies Centre (SETT), Research Leaders programme (RLP) and delivery infrastructure. Anticipate an impact on growth in activity and the financial return from the investment as a result of staffing challenges across the research infrastructure. | On track. New Project Manager in place from start of Q3 with development and implementation of RLP awardee tracking now underway. SETT conference held in Q3 for >120 attendees received excellent feedback. Study numbers, conversion rates and long-term ambition to take place in Q4 as part of year 5 investment case planning. Activity growth and financial return from the investment case continues to be closely monitored, staffing has been challenging this year with some areas still feeling capacity constraints which have had an impact on activity levels. | Completed. Planning for 'year 6' (once investment case finishes) is underway. There has been an impact on the anticipated growth of activity due to staffing challenges across the infrastructure as predicted at the start of the year. |

| Ref | Lead | Objective | Q3 Update | Q4 Update |
|---|---|---|---|---|
| 2(b) | CMO | Deliver Year 2 of the five-year R&D strategy implementation plan (revised) for Research for Impact.<br>•Develop a set of initiatives to recognise and reward staff for engaging in research.<br>•Show a clear return on investment of the Research Leaders Programme.<br>•Develop a set of initiatives with QI, education, and innovation teams to develop an approach to collaborative / system working.<br>•Agree UHS/UoS collaborative clinical research centres of excellence and areas of strategic growth. | In progress/On track – implementation plan has been put into action with baseline measures collated and working groups formulating. In Q3, the RLP Annual Report was published, shared via R&D Comms outlets and copies shared directly with research leaders within the region. RLP metrics were presented in JEG-R and in Annual Report, demonstrating ROI of RLP. We have now mapped overlapping areas between UHS and UoS which will give us strategic priority areas to focus on. | In progress.<br>•Phase 1 of initiatives mapping completed with main initiatives identified. Mapping and results due for completion in Q1 25/26.<br>•Return on investment for Research Leaders Programme demonstrated with latest awarded cohort being the largest and most diverse to date.<br>•Agreement of areas of strategic growth to align with BRC application planning in 25/26 – plan to be implemented in 25/26. |

## World Class People

| Ref | Lead | Objective | Q3 Update | Q4 Update |
|---|---|---|---|---|
| 3(a) | CPO | To deliver a workforce plan for UHS for 2024/25 which is safe, sustainable and affordable. | At the end of December, as Forecast, the Trust is 7 above its NHS overall NHS plan. This is through a combination of planned increases of substantive staff during September and October for newly qualified employees and the NHSE plan reducing during Q3 and Q4. The reductions in the NHSE plan were based primarily on 218 WTE in both temporary and permanent staff linked to significant improvements in mental health and NCTR. Performance in these areas, linked to large-scale system transformation, has not improved and thus closure of bed capacity has not been possible. The plan is significantly backloaded to Q4 so it is anticipated we will move further away from plan.<br><br>Divisions are all still operating within their AWL limits as part of UHS controls and are forecast to remain so for the remainder of the 24/25.<br><br>At present the forecast for the end of year 24/25 is for UHS to finish at a total workforce (Substantive, bank and agency) of 13424 WTE which would be 146 over plan. | As of M12, the Trust is over the total plan (by 373 WTE).Substantive workforce fell in March, the overall workforce increased, driven by high bank usage in March. Substantive workforce reduced by 11 WTE to 12,690. The level of leavers was again lower than forecast and much lower than levels that would normally be seen in March.<br>All surge areas remained open during March. Whilst sickness fell, overall annual leave higher as staff utilised leave prior to year-end. This combined with a spike in mental health drove the higher level of bank. We are re-reviewing bank controls again in line with the increased target reduction for 2025/26 and a proposal is being considered through financial improvement group (FIG).<br><br>The Trust has set out and agreed its WF plan for 25/26. Increased recruitment controls have been implemented including a freeze on non-clinical recruitment, and only recruiting to 70% of clinical posts that leave.<br><br>Divisions have been asked to review opportunities for 5% pay cost savings, and THQ functions have been asked to review 10%. |

| Ref | Lead | Objective | Q2 Update | Q4 Update |
|---|---|---|---|---|
| 3(b) | CPO | To deliver targeted improvements in staff experience, engagement, and culture in line with the UHS People Strategy and Belonging and Inclusion Strategy. | Annual staff survey closed in December with participation rates below target and below the national average participation rates.<br><br>Full results remain embargoed until February 2025.<br><br>Significant focus has been placed on key risk areas. An industrial dispute with the portering department led by UNITE has been. The Trust has been in negotiations with UNITE, with support from ACAS regarding the porters dispute. A deal has been reached and focus now turns to implementation.<br><br>There has also been targeted work in Cardiac services to try to improve culture and capacity.<br><br>WeAreUHS week took place in October which proved to be a popular and well attended event. The Trust also celebrated the achievements of its staff during October at the We are UHS Champions awards. Over 600 nominations were made, a record for UHS.<br><br>UHS launched the #proudtobeadmin and #proudtobeops movements in partnership with the national support team. Events where attended by over 100 staff as a platform for creating a greater community with these vital roles. | Annual staff survey results showed a drop in participation from 2023, now at 39% from 41% previously. Broadly the results remained the consistent to 2023, with no significant declines or improvements. There were small improvements in satisfaction with flexible working, immediate managers and quality of appraisals, and encouraging signs of progress in relation to people feeling confident to report concerns.<br><br>Our Leadership and Management Development programmes have continued inn Q4. Three cohorts of our Operational and Team Leader programmes, as well as the launch of the Emerging Managers programme for new or aspiring managers. National Administrative Professionals Day saw the continued embedding of Proud2BAdmin network across the organisation. Health Care Science Week was also held with a variety of activities recognising and rewarding the work of Health Care Scientists in the NHS and within UHS.<br><br>Improvements to our Chapel specifically for Muslim staff, patients and visitors to carry our ablutions prior to prayer were unveiled, funded by the Hospital Charity. These new facilities have had a significant positive impact on the experience of the Muslim community at UHS.<br><br>Another cohort of our Positive Action Leadership Programme graduated in February 2025, this programme continues to have successful outcomes for participants and excellent feedback.<br>Due to the significant organisational change across UHS a series of support mechanisms have been developed to ensure managers and leaders are equipped and confident to lead people in times of ambiguity and challenge. Three workshops will be launched in Q1 25/26 and supportive team wellbeing offers. |

| Ref | Lead | Objective | Q3 Update | Q4 Update |
|---|---|---|---|---|
| 3(c) | CPO | To sustain turnover at less than 13% and maintain sickness absence under 4% to March 2025. | Turnover has reduced again in November, taking the UHS rate to 10.7% and well below target of 13.6%.<br><br>Overall sickness in December was 4.1% but rolling average remains below target.<br><br>The Trust has launched its Flu and COVID campaigns. At present uptake (both locally and nationally) is lower than desired. Uptake is currently 52% for Flu and 36% for COVID. | The sickness rate has fallen back below the target in March as winter illness has reduced. UHS continues to benchmark well on absence, and our policy and practice is being used as good practice across HIOW as part of a project to improve attendance.<br>Turnover at year end was 10.1%, significantly below the target of 13%. |

## Networks and Collaboration

| Ref | Lead | Objective | Q3 Update | Q4 Update |
|---|---|---|---|---|
| 4(a) | CMO | Work in partnership with acute trusts, working directly with priority areas to progress joint network strategies with the principle aim to create capacity onsite. Internally embed networking frameworks to drive delivery and demonstrate progress against the UHS maturity networks. | Minor delays/partially achieved – progress is being made in all priority areas.<br>**Plastics** – The working group has finalised the demand data and started assessment of income potential and modelling staffing options. Working with planning team on progress towards business case.<br>**Urology** – Progress remains challenging due to conflicting pressures and availability. There is a meeting scheduled in January to continue the work on the BPH pathway and another to look at MyMR. Urology is listed within the ICB priority programme.<br>**Upper GI** – The ICB has communicated that there needs to be one central service for the region that will include UHS, PHU and UHD. Going forward this work will be organised by the ICB.<br>**Pelvic Floor** – All three working groups have made significant progress and are close to finalising the initial objectives. The network will look to conduct a GAP analysis and organise an in-person meeting in March 2025 to discuss next steps.<br>**Neurology** – On October 18th there was a meeting between UHD/UHD to discuss the possibility of joint recruitment to support sustainability of the UHD service. It was agreed that there were good reasons to explore this and other areas of collaboration, such as MT cover, research trials, epilepsy nurse support. A working group has been organised which will meet in January.<br>Amber due to conflicting pressures and commitment to move forward. | Minor delays/ partially achieved - progress is being made in all priority areas.<br>**Plastics** – The network now has a dedicated planner supporting the working group in assembling all the necessary elements for the business case. Bi-weekly planning meetings and the monthly oversight group continue. There will be a workshop in June to address key questions including the scope of the project and business case options. It will also cover potential solutions, delivery models, phasing, and funding.<br>**Urology** – Progress remains challenging due to conflicting pressures and availability. The BPH working group met on the 4th of March and agreed on implementing changes to the pathway. Urology is listed within the ICB priority programme.<br>**Upper GI** – The ICB has communicated that there needs to be one central service for the region that will include UHS, PHU and UHD – but progress has been slow. Since late December the work has been organised by the ICB.<br>**Pelvic Floor** – All three working groups have made significant progress and are nearing completion of their initial objectives. A face-to-face meeting was held on 24th March, during which each step of the pathway was explored in greater detail. The network is now beginning to develop a strategic outline that will inform the upcoming business case.<br>**Neurology** – The working group held its second meeting on 24th February to discuss the structure of a joint recruitment role between UHS and UHD. It was agreed that the role will include three general neurology clinics per week, a half-day specialist clinic in Southampton, participation in the on-call rota, inpatient reviews for Dorset patients admitted to UHS, and access to Southampton's specialist MDTs. The next steps for the network are for Dorset to finalise the job plan and funding strategy, and to prepare the job advertisement by the end of June. |

| Ref | Lead | Objective | Q3 Update | Q4 Update |
|---|---|---|---|---|
| 4(b) | COO | Work with the Local Delivery System on vertical integration to reduce the number of patients without criteria to reside in UHS. | Patients without a criteria to reside in hospital remain very high.<br><br>2 key actions have taken place:- a discharge focus week was held between UHS and key partners and a workshop with all partners to focus on P1 delays and gaining a mutual understanding of the issues.<br><br>From these events an action plan to address the issues identified is being jointly agreed across the system with support from UHS transformation team.<br><br>Alongside this a visit was made to Oxford University Hospitals who have a very low number of patients without a criteria to reside. To progress a model of this nature a business case for investment would be required e.g. additional discharge officers, additional short term beds, changes to | The number of patients not meeting the criteria to reside remains unchanged. Work continues on improving processes, particularly across Pathway 1, to reduce delays. However, this is not currently having the required impact on the number of patients remaining in hospital. The ICB is re-setting the discharge programme, with a renewed focus on internal standards and process improvements. |

## Foundations of the future

| Ref | Lead | Objective | Q3 Update | Q4 Update |
|---|---|---|---|---|
| 5(a) | CFO | Deliver a stretching financial plan for 2024/25, including identifying what needs to be true to recover to a sustainable financial position and exit RSP. This will be supported by delivery of the CIP plan and improvements in productivity across all Divisions/Departments. | UHS financial position of £22.7m YTD deficit, £19.3m adverse to plan.<br><br>UHS has continued to deliver significant levels of savings (£48m YTD) and continues to benchmark well; however, the underlying position remains challenging at £6m per month deficit.<br><br>The main drivers of the deficit continue to be system-wide pressures, including NCTR, Mental Health and UEC activity. The Trust is effectively overtrading by undertaking activities well beyond funded levels.<br><br>The cash position has deteriorated to £14.7m, with a risk that cash reduces close to £0 in the coming months. | UHS has reported a breakeven position in month and a £7.0m deficit for the year. This is in line with the forecast submitted to NHS England, and is in line with the HIOW ICB 'landing plan'.<br><br>UHS continues to deliver significant levels of financial savings (£85.3m in 24/25 achieving the required plan), from UHS transformation programmes on patient flow, theatres and outpatients.<br><br>One of the main underlying deficit drivers continues to be the non-delivery of system transformation initiatives, in particular, Non-Criteria to Reside (NCTR).<br><br>The Trust continues to overtrade – undertaking activities beyond funding received. Additional rigour continues to be applied around financial grip and governance ensuring strong controls are in place. This includes a weekly FIG (Finance Improvement Group) being supported by the Financial Improvement Director with attendance from all divisions and directorates. The Trust also continues to work with Deloitte around savings opportunities.<br><br>Cash has increased to £16.9m in month, as per forecast. There is a significant risk in Q1 2025/26 that cash will reduce close to zero and mitigations are currently being explored and the subject of a further paper. |

| Ref | Lead | Objective | Q3 Update | Q4 Update |
|---|---|---|---|---|
| 5(b) | CEO | Engage the organisation in the challenge to manage demand so that capacity and demand are in equilibrium. Stop the PTL growth by Q3 and begin to see a reduction of the PTL in Q4. | PTL has remained static for the second quarter in a row at around 60K. The transformation team continue to deliver the agreed initiatives. | The PTL has slightly increased to just over 61.5k. The trending increases for quarter 4 are evident in dermatology, clinical genetics, cardiology, gynaecology and gastroenterology. These 5 areas account for increase of 1.2k of the overall PTL. |

| Ref | Lead | Objective | Q3 Update | Q4 Update |
|---|---|---|---|---|
| 5(c) | CNO | Deliver the aims of the 24/25 Transformation programmes and Always Improving strategic priorities. Realise targeted reductions in length of stay and outpatient follow-up and increases in theatre utilisation whilst increasing our maturity against the NHS Impact framework | All programmes continue to deliver improvements in key metrics (4.65% length of stay reduction, 52.8% new & OP procedure appts, 1,150 additional theatre cases) projecting delivery of 72% of the productivity benefits in our plans (£20.1m vs £27.6m). NHS IMPACT guides and benchmarking, the elective recovery plan and GIRFT Further Faster continue to drive focus and 25/26 plans. | All 3 programme achieved their key programme aims: 5.26% reduction in length of stay, reached 58% new and OPPROC appointments in outpatients and saw 1,211 additional patients in theatres. Plans for 25/26 reviewed and approved by TOG. |

| Ref | Lead | Objective | Q3 Update | Q4 Update |
|---|---|---|---|---|
| 5(d) | CFO | Deliver the prioritised 2024/25 capital programme and set a prioritised capital plan for 2025/26, as well as setting aspirations for future year programmes. | The Trust's capital programme is £11.6m behind plan YTD, with £50.4m to be spent in the remainder of the financial year. Slippage risks on schemes are currently being reviewed with the capital planning process for 2025/26 and 2026/27 having now commenced. | The Trust's capital programme ended the year as per the required forecast, with £45m spent in M12 to deliver this. Capital expenditure totalled £96m in 2024/25. |

| Ref | Lead | Objective | Q3 Update | Q4 Update |
|---|---|---|---|---|
| 5(e) | CMO | Complete Year 2 of the Public Sector Decarbonisation Scheme | The LED lighting and R22 split A/C replacements have both been completed along with the improvements required to the energy centre.<br>The AHU's and Solar CP will be completed but with a slight slippage on the timelines projected for September 2025.<br>The heat pump and desteam work remains with an amber rating due to timelines and the required extra capital for 2025/26 to complete the project. A paper went to Finance and investment committee in February.<br>It has been proposed to pause the L&P cladding and windows until additional funding can be sourced, this will allow the completion of the above projects. | A redesign to the programme on LTHW (low temperature hot water system) has slipped to November 2025 with remaining resilience equipment to be installed by Feb 2026. There remains risk in the programme: the cost of fuel for the temporary generators has increased , this is being compared against cost to run Plant Rooms as previously understood one would offset other. Additionally, risk in completing design of the above ground route as stanchion base locations and route through skybridge need full sign off by Trust stakeholders particularly regarding installation approach and impact to site, costs also need to be fixed but are currently within allowed budget.<br>Heat Pump Facility progressing with slab in place and steel frame under construction. Currently on programme for mid-September completion.<br>MSCP4 Solar CP aiming to mobilise late May with works likely to start in mid-June and currently aiming to complete works in mid-October.<br>Accruals 2 was submitted on time to Salix, this aimed to drawdown the full grant however this is currently subject to scrutiny by Salix and awaiting further update. |

University Hospital Southampton
NHS Foundation Trust

| Agenda Item 6.2 Report to the Trust Board of Directors, 13 May 2025 | |
|---|---|
| **Title:** | Board Assurance Framework (BAF) |
| **Sponsor:** | Gail Byrne, Chief Nursing Officer |
| **Author:** | Lauren Anderson, Corporate Governance & Risk Manager<br>Craig Machell, Associate Director of Corporate Affairs |

**Purpose**

| (Re)Assurance | Approval | Ratification | Information |
|---|---|---|---|
| x | | | x |

**Strategic Theme**

| Outstanding patient outcomes, safety and experience | Pioneering research and innovation | World class people | Integrated networks and collaboration | Foundations for the future |
|---|---|---|---|---|
| x | x | x | x | x |

**Executive Summary:**

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.

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.

The Board is asked to note the updated Board Assurance Framework and information contained within this report.

**Contents:**

Paper
Appendix A – The full Board Assurance Framework

**Risk(s):**

All BAF risks are contained within this report as well as the linked operational risks where applicable.

| Equality Impact Consideration: | N/A |
|---|---|

## 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 subcommittee 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 2025. Since then, all risks have been reviewed and updated by the responsible executive(s) and the appropriate BAF risks have also been reviewed at Finance & Investment Committee, People Board, and Quality Committee during this period.

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

**2.3.** No risk ratings have been amended however the target date for risk mitigation has been extended for three risks:

- Risk 2a (research and innovation) has been extended until the end of the financial year as it is predicted that the recent improvement in performance will be challenging to sustain within the current climate.

- Risks 3a (staffing availability) and 3b (diverse, compassionate and inclusive workforce) have both been extended until 2030 to ensure that they strategically align with other risks contained within the BAF given the interdependencies, as well as the totality of risk accumulating given the current financial and workforce pressures.

**2.4.** At present there are 6 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.

University Hospital Southampton NHS
NHS Foundation Trust

# UHS Board Assurance Framework (BAF)

Updated April 2025

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

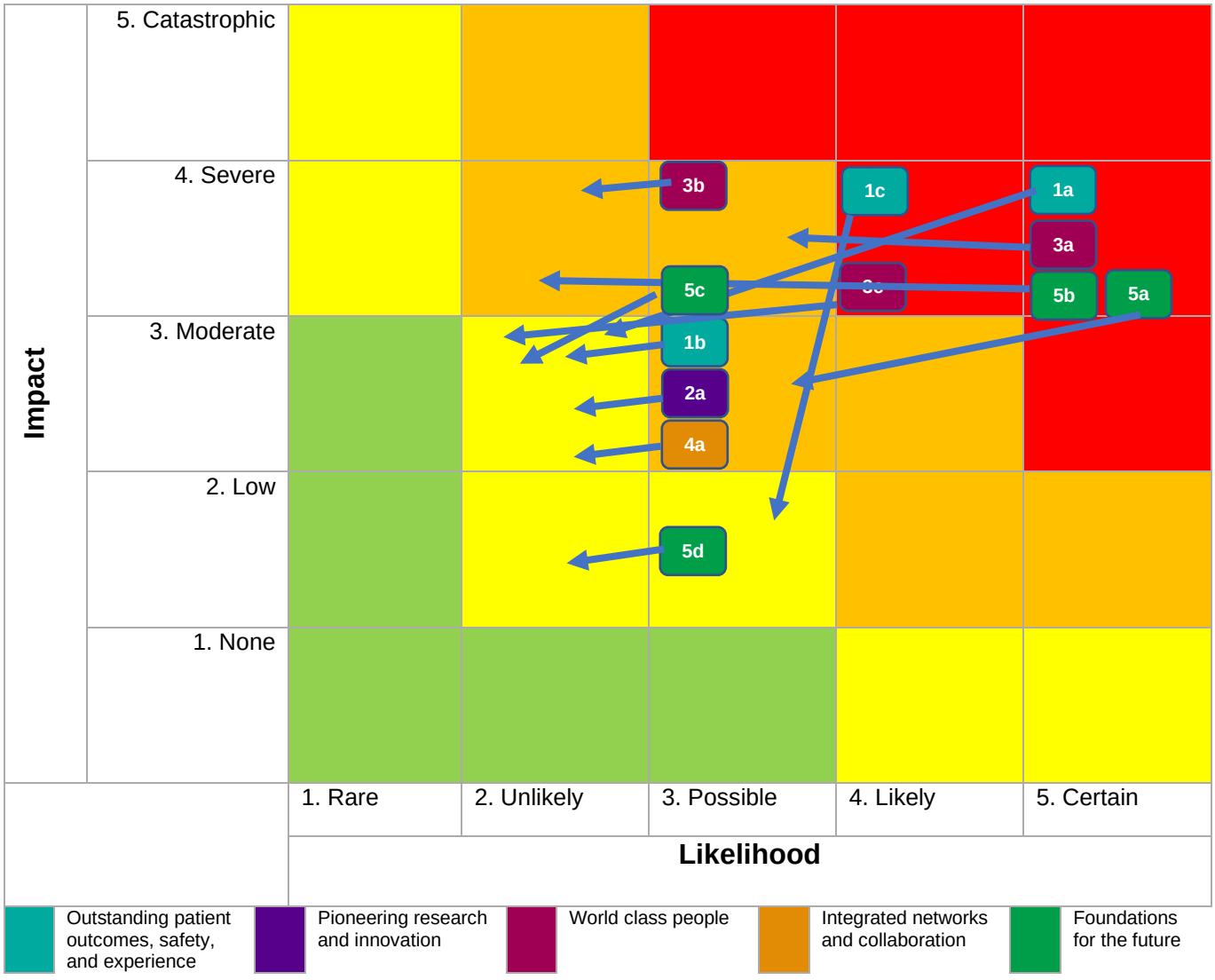
There are 6 critical strategic risks with a red risk rating above 15. These are:

- 1a) Capacity (4 x 5 = 20)
- 1c) Infection Prevention (4 x 4 = 16)
- 3a) Staffing (4 x 5 = 20)
- 3c) Future Workforce Planning inc. Training & Development (4 x 4 = 16)
- 5a) Finances (4 x 5 = 20)
- 5b) Estates (4 x 5 = 20)

At present there are 6 risks with a current risk rating outside of the optimal or tolerable appetite. These are: 1a, 1c, 3a, 3c, 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<br>*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<br>20 | April<br>2022 | 4 x 5<br>20 | April<br>2025 | 3 x 2<br>6 | April<br>2027 |

| **Risk progression:** (previous 12 months) | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 | Feb 25 | Mar 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 |

### Current assurances and updates

This risk has been reviewed by the responsible executives in April 2025 with minor updates included within the controls, assurances, and actions as appropriate to ensure the risk is current. No revisions to the risk rating or target are required at this time.

Current updates and assurances include:

- Funding for an Urgent Treatment Centre at Southampton General Hospital has been confirmed and it is anticipated that this will be opened in March 2026. Additionally, funding for phase 2 of the Same Day Emergency Care is confirmed with an expected opening of March 2026.
- Work continues to reconfigure the ambulatory majors corridor in ED, facilitating a better line of sight of patients which may reduce the number of admissions. It is now anticipated that this will be completed in May 2025.
- Further to the visit from the Emergency Care Intensive Support Team in February 2024, a second visit is planned in May 2025 to support in identifying improvements.

| Key controls | Gaps in controls |
|---|---|
| Clinical Prioritisation Framework.<br>Triage of patient lists based on risk of harm with consultant led flagging of patients of concern.<br>Capacity and demand planning, including plans for surge beds and specific seasonal planning.<br>Patient flow programme to reduce length of stay and improve discharge. 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 | 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.<br>Limited funding, workforce, and estate to address capacity mismatch in a timely way.<br>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. However emerging NHS HIOW transformation programmes are focussed on |

| | |
|---|---|
| underpinning the objectives include criteria led discharge and discharge lounge use.<br>Outpatients and operating services transformation programme focused on improving utilisation of existing capacity and reducing follow up demand.<br>Use of independent sector to increase capacity.<br>Urgent and Emergency Care Board established to drive improvements across UEC pathways.<br>UEC recovery plan to support improvements across UEC pathways.<br>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.<br>Rapid Improvement Plans to support improvements across cancer pathways. | discharge, planned care, local mental health care, and urgent and emergency care.<br>Challenges in staffing ED department during periods of extreme pressure.<br>Ongoing industrial action through 23-24 and into 24-25 has presented significant risk to the Trust's ability to meet ongoing demand on our services. This could continue into 25-26.<br>Staff capacity to engage in quality improvement projects due to focus on managing operational pressures.<br>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.<br>Lack of a clear capacity and demand plan to resolve cardiac capacity issues.<br>Lack of sustainable capacity in some specialities resulting in long wait breaches, e.g. gynae, ENT, some cancer specialities. |
| **Key assurances** | **Gaps in assurances** |
| Clinical Assurance Framework, reported quarterly to the executive. Reported bi-weekly via CPRP.<br>Harm reviews identifying cases where delays have caused harm.<br>Weekly divisional performance meetings with a particular focus on cancer and long waiting patients.<br>Live monitoring of bed occupancy and capacity data.<br>Monitoring and reporting of waiting times.<br>Implementation of PSIRF with oversight of red incidents at TEC.<br>Transformation programme work plans.<br>An assurance paper was taken to Trust Board in September 2024 in response to a recent BBC Dispatches documentary secretly filmed at Royal Shrewsbury Hospital showing significant delays in urgent and emergency care, and subsequent letter from NHSE outlining steps acute organisations must take to mitigate against potential similar concerns.<br>NHSE and NHS HIOW ICS supportive quality visit to ED (September 2024).<br>Increase in advice & guidance referrals. | Local system plans to reduce patients without a criteria to reside are emerging but will take time to evidence results. |
| **Key actions** | |
| Establish local delivery system plan for reducing delays and NCTR throughout the hospital.<br>Deliver ERF targets for 2024/25 to secure additional funding and address waiting lists - complete. Activity targets for 2025/26 set:<br>- < 1% patients waiting over 52 weeks<br>- > 72% of patients seen with 18 weeks<br>Pursue significant improvement in cardiac wait times through development of a demand and capacity plan and mutual aid.<br>Community Diagnostic Hub opening in 2025/26 to provide additional diagnostic capacity. Previously scheduled for 2023/4 however this has been delayed following redesign. | |

New theatres and MRI suite scheduled to open in September 2024 - complete. 5 new all day theatre lists opened.

Engagement in the NHSE Further Faster programme for elective care.

Continued delivery of improvement work in 2024/25 and 2025/26 on patient flow and optimising operating services and outpatients through the elective and UEC transformation programmes.

An external visit from the Emergency Care Intensive Support Team (ECIST) 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. Revised pathways have been trialled in ambulatory majors and pitstop both demonstrating improved safety and more timely access. Pilot is being reviewed and implemented further. A further ECIST visit is planned in May 2025.

Following a successful trial in Portsmouth, a single point of access within the ambulance service will commence with support from our ED clinicians. The intent is to divert suitable patients away from ED to the most appropriate place of care which may be in the community, or may be a direct speciality admission. Work is being led by the ICB to identify appropriate and affordable delivery of this.

**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 3 = 9 | 3 x 2 = 6 | 28/02/2025 |
| 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 | 30/06/2025 |
| 259 | Capacity and Demand in Maternity Services | 5 x 5 = 25 | 2 x 2 = 4 | 30/04/2025 |
| 266 | There is a risk that Maternity and Obstetric Theatre Capacity and availability is not able to meet demand at PAH this includes elective and emergency C-section capacity | 4 x 4 = 16 | 2 x 2 = 4 | 06/01/2025 |
| 395 | This risk is related to the cardiac surgical patients who are on our waiting list that may come to harm whilst they wait for their surgery. | 4 x 5 = 20 | 2 x 3 = 6 | 30/06/2025 |
| 443 | Lack of capacity within the sleep service resulting in long waits for respiratory and neurological sleep studies, and long waits for outpatient appointments within the neurological sleep service. | 3 x 4 = 12 | 3 x 2 = 6 | 31/07/2025 |
| 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 | 16/12/2024 |
| 473 | Insufficient capacity within the Paediatric Neurology to cope with current demand. | 3 x 3 = 9 | 2 x 2 = 4 | 11/04/2025 |
| 610 | Insufficient capacity to provide a safe and effective Out of Hours medical and ANP service across Div B | 4 x 3 = 12 | 3 x 2 = 6 | 30/04/2025 |
| 652 | Prostate cancer capacity | 4 x 4 = 16 | 3 x 2 = 6 | 31/08/2025 |
| 671 | Capacity within the melanoma and soft tissue cancer pathways. | 3 x 4 = 12 | 3 x 2 = 6 | 31/10/2025 |
| 681 | Adult inpatient pain service is struggling to deliver a robust service - demand is exceeding the current capacity in the pain service. | 3 x 4 = 12 | 3 x 1 = 3 | 31/03/2025 |
| 687 | Impact on patient care due to delayed recovery discharges, because of lack of patient flow throughout the hospital. | 3 x 4 = 125 = 15 | 3 x 1 = 3 | 31/03/2025 |
| 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 | 30/06/2025 |
| 758 | Urology stone service - including stent change delays & capacity challenges | 4 x 4 = 16 | 3 x 2 = 6 | 31/10/2025 |
| 766 | Inability to deliver a critical service to those with a life threating illness/injury due to our resuscitation bays being | 5 x 5 = 25 | 4 x 2 = 8 | 30/06/2025 |

| | | | | |
|---|---|---|---|---|
| | overcrowded. Compromised ability to function as the Regional Major Trauma Centre. | | | |
| 767 | HoLEP capacity issues | 3 x 3 = 9 | 3 x 1 = 3 | 31/07/2025 |
| 775 | Patients with kidney cancer may experience worse outcomes and survival due to capacity issues and delays in their treatment pathways | 4 x 3 = 12 | 4 x 1 = 4 | 31/07/2025 |
| 804 | Congenital cardiac (adult & paeds) surgery demand | 4 x 4 = 16 | 4 x 2 = 8 | 30/09/2025 |
| 814 | Inability to provide a safe pleural service | 4 x 1= 4 | 2 x 2 = 4 | 30/05/2025 |
| 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 | 31/03/2026 |
| 822 | Ophthalmology Glaucoma Capacity | 4 x 4 = 16 | 4 x 4 = 16 | 30/06/2025 |
| 823 | Ophthalmology Medical Retina Service Capacity | 4 x 4 = 16 | 4 x 2 = 8 | 30/09/2025 |
| 840 | Paediatric haemodialysis capacity | 4 x 3 = 12 | 2 x 2 = 4 | 18/04/2025 |
| 845 | There is a risk that the obstetrics service will be compromised due to excess levels of demand and unmatched capacity within the consultant team | 3 x 4 = 12 | 4 x 1 = 4 | 01/04/2025 |
| 850 | Inability to effectively run the pelvic floor service due to staffing and capacity | 3 x 3 = 9 | 2 x 2 = 4 | 31/08/2025 |
| 857 | Prostate PIFU Capacity | 4 x 3 = 12 | 3 x 2 = 6 | 31/12/2025 |
| 890 | Risk of Patient Harm and Increased Admissions Due to Heart Failure Service Capacity Issues | 4 x 3 = 12 | 4 x 1 = 4 | 31/12/2025 |

**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<br>*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<br>9 | April<br>2022 | 3 x 3<br>9 | April<br>2025 | 3 x 2<br>6 | March<br>2026 |

| **Risk progression:** (previous 12 months) | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 | Feb 25 | Mar 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 |

**Current assurances and updates**

- This risk has been reviewed by the responsible executive leads in April 2025. No revisions to the risk rating or targets are required.
- Full deployment and implementation of NATSIPPS2 continues to be a priority for the organisation and actions are progressing with the invasive procedures committee now established and two meetings held to date, as well as a number of audits underway, and actions taken around education/promotion such as introduction of the NATSIPPS2 screensavers. A thematic analysis of the organisation's recent never events has taken place and each incident is also investigated individually. This will include the most recently declared never event, in Dermatology.
- Patient Experience Week is planned for May 2025 to celebrate patient focussed initiatives and share learning. This includes a listening event for carers who are invited to engage with the organisation to share their experiences. This supports ongoing initiatives to listen to, and involve, patient voices with a directory now set up with 2500 voluntary patients who can be contacted for opinions or surveys.
- To support the recently established Financial Improvement Group (FIG), a Quality & Equality Impact Assessment Review Group is also being set up to support FIG in making informed decisions by evaluating the potential equality and quality impacts to proposed business changes.

| Key controls | Gaps in controls |
|---|---|
| Trust Patient Safety Strategy and Experience of care strategy.<br>Organisational learning embedded into incident management, complaints and claims.<br>Learning from deaths and mortality reviews.<br>Mandatory, high-quality training. | Patient experience strategy is out of date and now not in keeping with national and local objectives. New strategy to be co-designed with involved patients once the Trust strategy is finalised in 2025.<br>Staff capacity to engage in quality improvement projects due to focus on managing operational pressures . |

| | |
|---|---|
| Health and safety framework.<br>Robust safety alert, NICE and faculty guidance processes.<br>Integrated Governance Framework.<br>Trust policies, procedures, pathways and guidance.<br>Recruitment processes and regular bank staff cohort.<br>Culture of safety, honesty and candour.<br>Clear and supportive clinical leadership.<br>Delivery of 23/24 and 24/25 Always Improving Programme aims, continuing into 25/26.<br>Involvement of patients and families through our Quality Patient Safety Partners (QPSPs) in PSSG, SISG and Quality Improvement projects. Governance of this through role cards, allocation process, and annual reviews.<br>Directory of 2000 patients who are willing to engage in projects and provide a patient voice.<br>Implementation of PSIRF.<br>Patient Involvement and engagement in capital build projects<br>Working with communities to establish health inequalities and how to ensure our care is accessible and equitable. Health inequalities board established with sponsors for priorities, health inequalities liaison role sitting within patient experience, and allocation of dedicated time across multiple roles in the clinical strategy and BI teams.<br>Maternity safety champions.<br>Listening events and community engagement.<br>Equality & Quality Impact Assessment (EQIA) review group. | Reduction in head count (decreased bank utilisation) due to the measures taken because of financial challenges.<br>There is no longer any dedicated resource for SDM due to recruitment restraints and prioritisation of work. The clinical strategy team can only respond to small, adhoc, requests for support. However, work across the system on value based care will feed into this. |
| **Key assurances** | **Gaps in assurances** |
| Monitoring of patient outcomes with QPSP input.<br>CQC inspection reporting: Good overall.<br>Feedback from Royal College visits.<br>Getting it right first time (GIRFT) reporting to Quality Committee.<br>External accreditations: endoscopy, pathology, etc.<br>Kitemarks and agreed information standards.<br>Clinical accreditation scheme (with patient involvement).<br>Internal reviews into specialties, based on CQC inspection criteria.<br>Current and previous performance against NHS Constitution and other standards.<br>Matron walkabouts and executive led back to the floor.<br>Quality dashboard, KPIs, quality priorities, clinical audits and involvement in national audits.<br>Performance reporting.<br>Governance and oversight of outcomes through CAMEO and M+Ms<br>Patient Safety Strategy Oversight Committee | Ongoing industrial action through 22-23, 23-24 and 24-25, and into 25-26 presents risk to the Trust's ability to meet ongoing demand on our services. |

| | |
|---|---|
| Transformation Oversight Group (TOG) including TOG dashboard to oversee impact.<br>Health Inequalities Board<br>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).<br>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.<br>Patient experience week (May 2024 and 2025) evidencing and celebrating FFT and sharing learning from complaints. | |

**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 and beyond.

Embed learning from deaths lead & lead medical examiner roles (primary and secondary care) and develop objectives and strategy: end of life strategy was signed off and launched April 2025. Learning from death report embedded.

Introduce thematic reviews for VTE.

Implement the second round of Ockenden recommendations – completed.

**Always Improving programme**

Delivery of 23/24 and 24/25 aims of patient flow, outpatient and optimising operating services programmes and associated quality, operational and financial benefits (incl. outpatient follow-up reduction) completed with a 5% reduction in LOS and 81.7% YTD optimisation in theatres. 2025/26 projects realigned with national priorities: Emergency & Urgent Care (Flow), Improving Value, and Elective Care.

Embedding 'voice of the patient' into all improvement activities through aligning each Division with a QPSP who will champion patient insight and involvement. Complete, including QPSP at TOG. Next steps are to work closely with patient experience to embed the patients' lived experiences in all layers of improvement work and planning.

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

Introducing exec and senior leadership team walkabouts focussed on improvement have been embedded with focus on sustaining these and facilitating a continuous loop of feedback to inform decisions and measure effectiveness.

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 taken to Trust Board in December 2023.

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. This in part has started, the ED SMS survey has proven to be a success and yielded a 700% improved response rate for ED. The learning from this has now been shared trust wide and Eye Casualty and Ophthalmology are now next to move to FFT SMS, which captures a wider demographic of patients. This remains an aspiration however financial constraints, and digital capacity, cannot facilitate this at the moment.

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. This is ongoing work, there have been several vacancies in the Experience of Care, but with the recruitment of a new Head of Patient Experience there is now a renewed focus to provide divisional tailored reports at care group and divisional level.

We are listening events to be held with the 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. There has been a refresh on the 'Learning from Death' and 'Experience of Care', with both board reports now reporting on patients lived experiences and including cross sections of patient experience related AERS which previously did not feature. For example, there is a now a review of AERs relating to End of Life care and a current theme on deaths outside of a side room/private area.

**Health inequalities Programme**

The UHS health inequalities programme and board have been initiated with key priorities crossing how we enable change within our organisation, how we have impact on nationally recognised drivers of health inequalities with high prevalence in Southampton, data and measurement and engagement and communications.

A health inequalities liaison post has been recruited within patient experience. They will be working with the clinical strategy team and transformation to support the organisation to understand health inequalities, to recognise inequalities within their service provision, to make changes to reduce the impact of health inequalities and to escalate challenges and risks as required. These actions will support to improve the experience and outcomes of our patients.

**Linked operational risks**

| No. | Title | Current risk rating | Target risk rating | Target Date |
|---|---|---|---|---|
| 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 | 31/03/2025 |
| 645 | Increase in mental health patients and ligature risk in ED and AMU | 3 x 5 = 15 | 2 x 2 = 4 | 06/05/2025 |
| 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 | 31/12/2024 |
| 805 | Clinical harm and never events may occur if NATSIPPS2 cannot be embedded due to insufficient resource | 4 x 4 = 16 | 3 x 1 = 3 | 31/12/2025 |

**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<br>*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<br>9 | April<br>2022 | 4 x 4<br>16 | April<br>2025 | 2 x 3<br>6 | April<br>2027 |

| **Risk progression:** (previous 12 months) | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 | Feb 25 | Mar 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 4 x 4<br>16 | 4 x 4<br>16 | 4 x 4<br>16 | 4 x 4<br>16 | 4 x 4<br>16 | 4 x 4<br>16 |

**Current assurances and updates**

- The risk has been reviewed by the responsible executive with no alterations to the risk rating or target required at this time.
- Proactive learning with senior engagement and oversight remains a priority with actions underway including the CNO meeting with ward leaders to explore low scoring audits in hand hygiene audits, and the CNO and CMO reviewing any MRSA cases with the clinical teams.

| Key controls | Gaps in controls |
|---|---|
| Annual estates planning, informed by clinical priorities.<br>Digital prioritisation programme, informed by clinical priorities.<br>Infection prevention & control agenda, annual work plan, audit programme.<br>Local infection prevention support provided to clinical teams.<br>Compliance with NHSIE Infection Prevention & Control Assurance Framework.<br>Focused IP&C educational/awareness campaigns e.g. hand hygiene, 'Give up the gloves' winter virus. campaigns. PPE requirements, specifically the requirement for use of gloves, updated in the Trust Isolation policy (published June 2024) to support the 'give up the gloves' campaign.<br>Digital clinical observation system.<br>Implementation of My Medical Record (MMR).<br>Screening of patients to identify potential transmissible infection and HCAIs. | Transmissibility of respiratory virus infections (e.g. COVID-19, Influenza, RSV), Norovirus and other infections.<br>Resurgence of infections such as measles and pertussis plus emergence of newer infections e.g. Candida Auris and increased national prevalence of multi-drug resistant organisms such as CPE.<br>Familiarisation with response to resurgence of infections such as norovirus, measles, pertussis plus new infections.<br>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. |

| | |
|---|---|
| Programme of monitoring/auditing of IP&C practice and cleanliness standards.<br>Review of incidents/outbreaks of infection and sharing learning and actions.<br>Risk assessments in place for individual areas for ventilation, bathroom access, etc. to ensure patient safety.<br>Guidance disseminated around identifying potential cases of measles and pertussis and monitoring symptoms following a national and local increase in presentations. Supported by national messaging and encouragement of vaccinations.<br>Education and support provided to clinical areas not meeting expected cleanliness standards, providing by EMT and external providers.<br>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.<br>Focussed activity/support to wards by the Infection Prevention Team in response to need, including ward reviews/feedback and education and training.<br>Monthly infection prevention and control newsletter continues to be issued in response to current trends, themes, and need.<br>Point of Care testing in AMU.<br>Expedited laboratory testing facilities for respiratory and GI infections. | IPC measures are reliant on people and their actions will be influenced by human factors, therefore 100% compliance cannot be enforced.<br>Lack of established administrative support with appropriate capacity to facilitate timely contact tracing. Requirement and mitigations to be scoped although currently there are no extraordinary requirements for contact tracing. |
| **Key assurances** | **Gaps in assurances** |
| Infection Prevention Committee and IP&C Senior Oversight Group. Hand hygiene, IP&C and cleanliness audits.<br>Patient-Led Assessment of the Care Environment.<br>National Patient Surveys.<br>Capital funding monitored by executive.<br>NHSE/I infection prevention & control assurance framework compliance reporting to executive, Quality Committee and Board.<br>Clinical audit reporting.<br>Internal audit annual plan and reports.<br>Finance and Investment Committee oversight of estates and digital capital programme delivery.<br>Digital programme delivery group meets each month to review progress of MMR.<br>Quarterly executive monitoring of Estates KPIs (maintenance, cleanliness, fire safety, medical devices, etc.).<br>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. | Ward and bay closures due to norovirus outbreaks.<br>Increase in cases of C.Diff , MRSA BSIs (blood stream infections) and other gram negative BSI above national set thresholds.<br>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 and other national guidance. e.g.standard infection control precautions policy, high consequences infectious disease policy, policy for the management of patients with unexplained/unexpected diarrhoea and/or vomiting. |
| 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; this is improving. |
| Delivery of IPT work plan to support improvements in practice (e.g. MRSA focus in Q1 2024/25, 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. |
| Ongoing review of new cases of healthcare associated bloodstream infections (E-Coli, klebsiella, pseudomonas, MRSA, MSSA, VRE) to identify potential gaps in practice, learning and actions for improvement. |
| Monthly Infection Prevention Newsletter to provide updates/education and share learning. |

## 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:<br>• insufficient research workforce and limited capacity in clinical support services;<br>• an organisational culture which does not encourage and support staff to engage with research and innovation. | This could lead to:<br>• an inability to set-up and deliver research studies in a safe and timely manner;<br>• a lack of development opportunities for staff which impacts the next generation of researchers and innovators. | Resulting in:<br>• failure to deliver against existing infrastructure awards;<br>• impact our national ranking;<br>• reduced access for patients to innovative new treatments;<br>• reputational damage to our university teaching hospital status and ability to secure funding awards in the future. |

| Category | Appetite | Status |
|---|---|---|
| Technology & Innovation | Open<br>*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<br>8 | April<br>2022 | 3 x 3<br>9 | April<br>2025 | 3 x 2<br>6 | March<br>2026 |

| **Risk progression:** (previous 12 months) | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 | Feb 25 | Mar 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 |

### Current assurances and updates

This risk has been reviewed by the responsible executive in April 2025 with no revisions required to the risk rating, however the target date for full mitigation has been extended until the end of 2025/2026 as the recent improvement in performance in Trust Board KPI national ranking will be challenging to sustain against the current NHS financial and workforce pressures.

| Key controls | Gaps in controls |
|---|---|
| Research strategy, approved by Board and fully funded.<br>Always improving strategy, approved by the board and detailing the UHS improvement methodology.<br>Partnership working with the University and other partners.<br>Clinical academic posts and training posts supporting strategies.<br>Secured grant money.<br>Host for new regional research delivery network, supporting regional working.<br>Local ownership of development priorities, supported by the transformation team. | Operational pressures, limiting time for staff to engage in research & innovation.<br>Limited capacity to support new studies and research areas, relating to hard to recruit areas, turnover, and existing clinical priorities.<br>Research priorities with partners not necessarily led by clinical or operational need.<br>Impact of recruitment processes on vacancy rates in research workforce and clinical support services is impacting performance, with vacancy rates having a particular impact in R&D office and clinical trials pharmacy. Vacancies being filled, but R&D turnover still higher than Trust average. It is anticipated that the impact of the current financial and workforce pressures will worsen our national position. New national site metrics introduced around commercial clinical trial setup and delivery will be introduced as Trust Board KPIs. |

| | |
|---|---|
| **Key assurances** | **Gaps in assurances** |
| Governance structure surrounding University partnership.<br>Board to Council meetings.<br>Joint Senior operational group.<br>Joint Research Strategy Board.<br>Joint executive group for research.<br>Joint Innovations and Commercialisation Group – UHS/UoS.<br>Monitoring research activity funding and impact at R&D steering group.<br>MHRA inspection and accreditation.<br>Strategy and transformation process.<br>CQC review of well-led criteria, including research and innovation.<br>R&D Trust Board KPI's being monitored closely to benchmark our performance nationally. In 24/25 we saw the impact of the focus on our recruitment with improvement in our national performance: recruitment rankinghad improved from 16th in 23/24 to 10th in March 2025, and weighted recruitment had improved from 13th in 23/24 to 10th in September 2024, but has since slipped back to 12th in March 2025. | Limited corporate approach to supporting innovation across the Trust.<br>National benchmarking: previously ranking was below optimal although improvements are being seen since September 2023. Action plan underway. Now meeting Trust Board KPI for recruitment ranking (improvement from 16th in 2023/2024 to 10th 2024/2025) and weighted recruitment had improved (from 13th in 23/24 to 10th September 2024) but has now slipped to 12th for overall 2024/2025 weighted recruitment.<br>New national site metrics introduced around commercial clinical trial set up and delivery will be introduced as Trust Board KPIs. |
| **Key actions** | |
| Staff survey to test staff engagement and understanding of innovation at UHS.<br>Deliver R&I Investment Case. Annual Plan for 25/26 will be taken to TB which includes investment RoI evaluation.<br>Established mechanisms to capture RoI on investment are now built into annual planning process. International Development Centre, attracting external funding to support staff in pursuing innovation.<br>Maximise the benefits of the newly established Wessex Health Partnership as a founding member. WHP Annual Review starting to identify RoI, UHS has committed to supporting next 3 year term.<br>Supporting departments in increasing recruitment and retention through work with R&D to create innovative roles. Staff engagement initiatives were presented to TBSS in February 2025.<br>Review the Trust's approach to corporate-wide innovation.<br>Processes being streamlined and new digital tools being adopted to increase clinical research delivery efficiency. On-going improvement programme, but impact being felt as we saw an improved recruitment ranking in 24/25<br>Joint Research Vision, developed with University of Southampton, went to Senior Operational Group in June 2024, and was finalised by the Joint Research Strategy Board in Q4 2024/25.<br>UHS led on a regional bid for an NIHR Commercial Clinical Research Delivery Centre supported by all Wessex NHS Partners, Dorset and HIOW ICBS, Wessex Health Partners and Heath Innovation Wessex. Funding £4.7m over 7 years awarded, to start 1st April 2025.<br>UHS as host have submitted regional bid in partnership with UoS for renewal of the NIHR Applied Research Collaboration (ARC) Wessex. Application for £16m (uplift from £9m from previous award). Notified through to second stage of the application.<br>Funding application from Wessex Health Partners to take forward outputs from Innovation workshop unsuccessful but funding secured from the NHSE Secure Data Environment<br>To develop processes for UHS/UoS partnership and in the longer term a UHS innovation strategy. Links to review of corporate wide innovation approach above. | |

## 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<br>*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<br>16 | April<br>2022 | 4 x 5<br>20 | April<br>2024 | 4 x 3<br>12 | March<br>2030 |

**Risk progression:** (previous 12 months)

| Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 | Feb 25 | Mar 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 |

### Current assurances and updates

- This risk has been reviewed by the responsible executive in April 2025. The risk rating has been confirmed to still be accurate, however the target date for risk reduction has been extended from 2026 until 2030 in recognition of the totality of risk in the organisation and interdependencies between the BAF risks.

- 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. To manage this a workforce plan has been agreed to reduce the size and scale. This will be achieved through:
  - Ongoing ICB wide recruitment controls including a freeze on non-clinical recruitment (limited internal recruitment approved), and reduced levels (70%) of clinical recruitment.
  - Planned organisational restructure to consolidate 4 divisions into 3, with implementation planned by 30th June 2025. This will help to facilitate a 5% reduction in overall headcount across the clinical divisions.
  - Corporate services are also being reviewed to generate a 10% reduction in headcount. To support this, CEOs across the system collaborating on a vision for shared services across Hampshire and Isle of Wight. The first planned shared service is recruitment services and this will be launched in Autumn 2025.
  - UHS initiated a Mutually Agreeable Resignation Scheme (MARS) earlier this year which has now concluded with agreed exits being managed. A further MARS will be initiated in May 2025 which will be open to a wider pool of candidates.

- In November 2024 Unite union issued notice of a series of strike days throughout December and January, however through ongoing discussion and negotiation between UHS, portering staff and ACA, a deal was agreed and industrial action avoided. Work is underway to deliver a series of agreed actions, with UHS and Unite working closely together.

- Similarly, discussions and negotiations have been ongoing with Unison regarding the national dispute around banding, duties and pay for band 2 and 3 HCA staff. Following consultation with their members in Q4 2024/25, Unison have accepted the resolution proposal and this is currently being implemented.

| Key controls | Gaps in controls |
|---|---|
| New 5-year People Strategy and clear objectives for Year 2 monitored through POD.<br>Recruitment and resourcing processes.<br>Workforce plan and overseas recruitment plan.<br>General HR policies and practices, supported by appropriately resourced HR team.<br>Temporary resourcing team to control agency and bank usage.<br>Overseas recruitment including a reduced level of nurse vacancies.<br>Recruitment campaign.<br>Apprenticeships.<br>Recruitment control process to ensure robust vacancy management against budget.<br>Workforce reviews to respond to specific recruitment and retention issues (e.g. the ACP review).<br>Improved data reporting.<br>ICB wide transformation programme established with leadership including the UHS CEO. The focus is on grip and control of temporary staffing use, including supply issues, and corporate services.<br>ICB recruitment panel established to limit recruitment within HIOW for specific roles.<br>Affordable workforce limits have now been agreed with all divisions and THQ.<br>Workforce plan for 2024/25 submitted to ICB, planning for 2025/26 underway.<br>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. Planning for 2025/26 underway.<br>Organisational change policy including management of redeployment.<br>RCP (Recruitment Control Panel).<br>Creation of an organisational change management group to govern the current restructure.<br>Financial Improvement Group established with a supporting Equality and Quality Impact Assessment Review Group.<br>Planned change management and wellbeing support for staff and managers. | Completion of objectives for South-East temporary collaborative for 2024/25, 2025/26 and beyond. |
| **Key assurances** | **Gaps in assurances** |
| Fill rates, vacancies, sickness, turnover and rota compliance .<br>NHSI levels of attainment criteria for workforce deployment.<br>Annual post-graduate doctors GMC report.<br>WRES and WDES annual reports - annual audits on BAME successes.<br>Gender pay gap reporting.<br>NHS Staff Survey results and pulse surveys. | Universal rostering roll out including all medical staff.<br>Review of implications for education and training infrastructure from national workforce plan. |

| | |
|---|---|
| Joint finance and Workforce working group on data assurance.<br>Temporary staffing collaborative diagnostic analysis on effectiveness.<br>A system wide rostering audit has taken place across Hampshire and Isle of Wight, and UHS have now received the findings which provides strong, positive, assurance of our practice with continued opportunities around medical rostering and job planning. | |

**Key actions**

2025/2026

Deliver a plan of organisational change in a safe and sustainable manner to scale back workforce.

Refresh the Trust's People Strategy once the Trust's Corporate Strategy has been agreed.

2024/2025

Delivery of the workforce plan for 2024/25 including increasing substantive staff in targeted areas offset by reducing temporary agency spend.

Development and implementation of Divisional Workforce Plans.

Completion of objectives for South-East temporary collaborative for 2024/25 and beyond.

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. This is to continue into 2025/26.

**Linked operational risks**

| No. | Title | Current risk rating | Target risk rating | Target Date |
|---|---|---|---|---|
| 20 | Potential for mis-diagnosis from non-optimised imaging or unnecessary radiation exposure due to staffing levels in Radiation Protection | 3 x 4 = 12 | 1 x 5 = 5 | 01/10/2025 |
| 67 | There is a risk that Consultant demand v capacity shortfall will be the cause of non covered sessions. This includes all areas that require anaesthetic support, such as theatres; POAC - gen and PAH; Critical care; POM etc. | 2 x 4 = 8 | 3 x 2 = 6 | 31/10/2025 |
| 86 | Reduced skill mix, education and experienced critical care nursing staff | 4 x 3 = 12 | 3 x 2 = 6 | 31/03/2025 |
| 167 | MRI physics staffing risk | 4 x 2 = 8 | 2 x 1 = 2 | 31/03/2025 |
| 180 | Lack of pathology staff and inappropriate skill mix | 3 x 4 = 12 | 3 x 2 = 6 | 31/07/2025 |
| 286 | Inadequate staffing in Nuclear Medicine Physics for the size and complexity of the expanded service | 3 x 4 = 12 | 3 x 3 = 9 | 31/12/2025 |
| 458 | Demand for therapy input exceeding available workforce capacity putting patients at risk of ELOS and suboptimal input. | 3 x 4 = 12 | 2 x 2 = 4 | 31/03/2025 |
| 604 | Risk in epilepsy nursing service | 3 x 3 = 9 | 2 x 2 = 4 | 18/06/2025 |
| 623 | Insufficient reporting capacity (Specialist radiologist reporters) | 4 x 3 = 12 | 2 x 1= 2 | 24/06/2025 |
| 646 | Reduced ACP Cover across Neurosciences care group | 3 x 3 = 9 | 4 x 1 = 4 | 03/09/2025 |
| 661 | Insufficient Medical staff to safely manage patient activity within cancer care | 4 x 4 = 16 | 2 x 3 = 6 | 31/10/2025 |
| 662 | Cellular Pathology Staffing and Capacity | 4 x 5 = 20 | 4 x 2 = 8 | 31/07/2025 |
| 711 | Insufficient staff resource in Robotic SFA to meet the Robotic service demand | 2 x 4 = 8 | 3 x 1 = 3 | 31/08/2025 |
| 712 | Risk to patient safety due to no designated junior doctors on the major trauma unit | 4 x 3 = 12 | 4 x 2 = 8 | 18/05/2025 |
| 726 | Ophthalmology clinical/AHP workforce | 4 x 3 = 12 | 4 x 1 = 4 | 31/01/2025 |
| 730 | Risk of patient harm due to lack of administrative support for clinical services in surgical care group. | 4 x 4 = 16 | 2 x 2 = 4 | 31/08/2025 |

| | | | | |
|---|---|---|---|---|
| 748 | There is a risk that patients may be cancelled, have peri-op complications, or longer hospital stays due to staffing concerns within the perioperative care and perioperative assessment clinic service | 3 x 4 = 12 | 2 x 1 = 2 | 31/08/2025 |
| 776 | Insufficient clinical pharmacy workforce | 3 x 5 = 15 | 3 x 3 = 9 | 31/03/2025 |
| 782 | Paediatric dietetics staffing risk | 3 x 3 = 9 | 2 x 3 = 6 | 31/01/2025 |
| 785 | The provision of the congenital cardiac service in theatres may be affected due to high vacancy and slow throughput of learners | 3 x 2 = 6 | 3 x 1 = 3 | 31/07/2025 |
| 791 | Outpatients Administration Centre (OAC) - Staffing Risk | 3 x 3 = 9 | 2 x 3 = 6 | 31/03/2026 |
| 797 | Paediatric Speech and Language Therapy Staffing Risk | 3 x 3 = 9 | 2 x 3 = 6 | 03/03/2025 |
| 820 | CED consultant under staffing due to vacancies and also increased capacity | 4 x 3 = 12 | 3 x 1 = 3 | 31/04/2025 |
| 837 | Quality of patient care and the wellbeing of staff may be compromised if recruitment controls on the nursing workforce are not implemented safely with appropriate oversight and flexibility to meet individual services needs | 3 x 4 = 12 | 3 x 2 = 6 | 31/03/2026 |
| 844 | Patients may not receive lifesaving emergency cardiac surgery due to a lack of cardiac trained staff. | 4 x 3 = 12 | 4 x 1 = 4 | 30/09/2025 |
| 859 | Reduced Portering workforce (volume and skill/knowledge) due to industrial action may affect the operational ability of UHS to provide safe and efficient patient care | 3 x 5 = 15 | 3 x 1 = 3 | 31/03/2025 |
| 872 | Lack of administrative support within cancer care | 3 x 5 = 15 | 2 x 1 =2 | 31/08/2025 |

**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, and necessary system and organisational change is not managed safely, sustainably, and equitably; | 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<br>*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<br>12 | April<br>2022 | 4 x 3<br>12 | April<br>2025 | 4 x 2<br>8 | March<br>2030 |

| **Risk progression:** (previous 12 months) | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 | Feb 25 | Mar 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 |

**Current assurances and updates**

- This risk has been reviewed by the responsible executive in April 2025. The risk rating has been confirmed to still be accurate, however the target date for risk reduction has been extended from 2026 until 2030 in recognition of the totality of risk in the organisation and interdependencies between the BAF risks. The risk description has also been updated to reflect the potential impact of organisational change in relation to this risk. As a mitigation to this an Equality & Quality Impact Assessment (EQIA) review group is being established to support the Trust's Financial Improvement Group (FIG) in making informed decisions. Where operational and organisational changes are proposed at FIG, an EQIA will be completed and reviewed at the group, focussing on the impact to both patients and staff. This will help to mitigate the risk of discrimination where changes are proposed.
- 'Proud to be ops' and 'Proud to be admin' campaigns continue to run and a further event was held in April with information and networking opportunities for staff.
- UHS staff survey results have now been published and the Trust has remained above average on all people promise areas. However, the participation rate had fallen at 39%.
- A new positive action leaders programme is launching in May 2025.

| Key controls | Gaps in controls |
|---|---|
| **Great place to work including focus on wellbeing**<br>UHS wellbeing plan developed.<br>Guardian of Safe Working Hours.<br>Re-launched appraisal and talent management programme.<br>Comprehensive employee recognition programme embedded including monthly staff spotlight and annual awards. | Ensure each network has dedicated leadership to continue to support well-functioning and thriving networks.<br>Coverage of allyship training to increase to 80% compliance by 31/03/2025.<br>Launch of digital appraisal process.<br>Improving implementation of national improving working lives actions for junior doctors following national letter May 2024. |

| | |
|---|---|
| Proud2BeAdmin & Proud2Bops campaigns and networks.<br>Working group improving working facilities, including oversight of charitable funding allocated to staff wellbeing.<br><br>**Building an inclusive and compassionate culture**<br>Inclusion and Belonging Strategy signed off at Trust Board.<br>Creation of a divisional steering group for EDI.<br>FTSU guardian, local champions and FTSU policies.<br>Diversity and Inclusion Strategy/Plans.<br>Collaborative working with trade unions.<br>Launch of the strategic leaders programme with a cohort of 24 across UHS.<br>Senior leader programme launched.<br>Positive action programme completed – cohort 2. Cohort 3 advertised.<br>Nurse specific positive action programme also launched.<br>All leadership courses now include management of EDI issues and allyship training has been rolled out across the organisation with good uptake.<br>A review of long term illness and disability has been undertaken to utilise external expertise to help review our approaches to reasonable adjustments.<br>Inclusive recruitment review undertaken. | Organisational capability and capacity to fully support LID, external support being sought. |
| **Key assurances** | **Gaps in assurances** |
| **Great place to work including focus on wellbeing**<br>Annual NHS staff survey and introduction of quarterly pulse engagement surveys.<br>Guardian of Safe Working Hours report to Board.<br>Regular communications monitoring report Wellbeing guardian.<br>Staff Networks.<br>Exit interview process.<br>Wellbeing Guardian and wellbeing champion.<br><br>**Building an inclusive and compassionate culture**<br>Freedom to Speak Up reports to Board.<br>Qualitative feedback from staff networks data on diversity.<br>Annual NHS staff survey and introduction of quarterly pulse engagement.<br>Listening events with staff, regular executive walkabouts, talk to David session.<br>Insight monitoring from social media channels. | Maturity of staff networks<br><br>Maturity of datasets around EDI, and ease of interpretation<br><br>Areas for improvement identified through the annual staff survey (March 2024) – remedial action reflected within the People objectives for 2024/25.<br><br>NHSE review of surgical training has resulted in enhanced monitoring from the GMC. Full action plan |

| | |
|---|---|
| Allyship Programme.<br>Gender Pay Gap reporting.<br>External freedom to speak up and employee relations review. | being implemented including completion of workshops with all consultants working within the area.<br>An independent external review has highlighted issues relating to culture, capability, and capacity within the UHS portering service. Work is underway to address these concerns including negotiations with the Unite union. |

**Key actions**

**2024/2025**

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 (February 2025, 72%).
- 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.

Following allocation of charitable funding to refurbish the Muslim prayer facilities at UHS for both staff and patients, this work has been undertaken and was completed ahead of this year's Ramadan to ensure facilities were fit for purpose.

**2025/2026**

Continue implementation of the inclusion and belonging strategy within available financial and people resources.

Delivery of Organisational Development support to complement organisational change.

Ensure that equality impact assessments are completed and monitored through the EQIA review group.

## 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:<br>• Limited ability to recruit staff with suitable skills to support education;<br>• Lack of current national education financing and changes in the way the education contract will function;<br>• Inflexibility with apprenticeship regime; | There may be:<br>• Inability to develop and implement a strategic vision for development of staff;<br>• A lack of development for staff affecting retention and engagement;<br>• Reduced staff skills and competencies;<br>• Inability to develop new clinical practices. | This could result in:<br>• An adverse impact of quality and effectiveness of patient care and safety;<br>• An adverse impact on our reputation as a university teaching hospital;<br>• Reduced levels of staff and patient satisfaction. |

| Category | Appetite | Status |
|---|---|---|
| Workforce | Open<br>*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<br>9 | April<br>2022 | 4 x 4<br>16 | April<br>2025 | 3 x 2<br>6 | March<br>2029 |

**Risk progression:** (previous 12 months)

| Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 | Feb 25 | Mar 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 4<br>16 | 4 x 4<br>16 |

### Current assurances and updates

This risk has been reviewed in April 2025 by the responsible executive and no significant changes were required as the risk was extensively reviewed in February 2025 when the risk rating was increased. At present there is still a lack of national directive, although a longer term plan is expected in Spring and new workforce plans will be published, which will help to guide direction.

| 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 |
| TNA process completed for 2024/25. | |

| | |
|---|---|
| Escalation to NHSE with offer to assist in identifying future solutions. | National CPD guidance for 2024/25: scope of application is limited by rigid national rules.<br><br>New national education funding contract published for consultation 29 Feb. Reduced resources and higher levels of control included.<br><br>Lack of/tighter restrictions in national funding, alongside inflexibility within the apprenticeship regime, remains a significant concern as this may present a reduction in opportunities for staff development, particularly for level 7 apprenticeships. |
| **Key assurances** | **Gaps in assurances** |
| Annual Trust training needs analysis reported to executive.<br>Trust appraisal process<br>GMC/NETs Survey<br>Education review process with NHSE WTE.<br>Utilisation of apprenticeship levy.<br>Talent development steering group<br>People Board reporting on leadership and talent, quarterly | Need to develop quantitative and qualitative measures for the success of the leadership development programme.<br>Review of implications for education and training infrastructure from national workforce plan.<br>There is a reported inability of staff to participate in statutory, mandatory, and other training opportunities. |

**Key actions**

To increase the proportion of appraisals completed and recorded to 85% and increase staff quality perceptions on appraisal.

Ongoing 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 – complete.
- Run 2nd cohort of Human Leaders and integrate psychology and trauma informed approaches to leadership programmes – complete.
- Roll out of a targeted programme of development for Care Group Clinical Lead – complete.

A review is underway within T&D to look at the infrastructure and longterm workforce plan.

| Linked operational risks | | | | |
|---|---|---|---|---|
| **No.** | **Title** | **Current risk rating** | **Target risk rating** | **Target Date** |
| 173 | Patients may not be safeguarded appropriately if staff are unaware of their duties and do not have the correct knowledge and skillset due to being non compliant with Safeguarding Adults, MCA, & DOLs training. | 3 x 3 = 9 | 3 x 1 = 3 | 31/12/2025 |
| 833 | Safeguarding children Statutory Training Compliance Levels are below required. | 4 x 3 = 12 | 4 x 1 = 4 | 31/05/2025 |
| 894 | Delivery of training and development for staff may be compromised if funding is not available due to national restrictions | 4 x 3 = 12 | 2 x 2 = 4 | 31/03/2026 |

## 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 Strategy & Partnerships |
|---|---|

| 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.<br>Efficiencies arising from consolidation of specialities would not be realised. |
| **Category** | **Appetite** | **Status** |
| Effectiveness | Cautious<br>*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<br>9 | April<br>2022 | 3 x 3<br>9 | April<br>2025 | 3 x 2<br>6 | Dec<br>2025 |

| **Risk progression:** (previous 12 months) | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 | Feb 25 | Mar 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 |

### Current assurances and updates

This risk has been continually reviewed and updated with the executive leads throughout 2024/25 and into 2025/26 and minor changes made to the controls, assurances, and actions, to ensure it is up to date. Significant work is underway to advance integrated and networked care and progress continues to be made. There is an expectation that this will take time to establish and embed as it is a complex workstream due to the number and nature of stakeholders and the need to engage and negotiate with them, both internally and externally.

Work is ongoing to enhance the process to proactively identify risk within elective waiting lists across the system and plan ahead to address this collaboratively in a structured manner. This is facilitated through introduction of a singular database across HIOW which allows modelling by both provider and speciality, thus ensuring that provision of care is responsive to patient need and that the right patient is seen in the right place and at the right time.

It is noted that current pressures and directive to reduce workforce spend across the NHS may impact on the ability and capacity to execute plans if these are not adequately resourced, however the requirement for savings and efficiency may also assist as a driver for working collaboratively.

| Key controls | Gaps in controls |
|---|---|
| • Key leadership role within local ICS<br>• Key leadership role within local networked care and wider Wessex partnership<br>• UHS strategic goals and vision<br>• Establishment and development of Hampshire and Isle of Wight Acute Provider Collaborative (HIoW APC) to drive improvements in outcomes.<br>• Establishment of UHS Integrated Networks and Collaboration Board<br>• Collaborative CMO/ Director of Strategy meetings have begun/ are being arranged with partner organisations to agree priorities and ensure there | • Potential for diluted influence at key discussions<br>• Arrangements for specialised commissioning – delegated from centre to ICS – historically national and regional, rather than local.<br>• Engagement and pace from organisations we are looking to partner with is not within our control.<br>• Resource within the UHS clinical programme team can prove challenging.<br>• Resource and capacity within clinical services can also prove difficult, for example pelvic floor has been chosen as a clinical speciality focus, however capacity at UHS is a challenge as evidenced on the operational risk register. |

| | |
|---|---|
| is executive commitment to delivering network models.<br>• ICS agreement on clinical specialty focus including dermatology, ophthalmology, UGI and pelvic floor.<br>• Support for networks from clinical programme team continues. Integrated networks and collaboration project management post recruited to.<br>• 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.<br>• 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. Positive outcomes are being seen from this work as UHS has successfully increased the number of cataract operations undertaken which has resulted in an increased number of referrals due to reduced waiting times, with NHS referrals now outweighing private referrals Further targeted work includes introduction of a Single Point Of Access for ENT to establish a network for procedures of limited clinical value. The UHS CEO is the SRO for this project and is ensuring alignment with UHS and overall ICB strategy.<br>• Network arrangements in Urology, pelvic floor and plastics have also been prioritised for focus during 2024/25.<br>• 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.<br>• The 'Acute Clinical Services Operating Model programme' has been initiated with agreed focus areas from providers and the ICB, these are Breast surgery, Upper GI, Pelvic floor, Urology, Ophthalmology, Dermatology and Orthodontics.<br>• ICS oversight of waiting lists and forecasts in addition to provider level intelligence. | |
| **Key assurances** | **Gaps in assurances** |
| • CQC and NHSE/I assessments of leadership<br>• CQC assessment of patient outcomes and experience<br>• National patient surveys<br>• Friends and Family Test<br>• Outcomes and waiting times reporting. Included within cases for change being built for networks.<br>• 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.<br>• Ability to network is difficult and manifests in capacity challenges.<br>• Currently there are no established metrics regarding the establishment of networks due to the significant length of time it takes to set the networks up, however work is underway to set up quarterly objectives and consider KPIs to evidence whether networks being set up are on track. |
| **Key actions** | |
| 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. | |

Business case for future working of the Southern Counties Pathology Network is being developed following a CFO/COO workshop Q4 2024/25. This is in consideration of what savings may be achieved as provider of managed equipment and is anticipated to be developed July 2025.

Business case for a Southampton elective hub has been written and approved at TIG and Trust Board, with a letter of support provided by the ICB as well. Capital funding has been set aside and plans have been sent to NHSE for approval, with the aim of opening this in April 2026.

NHSE has approved the business case, and funds have been received, for the Winchester Elective Hub which is due to be opened August 2025.

Mr AK, Ophthalmology clinical lead, leading ongoing improvement work focussed on theatre productivity and point of access for cataract referral. This has been established and NHS provision of cataract care has increased from 40% to 72%, with all patients waiting less than 10 weeks for treatment.

A high level options paper has been developed for Upper GI across UHS and UHD. This has been shared with executives and broadly agreed between CMOs and Directors of strategy. A detailed options appraisal to follow this which UHS are committed to provided, but will require continued engagement from UHD too. The ICB and NHSE South East region have also requested that UHS work in collaboration with Portsmouth in consideration to UGI and as of December 2024, 3 consultant meetings have been held between UHS and Portsmouth to progress this.

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.

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 held to discuss challenges and opportunities and to gain agreement on a way forward. A case for change paper is now being developed, setting out proposal for a single plastics service between Salisbury and UHS. Plastic leadership has been strengthened within UHS to support this change, oversight will now sit within division D.

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.

Once networks have been established, define a core set of KPI metrics to be monitored and reported through INC board.

Following conversations between clinical leads at UHS and HHFT regarding future networking opportunities that may arise because of and in advance of the development of a new HHFT hospital in North Hampshire (2037 onwards), individual speciality clinical leads have been asked to continue exploring and progressing this. There will be a need to consider clinical reconfigurations to bridge this gap however a forum hasn't yet been established. UHS are keen to work closely with HHFT on this to ensure that we understand any need for redirection of emergency or urgent presentations in the South, which are likely to be the elderly or frail population, and maternity.

**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<br>*The current risk rating sits outside of the stated risk appetite, however the long term target risk rating is within the tolerable risk appetite.* | Treat |

| **Inherent risk rating (I x L)** | | **Current risk rating (I x L)** | | **Interim & long term target (I x L)** | |
|---|---|---|---|---|---|
| 4 x 5<br>20 | April<br>2022 | 4 x 5<br>20 | April<br>2025 | 3 x 5 = 15<br>3 x 3 = 9 | April 2027<br>April 2030 |

| **Risk progression:** (previous 12 months) | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 | Feb 25 | Mar 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 3 x 5<br>15 | 3 x 5<br>15 | 3 x 5<br>15 | 3 x 5<br>15 | 3 x 5<br>15 | 3 x 5<br>15 | 3 x 5<br>15 | 3 x 5<br>15 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 |

**Current assurances and updates**

- This risk has been reviewed and updated by the Chief Finance Officer in April 2025. The risk rating remains at 20 (severe x certain) considering the significant and sustained fiscal pressures present within the organisation and wider system. Following previous discussion at the Finance & Investment Committee an interim target for risk reduction has been added to evidence the intention of incremental and sustainable risk reduction over the next 5 years.
- The 2024/25 year closed with a deficit of £7m and whilst this is a better position than previously anticipated, the level of current risk is still significant with a predicted £6m per month deficit in 2025/26. To mitigate this a breakeven plan has been established which includes enhanced recruitment controls to limit spend, including a current freeze on non-clinical recruitment, and reduced clinical recruitment. This will be supported by a planned £110m (9%) saving, including in workforce spend through a 10% reduction in headcount in THQ and 5% reduction in clinical divisions.
- The deteriorating cash balance remains a significant, and imminent, concern. To mitigate this supplier payments are being timescale managed to maintain cash flow.
- Further risk is present within the new framework for 2025/26 (previously the Elective Recovery Fund) which places a ceiling on funding for activity. Plans will be formed within the ICB indicative of what can be afforded, however this may be at tension with performance and quality risks. Mitigations are currently being agreed and implemented including agreement and movement of organisational ceilings across the system, and potential reduction of work outsourced to independent providers.
- As previously reported HIOW ICS escalated into segment 4 of the Recovery Support Programme which triggered the initiation of the Investigation & Intervention (I&I) regime, and subsequent appointment of Deloitte to facilitate this process within the system. Deloitte's investigation findings are now being reviewed to identify learning and improvement opportunities at Trust and system level.

| Key controls | Gaps in controls |
|---|---|
| **Internal**<br>• Financial strategy and Board approved financial plan.<br>• Newly (2025/26) established Financial Improvement Group supported by the Financial Improvement Director.<br>• Improving Value Board (previously Trust Savings Group).<br>• Financial Recovery Plan (submitted to HIOW ICB and NHSE) with Trust and system led actions, and a 2025/26 landing plan.<br>• Transformation Oversight Group (TOG) overseeing delivery of transformation programmes including financial benefits.<br>• Implementation of revised recruitment controls, including setting revised divisional Affordable Workforce Limits which are being revised in 2025/26.<br>• Robust business planning and bidding processes<br>• Robust controls over investment decisions via the Trust Investment Group and associated policies and processes<br>• Monthly VFM meetings with each Care Group<br>• Bi Monthly cash flow forecast review. Improving Value transformation programme.<br>• Mutually Agreed Resignation Scheme<br><br>**System wide/external**<br>Financial Recovery Programmes / Transformation Programmes:<br>• Planned Care<br>• Urgent & Emergency Care<br>• Discharge<br>• Local Care<br>• Workforce<br>• Mental Health<br>Formation of new Delivery Units & mapping of UHS resources to support delivery.<br>Improved “grip and control” measures with consistent application across all organisations. | **Internal**<br>• Remaining unidentified and high-risk schemes within CIP programme.<br>• Ability to control and reduce temporary staffing levels.<br>**System wide/external**<br>• Elements of activity growth unfunded via block contracts.<br>• Reliance on external organisations and partners to support reductions in NCTR and Mental Health. Emerging NHS HIOW transformation programmes focus on this but currently lack detail to provide assurance. |
| **Key assurances** | **Gaps in assurances** |
| • Regular finance reports to Trust Board & F&IC.<br>• Full financial report for the system to Trust Board.<br>• Divisional performance on cost improvement reviewed by senior leaders – quarterly.<br>• Trust Savings Group / Improving Value Board oversight of financial recovery plan and CIP programme actions<br>• F&IC visibility and regular monitoring of detailed savings plans<br>• Capital plan based on cash modelling to ensure affordability. | • Current short-term nature of operational planning<br>• System wide plans under development to work collaboratively focussing on reduction in NCTR, and mental health, however there remains a lack of assurance around the detail to ensure delivery.<br>• Lack of reporting on system transformation initiatives to individual Trust Boards.<br>• Concern over any further industrial action not incorporated into plan. |

| | |
|---|---|
| • Regular reporting on movements in overall productivity.<br>• Bi-monthly cash reporting to F&IC. | |

**Key actions**

- Finalise 25/26 plan to be agreed with NHSE – complete.
- Set Divisional/Directorate budgets and ensure appropriate sign-off of budgets, inclusive of revised AWL limits - underway.
- Reset CIP and transformation programmes based on 25/26 targets - underway.
- Set programmes/projects for delivery as part of the Financial Improvement Group – underway.
- Engage with Deloitte and the HIOW ICS in the I&I regime and deliver agreed outputs.
- Embed additional controls to support delivery of the plan, including revised AWL limits and recruitment controls – underway.

**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:** CFO |
|---|---|

| 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. Key areas of concern are an insufficient electrical supply, aged electrical systems, inadequate and aged ventilation systems, and aged water and sewage distribution. | This would result 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<br>*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<br>16 | April<br>2024 | 4 x 5<br>20 | April<br>2025 | 4 x 2<br>8 | April<br>2030 |

| **Risk progression:** (previous 12 months) | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 | Feb 25 | Mar 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 4 x 4<br>16 | 4 x 4<br>16 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 |

**Current assurances and updates**

This risk has been reviewed with the Chief Finance Officer in April 2025 and the current and target risk ratings agreed to be accurate. Key updates

- The transfer of EFCD to UEL is now complete which will support efficiency and collaborative working across the support services.
- The 2025/26 capital plan has been approved at Board and to further support this a £7.3m bid for backlog maintenance has been generated. To support risk management and value for money, available funding is prioritised to address the most significant concerns as the level of investment does not match the increasing backlog year on year. As such all of the highest rated risks (rated 25) within the six facet survey have now been addressed.

| Key controls | Gaps in controls |
|---|---|
| Multi-year estates planning, informed by clinical priorities and risk analysis | Scale of investment and funding is insufficient to fully address identified gaps in the critical infrastructure. |
| Up-to-date computer aided facility management (CAFM) system – new system is in the process of procurement and implementation. | Continuing revenue budget pressures to reduce costs as infrastructure is getting more costly to maintain. |
| | Operational constraints and difficulty accessing parts of the site affecting pace of investment including refurbishment. |
| | Lack of decant facilities. |
| | Reactive system requires re-prioritisation review. |
| Asset register (90% in place) | Planned maintenance will drop out of the asset register work. |
| Maintenance schedules | Recruitment controls prohibiting recruitment to key roles, now managed within affordable workforce limits. |
| Trained, accredited experts and technicians | |

| | |
|---|---|
| Asset replacement programme<br><br>Construction Standards (e.g. BREEM/Dementia Friendly Wards etc.)<br>Six Facet survey of estate informing funding and development priorities<br>Estates masterplan 22-23 approved.<br>Clear line of sight to Trust Board for all risks identified. | Lack of Estates strategy for the next 5 years. |
| **Key assurances** | **Gaps in assurances** |
| Compliance with HTM (Health Technical Memorandums) / HBN (Health Building Notes) monitored by estates and reported for executive oversight<br>Patient-Led Assessments of the Care Environment. Reported to QGSG.<br>Statutory compliance audit and risk tool for estates assets<br>Monitoring at Finance and Investment Committee, including progress of capital investment and review of critical infrastructure risk and updates to Six Facet survey<br>Quarterly updates on capital plan and prioritisation to the Board of Directors | 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 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, but this is currently under consideration as to how to move this forward.<br>Identify future funding options for additional capacity in line with the site development plan.<br>Delivery of 2025/26 capital plan.<br>Implement the HIOW elective hub.<br>Deliver £4.2m of critical infrastructure backlog maintenance 2024/25 and £3.5m in 2025/26.<br>Agree plan for remainder of Adanac Park site.<br>Site development plan for Princess Anne hospital. | |

**Linked operational risks**

| No. | Title | Initial Date | Current risk rating | Target risk rating | Target Date |
|---|---|---|---|---|---|
| 16 | Estates Maintenance PPM Programme | 26/06/2019 | 4 x 2 = 8 | 4 x 1 = 4 | 28/11/2025 |
| 75 | Site wide electrical infrastructure resilience | 05/03/2019 | 4 x 3 = 12 | 4 x 1 = 4 | 31/01/2025 |
| 157 | Site wide electrical infrastructure resilience, HV and LV. | 05/03/2019 | 4 x 3 = 12 | 4 x 1 = 4 | 30/11/2024 |
| 260 | Insufficient space in the induction of Labour Suite. | 28/10/2019 | 4 x 4 = 16 | 3 x 1 = 3 | 31/12/2025 |
| 421 | There is a risk that the Trust does not appropriately manage or maintain its assets. | 28/08/2020 | 4 x 3 = 12 | 4 x 1 = 4 | 30/06/2025 |
| 489 | Inadequate ventilation in in-patient facilities increases the risk of nosocomial infection and may result in a suboptimal experience for patients and staff who are subject to uncomfortable and excessive environmental temperatures | 07/02/2021 | 5 x 3 = 15 | 5 x 1 = 5 | 31/03/2027 |
| 727 | Black start electrical test | 25/07/2023 | 5 x 2 = 10 | 5 x 1 = 5 | 31/08/2025 |

| | | | | | |
|---|---|---|---|---|---|
| 773 | Impact of the Building Safety Act (2022) on Capital Project Delivery | 24/01/2024 | 3 x 3 = 9 | 3 x 2 = 6 | 30/05/2025 |
| 817 | Lack of UPS backup on power failure | 28/05/2024 | 5 x 3 = 15 | 5 x 1 = 5 | 31/03/2025 |
| 818 | Centralised Chilled water system - power supply resilience | 28/05/2024 | 5 x 2 = 10 | 5 x 1 = 5 | 31/03/2025 |
| 846 | PAH – General ward areas and Neonatal Unit air handling units beyond service life | 11/10/2024 | 5 x 3 = 15 | 5 x 1 = 5 | 01/12/2025 |
| 851 | Lab and Path Chiller 1 Aged and Not Operational | 06/11/2024 | 5 x 3 = 15 | 5 x 1 = 5 | 01/12/2025 |
| 853 | Lab and Path Chilled Water Pumps | 06/11/2024 | 4 x 3 = 12 | 5 x 1 = 5 | 01/12/2025 |
| 854 | P.M.S Computer room AC Chillers | 06/11/2024 | 4 x 3 = 15 | 5 x 1 = 5 | 01/12/2025 |
| 855 | West Wing SHDU AC Units - Beyond Service Life | 06/11/2024 | 5 x 3 = 15 | 5 x 1 = 5 | 01/12/2025 |
| 856 | Non-compliant & unmaintainable fire dampers in West wing | 12/11/2024 | 5 x 3 = 15 | 5 x 1 = 5 | 31/08/2025 |
| 861 | PICU Computer hub gas suppression system faults alongside various breaches in fire compartmentation and fire stopping. | 18/12/2024 | 5 x 2 = 10 | 5 x 1 = 5 | 31/05/2025 |
| 875 | John Atwell ward, Single means of fire escape, non-compliant to HTM 05:02, Fire safety legislation. | 11/02/2025 | 5 x 2 = 10 | 5 x 1 = 5 | 31/12/2025 |
| 876 | Fire-fighting dry riser water supply accessibility to Urology Centre, Day surgery unit, is non compliant to HTM 05:02, current Fire legislation. | 11/02/2025 | 5 x 2 = 10 | 5 x 1 = 5 | 31/12/2025 |

**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. Key areas of concerns are the ability to provide reliable and fit for purpose hardware and infrastructure, defence against cyber threats, and being able to recruit and retain the right number of staff with the right skill mix. | Resulting in an inability to provide and maintain the digital infrastructure required to facilitate outstanding patient care, and leading to incidents which would require reporting to national governing bodies. |

| Category | Appetite | Status |
|---|---|---|
| Technology & Innovation | Open<br>*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<br>12 | April<br>2022 | 4 x 3<br>12 | April<br>2025 | 3 x 2<br>6 | April<br>2027 |

| **Risk progression:** (previous 12 months) | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 | Feb 25 | Mar 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 3 x 4<br>12 | 3 x 4<br>12 | 3 x 4<br>12 | 3 x 4<br>12 | 3 x 4<br>12 | 3 x 4<br>12 | 3 x 4<br>12 | 3 x 4<br>12 | 3 x 4<br>12 | 3 x 4<br>12 | 3 x 4<br>12 | 3 x 4<br>12 |

**Current assurances and updates**

This risk has been reviewed with the Interim Chief Operating Officer in April 2025. The risk rating and target has been confirmed to be correct with no alterations required.

Key actions which are progressing which aid in mitigation of this risk are:

- The rollout of the Windows 11 and RAM upgrade is progressing well with over 900 devices upgraded and 1000 devices replaced. A plan has been developed for the remaining 2,300 devices which require replacement to occur over 2025/26 and 2026/27.
- The data centre has been included within the 2025/26 capital plan.

| Key controls | Gaps in controls |
|---|---|
| **Failure in physical network infrastructure**<br>• All Digital UPS tested.<br>• Investment cases for key infrastructure (air cooling and data centres) being developed. ICU and ONH air conditioning has been upgraded to support this.<br>• Replacement of key infrastructure on a case-by-case basis once it fails. | **Failure in physical network infrastructure**<br>• The current Data Centre is end of life and requires a capital plan for replacement.<br>• There is currently no phased replacement of switch and network equipment due to absence of funding. |

| | |
|---|---|
| **Cyber Risk**<br>• Cyber security infrastructure refreshed and in place.<br>• Staff training on cyber risks, with regular refreshers and clear policies.<br>• Key cyber roles recruited to, with one remaining outstanding. | **Cyber Risk**<br>• Funding: cyber security and recovery capability requires ongoing investment and development.<br>• Ability to enforce more robust training due to lack of time for staff training.<br>• Penetration testing contract pulled forward to 2024/25. |
| **Single points of failure in staffing**<br>• Partial implementation of Digital workforce plan.<br>• Prioritisation of key posts.<br>• Upskilling existing staff to provide cross cover. | **Single points of failure in staffing**<br>• Financial constraints impacting ability to implement workforce plan needed to underpin strategy. This, alongside the rigidity of the AFC banding structure, can result in difficulties attracting skilled staff in a competitive industry. |
| **Implementation and sustainability of digital technology**<br>• Inpatient noting for nursing has been rolled out to all appropriate wards, and further developments are being made. Doctors rollout planned for 2025/26.<br>• Single EPR business case via NHS England EPR Investment Board. | **Implementation and sustainability of digital technology**<br>• Funding to cover the development programme, improvements, and clinical priorities. |
| **Loss of access to critical IT systems**<br>• Absolute back-ups of data created.<br>• Business continuity plans developed for Digital team and Wards.<br>• Robust system and regression testing completed on system developments.<br>• Scenario testing completed. | **Loss of access to critical IT systems**<br>• Time to fully stress test business continuity plans. |
| **Key assurances** | **Gaps in assurances** |
| Finance oversight provided by the Finance and Investment Committee.<br>Quarterly Digital Board meeting, chaired by the CEO.<br>Digital risks and actions reviewed weekly on UHS Digital leadership team call.<br>UHS Digital risk and benefit manager in post to manage digital risk alongside operational Digital teams.<br>UHS Digital projects and programmes follow standardised project management delivery mechanism which includes risk management embedded as part of their delivery processes (APM, Prince2, Agile, etc).<br>Standardised change control, testing, and assurance processes implemented across the Development team.<br>NHSE annual DPST assessment completed to highlight gaps in services.<br>Business Continuity Plans in place for clinical areas in the event of IT outages. | Funding to cover the development programme, improvements, and clinical priorities.<br>Difficulties in understanding benefits realisation of digital investment.<br>ICS digital strategy yet to be agreed.<br>UHS digital strategy to be reviewed (runs until 2026 but requires prior review).<br>Digital team provide guidance to clinical services developing BCPs but the team do not review these at service/ward level due to time and capacity. |

**Key actions**

- Ongoing recruitment of key Digital resource to mitigate operational risk.
- Inpatient noting for doctors scheduled for 2025/26.
- Replacement of key clinical systems to more modern systems: Alcidion previously scheduled in April 2025, now deferred to September 2025.
- Lessons learned from LIMS project were shared across UHS Digital, Estates, and other major project teams.
- Procurement of Single EPR across HIOW to provide a more modern EPR.
- Identify opportunities for funding for digital transformation and programmes.
- Acceleration of cyber software upgrades completed 2024/25.
- The air conditioning in the ICU and Old Nurses Home data centres has been upgraded, enhancing its resilience. The air conditioning for the A-Level communications room is also now under review.

**Linked operational risks**

| No. | Title | Current risk rating | Target risk rating | Target Date |
|---|---|---|---|---|
| 282 | Workforce Resourcing - There is a risk that the ophthalmology service is not appropriately supported by IT systems to safely deliver current activity. | 3 x 4 = 12 | 2 x 2 = 4 | 30/05/2025 |
| 556 | Workforce Resourcing - Risk to provision of Pathology test results (all departments) if there are delays or errors in the implementation of the new Path IT system | 4 x 3 = 12 | 4 x 1 = 4 | 30/04/2025 |
| 634 | Accommodation / Infrastructure - Fibre optic cabling at the ONH | 4 x 3 = 12 | 4 x 3 = 12 | 29/09/2025 |
| 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 | 29/09/2025 |
| 676 | Cyber Security - UHS does not sufficiently manage the increased threat from cyber risk. | 4 x 4 = 16 | 2 x 3 = 6 | 31/12/2025 |
| 677 | Workforce Resourcing - Insufficient resilience in the UHS network team to support mission critical infrastructure. | 5 x 3 = 15 | 2 x 3 = 6 | 30/05/2025 |
| 679 | Accommodation / Infrastructure - Single point of failure on the UHS network (external connections) | 4 x 3 = 12 | 4 x 1 = 4 | 31/03/2026 |
| 709 | Workforce Resourcing - There is inconsistency in the sharing and coding of co-morbidities, diagnoses, allergies and past medical history within and between different clinical systems - potentaillly resulting in critical patient information being missed pre, during and post treatment | 3 x 4 = 12 | 2 x 1 = 2 | 30/04/2025 |
| 736 | Accommodation / Infrastructure - Supply of Multitone Devices - Bleeps | 3 x 4 = 12 | 1 x 2 = 2 | 29/09/2025 |
| 757 | Cyber Security – If there are unsupported server operating systems this could expose the Trust to cyber attack. | 4 x 2 = 8 | 2 x 1 = 2 | 28/03/2025 |
| 800 | Cyber security – Clinical care may be compromised if data cannot be accessed via the iPads in secondary locations. | 3 x 4 = 12 | 2 x 1 = 2 | 28/03/2025 |
| 829 | Cyber Security - Windows 11 Roll-out before Win10 EOL | 4 x 3 = 12 | 2 x 2 = 4 | 14/10/2025 |

**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, as well as adding to risks of worse health for our local population and staff, and increased risk of major climate change consequences. | Resulting in higher costs, reduced national standing and reduced resilience to climate change |
| **Category** | **Appetite** | **Status** |
| Technology & Innovation | Open<br>*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<br>6 | April<br>2022 | 2 x 3<br>6 | April<br>2025 | 2 x 2<br>4 | December<br>2027 |

| **Risk progression:** (previous 12 months) | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 | Feb 25 | Mar 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2 x 3<br>6 | 2 x 3<br>6 | 2 x 3<br>6 | 2 x 3<br>6 | 2 x 3<br>6 | 2 x 3<br>6 | 2 x 3<br>6 | 2 x 3<br>6 | 2 x 3<br>6 | 2 x 3<br>6 | 2 x 3<br>6 | 2 x 3<br>6 |

**Current assurances and updates**

This risk has been reviewed in April 2025 by the responsible executive. No significant changes are required however it continues to be noted that whilst there is assurance that the risk of not reducing direct emissions is very low and well managed, there is less assurance in relation to indirect emissions as this is more challenging to address. An additional challenge at present is the lack of leadership as the Head of Sustainability, as well as another member of the sustainability team, have left their roles. This slows the pace of ongoing work, such as review of the Green Plan which is hoped to be ratified in July 2025. To mitigate this, leadership across Hampshire & Isle of Wight is being explored. Despite this challenge though, work continues to progress to secure funding to deliver key initiatives, and a £19m bid has been submitted to Salix to support the heat recovery programme of work.

| Key controls | Gaps in controls |
|---|---|
| Governance structure including Sustainability Board<br><br>Clinical Sustainability Lead<br>Head of Sustainability and Energy<br><br>Appointment of Executive, Non-Executive and Council of Governors Lead(s) for Sustainability in post.<br><br>Green Plan 2022-2025. | Clinical Sustainability Plan/Strategy (CSP)<br><br>Long-term energy/decarbonisation strategy<br><br>Communications plan.<br><br>Capacity and reach of the clinical sustainability lead as there are not designated leads/champions within each speciality to influence this change. A proposal for champions has been submitted to TIG ad approved, however recruiting to the roles hasn't yet occurred due to the recruitment controls in place.<br><br>Do not have a fully funded plan to achieve the national targets set out. |
| **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. | Definition of and reporting against key milestones. |

| | |
|---|---|
| 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.<br>Quarterly reporting to NHS England and NHS Improvement on sustainability indicators.<br>Green Plan and Clinical Sustainability Programme has been approved by Trust Investment Group and Trust Board.<br>Sustainability Board | |

**Key actions**

Agree further funding requirements to commence the delivery of the strategies and identify opportunity. (Explore Low carbon skills funding)

Progress improvements to the Trust's estate and energy supply, including use of funding from the Public Sector Decarbonisation Scheme.

Continue to further develop metrics and establish governance processes in respect of the Trust's Green Plan and other related strategies.

Finalise energy performance contract to deliver a responsive and progressive energy plan.

It is also noted that whilst the majority of planned programmes of work funded by the public sector decarbonisation scheme has progressed, there have been challenges in the steam duct programme which has meant that further work in the lab and path block has now been put on hold.

Delivery of local initiatives, such as a project to reduce use of single use oxygen probes in ED.

| **Agenda Item 6.3 i) Report to the Trust Board of Directors, 13 May 2025** | |
|---|---|
| **Title:** | South Central Regional Research Delivery Network 2024-25 Annual Performance Review |
| **Sponsor:** | Mr Paul Grundy, Chief Medical Officer |
| **Author:** | Clare Rook, Network Director, SC RRDN and Graham Halls, Data and Analytics Senior Manager, SC RRDN |

**Purpose**

| (Re)Assurance | Approval | Ratification | Information |
|---|---|---|---|
| | | | **x** |

Strategic Theme

| Outstanding patient outcomes, safety and experience | Pioneering research and innovation | World class people | Integrated networks and collaboration | Foundations for the future |
|---|---|---|---|---|
| **x** | **x** | | | |

Executive Summary:

This report informs the Board of the health and care research activities within the Clinical Research Network Wessex (CRN Wessex) region in the first half of the 2024/25 financial year (April to September 2024), as well as the South Central Regional Research Delivery Network (SC RRDN) region during the second half (October 2024 to March 2025).

**Key points to highlight:**

- **Transition:** The report details the transition from NIHR CRN Wessex and CRN Thames Valley and South Midlands to the new SC RRDN in October 2024. The new SC RRDN covers three NHS integrated care board regions and is hosted by University Hospital Southampton NHS Foundation Trust (UHS).
- **Research activity:**
  - Organisations in the Wessex region (Hampshire, Isle of Wight, Dorset and South Wiltshire) recruited 33,486 participants to 505 studies in the first six months of the year.
  - Organisations in the South Central region (Berkshire, Buckinghamshire, Oxfordshire, Hampshire, Isle of Wight and the Frimley area) recruited 35,275 participants to 819 studies in the following six months.
  - Recruitment trends are being monitored due to a slight downward trend and reduced new study registrations nationally.
  - Commercial research remains a priority, with the South Central region ranking highly in commercial recruitment within England, relative to our comparatively small population.
- **Participant Experience:** The Participant in Research Experience Survey (PRES) achieved its national target, with generally positive responses, but identified communication from study teams and sponsors as an area for improvement.
- **Risk:** NHS pressures and a reduction in study availability are identified as risks to research delivery. SC RRDN will ensure our 2025/26 financial year activities, in collaboration with stakeholders, sustain the delivery of high-quality research in our newly established region.

Contents:

South Central Regional Research Delivery Network 2024-25 Performance Report, Appendix 1 – South Central RRDN Risk Register, Appendix 2 - Glossary.

Risk(s):

1b, 2a (for full details, please see Appendix 1)

| Equality Impact Consideration: | N/A |
|---|---|

University Hospital Southampton
NHS Foundation Trust

NIHR | Research Delivery Network

# South Central Regional Research Delivery Network

# 2024-25 Annual Performance Report

**Clare Rook, Network Director**

**Graham Halls, Data and Analytics Senior Manager**

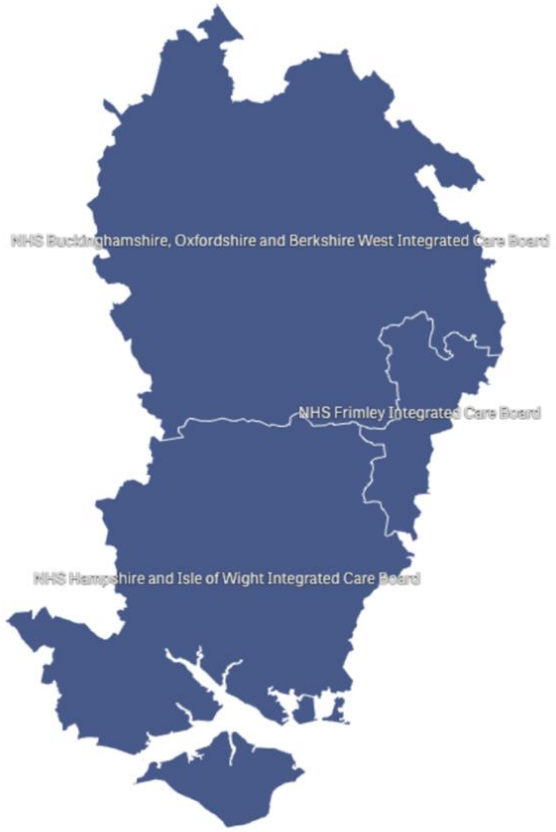
**May 2025**

## Introduction

This report informs the Board of the health and care research activities within the National Institute of Health and Care Research (NIHR) Clinical Research Network Wessex (CRN Wessex) region in the first half of the 2024/25 financial year (April to September 2024), as well as the NIHR South Central Regional Research Delivery Network (SC RRDN) region during the second half of the year (October 2024 to March 2025).

### Transition from NIHR Clinical Research Network Thames Valley and South Midlands and NIHR Clinical Research Network Wessex to NIHR SC RRDN

For the first six months of the financial year, the NIHR funded fifteen local clinical research network (CRN) regions in England. CRN Wessex operated for ten years across Dorset, South Wiltshire, Hampshire and Isle of Wight, and was hosted by UHS during that period. The next section of this report focusses on CRN Wessex's performance.




In October 2024, CRN Wessex and CRN Thames Valley and South Midlands transitioned to become a new organisation: **South Central Regional Research Delivery Network**. This included changes to the geographical area covered by the new organisation, which is now coterminous with three National Health Service (NHS) integrated care board regions (Figure 1). UHS is the host for SC RRDN.

The final section of this report summarises SC RRDN's performance in the first six months of operating between October 2024 and March 2025.

Figure 1 - Map of the NIHR South Central Regional Research Delivery Network region

## About the NIHR RDN

The NIHR Research Delivery Network (RDN) is funded by the Department of Health and Social Care (DHSC) to enable the health and care system to attract, optimise and deliver research across England.

The RDN consists of twelve RRDNs and a Coordinating Centre, working together as one organisation with joint leadership. The RDN contributes to NIHR's **mission** to improve the health and wealth of the nation through research.

### RDN vision, mission and purpose

The RDN's **vision** is for the UK to be a global leader in the delivery of high quality research that is inclusive, accessible, and improves health and care.

The RDN's **mission** is to enable the health and care system to attract, optimise and deliver research across England.

The RDN has two primary **purposes**:

- to support the successful delivery of high quality research, as an active partner in the research system
- to increase capacity and capability of the research delivery infrastructure for the future.

This will:

- enable more people to access health and social care research where they live
- support changing population needs by delivering a wider range of research and deliver research in areas of most need
- provide support to the health and care system through research
- encourage research to become a routine part of care
- support economic growth by attracting investment to the UK economy.

# CRN Wessex performance in April to September 2024

## 2023/24 CRN Wessex annual report: lessons learnt

The 2023/24 CRN Wessex annual report identified lessons learnt about maintaining strong research delivery and identified some necessary improvements. These learnings, which informed the Network's actions during 2024/25, are summarised below:

- **Early concerns addressed:** Early concerns about low predicted recruitment were addressed by the efforts of CRN Wessex partner organisations, enabled by the Network team.
- **Study delivery challenge:** Wessex did not fully meet the NIHR's study delivery high-level objective, particularly for commercial studies. However, non-commercial study delivery was closer to the target. This meant that some recruitment targets assigned by sponsors were not met or were met later than planned.
- **Participant experience:** Wessex met the high expectations in research participant experience with primarily positive feedback. Communications during the study and sharing the overall study results were identified as challenges, both locally and nationally.
- **Portfolio imbalance:** Early in the 2023/24 financial year, the research portfolio was considered unbalanced, with a skew towards smaller interventional studies. Adjustments were made to accelerate recruitment to all studies, bring in new projects, and reduce the time to open locally led research.
- **Importance of collaboration:** Collaboration between Wessex partner organisations was important in addressing recruitment challenges and increasing participant numbers.
- **Adaptability:** The ability to adapt research delivery and to be agile was beneficial. For example, the "core studies" approach at Portsmouth Hospitals NHS Trust ensured that there were projects supported by research staff based anywhere in the organisation who had less specialised skills.
- **Importance of Primary Care:** Primary care recruitment reached its highest levels in over a decade, showing the setting's critical role in research delivery and supporting the current Government's shift to care in the community.

## Overview of research activity in Wessex (April - September 2024)

This section describes research activity in the region covered by CRN Wessex. The CRN contract ended on 30 September 2024.

### Recruitment in Wessex

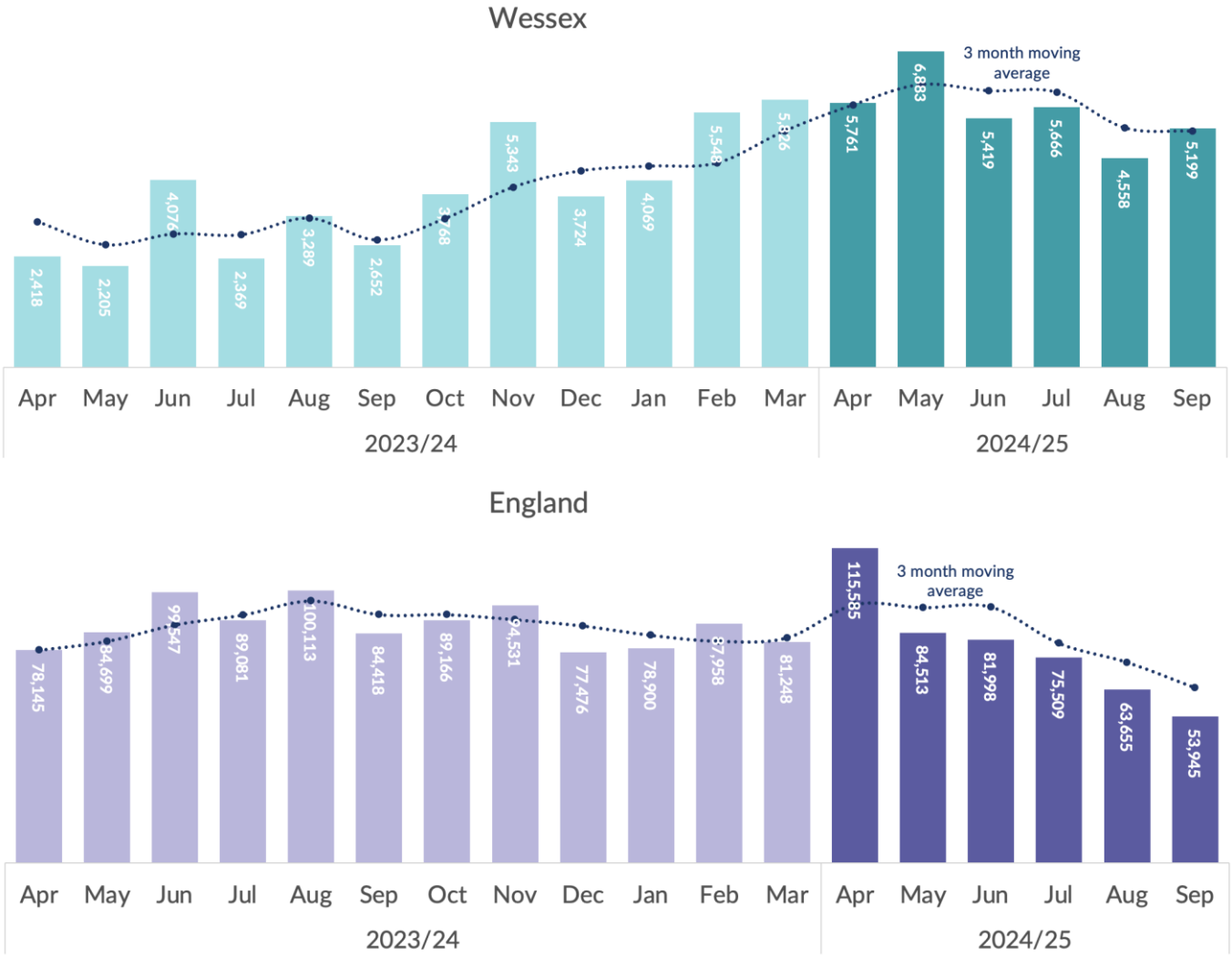



Figure 2 - Wessex research recruitment benchmarked against England since April 2023.

Figure 2 compares recruitment in the region previously covered by CRN Wessex to the whole of England since April 2023. With the interventions the CRN and its partners took in 2023/24, monthly recruitment generally increased to an average of around double previous levels. It was maintained at this level in the first six months of the 2024/25 financial year. At the same time, English recruitment was falling, to the extent that in March 2024 Wessex had close to ten percent of the enrolment from five percent of the English population. In total during this period, **33,486**

**participants** were recruited to **505 studies** at **149 sites** and across **all main clinical specialties**. Except for during the COVID-19 pandemic where recruitment was focussed on a small number of pandemic related studies, this was the highest recruitment ever in the first half of a year within Wessex.

## Recruiting studies in Wessex

The number of recruiting studies fell slightly during the final six months of the CRN Wessex contract (Figure 3). This coincided with a general decrease in the number of new studies registering on the NIHR's national Portfolio of research studies which CRN Wessex's partner organisations deliver (Figure 4).

As existing studies close to recruitment, the pipeline of new studies to replace them has reduced nationally. The average overall recruitment target (the sample size) for these studies has not significantly increased over the same period. This situation is likely to lead to lower recruitment across the system, increased competition to be selected as a recruiting site by study sponsors and therefore less availability of studies to offer to potential participants.

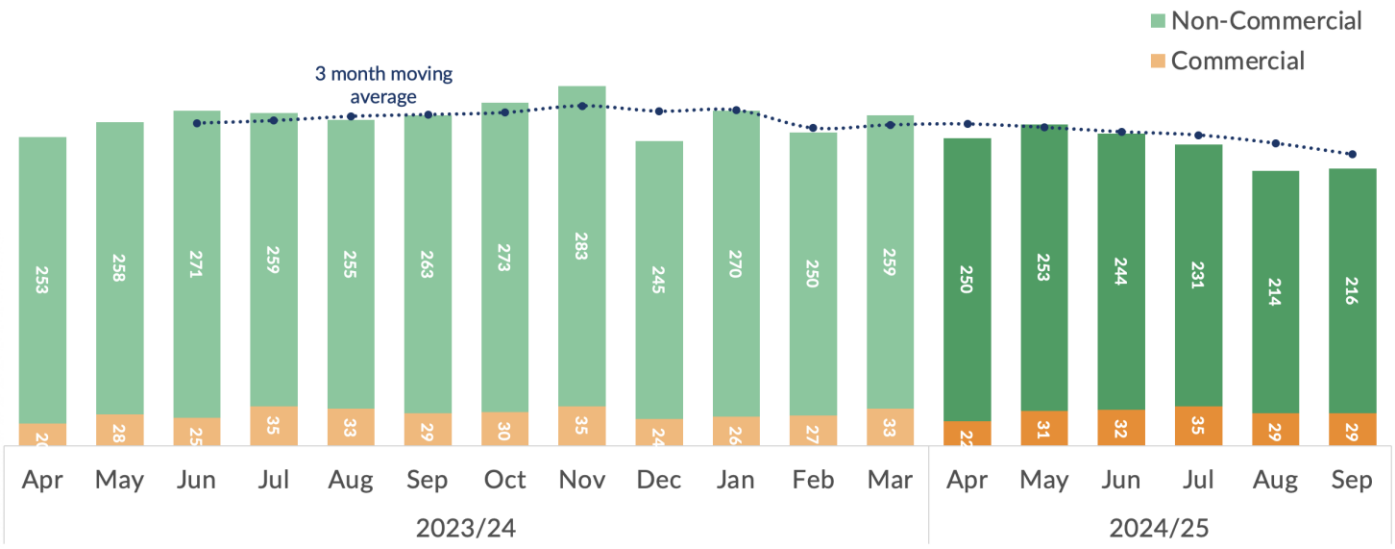



Figure 3 - Recruiting studies in the Wessex region since April 2023

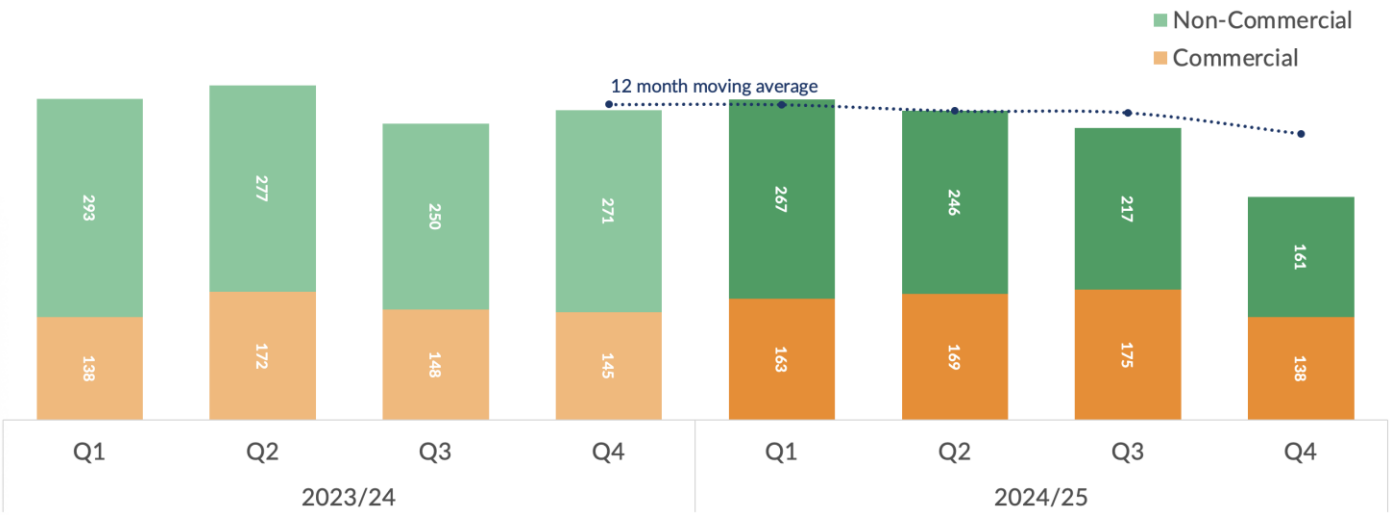



Figure 4 - Studies adopted on to the NIHR Portfolio nationally since April 2023

## Recruitment by organisation in Wessex

For reference, recruitment by organisation and organisation type during the four quarters leading up to the end of the CRN Wessex contract is provided in Figure 5. Organisation acronyms are available in the Glossary in Appendix Two.

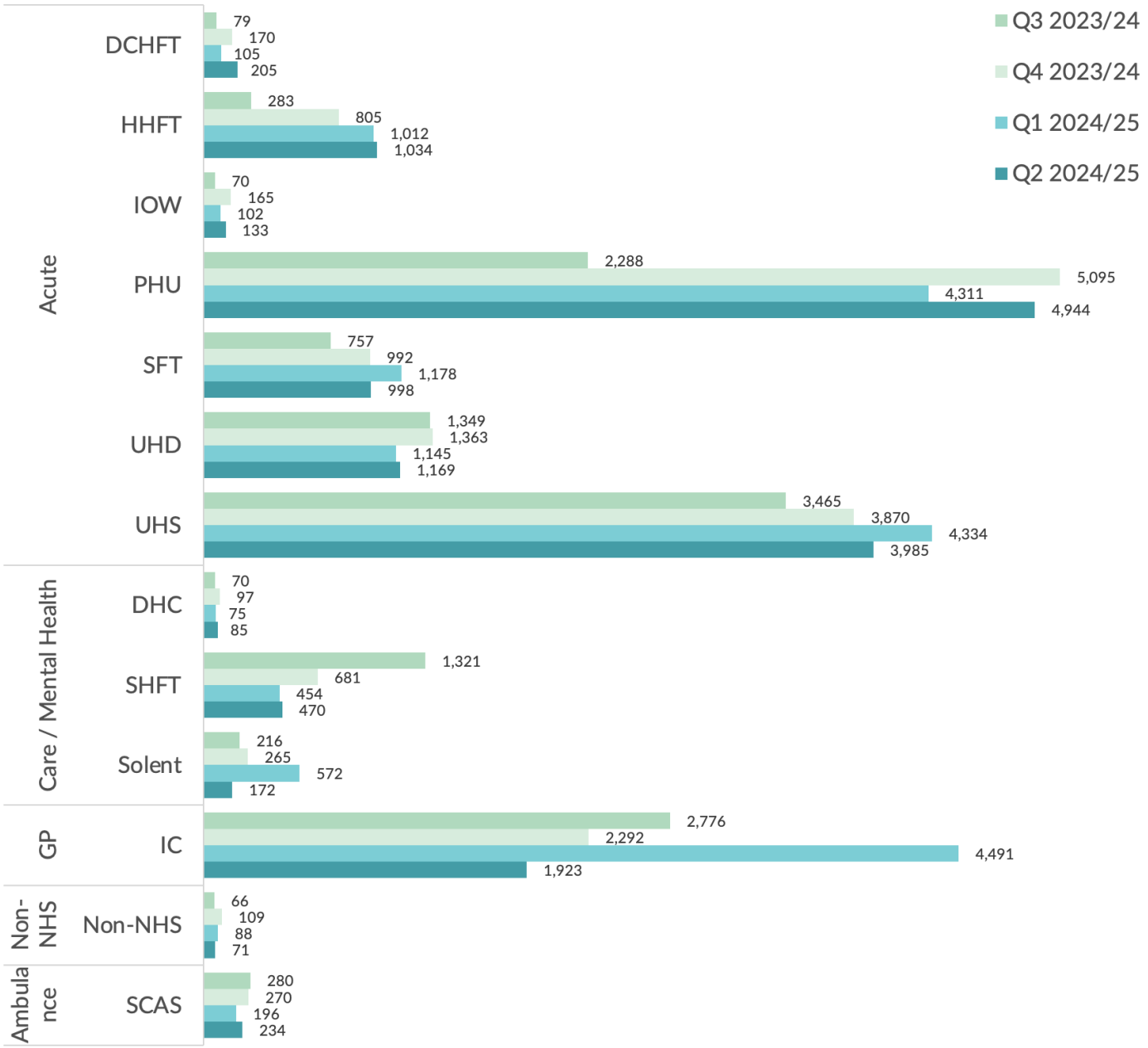



Figure 5 – Recruitment by organisation and organisation type in the Wessex region in the final four quarters of CRN Wessex contract

## Overview of research activity in South Central (October 2024 – March 2025)

This section describes research activity in the South Central RRDN region, which was established on 1 October 2024.

### Recruitment in South Central

The South Central region includes the organisations listed in Appendix Two. For comparison, recruitment at the organisations within the three ICB regions (Figure 1) has been included in Figure 6 and backdated to April 2023. The three month average recruitment fell during the last six months of the 2024/25 financial year, relative to earlier months. After adjusting for outliers by removing the top three recruiting studies, the underlying trend shows stable monthly recruitment in the South Central region, averaging over 4,700 participants for the remaining studies across the past twelve months. In total during the first six months of South Central RRDN, **35,275 participants** were recruited to **819 studies** at **212 sites** and across **all main clinical specialties**.

Recruitment is reliant on the availability of studies and their complexity, the availability of eligible participants and the continued resources required to deliver all study procedures for existing research participants. NHS pressures, such as staff recruitment freezes and financial restrictions, have been identified as a significant risk to research delivery by delivery organisations in the new South Central region. Organisations also report a reduction in the availability of studies, which is evidenced in Figure 4.

Recruitment on to the portfolio of research studies at organisations in the South Central region was considered balanced relative to the complexity of the studies (Figure 7). Large scale studies have a sample size over ten thousand participants and are usually designed to be simpler to deliver. Observational studies require no change to a participant's care pathway and may include data collection, surveys or interviews only. Interventional studies and the majority of those that are commercially funded and sponsored typically have more intensive requirements, including frequent visits and additional procedures. Notably for organisations in the South Central region, there has been a decrease in recruitment compared to previous financial years on to less complex research study types. This indicates that the studies that are being delivered require increased resources.

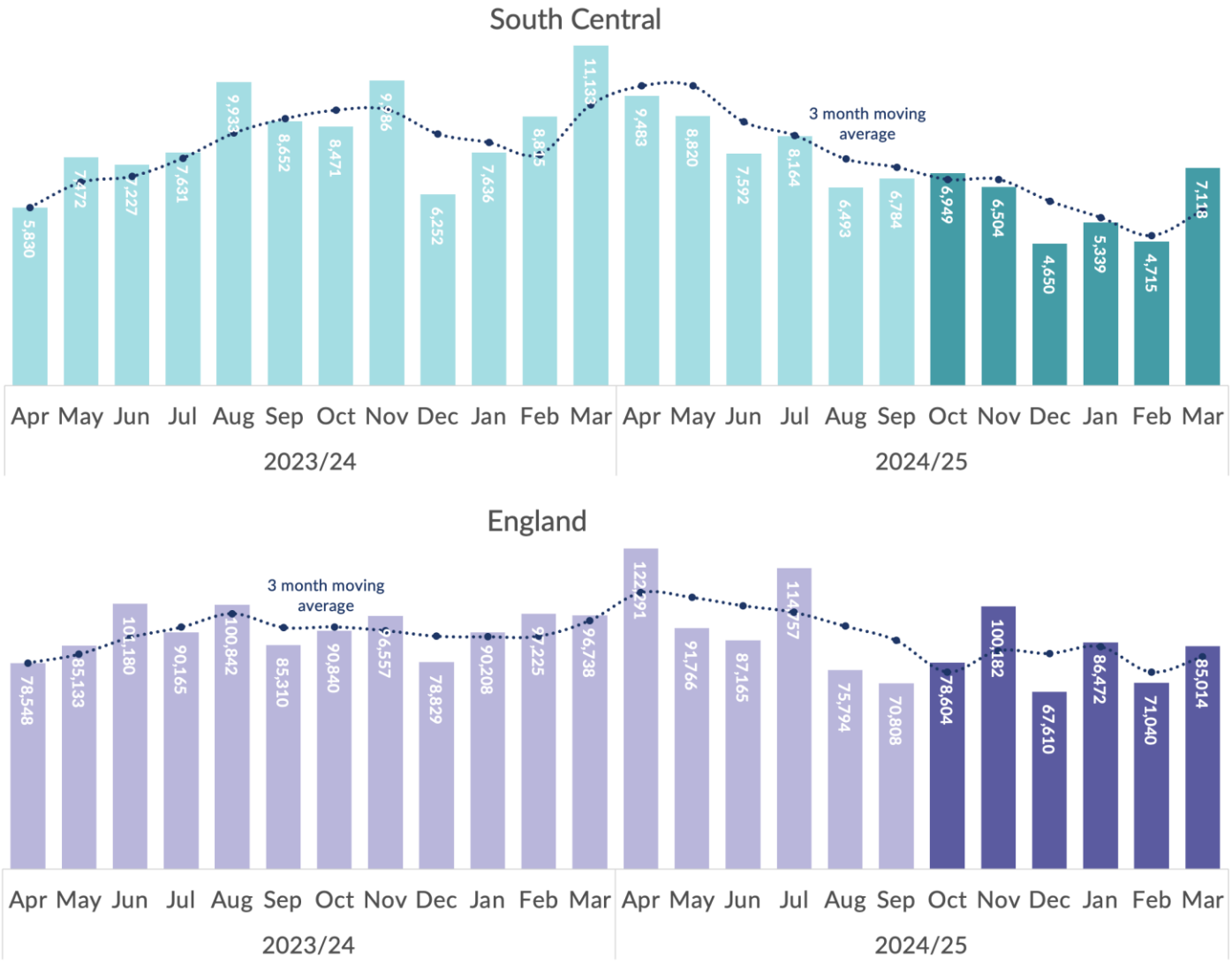



Figure 6 – South Central research recruitment benchmarked against England since April 2023.

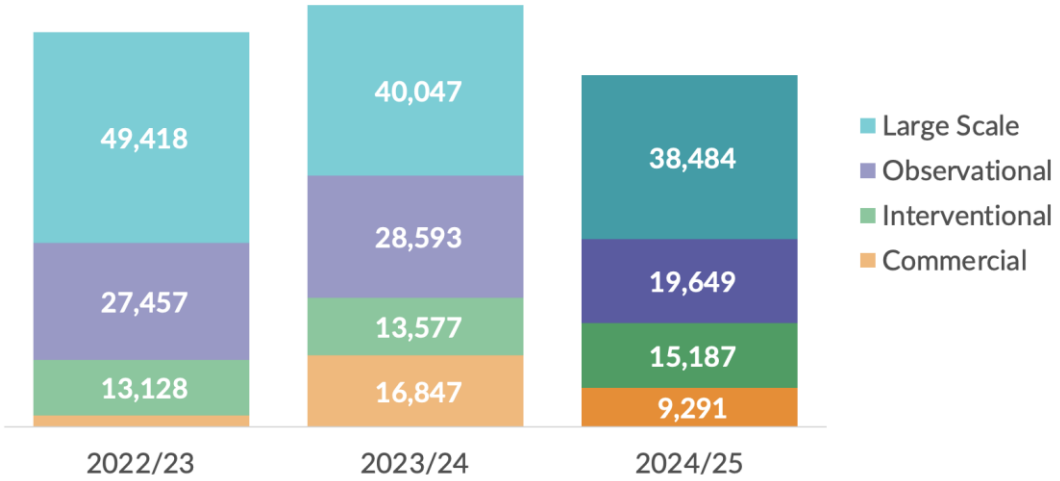
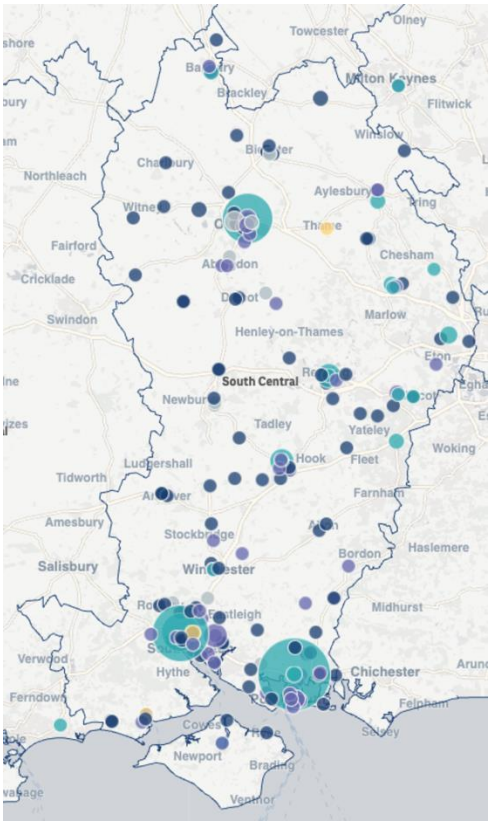



Figure 7 - Recruitment by study complexity category at organisations within the South Central region since April 2023

## Recruitment by organisation in South Central




| Organisation type | Trusts | Recruiting sites | Recruitment |
|---|---|---|---|
| Acute | 8 | 33 | 27,634 |
| Ambulance | 1 | 11 | 394 |
| Primary care | N/A | 102 | 3,098 |
| Mental Health | 3 | 62 | 3,585 |
| Non-NHS | N/A | 6 | 619 |

Figure 8 shows how research activity is distributed across the South Central region by type of organisation. All South Central NHS Trusts are research active and more rural areas have been reached by primary care, mental health services and non-NHS organisations.

Figure 8 – Research activity in the South Central region by organisation type in the first six months of the SC RRDN contract (October 2024 to March 2025)

| Organisation type | Trusts | Recruiting sites | Recruitment |
|---|---|---|---|
| Acute | 8 | 33 | 27,634 |
| Ambulance | 1 | 11 | 394 |
| Primary care | N/A | 102 | 3,098 |
| Mental Health | 3 | 62 | 3,585 |
| Non-NHS | N/A | 6 | 619 |

For reference, recruitment by organisation and organisation type during the 2024/25 financial year is provided in Figure 9. Organisation acronyms are available in the Glossary in Appendix Two.

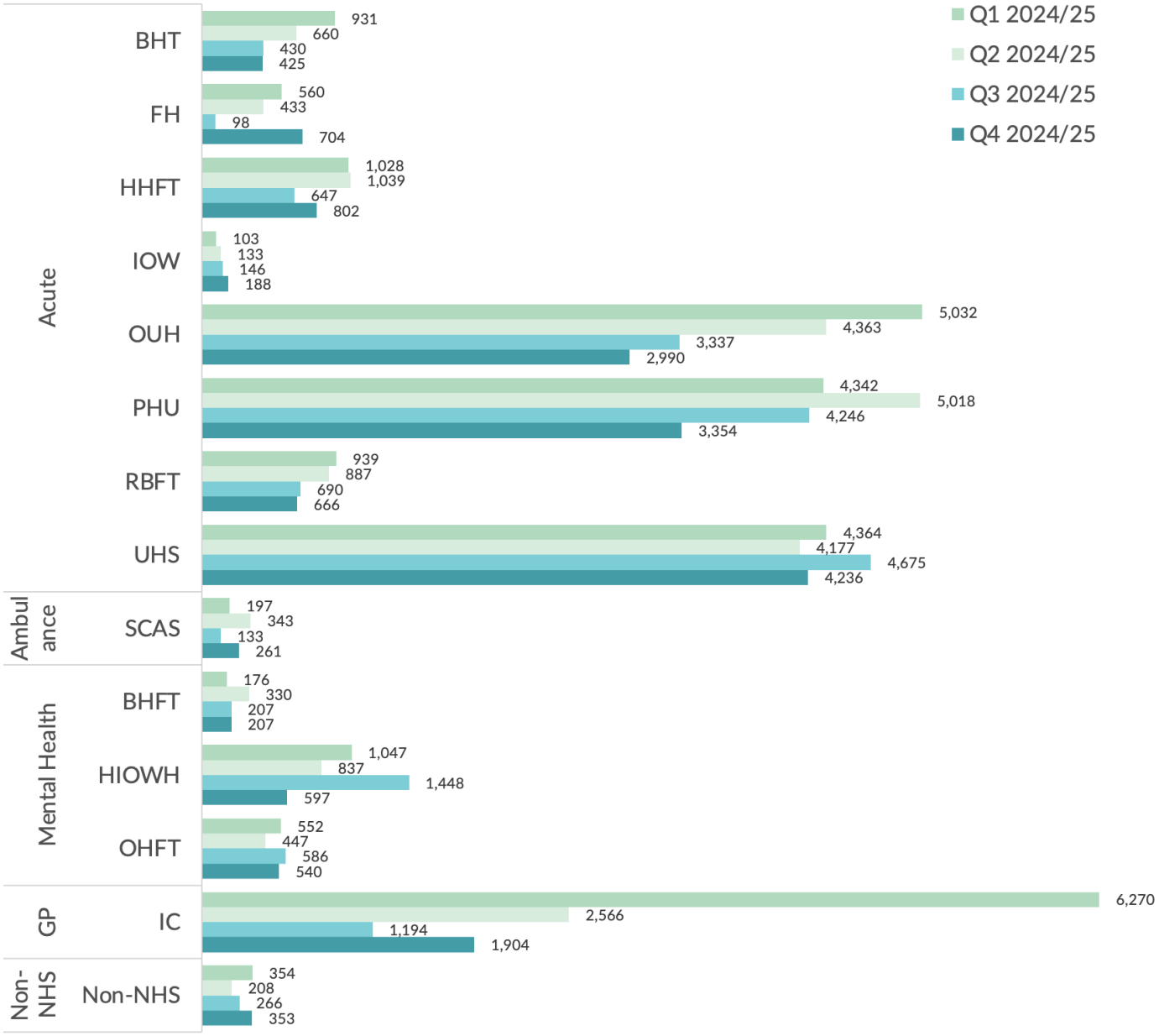



Figure 9 – Recruitment by organisation and organisation type in the South Central region in the 2024/25 financial year

## Recruiting studies in South Central

With the change in geography of the Network's region, the number of studies that have recruited each month has increased to over 400 (Figure 10) compared to CRN Wessex's previous average of 284. There is a slight downward trend evident and the reasons for this are believed to be common between the previous and new regions (as described above). SC RRDN will continue to monitor this

trend and review the balance of the region's portfolio, with updates provided to the Board in future reports.

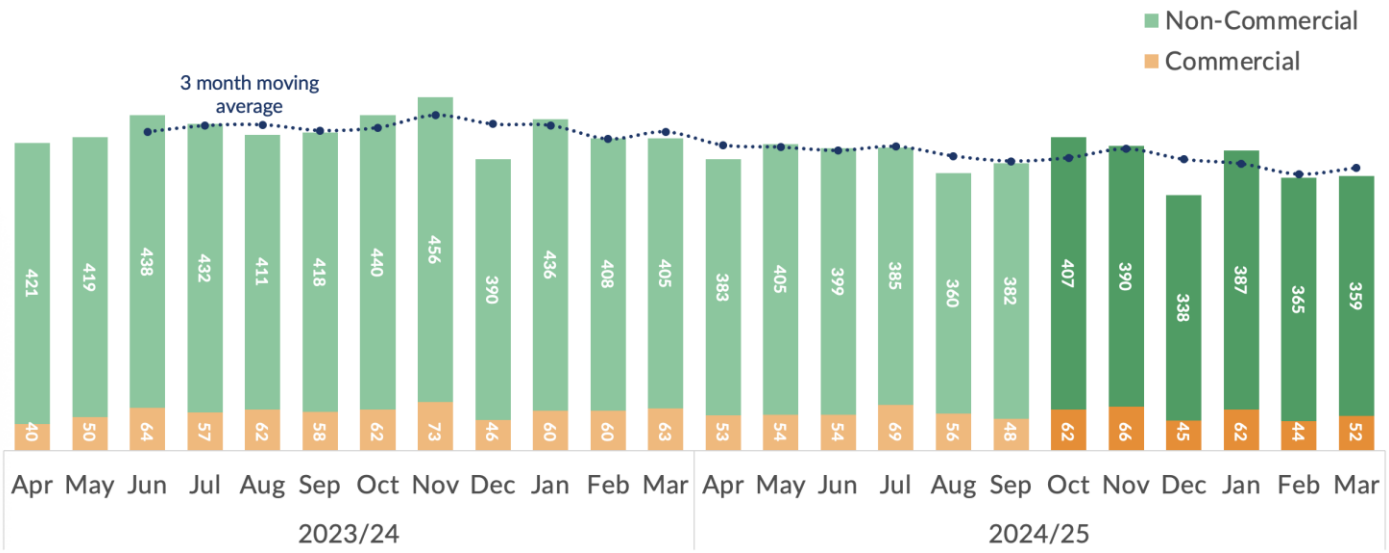



Figure 10 - Recruiting studies in the South Central region since April 2023

## Participant Experience (PRES)

The experience of participants while supporting a research study is measured using a national 'Participant in Research Experience Survey' (PRES). There were **1,029 responses** in the first six months of the South Central RRDN contract. This met the regional target of 1,000 responses.

Responses to PRES have been generally positive, with above ninety percent agreeing with most statements (Figure 11), except those related to outgoing communications from the sponsor and study teams. Research governance requires contact with participants to be approved by an ethics committee, therefore this needs to be considered during the early study design or subsequent formal amendments. The SC RRDN patient and public involvement and engagement team are working with the NIHR Research Support Service to ensure that sponsors are advised to include additional contact with participants in their study protocols.

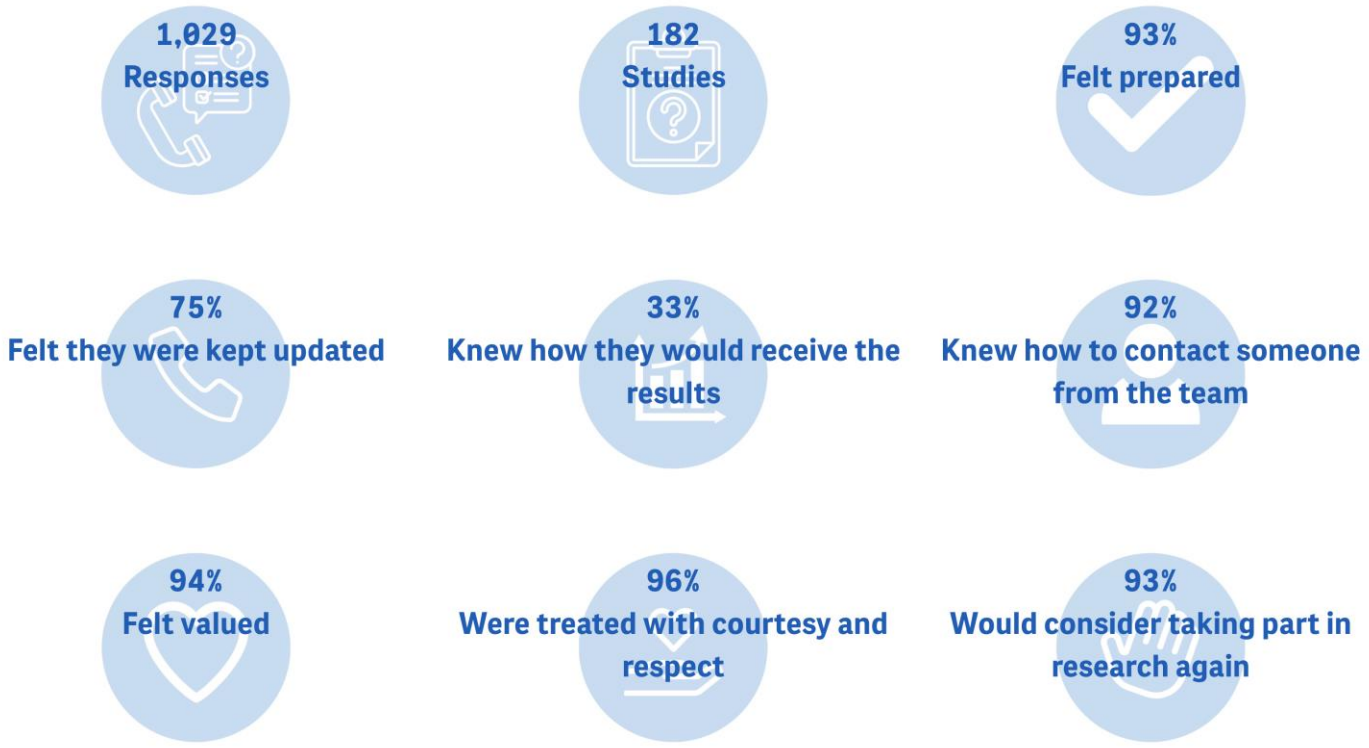



Figure 11 - Summary of the Participant in research experience survey results in the South Central region in quarters three to four of the 2024/25 financial year

## Commercial research activity in the South Central region

Commercial research, funded and sponsored by the life sciences industry, is important to the South Central 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. This supports the NIHR's mission to increase the health and wealth of the nation through research (NIHR website). Lord O'Shaughnessy's review of commercial clinical trials in the UK also recommended substantial increases in commercial recruitment in the UK (Lord O'Shaughnessy review).

In the first six months of the RRDN, organisations in the South Central region have recruited **1,854 participants** across **47 sites** on **165 commercial studies**. South Central was the **fourth highest recruiting RRDN region in England**, with the eighth largest population (Figure 12).

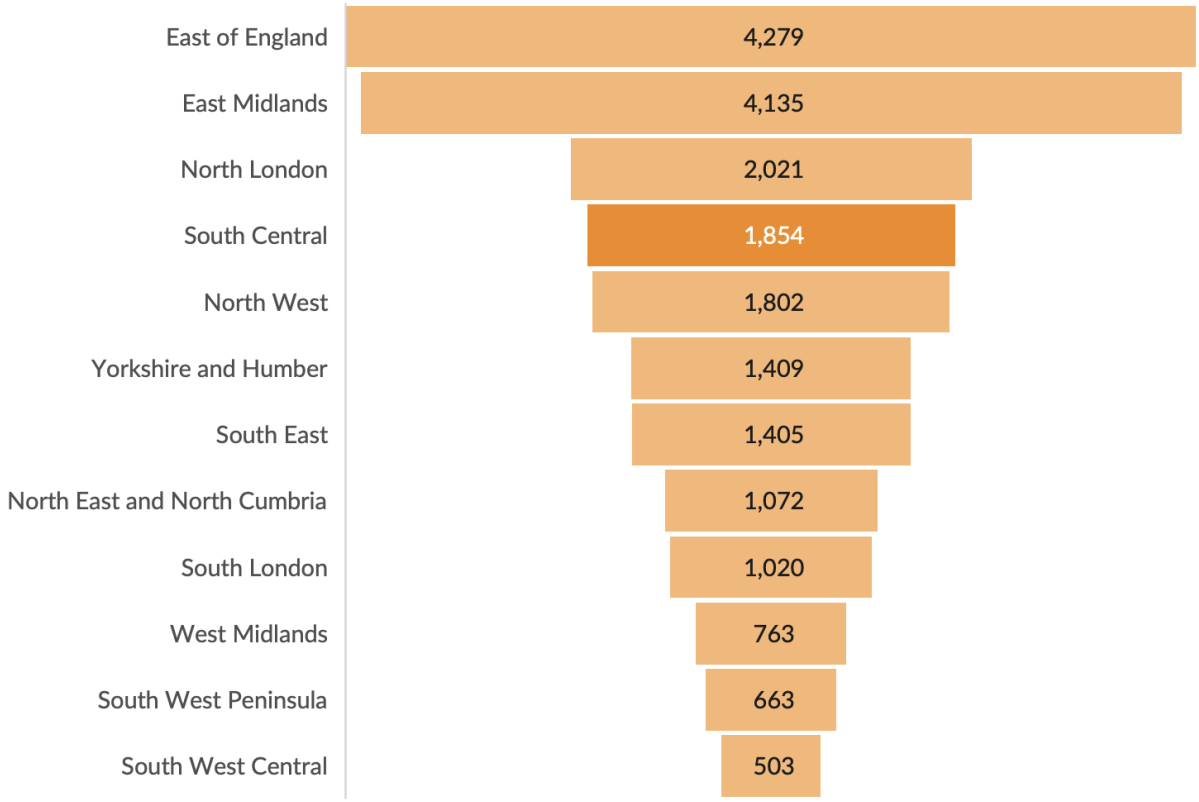



Figure 12 - Commercially funded and sponsored study recruitment by RRDN region in quarters three to four of the 2024/25 financial year

## Conclusion

The 2024-25 financial year has been a period of significant transition, but research activity across all specialties and health and care settings has continued within the South Central region. While we have seen high levels of participant recruitment and positive participant experience reported, it is necessary to acknowledge the emerging challenges. Factors such as national recruitment trends, study availability, and NHS operational pressures pose risks to future performance. SC RRDN will continue to monitor these trends closely, adapt its strategies, and collaborate with delivery organisations to ensure the sustained delivery of high-quality research. The Department of Health and Social Care has signalled that there will be a renewed focus on the time taken to set up commercially funded and sponsored studies in the UK from 2025/26.

SC RRDN will also focus on addressing identified areas for improvement in participant communication and further strengthening our position in commercial research. SC RRDN remains

committed to supporting the NIHR's mission to improve the health and wealth of the nation through research and will provide regular updates to the Board on our progress and performance.

# Appendix

## Appendix 1 – South Central Risk Register

| South Central Regional Research Delivery Network | | PENDING RISK DESCRIPTION | | | Pre Respone Rating | | | Response | | CURRENT (RESIDUAL) RATING | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Risk Category** | **Risk Title** | **SCRRDN Reference Number** | **Risk Description (to include cause/event)** | **Effect/Impact** | **Probability Value** | **Impact Value** | **Score (Col JxK)** | **Mitigation Actions** | **Mitigation actions Outstanding** | **Current Likelihood** | **Current Impact** | **Current Score** | **Notes** | Last Review Date | Comment |
| **20. Workforce Learning and Organisational Development** | Research Registered NMAHPs shortage in partner organisations and job freezes in place. | SCRRDN 001 | **Cause:** Lack of availability of registered NMAHPs. **Event** :Leading to a shortfall in registered staff qualified to deliver clinical trials | Fewer clinical trials are delivered and/or quality of research conducted becomes reduced leading to repuational damage. | 3 | 3 | 9 | 1. Recruit band 3 CTAs and train up to band 4 level to relieve existing nursing staff of some duties 2. Recruit CRPs to relieve existing nursing staff of some duties 3. Recruitment campaign to attract graduates to research delivery careers. 4. to be aware of trusts with job freezes and implications of RRDN funded posts 5. Letter circulated to SC region R&D DIrectors to remind that RDN funding is ringfenced and posts funded through this stream should not be impacted by recruitment freezes, as per the RDN research delivery organisation contract | all Ongoing | 2 | 2 | 4 | | 11/3/25 | |
| **20. Workforce Learning and Organisational Development** | Network Agile Research Delivery Team (ARDT) Workforce | SCRRDN 002 | **Cause:** Staff exhaustion due to ongoing workload and uncertainty. Recruitment Freeze pending organisational change. **Event**: Staff we have invested in and developed to work in this Agile capacity leave and we lose this capability without being able to recruit | Unable to deliver Goverment priority studies as DHSC expectations of new RRDN contract. Fewer Clinical trials are delivered. This has been further impacted by the seperate organisational change processes of the ARDT and management team. Decrease in the number of studies that can be delivered. | 4 | 4 | 16 | 1. Ongoing recruitment to the direct delivery team - PAUSED 2. Reinvestment of hub income to increase head count - PAUSED 3. Wellbeing programme established for the team and delivered by the team 4. Ensure regular check-ins at 1:1 meetings with all staff 5. Continue to keep a close eye on any changes using all possible tools, e.g. 1:1s, team meetings, welbbeing surveys etc 6. Encourage regular taking of annual leave throughout the year, limiting the accrual of TOIL wherever possible. 7. Encourage all staff to take regular breaks during the working day and consider the use of walking meetings etc as a way of stepping away from screens, encouraging interactions. | Recruitment paused, reinvestiment of hub income paused, dependent on organisational change . | 4 | 4 | 16 | | 24/4/25 | Revised risk for SCRRDN |
| **20. Workforce Learning and Organisational Development** | All Core Team workforce Management moral and anxiety after restructure | SCRRDN 003 | **Cause:** Staff wellbeing affected due to the longevity and emotional impact of transition. **Event:** Staff mental health impacted and unable to be at work and post transition | SC RRDN unable to meet contract requirements | 3 | 1 | 3 | 1.Wellbeing leads and champions identified, planning for wellbeing initiatives in situ, 2.UHS wellbeing check ins and informal check in with Line Managers. 3.Signposting to the services available via UHS to support staff wellbeing. | Need for actions for management team decreasing | 1 | 3 | 3 | | 11/3/25 | Residual risk only now that MOC has been completed |
| **15. Research Delivery** | NHS Pressures | SCRRDN 004 | Impact of NHS pressures on clinical services impacting on delivery of Research | Thus causing research staff to be redeployed to clinical services | 4 | 4 | 16 | 1. Raise locally and nationally for advice on prioritisation of key activities/studies | Ongoing | 4 | 4 | 16 | | 23/4/25 | |
| **15. Research Delivery** | PET Scanning Access | SCRRDN 005 | Cause: Reduced access to PET scanning capacity and tracers (amyloid and tau) required for both clinical and research scans Event: Limited access to PET scans for research purposes. Reduced opportunities for access to research for neurology and oncology patients. | Threat to safety and data integrity if schedule of imaging events cannot be adhered to. | 4 | 4 | 16 | 1. Raised at OMG and IOM/BDM meeting, to monitor.<br>2. Discussed with COO and local escalation to ICBs via WHP | Ongoing | 3 | 3 | 9 | | 23/4/25 | |

| South Central Regional Research Delivery Network | | PENDING RISK DESCRIPTION | | | Pre Respone Rating | | | Response | | CURRENT (RESIDUAL) RATING | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Risk Category | Risk Title | SCRRDN Reference Number | Risk Description (to include cause/event) | Effect/Impact | Probability Value | Impact Value | Score (Col JxK) | Mitigation Actions | Mitigation actions Outstanding | Current Likelihood | Current Impact | Current Score | Notes | Last Review Date | Comment |
| **19. Health and Care Services Engagement** | BOB and Frimley ICB Engagement | SCRRDN 006 | Difficulties engaging with ICS organisations that cover the South Central Region. Slow establishment of BOB ICS compared with other regions. | Failure to progress with workstreams and opportunities missed. | 3 | 2 | 6 | 1) Liaise with RDN CC and with fellow RRDNs to align work. 2) Leverage relationships already in place with the BOB ICS (eg OUHFT and AHSN) 3) ICS-focussed Stakeholder Day was held in January 2025 | Ongoing | 3 | 2 | 6 | | 23/4/25 | |
| **17. Communications** | Low researcher useage of Be Part of Research volunteer service | SCRRDN 007 | Low awareness and useage of Be Part of Research volunteer service by researchers could see opportunities missed to enhance recruitment to trials. Could result in volunteers not being contacted about studies, leading to negative perception of service / volunteers de-registering. Details about trials using the service have been requested from CC. | Opportunities missed to enhance recruitment to trials. Could result in volunteers not being contacted about studies, leading to negative perception of service / volunteers de-registering | 3 | 2 | 6 | Promotion of service to researchers through study support service and other teams and wider promotion e.g. newsletters | Ongoing | 3 | 1 | **3** | | 17/4/25 | Not possible to update further - volunteer registration data has not been updated since September 2024 and data about use of the volunteer registry by researchers has not been made available by NIHR |
| **17. Communications** | Low awareness of branding guidelines | SCRRDN 008 | Low awarness of name change to RDN and inappropriate use of South Central RRDN name with external stakeholders could result in negative impact on perception of the RDN as one network | Could result in negative impact on perception of the RDN as one network | 3 | 2 | 6 | Promotion of branding guidelines and files to RRDN staff and delivery organisations, responses ot queries via shared inbox | Ongoing | 3 | 1 | **3** | | 17/4/25 | Decreased risk but still requires regular reminders to RRDN and delivery organisation staff |
| **14. RDN Specialties and Settings** | Failure to appoint to all specialty and setting lead posts | SCRRDN 010 | Risk of having vacant specialty or settting lead post due to absence of applications or inability to appoint | Lack of strategic clinical oversight and leadership. Lack of local clinical engagement | 3 | 1 | 3 | Re-advertise posts<br>Identify and directly approach appropriate individuals<br>Encourage NMAHP applications<br>Consider job shares | Ongoing only 2 vacant posts | **3** | **1** | **3** | | 25/4/25 | Decreased risk large majority of posts now appointed to plans in place to recruit remainder 2 posts for renal and ENT |

| South Central Regional Research Delivery Network | | PENDING RISK DESCRIPTION | | | Pre Respone Rating | | | Response | | CURRENT (RESIDUAL) RATING | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Risk Category | Risk Title | SCRRDN Reference Number | Risk Description (to include cause/event) | Effect/Impact | Probability Value | Impact Value | Score (Col JxK) | Mitigation Actions | Mitigation actions Outstanding | Current Likelihood | Current Impact | Current Score | Notes | Last Review Date | Comment |
| **18. Patient and Public Involvement and Engagement (PPIE)** | Engagement with Public Partnerships Commmunity of Practice | SCRRDN 011 | **Cause:** Uncertainty around roles and responsbilities<br>**Event:** Transition from Clinical Research Network to Research Delivery Network | Uncertainty around who should represent South Central Regional Research Delivery Network at Public Partnerships Community of Practice meetings, working groups, and other activities leading to inefficiencies if multiple people attend etc | 3 | 2 | 6 | Review at Senior Management Group Meetings and internal discussion within the local Strategic directorate team | Ongoing | 1 | 1 | 1 | | 30/4/25 | As Team and functions establishing, remits and decision making processes(eg team meetings) reducing the risk |
| **18. Patient and Public Involvement and Engagement (PPIE)** | Relationship management - building and maintaining positive connections | SCRRDN 012 | **Cause:** Change of region/staff/uncertainty<br>**Event:** Transition from Clinical Research Network to Research Delivery Network | Risk to relationship continuity with the following:<br>1. Organisations participating in Research Ready Communities initiative<br>2. Research Champions<br>3. Public Contributors | 3 | 3 | 9 | Maintain relationships through regular contact | Ongoing | 2 | 3 | **6** | | 30/4/25 | |
| **15. Research Delivery** | Delivery to RDN High Priority Studies - Lead Network | SCRRDN 013 | Failure to succesfully deliver high priority studies led by SC RRDN | 1. Reputational damage to SC RRDN as a lead network, the UK as a place to deliver research and individual delivery organisations<br>2. Potential loss of future studies and associated income<br>3. Negative impact of staff moral<br>4. Reduction in commercial income could hinder capacity build and growth within delivery organisations | 2 | 4 | **8** | 1. Early engagement and frequent communication with sponsor, CRO, VIP, RDNCC, RRDNs, Key Account Managers and delivery organisations.<br>2. Agile delivery team resource allocated to support delivery in all RRDNs<br>3. Importance of high priorty studies communicated to delivery organisations at a senior level<br>4. Supporting sponsor and sites with timely rectuitment uploads to allow recruitment to be closely monitored and issues identified | All ongoing | 2 | 3 | **6** | | 24/4/25 | |
| **15. Research Delivery** | Delivery to RDN High Priority Studies - Participating Site | SCRRDN 014 | Failure to succesfully deliver high priority studies at delivery organisations within SC RRDN | 1. Reputational damage to SC RRDN delivery onrganisations and to the UK as a place to deliver research<br>2. Potential loss of future studies and associated income<br>3. Negative impact of staff moral<br>4. Reduction in commercial income could hinder capacity build and growth within delivery organisations | 3 | 4 | **12** | 1. Early engagement and frequent communication with sponsor, CRO, VIP, RDNCC, RRDNs, Key Account Managers and delivery organisations.<br>2. Local Agile delivery team resource allocated to support delivery organisations.<br>3. Importance of high priorty studies communicated to delivery organisations at a senior level | All ongoing | 2 | 3 | **6** | | 24/4/25 | |

| South Central Regional Research Delivery Network | | PENDING RISK DESCRIPTION | | | Pre Respone Rating | | | Response | | CURRENT (RESIDUAL) RATING | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Risk Category** | **Risk Title** | **SCRRDN Reference Number** | **Risk Description (to include cause/event)** | **Effect/Impact** | **Probability Value** | **Impact Value** | **Score (Col JxK)** | **Mitigation Actions** | **Mitigation actions Outstanding** | **Current Likelihood** | **Current Impact** | **Current Score** | **Notes** | Last Review Date | Comment |
| **20. Workforce Learning and Organisational Development** | Non-patient facing staff role security during the SC RDN organisational change process. | SCRRDN 015 | Risk to role security for non-patient facing roles within ARDT during the RRDN agile organisational change process. | 1) Negative impact on staff moral and well-being. 2) Disruption during the organisational changes and potential resulting impact on research support and delivery. 3) Reputational risk of damage if changes impact on study delivery and external comms. | 4 | 3 | **12** | 1) Continuous monitoring of staff morale through line management, 1:1s and team meetings. 2) standing agenda item on the senior agile management team meeting that happens bi-weekly. 3) regularly discussed at SC RDN meetings including the SMT. 4) SC RDN Senior management to review regularly and respond appropriately. 5) SC RDN well-being leads involved in key discussions. | All ongoing | 4 | 2 | 8 | | 24/4/25 | |
| **15. Research Delivery** | Agile team members working in new environments | SCRRDN 016 | Expectation for the Agile team to expand research delivery to wider commmunity and out of hospital settings. This will include settings where SC RDN does not have prior experiece of delivering research, which may present unfamiliar risks to the safety and well-being of staff members e.g. prisons and probation service, severe mental health services. There is a lack of national guidance for staff working in these new settings and current training may not sufficently cover. | 1) Potential threat to agile staff work place safety and well-being when working in new environments and participant groups. 2) Unforseen safety considersations and risks that potentially prevent continuation of research delivery. 3) Additional time may be required during study set up to train staff in preperation for the study to be delivered. | 3 | 3 | **9** | 1) Wider SC RRDN agile meeting 21/11/24 - agreed management plan. 2) Expand SC RRDN training where gaps are identified during study specific feasibility assessment. Training can can be sourced from in-house expertise, regional expertise and nationally available training resources. General training (e.g. de-escalation methods) to be provided as required to benefit staff who deliver research across settings and during engagement activities with patients, service users and the public. 3) Nancy to raise risk at the next national agile meeting to discuss, including how RDNs can collectively pool resources such as best practice, SOPS and training resources 4) Agile and primary care teams to adapt national/supr-regional resources and apply to SC RDN region when appropriate to do so. | All ongoing | 2 | 3 | 6 | | 24/4/25 | |
| **15. Research Delivery** | Risk of studies not being delivered at OUH sites due to the withdrawal of the SC RDN agile team based in Oxford and Horton. | SCRRDN 017 | New studies not being approved to be delivered at OUH sites due to SC RDN organisational changes and expectation for the OUH based agile team withdrawal. Timeline not yet known. Risk to current studies on the portfolio not being delivered in their entirety. | 1) studies not delivered at OUH due to workforce limitations. 2) SC RDN and OUH organisational reputational damage. 3) uncertainty regarding agile team availability for current and future study delivery. | 4 | 4 | **16** | 1) Meeting held between RC, MD and Sandie Wellman 11.4.25 2) Meeting to be set up between MM, RC, MD, Sandie Wellman and Chris Bray to review the OUH SC RDN portfolio of studies on a regular basis during the RDN organisational change process, this will include new studies requesting agile to support. 3) regular review by the senior agile, management team including at the bi-weekly agile management meeting. 4) Transitional arrangements to be agreed to ensure continuity of study delivery. 5 Meeting held between MD, CR, SW, CB, KA (24/5/25 | All ongoing | 4 | 3 | 12 | | 25/4/25 | |

## Appendix 2 - Glossary

South Central research delivery organisation acronyms:

| Delivery organisation | Acronym |
|---|---|
| Berkshire Healthcare NHS Foundation Trust | BHFT |
| Buckinghamshire Healthcare NHS Trust | BHT |
| Frimley Health NHS Foundation Trust | FH |
| Hampshire and Isle of Wight Healthcare NHS Foundation Trust | HIOWH |
| Hampshire Hospitals NHS Foundation Trust | HHFT |
| Isle of Wight NHS Trust | IOW |
| Independent contractors (primary care) | IC |
| Non-NHS organisations in the South Central region | Non-NHS |
| Oxford Health NHS Foundation Trust | OHFT |
| Oxford University Hospitals NHS Foundation Trust | OUH |
| Portsmouth Hospitals University National Health Service Trust | PHU |
| Royal Berkshire NHS Foundation Trust | RBFT |
| Solent NHS Foundation Trust | Solent |
| South Central Ambulance Service NHS Foundation Trust | SCAS |
| University Hospital Southampton NHS Foundation Trust | UHS |

Partner organisation abbreviations previously used by CRN Wessex:

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

NIHR Regional Research Delivery Network abbreviations and their population:

| NIHR Regional Research Delivery Network (RRDN) | Acronym | Population |
|---|---|---|
| East Midlands | EM | 4,934,939 |
| East of England | EoE | 6,697,937 |
| North East and North Cumbria | NENC | 3,005,519 |
| North London | NL | 5,561,092 |
| North West | NW | 7,199,831 |
| South Central | SC | 4,418,268 |
| South East | SE | 4,655,433 |
| South London | SL | 3,305,088 |
| South West Central | SWC | 3,384,367 |
| South West Peninsula | SWP | 2,387,206 |
| West Midlands | WM | 6,021,653 |
| Yorkshire and Humber | YH | 5,535,065 |

University Hospital Southampton NHS Foundation Trust

| Agenda Item 6.3 ii) | Report to the Trust Board of Directors, 13 May 2025 |
|---|---|
| **Title:** | South Central Regional Research Delivery Network 2025-26 Annual Plan |
| **Sponsor:** | Mr Paul Grundy, Chief Medical Officer |
| **Author:** | Clare Rook, Network Director, SC RRDN |

**Purpose**

| (Re)Assurance | Approval | Ratification | Information |
|---|---|---|---|
| | | | x |

**Strategic Theme**

| Outstanding patient outcomes, safety and experience | Pioneering research and innovation | World class people | Integrated networks and collaboration | Foundations for the future |
|---|---|---|---|---|
| x | x | | | |

**Executive Summary:**

This report informs the Board of the high-level Annual Plan for the South Central Regional Research Delivery Network (SC RRDN) region for 2025/26. SC RRDN commenced on 1st October 2024 and is hosted by University Hospital Southampton. SC RRDN covers the geography of Hampshire and Isle of Wight, Berkshire West, Oxfordshire, Buckinghamshire and Frimley. The SC RRDN team includes staff from across the previous CRN Wessex and CRN Thames Valley & South Midlands teams. This plan outlines the work that will be undertaken by the newly formed team, through the RRDN services and functions they support. The plan is framed around the National Institute for Health Research (NIHR) 7 strategic areas of focus:

- Build on learnings from the research response to COVID-19 and support the recovery of the health and social care system
- Build capacity and capability in preventative, public health and social care research
- Improve the lives of people with multiple long-term conditions through research
- Bring clinical and applied research to under-served regions and communities with major health needs
- Embed equality, diversity and inclusion across NIHR's research, systems and culture
- Strengthen careers for research delivery staff and under-represented disciplines and specialisms
- Expand our work with the life sciences industry to improve health and economic prosperity

**Contents:**

South Central Regional Research Delivery Network 2025-26 Annual Plan

**Risk(s):**

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.

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.

| Equality Impact Consideration: | N/A |
|---|---|

NIHR | Research Delivery Network

# South Central RRDN annual plan 2025/26

## Introduction

South Central Regional Research Delivery Network (SC RRDN) commenced on 1st October 2024 and is hosted by University Hospital Southampton NHS Foundation Trust. SC RRDN covers the geography of Hampshire and Isle of Wight, Berkshire West, Oxfordshire, Buckinghamshire and Frimley. The SC RRDN team includes staff from across the previous CRN Wessex and CRN Thames Valley & South Midlands networks. This plan outlines the work that will be undertaken by the newly formed team, across the RRDN services and functions they support. The plan is framed around the National Institute for Health Research (NIHR) 7 strategic areas of focus and will demonstrate regional work in support of key national drivers. The 7 strategic areas of focus are outlined below.

**Build on learnings from the research response to COVID-19 and support the recovery of the health and social care system**

**Build capacity and capability in preventative, public health and social care research**

**Improve the lives of people with multiple long-term conditions through research**

**Bring clinical and applied research to under-served regions and communities with major health needs**

**Embed EDI across NIHR's research, systems and culture**

**Strengthen careers for research delivery staff and under-represented disciplines and specialisms**

**Expand our work with the life sciences industry to improve health and economic prosperity**

NIHR | Research Delivery Network

# South Central RRDN annual plan 2025/26

**Overarching objectives**

- Deliver a Strategic Funding Call across the SC region supporting the delivery of initiatives that respond to national strategic areas of focus, expand access to high quality research to under-served populations, build research partnerships and demonstrate value for money and impact.
- Convene a Stakeholder Group for the region to provide a key forum for collective engagement with partners, to ensure support & constructive mutual challenge on SC RRDN plans, activities, performance and reports in adherence with national strategies and metrics.
- Enable & support Specialty and Settings Leads to maximise opportunities for research participation across clinical areas including under-served specialties, settings, professions and populations.

## Build on learnings from the research response to COVID-19 and support the recovery of the health and social care system

- Develop & embed the Agile Research Delivery Team infrastructure to provide additional support for studies of national importance, seasonal studies such as vaccine trials and research delivery in wider health & care settings.
- Utilise strategic funding to assist in the resolution of issues related to the delay of study set-up activities and delivery in relation to Clinical Support Services (pharmacy, imaging & radiology and pathology).
- Support and enable the collaborative delivery of commercial studies across organisations and settings through facilitation of work towards a single commercial contracting model.

## Build capacity and capability in preventative, public health and social care research

- Undertake a scoping exercise to understand the potential to deliver studies in a range of wider health and care settings.
- Undertake a training needs analysis to identify the training, support and development requirements of the research delivery workforce to enable them to work safely and effectively in wider health and care settings such as prisons, schools, care homes and hospices.
- Expand and embed regional services and functions, ensuring national alignment to provide support for stakeholders across all settings and specialties.

## Improve the lives of people with multiple long-term conditions through research

- Provide support for the delivery of studies that address Multiple Long Term Conditions (MLTCs) and ensure the research delivery workforce is aware of the importance of research that is inclusive of MLTCs.
- Support the development of new collaborations across organisational boundaries as a foundation to the delivery of trials across care pathways and clinical pathways.
- Raise awareness of and promote Be Part of Research and Join Dementia Research registries through participation in regional and national communications campaigns.

## Bring clinical and applied research to under-served regions and communities with major health needs

- Build and launch a regional dashboard to provide intelligence about the NHS England South East region that seeks to identify where there are gaps in research delivery when compared to population statistics and disease prevalence as well as the region's research strengths.
- Develop and run an educational programme with the SC RRDN team to ensure involvement, engagement and inclusion is included in all workstreams.
- Create the systems and processes required to ensure the voice of the patient, the public and community organisations are listened to throughout RRDN workstreams.

## Embed EDI across NIHR's research, systems and culture

- Take part in public events such as health fairs and carnivals as well as hosting information stands at public venues to raise awareness of research and promote participation in research across broad and diverse communities.
- Deliver the regional Participant in Research Experience Survey (PRES) to collect, interpret and address feedback from participants taking part in research across sites in the SC region.
- Implement a ‘digital first’ approach to PRES by working with the Coordinating Centre to develop and deliver an implementation plan to move to the new national online platform. Engage with delivery organisations to pilot and roll out the new national online platform.

## Strengthen careers for research delivery staff and under-represented disciplines and specialisms

- Create and deliver a regional workforce strategy that seeks to create capacity & capability across the research delivery workforce in a range of specialties and settings and is inclusive of all roles and professions.
- Engage with senior leadership across the region to increase inclusion of research delivery as part of nurse, midwife and allied health professional roles.
- Undertake a gap analysis to identify the future needs of the research delivery workforce in response to advancements in research study design and delivery to be ready and able to deliver studies of the future.

## Expand our work with the life sciences industry to improve health and economic prosperity

- Facilitate the successful adoption and implementation of the national locations for research app  (Government Priority Project 2) within South Central delivery organisations across primary and secondary care.
- Work with delivery organisations to identify their portfolio monitoring and reporting requirements to enable their understanding of and engagement with UK Clinical Research Delivery (UKCRD) metrics.
- Create bespoke self service business intelligence tools to facilitate delivery organisations access to timely, accurate portfolio data to underpin their understanding and engagement with UKCRD programme metrics.
- Work with delivery organisations at an individual and regional level across both primary and secondary care to identify strategic growth or investment opportunities aligned to commercial pipeline intelligence and analysis of current capacity and capabilities.

University Hospital Southampton
NHS Foundation Trust

| Agenda Item 7.2 | Report to the Trust Board of Directors, 13 May 2025 |
|---|---|
| **Title:** | Register of Seals and Chair's Actions Report |
| **Sponsor:** | Jenni Douglas-Todd, Trust Chair |
| **Author:** | Craig Machell, Associate Director of Corporate Affairs |

**Purpose**

| (Re)Assurance | Approval | Ratification | Information |
|---|---|---|---|
| | | x | |

**Strategic Theme**

| Outstanding patient outcomes, safety and experience | Pioneering research and innovation | World class people | Integrated networks and collaboration | Foundations for the future |
|---|---|---|---|---|
| | | | | x |

**Executive Summary:**

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.

The Board has agreed that the Chair may undertake some actions on its behalf.

This report includes retrospective items 1.1-1.4, not previously received due to an issue with the DocuSign system.

The report provides compliance with The NHS Foundation Trust Code of Governance (probity, internal control) and UHS Standing Financial Instructions and Scheme of Delegation.

**Contents:**

Report

**Risk(s):**

N/A

| Equality Impact Consideration: | N/A |
|---|---|

## 1 Chair's Actions

The Board has agreed that the Chair may undertake some actions on its behalf. The following action has been undertaken by the Chair.

1.1 **Variation Agreement** for Updating Sub-contracts with Spire Healthcare for 2 years and 9 months at a total cost of £13,992,871, excluding VAT (exempt). Signed by the Chair on 18 March 2024.

1.2 **Variation to Contract** for Cleaning and Catering Costs to Serco Ltd for 12 months, to reflect variable charges now incorporated into the annual contract review, at a total cost of £17,460,402 excluding VAT. Signed by the Chair on 11 June 2024.

1.3 **Award of Contract** for the supply of natural Gas to Southampton General Hospital and Princess Anne Hospital to Total Gas and Power Limited, for 12 months at a total cost of £6,899,750 excluding VAT. Signed by the Chair on 18 July 2024.

1.4 **Sub-contract** between Spire Southampton Hospital and University Hospital Southampton NHS Foundation Trust for the provision of clinical services for use with the NHS Standard Contract 2024-25. Signed by the Chair on 26 January 2025.

1.5 **Extension of Contract** for Bank/Agency Staff under the NHS Professionals Bankshare Agreement, for 12 months at a total cost of £41,876,995 excluding VAT. Signed by the Chair on 1 April 2025.

1.6 **Novation Agreement** between LST Partnerships LLP (trading as LST Projects) (Supplier), University Hospital Southampton NHS Foundation Trust (UHSFT) and UHS Estates Limited (UEL), relating an agreement for Neonatal Unit dated 3 October 2023 (Contract) and the transfer of UHSFT rights and obligations under the Contract to UEL with effect from 1 April 2025. Signed by the Chair on 6 May 2025.

1.7 **Novation Agreement** between Serco Limited (Supplier), University Hospital Southampton NHS Foundation Trust (UHSFT) and UHS Estates Limited (UEL), relating an agreement for Outsourced Facilities (Catering & Cleaning) dated 30 May 2017 (Contract) and the transfer of UHSFT rights and obligations under the Contract to UEL with effect from 1 April 2025. Signed by the Chair on 6 May 2025.

## 2 Signing and Sealing

2.1 **Agreement** between Desmond Allen Houston-Robb and Doreen Rosina May Houston-Robb (the Seller) and University Hospital Southampton NHS Foundation Trust (the Buyer) relating to sale and purchase of Garage 1 lying to the rear of 65/67 Laundry Road and Garage 2 to the rear of 57/57A Laundry Road conditional upon the Buyer's Works. Seal number 297 on 25 March 2025.

2.2 **TP1 Land Registry** between Desmond Allen Houston-Robb and Doreen Rosina May Houston-Robb (the Transferor) and University Hospital Southampton NHS Foundation Trust (the Transferee) relating to Garage 2 lying to the north of Laundry Road, Shirley. Seal number 298 on 25 March 2025.

2.3 **TP1 Land Registry** between University Hospital Southampton NHS Foundation Trust (the Transferor) and Desmond Allen Houston-Robb and Doreen Rosina May Houston-Robb (the Transferee) relating to 57/57A Laundry Road, Shirley. Seal number 299 on 25 March 2025.

2.4 **Renewal Lease** by Reference to an Existing Lease between Edward Ivan Bastian and Richard Wayne Bastian (the Landlord) and University Hospital Southampton NHS Foundation Trust (the Tenant) relating to Unit 7, Berrywood Business Village, occupied by South Central Regional Research Delivery Network as part of hosting arrangement and fully funded by the Department of Health and Social Care as an element of the hosting fee paid to UHSFT under the host contract. Seal number 300 on 25 March 2025.

2.5 **Duty of Care Deed** between Kone PLC (the Sub-Contractor), Willmott Dixon Construction Limited (the Contractor) and University Hospital Southampton NHS Foundation Trusts (the Beneficiary) relating to a new Sterile Services Facility and Aseptic Pharmacy and Offices at Adanac Park, Nursling, Southampton. Seal number 301 on 8 April 2025.

## 3 Recommendation

The Board is asked to ratify the Chair's actions and application of the seal.